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Congress of the United States

U.S. House of Representatives

Committee on Small Business

2361 Rayburn House Office Building
Washington, DC 20515–6315

Memorandum

To: Members, House Small Business Subcommittee on Investigations, Oversight and Regulations
From: Committee Staff
Date: March 12, 2012
Re: Hearing: "The Health Care Reform Law: Its Present and Future Impact on Small Businesses and Job Creation"

On Friday, March 16, 2011 at 10:00 a.m. at Greenwood Village City Hall Auditorium, 6060 South Quebec Street, Greenwood Village, CO, the Small Business Subcommittee on Investigations, Oversight and Regulations will hold a hearing for the purpose of receiving testimony from witnesses regarding the impact of the Patient Protection and Affordable Care Act ("PPACA" or "health care law") on small businesses.

I. Background

The Patient Protection and Affordable Care Act[1] (PPACA) was signed into law on March 23, 2010, and the reconciliation legislation containing amendments to the Act[2] was signed into law on March 30, 2010. Although many people agreed that our health care system needed reform, the debate that resulted in the comprehensive health care law was a contentious one.

PPACA requires individuals to purchase and maintain at least minimum essential health insurance coverage or, with certain exceptions, pay a penalty for not doing so, and establishes health insurance exchanges where individuals will be able to purchase health insurance. Certain individuals may be eligible for subsidies to help defray the cost of insurance. PPACA also mandates that employers provide at least minimum essential coverage for their employees or pay a penalty.

The health care law will become effective in stages over time. The law has remained controversial, raising questions about the access to, affordability of, and delivery of health

[1] Patient Protection and Affordable Care Act, [hereinafter PPACA], 26 U.S.C. § 5000A (2010).
[2] The Health Care and Education Reconciliation Act of 2010, 26 U.S.C. § 1305 note (2010).

care.[3] These questions can be particularly important for small businesses, because they are often disproportionately affected by changes to the law.

This hearing will provide an opportunity for Members to hear from small businesses about whether under PPACA and its major regulations, they will be able to maintain the coverage they currently have for themselves and their employees.

II. Small Businesses and Health Insurance

During the 111th and 112th Congresses, the Committee has held several hearings on topics related to health care and small businesses. Many agreed that the health care system needed reform, because the cost of health care continued to escalate, and entrepreneurs found health insurance difficult to obtain in the individual or small group markets. Small company owners said that although they had traditionally offered health care to their employees, and wanted to continue to do so, the concentration of health insurers gave them few options for purchasing coverage, and those options were extremely expensive.

Witnesses suggested a number of solutions, such as allowing small companies to join together to purchase health insurance across state lines, which could increase competition and reduce costs; tort reform to bring down the cost of physicians' malpractice insurance; and permitting physician assistants, nurses, and other health practitioners to expand their duties to reduce the cost of health care delivery.

The Kaiser Family Foundation reported that the percentage of firms with three to nine employees offering health insurance rose from 46% in 2009 to 59% in 2010.[4] According to the study, the increase was due to the high failure rates of small businesses during the economic downturn. With fewer small companies not offering health insurance in the sample, the share of those offering health insurance increased.[5] An Agency for Healthcare Research and Quality survey found that approximately 41% of small firms with less than 50 employees currently offer health insurance.[6]

A July 2010 Fidelity Investments survey[7] found that 22% of small employers were seriously considering eliminating health care coverage, compared with 14% of larger employers.[8]

III. The Employer Mandate

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[3] KAISER FAMILY FOUNDATION, HEALTH TRACKING POLL, February, 2011, *available at* http://www.kff.org/kaiserpolls/8156.cfm.
[4] *Id.*
[5] *Id.*
[6] AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, MEDICAL EXPENDITURE PANEL STUDY, *available at* http://www.meps.ahrq.gov/mepsweb/.
[7] FIDELITY INVESTMENTS SURVEY (July 2010), *available at* http://www.fidelity.com/inside-fidelity/employer-services/fidelity-survey-finds-majority-of-employers-rethinking-health-care-strategy-post-health-care-reform.
[8] *Id.*

Beginning in 2014, PPACA requires any employer with more than 50 full-time equivalent employees[9] during the preceding calendar year to provide health insurance to their employees. If the employer fails to do so, and at least one full-time employee receives a premium subsidy to purchase health insurance through the new health insurance exchanges, a penalty of $2,000 per employee will be assessed. Employers with more than 50 employees who offer coverage but have at least one full-time employee receiving a premium tax credit will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 per full-time employee.

