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LEGISLATIVE PROPOSALS TO IMPROVE HEALTH CARE COVERAGE AND PROVIDE LOWER COSTS FOR FAMILIES

HEARING

BEFORE THE

COMMITTEE ON EDUCATION
AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

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LEGISLATIVE PROPOSALS TO IMPROVE HEALTH CARE COVERAGE AND PROVIDE LOWER COSTS FOR FAMILIES

Wednesday, March 1, 2017
House of Representatives
Committee on Education and the Workforce,
Washington, D.C.

The Committee met, pursuant to call, at 10:07 a.m., in Room 2175, Rayburn House Office Building, Hon. Virginia Foxx [chairwoman of the Committee] presiding.

Present: Representatives Foxx, Wilson of South Carolina, Roe, Thompson, Walberg, Guthrie, Barletta, Messer, Byrne, Brat, Grothman, Stefanik, Allen, Lewis, Rooney, Mitchell, Smucker, Scott, Davis, Courtney, Fudge, Polis, Bonamici, Adams, DeSaulnier, Norcross, Blunt Rochester, Krishnamoorthi, Shea-Porter, and Espaillat.

Staff Present: Bethany Aronhalt, Press Secretary; Andrew Banducci, Workforce Policy Counsel; Courtney Butcher, Director of Member Services and Coalitions; Ed Gilroy, Director of Workforce Policy; Jessica Goodman, Legislative Assistant; Callie Harman, Legislative Assistant; Nancy Locke, Chief Clerk; John Martin, Professional Staff Member; Dominique McKay, Deputy Press Secretary; James Mullen, Director of Information Technology; Michelle Neblett, Professional Staff Member; Krisann Pearce, General Counsel; Whitney Riggs, Professional Staff Member; Molly McLaughlin Salmi, Deputy Director of Workforce Policy; Alissa Strawcutter, Deputy Clerk; Tylease Alli, Minority Clerk/Intern and Fellow Coordinator; Austin Barbera, Minority Press Assistant; Michael DeMale, Minority Labor Detailee; Denise Forte, Minority Staff Director; Nicole Fries, Minority Labor Policy Associate; Christine Godinez, Minority Staff Assistant; Carolyn Hughes, Minority Senior Labor Policy Advisor; Udochi Onwubiko, Minority Labor Policy Counsel; Kiara Pesante, Minority Communications Director; Veronique Pluviose, Minority Civil Rights Counsel; and Elizabeth Watson, Minority Director of Labor Policy.

Chairwoman FOXX. The Committee on Education and the Workforce will come to order. Good morning. I apologize that we are a little bit late this morning. I like to honor people's time, and I am always mortified when we run a little late, but thank you for your patience.

We have a very distinguished panel of witnesses for today's hearing. Thank you for taking the time to be with us and sharing your personal expertise on a very important issue affecting the lives of millions of Americans across the country.

"It's in a death spiral." That is how Aetna's chief executive, Mark Bertolini, recently described the Democrats' failed healthcare law. Citing higher premiums and insufficient enrollment among young, healthy individuals, Mr. Bertolini predicted that more insurers will quit ObamaCare next year. When they do, as they have done year after year, families will find it even harder to access the doctors they want and the affordable coverage they need.

A death spiral. That is the honest assessment of someone who has looked closely at the facts and who cannot ignore reality. Of course, there are those who are still living in an alternate reality, and they are trying desperately to protect a law that is wreaking havoc on families and small businesses across the country.

Powerful special interest groups are peddling scare tactics and doing all they can to defend the status quo. One prominent organization in particular is promoting a manual that includes tips on how to disrupt town halls. The manual recommends to "grab seats at the front half of the room, but do not all sit together" in order to "reinforce the impression of broad consensus." It even asks the activists to boo Republican members of Congress.

All these desperate tactics are aimed at protecting a failed law that has resulted in nearly 5 million Americans losing the health care they like and were promised they could keep.

A failed law that has left millions of Americans with access to just one insurance provider. A failed law that has caused countless families to lose access to the doctors they trusted.

A failed law that has forced healthcare costs to skyrocket and destroyed hundreds of thousands of small business jobs.

Ultimately, they are fighting to maintain government control, government control over the kind of health insurance you can buy. Government control over the kind of health insurance employers can and cannot offer workers. Government control over the doctors you can see and the doctors you cannot see, and government control over certain healthcare benefits that many individuals may not need.

Yet, despite the costs and pain inflicted on so many Americans by ObamaCare, the answer for some is still more government control. We believe there is a better way, and that is what the legislative proposals we will discuss today are all about.

We believe patients, not Washington bureaucrats, should be in charge of their healthcare decisions. We believe employers should have more choices, not fewer, to provide their workers with access to affordable coverage. We believe small businesses should be empowered to negotiate for the best coverage at the best possible price for their employees.

I expect the sponsors and our witnesses will discuss in greater detail the specifics of each legislative proposal, but all three are designed to promote more choices, more flexibility, greater access, and lower costs. That is exactly what the American people want and need.

We are at a crossroads right now when it comes to our Nation's health care. When people, through no fault of their own, are experiencing pain and havoc created by the ObamaCare death spiral, the only responsible thing to do is provide relief. We simply cannot continue down the unsustainable path we are on and sit back and watch as this fundamentally flawed law collapses under its own weight.

We must change course. That is why House Republicans are on a rescue mission not only to save families struggling under ObamaCare, but also to deliver the meaningful healthcare reforms the American people have demanded for years.

Today, we are taking an important step in this process by examining a number of commonsense solutions that will help more Americans access high-quality, affordable health care.

I want to thank my colleagues, HELP Subcommittee Chairman Tim Walberg and Representative Phil Roe, as well as a former member of this committee, Representative Sam Johnson, for their leadership on several of the reforms we will discuss today.

We have a lot of ground to cover. So, I now yield to Ranking Member Scott for his opening remarks.

Fast Facts: Obamacare Reality

- Premiums increased by an average of 25% this year.
- Starting in 2014, at least 4.7 million Americans have been kicked off their health care plans.
- 300,000 small business jobs destroyed.
- An estimated 10,000 small businesses were forced to close because of Obamacare.

[The statement of Chairwomen Foxx follows:]

Prepared Statement of Hon. Virginia Foxx, Chairwoman, Committee on Education and the Workforce

"It's in a death spiral." That's how Aetna's chief executive Mark Bertolini recently described the Democrats' failed health care law. Citing higher premiums and insufficient enrollment among young, healthy individuals, Mr. Bertolini predicted that more insurers will quit Obamacare next year. When they do—as they've done year after year—families will find it even harder to access the doctors they want and the affordable coverage they need.

A death spiral. That's the honest assessment of someone who has looked closely at the facts and who can't ignore reality. Of course, there are those who are still living in an alternate reality, and they are trying desperately to protect a law that is wreaking havoc on families and small businesses across the country.

Powerful special interest groups are peddling scare tactics and doing all they can to defend the status quo. One prominent organization in particular is promoting a manual that includes tips on how to disrupt town halls. The manual recommends to "grab seats at the front half of the room, but do not all sit together" in order to "reinforce the impression of broad consensus." It even asks activists to boo Republican members of Congress.

All of these desperate tactics are aimed at protecting a failed law that has resulted in nearly 5 million Americans losing the health care they liked and were promised they could keep. A failed law that has left millions of Americans with access to just one insurance provider. A failed law that has caused countless families to lose access to the doctors they trusted. A failed law that has forced health care costs to skyrocket and destroyed hundreds of thousands of small business jobs.

Ultimately, they are fighting to maintain government control; government control over the kind of health insurance you can buy; government control over the kind of health insurance employers can and cannot offer workers; government control over the doctors you can see and the doctors you can't see; and government control over certain health care benefits that many individuals may not need.

Yet, despite the costs and pain inflicted on so many Americans by Obamacare, the answer for some is still more government control. We believe there is a better way, and that is what the legislative proposals we will discuss today are all about.

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I expect the sponsors and our witnesses will discuss in greater detail the specifics of each legislative proposal, but all three are designed to promote more choices, more flexibility, greater access, and lower costs. That's exactly what the American people need.

We are at a crossroads right now when it comes to our nation's health care. When people—through no fault of their own—are experiencing pain and havoc created by the Obamacare death spiral, the only responsible thing to do is provide relief. We simply cannot continue down the unsustainable path we are on and sit back and watch as this fundamentally flawed law collapses under its own weight.

We must change course. That's why House Republicans are on a rescue mission not only to save families struggling under Obamacare, but also to deliver the meaningful health care reforms the American people have demanded for years. Today, we are taking an important step in this process by examining a number of commonsense solutions that will help more Americans access high quality, affordable health care.

I want to thank my colleagues—HELP Subcommittee Chairman Tim Walberg and Representative Phil Roe—as well as a former member of this committee, Representative Sam Johnson—for their leadership on several of the reforms we will discuss today.

Mr. SCOTT. Thank you, Madam Chair, and I would like to welcome our witnesses and thank them for their testimony. In this hearing, we will discuss three legislative proposals that will weaken insurance protections for consumers and shift costs on to workers.

The title, "Legislative Proposals to Improve Health Care Coverage and Provide Lower Costs for Families," insinuates the goal of these proposals is to reduce costs for families. In fact, these bills will lower costs for only a lucky few while others will pay more.

Let us be clear. This hearing is a distraction from the larger debate about the future of America's health care. Across the country millions of people are lining up in town halls and expressing their deep concern over the Republicans' reckless attempts to repeal the *Affordable Care Act*.

I think it is important to remind people what the situation was before the *Affordable Care Act* passed. Costs were going through the roof. Those with preexisting conditions could not get insurance or, if they did, it was unaffordable. Women were paying more than men, and every year, millions of people were losing their insurance.

Since the passage of the *Affordable Care Act*, the costs have continued to go up, but at the lowest rate in about 50 years. Those with preexisting conditions can get insurance at the standard rate. Women are not paying more than men. Instead of millions of people losing their insurance every year, 20 million more people have insurance.

The full name of the *Affordable Care Act* is "Patient Protection and Affordable Care Act." There are patient protections, like insurance companies cannot cut you off after they have paid a certain amount over your lifetime. We are closing the doughnut hole. Those young people up to 26 can stay on their parents' policies; prevention and cancer screening; annual checkups; no co-pays and deductibles.

We have heard a lot of complaints about the so-called "failed law," but one thing that is conspicuously absent is any proposal that will make things any better.

The Republican draft proposal leaked just last week shows the concerns about whether or not there is a replacement plan are well founded. To whatever extent the plan has any direction in replacement efforts, it is in the wrong direction.

It is not clear whether or not the leaked draft is the proposal that the majority intends to move forward, but Republicans have yet to communicate any concrete timetable for action and, in fact, have already missed their own legislative deadline directed by the recent budget. Their plans were supposed to have been available over a month ago.

For seven years, we have heard calls for repeal, but no concrete proposal to replace. We have heard a lot of complaints about the *Affordable Care Act*, but no concrete proposal or idea to make things better.

If this leaked draft is any indication of priorities, one thing is clear, and that is the proposals will push more costs on to working families, seniors, and average Americans, and, at the same time, we are considering tax breaks for corporations and the wealthy.

There is one proposal to dismantle Medicaid. Most of the funding under Medicaid goes to the elderly and those with disabilities, the rest to low-income families.

Another idea includes taxing workers' health insurance policies, which has the effect of funding tax breaks for corporations and the wealthy. That is right. One proposal to tax workers' health care

while, at the same time, we are considering tax breaks for those making more than $200,000 a year.

One of the proposals we will be discussing today expands Association Health Plans, a recycled idea from about 20 years ago that has been widely discredited as possibly doing nothing for most Americans. While a few might pay less, a lot will pay more.

In 2000, the Congressional Budget Office found the proposal would have little effect on increasing health coverage. Researchers, including the American Academy of Actuaries, have expressed concern that Association Health Plans lead to market segmentation, where a few healthy people may be better off as long as they stay healthy, while older and less healthy workers will be left out in the cold.

In a press release back in 2003, the academy categorized the legislation as flawed because it was neither actuarially sound nor did it protect consumers. These flaws are still present in the idea today.

For example, a small business owner who is older and perhaps has struggled with mental or physical illness in the past with a so-called "preexisting condition," may not be an attractive partner for the association, so they will not get in. Proposals like this allow for cherry-picking to serve only the healthy at lower cost and accessible only to those that need it while everybody else will pay more.

The problem is simple arithmetic. Under the *Affordable Care Act*, essentially everybody pays the average. If you have a scheme where some people can pay less, then other people necessarily will have to pay more. That is just simple arithmetic.

The second proposal insulates stop-loss insurance from certain Federal oversight. It is unclear how this does anything to help workers get quality health insurance. It might help the employers mitigate risk with their questionable implications for both employers and workers, particularly when smaller businesses decide to self-insure.

If anything, the committee should look into making sure businesses and workers are being protected in the variety of new health insurance arrangements that have arisen over the past few decades.

The third proposal allows workplace wellness programs to circumvent protections under the *Americans With Disabilities Act* and the *Genetic Information Nondiscrimination Act*. Because wellness programs can carry large financial penalties, this legislation makes it easier for workplace wellness programs to penalize people who do not want to divulge information that may be medically sensitive or genetic information, and, therefore, if they do not give it up, they may be penalized, and that would undermine key workplace civil rights.

This is just another policy that will harm sicker and older people, including those who have disabilities that may not be readily noticeable, and they may not want to divulge.

A range of consumer and disability groups, including AARP, have been vocal supporters of ensuring that important civil rights protections remain in place in workplace wellness programs. Wellness programs if done correctly have the potential to benefit both work-

ers and employers. There is no compelling reason to subvert civil rights laws and protections to administer them.

So we will hear about some of these ideas that we know do not work, will not do anything to protect millions of Americans who now benefit from the ACA. As we discuss these legislative proposals, let us not lose sight of the larger debate that continues to play out in town halls and the need for constituents who are so vocal in expressing their fears.

We hope we can refocus our efforts on the financial security of American families by making sure we improve health care instead of revisiting policies that do little more than shift costs on to the American worker and families, and make sure that before we repeal anything, that a replacement is ready to go. And if you can come up with a replacement that is better than the *Affordable Care Act*, I commit today to support it. I do not think such a plan exists because if it did exist, we would have seen it by now.

In any case, Madam Chair, I thank you for having the hearing, and look forward to the testimony of the witnesses.

[The statement of Mr. Scott follows:]

Prepared Statement of Hon. Robert C. "Bobby" Scott, Ranking Member, Committee on Education and the Workforce

I would like to welcome our witnesses and thank them for their testimony. This hearing will discuss three legislative proposals that will weaken insurance protections for consumers and shift costs onto workers. While the title insinuates that the goal of these proposals is to reduce costs for families, in truth, these bills will lower costs for only a lucky few, at the expense of others.

But let's be clear. This hearing is a distraction from a larger debate about the future of America's health care. All across the country, millions of people are lining up in town halls and expressing their deep concern over Republicans' reckless attempts to repeal the *Affordable Care Act*.

A Republican draft health care proposal leaked just last week shows these concerns are well founded. Insofar as the Republicans have any direction on their replacement efforts, it is the wrong direction. Now, it is not clear whether or not this leaked draft is the proposal the Majority intends to move forward. Republicans have yet to communicate any concrete timetables for action and have missed their own legislative deadlines by more than a month.

But, for seven years we have heard calls for repeal. We've heard a lot of complaints about the *Affordable Care Act*, but every proposal or idea we have heard from the Majority fails to make things better. But, if this leaked draft is any indication of their priorities, one thing is becoming increasingly clear. The Majority's vision for health care in America is to push more costs onto working families, seniors, and average Americans, while giving bigger breaks to corporations and the wealthy.

This means dismantling Medicaid, which primarily provides funding for the elderly and those with disabilities. And their ideas include taxing workers' health insurance to foot the bill for big tax breaks for the wealthy. That's right – the leaked proposal includes a provision allowing workers' health insurance to be taxed so that a current tax on high-income earners, those making over $200,000, can be repealed.

The Majority believes that affordable, quality health care is a privilege reserved for the young, healthy, and wealthy – not a right for all Americans.

The three legislative proposals being discussed today reflect this belief. One of these proposals expands association health plans, a recycled idea from nearly 20 years ago that has been widely discredited as doing nothing but accelerating a race to bottom for health coverage at the expense of both workers and employers. In 2000, the Congressional Budget Office found that the proposal would have little effect on increasing health coverage. Researchers, including the American Academy of Actuaries, have expressed concern that association health plans lead to market segmentation, where a few healthy people may be better off – so long as they stay healthy – while older and less healthy workers and employers are left out in the cold. In a press release back in 2003, the Academy characterized the legislation as "flawed" because it is neither actuarially sound nor does it protect consumers. These flaws are still present in the idea today. For example, a small business owner who

is older or who perhaps has struggled with a mental or physical illness in the past will not be a very attractive partner for an association. Proposals like these that allow for cherry picking only serve to make health coverage less affordable and accessible for those who need it the most.

The second proposal insulates stop-loss insurance from certain federal oversight. It is unclear to me how this does anything to help workers get quality health insurance. While stop-loss can help self-insured employers mitigate risk, there are questionable implications for both employers and workers, particularly when smaller businesses decide to self-insure. If anything, perhaps the Committee can look into making sure businesses and workers are being protected in the variety of new health insurance arrangements that have arisen over the past few decades.

The third proposal allows workplace wellness programs to circumvent the protections in the *Americans With Disabilities Act* and the *Genetic Information Nondiscrimination Act*. Because wellness programs can carry large financial penalties, this legislation makes it easier for workplace wellness programs to penalize people who are not comfortable divulging sensitive medical or genetic information, undermining key workplace civil rights. This is yet another policy that will harm sicker and older people, including those who have disabilities that may not be readily noticeable. A range of consumer and disability groups, including AARP, have been vocal supporters of ensuring that important civil rights protections remain in place in workplace wellness. While wellness programs – if done correctly – have the potential to benefit both workers and employers, there is no compelling reason to subvert civil rights laws and protections to administer them.

So today we will hear about some ideas that frankly just won't work or won't do anything to protect the millions of Americans who now benefit from the ACA.

As we discuss these legislative proposals, let's not lose sight of the larger debate that we will continue to play out in town halls and the needs of our constituents who are so vocally expressing their fears. I hope that we can refocus our efforts on the financial security of American families by working to improve health care, instead of revisiting policies that do little more than shift costs onto American working families. Thank you.

Chairwoman FOXX. Thank you very much, Mr. Scott.

Pursuant to Committee Rule 7(c), all members will be permitted to submit written statements to be included in the permanent hearing record. And without objection, the hearing record will remain open for 14 days to allow such statements and other extraneous material referenced during the hearing to be submitted for the official hearing record.

We now turn to introductions of our distinguished witnesses. Ms. Allison Klausner is a principal at Conduent Human Resources Service, and serves as the government relations leader for the Knowledge Resource Center, where she focuses on human resources and employee benefits. She will testify on behalf of the American Benefits Council.

Ms. Lydia Mitts is associate director of Affordability Initiatives at Families USA, specializing in health system improvement issues.

Mr. Jay Ritchie is executive vice president of Tokio Marine HHC, and has 20 years of experience in insurance underwriting and management. He will testify on behalf of the Self-Insurance Institute of America.

Mr. Jon Hurst is the president of Retailers Association of Massachusetts. He will testify on behalf of the National Retail Federation.

I now ask our witnesses to raise your right hand.

[Witnesses sworn.]

Chairwoman FOXX. Let the record reflect the witnesses answered in the affirmative.

Before I recognize each of you to provide your testimony, let me briefly explain our lighting system. We allow five minutes for each witness to provide testimony. When you begin, the light in front of you will turn green. With one minute left, the light will turn yellow. At the five-minute mark, the light will turn red, and you should wrap up your testimony. Members will each have five minutes to ask questions.

I now will recognize Ms. Allison Klausner for five minutes.

TESTIMONY OF ALLISON KLAUSNER, PRINCIPAL AND GOVERNMENT RELATIONS LEADER, KNOWLEDGE RESOURCE CENTER, CONDUENT HUMAN RESOURCES SERVICES, TESTIFYING ON BEHALF OF THE AMERICAN BENEFITS COUNCIL

Ms. KLAUSNER. Hello. My name is Allison Klausner, and I am a principal and government relations leader of the Knowledge Resource Center at Conduent Human Resources Service.

It is my honor to testify today on behalf of the American Benefits Council, of which Conduent is a member, and I am the chair of the Policy Board of Directors.

Collectively, the council's members either sponsor directly or provide services to health and retirement plans that cover more than 100 million Americans. Many of the council's members are at the forefront of the workplace wellness revolution, developing programs to help employees and their families enjoy healthier and more productive lives.

Employer-sponsored benefit plans are designed with the express purpose of giving each employee the opportunity to achieve personal health and financial well-being. This well-being serves as the foundation for employees to receive optimal performance and productivity, and, in turn, drives successful organizations.

For these reasons, in recent years, employers of all sizes have increasingly been designing and implementing wellness programs. This has helped to make wellness an area of tremendous promise for the future of health care and employer-sponsored benefits.

Despite the growing popularity of employer-sponsored plans, I believe the future of these valuable programs are at risk due to the inconsistent regulatory framework that applies to them.

My testimony today will address this problem, and will provide recommendations for creating a consistent regulatory framework.

In my role at Conduent, I have significant exposure to innovative wellness programs that employers are developing. I also have great insight into the chilling effects that recent regulations issued by the EEOC and the lack of consistent Federal policy have on employer sponsorship of these programs.

In 2010, Congress effectively codified as part of the *Affordable Care Act* the longstanding wellness program regulatory framework under HIPAA. Despite this explicit congressional support of the HIPAA wellness program rules, employers are nevertheless subject to inconsistent Federal regs when it comes to wellness program design and operation. The inconsistency is most recently the result of the regulations relating to wellness finalized by the EEOC.

These recently finalized rules under Title II of GINA and the *Americans With Disabilities Act* are not consistent with the well-

established employee protective wellness program regulatory framework under HIPAA.

As a result, many wellness programs already subject to HIPAA may now also be subject to incongruent and competing regulations under GINA and the ADA.

In addition, many wellness programs that are not subject to HIPAA, which are highly beneficial, such as diabetes management programs, may now be subject to these EEOC requirements. These requirements are so burdensome that employees may lose access to them if employers conclude they are no longer able to offer them.

The development and implementation of these programs requires a substantial investment of financial, intellectual, and human capital on the part of employers. Unfortunately, the need to comply with the inconsistent regulatory framework under HIPAA, GINA, and the ADA has caused many employers to take a step back or to pause in their implementation of innovative wellness programs. This, in turn, will weaken the positive steps and impact that wellness programs can have on employees, employers, and long-term health costs.

I believe the committee can take steps to develop a consistent regulatory policy for wellness programs. In this regard, I do appreciate the prior work of this committee in introducing H.R. 1189, the *Preserving Employee Wellness Programs Act*.

This act clarifies that wellness programs that do comply with HIPAA and the *Affordable Care Act* would not violate the ADA or GINA merely by offering an award, an important move towards consistent Federal policy.

Since the introduction of the act, the EEOC issued its wellness regulations under the ADA and GINA. We encourage the committee to reintroduce the act with certain modifications to address the inconsistencies introduced by the EEOC rules.

First, we suggest modifying the act to provide that wellness programs that are subject to and comply with the HIPAA wellness rules are deemed to comply with the ADA and GINA if they offer awards that comply with the limits imposed on health contingent programs under HIPAA.

Second, we recommend modifying the act to provide that wellness programs that are not subject to HIPAA wellness regs are deemed to comply with the ADA and GINA if they offer awards that comply with the limits imposed on health contingent programs under HIPAA.

Third, we believe the act should state that wellness programs that provide for more favorable treatment of individuals with adverse health factors, such as diabetes management programs, are deemed to comply with the ADA and GINA.

Fourth, we suggest modifying the act to provide that the collection by a wellness program of information about the manifested disease or disorder of a family member should not be considered an unlawful acquisition of genetic information with respect to another family member, and should not violate GINA. This would enable employers to provide spouses and children with the same important wellness programs they offer employees.

I want to thank you for your interest in employer-sponsored wellness programs. I appreciate the opportunity to testify, and the

council and I look forward to working with you to enact commonsense reforms and restore certainty to employers who are focusing on improving the health of their workforces by creating a consistent Federal policy for employer-sponsored wellness programs.

[The statement of Ms. Klausner follows:]

AMERICAN BENEFITS COUNCIL

TESTIMONY OF

ALLISON R. KLAUSNER,
PRINCIPAL, GOVERNMENT RELATIONS LEADER
KNOWLEDGE RESOURCE CENTER
CONDUENT HUMAN RESOURCE SERVICES

ON BEHALF OF THE

AMERICAN BENEFITS COUNCIL

BEFORE THE

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON EDUCATION AND THE WORKFORCE

HEARING ON "LEGISLATIVE PROPOSALS TO IMPROVE HEALTH CARE COVERAGE AND PROVIDE LOWER COSTS FOR FAMILIES"

MARCH 1, 2017

My name is Allison Klausner, and I am a Principal and Government Relations Leader of the Knowledge Resource Center at Conduent Human Resource Services. I am testifying today on behalf of the American Benefits Council (the "Council"), of which Conduent is a member. I am also the Chair of the Council's Policy Board of Directors.

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to health and retirement plans that cover more than 100 million Americans. Many of the Council's members are at the forefront of the workplace wellness revolution, developing programs to help employees and their families enjoy healthier and more productive lives.

As stated in the Council's public policy strategic plan, *A 2020 Vision: Flexibility and the Future of Employee Benefits*,[1] employer-sponsored benefit plans are designed with the express purpose of giving each employee the opportunity to achieve personal health and financial well-being. This well-being serves as the foundation for employees to achieve optimal performance and productivity and, in turn, drives successful organizations.

The Council has asked me to testify on its behalf because, in my role as Principal and Government Relations Leader at Conduent's Knowledge Resource Center, I have extensive experience helping my organization and its employer clients understand and navigate important legislative and regulatory developments related to employee benefits, including wellness programs. In my role at Conduent, I not only have significant exposure to the innovative wellness programs that employers are developing for their employees, but I also have great insight into the chilling effects that recent regulatory developments in the wellness field continue to have on employer sponsorship of wellness programs. In addition, in my prior role as Assistant General Counsel at Honeywell International Inc., I experienced firsthand the difficulties that can arise for employers and their employees when there is a lack of consistent federal policy on important issues such as employer-sponsored wellness programs.

We applaud Congress for having worked on a bipartisan basis to craft the wellness provisions in the Patient Protection and Affordable Care Act ("PPACA") that built on the existing framework created in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). PPACA's bipartisan wellness provisions increased employer flexibility in designing programs to improve the health of employees and their families. Additionally, it recognized the important role of wellness programs as a cornerstone of health reform.

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[1] http://www.americanbenefitscouncil.org/newsroom/2020vision.cfm.

As I will discuss today, the future of workplace wellness programs remains at risk. Despite explicit Congressional support of wellness programs in recent years (for example, through PPACA's codification of the HIPAA framework), employers continue to face complex and inconsistent regulations for the design and administration of these programs, most recently as the result of regulations relating to wellness programs finalized by the U.S. Equal Employment Opportunity Commission ("EEOC").

The Council's public policy strategic plan, *A 2020 Vision: Flexibility and the Future of Employee Benefits*, notes that "[a] critical component of encouraging employers to offer meaningful wellness programs is consistent federal policy that promotes the health of Americans and is aligned across multiple agencies and Congress." Unfortunately, the EEOC's recently finalized rules, which address the application of Title II of the Genetic Information Nondiscrimination Act ("GINA") and Title I of the Americans with Disabilities Act ("ADA") to wellness programs, are not consistent with the well-established and employee-protective wellness program regulatory framework under HIPAA.

The result is that many wellness programs already subject to regulation under HIPAA may now also be subject to incongruent and competing regulations under Title II of GINA and the ADA. In addition, many wellness programs that are not subject to HIPAA, but which are highly beneficial - such as healthy mother/healthy baby and diabetes management programs - may now be subject to rules so burdensome that employees may lose access to these programs where employers conclude they are no longer able to offer such programs.

My testimony will describe the current state of employer-sponsored wellness programs and how they benefit employees. Not only are these programs important for achieving better health outcomes for employees and their families, they also have the potential to increase employee productivity, improve workforce morale and engagement and reduce health care spending. The bulk of my data is drawn from Conduent's 2016 survey report, Working Well: A Global Survey of Workplace Wellbeing Strategies,[2] which represents the views of 428 employer respondents based in 33 countries, including 187 respondents in the United States alone.

I will also explain how the inconsistent and unnecessarily complex federal regulatory landscape is adversely affecting employers' wellness initiatives. I will close with suggestions for how the Committee may be able to alleviate the problem as it considers any future legislation.

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[2] Conduent Human Resource Services, Working Well: A Global Survey of Workforce Wellbeing Strategies (2016).

WHAT IS A WELLNESS PROGRAM?

HealthCare.gov defines a wellness program[3] as "a program intended to improve and promote health and fitness that's usually offered through the work place, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships, and other incentives to participate. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs, and preventative health screenings."

As we study wellness at Conduent, with the benefit of a broad range of employer experience, we have learned to subdivide wellness strategies into three distinct phases.

Wellness 1.0 demonstrates a focus on general health promotion and prevention activities, such as fun runs, competitions, and health risk appraisals, and some programs designed to support behavioral changes, such as tobacco cessation.

Wellness 2.0 incorporates rapid adoption of health risk appraisals and biometric screenings to assess the health of the covered population. These more advanced approaches are increasingly integrated with employee assistance programs ("EAPs")[4] and/or disease management programs, often leveraging portals and tracking of incentives with appropriate privacy and security safeguards. External (often financial) incentives are more frequently used to motivate participation in various activities, sometimes with the goal of meeting defined clinical outcomes.

Wellness 3.0, the most advanced approach to wellness, encompasses a broader focus on *overall* well-being, including a more holistic view and integrated approach to supporting employees in their health, wealth and careers, with employers taking a shared responsibility for well-being as part of a compelling value proposition for employees. While external incentives are often still used, Wellness 3.0 relies on the development of intrinsic incentives/motivators and the value a supportive company culture and workplace environment can play in behavior change, leveraging newer personal engagement methods such as social media, gamification, mobile technology, automated coaching, and personalized challenges. Very often, these programs are extended more fully to the family and sometimes to the community at large.

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[3] See https://www.healthcare.gov/glossary/wellness-programs/.

[4] According to the IFEBP, an EAP is an "employment-based program designed to assist in the identification and resolution of a broad range of employee personal concerns that may affect job performance. These programs deal with situations such as substance abuse, marital problems, stress and domestic violence, financial difficulties, health education and disease prevention. The assistance may be provided within the organization or by referral to outside resources. Also called an employee assistance plan." International Foundation of Employee Benefit Plans, Benefits and Compensation Glossary, 12th Edition, 185 (2010).

This holistic approach is consistent with the Council's *2020 Vision*, in which we posit that health and retirement benefits will no longer be considered in separate silos, but instead focused on the concept of "personal health and financial well-being," encompassing physical and mental health as well as financial security, both when actively employed and in retirement.

To start on this path, employers have developed a variety of wellness program designs. The most recent Conduent survey lists the following health promotion/wellness components, from most prevalent to least prevalent, in the United States:

1. Employee Assistance Program (EAP)
2. On-site immunizations/flu shots
3. HR policies (e.g., flexible work schedules)
4. Regular communications (e.g., online mailings, posters)
5. Health risk appraisal (health and lifestyle questionnaire)
6. Nurse line or other health decision phone support
7. Biometric health screenings (such as blood pressure, cholesterol, glucose, body fat)
8. Ergonomic adaptations and awareness
9. Work/life balance support (e.g., legal, financial services, elder or child care support)
10. Telephonic chronic disease management support or coaching

The fastest-growing wellness programs in the United States include:

1. Telephonic physician support (telemedicine services)
2. Cycle-to-work program
3. On-site healthy lifestyle programs and coaching (e.g., nutrition, weight loss, stress reduction, smoking cessation)
4. Personal health record (electronic summary of personal health information)
5. On-site medical facility

Some wellness program designs include a reward or incentive element to encourage participation in wellness programs, increase overall participation, and inspire employees to strive for healthy results. Ninety percent of U.S. employers with wellness programs responding to the Conduent survey currently offer incentives, including rewards, penalties, or both, to encourage participation in wellness initiatives. The most common activities for which incentives are offered include the completion of a health risk appraisal or biometric screening, or participation in tobacco cessation programs or workplace health "challenges" (such as walking).

Incentives most frequently take the form of gift cards, travel, merchandise or cash awards, although some employers offer reduced premium cost-sharing or lower deductibles, or provide for additional employer contributions to an account-based arrangement (such as employer flex credit contributions to health flexible spending arrangements or employer contributions to Health Savings Accounts or health reimbursement arrangements.)

