Testimony of Professor Adam Beck to the Subcommittee on Health and Technology

Committee on Small Business

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Good morning.

Thank you Mr. Chairman, Ranking Member Hahn and members of the Subcommittee for the opportunity to appear before you today. My name is Adam Beck and I am an assistant professor of health insurance at The American College in Bryn Mawr, PA. Since the College was founded in 1927, it has grown to become the nation's leading non-profit provider of higher education for professionals in the financial services industry. Today, The American College has the highest level of accreditation available and offers twelve professional designation and exam preparation programs, two master's degrees and a PhD in Financial and Retirement Planning. At The American College, I lead the Chartered Healthcare Consultant designation and teach courses focused on Health Care Reform for Employers and Advisers, Healthcare Consulting, Financing Long-Term Care for Seniors, and Life Insurance Law. I am the author of a textbook on the Essentials of Health Care Reform and the co-author of texts on healthcare consulting and long-term care financing. Additionally, I am an attorney with active licenses in New Jersey and Pennsylvania and advise medical and psychotherapy practices on matters relating to health insurance, Medicare, HIPAA and compliance with the Affordable Care Act.

Small businesses and the people who work for them comprise the backbone of the American economy. Health insurance is a tremendously valuable, often life-saving, financial

product, which our federal tax code affords special status. Therefore, it is an important and essential goal to allow small business owners the opportunity to offer quality, affordable health insurance coverage to their employees. Prior to the implementation of the Affordable Care Act, half of the uninsured in this country were part of the small business community – owners, employees and dependents.[1] That is not for a lack of desire on the part of small business owners to offer health insurance coverage. The Small Business Health Options Program, or SHOP Marketplace, was designed by the 111th Congress to lower health costs for small business, increase competition and therefore choice for business owners, and simplify the process of offering health coverage. These are laudable goals, however it is my opinion that the SHOP Marketplace as it is currently structured and presented falls short of these goals. I believe the SHOP Marketplace will remain inadequate and continue to enroll relatively few companies so long as three factors remain: the existing tax incentives, the lack of engagement of agents and brokers, and shortcomings in information technology infrastructure.

I. The Small Business Health Care Tax Credit is Overly Complicated and Too Small

The Patient Protection and Affordable Care Act created the Small Business Health Care Tax Credit to be an accompanying incentive to participate in the Small Business Health Options Program. Prior to the launch of SHOP marketplaces on January 1, 2014, the tax credit was available in a smaller form for most private market small group health plans enrolled in by qualifying business organizations during the tax years 2010 through 2013. For the initial four years of the tax credit's existence, the maximum credit available was 35 percent for for-profit

[1] Gardiner, Terry and Pereera, Isabel. "SHOPping Around" Report of the Center for American Progress and Small Business Majority. June 2011. http://www.smallbusinessmajority.org/reports/shop_exchange.pdf

entities and 25 percent for tax-exempt organizations. Beginning in 2014, the tax credit increased and became conditioned upon participation of eligible employers in a SHOP plan. The maximum available tax credit is today 50 percent for for-profit entities and 35 percent for tax-exempt organizations.

While a fifty-percent tax credit may sound like a substantial incentive – particularly considering that employers may still use pre-tax funds to pay for employee health benefits – the reality is far more nuanced. First, there is the limited universe of eligible employers. The credit is only available to business organizations with 25 or fewer full-time equivalent employees and average annual wages below $50,000. While this undoubtedly includes a substantial number of small businesses, it requires employers to engage in tedious and somewhat complex calculations of how many full-time equivalent employees they maintain in a given year, continually monitor compensation and face a perverse incentive for limiting pay, should increasing pay lead to average annual wages exceeding $50,000. Second, there is the sliding scale nature of the tax credit. The maximum credit of 50 or 35 percent is available only to businesses with 10 or fewer full-time equivalent employees and average annual wages below $25,000. The credit is then available in diminishing percentage amounts as the businesses grow larger or pay more. This again requires a complex calculation just so employers can estimate the potential tax incentives they could achieve from purchasing plans through a SHOP exchange. Third, the credit is time-limited. Those who qualify may only claim the tax credit for two consecutive years.