In addition, the employer must offer a minimum set of benefits, defined as "minimum essential coverage,"[10] or a penalty may be assessed. Regardless of whether the employer offers coverage or not, the employer will be subject to a penalty if any full-time employee receives a premium credit toward coverage through a health insurance exchange.[11] The employer mandate applies to for-profit and non-profit enterprises.

Beginning in 2014, employers will have additional reporting requirements related to health insurance. Under the law, large employers and employers who offer minimum essential coverage will be required to file a return with the Internal Revenue Service (IRS). The IRS form must include the name, address, and tax identification number of the insured employee and others covered under the policy; whether the coverage is provided through a health exchange, and if so, the cost-sharing or tax credit provided; the length of coverage provided; and if the coverage is provided by the employer's group plan, the premium or portion of premium provided by the employer.

Beginning with taxable years after 2010, employers are required to provide on an employee's W-2[12] the cost of employer-sponsored insurance coverage, and will indicate the share paid by the employer and by the employee. This amount will not be included in the employee's taxable income.

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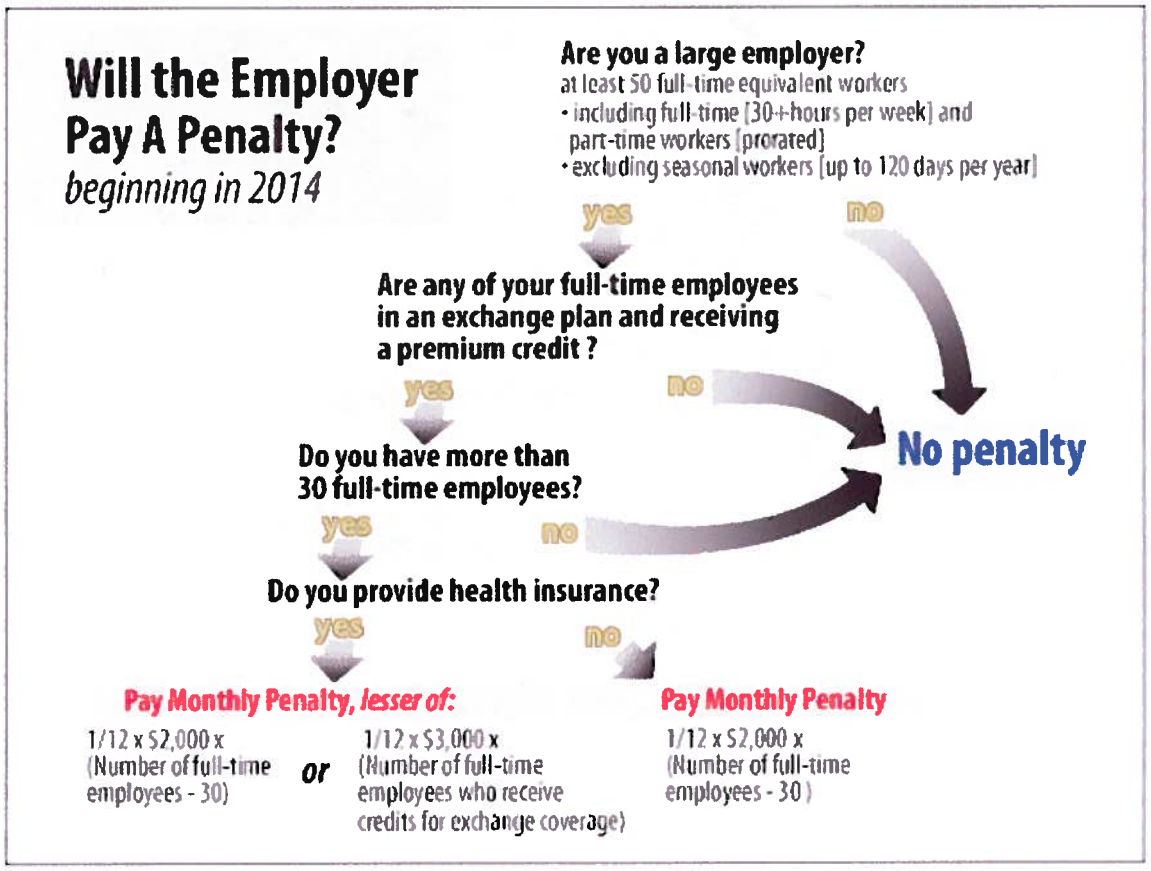
[9] In determining whether a company is a large employer, both full-time and part-time employees are included in the calculation. Full-time employees are those working 30 or more hours per week. The hours worked by part-time workers are included on a monthly basis by determining their number of hours worked and dividing by 120. Seasonal workers are excluded if they work less than 120 days per year.

[10] 26 U.S.C. § 5000A (2010).