According to *The Wall Street Journal*, studies have shown that wellness program participation rates can be increased from 40 percent without an incentive to more than 70 percent with a $200 incentive and to 90 percent when incentives are built into health-plan premiums or deductibles.[5]

While incentives can be tied to participation, wellness programs may also be designed to link receipt of the incentive to the achievement of a specific health outcome. For example, a survey by Aon Hewitt found that 58% of responding employers offer incentives for completion of a lifestyle modification program (*e.g.*, participating in a smoking cessation or weight loss program), and approximately 25% offer incentives for progress toward or attainment of a specified health goal (*e.g.*, improved blood pressure, BMI, blood sugar or cholesterol).[6]

A company's wellness strategy is dictated not only by its choice of programs but also by its participant scope. Our survey found that 69 percent of programs include spouses, 56 percent include domestic partners and 42 percent include children. Our survey also found that 23 percent of responding firms offer wellness programs to their retirees.

Additionally, as suggested in the Council's 2015 testimony[7] before the Senate Health, Education, Labor and Pensions Committee, delivered by Catherine Baase, Chief Medical Officer for The Dow Chemical Company, population health is best achieved with business strategies that address employees as well as the community. Consistent with the Center for Disease Control and Prevention's "Health in All Policies" efforts, the worksite is a critical venue to address health needs and health improvement.

WHY WELLNESS?

The development and implementation of a wellness strategy requires substantial financial, intellectual and human capital on the part of employers. This investment is made with the goal to improve employee well-being, increase productivity and lower

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[5] Michael P. O'Donnell, Should Employees Get Insurance Discounts for Completing Wellness Programs?, *Wall Street Journal*, Feb. 18, 2013, at R5.

[6] Aon Hewitt, 2012 Health Care Survey (2012).

[7] See http://www.help.senate.gov/imo/media/doc/Baase2.pdf.

long-term health costs.

While "improving performance and productivity" is cited as the most important wellness program objective to U.S. employers (with 83 percent of respondents calling it "very important" or "extremely important"), these programs hold the promise of more direct economic benefits under the principle that successful preventive actions, better-managed chronic conditions and fewer episodes of care will result in reduced health service utilization and fewer claims.

The potential for cost savings is particularly appealing to U.S. employers, with 76 percent of respondents in the United States telling Conduent that "reducing health care or insurance costs" is "very important" or "extremely important." While measurement is still inconsistent even among program sponsors, 24 percent of employers told us that their wellness program had an impact on their population's health care trend rate, and 67 percent of those respondents reported a trend rate reduction of two percent or more. The potential of wellness programs to reduce costs is particularly important for employer health plan sponsors as they assess the impact of the PPACA's 40 percent excise tax on "high-cost" plans on their health benefits coverage.[8] Although the effective date of the tax is delayed until 2020, employers continue to model its impact on their plans and consider and implement changes to health benefits coverage to help avoid the tax.

A RAND Employer Survey[9] examining wellness program outcomes, sponsored by the U.S. Department of Labor, found that while it is not clear at this point whether improved health-related behavior will translate into lower health care cost, there is reason to be optimistic. Fully 60 percent of respondents indicated that their wellness program reduced health care cost,[10] with reductions in inpatient costs accounting for 62 percent of the total cost reduction, compared to outpatient costs (28 percent) and prescription drug costs.[11]

The available evidence also supports the aspirational goals of wellness programs – like improving productivity, morale and safety. Data from the RAND survey shows 78 percent of responding employers stated that their wellness program has decreased absenteeism and 80 percent stated that it has increased productivity.[12] Likewise, 32 percent of respondents to a 2014 Mercer Survey said specifically that the health risks of

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[8] Code section 4980I imposes a 40 percent excise tax on "applicable employer-sponsored coverage" offered to an employee that exceeds specified statutory thresholds (For 2018, the thresholds are $10,200 for self-only coverage, and $27,500 for coverage other than self-only, subject to certain adjustments).

[9] RAND, Workplace Wellness Programs Study: Final Report (2013).

[10] Id at 53.

[11] Id at 57.

[12] Id at 53.

the population served by their wellness programs were improving.[13]

These results support published research findings that workplace wellness programs can improve health status, as measured with physiological markers (such as body mass index, cholesterol levels and blood pressure).[14] According to our data, 45 percent of responding employers were measuring specific outcomes from health promotion programs in 2016.

The evidence that workplace health promotion is effective continues to evolve, with employers and vendors making greater use of population strategies and evidence-based approaches. As they do, existing strategies will evolve correspondingly and adoption of new programs will grow.

THE CURRENT STATE OF EMPLOYER SPONSORSHIP OF WELLNESS PROGRAMS

The prospect of a healthier workforce has compelled a growing number of companies to develop and implement wellness strategies. As part of our 2014 study, we asked employers whether they had a wellness strategy. A full 65 percent of U.S. respondents indicated that they do have a wellness strategy. This 65 percent included 29 percent who said their strategy was fully implemented and another 31 percent who said their strategy was partially implemented. These results are consistent with other recent broad-based surveys from Willis,[15] SHRM[16] and The Families and Work Institute.[17]

The trend is particularly strong among large employers. According to the Kaiser Family Foundation's Employer Health Benefits 2016 Annual Survey,[18] 83 percent of large U.S. companies (with 200 or more workers), compared to 46 percent of smaller U.S. companies, offered at least one wellness program in 2014. Large firms are also more likely to offer financial incentives to employees for participating (42 percent vs. 14 percent).[19]

It is estimated that more than 75 percent of U.S. employees now have access to

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[13] Mercer, Taking health management to a new level (2014) via Sloan Center, *supra* note 2, at 3.

[14] RAND, *supra* note 10 at 61.

[15] Willis, The Willis Health and Productivity Survey Report (2015).

[16] SHRM, State of Employee Benefits in the Workplace - Wellness Initiatives (2013).

[17] Matos, K., & Galinsky, E., Families and Work Institute, 2014 National Study of Employers (2014).

[18] Kaiser Family Foundation, Employer Health Benefits 2016 Annual Survey - Health Risk Assessments, Biometric Screening and Wellness Programs 224 (2016).

[19] Id at 225.

wellness programs.[20]

The remarkable take-up of these programs by employers and employees, combined with the capacity and incentives for growth, make wellness an area of tremendous promise for the future of health care and employer-sponsored benefits. The Council believes that public policy should generally support private sector investment in wellness by giving all employers the flexibility to design these programs.

CHALLENGES WITH CURRENT PUBLIC POLICY

Employers applaud Congress for working on a bipartisan basis to craft the wellness provisions in the PPACA that built on the existing framework created in HIPAA. PPACA's bipartisan provision increased employer flexibility in designing programs to improve the health of employees and their families and reinforced wellness programs as a cornerstone of health reform.

A critical component of encouraging employers to offer meaningful wellness programs for the benefit of employees and their families is consistent federal policy with respect to the regulation of wellness programs. We appreciate the work of this Committee in introducing H.R. 1189, Preserving Employee Wellness Programs Act ("Act"). The Act included important clarification that wellness programs that comply with HIPAA and the PPACA would not violate the ADA or GINA merely by offering a reward - a step toward consistent federal policy.

Following the 2015 introduction of the Act, the EEOC issued regulations under Title II of GINA and the ADA governing wellness plans, which are inconsistent with HIPAA. The unnecessary burdens imposed on employers by multiple incongruent regulatory structures stifle adoption and innovation of wellness programs. We are concerned the future of workplace wellness programs is at risk. We encourage the Committee to consider approaches for alleviating these unnecessary regulatory burdens in any future legislation. We look forward to working with the Committee to achieve a consistent federal regulatory scheme for workplace wellness programs.

Legal Landscape

Wellness programs are subject to the jurisdiction of the Department of Labor ("DOL"), the Department of the Treasury ("Treasury"), the Department of Health and Human Services ("HHS"), and the EEOC via a range of federal statutes and regulations. Many states have laws governing wellness programs, as well. The discussion below sets

[20] Sloan Center on Aging & Work at Boston College, Fact Sheet 38: Health and Wellness Programs in the Workplace 1 (July 2014).

forth the basic federal legal framework applicable to the oversight of wellness programs. This is not intended to be an exhaustive discussion of all federal legal issues related to wellness programs but rather to provide a basis for understanding compliance and other issues employers face with regard to wellness programs.

Health Insurance Portability and Accountability Act of 1996

For years, wellness programs have been subject to extensive regulation by the DOL, HHS, and Treasury through the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 ("HIPAA"). HIPAA provides privacy and nondiscrimination protections to consumers in connection with group health plans.

Specifically, Titles I and IV of HIPAA added provisions to the Internal Revenue Code ("Code"), the Employee Retirement Income Security Act ("ERISA"), and the Public Health Service Act ("PHSA")[21] that generally prohibit group health plans and group health insurance issuers from discriminating against individuals in eligibility, benefits, or premiums based on a health factor, which includes, among other things, disability.[22] An exception to the general rule allows plans and issuers to provide premium discounts, rebates, and cost-sharing modifications in return for an individual's adherence to certain programs of health promotion and disease prevention, such as a wellness program.[23]

Final regulations issued by the DOL, HHS and Treasury to implement these provisions of HIPAA took effect in 2007, and imposed rules that certain wellness programs must satisfy in order to allow incentives to be provided to participants.[24] Programs that either do not require an individual to meet a standard related to a health factor in order to obtain a reward or that do not offer a reward at all ("participatory wellness programs") are not subject to the additional rules if participation in the program is made available to all similarly situated individuals.[25] Programs that require individuals to satisfy certain health factor standards in order to obtain a reward ("health-contingent wellness programs") must satisfy a host of requirements in order to

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[21] *See* Code § 9802, ERISA § 702, PHSA § 2705.

[22] *See* Code § 9802(a)-(b). Code § 9802(a)(1) identifies the following as health factors: (i) disability, (ii) health status, (iii) medical condition (including both physical and mental illnesses), (iv) claims experience, (v) receipt of health care, (vi) medical history, (vii) genetic information, and (viii) evidence of insurability (including conditions arising out of acts of domestic violence).

[23] Code § 9802(b)(2).

[24] Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75,014 (Dec. 13, 2006).

[25] *See* 26 C.F.R. § 54.9802-1(f)(2). Examples of participatory wellness programs include reimbursement of gym memberships, diagnostic testing that does not condition receipt of a reward on attainment of certain outcomes, and a program that reimburses employees for the costs of smoking cessation programs regardless of whether an employee stops smoking.

satisfy the HIPAA nondiscrimination rules.[26]

The requirements are intended to prevent discrimination in the use of incentives in connection with wellness programs based on a health factor such as disability. In particular, the requirements that a wellness program (1) "not be a subterfuge for discriminating based on a health factor, and not be highly suspect in method," and (2) the requirement that a "reasonable alternative standard (or waiver of the otherwise applicable standard)" be provided to individuals for whom it is unreasonably difficult due to a medical condition to satisfy the standard or for whom it is medically inadvisable to attempt to satisfy the standard each provide stringent protections to individuals with disabilities.

Patient Protection and Affordable Care Act

Congress signaled its strong support for wellness program incentives in a bipartisan provision of the PPACA. Specifically, PPACA Section 1201 codifies the HIPAA regulations and increases the permitted incentive from 20 percent to 30 percent (and permits regulators to increase incentives up to 50 percent at their discretion). This is a rare bipartisan provision in the otherwise controversial health care reform law and reflects Congress's approval of the offering of incentives for health-contingent wellness programs.

On June 3, 2013, the DOL, HHS and Treasury issued final rules on "Incentives for Nondiscriminatory Wellness Programs in Group Health Plans."[27] These final wellness rules are based on the same general framework as the 2007 HIPAA wellness rules. They only apply to wellness programs that are offered in connection with, or that are themselves, group health plans.

Under the PPACA – as under the previous HIPAA rules – plans first must determine whether their wellness program is participatory or health-contingent. A program will be considered participatory if none of the conditions to obtain a reward are based on an individual satisfying a health standard, and thus participatory programs are not required to meet the HIPAA wellness rule requirements as long as any reward is available to all similarly situated individuals. Health-contingent programs must meet the additional requirements of the HIPAA wellness rules in order to be in compliance with the HIPAA nondiscrimination rules. A wellness program is considered to be health-contingent if it requires an individual to satisfy a standard related to a health factor in order to obtain a reward. The June 3, 2013, final rules break the health-contingent category down further into activity-based and outcome-based,

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[26] *See* 26 C.F.R. § 54.9802-1(f)(3)-(4). Examples include not smoking, attainment of certain biometric screening results, and achieving exercise targets.

[27] 78 Fed. Reg. 33,158.

with different requirements for each depending on the type of program.

The HIPAA wellness program regulations promulgated pursuant to PPACA require that health-contingent programs satisfy a number of new requirements. Health-contingent programs must limit the maximum incentive to 30% of the total cost of coverage (up to 50% for tobacco cessation programs). The limit is based on the total cost of employee-only coverage (or enrolled coverage if dependents may participate). The regulations also enhanced protections for participants by requiring that health-contingent programs must make available a reasonable alternative standard in certain situations where an individual cannot satisfy the initial standard. In addition, the regulations require a notice alerting individuals to the availability of a reasonable alternative standard.

Genetic Information Nondiscrimination Act of 2008

Wellness program design and implementation is also affected by the Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233 ("GINA"). Title I of GINA, which is under the jurisdiction of DOL, HHS and Treasury, addresses whether and to what extent group health plans may collect or use genetic information, including family medical history. Title II of GINA, under the jurisdiction of EEOC, restricts how employers and certain other "covered entities" (collectively referenced herein as "employers" for purposes of clarity) may collect and disclose genetic information and prohibits employers from using genetic information in employment decisions.

Title I: Title I of GINA, in relevant part, prohibits group health plans and health insurance issuers in the group and individual markets from discriminating against covered individuals based on genetic information. Interim final rules were published in the Federal Register on October 7, 2009.[28] Title I applies to a wide variety of group health plans, including wellness programs that constitute or are related to group health plans. Title I generally prohibits a group health plan and a health insurance issuer in the group market from:

- increasing the group premium or contribution amounts based on genetic information;
- requesting or requiring an individual or family member to undergo a genetic test; and
- requesting, requiring or purchasing genetic information prior to or in connection

[28] Interim Final Rules Prohibiting Discrimination Based on Genetic Information in Health Insurance Coverage and Group Health Plans, 74 Fed. Reg. 51,664 (Oct. 7, 2009).

with enrollment, or at any time for underwriting purposes.[29]

The prohibition on requesting, requiring or purchasing genetic information at any time for underwriting purposes affects wellness programs. The term "underwriting purposes" is defined broadly to include rules for eligibility for benefits and the computation of premium or contribution amounts, and it does not merely encompass activities relating to rating and pricing a group policy.[30] The regulations clarify that the term "underwriting purposes" includes changing deductibles or other cost-sharing mechanisms, or providing discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing a health risk assessment (HRA) or participating in a wellness program.[31] "Genetic information" is defined for purposes of GINA Title I to include family medical history.[32]

Wellness programs cannot provide rewards for completing HRAs that request genetic information (including family medical history), because providing rewards would violate the prohibition against requesting, requiring or purchasing genetic information prior to or in connection with enrollment, or at any time for underwriting purposes. A plan or issuer can collect genetic information through HRAs under Title I of GINA as long as no rewards are provided for such genetic information (and if the request is not made prior to or in connection with enrollment).[33] A plan or issuer can provide rewards for completing an HRA as long as the HRA does not collect genetic information.

Title II: Title II of GINA, which is under EEOC's jurisdiction, restricts how employers may collect and disclose genetic information and prohibits employers from using genetic information in employment decisions. Final regulations under Title II were published in the Federal Register on November 9, 2010.[34]

Title II generally prohibits employers from requesting, requiring or purchasing genetic information of an individual or a family member of the individual. An exception is provided where health or genetic services are offered by the employer, including where they are offered as part of a wellness program, if the employer meets certain requirements:

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[29] Id.

[30] Code § 9832(d)(10).

[31] 26 C.F.R. § 54.9802-3T(d)(1)(ii); 29 C.F.R. § 2590.702-1(d)(1)(ii); 45 C.F.R. § 146.122(d)(1)(ii).

[32] 26 C.F.R. § 54.9802-3T(a)(3); 29 C.F.R. § 2590.702-1(a)(3); 45 C.F.R. § 146.122(a)(3).

[33] Interim Final Rules Prohibiting Discrimination Based on Genetic Information in Health Insurance Coverage and Group Health Plans, 74 Fed. Reg. at 51,669.

[34] Regulations Under the Genetic Information Nondiscrimination Act of 2008, 75 Fed. Reg. 68,912 (Nov. 9, 2010).

- The provision of genetic information by the individual is voluntary, meaning the covered entity neither requires the individual to provide genetic information nor penalizes those who choose not to provide it;

- The individual provides prior knowing, voluntary, and written authorization, meaning that the covered entity uses an authorization form that (1) is written in language reasonably likely to be understood by the individual from whom the information is sought, (2) describes the information being requested and the general purposes for which it will be used, and (3) describes the restrictions on disclosure of genetic information;

- Individually identifiable genetic information is provided only to the individual (or family member and the health care professional or genetic counselor providing services); and

- The information cannot be accessed by the employer (except in aggregate terms).[35]

The 2010 regulations raised questions as to whether incentives could be offered to spouses for completing HRAs that request health information. This is because, when an employer requests information from an employee's spouse about the spouse's current or past health status, this request itself may be considered a request for the employee's genetic information (i.e., an inquiry regarding the manifestation of a disease or disorder in a family member). This is due to the fact that GINA and the 2010 regulations define "genetic information" by reference to a "family member," which is defined to include an individual's spouse.

In May 2016, the EEOC finalized regulations addressing the question of spousal HRAs.[36] The 2016 GINA regulations provide that an employer may offer an incentive to an employee as part of an ADA-compliant employee health program in exchange for an employee's spouse providing information about the spouse's manifestation of disease or disorder as part of an HRA or biometric screening administered in connection with an employer-sponsored wellness program. The maximum total incentive is limited to 30% of the total cost of employee self-only coverage (as opposed to enrolled coverage, as is the case with HIPAA where a dependent participates in a wellness program). Notably, incentives may not be offered for a child's provision of this information (unlike under HIPAA). The EEOC rules also require that the spouse provide prior knowing, voluntary, and written authorization when the spouse is providing information regarding his or her own manifestation of disease or disorder.

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[35] 29 C.F.R. §1635.8(b)(2).

[36] Genetic Information Nondiscrimination Act, 81 Fed. Reg. 31,143 (May 17, 2016).

The 2016 GINA regulations apply to wellness programs regardless of whether they are part of a group health plan (unlike HIPAA, which is limited to wellness programs that are part of a group health plan).

Americans with Disabilities Act

The EEOC also regulates wellness programs pursuant to Title I of the Americans with Disabilities Act ("ADA"). Title I of the ADA prohibits discrimination against qualified individuals with disabilities.[37] The ADA prohibits employers from conducting medical examinations or making inquiries regarding disabilities at any point during the hiring process or during employment, with certain limited exceptions.[38]

Title I of the ADA allows employers to conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees at a work site. Any medical information acquired as part of the program is kept confidential and separate from personnel records. Until the issuance of proposed and final regulations in 2015 and 2016, respectively, there was little guidance regarding what the term "voluntary" means in this context.

In May 2016, the EEOC also finalized regulations addressing what constitutes a "voluntary" wellness program for purposes of the ADA.[39] The 2016 ADA regulations provide that an employer may offer an incentive to an employee in connection with a medical examination or a disability related inquiry where offered as part of an employee health program. The maximum total inducement is limited to 30% of the total cost of employee self-only coverage (as opposed to enrolled coverage, as is the case with HIPAA where a dependent participates in a wellness program).

In addition to HIPAA's existing notice requirements, the final EEOC regulations require the use of a much more prescriptive and lengthy notice, which must be provided to employees in advance of their participation in an ADA-subject wellness program. Additionally, the 2016 ADA regulations provide that a "voluntary" wellness program cannot – based upon program participation – deny coverage under any group health plan or particular benefits package within a group health plan, or otherwise limit the extent of medical benefits or services.[40] Accordingly, wellness programs subject to the ADA cannot encourage wellness program participation by tying access to special or additional group health plan coverage or benefits packages to wellness program participation.

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[37] 42 U.S.C. § 12112(a).

[38] 42 U.S.C. § 12112(d).

[39] Regulations Under the Americans With Disabilities Act, 81 Fed. Reg. 31,126 (May 17, 2016).

[40] See 81 Fed. Reg. at 31,139.

Another important misalignment in the regulatory schemes is that the 2016 ADA regulations apply to wellness programs regardless of whether they are part of a group health plan. This is unlike HIPAA, which applies solely to wellness programs that are part of a group health plan.

Additionally, and quite importantly, many employers now sponsor wellness programs with a disease management component. Under these programs, individuals with a health factor may be provided financial incentives to engage with the wellness program - but at all times they must be treated better than similarly situated employees who lack the health factor. Many employers sponsor disease management programs under this rubric, such as healthy mother/healthy baby programs, or diabetes management programs. One example is that a plan may charge a copay for the purchase of insulin, but may waive the copay for their enrollees with diabetes given the clinical evidence supporting the importance of properly managing blood sugar levels.

While these programs are excepted from HIPAA's prescriptive regime - which is appropriate given the favorable treatment under these programs of persons with an adverse health status - the 2016 ADA regulations could subject these types of disease management programs to the regulations' requirements, which, as discussed below, would likely cause many employers to reconsider offering these very valuable and helpful programs.

KEY CONCERNS FOR EMPLOYERS

Notwithstanding the important role of wellness programs in promoting the health and productivity of employees and their families, the inconsistent federal regulatory framework under HIPAA, GINA, and the ADA has caused many employers to take a step back or pause in their implementation of innovative wellness programs. This is because the new rules under GINA and the ADA added complexity and inconsistency and have made it significantly more difficult for employers to structure programs that comply with all applicable federal regulatory regimes.

The Council's *A 2020 Vision* strategic plan, urged that "federal agencies promulgating regulations should proceed in a consistent, collaborative manner that supports participatory and outcomes-based wellness initiatives." We are concerned that the recent final EEOC regulations under GINA and the ADA have resulted in more inconsistency, not less. Programs that are subject to comprehensive and robust regulation under HIPAA nonetheless are now also subject to a different - and sometimes conflicting - framework under GINA and the ADA. Moreover, effective programs that previously were subject to minimal regulation - such as healthy mother/healthy baby programs and participatory disease management programs - are now subject to unnecessarily burdensome rules that will cause some employers to

consider whether to continue them.

Because federal regulations are not aligned in a consistent manner, they have put at risk the availability and effectiveness of workplace wellness programs. This would have the adverse consequence of depriving employees and their families of the meaningful wellness benefits that such programs offer, including improved health and productivity.

POLICY RECOMMENDATIONS

We urge the Committee to consider the issues discussed above and identify solutions aimed at bringing greater consistency to federal regulation of wellness programs and reducing unnecessary burden.

The Council encourages the Committee to consider the following in the development of any future legislation:

- Wellness programs that are subject to, and comply with, the wellness provisions of HIPAA (as amended by PPACA) should be deemed to comply with the ADA and GINA Titles I and II, respectively, if they offer rewards that comply with the limits imposed on health-contingent programs under HIPAA. It would minimize unnecessary regulatory burden on wellness programs and ensure that employers are able to rely on Congress's prior stated support for HIPAA-compliant wellness programming.

- Wellness programs that are not subject to the wellness provisions of HIPAA (as amended by PPACA) should be deemed to comply with the ADA and GINA Titles I and II if they offer rewards that comply with the limits imposed on health-contingent programs under HIPAA. In general, this would apply to wellness programs that are not offered as part of, or in connection with, an employer group health plan, but which voluntarily comply with HIPAA's incentive limits for health-contingent programs.

- Wellness programs that provide for more favorable treatment of individuals with adverse health factors (i.e., disease management programs that are excepted from HIPAA) should be deemed to comply with the ADA and GINA Titles I and II.

- The collection of information about the "manifested disease or disorder of a family member" should not be considered an unlawful acquisition of genetic information with respect to another family member as part of workplace wellness programs and should not violate GINA. This provision, if enacted,

would ensure that employers can offer to an employee's spouse or child the same opportunities afforded to the employee to earn incentives in connection with undertaking activities to better understand or manage his or her current health status and related health risks.

CONCLUSION

It is my hope that this testimony has reinforced the imperative to support and strengthen the efforts of employers to be effective in their role of advancing the health and well-being of their employees and their family members.

As the Committee considers any future legislation, we urge you to do so with the goal of achieving consistent federal policy and a regulatory framework that is minimally burdensome while protecting individuals from discrimination. We believe that framework exists in the current HIPAA regulations implemented under PPACA.

The employer community appreciates this Committee's recognition of the importance of wellness programs and the existing regulatory framework that protects individuals against unlawful discrimination, and notes PPACA was amended on a bipartisan basis to endorse and expand HIPAA-compliant wellness programs.

As the Council's *A 2020 Vision* states, employer-sponsored benefit plans are now being designed with the express purpose of giving each employee the opportunity to achieve personal health and financial well-being. This well-being serves as the foundation for employees to achieve optimal performance and productivity, which, in turn, drives successful organizations.

Thank you for your interest in employer-sponsored wellness programs. I appreciate the opportunity to testify, and look forward to working with you to create a consistent federal policy for employer-sponsored wellness programs to improve the health and productivity of employees and their families.

Chairwoman FOXX. Thank you very much. The staff gave me phonetically how to pronounce your name, and I read it wrong. Ms. Klausner, thank you. I apologize.

Ms. Mitts, I recognize you for five minutes.

TESTIMONY OF LYDIA MITTS, ASSOCIATE DIRECTOR OF AFFORDABILITY INITIATIVES, FAMILIES USA

Ms. MITTS. Good morning, Chairwoman Foxx, Ranking Member Scott, and distinguished members of the committee. Thank you for the opportunity to testify today.

I am Lydia Mitts, associate director of affordability initiatives at Families USA, a nonprofit, nonpartisan consumer advocacy organization that has worked since 1982 to promote high-quality, affordable health care for all in this country.

The three bills before you today would make various changes to employer-based coverage that would promote the scaling back of plan benefits and shift a greater share of cost to workers, particularly older and sicker workers.

I would like to specifically address two of the bills before you today, starting with the *Preserving Employee Wellness Programs Act*. We believe that preserving and strengthening access to care should be a pillar of workplace wellness efforts.

We have long had concerns with wellness program incentives that vary workers' healthcare premiums or other healthcare costs based on their completing health screenings or meeting certain health goals. Such programs can simply be a backdoor way to medically underwrite.

In addition, national research from RAND has found that simply offering a comprehensive wellness program that includes extensive lifestyle management and disease management services is almost equally as effective as incentives at generating high participation.

Premium surcharges tied to completing invasive health screenings also undercut key protections of the *Americans With Disabilities Act* and the *Genetic Information Nondiscrimination Act* that protect the privacy of workers' sensitive medical and genetic information.

Our concerns with these collection practices are elevated given research showing that over half of workplace wellness programs provide limited services or focus only on providing health screenings. These raise significant concerns that many programs are focused on collecting sensitive information, not making investments in services to help workers address health problems.

The *Preserving Employee Wellness Programs Act* would open the door for employers to charge workers and their families even higher healthcare costs if they refuse to complete invasive health screenings.

Under current regulations, employers can already charge premium surcharges as high as 30 percent of the premium for employee only coverage, which is around $2,000 on average. This bill drastically increases maximum surcharges to 30 percent of the cost of family coverage, which translates to close to $5,500 on average. This change will just make coverage less affordable for many families, and further undercut important worker protections against discrimination.

The bottom line is that efforts to support employee health need to focus on providing evidence-based services, not shifting healthcare costs to workers.

The second bill I would like to speak to is the *Small Business Health Fairness Act*. This bill would exempt Association Health Plans from adhering to critical State and Federal requirements for small group coverage. These requirements have benefited small employers and their workers alike.

They include protections that prevent plans from charging small employers exorbitantly higher premiums because their employees have poorer health, are older, or are disproportionately women. They also include requirements that plans cover comprehensive benefits that meet the needs of a diverse workforce.

By allowing Association Health Plans to ignore these key protections, this bill would increase premiums and threaten stable access to comprehensive coverage for many small employers and their workers.

Employers with a young workforce that is in pristine health may be able to get lower premiums. However, the rest of small businesses would see coverage become less affordable, although they sought it through an association or the existing small group market.

On top of this, employees that move to association plans would be at risk of facing skimpier coverage that doesn't cover the care they need. This bill would just move us backward to a two-tier system that makes it harder to purchase comprehensive, affordable coverage for all but a minority of small businesses.

In closing, I want to note the real threat that other proposals to repeal the *Affordable Care Act* also pose to the health coverage of workers and their families. While not before the committee today, these proposals would have grave impacts on access to affordable coverage for working people in this country.

As we discuss solutions to improve affordability of coverage and care for businesses and their workers, we need to focus on solutions that do not simply shift healthcare costs to working families or undermine their access to coverage that fully meets their needs.

I hope this testimony has provided you with a valuable overview to help inform your deliberations on the legislation before this committee. Again, thank you for the opportunity to testify before you today.

[The statement of Ms. Mitts follows:]

March 1, 2017

"Legislative Proposals to Improve Health Care Coverage and Provide Lower Costs for Families"

Testimony of Lydia Mitts

Associate Director of Affordability Initiatives, Families USA

Before the Education and the Workforce Committee

Good morning, Chairwoman Foxx, Ranking Member Scott, and distinguished members of the Committee. Thank you for the opportunity to testify today. I am Lydia Mitts, Associate Director of Affordability Initiatives at Families USA, a non-profit, non-partisan, consumer advocacy organization that has worked since 1982 to promote high-quality, affordable health care for all in this country.

The three bills before you today would make various changes to the requirements governing coverage available to workers. All of these bills would promote the scaling back of employee health plan benefits and shift a greater share of costs to workers. These changes would harm access to affordable, comprehensive coverage, particularly for older and sicker workers.
I would like to specifically address two of the bills before you, starting with the "Preserving Employee Wellness Programs Act." We have strong concerns that this bill will proliferate the use of wellness programs as a backdoor way to charge sicker workers more for health coverage and will further undercut critical workforce non-discrimination protections.

First, I want to emphasize that we support efforts to provide employees with resources to improve their health and well-being. However, it is critical that these efforts are grounded in evidence, do not open the door to workforce discrimination, and do not threaten workers' access to affordable health coverage and care. We believe that preserving and strengthening access to care should be a pillar of any workplace wellness efforts. Workplace wellness programs that increase workers' health care premiums or other health care costs if they do not meet certain

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program requirements do the opposite of support well-being; rather these types of programs make it harder for workers to access the clinical care they need to achieve good health.

Background: Evidence on Workplace Wellness Programs and Incentives

Before speaking to the bill specifically, I would like to provide some background on workplace wellness programs and the risks they potentially pose to workers. The RAND Corporation conducted a review of workplace wellness programs, commissioned by the federal government.

This RAND review found that many wellness programs do not provide extensive services beyond health screenings. It found that only 13 percent of all employer wellness programs are considered comprehensive. This means that in addition to health screenings, these programs have comprehensive lifestyle management and disease management services. Perhaps most concerning, just over half of all programs (54 %) provide only limited services across the board, or focus only on providing health screenings.[1] These trends raise significant concerns that many workplace wellness programs are failing to make significant investments in services that could actually help workers improve their overall health and well-being.

RAND also looked at the efficacy of the use of financial incentives to boost participation in wellness programs. It found that incentives can increase participation, particularly in programs that offer very limited services. However, more importantly, RAND found that simply offering a comprehensive program that includes extensive lifestyle management and disease management services is almost equally as effective at generating high participation. Among programs that used no incentives at all, comprehensive programs had 52 percent participation, while limited programs had only 20 percent participation.[2] RAND stated that their findings, "*question whether employers' enthusiasm for incentives, which have the unintended consequence of shifting cost to employees with poor health, is warranted.*"[3] Put simply, employers should not need to use

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[1] Soeren Mattke et al., *Workplace Wellness Programs Study: Final Report,* (Santa Monica, CA: RAND Corporation, 2013), available online at http://www.rand.org/pubs/research_reports/RR254.html.
[2] Soeren Mattke et al., *Workplace Wellness Programs Study: Final Report,* (Santa Monica, CA: RAND Corporation, 2013), available online at http://www.rand.org/pubs/research_reports/RR254.html.
[3] RAND Corporation, *Incentives for Workplace Wellness: They Increase Employee Participation But Building a Better Program Is Almost as Effective,* (Santa Monica, CA: RAND Corporation, 2015), available online at http://www.rand.org/content/dam/rand/pubs/research_briefs/RB9800/RR9842/RAND_RB9842.pdf

incentives at all if they design a wellness program that actually provides meaningful services to their employees.