The Government Accountability Office estimates that up to 4 million small businesses could qualify for the credit[2], but this requires that small businesses know about the credit and go

[2] "Small Employer Health Tax Credit: Factors contributing to low use and complexity." Report of the U.S. Government Accountability Office. May 2012. http://gao.gov/assets/600/590832.pdf (page 10)

through the difficult process of determining eligibility. Further, even by the GAO's own admission, advocacy groups identify the 4 million figure as the likely high point of potentially eligible businesses, with some estimating that as few as 1.4 million employers would qualify. Linda Blumberg and Shanna Rifkin of the Urban Institute analyzed this issue in a report issued last month that was commissioned by the Robert Wood Johnson Foundation.[3] They found that qualifying for the credit was particularly difficult in high cost-of-living areas, as the $50,000 limit in average annual wages applies uniformly nationwide. By way of comparison, someone earning $50,000 in Mason City, Iowa in 2014 would need to earn $73,104 annually to maintain the same standard of living in Los Angeles, California.[4] Data from the first year of the tax credit (2010) indicate that the overwhelming majority of employers who were eligible for any credit were not eligible for the full credit. Only 17 percent were eligible for the full credit.[5] The greatest obstacle, according to GAO analysis, was the annual wage requirement. In the first year, 68 percent of businesses who received less than the full credit would have qualified for the maximum percentage based on the number of full-time equivalent employees but failed to qualify based on wages.[6] According to the Urban Institute report, many employers reported that they felt they needed the assistance of an accountant just to determine eligibility for the credit, a cost that sometimes exceeded the actual value of the credit.[7] The GAO report offers a succinct summary of the degree of complexity involved in calculating the credit[8]:

[3] Linda Blumberg and Shanna Rifkin. "Early 2014 Stakeholder Experiences With Small-Business Marketplaces in Eight States." Report of the Urban Institute. August 2014.
http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf414995
[4] http://money.cnn.com/calculator/pf/cost-of-living/
[5] GAO report, *supra*, at page 10.
[6] *Id.*
[7] Blumberg and Rifkin at page 3.
[8] GAO report, *supra*, at page 13.

> On its Web site, I.R.S. tried to reduce the burden on taxpayers by offering "3 Simple Steps" as a screening tool to help taxpayers determine whether they might be eligible for the credit. However, to calculate the actual dollars that can be claimed, the three steps become 15 calculations, 11 of which are based on seven worksheets, some of which request multiple columns of information.

Setting aside the studies and statistics, it is very difficult to find a small business that has actually claimed the credit. They indeed exist, as we know from tax filings, but apparently in such small numbers that even a media outlet with the reach of the *New York Times* was unable to find one to profile.[9] When I teach my students about the tax credit, I always ask if any of the students – who are active brokers and financial advisers – have assisted any clients with this particular tax credit. No student has yet to answer in the affirmative.

While the cost of premiums for plans available on many state SHOP marketplaces have been comparable to – and in many cases slightly lower than – similar plans prior to the opening of the SHOP, they generally remain higher than what many small businesses have determined they can afford to pay. This is where the tax credit is supposed to mitigate costs and increase the likelihood that a small business can actually afford to offer coverage. An expanded, simplified tax credit that is available for longer than two years would offer a real financial incentive for companies to either begin or continue offering health benefits.

[9] Robb Mandelbaum. "Why the Health Care Tax Credit Eludes Many Small Businesses." *The New York Times*. September 25, 2012. http://boss.blogs.nytimes.com/2012/09/25/why-the-health-care-tax-credit-eludes-many-small-businesses/

II. The Inclusion and Empowerment of Brokers has been Minimal

For many small businesses that offer health insurance coverage to their employees, a health insurance agent or broker performs the bulk of the work necessary to facilitate benefit offerings. Small business owners frequently wear many (proverbial) hats, including that of human resources director, marketing director, and controller, among others. Thus, health agents and brokers play a critical role for small businesses. Many of these agents or brokers are comprehensive financial planners and advisers who work with small business clients on matters relating to life insurance and retirement benefits, investments and health insurance. The SHOP Marketplace will not succeed without a substantial buy-in from the agent and broker community. This much was readily acknowledged by John Arensmeyer, CEO of the pro-reform Small Business Majority, who said "at the end of the day, the success of the small-business exchanges is going to be very heavily dependent on brokers and agents."[10]

Health insurance, like any financial product, is complicated and its purchase often requires the advice and assistance of a licensed professional, such as an insurance agent or broker. Particularly for small group policies, where the health and financial well-being of multiple lives and families is at stake, there should be substantial involvement of agents and brokers to ensure that business owners make decisions that are in the best interest of both their company and their employees.