Wellness Incentives Shift Health Care Costs to Vulnerable Workers

We have long had concerns with wellness program incentives that vary workers' health care premiums or other health care costs based on their completing health screenings or their meeting certain health goals. There is no evidence that charging people more for coverage or care leads to sustained improvements in health outcomes or behaviors— rather it is simply a backdoor way to medically underwrite and shift premium costs to workers in poorer health. Furthermore, premium surcharges tied to completing invasive health screenings undercut key protections of the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act that have prohibited employers from compelling their workers to share sensitive medical and genetic information. Such programs run an equal risk of shifting costs to workers in poorer health, who are more likely to be wary of disclosing sensitive medical information out of fear of discrimination or privacy concerns. Our concerns with these practices are elevated given the earlier mentioned research showing that: 1) more than half of programs do little beyond collect employee health data through screenings; and 2) truly comprehensive wellness programs built to help employees address health problems do not need discriminatory incentives to encourage participation.

"Preserving Employee Wellness Programs Act" Paves Road for Greater Cost-Shifting to Workers

The "Preserving Employee Wellness Programs Act" would open the door for employers to charge workers and their families even higher health care costs if they refuse to complete invasive health screenings. This would further undercut affordability of coverage and weaken longstanding worker protections. Under current regulations, employers can already charge premium surcharges as high as 30 percent of the premium for employee-only coverage if workers refuse to complete health screenings; based on the average cost of employer-based

employee-only coverage in 2016 that is close to $2,000 ($1,930).[4] This bill would drastically increase this maximum surcharge to 30 percent of the cost of family coverage; based on the average cost of employer-based family coverage, this translates to a premium surcharge of close to $5,500 ($5,442)[5] This change will do nothing to support the health and well-being of workers. Rather, it will just make coverage less affordable for many workers and their families. The bottom line is that efforts to support employee health need to focus on providing evidence-based services, not shifting health care costs to workers.

"Small Business Health Fairness Act" Not the Solution to Improve Affordability of Coverage for Small Businesses

The second bill I would like to speak to is the "Small Business Health Fairness Act." This bill would exempt association health plans marketed to small businesses from adhering to critical state and federal requirements for small group coverage. These requirements have benefitted small employers and their workers alike. They include protections under the Affordable Care Act that prevent small group plans from charging employers exorbitantly higher premiums because their employees have poorer health, are older, or are disproportionately women. They also include state and federal requirements that small group plans cover comprehensive benefits that meet the needs of a diverse workforce.

By allowing association health plans marketed to small businesses to ignore these key protections, this bill would increase premiums and threaten stable access to comprehensive coverage for many small employers and their workers. Employers with a young workforce that is in pristine health may be able to get lower premiums. However, the rest of small businesses would see coverage become less affordable, whether they sought it through an association or the existing small group market. Small businesses with a workforce that is older, disproportionately

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[4] According to Kaiser Family Foundation/Health Research and Education Trust's 2016 Employer Benefits Survey the average total premium for employee only coverage in 2016 was $6,435. Kaiser Family Foundation and Health Research and Education Trust, *2016 Employer Benefits Survey,* (Washington, DC: Kaiser Family Foundation, September, 2016), available online at http://kff.org/health-costs/report/2016-employer-health-benefits-survey/

[5] According to Kaiser Family Foundation/Health Research and Education Trust's 2016 Employer Benefits Survey the average total premium for family coverage in 2016 was $18,142. Kaiser Family Foundation and Health Research and Education Trust, *2016 Employer Benefits Survey,* (Washington, DC: Kaiser Family Foundation, September, 2016), available online at http://kff.org/health-costs/report/2016-employer-health-benefits-survey/

women, or that has more health problems would suffer the most. On top of this, employees moved to association plans would be at risk of facing skimpier coverage that comes with significantly higher cost-sharing or doesn't cover the care they need. Exempting association health plans from important protections is not the solution to make coverage more affordable for small businesses and their workers. This bill would just move us backward to a two-tiered system that makes it harder to purchase comprehensive, affordable coverage for all but a minority of small businesses.

Threats Posed by Repealing the Affordable Care Act

In closing, I want to note the real threat that Affordable Care Act repeal proposals pose to the health coverage of workers and their families. While they are not before the Committee today, policies are being discussed and considered by the House that would repeal the Affordable Care Act, give large tax breaks to the wealthy, and significantly cut back on financial assistance with coverage for lower- and moderate-income families. These policies would have devastating consequences to millions of working individuals who have gained health insurance under the Affordable Care Act. It is critical that we find solutions to improve affordability of coverage and care for businesses and their workers. However, we need to focus on solutions that do not simply shift health care costs to working families or undermine their access to coverage that fully meets their needs.

In closing, I hope this testimony has provided you with a valuable overview to help inform your deliberations on the legislation before this Committee. Again, thank you for the opportunity to testify before you today.

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Chairwoman FOXX. Thank you, Ms. Mitts. Mr. Ritchie, you are recognized for five minutes.

TESTIMONY OF JAY RITCHIE, EXECUTIVE VICE PRESIDENT, TOKIO MARINE HHC, TESTIFYING ON BEHALF OF THE SELF-INSURANCE INSTITUTE OF AMERICA

Mr. RITCHIE. Thank you. Chairwoman Foxx, Ranking Member Scott, and distinguished members of the committee, my name is Jay Ritchie and I'm an executive vice president with Tokio Marine HHC Stop-Loss Group.

Tokio Marine HHC Stop-Loss Group provides coverage for over 3,000 self-insurance employers and Taft-Hartley plans. We are one of the largest providers of medical stop-loss in the U.S., covering 3.4 million employees and their dependents.

Today, I'm testifying on behalf of the Self-Insurance Institute of America, a national nonprofit trade association representing the business interests of companies involved in the self-insurance marketplace, of which I am the current chairman.

SIIA and its members strongly support the *Self-Insurance Protection Act*, and we thank Dr. Roe for his sponsorship of the legislation, as well as the support of many of you on this committee.

Self-insurance offers employers across the country a platform to effectively and efficiently manage their healthcare expenditures. The self-insurance market is focused on creating cost-effective and beneficial outcomes for employee populations. Self-insurance is not limited to just private sector employers. Local cities, counties, and school districts make up 9 percent of my own block of business. Another 5 percent is made up by Taft-Hartley plans.

I will also balance my remarks today by saying that self-insurance is not the right option for everyone. Self-insurance does carry additional responsibilities for the plan sponsor, but I feel strongly that every employer should have the right to examine their options on how to best finance their employee health benefit costs.

We have submitted to this committee a more detailed written testimony, so I will not re-read it in its entirety in respect to our allotted time.

I would like to highlight some of the important reasons why the *Self-Insurance Protection Act* is so important to encourage competition and maintain current market forces. The largest differentiator between health insurance and self-insurance is ownership, who controls the plan.

Self-funded employers made the choice to take ownership of their plan in a fiduciary capacity. While this gives the plan control of the benefit design and claim data, it also makes the employer financially responsible for all administrative expenses and healthcare claims of the enrolled members. This financial responsibility can be assumed by the largest employers or Taft-Hartley plans.

However, for those who want to have the benefits of self-insurance but need to manage the fiscal risk of large catastrophic claims, they purchase an insurance product called "medical stop-loss insurance."

Medical stop-loss insurance, also known as simply "stop-loss," is not health insurance. Stop-loss does not insure employees, nor do we reimburse medical providers for care. Rather, we reimburse a

self-funded entity for healthcare payments incurred by the plan to the extent they exceed a certain predetermined threshold or deductible, similar to a liability product.

To further tell the differences between stop-loss and health insurance, I would offer you the fact that of the 3,000 stop-loss policies my company sells, our average deductible is $140,000. Smaller policyholders will buy a deductible lower than the average while larger plans will buy much higher, but the reality is that stop-loss does not cover the same risks as health insurance, and that is by design.

Stop-loss is what makes self-insurance work for employers that are not large enough to self-fund the largest claims. Without medical stop-loss insurance, these plans cannot afford to be self-funded as a single catastrophic claim could create financial hardship for the plan, so they purchase stop-loss coverage to transfer the risk of large dollar claims.

We're advocating for the passage of the *Self-Insurance Protection Act* to preclude regulatory action that would limit access to stop-loss coverage. If regulators are permitted to redefine stop-loss coverage as health insurance, the availability and access to stop-loss will be significantly reduced.

It would mean that stop-loss is only available for health insurers when they control the plan. This would eliminate the most valuable aspects of self-insurance and restrict plans to a limited amount of health insurers. This would also lead to self-insurance only being available for the largest corporations, and we would see its benefits and advantages eliminated for small- and medium-sized organizations that need it the most.

Stop-loss insurance, while clearly not health insurance, is still an insurance product, meaning states still regulate how insurance operates. Certain states have taken action to restrict availability of stop-loss based on a specific deductible for certain group sizes.

While we acknowledge the responsibility of a state to regulate change for insurance products under their jurisdiction, a Federal regulation that would alter the definition of "stop-loss coverage" into a product it is clearly not intended to be is very concerning.

To prevent this, the *Self-Insurance Protection Act* simply seeks to amend the definition of "health insurance coverage" under the *Public Health Services Act* and parallel sections of ERISA and the Tax Code to clarify that stop-loss insurance is not health insurance. This legislation does not amend the ACA.

In conclusion, self-insured employers, benefit brokers, consultants, and third party administrators, who are all members of SIIA, strongly support the passage of the *Self-Insurance Protection Act*, to promote and protect the ability of organizations to self-insure with access to stop-loss insurance based on their specific needs.

Self-insurance provides affordable health coverage to businesses of all sizes, helping many employers access coverage they may not otherwise have. While self-insurance is not the only solution to accessible and affordable employer health care, it is an essential part of the solution and should remain available.

Thank you for the opportunity, and I look forward to speaking with the committee.

[The statement of Mr. Ritchie follows:]

Testimony of Jay Ritchie
Executive Vice President, Tokio Marine HCC Stop-Loss Group
Chairman, Self-Insurance Institute of America, Inc. (SIIA)
Before the House Education & Workforce Committee
"Legislative Proposals to Improve Health Care Coverage and Provide Lower Costs for Families"
March 1, 2017

Chairwoman Foxx, Ranking Member Scott and distinguished members of the Committee, my name is Jay Ritchie and I am an Executive Vice President of Tokio Marine HCC-Stop Loss Group. I also serve as chairman of the Self-Insurance Institute of America, Inc.

Tokio Marine HCC – Stop Loss Group provides coverage for over 3,000 self-insurance employers and Taft-Hartley plans. We are one of the largest providers of medical stop loss insurance for self-insurance plans in the U.S., covering 3.4 million employees and their dependents.

Today, I am testifying on behalf of the Self-Insurance Institute of America (SIIA), a national non-profit trade association representing the business interests of companies involved in the self-insurance marketplace. SIIA and its members strongly support the *Self-Insurance Protection Act* (SIPA) and we thank Dr. Roe for his sponsorship of the legislation, as well as the support of many of you on this committee.

Self-insurance offers employers across the country a platform to effectively and efficiently manage their healthcare expenditures by using both individual employer and benchmarking data combined with effective healthcare systems, to improve outcomes and eliminate waste. The self-insured market is focused on creating cost-effective and beneficial outcomes for employee populations. Self-insurance is not limited to just the private sector. Cities, counties and school district's make up 9% of our total block of business, with another 5% made up of Taft Hartley and collective bargained labor plans.

I will also balance my remarks today by saying that self-insurance is not the right option for everyone. An organization needs to understand the financial requirements because self-insurance is more responsibility than just handing it off to a health insurer. Self-insurance carries additional liabilities and time commitments to ensure the plan is successful, but I feel strongly that every employer should have the right examine their options on how to best finance their employee health care costs

Fully Insured vs. Self-Insured Health Plans

Traditionally, a fully insured arrangement (i.e. health insurance) offers little risk to the plan sponsor, who purchases a policy from an insurance company. The plan agrees to pay a set premium per employee per month and the insurance company pays all eligible claims incurred during the policy period. The benefits of the policy are often predefined based on standardized plan designs and systematic processing. The insurer is the covered entity under the law as the risk taker and therefore governs the plan. This is certainly a viable option that employers have at their disposal.

A self-insured arrangement can include the same services and the same benefits, but the financing of the plan is different. Instead of paying a monthly premium to an insurance company, they fund a claim account that pays for claims incurred under their plan. The employer is now the covered entity for the plan and makes the determinations on plan design and benefits payable. Because the plan

is now the risk assuming entity, they often elect to purchase stop loss insurance to manage the potential of a catastrophic risk and we will discuss that topic in a moment. The biggest difference between health insurance and self-insurance is simple - who owns the funds at the end of the year when budgeted costs are below expectations. In fully insured arrangements it is the health insurer. In self-insurance, it is the plan. Money not spent by the self-insured plan stays with the plan.

A well-run self-insured plan is normally less expensive over time compared to a fully-insured plan. Traditional insurance premiums account for profit and marketing costs that are passed on to the plan in every premium dollar. These profit costs are not applicable to a self-insured plan, which are essentially not-for-profit health plans. In addition, federal law provides self-insured plans flexibility in designing benefit packages that meet the specific needs of plan participants and allows the plan to structure more innovative reimbursement arrangements when warranted

Self-insuring also allows claims to be funded as they are paid, instead of the pre-payment seen in the fully-insured market. A self-insured plan pays health plan costs as they are actually paid to the medical service providers.

Another key point is ownership of health claims data, an extremely valuable tool for plan design benefits. Self-insured organizations own all claims data and can use it to help deliver benefits efficiently while being cost-effective. Self-insured plan sponsors are at the forefront of reducing medical costs by emphasizing wellness programs, including preventative care and chronic disease management. Employer sponsors of self-insurance plans have both the ability and the incentive to create and integrate health risk assessments, prevention and wellness programs tailored to the employer's specific demographic and need. For instance, a tech company with a younger employee population may see that they are having a large portion of their claims in prenatal care, so they could implement a program to ensure proper pre-natal screening and create a new incentive or benefit for mothers to participate in post-delivery mental health screening. While a manufacturing company with an older employee population may want to increase cardiac wellness visits due to an increased frequency of cardiac claims.

Stop Loss is Critical to Self-Insured Plans

Let me also further explain about stop loss insurance. Stop loss insurance may be purchased by self-insured organizations to provide a financial backstop guarding against catastrophic health care claims. While the plan is self-insurance, not every plan can or wants to self-finance large catastrophic claims that can be unpredictable. It is important to note that stop-loss does not insure employees nor do we reimburse medical providers for care, but rather stop loss reimburses a self-insured entity for health care payments they have made that exceed a certain, pre-determined level similar to a liability product. This pre-determined level is also known as an attachment point. These attachment points can either be for a specific plan participant, called specific stop loss coverage, or for total claims paid by the plan, called aggregate stop loss.

Stop loss coverage is not purchased by all self-insurance plans. Very large plans have large enough group populations where even the catastrophic claims become fairly predictable. Stop loss is also a unique product in that the plan decides where it wants to set its specific coverage thresholds. As groups get larger, the specific retention gets larger. For our block of business the average specific deductible is over $140,000. As you can surmise, this means the plans retains a large portion of the day to day risk of the plan and stop loss covers the catastrophic claims. This results in stop loss premiums

being a fraction of the size of health insurance premiums simply because we take a materially different risk than health insurance does.

The requirements of the Affordable Care Act (ACA) have challenged many organizations with self-insurance health care plans and stop loss. For many plans, the removal of annual claims limits and lifetime coverage maximums have led plans to purchase stop loss coverage to protect their plans from large scale claims and ensure financial reserves. If stop loss is defined as health insurance coverage, it will dramatically change the nature of stop loss coverage, potentially leading to few or no carriers in the market, which will drive up the cost and threaten the existence of self-insured plans. By limiting the availability of stop loss, employer sponsors would be forced to move back to a more expensive fully-insured model, passing those costs on to employees and restricting their ability to offer more customized benefits and access to data.

Wellness Programs Under Self-Insurance

Given the higher level of engagement when employers choose a self-insurance option, it can empower them to focus more on employees' health. Many businesses have turned to wellness programs such as smoking cessation, on-site clinics and indoor walking paths to help encourage healthy lifestyles. Disease-management programs have been shown to reduce hospital visits and lower health costs. This emphasis on health supports the employees and helps businesses lower health care costs.

Criticism of Self-Insurance

I would like to address some of the criticisms raised over self-insured health plans, primarily those surrounding small business. The main criticism being raised by opponents is that self-insured plans are not regulated, and are removing important patient protections. These criticisms are patently false. In fact, self-insurance plans are regulated by no less than 10 federal laws, including the Employment Retirement Income Security Act (ERISA) and the Health Insurance Portability and Accountability Act (HIPAA).

Critics have also included the idea of adverse selection, based on the mistaken assumption that small businesses will offer only "bare bones" benefit packages through self-insured plans. There is broad agreement that "bare bones" plans, wherever they have been tried, have failed due to lack of demand. This is because small business workers want Fortune-500 style benefits like those enjoyed by workers in large companies. Also, small businesses must offer benefit options comparable to those offered by large companies if they are going to attract and retain quality employees.

Self-Insured Health Plans under the ACA

Non-grandfathered self-insured group health plans are subject to almost all of the ACA market reforms, regardless of whether stop-loss insurance is utilized or not. Self-insured plans are also regulated under ERISA, HIPAA and the Tax Code, making it important to emphasize that self-insurance does not constitute a regulatory loophole.

Opponents state that self-insurance plans are not subject to all the provisions of the ACA. In fact, the employer is still subject to all the employer responsibilities requirements of the ACA. What the self-insurance plan is not subject to is the insurance company rules that are no longer applicable due to the fact that the insurer is now the plan itself. For example, a self-insurance plan is not subject to the

medical loss ratio rule. Why? Because now 100% of the claims are paid by the plan for health care claims and quality improvements, so a rule that regulates what the insurance company spends on health claims and quality improvements is illogical.

Critics further argue that this trend toward self-insurance, especially in the small and mid-sized employer market segments, will compromise the viability of the ACA Exchanges (in particular, the SHOP Exchanges) because self-insured plans will cover healthy populations, leaving "bad" health risks for the Exchanges. There is no data to substantiate these arguments, and efforts to make it more difficult for employers to self-insure by restricting the availability of stop-loss insurance restricts choice and could lead to more employers discontinuing coverage.

Self-Insurance Protection Act: Strengthening Access to Self-Insurance

The *Self-Insurance Protection Act* would preclude harmful regulatory action that would limit access to stop-loss coverage, ensuring that many groups seeking to self-insure are able to access the necessary tools to do so. Already regulated under ERISA, PHSA and the Tax Code, access to self-insured plans will become further restricted if regulators are permitted to redefine stop loss coverage as health insurance. Doing so would force the market to only purchase stop loss coverage from the ever decreasing health insurance market where the insurer would take full and complete control of the plan. Thus, eliminating the most valuable aspects of self-insurance and restricting plans to a limited amount of options offered only by health insurers. Resulting in self-insurance only being available for the largest corporations and to see it numerous benefits and advantages eliminated for small and medium sized plans.

Stop loss insurance, while clearly not health insurance, is still an insurance product, meaning states still regulate how insurance operates. Certain states have taken action to restrict availability of stop loss based on specific deductible for certain group sizes. While we all acknowledge the responsibility of the state to legislate change for insurance products under their jurisdiction, a federal regulation that would alter the definition of stop loss coverage into a product it is clearly not intended to be would be concerning.

To prevent this, the SIPA simply seeks to amend the definition of "health insurance coverage" under the Public Health Services Act (PHSA), and parallel sections of ERISA and the Tax Code, to clarify that stop-loss insurance is not health insurance. The legislation does not amend the ACA.

Since the passage of the Affordable Care Act, the share of small businesses offering coverage has plummeted to 29%. Among firms who have ended their health benefits programs, half cite cost as the top reason. Throughout this time, self-insurance has been a viable option for some small businesses and the passage of SIPA is needed to maintain that ability.

Conclusion

In conclusion, self-insured employers, consultants, brokers, plan administrators and SIIA members strongly support the passage of the *Self-Insurance Protection Act*, and the ongoing ability of organizations to self-insure with access to stop loss insurance based on their specific needs. Self-insurance provides affordable health coverage to businesses of all sizes, helping many employers access

coverage they may not otherwise have. While self-insurance is not the only solution to accessible and affordable employer health care, it is an essential part of the solution and should remain available. Hard working employees and their families depend on self-insured plans, along with the high-quality coverage they need. Often, that coverage includes access to customized wellness benefits, onsite medical clinics and so forth. We look forward to continuing a constructive dialogue on how to increase access to affordable and competitive employer sponsored health coverage for all businesses.

Thank you for the opportunity to submit this testimony. I look forward to answering any questions you may have.

Chairwoman FOXX. Thank you, Mr. Ritchie. Mr. Hurst, you are recognized for five minutes.

TESTIMONY OF JON B. HURST, PRESIDENT, RETAILERS ASSOCIATION OF MASSACHUSETTS, TESTIFYING ON BEHALF OF THE NATIONAL RETAIL FEDERATION

Mr. HURST. Thank you, Chairwoman Foxx, Ranking Member Scott, and honorable members of the committee. My name is Jon Hurst. I'm president of Retailers Association of Massachusetts. We're a state trade association of 4,000 mom-and-pop businesses across the Commonwealth. You will find organizations like ours in every state capital across the country.

We are all members of the National Retail Federation. We collectively represent what is the most competitive industry on the face of the planet, the retail sector. It is most competitive because our industry empowers consumers. When you think about the consumer, the consumer has all the power to make the decisions of what they buy, where they buy it, for how much, and when they buy it.

If we could only translate some of that same power into the healthcare industry, and that is what we're trying to get done with some of this legislation and some of these reforms for small businesses.

I'll take you back 11 years ago in Massachusetts. Our legislature and former governor, Mitt Romney, passed what was called "Chapter 58," better known as "RomneyCare." RomneyCare had a lot of important objectives and a lot of important wins, one of which was greatly lowering the level of uninsured. We went down below 3 percent.

The other objective was to make sure that we didn't hurt employment of large employers that were at the table and effectively involved in the lobbying of that legislation.

What was overlooked though, Madam Chairwoman, were the small businesses. The small businesses were not at the table, and those developing that legislation thought that really all small businesses needed was an exchange, a marketplace to go to and buy health insurance.

If you fast forward for a few years, we kept on measuring what was happening with the health insurance rates for our 4,000 members. Each and every year between 2006 right on up through now, our average increases for these small businesses have been 12 percent.

We always benchmark ourselves against a self-insurance group, which is the state, our Group Insurance Commission, which is a self-insured group of state employees. Our small members, which is a cross section of society, have been annually seeing increases three times the rate of the self-insured group of the state.

We find it very hard to believe that employees of Main Street businesses were three times less healthy than employees of State government.

So, it didn't take very long for us to decide we needed to do something different. We went back to the legislature in 2010 and got passed unanimously an update of the old Association Health Plan

law, which had been repealed in Massachusetts about 15 years earlier.

We called it "The Small Business Cooperative Law." It allowed for small businesses to band together with their trade associations, their chambers of commerce, and see real savings and real tools that large competition, the competition across the street, and from big business and from big government have every day, from savings on wellness programs, to savings on using transparency on costs and quality, to make sure that your employees are well educated about the right place, the right service, with the right provider for whatever form of health care they need.

We acted as their H.R. departments. Between our association, 100 local chambers of commerce across the Commonwealth, this passed unanimously. The legislation was signed into law by former Governor Deval Patrick. It was extremely supported, and even to this day, we have more small businesses and their employees buying through these cooperatives and buying through our State exchange, our connector. We don't cost the taxpayer one dime.

You know, it's time that we look at ways to level the playing field for small businesses and their employees. They compete, Madam Chairwoman, every day with large businesses, not only for customers, but also for employees. Whether we have a law or not that says you must buy health insurance, or if the employees of the small businesses themselves feel like they need to have health insurance for themselves and their families, it is incumbent upon us and government to make sure that we do not throw up roadblocks and cause discrimination based upon where you work.

If employees of large employers have the ability to self-insure and to group buy and get discounts on wellness and transparency uses, so should the small businesses. They should not be held back. They should not see increases that are far higher than their competition across the street. That is incumbent upon government. It's incumbent upon our markets to make sure that we have equality in the marketplace.

We look forward, Madam Chairwoman and members of the committee, of working with you on this very important legislation, H.R. 1101, because we think this is an important step to reforming our healthcare policies across the country for our small businesses and their employees.

Thank you very much.

[The statement of Mr. Hurst follows:]

Statement of the
Retailers Association of Massachusetts
on behalf of
National Retail Federation

submitted to the

U.S. House of Representatives Committee on Education and the Workforce

for its hearing on

"Legislative Proposals to Improve Health Care Coverage and Provide Lower Costs for Families"

March 1, 2017

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Chairwoman Foxx, Ranking Member Scott and honored members of the Committee, I thank you for the opportunity to appear before you today to offer comments regarding the various legislative proposals currently before the Committee to improve health care coverage for small businesses. My name is Jon Hurst and I am the president of the Retailers Association of Massachusetts (RAM) and a member of the National Retail Federation (NRF).

Established in 1918, RAM is a statewide trade association of approximately 4,000 member companies. Our membership ranges from independent, "mom and pop" owned stores to larger, national chains operating in the general retail, restaurant and service sectors of the retail industry. The retail industry in the Commonwealth of Massachusetts is the backbone of our local Main Streets, supporting over 928,000 jobs and operating in more than 73,000 brick-and-mortar establishments.

NRF is the world's largest retail trade association, representing discount and department stores, home goods and specialty stores, Main Street merchants, grocers, wholesalers, chain restaurants and Internet retailers from the United States and more than 45 countries. Retail is the nation's largest private sector employer, supporting one in four U.S. jobs – 42 million working Americans. Contributing $2.6 trillion to annual GDP, retail is a daily barometer for the nation's economy.

As a leading employer organization advocating for equitable and affordable health insurance coverage for small businesses, RAM would like to voice its support for the Small Business Health Fairness Act (H.R. 1101) as the legislation would allow small businesses to join together through association health plans to provide greater access to affordable health care for their employees. In doing so, this legislation would offer small businesses access to the same cost savings available to larger employers under the ERISA Act. Trade associations, professional societies, and local chambers of commerce and in particular state retail associations can offer a vital bridge to such affordable coverage for their small employer members and their employees.

Group health benefits are the key to coverage for more than 170 million Americans. But, not all groups are created equally. NRF has long noted the discrepancy between larger and smaller companies and has supported past iterations of the Johnson-Walberg bill H.R. 1101 to help provide smaller companies better and more affordable access to health benefits. NRF continues that support today and endorses H.R. 1101.

Group health coverage balances the risk of health care utilization between younger and older employees, healthy or less so. Employment-based group coverage can be distinguished from public pools because employees come to the business to work rather than to seek coverage, as opposed to a public pool where the sole objective is to obtain coverage. The difference in presentation of risk, though subtle, is important. Private, employment-based group plans work better and provide more affordable coverage.

Smaller employers have fewer employees to balance their employees' various risk profiles. Strategies taken by the Affordable Care Act – the SHOP plans and the rather byzantine small business tax credit – have not helped smaller employees. Steps must be taken to better support these smaller businesses in providing coverage.

Association Health Plans are an important answer in our view. Not only do they offer the potential to band with additional small employers in their local state through bona fide trade or professional associations, but it also offers potential to band together with other employer groups in other states utilizing the federal ERISA law to maintain common benefits across state lines.

Under the Affordable Care Act (ACA) our nation's small businesses and their employees have been relegated to a second class consumer status versus their large, self-insured, ERISA exempt competitors when it comes to access and affordability of health insurance coverage. Allowed to group rate, such large employers avoid the costs associated with unfair levels of cross subsidization experienced in the individual and small group markets. They are also able to avoid the costs of provider pushed, costly state mandates which most consumers don't want, will never use, and can't afford. Avoidance of these costs provides significant savings for these employers and places their small competitors at a competitive disadvantage. The ACA, in mandating the purchase of health insurance coverage yet failing to provide consumers equitable treatment under the law in terms of access and pricing is not only unfair it is discriminatory.

As called for in the proposal before you today, the solution to this problem is to provide small businesses more flexibility under the ACA to look outside the traditional markets available to them to secure their coverage. This includes providing small businesses, either through industry or professional organizations or on their own, the ability to band together to self-insure and be group rated or in the alternative band together and purchase fully insured products outside the community rated small group and individual markets. Such changes would not only level the playing field for small businesses, but as experienced in Massachusetts under our group purchasing cooperative program, leveraging existing relationships with industry organizations provides small businesses with additional benefits beyond simply securing health insurance coverage.

The adoption of the cooperative model in Massachusetts is indicative of our leaders' bi-partisan support of the concepts underlying the legislation currently before the Committee. And in a recent letter to House Majority Leader Kevin McCarthy, Massachusetts Governor Charles Baker reiterated that support when he called on Congress to amend the ACA to "permit insurance products offered through group purchasing cooperatives and professional employer organizations."[1] Today, I echo this request for flexibility for our nation's small businesses and urge your support the Small Business Health Fairness Act.

Introduction to Universal Healthcare in Massachusetts

Eleven years ago, the Massachusetts General Court adopted Chapter 58 of the Acts of 2006[2], (often referred to as "RomneyCare") mandating universal coverage for Massachusetts residents. While successful in moving Massachusetts towards universal coverage, the law failed to rein in the ever growing cost of coverage and created a system where a subset of consumers—small businesses—were relegated to second class status under the law. As a result, affordability became a significant issue for Massachusetts small businesses, as did their inability to take advantage of essential cost saving tools due to the nature of the state's merged individual and small business risk pool.

Chapter 58 also failed to recognize how small businesses make their employee purchasing decisions, and the important relationship industry and professional organizations play in the ability

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[1] Governor Charles D. Baker to The Honorable Kevin McCarthy, January 11, 2017, http://www.bostonglobe.com/metro/2017/01/12/read-letter-governor-baker-sent-congress/h9m7B1HrkewyRjxNiNgJnK/story.html?p1=Article_Related_Box_Article

[2] https://malegislature.gov/Laws/SessionLaws/Acts/2006/Chapter58

of small businesses to adequately assess and access health insurance options. Rather than leverage these relationships and allow these trusted advisors to serve as access points to the health insurance marketplace, the law relied on government run exchanges to offer small businesses options they did not want.

Recognizing these issues, Massachusetts began work on a second set of health care reforms focusing on cost containment, which would eventually pass into law in August of 2010 as Chapter 288 of the Acts of 2010[3]. By that time, the Affordable Care Act (ACA), which borrows heavily from the Massachusetts model had already been passed into law at the federal level. In doing so the ACA not only replicated the affordability issues experienced in Massachusetts under Chapter 58, but it also preempted important provisions of Chapter 288 intended to address the problem. As a result our small businesses continue to experience year over year premium increases well in excess of their large competitors and government insureds.

Merged Market and State Mandates under Chapter 58

As part of Chapter 58, Massachusetts merged its non-group (individuals) and small group (employers with less than 50 employees) insurance markets into one guaranteed issue "merged" market and prohibited insurers from basing merged market rates on any individual's or group's past or projected health claim experience. The rates in the merged market are therefore community rated based on the claims experience of the entire merged market pool.

By nature, the community rating structure utilized in the merged market results in significant cross subsidization of individuals by small groups within the merged market. Furthermore, by prohibiting the use of an individual's or employer's past or projected health claim experience, community rating also effectively prevents feasible utilization of cost containment tools typically available to larger groups purchasing coverage outside the merged market. In short, an insured's effort to reduce one's risk and claims cannot be translated into direct premium savings by merged market consumers.

Merged market consumers also incur the increased costs associated with covering state-adopted mandated benefits. However, these costly mandates may be completely avoided by larger self-insured groups which make up 60% of commercial marketplace in Massachusetts. Since the adoption of Chapter 58 in 2006, 19 new mandates and/or assessments have been passed in Massachusetts – an average of three per year. A 2013 report by the Massachusetts Division of Insurance (DOI)[4], required by 211 CMR 149.00, found that 12 state mandated benefits fully insured plans are required to cover are NOT covered at all by more than 90% of the self-insured plans in the Commonwealth.

As a result of community rating and unavoidable mandated benefits, from 2006 to 2010, RAM small group members experienced a cumulative average premium increase of 73%, or about 15% per year, with no ability to effect positive change in their premiums. Large employers and even the Commonwealth itself saw annual increases of only about a third of that amount each and every

[3] https://malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter288

[4] Massachusetts Division of Insurance, "Annual Report of Self-Insured Accounts as of December 2013- membership Data," December 2013, http://www.mass.gov/ocabr/docs/doi/companies/tpa-financial-2013.pdf

year. Chapter 58 essentially relegated small businesses in Massachusetts and their employees to second class consumer status compared to their larger competitors.

Cost Containment Reform

In an effort to level the playing field for small employers and provide them more flexibility to access coverage through industry organizations, the Massachusetts General Court, in a bi-partisan effort, responded with the passage of Chapter 288 of the Acts of 2010. Among other changes, the legislation established small business group purchasing cooperatives designed to give merged market consumers the ability to negotiate with providers and carriers, create new plan options and choices and enable such consumers to realize true financial incentives for implementing wellness and consumer educational programs.

The law authorized the creation of six small business group purchasing cooperatives. Cooperative applicants are limited to nonprofit or not-for-profit corporations or associations organized in Massachusetts (i.e. industry trade associations, chambers of commerce, professional societies). Applicants must have been organized for purposes other than securing health insurance for their members.

Unlike the ACA's Consumer Operated and Oriented Plans (CO-OPs) which were designed to compete with the commercial market, the Massachusetts cooperatives are designed to exist as part of the commercial insurance market. The law requires all plans offered through the cooperatives to be fully-insured and based on products available in the merged market by the issuing carrier. Rates offered by the issuing carrier through the cooperatives must be based on the rates available in the merged market outside the cooperatives but may differ based on the relative difference in the projected experience of the cooperative members versus the projected experience of insureds enrolled in merge market products outside the cooperative. This is commonly referred to as the cooperative adjustment factor or cooperative rating factor. The amount of the cooperative factor is determined through negotiation between the cooperative and the contracting insurance carrier within certain limitations and subject to DOI approval.

In order to ensure positive claims experience within the cooperative population and thus positively impact future carrier negotiations, the law also required all cooperatives to provide members access to a sponsored wellness program. Each cooperative must maintain a wellness participation rate of 33% of covered subscribers. The goal is to reduce claims and ensure proper utilization through transparency tools and creation of a healthier, more educated healthcare consumer. The resulting reduction in costs to the insurer may then be reflected in premium discounts derived from the cooperative rating factor.

The law designates the DOI as the regulatory agency responsible for the oversight of the cooperative program. The regulatory framework promulgated by the DOI (211 CMR 151: Certified Group Purchasing Cooperatives[5]) includes a comprehensive approval and renewal process as well as stringent reporting requirements designed to ensure protection of the consumer and compliance with the law. Approved cooperatives are required to file for annual renewal with the Division of Insurance.

[5] http://www.mass.gov/courts/docs/lawlib/210-219cmr/211cmr151.pdf

Massachusetts Cooperatives Experience

To date, five organizations, starting with RAM in January of 2012, have been approved by the DOI to operate as certified group purchasing cooperatives. Of the five, RAM, the Massachusetts Association of Chamber of Commerce Executives (MACCE) and the Spring Healthcare Cooperative, are currently operating in the marketplace. The Associated Subcontractors of Massachusetts and the Massachusetts Society of Certified Public Accountants have both been certified as group purchasing cooperatives but have ceased operation due to limitations imposed by the ACA. Both groups have indicated an interest in continuing operation should changes in the ACA make it feasible again.

Initially, the approved cooperatives had been able to offer members between a 3% and 5% discount on their premiums by demonstrating their commitment to creating a healthier, more educated population of health care consumers through adoption of wellness participation requirements beyond what is required by the law. The model began working as designed until implementation of the ACA removed the state's ability to utilize certain rating factors including the cooperative factor.

Impact of the ACA

The cooperative concept followed six years of experience under a mandated universal health insurance law in Massachusetts. An innovative approach, strongly supported by our elected and regulatory officials, cooperatives should have served as a model cost containment measure for small group markets throughout the rest of the country under the ACA. Instead, rigid market rating rules adopted as part of the ACA implementation essentially prohibited the continued operation of the Massachusetts cooperative model as it was originally designed.

In November of 2012 the federal Centers for Medicare and Medicaid Services (CMS) published regulation CMS-9972-P: Health Insurance Market Rules[6] as part of the implementation of the ACA. A key provision in the regulation required that state regulators limit rate variation within the individual and small group markets to four listed rating factors: (1) whether the plan covered an individual or family, (2) the insured's geographical rating area, (3) age, and (4) tobacco use. In doing so the regulation prohibited Massachusetts from using the cooperative rating factor to provide discounts under Chapter 288.

These changes to the state's rating factors were originally scheduled to take effect on January 1, 2014. However, through a series of waivers the Department of Health & Human Services (HHS) granted Massachusetts a transition period for the elimination of state rating factors (industry, use of intermediary, participation rate, size, and cooperative) which would otherwise be disallowed under the ACA. Under the transition period Massachusetts may utilize certain rating factors at a diminished value until policy year 2018.

RAM Cooperative

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[6] https://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf

RAM was the leading employer organization advocating for the passage of small business group purchasing cooperatives, and was the first certified to operate as a cooperative in January of 2012. For the past four years the Retailers Association of Massachusetts Health Insurance Cooperative (RAMHIC), has worked to create a market based solution to disproportionate premiums for small businesses versus their larger competition. In addition to offering discounted premium rates RAMHIC has sought innovative approaches to delivering comparable coverage for comparable premiums using tools ranging from low administrative costs, to taking proactive initiatives designed to make members healthier and more educated consumers of health care services.

Through the cooperative model, RAM has not only been able to directly impact the cost of coverage through discounts to members but have also provided members additional value to their basic health care coverage through the offer of ancillary benefits such as hospital care plans, dental plans and negotiating with carriers to secure wellness programs that provide financial incentives at the business and employee level.

As required by law, RAMHIC is a fully insured program offering plans based on small group market products from two contracting insurance carriers—Fallon Health (FH) and Blue Cross Blue Shield of Massachusetts (BCBSMA). Offerings include limited network, HMO and PPO plan options which may be coupled with varying deductibles, flexible spending accounts and health reimbursement arrangements to allow the consumer to design and choose a plan that fits the needs of their business and those of their employees. Both carriers allow businesses to offer their employees choice by selecting multiple plan designs to offer to their employees who then may choose their desired plan.

RAMHIC currently utilizes the wellness programs offered through our carrier partners as part of their health plans. Both programs provide financial incentives to subscribers for participating in the program. The BCBSMA program also provides small businesses a year end rebate based on the percentage of their employees that participate in the program. Through continuous marketing and educational efforts, RAMHIC has consistently exceeded the statutorily required 33% wellness participation. Despite this success, the resulting positive impact on the population's claims experience and utilization may not be translated into additional savings due to the ACA's limitation on the cooperative factor.

Despite limitations caused by the ACA, RAMHIC has experienced consistent overall year to year growth. As of December 2016 the cooperative services 287 member businesses for a total of 5,121 lives. This exceeds the number of small group lives covered by the Massachusetts Health Connector and comes at no cost to the tax payer and with no discrimination on coverage.

Analysis of the cooperative's experience indicates that the group is outperforming similarly sized large groups in terms of overall claims experience and is below several small group benchmarks. Prior to implementation of the ACA, similar analysis had resulted in both carriers requesting an increase in the cooperative rating factor applied to RAMHIC. The terms of the federal waiver prevented the Commonwealth from considering such requests.

In an effort to explore all options for providing members the most affordable coverage available, RAM has also considered a number of alternatives to traditional commercial insurance including

transitioning the group into a Multiple Employer Welfare Arrangement, creating a stand-alone captive, and joining an existing captive. None of these options have been determined feasible at this time.

RAM continues to advocate at the state and federal level for a Massachusetts waiver from some of the more onerous and costly provisions of the ACA, including the limitation of state small group rating factors designed to seek fair rates and to incent job growth. At the same time RAM continues to seek Congressional changes to the ACA which will return small group rate setting flexibility to the states, as well as federally authorized solutions such as association health plans for small employers across the country. Providing high quality health insurance coverage for small employers and their employees at rates comparable to those experienced by large self-insured groups should be a primary objective for us all.

Conclusion

The parallels between the experience in Massachusetts under Chapter 58, and now across the country under the ACA are very clear. Individuals were helped, insurance coverage was expanded, and large self-insured employers were not particularly harmed financially. Yet small businesses and their employees saw government imposed discrimination in their choices, their tools, and their costs. Small businesses compete every day with large employers for both customers and employees. And whether required by law to buy health insurance or not, employees of small businesses deserve the same marketplace rights to obtain comparable coverage at comparable rates as those that work for big business and big government.

RAM and NRF appreciate the opportunity to appear before you today and for your consideration of these comments. We urge this Committee and Congress to support the Small Business Health Fairness Act and its underlying intent of eliminating discrimination and seeking equality for small businesses and their employees.

We look forward to working with you on an ongoing basis to identify solutions to the significant problems facing small businesses and stand ready to help this Committee and Congress on the vital issue of fair and affordable health care and health insurance.

Chairwoman FOXX. Thank you very much, Mr. Hurst, and all of our witnesses for your excellent testimony today. I now will recognize members for five minutes of questioning and answers. Mr. Wilson, you are recognized for five minutes.

Mr. WILSON of South Carolina. Thank you, Madam Chair, and thank you, Madam Chair, for your leadership in providing such extraordinary witnesses today. We appreciate very much your input.

Ms. Klausner, I am grateful that the South Carolina Hospital Association under the leadership of President Allan Stalvey has been leading the efforts to establish wellness programs in businesses, hospitals, and government offices. To date, their Working Well Program has established wellness programs in 110 multisector worksites.

Under the hospital association's leadership, wellness programs have increased in our State. What are some of the benefits that employers achieve because of wellness programs, and what are some of the results that employees have seen?

Ms. KLAUSNER. Thank you very much for your question. Wellness programs have been enormously successful, and for different employers and different employee populations, they see different successes, but all success, nevertheless.

Some see benefits directly for employees in terms of reducing their healthcare costs. They learn about it through their health risk assessments or their biometrics screenings, or other opportunities, what may be their weaknesses that they can address with their own physicians, with their own health care. Ultimately, they have an opportunity to reduce those costs.

They also see as absenteeism goes down, individuals that are at work are more productive, and, as a result, the employees see a greater value in terms of their contribution to the employers. We also see that morale increases as everybody becomes healthier.

So, ultimately, we see across the board many things. Healthier individuals create a more productive work environment and a reduction of healthcare costs.

Mr. WILSON of South Carolina. I appreciate your pointing out wellness screening preventive care, how helpful that is.

Mr. Ritchie, Hubner Manufacturing of Mount Pleasant, South Carolina, supplies products for buses, trains, and the air transportation industry. They discovered they were going to have a spike in healthcare insurance premiums. To help control the insurance costs, the company began making a change towards a healthier working environment.

I am grateful for the leadership of Hubner Manufacturing's chief executive officer, Ron Paquette. He has made a real difference.

As Congress looks at various ways to control affordability in health care, wellness programs and initiatives should be part of the discussion. What are some of the roadblocks that employers face when implementing their first wellness programs? Can Congress assist employers in working past these roadblocks?

Mr. RITCHIE. I would say for wellness programs, one thing that is important, and I would stress this is where the self-insurance aspect comes from, one thing we always talk about on self-insurance is that the employer controls the claim data. In other words, they get the claim data and they can react to that data.

So, if you see something, you know, an example of we know we have a higher incidence of pre-diabetic care, we can create a wellness program custom made just for that employer, that helps people with pre-diabetic care or helps them in controlling their diet, or other types of programs that can incentivize people to take a little bit better care of themselves, or to early identify an issue, to react to it.

This is something you won't see in a normal health insurance market. Why? Because the health insurance market isn't going to be customized to the employer. When the employer is self-funding, they become their own self-funded plan, they become a 100 percent nonprofit plan, because, again, the employer is not taking a profit off the employee benefits.

They have an incentive to create healthy employees and productive employees. That's why we see the benefit of self-insurance and the ability to access wellness benefits as critical to that component.

Mr. WILSON of South Carolina. Thank you very much. Mr. Hurst, you provided a unique perspective with the different healthcare mandates that have been suggested, imposed, or mandated in Massachusetts.

Can you provide insight into the impact ObamaCare has had on small businesses that face the increasing cost, and what would the *Small Business Health Fairness Act* do to improve the situation?

Mr. HURST. Thank you, Mr. Wilson. I believe that this legislation is critical because you have to look at what's happening in the marketplace. In Massachusetts, 60 percent of the commercial marketplace is already self-insured, and growing.

What happens when you go self-insured, you have opportunities, particularly if you're a small business buying in a merger, small group marketplace, you have the ability, for instance, to certainly do the wellness programs and to educate your employees on the proper location for various services, but you also have to deal with what you're talking about, the mandates.

You have the opportunity of avoiding State mandates. I can give Massachusetts as an example. Since RomneyCare passed 11 years ago, we passed 19 State mandates, nearly two per year, through our legislature.

You know, it's no secret that the healthcare industry is very, very powerful. You know, to pass more mandates, what it does, it puts more money in their pocket, it raises their utilization. If you're a retailer it's called "raising traffic," right; for healthcare providers it's raising utilization. It also affords them the ability to raise their prices. You know, if there's no choices, if there is not the ability for consumers to say no, the provider, whether it be a Big Pharma company or a hospital, are going to raise their prices.

Under ERISA, these big self-insurance companies can, in fact, avoid the State mandates. In Massachusetts, we survey every year, at least 12 on any given year are not covered by over 90 percent of the ERISA-exempt self-insureds, and that is government discrimination, okay.

So, if you're a large company and you're self-insured, you're avoiding State mandates. If you're a small business, there's another reason why your premiums are much higher.

Mr. WILSON of South Carolina. Thank you. Thank you for your insight.

Chairwoman FOXX. Thank you, Mr. Hurst. Thank you, Mr. Wilson. Mr. Courtney, you are recognized for five minutes.

Mr. COURTNEY. Thank you, Madam Chairwoman, and to the witnesses for being here today.

Again, I would just like to sort of follow up on a couple of the opening comments that the Chairwoman quoted, actually someone from Connecticut, Mark Bertolini from Aetna, regarding the question of death spiral.

He raises a very significant issue right now in terms of the stability of the exchanges, but I think if you read a little bit deeper into his comments, the question of stability is really about the future of subsidies for next year in terms of whether or not carriers are going to have any confidence that people have benefited from enrolling in the individual market and the small market. And I can tell you some stories about some small businesses that have actually done quite well with the exchanges and the tax credit, which your remarks did not mention, Mr. Hurst, through the ACA.

Again, Mr. Bertolini went on to say, you know, there is a solution here, which is basically to set up a reinsurance mechanism, kind of like a stop-loss, for high-cost claims that again flow through these markets.

Again, we did have reinsurance in the first three years of the ACA. That expired. You know, a clear fix to try to stabilize those markets is to extend that reinsurance mechanism that was in the law originally.

Again, reinsurance is a tried and true mechanism in Federal programs, whether it is flood insurance, terrorism insurance, nuclear power plant insurance, and it actually was in the Republican prescription drug plan, the part D program, which has a reinsurance mechanism that has actually kept premiums in the Medicare part D program quite stable.

Kudos to the Republican leadership who incorporated that into the prescription drug plan that was enacted back around 2002 or 2003.

So, again, there are solutions here to deal with some of the instability that exists in the market, but, frankly, that is not what we are hearing from the Republican majority. It is too bad.

Again, I think there are a lot of people who are serious, people who actually do know the complexity of the health insurance market, that could address these problems.

Even with that, in Connecticut, we just closed the books on an enrollment period for 2017. We again had a very strong enrollment. The average age of new enrollees in the Connecticut individual market exchange actually went down last year from 39 to 35. I want to repeat that. The average age went down from 39 to 35.

That is not an indicator of a death spiral. I mean, again, we had younger, healthier lives enrolling in the exchange, even with the spike in premiums, because, again, the subsidies shielded 75 percent of the people who were enrolling in that marketplace.

To the extent, again, looking forward, there is uncertainty regarding the future of the subsidies, that is what is making insurers skittish about actually participating in the 2018 enrollment period.

Madam Chairwoman, I actually have an AP story which quotes the American Academy of Actuaries about whether or not, in fact, we are seeing a death spiral in terms of the enrollment. Again, this is not a partisan organization. If they debate something, it is usually about numbers. That is what actuaries do. We have a lot of them who live in Connecticut.

Again, I ask that the "AP Fact Check, ObamaCare is not in a Death Spiral" be entered into the record.

Chairwoman FOXX. Without objection.

[The information follows:]

BUSINESS INSIDER

AP FACT CHECK: Obamacare is not in a 'death spiral'

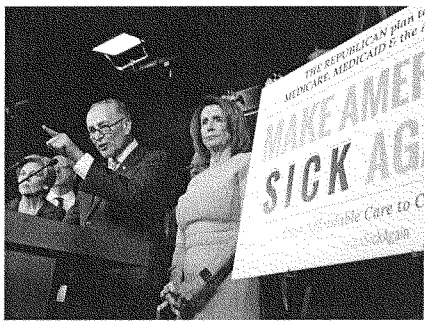
AP ERICA WERNER, ASSOCIATED PRESS
JAN. 10, 2017, 5:24 AM

WASHINGTON (AP) — President-elect Donald Trump says that President Barack Obama's health care law "will fall of its own weight."

House Speaker Paul Ryan says the law is "in what the actuaries call a death spiral."

And Senate Majority Leader Mitch McConnell says that "by nearly any measure, Obamacare has failed."

The problem with all these claims: They are exaggerated, if not downright false.



Kevin Lamarque/Reuters

As congressional Republicans prepare to repeal the health law, they are working to portray it as a mess of Democrats' making, and themselves as the ones who will clean up that mess.

In the process they are exaggerating the law's very real problems, according to health care experts, who largely believe that the Affordable Care Act's troubles with high prices and lack of competition could be addressed with bipartisan solutions.

Republicans, who've gained political advantage from campaigning against the law since its passage in 2010, aren't interested in playing along. Instead they've denounced the law and made the case to repeal it, although there are signs some are getting cold feet now that the reality is upon them.

Democrats, too, are guilty of rhetorical excesses around the health care law, often claiming that it's working as intended while downplaying its flaws.

But with Republicans in the majority and driving the agenda, here's a look at some of the GOP claims about the law, and how they compare with the facts:

TRUMP, RYAN AND MCCONNELL: The law will "fall of its own weight," is in a "death spiral" and "has failed."

THE FACTS: Experts agree that the law is not currently in a "death spiral," an actuarial term that refers to a vicious cycle when rising insurance costs force healthy customers out of the marketplace, resulting in still higher

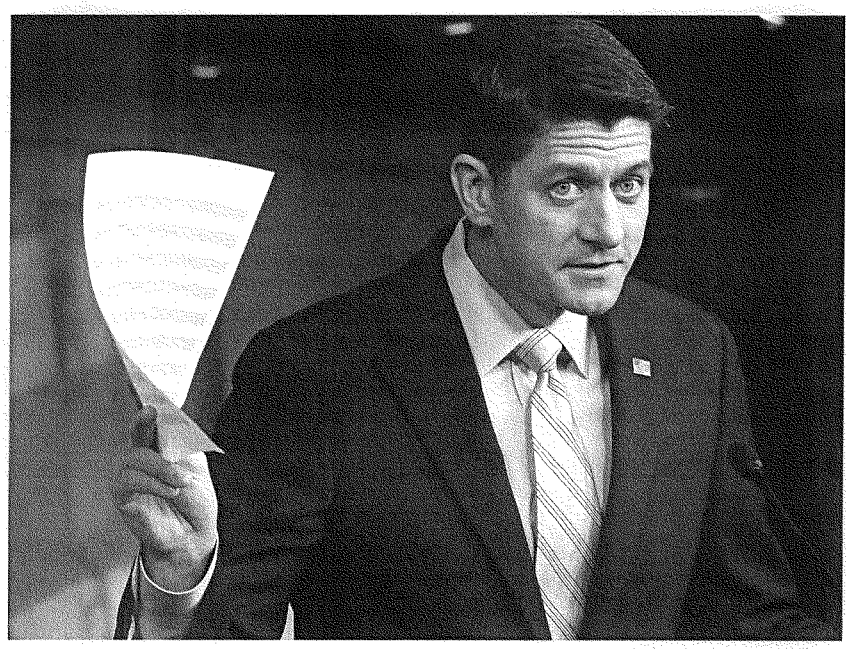
prices, which cause even more customers to bail, etc., until the system collapses.

But some say that if the current situation continues, that is a likely or possible scenario. Health care premiums are jumping by double digits this year, and the health care marketplaces created by the law are short on the healthy consumers who make insurance companies profitable.

"It's not a failure in that 20 million people or more have insurance that didn't used to have insurance. Everything else, it's too early to judge," said economist Gail Wilensky, who ran Medicare under former President George H.W. Bush.

"To say that the exchange markets remain unstable and in turmoil is an appropriate statement," she said. "To say that they're in a death spiral really depends on what happens."

The American Academy of Actuaries itself disputed the "death spiral" claim Monday. The group provided a statement from its senior health fellow asserting that high premium increases in many states this year "do not necessarily indicate that a premium spiral is occurring" and could be a one-time adjustment.



House Speaker Paul Ryan (R-WI) speaks to the media on repealing the Affordable Care Act, during his weekly news conference on Capitol Hill January 5, 2017 in Washington, DC.

Mark Wilson/Getty Images

RYAN: "You cannot fix a fundamentally broken law; you've got to replace it."

THE FACTS: Experts agree that Congress could fix the law's problems, should it choose. Indeed many argue that some of the law's problems can be traced to the decision by Obama and Democrats to push it through on a partisan basis — alienating Republicans who have refused ever since to participate in any attempt to tweak the law to improve it, as would be necessary with any program of such size and complexity.

Some predict that when Republicans get through with their repeal-and-replace effort, what it will really amount to will be an improved Obamacare — even if they don't admit it.

The health care exchanges, for example, could be improved with changes aimed at getting more young and healthy people to sign up, such as giving insurers more flexibility to charge older people higher prices.

"You could, I think, relatively simply address the issues that the exchanges have," said Dan Mendelson, president of Avalere Health, a health consulting firm, noting that other major programs including Medicare have been tweaked repeatedly since their creation. "If you freeze a program in a point of time, it is likely to have problems, and that's exactly what's happening."

Bob Laszewski, a health care consultant, predicted: "Before this all ends they're going to fix it ... The Republicans are going to say they repealed and replaced, and the Democrats are going to say they fixed it."

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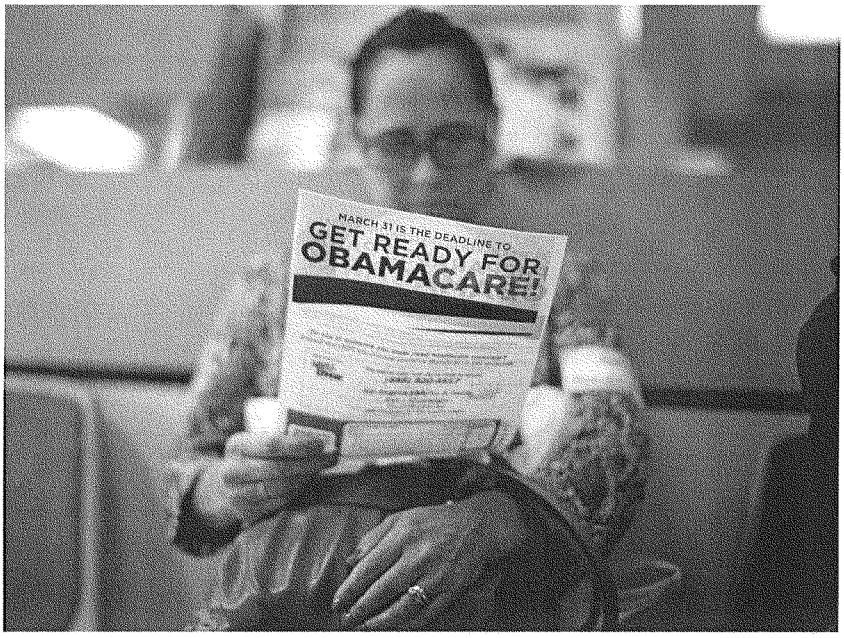

Arminda Murillo, 54, reads a leaflet on Obamacare at a health insurance enrollment event in Cudahy, California, U.S. March 27, 2014.

Lucy Nicholson/Reuters

MCCONNELL: Obamacare "didn't lower costs, it didn't increase choice."

THE FACTS: McConnell's comments are true in part.

The first five years of Obama's presidency saw historically slow growth in U.S. health care spending, though experts differ on whether the law had anything to do with that. Some credit the global recession. Individual consumers in the law's marketplaces, meanwhile, face higher premiums this year, though subsidies protected most customers from the increases.

And while the Affordable Care Act did increase choice initially in the individual market, that is not the case now with brand-name insurers bailing out of the online state markets, although the many Americans with employer-based health coverage have been insulated from such changes.

In about one-third of U.S. counties, consumers in the individual markets don't have a choice of plans.

"It depends for whom you're talking about," said Larry Levitt, senior vice president at the Kaiser Family Foundation. "For people with pre-existing conditions, choices are infinitely more abundant because they couldn't get coverage at all. For someone who's young and healthy there are likely fewer choices available now than before."

Associated Press writer Ricardo Alonso-Zaldivar contributed to this report.

EDITOR'S NOTE _ A look at the veracity of claims by political figures

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Mr. COURTNEY. So, again, real quick, Ms. Mitts, in terms of the Association Health Plan that is before us right now, again, as a former small employer, you know, I understand the fact that because of the smallness of the groups, you know, it is harder to spread risk, but I guess the real question is what we are really looking at is relaxing some of the patient protections that were built into the ACA that this legislation seeks to do, for example, lifetime limits. Maybe just sort of talk about that in terms of what we are sacrificing with that kind of legislation.

Ms. MITTS. So, if we moved backwards to a situation where small group coverage wasn't protected under rating requirements that they now are, so now all small groups need to be community rated, and it's been a huge benefit for many small employers who have workforces that did have healthcare needs, who prior to the *Affordable Care Act* had trouble getting competitive rates in the marketplace because they could be charged higher premiums, we would move back to a situation where we have some small employers who are able to get competitive rates through an Association Health Plan, who have risk segmentation, so the people who really can't benefit from an Association Health Plan because they're not offered competitive rates because they do have workers who have healthcare needs.

That's not a viable option for them, and now we've left this small group market with a less robust risk pool, and premiums will go up for everyone. So, there definitely is an impact on premiums.

Beyond that, workers could lose coverage of really important benefits, including maternity coverage. Previously, it was less likely for Association Health Plans to sometimes cover autism benefits that are a lifeline for many working families.

So, there is a lot on the line if we move backwards to a deregulated market for some small businesses.

Mr. COURTNEY. Thank you.

Chairwoman FOXX. Thank you. Mr. Walberg, you are recognized for five minutes.

Mr. WALBERG. Thank you, Madam Chairwoman. Thank you to the panel for being here. Representative Sam Johnson and I recently introduced H.R. 1101, as you know, the *Small Business Health Fairness Act*. It was introduced to allow small businesses the option to pool together to offer health benefits.

I want to make it very clear, the option. Hearing some of the dire suggestions is just concerning. We can make up all of the opportunities that would go in the wrong direction, in fact, and forget about the fact that did happen with the *Affordable Care Act*. Neither is it affordable anymore. The outcome, you may have a piece of paper, but you do not have coverage. You do not have options.

We have heard many stories of how small businesses find it difficult to find affordable coverage. According to a 2015 study by the National Federation of Independent Businesses, the cost of health insurance is the principal reason that small businesses do not offer coverage. Of the 60 percent of small employers that do not offer coverage, 52 percent cited cost as the reason.

Small businesses continue to drop coverage. According to the Employee Benefits Research Institute, since 2008, approximately 36

percent of small businesses with fewer than 10 employees have stopped offering coverage.

So, I would like to submit for the record a letter coming from over 35 business associations, small business associations, that stand in favor of the opportunity that is afforded by H.R. 1101. I would like to submit that for the record.

Chairwoman FOXX. Without objection.

[The information follows:]

February 28, 2017

The Honorable Sam Johnson
U.S. House of Representatives
2304 Rayburn House Office Building
Washington, DC 20515

The Honorable Tim Walberg
U.S. House of Representatives
2436 Rayburn House Office Building
Washington, DC 20515

Dear Representatives Johnson and Walberg:

The undersigned groups thank you for your leadership in introducing H.R. 1101, the Small Business Health Fairness Act. This legislation allows small businesses an option to access affordable health insurance coverage through Association Health Plans (AHPs) and is a step towards building a more competitive market.

The rising cost of health insurance remains a major problem for small business owners. In 2015, 25 percent fewer small businesses offered health insurance than when the Affordable Care Act (ACA) passed in 2010, a significant drop in small business coverage. As health insurance costs continue to increase, fewer employers and working families can afford coverage.

We believe AHPs will help lower the cost of health insurance by allowing small business owners the same opportunities that larger businesses now experience. AHPs will allow small business owners to band together across state lines through their membership in a bona fide trade or professional association to purchase health coverage. Establishing health insurance benefits through associations will make coverage more affordable by spreading risk among a much larger group, strengthening negotiating power with plans and providers, and reducing administrative costs.

Thank you again for your leadership on this issue. As congressional action takes place to replace the ACA with market-based solutions, we look forward to working with you to improve the health insurance markets where small businesses and employees purchase coverage. Small business needs legislative solutions that lower health insurance costs and increase flexibility to maintain a competitive workforce.

Sincerely,
4A's - American Association of Advertising Agencies
Air Conditioning Contractors of America
American Council of Engineering Companies
American Farm Bureau Federation
American Foundry Society
American Hotel & Lodging Association
American Rental Association
American Society of Association Executives
American Veterinary Medical Association
Associated Builders and Contractors
Associated General Contractors
Auto Care Association
Electronic Security Association

Far West Equipment Dealers Association
Farm Equipment Manufacturers Association
Independent Electrical Contractors
International Franchise Association
Manufacturers Education and Training Alliance of CT
National Association of Chemical Distributors
National Association of Home Builders
National Association of Manufacturers
National Association of REALTORS®
National Association of Wholesaler-Distributors
National Federation of Independent Business
National Restaurant Association
National Retail Federation
National Roofing Contractors Association
National Tooling and Machining Association
National Utility Contractors Association
North American Die Casting Association
Precision Machined Products Association
Precision Metalforming Association
Self-Insurance Institute of America, Inc.
Small Business & Entrepreneurship Council
U.S. Chamber of Commerce
Western Equipment Dealers Association

Mr. WALBERG. Thank you. Mr. Hurst, you testified that ObamaCare relegated small businesses and their employees to a second-class consumer status versus their larger self-insured competitors. You also stated that ObamaCare prohibits you from taking full advantage of steps your State took to offer small businesses more options for coverage.

Based on your experience, let me ask, how will the *Small Business Health Fairness Act* help small businesses like those that belong to the Retailers Association of Massachusetts?

Mr. HURST. Thank you, Congressman. What ObamaCare, what the ACA did, it preempted a whole lot of innovation in States, one of which was a very socialized effort in the small group market as far as rating factors. Rating factors are what State regulators use to set premiums for small businesses. The more rating factors you have, the fairer the rates that you have for the small businesses.

What the ACA did, it rolled back rating factors to only four. In Massachusetts, we used to have 11. You know, what you want to try to do is to have fair rates, to make sure people are not unfairly cross-subsidizing others.

If this legislation passes, I believe you're going to see a lot of associations, a lot of the chambers of commerce, looking at an option, whether it be they self-insure or fully insure, to get out there and be proactive in lowering costs for their employees. Not only for them, but also we have a big growing pot of health care, and there's an issue of how we divide that up. Right now, it's not being divided up fairly. It's being divided up unfairly.

We need to stop the growth, but we also need to divide it more fairly, and this will help do that, but it also will engage those business associations, the professional societies, and chambers of commerce to better educate their employees and members about the importance of wellness programs, the importance of going to the community hospital instead of the big teaching hospital where the costs are three times higher.

We need more education of our consumers out there and our associations are the right vehicle to do that.

Mr. WALBERG. Thank you. Mr. Ritchie, can you explain the benefits of a self-funded Association Health Plan for an employer offering benefits to employees under this bill?

Mr. RITCHIE. Yes. One thing I'd like to talk about, we just had the analysis of these are small employers and they're trying to compete. Well, when you talk about putting them in an Association Health Plan, you're pulling them out. They're not small employers anymore from a risk basis. They have bound together in a bona fide association, so it's not been a newly created association, it's a bona fide association, and now they're able to purchase coverage as a larger employer.

One thing we talked about was Mr. Bertolini and his comments about whether the individual market is in a death spiral or not. What we know as a fact is the employer market is not in a death spiral. It's a very healthy market. It's a very competitive market, and it's mainly what is controlling costs in the USA right now. Sixty-one percent of all employees who get coverage through their employer get it under a self-funded plan.