In its first year, at least in the states with fully or mostly functioning SHOP marketplaces, the marketing of the program to brokers, as well as the overall inclusion of brokers in the program, including empowerment, compensation and training, has been severely lacking. In

[10] Robb Mandelbaum. "Small Businesses Showing Little Interest in State SHOP Exchanges." *The New York Times*. December 23, 2013. http://boss.blogs.nytimes.com/2013/12/23/small-businesses-showing-little-interest-in-state-shop-exchanges/

short, even for those brokers who are aware of the SHOP marketplace in their state and the potential benefits available to clients, they must undergo state-mandated training and spend twice as much time on SHOP applications, all for the exact same level of compensation they would receive to sell a non-SHOP plan.

In the states that operate their own SHOP marketplace, brokers are required to be certified through a state-specific training process, which may either be in-person or delivered on the web. Brokers who went through the training programs have indicated that the materials were ineffective or even factually inaccurate. This included inaccurate exam questions and instructors who were required to teach material that was outdated. Further, many of the training programs covered SHOP only as part of a larger health care reform training, therefore requiring small business brokers to become educated upon issues unique to Medicaid, as opposed to more in depth discussion of SHOP.

Those issues only apply to the brokers who feel they were included in the SHOP process. The marketing campaigns for state SHOP exchanges have often failed to target or reach small business health brokers, instead focusing on the federally-funded navigators who primarily support individual exchanges. Additionally, and perhaps most importantly, the outreach to the business community about the existence of SHOP and the role that brokers can play in facilitating enrollment has been minimal. Many businesses remain unaware that they can turn to a local broker to discuss potential options under the Small Business Health Options Program.

The degree and structure of compensation for brokers has discouraged substantial involvement. A broker will earn the same commission or fee for selling a plan directly through an affiliated carrier as he or she would for selling a plan through the SHOP marketplace.

However, the time involved in enrolling a client in a SHOP plan is often double that required to enroll in a plan directly through a carrier. Some, including Lev Ginsburg of the Business Council of New York, estimate that the SHOP process is even more laborious, possibly as much as three or four times what it necessary to enroll in a non-SHOP plan.[11] The additional time is due to the complexity of the IT system and application interface necessary to complete the SHOP process, as well as the opportunity cost involved with the time that often must be spent explaining the new employee choice model to client companies.

The commissions are not the doing of CMS. In its May 2013 guidance, the Department of Health and Human Services clarified that broker commissions do not come from SHOPs, but rather from a negotiated arrangement between carriers and the brokers, but required that the rates be the same for a plan sold within a SHOP as it is for a plan outside of SHOP.[12]

This is not to say that either CMS or the state-run SHOPs have excluded agents or brokers. Indeed, they all have provided resource pages on their websites promoting the value of health insurance brokers and making materials available for the brokers themselves. It can be safely assumed that some broker perceptions are attributable to the focus during 2013 and 2014 on the individual health insurance exchanges, while SHOPs were delayed or given a lower priority. Hopefully, as the SHOP marketplaces fully launch later this year, CMS and the state marketplaces will prioritize the inclusion of brokers and the trade organizations that support them.

[11] *Id.*
[12] Memorandum from the Centers for Medicare and Medicaid Services. May 1, 2013. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/agent-broker-5-1-2013.pdf

III. The Website Delay and IT Issues Increased Uncertainty, Hindering SHOP

Third, and hopefully most obviously, the delay by the Administration of the Federal Facilitated SHOP Marketplace and the accompanying website limited the ability of small businesses in the 32 states relying on the federal marketplace, but it also created confusion for business owners, brokers and navigators in the states that had functioning SHOPs. Additionally, states that were operating their own SHOP Exchanges in 2014 experienced their own IT problems that hindered enrollments.

On November 27, 2013, the Obama administration announced that the online enrollment component of SHOP would be delayed until November 2014, as opposed to launching in October 2013 as originally planned.[13] (An earlier delay, announced September 26, 2013, pushed back the October start to November.) While consumers were ultimately well aware of the online health exchanges, accessible through healthcare.gov, as evidenced by the 9.21 million online enrollments[14], small business owners who visited the site in one of the federal-facilitated states found themselves unable to browse and compare plans online, as promised. This delay had real effects on the efficacy of SHOP. Promoters of the law and brokers speaking with small business clients were unable to say "go to the website and explore your options." Further, the delays caused confusion among the small business community, which leads to uncertainty about SHOP as an effective means of obtaining insurance in the future.