That's a material thing. That shows you that self-insurance is working. It is not broken. So, when we talk about an association, we're allowing small employers in another format, if they can't do it on their own and standalone basis, to come forward and say, yes, I want to be part of a larger group. I want to look at maybe having a health insurance product, maybe I want to be self-funded. I want to have the choices, but I want to be together with a bona fide association to provide coverage for my members or my employees.

Mr. WALBERG. Thank you. I yield back.

Chairwoman FOXX. Thank you very much. Ms. Fudge, you are recognized for five minutes.

Ms. FUDGE. Thank you very much, Madam Chair, and thank you all for being here today. You know, it is interesting to me that any time the majority does not like something, they just deal with it ad nauseam, over and over and over again.

We have voted more than 60 times to repeal the *Affordable Care Act*, and they did not even pretend to have a replacement. Just repeal it. What would make you think they have a replacement now? This is nothing more than just stalling until they can come up with a plan. They have no clue what to do to replace it.

As a matter of fact, the President said it is just complicated. It is complicated. I know it is hard. Sixty-five times with no replacement plan.

You know, I listened to the Chairwoman talking about people coming to town halls. I had a town hall on Saturday, because I know that when I was elected, I was elected to represent every single person in the district I represented, even those who disagree with me. That is my job.

So, I listened to what the people said. There was not one who believed that we should repeal the *Affordable Care Act*. Can we make it better? Absolutely. They want it fixed. They do not want it destroyed. What we want to do here is to destroy it because we have no earthly idea how to fix it.

I wonder how many hearings we are going to have on this. They did not like NLRB. We had 26 hearings. I wonder how many we will have on this before they come up with a plan.

Ms. Mitts, even though we have not talked about this today, they have this great idea that health savings plans are the answer to all of our problems. Could you please talk a bit about how someone maybe with cancer or someone who has some long-term illness would go into absolute bankruptcy with a health savings plan?

Ms. MITTS. Thank you for your question. Health savings accounts do not work for the vast majority of working people in this country, middle-income families who are living paycheck to paycheck. Basically, it asks people to pay full freight for their health care, they're tied to plans with high deductibles.

Data has shown and research has shown that most families do not have that type of money in liquid assets, in any financial assets, to pay $2,000, $3,000 in medical bills.

So, health savings accounts are not the solution for working families. They just cannot afford to put that money aside in an account where literally they cannot use it for anything other than health care. They have an emergency fund for health care, for their house, for their children, so it's really not a solution, and it's a cost shift

to families, and would leave them exposed to bankruptcy and medical debt.

Ms. FUDGE. Even though some people think we live in an alternative universe, I do not deal in alternative facts. It is a fact that 20 million more people have health care because of the *Affordable Care Act*. It is a fact that people are no longer going into bankruptcy because they are sick. It is a fact that young people can stay on their parents' insurance until they are 26. It is a fact that right now, a person who is sick can get help and not have to worry about paying their bills.

So, let us just deal with some facts. What happens if we restrict or reduce the amount of Medicaid expansion in our States? What happens to these people who now have insurance, who after we change whatever it is they are going to change, because I still do not know what that is, what happens if we roll back Medicaid expansion?

Ms. MITTS. Medicaid expansion has expanded coverage to millions of working people in this country. The majority of people who have benefited from Medicaid expansion are working adults. They would be left without any affordable coverage option and likely go uninsured.

We've seen people's access to preventive care and primary care improve thanks to the Medicaid expansion, and that's benefited enrollees of the expansion, as well as their workers, who now have a healthier workforce coming into work every single day.

Rolling back the Medicaid expansion would have dire consequences for States who have seen an economic boost from the Federal funds coming in. It's created jobs and lifted up their economies. So, the cuts have dire consequences for the low-income people who have relied on Medicaid for affordable coverage as well as their States.

Ms. FUDGE. Thank you for just the facts, just the facts. Thank you. I yield back.

Chairwoman FOXX. Thank you, Ms. Fudge. Mr. Barletta, you are recognized for five minutes.

Mr. BARLETTA. Thank you. Mr. Hurst, thank you for being here today. As you well know, many individuals do not have the luxury of employer-sponsored health coverage on the sole basis that they are, in fact, their own boss. I have heard from many of my constituents who are faced with this problem, especially farmers.

Luckily, they were afforded the opportunity to receive coverage through the Pennsylvania Farm Bureau. At one point in time, the Pennsylvania Farm Bureau provided coverage to almost half of the farmers that belong to the organization through an Association Health Plan. This arrangement worked very well for the Farm Bureau's hardworking members. When they had a question concerning their coverage, they were able to simply call the Pennsylvania Farm Bureau, a welcomed alternative to calling a 1–800 number that likely would have immediately put them on hold.

However, perhaps the best part of this arrangement was the cost for both the Farm Bureau and its membership. Since the rates were set by experience, the prices were affordable.

The farmers in my district will tell you they do not go to the doctor for every cut or every scrape they may have, and this char-

acteristic resulted in relatively low coverage costs. Of course, when they needed care, it was available to them, and the Farm Bureau prides itself on the benefits they were able to administer.

However, all of this changed thanks to ObamaCare. Under ObamaCare, arrangements like the one used by the Pennsylvania Farm Bureau were no longer viable. Costs for these farmers went up because the rates were no longer based on the Farm Bureau's coverage pool alone, but rather on a larger community rating based on individuals outside of the organization. This is because the Pennsylvania Farm Bureau could no longer offer their Association Health Plans to their members.

In short, President Obama's failed healthcare law decreased flexibility for groups like the Pennsylvania Farm Bureau and, in turn, hardworking farmers and their families.

I am a strong believer and supporter of Association Health Plans and the idea that small businesses should be able to pull together to offer their employees affordable health coverage. I agree with you that we must give organizations and small businesses this option.

However, I think that we must continue to explore innovative options that lower the cost of health care even further. Based on your experience in Massachusetts, what type of benefits and cost savings do you think groups like the Pennsylvania Farm Bureau and their members would experience if they were allowed to pool with groups across State lines to deliver health coverage?

Mr. HURST. Thank you, Congressman. I will say farm bureaus across the country had very viable programs, including in Massachusetts, and serving a very important part of the economy. What we've done is we've essentially asked them to unfairly cross-subsidize others, where we don't do the same thing for big business or big government who are ERISA-exempt.

So, that's unfair. It's discriminatory under the law and under the marketplace.

What the Pennsylvania Farm Bureau and other small business associations can do is they can get proactive with their employees, their families, and make sure they understand the importance of wellness, for instance.

If you get well and prevent certain accidents and certain diseases, you know, you're going to avoid claims. If you avoid claims, your premiums should come down. There's a reason why large employers self-insure, right? There's a reason why they do wellness programs, because if people get healthier, your premiums are going to drop.

It's the same thing if you educate your employee base that you need to go to XYZ provider rather than ABC who is a higher cost and no better in the area of quality. We need more education of the small business employees as well about the right setting for the right care, and that's what these plans can do.

Mr. BARLETTA. Thank you. Thank you, Madam Chair.

Chairwoman FOXX. Thank you very much. Mr. Polis, you are next for five minutes.

Mr. POLIS. Thank you, Madam Chair. Today, 20,000 coal miners received notice that their retiree healthcare benefits will be cut off for 60 days when the Continuing Resolution expires.

They received the notice because last December Congress passed a four month patch for coal workers' healthcare benefits instead of the permanent fix that many of us in a bipartisan way proposed to cover miners' health care.

A copy of that 60-day notice is on the easel in front of us. I would like to ask unanimous consent to enter this notice to miners into the record.

Chairwoman FOXX. Without objection.

[The information follows:]

UMWA HEALTH AND RETIREMENT FUNDS
2121 K Street, NW • Suite 350 • Washington, DC 20037 • Telephone: 202.521.2200

March 1, 2017 (Non-Medicare)

Name
Address
City State Zip

The UMWA 1993 Benefit Plan notified you in December 2016 that the U.S. Congress had passed the Continuing Health Benefits for Miners Act, which provided for the transfer of federal funds to the Plan to cover the health care benefits you receive through April 30, 2017. The Plan cautioned that further Congressional action would be necessary in order for the Plan to provide health care coverage to you after April 30. At this time, Congress has not taken the action needed to continue your benefits. **Unless Congress acts before the end of April, the 1993 Benefit Plan will not be able to provide you with the health benefits that you have been receiving from the 1993 Plan, and those benefits will terminate effective May 1, 2017. In addition, your Funds health service card will no longer be valid.**

Please see the attached information sheet for other coverage options that may be available to you if your 1993 Plan benefits terminate on May 1, 2017. Please feel free to call our call center at 1-800-291-1425 if you have questions or need assistance.

Sincerely,

Lorraine Lewis, Executive Director
On behalf of the Trustees of the UMWA 1993 Benefit Plan

Non-Medicare Coverage Options

Health Insurance Marketplace (Affordable Care Act) Coverage

If your 1993 Plan benefits terminate on May 1, 2017, you will have a 60-day special enrollment period to sign up for health coverage through the Health Insurance Marketplace. However, depending on the date that you enroll, your coverage may not become effective until June or July 2017. Depending on your circumstances, you may qualify for a premium tax credit or cost-sharing subsidies to help you pay for coverage. Please note that if your 1993 Plan benefits terminate and you do not enroll in other health coverage, you may have to pay a penalty when you file your federal income tax return.

There are four ways to apply for coverage through the Health Insurance Marketplace. You can:

- Apply online at www.healthcare.gov and select your state to get started.
- Apply by phone: Call 1-800-318-2596 (TTY: 1-855-889-4325). The Marketplace Call Center is open 24 hours a day, 7 days a week.
- Apply in person: Speak to trained people in your community like Navigators, assisters, agents, and brokers. Go to https://localhelp.healthcare.gov and enter your zip code to see a list of groups and people near you.
- Apply by mail: Complete a paper application and mail it in. To get an application, call the Marketplace Call Center number above.

Medicaid Coverage and Veterans Benefits

You may also be eligible for Medicaid or Veterans' medical benefits. You may apply for Medicaid at any time by filling out an application online at www.healthcare.gov or by contacting your state's Medicaid office directly. The VA encourages all Veterans to apply for VA health care benefits. To get more information about applying call 1-877-222-8387 or you may apply online at www.vets.gov/healthcare/apply/.

UMWA HEALTH AND RETIREMENT FUNDS
2121 K Street, NW • Suite 350 • Washington, DC 20037 • Telephone: 202.521.2200

March 1, 2017 (Medicare)

Name
Address
City State Zip

The UMWA 1993 Benefit Plan notified you in December 2016 that the U.S. Congress had passed the Continuing Health Benefits for Miners Act, which provided for the transfer of federal funds to the Plan to cover the health care benefits you receive through April 30, 2017. The Plan cautioned that further Congressional action would be necessary in order for the Plan to provide health care coverage to you after April 30. At this time, Congress has not taken the action needed to continue your benefits. **Unless Congress takes action before the end of April, the 1993 Benefit Plan will not be able to provide you with the health benefits that you have been receiving from the 1993 Plan, including prescription drug coverage, and will no longer pay your Medicare coinsurance and deductibles. Those benefits will be terminated effective May 1, 2017, and your Funds health service card will no longer be valid.**

As a Medicare beneficiary, your Medicare benefits will continue, including Medicare Part A coverage (for hospital benefits), and Medicare Part B coverage (for physician services and other services such as durable medical equipment). These benefits will be administered by the Medicare program and not by the UMWA Health & Retirement Funds, however, and you will need to show your Medicare cards to your health care providers. **Although there is no charge for Medicare Part A, you must continue to pay your monthly premium to continue to receive Medicare Part B.**

Please see the attached information sheet for other coverage options that may be available to you if your 1993 Plan benefits terminate on May 1, 2017. Please feel free to call our call center at 1-800-291-1425 if you have questions or need assistance.

Sincerely,

Lorraine Lewis, Executive Director
On behalf of the Trustees of the UMWA 1993 Benefit Plan

Medicare Coverage Options

Medicare Part D Prescription Drug Coverage

If you want to receive coverage for prescription drugs, you will need to select and enroll in a Medicare Part D prescription drug plan for an additional monthly premium. **You will have an opportunity to do so during a special enrollment period that is in effect now and ends on June 30, 2017.** The effective date is generally the first day of the month after the application is submitted. (NOTE: if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage). To join a Medicare Prescription Drug Plan: Enroll on the Medicare Plan Finder found on www.Medicare.gov or on the website of the Medicare Prescription Drug Plan that you want to join; Complete a paper enrollment form; Call the Medicare Prescription Drug Plan; or Call 1-800-MEDICARE.

Medicare Supplement Insurance (Medigap)

If you want to obtain Medicare Supplement Insurance (Medigap) to cover Medicare deductibles and coinsurance, you must obtain Medigap coverage, which will also require an additional premium. **You will have the right to do so during a special enrollment period that is in effect now and will end on July 2, 2017.** During the special enrollment period the Medigap issuer you select must sell you a policy, must cover any preexisting conditions you have, and cannot charge you more for the policy because of any past or present health problems. You can get more information about Medigap plans at www.medicare.gov/find-a-plan/questions/medigap-home.aspx or by calling 1-800-MEDICARE. You can also call your State Health Insurance Assistance Program (SHIP), and they can give you free help in choosing a policy. SHIP contact information can be found at www.shiptacenter.org/about-us/about-ships/.

Medicare Advantage Plans

You may also have the option of enrolling in a Medicare Advantage plan, if this type of Medicare plan is available in your area, during a **special enrollment period that is in effect now and ends on June 30, 2017.** The effective date is generally the first day of the month after the application is submitted. Most Medicare Advantage plans include Part D prescription drug coverage. You can get more information about Medicare Advantage plans sold in your at www.medicare.gov/find-a-plan/questions/home.aspx or by calling 1-800-MEDICARE.

Medicaid Coverage and Veterans Benefits

You may also be eligible for Medicaid or Veterans' medical benefits. You may apply for Medicaid at any time by filling out an application online at www.healthcare.gov or by contacting your state's Medicaid office directly. The VA encourages all Veterans to apply for VA health

care benefits. To get more information about applying call 1-877-222-8387 or you may apply online at www.vets.gov/healthcare/apply/.

Mr. POLIS. I am entering this nice small one into the record, Madam Chair.

Chairwoman FOXX. I was going to allude to that. I figured you would do that.

Mr. POLIS. I recognize that the record is better reflected for paper-sized pieces.

I joined on a bipartisan basis with Representative David McKinley and Representative Frederica Wilson in cosponsoring the *Miners Protection Act*, H.R. 179. It would transfer balances from the Abandoned Mines Land Fund to a healthcare plan to cover coal miners whose employers filed for bankruptcy in the last several years.

Frankly, if we fail to act on the *Miners Protection Act* by the end of April, miners who are not Medicare eligible, which is the vast majority, have been advised that they have the option of securing health insurance on the Affordable Care Exchange, but, as we know, the President and House leadership have vowed to repeal the Affordable Care Exchange, leaving the miners with no recourse.

Miners have held up their end of the bargain, giving up higher pay for retiree health care down the road, and I would hope that we could find bipartisan support to honor that agreement and ensure that these coal miners do not lose retiree healthcare benefits that they earned.

Moving on to the hearing before us, I want to thank the Chairwoman for yielding. We find ourselves again considering proposals that threaten to weaken the healthcare system that has insured over 20 million more Americans over the last 6 years.

In my own State of Colorado alone, the number of people without insurance dropped in half, to 6.7 percent. For Colorado children, the uninsured rate is even lower, 2.5 percent.

Well of course, the *Affordable Care Act* can be improved. Many of the proposals that I worry might come before us would weaken rather than strengthen health care in our country.

There is a lot of progress, and I hope that my colleagues on both sides of the aisle agree we need to keep—I hope we can keep the fact insurers can have some lifetime coverage, and it is a good way of preventing medical bankruptcies and devastating families.

I do not think we should charge women more just because of their gender. I do not think we should deny child coverage due to illness contracted at infancy. It is also important to keep mental health parity. That is an essential health benefit which has proven to lower costs in the long run.

We need to move forward from that baseline rather than return to a time when basic healthcare services were not guaranteed. Frankly, my constituents are deeply worried about what the absence of a plan means for them. I have heard from people who use mental health services as well as mental health professionals. I have heard from LGBT advocates. I have heard from parents of children with terminal illnesses. I have heard from self-employed entrepreneurs with preexisting conditions. I have heard from young adults. Each story is unique, but the common thread is that without the ACA, they worry a lot about where we are going to be.

Rolling back protections and coverage implemented in the ACA threatens the health and welfare of hundreds of thousands of Coloradoans and their families, millions of people across the country.

Ms. Mitts, my home State of Colorado was one of the 31 States that expanded Medicaid as part of the *Affordable Care Act*. That law allowed about 350,000 Coloradoans to receive health care.

If Congress were to eliminate the Medicaid expansion, our State is at risk of losing close to $2 billion in Federal Medicaid dollars that are absolutely essential to care for low-income residents in my State, and I do not know what the plan would be without that.

I spoke to a community health center in a mountain community that stressed the importance of the program, and do not know how they can reach their patient population without it.

Ms. Mitts, what do you foresee is the damage that weakening Medicaid would do to health insurance coverage for American families, and can you address proposals to block grant the program or institute per capita caps?

Ms. MITTS. Thank you for your question. Repealing the Medicaid expansion, which basically was a lifeline for millions of lower income people who up until that point did not have any access to affordable coverage, would basically scale back immense progress and leave those people uninsured.

In terms of proposals to block grant or per capita cap the Medicaid program, that translates to immense cuts to the program. They will leave states making hard decisions about rolling back the number of people enrolled in the program, cutting benefits, cutting provider rates.

The bottom line is that in all of those scenarios, enrollees lose out, and their access to care is harmed.

Mr. POLIS. Thank you, Madam Chair. I yield back.

Chairwoman FOXX. Thank you. Mr. Byrne, you are recognized for five minutes.

Mr. BYRNE. Thank you, Madam Chairman. Ms. Klausner, I really appreciate your testimony, but I have to admit, I am having a little deja vu listening to you.

Back in the 1990s, I was a labor employment attorney representing small- and medium-sized businesses when Congress passed the *Americans With Disabilities Act*, a bipartisan bill.

Everybody in America wants to see disabled people be successful in the workplace. Except when the law was passed, no one thought how that law was going to work with State and Workers' Comp laws, because some people become disabled because of a workplace injury.

A few years later, Congress passed the *Family Medical Leave Act*, and no one thought how the *Family Medical Leave Act* would work with the *Americans With Disabilities Act*, would work with State and Workers' Comp laws. So instead of accomplishing our objective, we simply made things a lot more complicated and difficult for the goal that everybody wanted to get to, to actually be achieved.

Now, here we are in the 2010s, and everyone wants wellness programs, except we get these regulations in 2013 that take us in one direction from the Secretary of Labor, HHS, Treasury, and in 2015,

we get a conflicting regulation from the EEOC under ADA and GINA. I think you have alluded to that in your testimony.

So, the goal we are trying to get to, which is to get wellness programs out in the workplace that are good for our American citizens and our workers, is impeded by the fact that we now have two competing regulations.

So, I am sorry, I am having deja vu all over again, to quote Yogi Berra. Maybe we have the best of intentions, but by having these conflicts, we are making it more difficult to achieve the goal we are trying to achieve.

We have a proposed law in front of us, the *Preserving Employee Wellness Program Act*. Tell me how in your judgment that would improve things. Tell me how that would improve things so we get to that goal.

Ms. KLAUSNER. Thank you for your question, Mr. Byrne. You're absolutely right, that the layering of the different laws and regulations has caused complexity and conflict, and ultimately a chilling effect on employers who are trying very hard to successfully design and implement wellness programs for their employees, as well as their families.

What employers are finding is that the *Affordable Care Act*, which codified the HIPAA rules, allowed employers to have a great amount of flexibility while providing tremendous protection to the consumer, the employee, and his or her family.

For example, it allowed the 30 percent rule to be one where the premiums or the incentives or the surcharges were done with respect to not only the self-only employee coverage, if that was the tier they were in, but also relative to family coverage. It also allowed there to be an increase for tobacco-related cessation programs, an additional 20 percent to bump up to 50 percent.

When the *Affordable Care Act* rules were there, it was very exciting. However, when the Americans With Disabilities rules came in recently, it did not align with those ACA rules, those HIPAA rules. Suddenly, employers were stuck with a position of saying, well, how do I access/leverage that terrific 20 percent bump to encourage my employees and perhaps their families to stop smoking or to otherwise use tobacco products, which ultimately lead to claims?

We're not suggesting that every tobacco user can stop, but to the extent that we can design programs that maximum the opportunities for people to take the initiative, take behavioral changes, to lower the risk that comes from tobacco use, we can no longer do that up to the 50 percent limit because of the *Americans With Disabilities Act*.

GINA is another example. Employers would like to be able to have wellness programs in their workplace that are not only for employees and not only for their spouses, but also for their adult dependent children. The *Affordable Care Act* has been a very strong reason why employers now allow the children of their employees to stay on their plans up to age 26. Perhaps some employer plans had that before the *Affordable Care Act*, but not necessarily that many.

The adult children who are up to age 26 may have valuable opportunities to learn from wellness programs. They may have an opportunity to understand their own biometrics, their own health

risks, that they can then go to their doctors under their own plans and learn how to make choices to lower their own health risks that are preventable. However—

Mr. BYRNE. My time is up, if you could make it real quick.

Ms. KLAUSNER. Absolutely. GINA does not really allow the wellness programs to be for dependent children, whereas they can be under the *Affordable Care Act* rules and the HIPAA rules.

So, if we were to have complexity simplified, if we could make the rules better aligned, employers will have better opportunities to customize and create flexible programs so their employees and their families can have their most optimal performance, both in terms of their health and at the workplace.

Mr. BYRNE. Thank you for your testimony. Thank you, Madam Chairman.

Chairwoman FOXX. You are quite welcome. Ms. Bonamici, you are recognized for five minutes.

Ms. BONAMICI. Thank you, Madam Chairwoman, and thank you to our witnesses for testifying today.

I appreciate the objectives that are named in the title of this hearing, "Improve healthcare coverage and provide lower costs for families." That sounds like the *Affordable Care Act* to me, and certainly the more than 2,600 people who showed up at a health care town hall meeting I had with our Senators recently share that sentiment.

We have talked a lot about small businesses here today. Mike Roach is the owner of Paloma Clothing in Portland, Oregon. He said, "I greatly benefited from the ACA during the years it has been in place, and I wish more of us had spoken up loudly so that the public, Congress, and the President had a better understanding of that." He said the ACA helped to slow the rising of insurance premiums for his small group of covered employees.

In my home State of Oregon, nearly one in five individuals had no health insurance coverage before the ACA. I used to, years ago, do financial counseling at Legal Aid, and many of the people who came in thinking that they really needed to file bankruptcy were there because they had medical bills. They either had no insurance or inadequate insurance.

Today, more than 95 percent of Oregonians are covered, including about 56,000 children, and low-income working adults in my district who benefit from the expansion of Medicaid.

Ms. Mitts, Oregon has done a lot of innovative work to provide coordinated care while reducing costs. This is true not just in urban and suburban areas, but in rural areas as well. Our coordinated care organizations are doing amazing work with coordinating health care, mental health care, vision care, dental care, working with early childhood, and really seeing great results.

So, I know you in response to Mr. Polis talked about the proposals such as block grants or per capita allotment and how that might affect those efforts. I wonder if you could talk a little bit about, geographically, how would this affect rural areas in terms of if there were block granting or per capita, how would it affect the rural communities where there are jobs there and increased access because of the *Affordable Care Act*?

Ms. MITTS. Thank you for your question. In the world of per capita caps, there would likely be huge enrollment cuts or benefit cuts that would have a detrimental impact on rural communities' access.

Rural communities have benefited immensely from the expansion of the Medicaid program, and you would see fewer people enrolled. You could see them losing benefits. You could see them having a harder time finding a provider because they have provider rates that they have to cut.

The real challenge of it is that it really leaves states holding the bag, like Oregon, who want to do innovative things and who have had the resources to do those innovative things and make immense progress in improving care coordination and quality of life for people. They won't have the resources to pursue those types of innovative strategies to connect medical care to community-based services any more.

Ms. BONAMICI. Thank you. I know my constituents are extremely concerned about it. And Ms. Mitts, the ACA included, as we know, unprecedented new consumer protections for patients, such as eliminating annual and lifetime limits, preventing insurers from dropping people when they get sick, and charging women higher premiums.

What will happen to these protections in Association Health Plans?

Ms. MITTS. Under the bill put forth to you today, those Association Health Plans would no longer have to comply with so many of those rating protections that have been a huge benefit to many small businesses that before the *Affordable Care Act* actually had a really hard time finding affordable coverage for their employees because they employed employees who actually had healthcare needs, who were maybe older, and the market didn't work for them before.

So, we would move back to a situation where we would have a segmented market, and people who are healthy and in pristine health could move into an Association Health Plan.

I think the thing that is important to keep in mind is that doesn't mean that an Association Health Plan would always be there and work for that small employer. If their workforce got older, claims went up, they might find that an Association Health Plan charges them more, and it's not a viable option for them anymore.

Ms. BONAMICI. I know there have been some solvency concerns about some of the Association Health Plans. Can you address that?

Ms. MITTS. Historically, there have been concerns about Association Health Plans not having adequate solvency funds. They have leaner, less rigid requirements than typical health insurance coverage. Partially, State oversight was added to that to help address some of these problems, the bigger problems for when they were just under ERISA.

When a plan goes insolvent, an Association Health Plan goes insolvent, their employers and their workers are still left with all of those unpaid medical claims, and are on the hook for them. If the plans are not under State jurisdiction, they won't be able to benefit

from State guaranty funds that help pay those claims, so they'll be left on the hook for them.

Ms. BONAMICI. Thank you. I see my time has expired. I yield back. Thank you, Madam Chair.

Chairwoman FOXX. Thank you very much, Ms. Bonamici. Mr. Allen, you are recognized for five minutes.

Mr. ALLEN. Thank you, Chairwoman. Thank you for being with us today. I think these hearings are good. I keep waiting for the magic formula that is going to fix this problem.

We know health care is basically a disaster for most Americans. I get story after story of people who actually are not getting preventive health care, Ms. Klausner, because their deductibles are too high, so they cannot get medical attention. Now, the costs are going to go up because the next thing that is going to happen is they are going to be forced to have critical care.

I agree with you that we spend about 25 percent, at least from what I researched, of every dollar on preventive care versus about 75 percent of every dollar on critical care. If we could just get that evened up, we would save huge sums of money.

Now, I am going to ask this question on behalf of my wife. She is big in nutrition, and I have to confess, she stays on me all the time about some things I eat. I am also on the Committee of Agriculture. We have had hearings on nutrition.

I just did some research, and I saw that the cost curve on nutrition and number of participants and the cost curve on Medicaid and the number of participants is on the same upward trend.

In your studies, have you looked at the nutrition side and any types of savings we could generate, particularly in dealing with the rising healthcare costs?

Ms. KLAUSNER. Thank you very much for your question. I am glad to see that families are together involved in trying to create wellness among each member of the family.

In terms of your absolute specific question, I would like to go back and look at our study and see whether or not we did, in fact, specifically look at the value of nutrition.

What I can say is that the wellness programs are ones that really are sought to help individuals identify for themselves where they have issues that ultimately they can work on, as I said before, with their doctors individually, but the aggregate information gets collected in a way that can then help employers to make changes, not only with their employer-sponsored plans, but also with the whole culture of the workplace.

So, if I were to look at your issue, not specifically yours, but the issue you raised in terms of nutrition, through health risk assessments we have learned that individuals might not actually know what food is causing their high blood pressure or what foods could lower their cholesterol, or how those different issues work together, or if they do have an illness, they have irritable bowel syndrome or Crohn's, how they can deal with it.

Ultimately, that information will help them personally with their doctors to getting preventive care and maintenance care or to deal with the actual illness, but it also allows the employer at the aggregate level to recognize that perhaps they would change something in their workplace. Their cafeteria might have more fresh

food. Their cafeteria might end up being set down the hall so it takes more steps to walk there.

It all works together. So what I think is very important is that employers are looking to create an environment by utilizing these workplace wellness programs to improve the health of the employee and their family, as well as to create a productive workforce.

Mr. ALLEN. Nutrition is a part of that program?

Ms. KLAUSNER. Absolutely, nutrition is a part of it.

Mr. ALLEN. Mr. Ritchie, on self-insured programs, obviously the business community—I am involved in small business—obviously, we are going to self-insurance because we are trying to stabilize costs, the cost increase.

I believe you said that program is working fairly well, but if we could basically release it and make it more available, it might be an answer to the rising cost of health insurance.

Mr. RITCHIE. I would say self-insurance is not going to answer the rising cost of health insurance. You still have the underlying medical costs which were increasing at a phenomenal rate that the market is really struggling to keep up with.

What self-insurance does is it doesn't allow them to double down. If you're a health insurer, you're going to take the increasing cost of medical insurance and, due to our new medical loss ratio law, get a profit percentage on the rising increase of that cost. So, you take it into a self-insured model and you're not paying the health insurer's profits on top of your rising costs. That's the value of self-insurance. You're taking it and you're controlling your own destination, and keeping it at a true cost basis.

Mr. ALLEN. I yield back.

Chairwoman FOXX. Thank you very much. Ms. Blunt Rochester, you are recognized for five minutes.

Ms. BLUNT ROCHESTER. Thank you, Madam Chair and Ranking Member Scott. I would also like to thank the panel.

First, I would like to ask unanimous consent to enter into the committee record a letter from Governor John Carney to Senator Ron Wyden dated February 22, 2017, to discuss the potential impact of the proposed Medicaid changes in the *Affordable Care Act* for my State of Delaware, as well as a letter from the National Association of Insurance Commissioners.

Chairwoman FOXX. Without objection.

[The information follows:]

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February 22, 2017

The Honorable Ron Wyden
Ranking Member
U.S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Sen. Wyden,

Thank you for your letter dated January 19, 2017 regarding the potential impact to Delaware of proposed changes to the Medicaid program. Please see the below responses to your questions. Should you have any additional questions or wish to discuss this matter in more detail, please do not hesitate to contact me. I can be reached through Emily Kuiken at (202) 624-7724 or Emily.Kuiken@state.de.us.

1. **How would a 30 plus percent cut in federal financial participation in Chairman Price's fiscal year 2017 budget proposal impact your state Medicaid program?**

   A budget cut of this magnitude would be devastating to the Medicaid program in Delaware. Absorbing an immediate reduction of this size could only be accomplished by eliminating coverage for non-mandatory eligibility groups, most notably non-caregiver adults (60,000 individuals out of a total enrollment of 230,000). Given that we are nearly half-way through the fiscal year, it is unlikely that even this draconian measure could achieve the necessary budget reduction.

2. **How would repeal of the Medicaid expansion affect health coverage rates in your state?**

   Delaware is proud of the gains we have made in improving health coverage rates through both the Medicaid Expansion and the Marketplace. It is important to note, however, that these efforts began in 1996 with a Medicaid demonstration waiver that expanded coverage to all adults below 100% of the federal poverty level. Repeal of the Medicaid expansion would eliminate enhanced federal funding that has allowed Delaware to maintain the prior expansion as well as implement the ACA expansion to 133% of the

FPL. The result, as noted above, could be the elimination of coverage for 60,000 adults reducing health coverage rates to levels not seen since 1996.

3. **How would repeal of the Medicaid expansion impact your state Medicaid budgets? What would be the impact on other state budget priorities such as education? Would your state be able to raise revenues or otherwise compensate for the loss of federal funding?**

   Repeal of the Medicaid expansion would result in a reduction in federal funding estimated at $170 million. This figure includes both savings from enhanced funding for the state's early expansion ($120 million) as well as funding for the ACA expansion ($50 million). That represents a 13% reduction in federal funding. The state would need to increase its current Medicaid appropriation by 21% to offset such a loss.

The Delaware Department of Education's concerns relative to school-age children and schools, are as follows:

1. Medicaid and CHIP provide necessary medical coverage to children with highest need, in terms of severe medical conditions and poverty. If there is a reduction in benefits for these children, their health will suffer. That will directly impact their ability to learn.
2. A number of our students with severe disabilities require the services of a one-on-one nurse or health aide to monitor 24/7 and provide life-saving interventions. If this service were disallowed or reduced, the child's life would, quite literally, be placed at risk. A full-time school nurse in a school building cannot assume responsibility for one-on-one care while also providing safe care for an entire school's population of students.
3. In the past, our schools for students with severe health conditions, like Howard T. Ennis or Leach, generated the most reimbursement for services and the money they generated was required to go directly back to that individual school. These schools have used the CSCRP funds to hire additional nurses and support. Reduction in funds to these schools could impact services and safety.
4. School Based Health Centers who may be dependent on or relying on Medicaid billing, a reduction in Medicaid dollars would compromise their ability to continue services.

4. **How would these levels of cuts impact your ability to meet the needs of an aging baby boomer population expected to require more long-term services and supports, including nursing home care and personal care services?**

   Delaware Medicaid has made significant progress in reforming the LTSS delivery system to better support individuals in community-based settings over the past five years. We recognize that demands for service will increase in the future. Significant funding cuts at

this point will force difficult choices to be made that will limit our ability to provide a full continuum of services and supports for this growing population.

5. **How would these level of cuts impact your ability to combat the opioid epidemic and mental health crisis and meet the needs of those with mental health and substance use disorder needs?**

   Delaware Medicaid has partnered with the Division of Substance Abuse and Mental Health in their efforts to enhance mental health and substance use disorder services. This includes expansion of Medicaid coverage for SUD treatment services as well as development of a new waiver program to offer specialized services for individuals with Severe and Persistent Mental Illness (SPMI). Funding cuts would not only eliminate access to many of these services if Medicaid eligibility levels are reduced but may require a review of these optional services to see if they can be sustained.

6. **How would these levels of cuts impact your ability to invest in innovative changes to your health care delivery system?**

   Delaware has been actively involved in a SIM health care delivery transformation planning and implementation effort for several years. We are at a critical stage now where initial efforts to provide practice transformation and care coordination support are being put in place to support value based purchasing strategies. Funding cuts now could halt these efforts designed to provide long term return on investment through better health outcomes and reduced costs.

7. **How would these levels of cuts impact your ability to respond to public health crises such as the Zika virus or increases in HIV cases?**

   Nearly all of DPH's funding to respond to HIV and Zika are federal funds. Therefore, a cut in federal funds would have critical direct impacts. It would most certainly mean laying off personnel who are responsible for tracking the occurrence of these infections, and, in the case of Zika, investigation of suspect cases. Testing for Zika virus and other mosquito borne viruses will be hampered. This testing is important not only to diagnose disease in individual patients but also to conduct surveillance for these diseases so that mitigation measures can be applied to protect the health of the public as is done through the non-human surveillance program that DPH carries out in collaboration with DNREC (looking for west nile virus in sentinel chickens and conducting mosquito surveillance for disease vectoring mosquitos). In addition, treatment and access to social supports for HIV infected persons- currently going on through the Ryan White program- would be hindered. It would likely mean cessation of educational efforts to prevent these

infections, and for HIV the provision of counseling and testing services, case management and community outreach.

Another direct impact of federal funding cuts would be that DPH laboratory will be unable to test for Ebola virus disease and other similar high impact emerging pathogens as this capacity is completely supported by federal funds (Through the epidemiology and laboratory capacity and the Public Health preparedness grants). This is particularly significant because for diseases such as Ebola for which there is such significant morbidity and mortality, hospital labs and commercial labs often do not have the capacity to test. At present, DPH laboratory is the only lab in the state that tests for Ebola. In addition, the laboratory preparedness network is a federally funded program that allows the Division of Public Health lab (and other state and territorial labs) to rapidly test and detect agents of bioterrorism in human and environmental samples. Cuts to federal funds could hinder or eliminate this capability

With regard specifically to the impact of the repeal of the Affordable Care Act on the prevention and control of infectious diseases in DE:

- 6 of our 9 infectious disease epidemiologists are funded by ACA/PPHF funds. 2 microbiologists (contractual) are also funded off of these funds. Loss of these staff will mean that we are severely hampered in our ability to investigate and contain disease outbreaks. Our ability to test for and halt outbreaks of gastrointestinal diseases; healthcare associated infections, influenza and emerging infectious diseases as well as our ability to test for other respiratory viral pathogens and for vaccine preventable diseases such as mumps and measles would be greatly impacted.
- The impact on vaccine preventable diseases would extend beyond inability to conduct laboratory testing. Childhood Immunization Section 317 grants help ensure that the right vaccines get to the right people at the right time to protect their health and the health of their communities and prevent resurgences of life-threatening vaccine preventable diseases. Section 317 maintains immunization infrastructure including vaccine registries, surveillance, outreach and service delivery. Loss of the PPHF funds will greatly impact our (highly successful and nationally recognized) immunization program by loss of staff (10.25 FTEs) and loss of funding to run the program
- Medicaid is the largest payer for HIV care. Access to early and effective HIV care significantly improves the health of people living with HIV and greatly reduces their risk of transmitting the virus to others. A reduction in federal Medicaid spending will shift costs to the states and widen state-based health disparities. By increasing state financial risk, Delaware's Medicaid program will

be unable to respond to increases in demand, new treatment advances or public health emergencies such as Zika. States will be forced to cut eligibility, essential services and provider payments.

8. **How would these levels of cuts impact your ability to respond to an economic downturn such as a recession?**

   Economic downturns are accompanied by increasing demands for health care and social services. In the past, the federal government has been very responsive in financially assisting states to address these challenges. Reduced federal funding and proposed federal Medicaid reforms such as block grants would severely limit states' ability to effectively serve impacted residents in such a crisis.

9. **How would these levels of cuts impact your ability to respond to new high-cost medical breakthroughs such as Sovaldi and other blockbuster drugs.**

   As stated above, reduced federal funding will severely limit our ability to respond to any unanticipated cost driver.

10. **How would these levels of cuts impact your ability to respond to natural and other disasters such as Hurricane Katrina, Superstorm Sandy, and the Flint water crisis?**

    As stated above, reduced federal funding will severely limit our ability to respond to any unanticipated cost driver.

11. **How would these levels of cuts impact your ability to provide affordable family planning services, including contraceptive coverage to low-income women and families?**

    Delaware Medicaid has partnered with the Division of Public Health to implement the Contraceptive Access Now (CAN) initiative to ensure that all women in Delaware have access to appropriate contraceptive strategies. We recognize the importance of avoiding unintended pregnancies to improve birth outcomes and promote overall family health. Funding cuts could jeopardize the future of this initiative and funding for Long Acting Reversible Contraceptives (LARCs).

12. **How would these levels of cuts impact hospital and provider payments? What types of increases in uncompensated care would you expect to see in your state given such cuts?**

    Since funding cuts would likely result in loss of coverage for a large number of adults, uncompensated care would increase dramatically. This would, most likely, be

accompanied by reductions in preventive care and care to manage chronic conditions. Consequently, health quality would decline and treatment would be concentrated in emergency rooms and urgent care centers. The increase in uncompensated care would also lead to demands for reimbursement increases from commercial and government payers.

13. How would these levels of cuts impact localities in your state, such as counties and local jails?

While an inmate is incarcerated they do not receive Medicaid. However, if an inmate goes to the hospital while in custody and is admitted (post 24 hours), Delaware Department of Corrections can apply for Medicaid, and if approved, receive Medicaid hospital rates. Unfortunately when the ACA was passed, it affected inmates over 65 as they could no longer get Medicaid if hospitalized. This already costs DOC and our medical provider millions of dollars. Therefore any further reduction in Medicaid would have a direct impact on DOC. Reduced funding would likely impact inmates when they leave DOC and go to the community where they will be expected to get their medical care.

14. What kind of cuts would state have to contemplate under these levels of cuts in federal financing for state Medicaid programs?

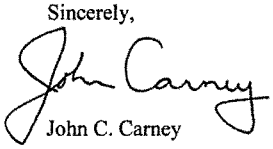
At a minimum, the state would very seriously consider rolling back eligibility and services to the levels that existed before the initial expansion of eligibility to 100% of the federal poverty level that occurred in 1996 under then-Governor Carper. We would also have to revisit Medicaid waivers created for long term supports helping those with severe and persistent mental illness remain in the community. An estimate of impact for these changes are 50,000 people would lose Medicaid coverage, and the remaining 175,000 enrollees would lose critical benefits that they need to remain healthy in their communities.

15. How else would these levels of cuts impact your state?

State governments throughout the nation are struggling to provide services to their citizens while facing uncertain economic times. According to the National Association of State Budget Officers (NASBO) Fall Fiscal Survey, twenty four states reported fiscal 2017 general fund revenues coming in below projections, the highest number of states expecting revenue shortfalls at that time in the fiscal year since 2010. Certainly Delaware has not been immune to such issues. Current year revenue projections as estimated by the Delaware Economic and Financial Advisory Council (DEFAC) for the State have fallen $70 million since the fiscal year 2017 budget was enacted in July, 2016.

The outlook for fiscal year 2018 remains similarly pessimistic. Delaware's fiscal year 2018 revenue is projected to be flat, increasing by only 0.4% over fiscal year 2017. In combination with mandated cost drivers for items such as projected enrollment increases in our schools, and projected growth in Medicaid it leads to an estimated gap for the Fiscal Year 2018 budget of approximately $350 million. Delaware policy makers will be faced with difficult decisions on funding essential services that Delawareans count on such as providing a quality education, protecting those most in need, and ensuring the public's safety. It is clear that in this context, the State would be hard pressed to absorb an estimated $120 million in additional obligations due to the federal government reneging on their share of the costs for the Medicaid expanded population.

Sincerely,



John C. Carney
Governor
State of Delaware

February 28, 2017

The Honorable Virginia Foxx, Chair
Committee on Education and the Workforce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Robert C. Scott, Ranking Member
Committee on Education and the Workforce
U.S. House of Representatives
Washington, D.C. 20515

Dear Madame Chairwoman and Mr. Ranking Member:

The U.S. House Education and the Workforce Committee is once again scheduled to consider legislation that would allow a new category of health insurance company, "Association Health Plans (AHPs)," to form and operate outside the authority of state regulators and beyond the reach of proven state consumer protections and solvency laws. This bill, H.R. 1101, would adversely impact consumers and the National Association of Insurance Commissioners (NAIC) urges you to oppose it.

The NAIC, which represents the nation's insurance regulators, shares the sponsors' concern for the growing number of small business owners and employees who cannot afford adequate coverage. However, the root cause of this problem is the steadily rising cost of healthcare merely reflected in premiums, and this legislation would do nothing to address that reality. In fact, we fear the legislation could actually ***increase*** the cost of insurance for many small businesses whose employees are not members of an AHP.

Even more troubling than prescribing a treatment that does not address the underlying disease, the legislation would actually harm consumers by further segmenting the small group market, eliminating critical state consumer protections, and could lead to increased fraud and plan failures. This legislation would encourage AHPs to "cherry-pick" healthy groups by designing benefit packages and setting rates so that unhealthy groups are disadvantaged. This, in turn, would make existing state risk pools even riskier and more expensive for insurance carriers, thus making it even harder for sick groups to afford insurance. In addition, the legislation as written would eliminate all state consumer protections and solvency standards that ensure consumers receive the coverage for which they pay their monthly premium. These protections are the very core of a state regulatory system that has protected consumers for nearly 150 years. As we have already seen in the past when such plans were allowed under federal law, consumers will be left with unpaid claims and nowhere to turn when they are harmed. A prior law along the lines of H.R. 1101 was repealed because it was found to harm consumers; the same mistake should not be made again.

We recognize that supporters of AHPs are well intentioned, looking for solutions to the same problems we are seeking to address, but history has demonstrated that AHP-type entities have done more harm than good to small businesses. A far broader approach to the existing problems – one that addresses healthcare spending, allows more innovation, and permits more state flexibility – is necessary to bring real relief to small businesses. The federal government and the states need to work with healthcare

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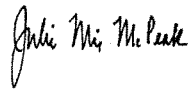
providers, insurers and consumers to implement effective reforms that will curb spending and make insurance more affordable to small businesses. Rehashing strategies that have failed would not be a step forward. It is time to move on and find more effective solutions.

Sincerely,

Ted Nickel
NAIC President
Commissioner
Wisconsin Office of the
Commissioner of Insurance



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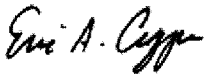

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NAIC Vice President
Superintendent
Maine Bureau of Insurance

David C. Mattax
NAIC Secretary-Treasurer
Commissioner of Insurance
Texas Department of Insurance

BLUNT ROCHESTER I would like to use my time to highlight a few concerns that I have about the House proposals to repeal the *Affordable Care Act*. First, I want to highlight for my colleagues two startling numbers.

One is the fact that repealing the Medicaid expansion part of the ACA would eliminate 60,000 adult Delawareans from our health care rolls, and open us up to a $170 million hole in my State's budget. For some, that might not seem big, but Delaware is very small, so it could have a catastrophic impact.

So, my first question is for Ms. Mitts. I really wanted to talk about the impact of Medicaid and whether or not a block grant versus a per capita cap is a viable option or a good solution, but you have already talked a lot about that. So one of the questions I did not hear answered was the fact that I think a lot of people have an impression of folks on Medicaid as single adults and families, but, Ms. Mitts, can you discuss the importance of Medicaid funding for long-term care for seniors and individuals with disabilities?

Ms. MITTS. Thank you for your question. So, Medicaid has long been a lifeline for individuals who are elderly, who are dual eligible, who get Medicaid benefits, are low income, and Medicaid helps them afford the care they need. They also provide critical long-term supports and services, nursing home care for many older adults.

Under a block grant or per capita cap situation, we're talking about in most proposals we have seen a 30 percent cut in the Medicaid budget. That's going to hit those highest cost patients in the Medicaid program. If a state is going to have to make cuts to their Medicaid program, they're going to have to make cuts there and really roll back coverage and care for some of the most vulnerable.

BLUNT ROCHESTER Thank you. My second question is actually for Ms. Klausner. You mentioned that consistent policy is key for businesses. Can you tell us how you and other members are reacting to the inconsistent policy proposals, messages, timelines? There are just so many different competing things out there.

I am just curious if you could talk about —and it is coming from the administration, it is coming from Republicans in the House and in the Senate, and also from governors. Can you talk a little bit about the impact of all this inconsistency?

Ms. KLAUSNER. Thank you for your question. Specifically, with regard to wellness programs, we are getting a lot of inconsistent information coming out of the different regulations. The impact of it is truly a chilling effect on employers being able to maximize reducing costs for employees and their families.

We have employees that desperately need the information, and employers that need the information, so they can create things like disease management programs, ones where the health risk assessment identifies for an individual that they have either diabetes or are pre-diabetic, some who may not have already known it through either a glucose test or a biometric screening.

Ultimately, we are able to then design plans on behalf of the employers so they could perhaps waive a co-pay for someone who has been identified as diabetic for maybe getting an eye exam or to get their insulin products.

However, it is unclear as to whether or not these management programs that are there to benefit employees who are either at risk for health conditions or, in fact, have adverse health conditions—we are challenged to create those programs because there is uncertainty or lack of clarity as to where they stand under the *Americans With Disabilities Act* as opposed to under the *Affordable Care Act*.

We would look to have more streamlined rules so we could maximize opportunities.

BLUNT ROCHESTER Thank you. I do not have a lot of time left, and I would have loved to ask everybody this question because one of my big concerns is the fact that because of this inconsistency of messaging, even the markets, whether it is insurers, others, are really skittish, as we have said.

So, I yield back the balance of my time. Thank you.

Chairwoman FOXX. Thank you. Ms. Blunt Rochester, you can submit questions to the witnesses and then ask for them to be answered. Thank you.

Mr. Rooney, you are recognized for five minutes.

Mr. ROONEY. Thank you, Chairman Foxx, Ranking Member Scott, and thank you to the panel. It has been very informative to me.

I would like to ask Mr. Ritchie right quick, as an employer like you, I think we would agree—I agree with your comments about how successful self-insurance plans have been. We know very well self-insurance aligns human motivation with their money, something which some people do not seem to understand, and stop-loss is critical to allowing smaller companies to offer them.

Would you just reiterate, just give us a little bit of your opinion about whether self-insurance might present an equally attractive option for public sector and multiemployer plans? I apologize if you already did this while I was out.

Mr. RITCHIE. Well, I would say, this is something I alluded to at the beginning of our testimony, for cities, local governments, and school districts, they represent 10 percent of my purchasers of stop-loss insurance. Taft-Hartley multiemployer plans represent 5 percent of it. So, they are a material utilizer of self-insurance and, therefore, stop-loss insurance when it makes sense for them. So, we've seen it as a huge opportunity and savings for those multiemployer plans.

One thing we talked about earlier was the miners' associations, and if there is a fund established for them. What I think is critical and what self-insurance does is it would say that all those funds go to pay benefits, and it allows it to do that, where it is not going into the health insurance mechanism where there is a profit percentage on it.

That's one thing that I think has been a little bit missed in this hearing so far. When we're talking about the *Self-Insurance Protection Act*, we are not talking about amending the *Affordable Care Act*. We are also just talking about protecting options for employers so they can finance the risk in an appropriate manner. That's all we are simply putting forth with this bill.

Mr. ROONEY. I would think with those low percentage market shares, there would be a lot of room to go up if the local government architecture supported it.

Mr. RITCHIE. I actually think the local districts are very much consumers. School districts are huge consumers of it. California School Districts have a large self-insurance program that they run through a broker in California. They have been utilizers of it. School districts usually tend to be around that 1,000 to 3,000 life market. That is in the absolute sweet spot for self-insurance with stop-loss coverage.

I think that market is robust, it's vibrant, and as I alluded to also earlier, the employer market is not the market that's broke. It's working. Employers have an incentive to take care of their employees. Small employers are competing with large employers. Large employers are also competing with small employers to attract and retain talent. They want to offer a benefit that makes sense.

If you're going to finance it, and you're going to ask me as an employer, I'm going to offer to pay for your coverage, I should have the right to know where the claims are going, to know what's happening with the spend, and then to customize my program to maximize that spend for the benefit of my employees.

Mr. ROONEY. Thank you very much. I have a little bit of time left. This is probably totally off message, but I am not a professional at this. This GINA law just takes the cake. I have to ask Ms. Klausner just a little bit about this GINA law. Just when you think you have seen it all with this Federal Government, you read about this thing.

I kind of feel like it's turning the back on allowing someone to know medical history and turning the back on the science of gene knowledge. It is kind of like when the medieval people would sail out to Gibraltar, the Pillars of Hercules, and turn around because they were scared the Earth was flat.

So, I would like to get your thoughts one more time about how we can make sure this law, which is concerning to me that it is on the books, can be stopped from preventing rewards and normal human incentives to make a wellness plan go well.

Ms. KLAUSNER. Thank you again for your questions. GINA is about genetic information, and genetic information is clearly something that is being utilized to improve the health of individuals. The science is developing. As the science develops, we want to make sure individuals have an opportunity to really understand it and use it for their own benefit.

What we are finding is that the inconsistencies in these rules are putting a real pause on the ability to design these programs. So, just by way of example, if we want to design a program that complies with the ACA rules, that allows there to be an incentive for a spouse to ultimately understand his or her own genetic makeup, that incentive is counted under one set of calculations under HIPAA, a different set of calculations or not counted perhaps at all under the *Americans With Disabilities Act*, and counted again differently under GINA in terms of the 30 percent rule, the 50 percent rule, et cetera.

So, we would like to see it to be streamlined so that we don't have to not do things that would acquire genetic information. When I say "acquire," they acquire on behalf of themselves and utilize at the risk of then saying, well, we wouldn't do another program, perhaps tobacco cessation or disease management program.

Mr. ROONEY. Thank you very much. Thank you, Ms. Foxx.

Chairwoman FOXX. Thank you, Mr. Rooney. Ms. Davis, you are recognized for five minutes.

Mrs. DAVIS. Thank you. Thank you, Madam Chair, and thank you all for being with us today.

I wanted to just go back to where we had been in terms of the discussions about flexibility and choice, because I think that is something we all feel is important, and yet we also know how that is developed has something to do with cost, and whether or not small businesses feel they can save money or any businesses, really, or any State for that matter. We want to be sure that if you lower the cost, you do not lower the quality of the care that is given.

So, could you share with me, do you support legislation that allows insurers to roll back consumer protections and benefits from the ACA? Are you in favor of legislation that would do that? To roll back that legislation? A simple yes or no is fine.

Ms. KLAUSNER. I think the answer to the question is that all of us in America would like to make sure that there are appropriate consumer protections in place.

Ms. MITTS. Our answer is simply no, we don't want to see the consumer protections that are in place right now rolled back in the health insurance industry.

Mr. RITCHIE. I think what we're talking about with the self-insurance is simply keeping choices alive, keeping choices to finance that risk however you wish to do it. You're correct, how you build this will be very critical.

One thing that has happened with the *Affordable Care Act* is we haven't seen costs controlled. You've seen expenses. Just like you talked about, just because you pay $100 for a doctor visit and someone pays $200 for a doctor visit, it doesn't mean there's a difference in the quality of that doctor visit.

We should incentivize and give employers the ability to say I want to build an incentive around getting the right providers with the right quality of choice.

Mr. HURST. Congresswoman, I believe what we're talking about, what I'm talking about, is empowering consumers to make some of these decisions on their own and, frankly, allowing insurers to make some of these decisions and work on behalf of the consumer rather than working on behalf of the provider.

If we dictate too much, "we" being government, dictate exactly what those plans have to look like, we're empowering the provider. We're not empowering the consumer. So, if we can let consumers decide really what type of plan they want, what they need, and what they can afford, that is better for everybody.

Mrs. DAVIS. Thank you. That sort of goes to one of the issues that has certainly been before a lot of us, and just talking about the protections in terms of what is available to people.

Do you support maintaining direct access to OB/GYN care, and continuing the ban on gender rating? Would you support maintaining direct access to OB/GYN?

Ms. KLAUSNER. I am here today testifying on behalf of the American Benefits Council and all its members. I have not surveyed them for the answer to that question, but I would imagine most would support that kind of access.

Mrs. DAVIS. And the ban on gender rating?

Ms. KLAUSNER. It is not something that I've had a conversation with our members on.

Ms. MITTS. Yes, we strongly support maintaining those protections. They've been essential for making sure that coverage is affordable for women and they actually can access the care they need.

Mr. RITCHIE. I'd like to go directly to the gender rating question. One thing I want to point out is under the *Health Insurance Affordability Act*, employers are not allowed to differentiate between a male employee or a female employee, or on age. A 21-year-old male pays the same thing as a 59-year-old female under the employer plan. They have to be treated the exact same. So, we've been under this rule for years.

What you guys do in the individual market is what you guys choose to do, but the employer market has been doing it, and we have been doing it well.

Mrs. DAVIS. It sounds like the employer market is basically alive and well, with some modifications. Mr. Hurst?

Mr. HURST. Congresswoman, you know what, I think reasonable people can sit down and talk about what coverages we need to maintain and what ones we need to give to the consumer, but some of them go overboard, particularly some of the State mandates.

In Massachusetts, we have a requirement for in vitro fertilization. I'm a 57-year-old male and my wife is the same age. Frankly, we don't need that coverage. We don't want that coverage. Many people in Massachusetts can't afford that coverage, yet we have to provide it because we're fully insured, yet if we were self-insured, we wouldn't have to cover it. And, frankly, most self-insureds do not, in fact, cover that mandate.

Mrs. DAVIS. Mr. Hurst, just in terms of maternity coverage and access to women's preventative services, is that something that should be part of all plans?

Mr. HURST. I believe so, yes.

Mrs. DAVIS. Anybody disagree with that, maternity coverage?

Mr. RITCHIE. I won't disagree with maternity coverage, but I will disagree with the fact that plans don't cover in vitro and don't cover those additional services. They absolutely do. It's the employer's choice if they want to cover it or not, and they'll do it over the population and the cost will be spread over the population.

Yes, I have quite a few plans—

Mrs. DAVIS. I am going to run out of time. I am sorry, sir. Preventative health services, is that something that should be part of the plans, generally? Does anybody disagree with preventative health services?

Ms. MITTS. I'll speak to it. Thank you for the question. I mean, preventive services with no cost-sharing has expanded access to

timely care for millions of people and help them do early identification, so we strongly support it being maintained.

Chairwoman FOXX. The gentlewoman's time has expired.

Mrs. DAVIS. Thank you.

Chairwoman FOXX. Ms. Stefanik, you are recognized for five minutes.

Ms. STEFANIK. Thank you, Madam Chair. When I travel across my district speaking with families and businesses, one of the most frequent concerns I hear about are related to their struggles with health care.

The *Affordable Care Act* has not been affordable. Premiums for families have skyrocketed and continue to climb. Average ACA premiums in New York alone rose by 16 percent last year, and deductibles have risen for many to a point where it does not even feel like they have insurance.

These concerns mirror my own personal experience with the ACA.

Coming from a small business family, I watched in 2013 as our employer insurance plan was canceled due to this law. This was in spite of the often-repeated falsehood that if you like your plan, you can keep it. What we got was a higher cost plan with lesser coverage.

ObamaCare is not working, and we must find a way for better options, more affordable options for health care. It would be irresponsible if lawmakers did nothing, while taxes and onerous mandates crush small businesses and families across this country and across my district.

Businesses such as Old Forge Hardware, which has been in existence since 1900 in the Adirondacks, will now be forced to stop offering their employees health coverage due to rate increases. As the owner of Old Forge Hardware stated herself, "If you want to see small towns in the Adirondacks disappear, then keep raising health insurance rates. There will be no small businesses left." This is not the future I want to see in my district.

This company employs 15 people year-round, and they treat their employees like family. Having to stop offering health insurance is a painful decision that is made out of necessity and not out of choices.

Fortunately, I am excited about solutions that we proposed to these problems. One of those is H.R. 1101, the *Small Business Health Fairness Act*, which would allow small businesses, like Old Forge Hardware, to join together through Association Health Plans.

My question is for Mr. Hurst. In your experience and in your opinion, can you discuss how Association Health Plans protect access to care for those employees who may suffer from rare or expensive diseases or medical conditions?

Mr. HURST. Absolutely, Congresswoman. In Massachusetts, I should recognize that we are a fully insured Association Health Plan. We are not self-insured. What this legislation could do is give us more flexibility to be self-insured. We follow all the State mandates. We do not discriminate amongst our members.

What we look to do is to make sure the margins are not taken off the backs of our small businesses. We look at following the law.

We do follow the law. We do not discriminate against our members that are really just for equality and nondiscrimination under the law.

Look, as long as the essential benefits package is there, no one is going to be ignoring the law, no one is going to be walking away from important mandates that everybody should and can have.

Ms. STEFANIK. My second question is also for you, Mr. Hurst. In your testimony, you state that small businesses should have the same marketplace rights to obtain comparable coverage at comparable rates as those that work for big businesses and the government. I think all here today would agree with that statement, and some would also argue that all businesses, both large and small, should face the same consumer protection requirements.

How would self-funded Association Health Plans be any different than their large business competitors in terms of consumer protection?

Mr. HURST. Absolutely the same. You know, 60 percent of the marketplace in Massachusetts is self-funded and growing. You know, to a large extent, the train is already leaving the station on this. Smaller and smaller businesses are self-funding on their own, or they're doing it through third parties. They are even looking at other options, such as professional employment organizations.

Not all these options are the great option for these small businesses. It works for some, not for others. This legislation is overdue by years. We need this because this is how small businesses and their employees want to buy health insurance, and it is how they can collectively make decisions and better their own employment base.

Ms. STEFANIK. Thank you. My time is about to expire. I yield back.

Chairwoman FOXX. Thank you very much. Ms. Adams, you are recognized for five minutes.

Ms. ADAMS. Thank you, Madam Chair, and Ranking Member Scott, thank all of you for your testimony today.

The Association of University Centers on Disabilities, the National Disabilities Rights Network, and the National Association of Councils on Developmental Disabilities all advocate for and provide hundreds of thousands of clinical services and home and community-based supports to people with disabilities and their families.

These organizations are concerned with the *Preserving Employee Wellness Program Act* as it would bypass certain protections within the ADA, which could result in workplace discrimination based on health status. The legislation would allow employers to penalize workers for not providing medical and genetic information, which could also leave them vulnerable to discrimination. So, without oversight by EEOC, it sets a dangerous precedent, that health plans can be exempted from civil rights status.

Ms. Mitts, are you concerned about how this legislation could impact people with disabilities?

Ms. MITTS. Thank you for your question. Yes. I think one of our primary concerns is that wellness program incentives are being potentially used in ways to shift costs to workers with disabilities who have higher needs, increasing their premiums, increasing their deductibles.

I think something that's been lost in this discussion so far is that right now employers can design consumer-friendly wellness programs that offer services, offer disease management programs, even offer health screenings to their employees, without putting their premiums and their access to coverage on the line. They do not need to use these types of discriminatory incentives that are problematic and undercut the ADA.

In fact, what research shows is that programs that offer disease management, lifestyle management services, and health screening services that are really comprehensive, they get a high participation rate without any incentives at all.

The research actually done by RAND questioned whether employer enthusiasm for incentives was warranted or whether building just a robust program that actually offered services to their employees was the better route.

Ms. ADAMS. Yes, ma'am. Thank you. The Republicans' leaked legislative draft includes placing those with health issues into high-risk pools. So, can you explain what this will do to individuals' insurance premiums, and how it is different from our current structure in ACA?

Ms. MITTS. Well, high-risk pools are an old idea, and they did not work for States before the *Affordable Care Act*. They covered a fraction of the people with preexisting conditions who are covered now under the ACA. There's about 52 million people in our country who without the ACA could be denied coverage because they have a preexisting condition.

Prior to the ACA, high-risk pools covered less than 500,000 people in total. On top of that, they had premiums 1.5 to 2 times the rate of healthy people. The premiums were unaffordable for many people, and oftentimes this coverage had waiting periods. They had to wait before their coverage kicked in.

There were lifetime caps, so if someone was really sick, they literally could be left with no coverage after they hit that lifetime cap, and sometimes the high-risk pool would literally exclude coverage for certain preexisting conditions for a certain number of months, leaving coverage useless at that point.

It was also expensive for States to operate. At the end of the day, it just is no replacement for the lifetime guarantee that people have right now, that they are guaranteed affordable coverage regardless of their preexisting condition.

Ms. ADAMS. Thank you. Finally, I want to hit on the overall impact that the Republicans' plan will have on patients versus what is offered in ACA. Of course, in my district my constituents are asking that we preserve and strengthen the ACA. You spoke about this as well.

Can you just give a brief overview of what this Republican plan would mean for patients and workers, particularly with regard to cost?

Ms. MITTS. You know, we have looked at a number of replacement plans and proposals, and really they would increase costs for millions of Americans. Many people would just simply go uninsured because coverage would be unaffordable. It would scale back incredibly important financial assistance for private coverage for lower- and middle-income people, and it would often leave people

in bare bone coverage with even higher deductibles, leaving them unable to afford care.

Ms. ADAMS. Thank you very much. I am out of time. Madam Chair, thank you. I yield back.

Chairwoman FOXX. Thank you very much, Ms. Adams. Mr. Guthrie, you are recognized for five minutes.

Mr. GUTHRIE. Thank you very much. This hearing is not on Medicaid, but I want to take a few seconds because we talked about Medicaid earlier. Medicaid expansion, if you let it go as it is, it doubles over the next 10 years. It is just unsustainable.

So, just to say we cannot do anything to Medicaid is just not addressing reality, unless you are here to offer or somebody is here to offer a broad-based taxing everybody in massive numbers to meet the growing costs. I do not think anybody is offering that. I guess they are just not wanting to address it.

Per capita caps. Every U.S. Senator that is in the Senate today, Patty Murray, a lot of them, Dick Durbin, who were in the U.S. Senate in the Clinton years, signed a letter to President Clinton to say they supported a per capita cap.

It is not a radical issue. It could be bipartisan if people chose to work together. Governors want flexibility. We had a previous governor of Kentucky last night talk about how great the expansion was, 100 percent Federal money. Our current governor is trying to come up with $100- to $200 million to make it work now. So, it is not just easy to deal with, and it is something we have to deal with and move forward.

I want to get to the bills before us today. Mr. Ritchie, how big or small is the self-funded health benefit market and how many employers are enrolled in plans that are self-insured and how many of those plans also carry stop-loss coverage?

Mr. RITCHIE. If you look at the self-funded market in terms of stop-loss coverage, we estimate that market to be somewhere between $12- to $14 billion. We consider ourselves one of the largest providers, and we are roughly at $1 billion, so it is about a 7 percent market share, which shows that it's a pretty competitive market. There is no one dominant carrier in the market, and there is no one person that holds all the market share.

When we look at the total population that is self-funded, I would refer back to the Kaiser Family Foundation study. They do an annual study every year. It's a fantastic study. What it says is that 61 percent of all people who get their coverage through their employer get it through a self-funded plan.

We could further break that down and say if those employers are over 200 lives, that number jumps to 82 percent. If it is below 200 lives, that number drops to about 13 percent.

So, obviously in the smallest markets, self-insurance is not that great of an option, not as popular as it is in the large employer market, but in the large employer market, it is very popular, self-insurance.