The delays at the federal level were coupled with IT issues and a low prioritization in states that were running their own marketplaces. A thorough analysis of the impact of the

[13] Sarah Kliff. "Obamacare's online SHOP enrollment delayed by one year." *The Washington Post.* November 27, 2013. http://www.washingtonpost.com/blogs/wonkblog/wp/2013/11/27/obamacares-online-exchange-for-small-businesses-is-delayed-by-one-year/
[14] Charles Gaba. http://acasignups.net/

Affordable Care Act in Pennsylvania was unable to draw meaningful conclusions about the efficacy of SHOP, as Pennsylvania did not have a functioning SHOP website.[15] A spokeswoman for CoveredCA admitted that the launch of the individual exchange was the priority, and the California head of the National Federation of Independent Businesses said that even in his state "the SHOP program has kind of taken a backseat."[16] In states with their own SHOP marketplaces, the low prioritization was often overshadowed by IT problems. Maryland and Oregon, for example, had online systems that were non-functional.

For brokers, there were IT issues that left many uncompensated for their work. Brokers would assist business clients with enrollment in a SHOP plan and then the online system would not record the involvement of the broker and the insurance carrier would not know to pay the broker. These IT issues discouraged both brokers and carriers alike.

The most recent SHOP-related delay by the Administration will likely further hinder the program in 2015. On May 27, 2014 the Administration issued final rules on the Employee Choice model in SHOP, which including transition relief allowing states the option of delaying Employee Choice until 2016.[17] Eighteen states will delay Employee Choice an additional year. The Employee Choice model is an essential component of SHOP. In the past, small employees have been largely unavailable to provide choice or variety in health plans to their employees. While large firms overwhelmingly offer more than two plans to their employees, very few small employers were able to do so. The Employee Choice model will allow small businesses to offer

[15] "Beyond the Website." Fels Institute of Government, University of Pennsylvania. February 2014. https://www.fels.upenn.edu/sites/www.fels.upenn.edu/files/aca_final_feb_6.pdf
[16] Anna Gorman. "California's Small Business Health Insurance Exchange Off To Slow Start." *Kaiser Health News*. May 8, 2014. http://www.kaiserhealthnews.org/Stories/2014/May/08/Californias-Small-Business-Health-Insurance-Exchange-Off-To-Slow-Start.aspx
[17] http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/2015-Transition-to-Employee-Choice-.html

employees a variety of plans within the same metallic tier or below a certain price point, which creates a real incentive for small employers to at least consider the options available within SHOP. An effective Employee Choice model, however, also requires a user-friendly information technology interface, which many states may not be fully prepared to offer.

While SHOP was supposed to be fully functional nationwide in 2014, what happened instead was a patchwork test run. In short, a key reason SHOP did not succeed in its first year was because its first year was postponed. A year with fully functioning structures and engaged players will be essential to truly judge efficacy.

IV. Other Factors Impacting the First Year of SHOP

Several other factors negatively affected SHOP during its initial year and will likely continue in the future. These include the many early renewals of small group plans in 2013, competition from private exchanges and the success of the individual marketplace.

Many insurers actively encouraged small business clients to renew (or "early-renew") their existing small group health insurance plans prior to December 31, 2013. Any plans renewed on or after January 1, 2014 were required to comply with a host of new requirements under the Affordable Care Act, namely to offer a package of ten essential health benefits and limit cost-sharing. Thus, businesses with these early-renewed plans had no need to purchase health insurance plans in 2014, at least not until later this year. As many as 70 percent of small businesses may have opted to early renew policies in 2013.[18] This dramatically limited the

[18] Paul Demko. "Small Business Exchanges off to rocky start." *Modern Healthcare*. July 14, 2014.

number of small businesses who otherwise may have been prime candidates for exploring plan options through the SHOP marketplace.

Private exchanges are likely to grow in popularity over the coming years. Because the ACA requires the pricing of plans to be the same within a SHOP exchange as it is outside, the free market can be expected to result in competition from private actors who feel they can provide a greater variety of plans or a better customer experience. Private exchanges have been increasingly popular among larger companies, but the private exchanges are actively seeking to sell to small groups.

Finally, despite the well-publicized disaster that was the launch of healthcare.gov, the Health Insurance Marketplace ended up enrolling far more people than nearly anyone had anticipated and millions of Americans found health insurance at a lower rate than they had previously paid. If employees of small businesses have the option of obtaining affordable health insurance on their own, usually with the assistance of a federal tax credit, many small businesses who have not offered coverage in the past will likely simply direct their employees to the public marketplace, thus rendering an employer-based plan unnecessary and alleviating a prospective burden from the employer.

In conclusion, many small businesses want to offer health coverage. It simply needs to be more affordable, simpler and be facilitated by an experienced insurance broker. The Small Business Health Options Program has the potential to offer just that, but marketing, tax credits, information technology and broker involvement need to be dramatically increased in order for the program to achieve its laudable goals.