Mr. GUTHRIE. Stop-loss?

Mr. RITCHIE. Yes, it's stop-loss. Let's go to who buys stop-loss. That is generally going to be an employer somewhere between the 50 to about 5,000 life range. I don't have the stats for you on how

many employers are in that number. I personally insure 3,000 of them.

What we see is once you get about 5,000 lives, claims become pretty predictable and, therefore, there is no reason to even purchase stop-loss insurance anymore. You don't need that risk transfer mechanism. Who does need that risk transfer mechanism are those as you get smaller, so the smaller an employer gets, the more risk transfer they need to support their self-funded plan.

Now, that deductible is going to range over size and what kind of risk they have. I will sell a spec down to $20,000, but my average spec is $140,000. We generally try to price the coverage to where we only have somewhere between one to three claims in a year.

So, what we're trying to do with the *Self-Insurance Protection Act*, obviously, health insurance pays every claim. You're using it to finance your medical costs. With stop-loss coverage, it's obviously not health insurance coverage, because if I'm only expecting even over 1,000 lives, I have three claims a year that hit me, that's obviously not health insurance.

Mr. GUTHRIE. Is self-insurance coverage skimpier, skimpier than fully insured coverage?

Mr. RITCHIE. Only if you believe the largest employers in America are not offering competitive benefits. It is not skimpier. It is still subject to all the employer requirements of the *Affordable Care Act*. It doesn't get you out of those benefits or out of those responsibilities. It simply is a financing mechanism.

Mr. GUTHRIE. In my last minute, I want to go to Mr. Hurst. Mr. Hurst, critics of Association Health Plans often say that the creation of national Association Health Plans result in cherry-picking. They mean the insurance market will segregate into two groups: one that is younger and healthier, and one that is older and sicker.

Based on your experience in Massachusetts with your own versions of AHPs, under state law, do you believe this will be the result, and how does the *Small Business Fairness Act* react to this?

Mr. HURST. Well, number one, Congressman, it's illegal under our law. It would be illegal under this bill.

Number two, associations, chambers of commerce, professional societies, they aren't in the business of discriminating against their members. Their members run the association. They join for the benefits.

Number three and most importantly, these employees of small businesses, they are a slice of society. They're no more sick, no more healthy, no more older or younger than the rest of society out there. They're a cross section of society, yet they are being charged too much for the health insurance because they're discriminated against.

Mr. GUTHRIE. Thank you. Perfect timing. I yield back my zero time.

Chairwoman FOXX. Very good, Mr. Guthrie. Mr. Espaillat, you are recognized for five minutes.

Mr. ESPAILLAT. Thank you, Madam Chair, Ranking Member Scott. Just for the record, Madam Chair, I would like to state that if the *Affordable Care Act* is repealed, a hole of $3 billion will be in New York State's budget, 2.7 million New Yorkers will lose their

coverage, including 218,000 New Yorkers in New York County, Manhattan, and 300,000 New Yorkers in Bronx County, where my district is.

Within the 15th Congressional District, a total of 120,000 people would lose some level of Medicaid or Medicaid coverage, and 34,000 people will lose their basic healthcare plan. It will impact dramatically hospitals like New York-Presbyterian Hospital, Mount Sinai Hospital, Harlem Hospital, North General, and Montefiore in the Bronx.

My question is for Mr. Hurst. I think you can agree that there are strong consumer protections under the *Affordable Care Act*, like no annual or lifetime caps on health care, and guaranteed access to those with preexisting conditions, that have benefited millions.

You mentioned this proposal gives small businesses flexibility, but it seems like this flexibility could avoid conforming to strong consumer protections. It is not clear which ACA consumer protections the majority seeks to repeal. Coupled with this proposal, is this not inviting a race to the bottom for quality of coverage?

Mr. HURST. Thank you, Congressman. I don't believe so at all. Look, small businesses reflect society. Small businesses compete every day for employees. You're talking about the coverage for themselves and their families. They want good coverage. They want affordable coverage.

You know, I'm one that believes that personal responsibility is important, and I'm not particularly opposed to a mandate requiring people to buy health insurance, but the question is what is in that insurance? Can we empower the consumer to make some of the decisions on their own or is government—

Mr. ESPAILLAT. Your plan promotes a somewhat reduction in coverage, does it not? You mentioned there are certain benefits, certain parts of the plan that are not really necessary. Does not your proposal promote a reduction in the level of coverage?

Mr. HURST. Congressman, the only thing that would potentially be reduced, and it would be up to the collaboration of small businesses, is whether or not you follow a lot of these State mandates.

I mentioned earlier Massachusetts has passed an incredible whopping 19 state mandates over the last 10 years, since RomneyCare was passed. That's two per year. These are lobbied by big health care providers, people that are looking for higher utilization, and, most importantly, to raise their prices. What we need to look at is empowering the consumer, not the provider.

Mr. ESPAILLAT. You mentioned a particular service that as a 57-year-old, you and your wife were not interested in. Are there other healthcare services/benefits that you can see prudent to be reduced or eliminated?

Mr. HURST. Well, you know, the State of Maine has what they call "mandates to offer." What they do is almost like your auto insurance and your homeowner insurance, there are certain mandates that they leave it up to the consumer to decide, yes, this is a coverage that I want, my family wants, at a certain price, and here are others I don't want. You're empowering the consumer instead of government telling them or the insurer telling them—

Mr. ESPAILLAT. Is that not the essence of health care, that although I am not a diabetic, maybe there is no diabetes history in

my family, I could very well at some point in my life become a diabetic. If I do not have that coverage in my health insurance, is that not the problem if I run into a catastrophic disease that will take up a lot of money and just wipe me out, take my home, my car, my savings? Is that not really the problem, that we have to be prepared for those types of illnesses?

Mr. HURST. Well, I think with the essential benefit package under the ACA, everyone will continue to follow that, however this turns out. What we are primarily talking about are a lot of other State-mandated benefits that are designed to benefit the provider and, frankly, cause unfair cost subsidies from one consumer's pocket to somebody else's, and that's not particularly fair.

There comes a level you have to ask yourself, is this really insurance or is this almost a tax, a borderline tax, when you're asking people to buy insurance that they don't want, they will never use, and they can't afford.

Mr. ESPAILLAT. Thank you, Madam Chair. I think I have run out of time.

Chairwoman FOXX. Thank you very much. Dr. Roe, you are recognized for five minutes.

Mr. ROE. Thank you, Madam Chairman, I appreciate that. First of all, I want to get to a bill I had last year, the *Self-Insurance Protection Act*. Basically what it said was the Federal regulators cannot redefine "stop-loss insurance" as traditional health insurance, preserving the option for self-funding.

The reason I am familiar with it, before I came here, I was a city commissioner and mayor of my local community, Johnson City, Tennessee. We had about 2,000 employees in our self-insurance plan. It worked wonderful. We designed wellness programs to help lower costs, and we did that. We kept the premiums flat. We put in various things to help control our costs. It is a great way to do it.

Mr. Hurst, I could not agree more with you. If you allowed an Association Health Plan and a self-insurance program, where you could combine these even across State lines, I think you could really lower costs. People are very innovative when they are spending their own money.

You are correct, Mr. Ritchie, you do take out that chunk that the insurance company keeps as profit, and you manage that and keep it in your benefit package, or you can provide it as salaries.

Let me just say quickly that the *Affordable Care Act* said it wanted to lower costs and increase access. Who could disagree with that? What happened is exactly what happened in our State of Tennessee 20 years ago when we expanded Medicaid called "TennCare."

What happened was I could have done two-thirds to three-fourths of what the *Affordable Care Act* did in two paragraphs. One, allow 26-year-olds to stay on their parents' plan; and, two, expand Medicaid, which is a plan that not a lot of providers, especially providers where I practiced medicine—we cannot get somebody to see somebody for the reimbursement they get. We added 10 or 11 million people.

What has happened on the ACA side in my state is there was a 62 percent increase in premiums this year. In a third of the coun-

ties in my district, there are no providers. Knoxville, which is the third largest city in my state, has no provider on the ACA Exchange.

Let me just point out a couple of things. When government dictates, as Mr. Hurst said, what you buy, what happens? The State of Oregon, which was mentioned a moment ago, their exchange went belly up and they spent tens of millions of dollars that could have gone to health care.

Right here in the District of Columbia where we are, $134 million in grants to sign up 10,630 people, it cost $12,600 per person to sign somebody up for insurance. How ridiculous is that?

In Hawaii, it gets even better. Their exchange went belly up and it cost $25,000. They got $205 million in grants that I could have used to take care of pregnant women, provide women's health care, to sign up 8,100 people. That is how this was when the government got involved.

Let me just go over this very quickly, Madam Chairman. This is not what is in the Republican plan. I want to make this very clear. The insurance regulations and mandates, coverage for preexisting conditions, under reconciliation that we passed in 2015, stays. They are guaranteed issue, no preexisting condition exclusions; no health status underwriting, in other words, charging sick people more; allowing kids to stay on until age 26; ban on lifetime or annual limits; preventive care coverage; and gender rating. That all stays. Closing the Medicare doughnut hole, that stays under reconciliation.

Unfortunately, the IPAB also stays. That should go. I would encourage my colleagues on the other side of the aisle to help us get rid of that.

It is not a matter, as Mr. Guthrie was saying, of us not doing something. We have to do something to repair this. It cannot continue the way it is.

You have small business people where I have seen their premiums triple, individuals in small business, in the last 2 years. Certainly, if you are getting a subsidy in my state, which 200,000 people do, 160,000 people in my state of Tennessee decided to pay the tax, the penalty, or fee, or whatever Judge Roberts wanted to call it, because they could not afford the coverage.

In the hospital where I practiced, 60 to 70 percent of the uncollectible debt in that hospital were people with insurance, and to keep quotes affordable, they raise the out-of-pockets and co-pays so high that folks where I live in rural Appalachia cannot pay it. It is not fair to them. We have to change it.

Mr. Ritchie, I want your comment on my bill before I run out of time.

Mr. RITCHIE. First of all, I want to personally thank you for supporting this bill for as long as you have. Your experience with Johnson City is the experience that we see from most of our policyholders.

Once somebody is under a plan, they don't want to go back to health insurance. They don't want to relinquish control. They don't want to pay more just so they have the right to offset some of the risk transfer. They can do that through other mechanisms, i.e., a company like mine, purchasing stop-loss coverage.

From the Self-Insurance Institute of America, we proudly support the *Self-Insurance Protection Act*. We think it's vital. We think it's critical to maintaining choice and options for employers on how they finance their risk.

Mr. ROE. Madam Chairman, just indulge me for 10 seconds. We bought when I was on the commission five policies at quarter of a million. We could fund that. That is what people used that for, and I think more companies are going to go to that. I think it is a wonderful model. Two-thirds almost of all people get their self-insurance now.

Thanks for indulging me. I yield back.

Chairwoman FOXX. Mr. Scott, you are recognized for five minutes.

Mr. SCOTT. Thank you, Madam Chair. Mr. Ritchie, you mentioned that some doctors charge $100, some $200 for essentially the same quality service. Is there any reason the self-insured cannot restrict the doctor panel just like insurance companies have preferred providers?

Mr. RITCHIE. Actually, no, the self-insurance plan can't restrict that.

Mr. SCOTT. It cannot?

Mr. RITCHIE. It cannot, because how do you know what the doctor is going to cost before you go? In the environment we work in, you don't know what the cost is until you go have the service, get it repriced through the network, then you get to find out what your cost is. If you ask for what the cash price is, you're going to get one number. If you ask for what your insurance price is, you're going to get a different number. The ability to restrict it, the data's not there to do that.

Mr. SCOTT. Is there any reason that you could not limit the doctor access, like an insurance company has a preferred provider network?

Mr. RITCHIE. An employer could design a program that was in-network only, no out-of-network benefits, but there's not an employer out there who's offering that today because it simply is not effective to retain employees. If you're an employee, you're going to go that's not good coverage and I'll go down the street and work somewhere else.

Mr. SCOTT. Mr. Hurst, on the maternity care, I was a little confused as to whether you supported maternity care being an essential benefit covered at the standard rate for everybody.

Mr. HURST. Personally, I believe there are certain things that should be in everybody's health insurance policy, preventative care, hospitalization, maternity care for women, young women particularly. Absolutely.

Mr. SCOTT. Everybody pays the standard rate, including women at the same rate, and they get maternity care, men would be paying the same rate whether they need that service or not? The alternative is if it is an optional care, then essentially the only people who would buy it are those who need it, and you are essentially paying it out of your pocket.

Mr. HURST. I believe that reasonable people can sit down and decide what is it that your average family is going to need over a pe-

riod of time. There are certain coverages, yes, all of us want, at a certain stage in our life, all of us need.

To make them pay and buy services that they'll never use and don't want and can't afford, that's what I'm talking about. That's where we need to empower the consumer to make the decision, not government and not the provider.

Mr. SCOTT. You would count maternity care as an essential benefit that everybody ought to have to pay for, whether they intend to use it or not?

Mr. HURST. I believe that should be part of a package.

Mr. SCOTT. Now, it is easy to see how Association Health Plans would be beneficial for those that can get into an association plan. Is it possible to underwrite and carve out a healthier group than average?

Mr. HURST. Number one, it would be illegal, and, number two—

Mr. SCOTT. If you had a group of, say, gym trainers, you know they are all healthy, and that is your group, is that illegal?

Mr. HURST. I'm sorry, Congressman. What group again?

Mr. SCOTT. Gym trainers.

Mr. HURST. Well, you know, I think if there is an association out there representing them and they want to get together, you know, I've seen gym trainers that are 60 years old and I've seen them that are 20 years old.

Mr. SCOTT. The reason Association Health Plans always work is if you have a group, whatever the group is, if they do not cost less than average, if the bids come in above the average cost, the association will not form, because nobody wants to join the group where the costs are going to be above average. They can go in the normal route and get insurance.

They will always work because you pull out a group of healthy people, which necessarily means that everybody else has to pay more because the insurance pool just got a little more expensive. Is that not right?

Mr. HURST. Well, I think you're assuming that small businesses actually have higher based on age or health status, which they do not. My members, my 4,000 members, they look just like employees of big government and big businesses, yet they are discriminated against under the law.

Mr. SCOTT. What happens when somebody gets sick and it goes above average? Are all the association members required to renew at an above average price when they can get insurance cheaper in the marketplace?

Mr. HURST. You know, in our association plan, we have rules that you cannot leave and then come back. If you leave, you cannot come back for three years. There are certain rules that you have to establish to make sure that this plan is going to be sustainable.

Mr. SCOTT. But if it gets above average and everybody bails, what happens?

Mr. HURST. Well, I don't know that's going to happen in very many instances because what we're talking about here is taking the margins out. We're talking about groups of small businesses and their employees that, frankly, are unfairly cross-subsidizing other people, that they have become the margins from the insurers and on behalf of the providers unfairly so.

Mr. SCOTT. Madam Chair, that is exactly the point, they cross-subsidize everybody. You have a group out that is cheaper to insure than everybody else by whatever mechanism you have formed the group, and it is cheaper, until they get sick, then everybody bails and they got back into the normal plan.

So, it will always work for those that can get into that group, but if you cannot get into the group, everybody else will pay exactly more. It is a zero-sum game.

Chairwoman FOXX. Yes, Mr. Hurst?

Mr. HURST. I guess my only response to that is why then do we allow Big Government to do this, and allow Big Business to do this, because they could do the very same thing. We're just discriminating against Main Street businesses.

Chairwoman FOXX. Thank you, Mr. Hurst. Mr. Grothman, you are recognized for five minutes.

Mr. GROTHMAN. Thank you. Mr. Ritchie, but maybe Ms. Klausner wants to weigh in as well, at what point do you think it is appropriate for a business to self-insure? How many employees?

Mr. RITCHIE. We generally like to see them around 50 employees, but that doesn't mean it doesn't work to go even lower than that.

Mr. GROTHMAN. You said 50?

Mr. RITCHIE. Fifty employee lives. That's obviously with dependents and it's going to be a larger group. That's what we generally like to see, but that doesn't mean there's not a unique group that could be lower than that. I would say, you know, a 50-life law firm is very different than a 50-life retail operation in terms of the amount of cash, how they understand risk, and how they process that. So, it does vary over time, but that's what we're talking about, giving them the option to do it.

There's also large employers who don't self-fund, so they have chosen they don't want to manage the plan. They want to hand it off to a health insurer and just be done with it. That's fine. It's a matter of choice. It's not a matter of what's right for everybody. It's a matter of what's right for this one individual situation.

Mr. GROTHMAN. Ms. Klausner, do you agree with that 50 number?

Ms. KLAUSNER. I don't have a number that I have in my mind. What I know is that employers of all sizes will evaluate whether or not self-insurance or fully insured is appropriate. The numbers are looked at with the totality of their compensation, their awards, how they want to allocate their resources, and allocate the dollars.

Whether or not they can connect them back to wellness programs, some employers find that wellness programs are better aligned if ultimately they are in a self-insurance environment. Others can find services and products where the fully insured environment connects them to wellness programs, again, primarily designed to lower the costs.

Mr. GROTHMAN. Just a comment on Congressman Scott's gym instructor thing. It just seems to me subjectively that when I see people walking around with a cast or whatever, a lot of times they hurt themselves in the gym. I am not sure that necessarily means you are spending less.

The next question I have, it kind of surprises me in the market that more providers or kinds of groups of providers do not get to-

gether and offer their own insurance. If you give them a capitated rate, the incentive they have to do less rather than right now on a fee-for-service thing do more, would cause health insurance costs to drop precipitously. Why does this not happen more?

I guess I will start with Ms. Klausner. Do you see what I am saying? I cannot think of what we have here—well, you are from New Jersey. I am sure in New Jersey, there are, just like in Wisconsin, groups of hospitals and clinics, and right now, the financial incentive is always more tests, sometimes even surgery. But if you said I have a life here, you know, I am going to go to whatever, Liberty Health Care, whatever, why does that type of arrangement not spring up more?

Ms. KLAUSNER. I'm not confident I can answer the exact question as to why that arrangement doesn't spring up. I think what employers are trying to do right now, working with their service providers, is specifically to find ways so that employees make those right choices, so there are other avenues of innovation.

Mr. GROTHMAN. You see what I am saying? Why cannot you as a business go—maybe there are legal restrictions. I do not know why you cannot go to say Liberty Health, and I do not know if there is such a thing called Liberty Health, and your hospitals and your clinics, and say here, I have 60 lives in my store, I realize they are going to have some separate coverage, people on vacation or something, but I have 60 lives in my company, how much will it cost for you to take those 60 lives, and then you take the risk.

Why does that not spring up more? It seems to me if that sprung up, you would have massive savings.

Ms. KLAUSNER. I'm sure there are a host of reasons as to why it hasn't sprung up. However, I think what we can do, on behalf of the American Benefits Council, is to—

Mr. GROTHMAN. Does anybody have any comments on this? Is there any doubt that one of the reasons healthcare costs are spiraling is right now the medical community had financial incentives to do more, right? More surgeries, more tests. You would have to be blind not to see it.

If you went to a medical provider and said I will give you $8,000 or $10,000 per life, incentives would go the other way. Why does this not happen?

Mr. RITCHIE. Actually, I would say in the employer market what we are seeing today, and it's one of the new innovations that happens through self-insurance, is we are seeing employers—let's say I'm a South Georgia employer. I have one hospital system and all my employees are within a 20-mile radius of that hospital system.

Well, they're not going to the hospital system and saying you provide all my services. They are direct contracting with them and saying instead of me going through a PPO network or through a health insurer, all my people are here, you're going to provide 80 percent of the care that we're going to get, I'm just going to get a contract directly with you.

It's happening. It's going on today. But now, like I said, it's only 80 percent. There are services that won't be services. If you've got a specialty transplant network, South Georgia may not have the facilities to offer the transplant. You may have to go to a Mayo Clinic, you may have to go somewhere else for that service.

Mr. GROTHMAN. One more question.

Chairwoman FOXX. Your time has expired, Mr. Grothman. Thank you. Mr. Smucker?

Mr. SMUCKER. Thank you, Madam Chair. Talking about self-insurance, I would just like to follow up on some of the questions. I was a small business owner. We employed about 150. We had fully funded. Then we had self-insured with the stop gap.

Our experience with self-insured was that over time, obviously, you can have bad years where it would cost more than a fully funded, but over time, we saw dramatically decreased costs while we thought it was providing even better care for the employees because of the attention everyone in our group paid to not only receiving quality care, but also to controlling those costs.

My question is—one other point before I get to the question. I have had a lot of discussions with businesses in regards to the impact of the ACA, in regards to the impact of increased health insurance costs. One of the things I have noted is that businesses over the past few years who were self-insured did not see some of the dramatic increases. Again, as I said earlier, it may vary year to year.

I guess my question is do we have any data to that point? In general, overall, do we see cost savings just by the fact that businesses are self-insured? If we do, I think it is because we are doing the wellness programs, we are doing the education with employees, everyone is working to reduce costs.

What data is out there in that regard? Mr. Ritchie?

Mr. RITCHIE. There is no mass aggregator of data between health insurance and self-funded and cost analysis. We are truly—I would argue that the self-funded employer is experiencing the same cost increases, but they are financing it.

Your analysis was that over time it was cheaper, and I agree with that, because over a three- to five-year period, we see that self-insurance is generally cheaper than health insurance. Now, on a year-to-year basis, that may be very different because the health insurance is prospectively priced where the self-insurance is actually priced. Whatever you actually spend that year is your cost, where for health insurance, they're predicting that.

They're doing the underwriting. They're doing the actuarial services to project your ultimate costs. If they go above, that will be profit to the health insurer. If the price is below actual cost, that will be a loss to the health insurer. That's the risk transfer mechanism.

To your question, there is no grand aggregator, but costs are going up for all employers. The self-funded employer over time does manage the costs. They're more proactive. They are more engaged. A lot of employers will actually tell their employees we are a self-funded plan, just so you know what that means.

I do think people understand medical costs and try to save medical costs when they can.

Mr. SMUCKER. That is what we saw. The other arrangement we were part of at some point was we banded together with other businesses in sort of what was called a "rent-a-captive program." These were like businesses that felt they had similar risks, and they worked together to control those risks. We also included in that

program Workers' Comp insurance and, in some cases, other insurance products, like general liability and so on.

Is that still being done today? Did ACA change any of that, and can you just talk a little bit about that?

Mr. RITCHIE. The ACA did not impact any of that. What you're talking about is the utilization of a group captive for the Workers' Comp and CGL product lines, and then of another segregated portion of that captive to cover the benefits.

I don't want to give the illusion that health benefits and comp benefits were intermingled somehow, but what you did is you had a facility that segmented them in proportionate captive cells for each product line, and then you shared that risk among the other employers.

Mr. SMUCKER. Today, can businesses still band together in that way without an association, for instance?

Mr. RITCHIE. Yes.

Mr. SMUCKER. How is that different than what we are talking about with associations?

Mr. RITCHIE. The association—one thing that has not been mentioned on the Association Health Plan is there are rules within that law that says it must be a bona fide association, so I can't go create an association tomorrow and say I'm going to be the guys wearing a blue tie today association, and have everybody come into that. It has to be an association that already existed for the benefit of the members.

You can't just create an association that everybody comes into. You have to have a legitimate, bona fide association that already exists, and then provide health care through that. Does that clarify your question?

Mr. SMUCKER. Yes. I am out of time, but I would like to maybe discuss with you later a little more about the captive program.

Mr. RITCHIE. Yes, sir.

Mr. SMUCKER. Thank you.

Chairwoman FOXX. Thank you, Mr. Smucker. As we pointed out earlier, any member can submit a question to the witnesses and get, I believe, a timely response. Thank you very much.

Now, it is my turn. I do not think there is any question that ObamaCare has been an unmitigated disaster. We were promised repeatedly that if you like your plan, you can keep it. That simply was not the case for at least 4.7 million Americans who were kicked off their health care plans under ObamaCare. We were promised that if you liked your doctor, you can keep your doctor, but that also has not been kept.

Meanwhile, small businesses have found it harder to provide their employees affordable coverage while facing mandates, reams of regulations, and insurance coverage premiums that just kept increasing year after year.

I want to thank our witnesses for their great comments today and providing so much information.

Mr. Hurst, would you agree that ObamaCare has been harmful for small businesses and their employees, and how has it made it harder for your small business association to offer more affordable coverage through your cooperative? And what can Congress do as we move forward with step-by-step regulations or laws, policy solu-

tions, to lower costs and empower small businesses to offer affordable healthcare benefits?

Mr. HURST. Thank you, Madam Chairwoman. Yes, to answer your question, it has been very damaging and it has been damaging, again, because we don't have a level playing field. We have discrimination, depending upon where you work.

One of the biggest problems that came in the ACA was the preemption of state innovation and state rating factors. Again, we had 11 rating factors in Massachusetts, one of which was this cooperative adjustment factor, which was the basis of our savings for our members.

Another was a size rating factor. Ironically, in Massachusetts these are things we learned the hard way under RomneyCare. We had a size rating factor because we felt like government, good healthcare policy, should incent small businesses to grow jobs, not to shed jobs. It's a fact that an employer with five employees versus one with 50 actuarially and administratively, it cost less per life to employ them.

This is one of the reasons why more people are going self-insured, because we're discriminating against employers of 50 and under or 100 and under and making it harder for them to compete with the people just above that regulatory scheme.

We are, unfortunately, forcing them and them alone to unfairly cross-subsidize individuals, and that's where the rubber hits the road. We need to reform those rating factors. We need to have Association Health Plan legislation. We may want to revisit essential benefits and lower them a bit.

I would also argue that the 30-hour definition of "full-time" was also wrong, and under RomneyCare we had a 35-hour requirement, and that didn't cause any real disruption. Most employers consider 35 hours full-time. Virtually none consider 30 hours full-time. That's not even four days full-time. That created disincentives both on the employer side and also the employee side to keep hours below a certain level, and that's wrong. It really hurt employer coverage for small businesses.

Chairwoman FOXX. Thank you very much. Ms. Klausner, you have given great comments about wellness plans, and I appreciate that. I think your comments particularly about the conflicting rules and regulations have been very valuable.

Can you describe how the EEOC rules have had a chilling effect on employers setting up these programs?

Ms. KLAUSNER. Absolutely. Thank you, Madam Chairwoman. It has absolutely had a chilling effect because employers are stuck evaluating too many things in order to ultimately design their programs and ultimately determining where the costs are.

For example, the first thing they need to determine is whether or not if they want to give a $100 incentive, for example, whether it's in cash, connected with a group health plan, how it complies or doesn't comply under each of the three rules, does it go into the 30 percent bucket or not. If instead that $100 is provided as seed money to a health savings account, it may have a different set of rules. If it's for a spouse giving a health risk assessment that includes a genetic information question, it has another set of rules.

So, ultimately it has created a serious chilling effect. And what this is converted to is then when they do, in fact, roll out these programs, which, of course, they are doing, they're trying to maximize them, they end up creating confusion even for employees.

There are many notices, different authorizations, different descriptions, and ultimately, the employer wants to provide these programs not only in a simplified way for themselves, they also want to do it in a simplified way for employees to benefit under them. And as a result of the complexity, they take a step back and they start shedding or shelving certain ideas because it's too complicated to either roll out or administer or explain to the employees.

Chairwoman FOXX. Thank you very much. Mr. Lewis, you are recognized for five minutes.

Mr. LEWIS. Thank you, Madam Chair, and thank you to all the witnesses. Mr. Ritchie, I have sort of a general question here, and I just want to get it for my own benefit, I guess. How has the ACA affected the self-insurers, the ERISA folks, with regard to mandates?

Before the ACA, States had different mandates. Minnesota, the state where I am from, led the Nation a couple of years in the number of state mandates, which I happen to think drives up insurance costs.

To some degree, but not completely, as I understand it, the *Affordable Care Act* did for some self-insurers what those states were doing to other plans before it. Is that accurate or am I misreading something?

Mr. RITCHIE. Well, with the passage of the *Affordable Care Act*, when the employer responsibilities or shared responsibilities section came out, yes, that did have an impact on self-funded employers.

Now, one thing I would state is remember, those self-funded employers before, they weren't subject to the state requirements because of ERISA.

Mr. LEWIS. Right.

Mr. RITCHIE. Today, they could design their plan design and have a uniform plan design across state lines, so a company like Coca-Cola, who has employees in every state in the Union, could have the same benefit plan for everybody.

Mr. LEWIS. And out from under some of the more costly state mandates. That is ostensibly why some folks did it, correct?

Mr. RITCHIE. They could be out of those or they could offer them if they choose. Many times we see the self-insured employer offer above what it is. Again, it's part of customizing it towards your plan. What do you want to pay for, what do you want to incentivize, and how do you want to create productivity and wellness within your own organization? It truly is the self-funded, not-for-profit health care plan for that single employer.

Yes, with the *Affordable Care Act*, we did see the employer responsibility sections impacting employers by them having to offer the benefits and asking them to comply with those on a uniform basis across the country.

Mr. LEWIS. Central wellness benefits and certain things like that, did it raise premiums in your opinion?

Mr. RITCHIE. The biggest increase to us was the unlimited nature of the coverage now. So I'm not saying that is right or wrong. I'm just saying from a risk and actuarial perspective, I did have a limit at one time, now I have no limit. Therefore, costs go up. We did see the frequency of $1 million claims almost double in 2014, the first year of truly unlimited health care.

Good or ill, right or wrong, I'm making a comment on risk perspective.

Mr. LEWIS. Good or ill, that is a mandated benefit. It is what it is. Ms. Klausner, we are talking a lot about pooling risk, and the idea of small businesses pooling for a larger network, I think, is pretty sound economics and a good idea.

One of the other aspects of the insurance markets is not only to pool risk, but to price risk. Have we seen limitations on that, in the name of fairness or whatever you want to say, that you have these bands where pricing has to be tight even in some group markets, would it be beneficial to let prices float more freely?

Ms. KLAUSNER. I'm not sure that I'm able to answer that question for you today, but would be happy to get back to you.

Mr. LEWIS. Yes, would you, please? I would be interested. Anybody else have a comment on that? Not everybody at once.

Okay. Thank you very much, Madam Chair. I yield back my time.

Chairwoman FOXX. Thank you very much. Mr. Scott, I recognize you for closing comments.

Mr. SCOTT. Thank you, Madam Chair. Madam Chair, the *Affordable Care Act* has been described as a disaster, but I think we need to recognize that a lot of problems were occurring in health care before the *Affordable Care Act*.

Certainly if they are going to have complaints, there ought to be a plan to do better, and it is hard to hold a constructive debate over an invisible plan, so we are waiting for the alternative.

I just want to make a point. On the Self-Insurance Institute of America website there is a provision that says an employer is free to contract with the providers or provider network best suited to meet the healthcare needs of its employees. That is on the website.

We have heard a lot about the Association Health Plans. It is easy to see how they work. You get a group together, however it is formed. If you figure out that the healthcare costs of the group are lower than average, you can insure that group at a lower than average cost, which works well while everybody in the association stays healthy.

As soon as a bunch of people get sick and the costs go above average and everybody bails, they can join the regular insurance pool. While they enjoy lower costs, everybody else in the pool they left will be paying higher prices.

The wellness plans, we know they can reduce long-term health costs and they ought to be encouraged, but you ought to be able to run one without requiring people to disclose sensitive healthcare information that they do not want to disclose. We have to figure out how that can take place without people having to disclose information that they believe is sensitive.

Stop-loss does economic security for the employer. It is unclear what it does for the employee, getting coverage they could not ordinarily get.

Madam Chair, again, if we are going to have a debate on health care, it would be helpful if the Republicans would conform with the directions of the reconciliation instructions and come up with a plan that we can actually debate.

With that, Madam Chair, thank you for the hearing, and I yield back.

Chairwoman FOXX. Thank you, Mr. Scott. Well, today, we are not talking about repealing and replacing ObamaCare. We are talking about issues outside that. Our colleagues have spent a lot of time talking about a speculative bill, and I am conscious of that. We had other issues here to talk about, talking about what would happen with Medicaid really was a waste of time, in my opinion, because that is not what we are talking about here today.

We are talking about three proposals that would not come under repeal and replace of ObamaCare, and I am very grateful, again, to our witnesses for having done that.

Everything the Republicans predicted about ObamaCare has come true because we were actually reading a bill that was written in the back rooms of the people in charge of the Democrat Party at the time, no Republicans voted for it. We predicted from an actual bill exactly what would happen, and it has happened. Every dire prediction has come true, unfortunately.

I do not know anybody that does not want every American to have affordable health care. We all want that. We all do. I think as I have sat here and listened to this debate today and listened to my colleagues on both sides of the aisle, it really comes down to a matter of freedom and coercion.

What the ObamaCare bill did was coerce people into buying insurance they did not need. People who did not need fertility insurance, people who do not need maternity insurance, they do not need that, but they are forced to buy that coverage in order to have—I forget exactly what the President calls it, "wealth distribution," I think. That is not the way we operate in this country.

Somebody else brought up the issue of car insurance. Many of us when we buy new cars buy collision or comprehensive insurance because we have a fairly expensive car and we want something more than liability insurance. We buy liability and then we buy others.

As the car gets older and we have maybe a $1,000 deductible on our comprehensive, we say, wow, maybe it is not worth paying that insurance anymore because my car is not worth a whole lot, and we decide to change that.

Many of us as we get older might want to change our health insurance policies. Under the coerciveness of the Federal Government, we are not allowed to do that with health care. That is wrong in the United States of America. We are based on freedom.

Ms. Mitts, you mentioned how horrible it would be if people had HSAs and low-income working families might have to pay up to $3,000, which they would not have under an HSA on their deductible.

Well, guess what? The Silver Plan in ObamaCare, the deductible is $3,572 for individuals; for families, it is $7,474. So, would people be worse off under HSAs? Perhaps not. Again, it is speculation. All speculation about what would happen if we had changes in Medicaid, all speculation about what a bill might look like.

I so appreciate Mr. Hurst, Mr. Ritchie, Ms. Klausner talking about how employers care about their employees. To hear our colleagues speak, you would think that we have Simon Legree running every company in this country. Now, most of you people are too young to know who Simon Legree is, so I will let you look it up.

We do not. My husband and I were small business owners. We cared about our employees. Every small business, even large businesses, I believe care about their employees.

Mr. Ritchie pointed out over and over again the labor market is extremely competitive these days. It is in the best interest of every employer to do everything he or she can to keep those employees, the good employees that they have, and give them every benefit they can possibly afford.

I want to thank you all very much for presenting that, and pointing out that is the case in the country.

I want to thank you all. I do want to thank our colleagues for being here today and answering questions, and illuminating, I think, these issues a great deal.

With that being said, the hearing is adjourned.

[Additional submissions by Chairwoman Foxx follow:]

David E. Gronewoller
President & CEO

3816 Forrestgate Drive
Winston-Salem, NC 27103
Telephone +1.336.767.1600

May 17, 2012

To: The Honorable Virginia Foxx
Chairwoman, House Education and Workforce Committee
U.S. House of Representatives
2176 Rayburn House Office Building
Washington, DC 20515

Dear Chairwoman Foxx,

I am writing to express my strong support of Rep. Sam Johnson's Small Business Health Fairness Act, which would provide small businesses with an opportunity to pool resources together to provide their employees with better, more affordable health insurance coverage. This legislation is a priority for not only my business but also the franchising community of 733,000 small business establishments across the country.

As a member of the International Franchise Association, I have seen first-hand how small businesses and franchisees are challenged in offering competitive health benefits. The federal Employee Retirement Income Security Act, which currently permits large corporations and labor organizations to "self-insure" and offer insurance with certain exemptions from state law, does not provide small business with the same advantage. The law must be reformed to empower small employers with the ability to obtain and offer competitively priced health insurance.

The Small Business Health Fairness Act would allow small business employers, including franchise owners, the ability to obtain and offer health insurance benefits through membership in a trade association, as well as a franchise system. With rising medical costs being a top concern of both individuals and employers, the impact of this increased availability of affordable insurance would be significant.

Please let me know if you have any questions, and thank you for considering my views. I appreciate your strong support of the small businesses and the franchise community.

Respectfully,

David E. Gronewoller

February 13, 2017

The Honorable Sam Johnson
U.S. House of Representatives
2304 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Johnson:

I am writing to express my strong support for the *Small Business Health Fairness Act*, which would provide small businesses with an opportunity to pool resources together to provide their employees with better, more affordable health insurance coverage. This legislation is a priority for the franchising community, which is a network of 733,000 small business establishments across the country. I commend you for your leadership on this important issue.

I have been in franchising for over 30 years, working for multiple franchisors, starting with Sir Speedy Printing Centers in 1980. I worked for PIP Printing & Marketing Services and then became CEO of FASTSIGNS in 2009. FASTSIGNS, the sign industry's leading franchise system, founded in 1985, is a sign and visual graphics company that provides comprehensive visual marketing solutions to customers of all sizes across all industries to help them meet their business objectives. Our network of sign centers includes 572 locations in the United States, 28 locations in Canada, plus locations in the United Kingdom, Mexico, Brazil, the Caribbean, Saudi Arabia, UAE and Australia, for a total of 643 locations worldwide.

As an expert in the franchising system, I have seen first-hand how small businesses and franchisees are challenged in offering competitive health benefits. The federal Employee Retirement Income Security Act, which currently permits large corporations and labor organizations to "self-insure" and offer insurance with certain exemptions from state law, does not provide small business with the same advantage. The law must be reformed to empower small employers with the ability to obtain and offer competitively priced health insurance.

Your legislation, the *Small Business Health Fairness Act*, would allow small business employers, including franchise owners, the ability to obtain and offer health insurance benefits through membership in a trade association, including a franchise system. With rising medical costs being a top concern of both individuals and employers, the impact of this increased availability of affordable insurance would be significant.

Please let me know if you have any questions, and thank you again for your leadership and support of the franchising system.

Sincerely,

Catherine Monson
Chief Executive Officer

February 16, 2017

Representative Lloyd Smucker
516 Cannon House Office Building
Washington, DC 20515

Dear Representative Smucker,

I am writing to express my strong support for Rep. Sam Johnson's *Small Business Health Fairness Act*, which would provide small businesses with an opportunity to pool resources together to provide their employees with better, more affordable health insurance coverage. This legislation is a priority for the franchising community, which is a network of 733,000 small business establishments across the country.

As a business owner, I have seen first-hand how small businesses and franchisees are challenged in offering competitive health benefits. I have 8 employees and struggle to offer group insurance because I fail to meet the insurance company's minimum coverage requirements. Not all of my employees want insurance through my company. When I looked at cost estimates for individual insurance, the prices were astronomical. Instead, I elected to give stipends to my employees' to assist with their costs, and three of them have seen over 40% price increases and have had to made additional changes, and on unfortunately, dropped coverage all together.

I know first-hand how difficult it is for micro-businesses to offer employee group health coverage, which is why I strongly support national association health plans. The federal Employee Retirement Income Security Act, which currently permits large corporations and labor organizations to "self-insure" and offer insurance with certain exemptions from state law, does not provide small business with the same advantage. The law must be reformed to empower small employers with the ability to obtain and offer competitively priced health insurance.

The *Small Business Health Fairness Act* would allow small business employers, including franchise owners, the ability to obtain and offer health insurance benefits through membership in a trade association, including a franchise system. With rising medical costs being a top concern of both individuals and employers, the impact of this increased availability of affordable insurance would be significant. I respectfully request your co-sponsorship of this very important legislation.

I appreciate your hard work and appreciate the fact that you purchased a banner from us when you represented a portion of York County (my business location) in the state legislature. Keep up the great work.

Please let me know if you have any questions, and thank you for considering my views.

Sincerely,

Jon Toy

Home Address: 125 Pentail Dr | Lancaster PA 17601

FASTSIGNS of York | 2801 E Market St • York • PA 17402
p: *717.840.6400* • f: *717.840.6402* • w: www.fastsigns.com/444 | 444@fastsigns.com

February 16, 2017

The Honorable Sam Johnson
U.S. House of Representatives
2304 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Johnson:

On behalf of the International Franchise Association (IFA), the world's oldest and largest organization representing franchising worldwide, I write in strong support of the *Small Business Health Fairness Act*. This legislation will increase small businesses' bargaining power with health insurance providers and ensure a level playing field for smaller entities that want to help their workers and families with health care costs. IFA commends you for your longstanding leadership on this important issue to the franchising community.

Locally owned franchises are America's hidden small businesses, with 733,000 establishments across the country. The entrepreneurs who make up the franchising system directly contribute $674.3 billion in economic output, accounting for roughly 2.5% of the private sector U.S. GDP.

While the small business community's economic output is great, its negotiating power in the health care market is at a competitive disadvantage. The federal Employee Retirement Income Security Act, which currently permits large corporations and labor organizations to "self-insure" and offer insurance with certain exemptions from state law, does not provide small business with the same advantage. The law must be reformed to empower small employers with the ability to obtain and offer competitively priced health insurance.

For these reasons, IFA strongly supports the *Small Business Health Fairness Act*, which will allow small businesses the opportunity to band together to provide their employees with better, more affordable health insurance coverage. With rising medical costs being a top concern of both individuals and employers, the impact of this increased availability of affordable insurance would be significant.

IFA commends your efforts to provide small businesses with health care options in a thoughtful and constructive manner. We look forward to working with you on this key legislation.

Sincerely,

Matt Haller
Senior Vice President of Government Relations & Public Affairs
International Franchise Association

1900 K Street, N.W., Suite 700 Washington, DC 20006 USA

Phone: +1 202/628-8000 Fax: +1 202/628-0812 www.franchise.org

N · A · W

James A. Anderson, Jr.
Vice President-Government Relations

February 16, 2017

To all Members of the US House of Representatives:

I write to express the support of the National Association of Wholesaler-Distributors (NAW) for H.R. 1101, *Small Business Health Fairness Act.*

The National Association of Wholesaler-Distributors (NAW) is the "national voice of wholesale distribution," an association comprised of employers of all sizes, and national, regional, state and local line-of-trade associations that span the $5.6 trillion wholesale distribution industry that employs over 5.9 million workers in the United States. Approximately 40,000 enterprises with places of businesses in all 50 states and the District of Columbia are affiliated with NAW.

HR 1101 authorizes the formation of multistate operation of association health plans (AHP). Enactment will enable smaller employers to realize cost-saving marketplace clout and economies of scale similar to that currently enjoyed by large corporations. The cost of providing health coverage as an employee benefit will consequently be brought within the reach of many small employers, and the ultimate beneficiaries will be small business employees and their dependents.

The considerable role the Nation's employers play in our health insurance delivery system combines with the capacity of trade associations to marshal the resources of the small and medium-size employer community, to render AHPs uniquely attractive vehicles for providing quality health coverage to more workers and their families. NAW is pleased to support this legislation and urges your cosponsorship of it.

Thank you for your consideration of NAW's views.

Sincerely,

James A. Anderson, Jr.
Vice President-Government Relations

NATIONAL ASSOCIATION OF WHOLESALER-DISTRIBUTORS
1325 G Street N.W., Suite 1000, Washington, DC 20005 · 202-872-0885 · FAX: 202-785-0586 · www.naw.org

February 16, 2017

The Honorable Sam Johnson
United States House of Representatives
2304 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Johnson:

On behalf of the members of the National Restaurant Association, we write to you in support of your recently introduced legislation entitled the Small Business Health Fairness Act. This important legislation to amend the Department of Labor (DOL) definition of Association Health Plans (AHPs) under ERISA will broaden health care access and lower overall costs of employer-sponsored health insurance.

Restaurants employ nearly 10 percent of the nation's workforce, or approximately 14.4 million Americans. With one million locations across the country, the $783 billion in sales from the restaurant industry makes up four percent of the US GDP. Restaurant jobs provide opportunities for promotion. Nine of ten salaried restaurant employees started in hourly positions. The typical hourly restaurant employee who starts out at an entry-level wage receives a pay raise after six months. Restaurants are a training ground for the American workforce. One-in-three Americans got their first job in the restaurant industry, and one-half of all Americans have work in the restaurant industry at some point in their lives.

The National Restaurant Association is the leading voice for American restaurateurs on commonsense reforms to the current health care law. By amending the current DOL definition of AHPs under ERISA, this would allow small, independent restaurants to pool together across state lines through their membership in a trade or professional association like the NRA, to purchase health coverage for their employees and their families. Additionally, AHPs increase small businesses' bargaining power, to help leverage discounts, and provide administrative efficiencies while freeing businesses from costly state benefit mandates. AHPs allow restaurants to balance administrative costs with their risk pools and ensure they have access to affordable health insurance. AHPs stand as a vehicle to lower cost of employer-sponsored health insurance and better health for all employees.

Thank you for your leadership in introducing the Small Business Health Fairness Act. We strongly support passage of this important piece of legislation and look forward to working with you to advance this bill through Congress.

Sincerely,

Cicely Simpson
Executive Vice President, Policy and Government Affairs
National Restaurant Association

February 16, 2017

The Honorable Sam Johnson
U.S. House of Representatives
2304 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Johnson:

I write to share the strong support of the National Retail Federation (NRF) for H.R. 1101, the Small Business Health Fairness Act. We strongly support your bill and urge that it be promptly adopted.

NRF is the world's largest retail trade association, representing discount and department stores, home goods and specialty stores, Main Street merchants, grocers, wholesalers, chain restaurants and Internet retailers from the United States and more than 45 countries. Retail is the nation's largest private sector employer, supporting one in four U.S. jobs – 42 million working Americans. Contributing $2.6 trillion to annual GDP, retail is a daily barometer for the nation's economy.

NRF has long sought to ease access to health coverage for smaller employees and have supported previous versions of this legislation. Your bill appropriately would offer small businesses access to the same cost savings available to larger employers under the federal ERISA Act. Trade associations – particularly state retail associations – can offer a vital bridge of more affordable coverage to small employers and their employees.

NRF commends you for introducing this necessary legislation. Group health purchasing enjoys bipartisan support and so should your legislation. We strongly support your efforts.

Sincerely,

David French
Senior Vice President
Government Relations

cc: The Honorable Virginia Fox
The Honorable Bobby Scott
The Honorable Tim Walberg
The Honorable Gregorio Sablan

NATIONAL RETAIL FEDERATION

1101 New York Avenue, NW, Suite 1200
Washington, DC 20005
www.nrf.com

February 28, 2017

Chairman Sam Johnson
Subcommittee on Social Security
2304 Rayburn House Office Building
Washington, D.C. 20515

Chairman Tim Walberg
Subcommittee on Health, Employment, Labor, and Pensions
2436 Rayburn House Office Building
Washington, D.C. 20515

Chairman Johnson and Chairman Walberg,

On behalf of Heating, Air-conditioning & Refrigeration Distributors International (HARDI) I write to you today to offer HARDI's strong support for the Small Business Health Fairness Act (H.R. 1101).

By way of background, HARDI is a trade association comprised of nearly 1,000 member companies, over 475 of which are U.S.-based wholesale distribution companies. More than 80 percent of HARDI's distributor members are classified as small businesses that collectively employ over 35,000 U.S. workers, representing more than $35 billion in annual sales and an estimated 80 percent of the U.S. wholesale distribution market of HVACR equipment, supplies, and controls.

A recurring inquiry from our member companies is for a solution to rising health care costs for their small business, which your legislation provides. The Small Business Health Fairness Act allows HARDI as a trade organization to formulate an Association Health Plan for our members, which would give them the ability to purchase quality health care coverage at a lower cost to them and their employees.

For these reason, HARDI applauds your efforts in offering a solution to a problem affecting many small businesses across the country.

On behalf of HARDI, I want to thank both of you for your leadership on this important issue. Due to your legislation, more American small businesses will be able to curb the rising cost of health care coverage for their employees, as well as offer quality health care packages to tens of thousands of working-class families.

HARDI vigorously endorses H.R. 1101 and encourages the passage of this important legislation. Please feel free to contact me if HARDI can be of assistance in providing background or context to this important issue.

Sincerely,

Jon Melchi
Vice President of Government & External Affairs
Heating, Air-conditioning & Refrigeration Distributors International

445 Hutchinson Ave, Ste. 550, Columbus, OH 43235
888-253-2128 / www.hardinet.org

February 28, 2017

The Honorable Virginia Foxx
Chairwoman
United States House of Representatives
2176 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Robert C. "Bobby" Scott
Ranking Member
United States House of Representatives
2101 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairwoman Foxx and Ranking Member Scott:

On behalf of the members of the National Restaurant Association, we write to you in support of the recently introduced legislation entitled the Small Business Health Fairness Act (H.R. 1101). This important legislation to amend the Department of Labor (DOL) definition of Association Health Plans (AHPs) under ERISA will broaden health care access and lower overall costs of employer- sponsored health insurance.

Restaurants employ nearly 10 percent of the nation's workforce, or approximately 14.4 million Americans. With one million locations across the country, the $783 billion in sales from the restaurant industry makes up four percent of the US GDP. Restaurant jobs provide opportunities for promotion. Nine of ten salaried restaurant employees started in hourly positions. The typical hourly restaurant employee who starts out at an entry-level wage receives a pay raise after six months. Restaurants are a training ground for the American workforce. One- in-three Americans got their first job in the restaurant industry, and one-half of all Americans have work in the restaurant industry at some point in their lives.

The National Restaurant Association is the leading voice for American restaurateurs on commonsense reforms to the current health care law. By amending the current DOL definition of AHPs under ERISA, this would allow small, independent restaurants to pool together across state lines through their membership in a trade or professional association like the NRA, to purchase health coverage for their employees and their families. Additionally, AHPs increase small businesses' bargaining power, to help leverage discounts, and provide administrative efficiencies while freeing businesses from costly state benefit mandates. AHPs allow restaurants to balance administrative costs with their risk pools and ensure they have access to affordable health insurance. AHPs stand as a vehicle to lower cost of employer-sponsored health insurance and better health for all employees.

We thank you for bringing the Small Business Health Fairness Act to the full committee for consideration. We strongly support passage of this important piece of legislation and encourage members of the committee to support this bill through Congress.

Sincerely,

Cicely Simpson
Executive Vice President, Policy and Government Affairs
National Restaurant Association

March 1, 2017

The Honorable Virginia Foxx
Chairwoman
Committee on Education and the Workforce
United States House of Representatives

Dear Chairwoman Foxx:

Thank you for your efforts to make healthcare affordable and accessible for all Americans. As the Committee on Education and the Workforce prepares to hold a briefing on this important topic, the Healthcare Leadership Council (HLC) welcomes the opportunity to share our thoughts with you.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century health system that makes affordable, high quality care accessible to all Americans. Members of HLC—hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, biotech firms, health product distributors, pharmacies, post-acute care providers, and information technology companies—are committed to advancing a consumer-centered healthcare system that values innovation, affordability, and accessibility.

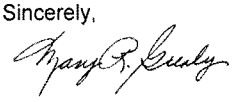
HLC conducted research in the early 2000s to identify the barriers small businesses face in offering health insurance coverage. Survey after survey found that while cost is one barrier, it is not the only one. Another significant barrier is knowledge and understanding of how health insurance works. During its research, HLC provided a short 15-minute educational session on insurance to small business owners through the Small Business Development Centers (SBDCs). These sessions led to an increase in knowledge about health insurance as well as an increase in the propensity by the small business owner to offer health insurance. These owners do not have large human resource departments that can explain all their health plan options to them and their employees. These consumers must be provided with decision support tools—including out of pocket cost calculators, smart plan-finder tools, searchable online provider networks and drug formularies, and clear cost information for common services—that will help them to understand their options and choose among plans. H.R. 1101, the Small Business Health Fairness Act, would allow small businesses to join together through association health plans (AHPs). HLC urges the Committee to ensure that the AHPs provide small businesses with the decision support tools necessary to compare their healthcare options.

HLC also understands the importance of ensuring that self-insured companies are able to continue to provide coverage to their employees. The Self-Insurance Protection Act would clarify that federal regulators cannot redefine stop loss insurance as health insurance. Stop loss insurance provides self-insured plans with a financial backstop to reimburse the employer or the plan for catastrophic claims. HLC thanks the Committee for its efforts to give self-insured companies this flexibility and protection.

HLC has long been a supporter of employee wellness programs. Much of the illness and early death related to chronic diseases is caused by modifiable health risk behaviors such as lack of physical activity, poor nutrition, and tobacco use. By 2020, the number of Americans with one or more of these illnesses will reach 157 million. HLC's member companies are at the forefront of working to reverse this trend by developing and implementing programs that give employees access to the tools, resources, and incentives to empower behavior change that will reduce, delay, or eliminate the impact of chronic disease. These efforts are described in HLC's compendium, The Future is Here, and HLC and its member companies strongly supported the bipartisan Affordable Care Act (ACA) provision that increased the ability of employers to vary premiums up to 50% based on participation in a wellness program. We are pleased that the Preserving Employee Wellness Programs Act clarifies that these discounts, rebates, and modifications do not violate the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act.

Thank you again for your work to make healthcare affordable and accessible. HLC looks forward to continuing to work with you. Should you have any questions, please do not hesitate to contact Debbie Witchey at (202) 449-3435.

Sincerely,



Mary R. Grealy
President

Advancing **Stewardship,** Creating **Connections**™

March 1, 2017

The Honorable Virginia Foxx
Chairwoman
Committee on Education and Workforce
U.S. House of Representatives
2262 Rayburn House Office Building
Washington, DC 20515

The Honorable Tim Walberg
Chairman
Subcommittee on Health, Employment,
Labor, and Pensions
U.S. House of Representatives
2436 Rayburn House Office Building
Washington, DC 20515

The Honorable Sam Johnson
Committee on Ways and Means
U.S. House of Representatives
2304 Rayburn House Office Building
Washington, DC 20515

Dear Chairwoman Foxx, Chairman Walberg, and Representative Johnson:

On behalf of the National Association of Chemical Distributors (NACD) and our membership, I applaud your efforts to improve health care coverage and lower health care costs for families. I especially would like to thank Chairman Walberg and Representative Johnson for introducing H.R. 1101, the Small Business Health Fairness Act. This legislation will provide small businesses and their employees access to more affordable health insurance coverage by expanding the use of Association Health Plans.

NACD is a trade association representing over 250 chemical distribution companies throughout North America. These companies process, transport, and market chemical products for an industrial customer base of about 750,000. Unique to NACD is our condition of membership requiring participation in the Responsible Distribution process, a management practice that embraces continuous improvement in health, safety, security, and environment protection performance.

The rising cost of health insurance premiums has long been a problem facing NACD members. Congress has recognized that action is needed to realize lower costs and provide better plan options for individuals and the employer community. Association Health Plans are a way to increase market leverage for small employers and give them the opportunity to band together to provide their employees with better, more affordable health insurance coverage. The Small Business Health Fairness Act will enable small businesses to provide valuable and affordable health benefits to their employees.

Thank you again for your leadership on this issue. As congressional action moves forward to replace the ACA with these various proposals, we look forward to working with you.

Sincerely,

Eric R. Byer
President

1560 Wilson Blvd., Suite 1100 Arlington, VA 22209 P: 703.527.6223 F: 703.527.7747 nacd.com

March 2, 2017

The Honorable Paul D. Ryan
Speaker
U.S. House of Representatives
H-232, The Capitol
Washington, D.C. 20515

Dear Speaker Ryan:

As Congress crafts legislation to repeal and replace the Affordable Care Act (ACA), the National Federation of Independent Business (NFIB) remains committed to advocating for health reform principles that prioritize affordability, increase flexibility, and ensure predictability. Small businesses were an afterthought when the ACA was considered and implemented, even though the cost of health insurance has been the number one problem facing small businesses for the past 30 years.

Under the ACA, small businesses' health insurance costs increased and benefit flexibility decreased, resulting in 25 percent fewer small businesses offering health insurance within five years of the law's enactment. Small businesses were so opposed to the ACA that NFIB challenged the constitutionality of the law as the lead plaintiff in *NFIB v. Sebelius.*

Repeal of the ACA will eliminate taxes that drive up the cost of health insurance and mandate penalties that inhibit job creation, providing important relief. However, repeal of the ACA is not enough; Congress must replace the law with proposals that lower health insurance costs and increase coverage options for small businesses.

To prioritize affordability, Congress must reconsider benefit mandates and health insurance requirements; amend tax laws to level the playing field for small businesses; and eliminate unnecessary compliance burdens. To increase flexibility, Congress must expand health insurance options for small businesses; permit innovative pooling arrangements; and improve Americans' ability to save and pay for healthcare with tax-favored health accounts. To ensure predictability, Congress must allow small businesses to keep the health insurance they currently enjoy and prevent disruption of the markets where small business owners purchase health insurance.

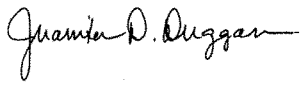
Multiple proposals contained within the *Better Way* agenda satisfy these goals. For example, H.R. 1101, the *Small Business Health Fairness Act*, creates an Association Health Plan option that allows small businesses to band together across state lines to

National Federation of Independent Business
1201 F Street NW * Suite 200 * Washington, DC 20004 * 202-554-9000 * Fax 202-554-0496

form larger risk pools with increased negotiating power and decreased administrative costs.

NFIB urges Congress to consider this legislation and other proposals that promote affordability, flexibility, and predictability for small businesses. Health reform that satisfies these goals will work for small business; health reform that works for small business will work for the rest of the country.

Sincerely,



Juanita D. Duggan
NFIB President and CEO

Attachment:
NFIB Small Business Health Reform Principles

cc: The Honorable Kevin McCarthy, Majority Leader
The Honorable Steve Scalise, Majority Whip
The Honorable Virginia Foxx, Chair, Education and the Workforce Committee
The Honorable Kevin Brady, Chair, Ways and Means Committee
The Honorable Greg Walden, Chair, Energy and Commerce Committee

National Federation of Independent Business
1201 F Street NW * Suite 200 * Washington, DC 20004 * 202-554-9000 * Fax 202-554-0496

NFIB
The Voice of Small Business.

SMALL BUSINESS
Health Reform Principles

Small businesses deserve health insurance that is affordable, flexible, and predictable. Repeal of the ACA is not enough; a replacement that repairs the health insurance markets is the only suitable outcome for small businesses.

The principles here detail the path to **affordability**, **flexibility**, and **predictability**.

AFFORDABILITY

- Do away with taxes and mandates that drive up the cost of health insurance and inhibit job creation
  - Repeal taxes on health insurance products and mandate penalties
  - Reconsider benefit mandates and health insurance requirements with a focus on affordability
- Equalize the tax treatment of health insurance for small business owners and self-employed individuals
  - Allow self-employed individuals and business owners the same tax treatment as business owners and employees who receive health insurance through their employers
  - Lift or remove contribution caps for small businesses that help employees who purchase insurance on their own
- Eliminate unnecessary compliance burdens
  - Eliminate the employer mandate compliance requirements after penalties are repealed
  - Eliminate outdated paperwork burdens and prevent new paperwork requirements

FLEXIBILITY

- Increase health insurance options for small businesses
  - Enhance the ability of small businesses to help employees purchase health insurance on their own
  - Allow small businesses the same health insurance opportunities as large businesses
- Permit innovative pooling arrangements
  - Enable groups of individuals and employers to band together to form larger, more stable risk pools with negotiating power
- Improve Americans' ability to save and pay for healthcare with tax-favored health accounts
  - Eliminate Affordable Care Act restrictions on tax-favored health accounts
  - Enhance tax-favored health accounts to make them more accessible and useful

PREDICTABILITY

- Allow individuals and businesses to keep the health insurance they currently enjoy
  - Relax grandfathered plan regulations
  - Extend the Obama Administration's transitional plan policy
- Prevent disruption of markets where individuals and small business owners purchase health insurance
  - Build a stronger market that services business owners and employees who purchase health insurance on their own

[Additional submissions by Mr. Johnson follow:]

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March 15, 2017

The Honorable Virginia Foxx
Chairwoman
Committee on Education and the Workforce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Bobby Scott
Ranking Member
Committee on Education and the Workforce
U.S. House of Representatives
Washington, D.C. 20515

Chairwoman Foxx, Ranking Member Scott and Members of the Committee,

Thank you for including the *Small Business Health Fairness Act* (H.R. 1101) in the Education and the Workforce Committee's recent hearing, "Legislative Proposals to Improve Health Care Coverage and Provide Lower Costs to Families." As you know, association health plans (AHPs) have long been an issue I have championed, and I continue to believe AHPs can help small businesses obtain and provide quality health insurance to their employees.

AHPs are particularly needed now after the failure of Obamacare. Since 2008, there has been a notable decline in small businesses offering health insurance to their employees, in large part due to Obamacare. The stated purpose of Obamacare was to provide health insurance to those without it, including those working for small businesses. Yet, as a result of this law's many flaws, we can now clearly see it has been a failure.

For this reason, on February 16, 2017, I introduced H.R. 1101 along with Congressman Tim Walberg. Our bill will allow small businesses to band together through association health plans to provide quality health care for workers and their families at a lower cost.

The basic rule of insurance is easy enough to understand: the bigger the risk pool, the lower the cost to those in the pool. As a result of their strength in numbers, larger corporations and unions are better able to provide quality, affordable health care to their employees. Similarly, small mom and pop businesses may band together through AHPs to provide health insurance to their workers, thus leveling the playing field in terms of cost and options. Further, AHPs would also allow small businesses to be exempt from many costly state and federal mandates – again, the same as large corporations and labor unions. It's high time we stop treating small businesses like second class citizens when it comes to health care.

This is a proposal that has passed the House of Representatives twice before, and it has also been included in numerous repeal and replace measures including Speaker Ryan's *A Better Way*, Rep. Tom Price's *Empowering Patients First Act* (H.R. 2300 in the 114th Congress), Rep. Phil Roe/RSC bill, *American Health Care Reform Act* (H.R. 277), and Sen. Rand Paul's *Obamacare Replacement Act* (S. 222).

I also wanted to clear the air on a few misconceptions that are out there regarding AHPs.

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MYTH: H.R. 1101 does not provide sufficient solvency requirements for AHPs.

FACT: That simply isn't accurate. 1) AHPs can only be formed through bona fide associations which have existed for at least three years before offering an AHP, and which were formed for purposes other than providing health insurance. 2) AHPs would need to have an indemnified back-up plan to be able to pay outstanding claims should the plan terminate. 3) AHPs would have to undergo quarterly certification for financial soundness. 4) AHPs would further be required to maintain surplus reserves beyond the aforementioned requirements. 5) Finally, when it comes to solvency, I would be remiss to not mention the failure of 19 of 23 CO-OPs under Obamacare, which were seeded with federal dollars and have lost taxpayers $1.9 billion as well as left thousands of beneficiaries without health care.

MYTH: H.R. 1101 does not subject AHPs to state requirements, which then hurts consumers due to exclusion from state benefit requirements and fraud laws.

FACT: It is simply false to assert that the AHP ERISA preemption would endanger consumers when plans offered by both large corporations and labor unions are already exempt. Not only that, but even Obamacare recognized how good large group coverage is and exempted large group plans with respect to federal Essential Health Benefits. If small businesses are able to form a large pool, why should they be treated any differently than other large groups? It makes no logical sense. Further, it is well known one of the challenges small businesses face is recruiting and retaining good, high quality employees. However, AHPs put small businesses on a more level playing field with large corporations and unions in terms of their ability to offer good, competitive health care to their employees. Employees and small business owners would both benefit.

In terms of fraud, AHPs must already meet a number of fraud protections. Also, there are strict criminal penalties in place for fraud.

MYTH: AHPs will increase the cost of insurance for small businesses outside of AHPs.

FACT: According to data compiled by the Employee Benefit Research Institute (EBRI), from 2008-2015 there has been a marked decline in the number of small businesses offering health coverage. For example, the percent of employers with fewer than 10 employees offering health insurance has fallen from 35.6 percent to 22.7 percent. Meanwhile, among employers with 10 to 24 employees, there has been a decline from 66.1 percent to 48.9 percent. Moreover, because of Obamacare, we have seen premiums skyrocket. This year, the nationwide average on premium increases on the individual and small group market is approximately 25%, with the highest increase in Arizona at 116%. Further, we have seen options in the Obamacare exchanges dwindle. Where I live in Collin County, Texas, over the past year we have gone from eight insurers on our exchange in 2016 down to three – only two of which are returning. Given this, AHPs offer small businesses a new opportunity to provide health insurance to their employees and their families.

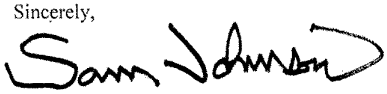
MYTH: AHPs will "cherry pick" who can get coverage and vary rates based on health status and age.

FACT: Since 1996, HIPAA has prevented adverse selection and "cherry picking" of beneficiaries. Thus, no group health plan can deny or condition coverage based on health status to individuals within the group. Further, H.R. 1101 requires that any active marketing must include all member employers, regardless of the claims history or health status of employees. AHPs are also restricted from setting their premiums in a way that might force higher claims companies to pay higher premiums than other similarly situated employers in the plan. Also, AHPs can only vary the rates that they

charge individuals based on current laws for large employer health plans – again, the same rules that apply to large corporations and labor unions.

In closing, let me thank you again for holding this important hearing and for including H.R. 1101 in the discussion. I look forward to working with you to make association health plans a reality.

Sincerely,



Sam Johnson
Member of Congress

[Whereupon, at 12:51 p.m., the Committee was adjourned.]

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