[11] According to the Congressional Research Service, in 2014, the monthly penalty assessed will be equal to the number of full-time employees minus 30 multiplied by one-twelfth of $2,000 for any applicable month. After 2014, the penalty would be indexed by a premium percentage adjustment for that calendar year.

[12] 42 U.S.C. § 9002 (2010).



Source: CRS analysis of P.L. 111-148 and P.L. 111-152.

IV. Health Insurance Tax Credit for Small Businesses

The law offers a temporary health care tax credit for certain small business owners who purchase health insurance. In 2010, the law provided a 35% tax credit for an employer's health insurance costs if they met the criteria outlined below. The tax credit is effective from 2010 through 2013. Beginning in 2014, the law provides a 50% credit for an employer's health insurance costs. The credit is available for two additional years, and only if the employer purchases health insurance through one of the exchanges.

Some small business owners and small business groups believe the tax cut may be too narrowly tailored to help more than a few entrepreneurs.[13] To be eligible for the full credit, a small business owner must: 1) have fewer than 10 full time equivalent employees, but at least one employee; 2) pay those employees an average annual wage of $25,000 or less; and 3) offer health insurance to those employees and pay at least 50% of the premium. To be eligible for a partial tax credit, the small business owner must: 1) have 11 to 25 full time employees; 2) pay an average wage of $25,000 to $50,000; and 3) offer health insurance to

[13] NATIONAL FEDERATION OF INDEPENDENT BUSINESS, *Will the Small Business Healthcare Tax Credit Help Small Business Owners?* available at http://www.nfib.com/issues-elections/issues-elections-item?cmsid=52260.

those employees and pay at least 50% of the premium.[14] The self-employed, although they represent 78% of all small businesses in the U.S., are excluded from the credit.[15]

Some business owners say that the tax credit has been slow to be adopted because it is complicated and temporary, and there are a number of strings attached.[16] Others say that the credit may spur them to offer health insurance.[17] The Internal Revenue Service[18] and NFIB[19] have developed some tools to help small business owners determine whether they will qualify for the credit.

In his Fiscal Year 2013 budget, President Obama proposed revising the tax credit to allow firms with up to 50 workers eligible, and allow firms with up to 20 full-time employees eligible for the maximum credit.[20] The budget also proposes a more generous phase-out schedule.[21]

V. Additional Tax Provisions in the Health Care Law

The additional tax provisions in the health care law may adversely affect small business owners. Some of these taxes are listed below.

Medicare Surtax on Investment Income - Beginning in 2013, a new 3.8% surtax on investment income for individuals with incomes over $200,000 and $250,000 for joint filers. Investment income encompasses interest, dividends, rent, royalties, passive activity income (such as income from partnerships or S corporations).

Reduced Annual Pre-Tax Flexible Spending Account (FSA) Contributions – Beginning in 2013, the maximum FSA contribution will be capped at $2,500.

Reduced Over-the-Counter (OTC) Products Eligible for FSA Reimbursement Without a Doctor's Prescription – Beginning in 2011, fewer non-prescribed OTC products will be eligible for reimbursement without a prescription.

Increased Penalties for non-Medical Health Savings Account (HSA) Withdrawals -- Under current law, penalties for withdrawals made for a non-medical purpose are 10%. That penalty will be doubled to 20%.

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[14] INTERNAL REVENUE SERVICE, *Small Business Health Care Tax Credit: Frequently Asked Questions,* December 3, 2010, *available at* http://www.irs.gov/newsroom/article/0,,id=220839,00.html.

[15] U.S. CHAMBER OF COMMERCE MAGAZINE, *Health Care Reform and Your Business,* May 1, 2010, *available at* http://www.uschambermagazine.com/article/health-care-reform-and-your-business.

[16] Michael Booth, *Small Business Tax Credits Not Catching on in Colorado Yet,* THE DENVER POST, December 6, 2010, *available at* http://www.denverpost.com/business/ci_16774968.

[17] Karen Klein, *How Health-Care Reform Will Affect Small Business,* BUSINESSWEEK, April 13, 2010, *available at* http://www.businessweek.com/smallbiz/content/apr2010/sb20100413_125807.htm.

[18] The Internal Revenue Service's tax credit calculator, *available at* http://www.irs.gov/pub/irs-tl/3_simple_steps.pdf.

[19] NFIB's tax credit calculator is available at http://www.nfib.com/issues-elections/healthcare/credit-calculator.

[20] THE WHITE HOUSE, FACT SHEET: PRESIDENT OBAMA'S BUDGET EXPANDS AND SIMPLIFIES SMALL BUSINESS HEALTH INSURANCE TAX CREDIT, available at http://www.whitehouse.gov/the-press-office/2012/02/16/fact-sheet-president-obama-s-budget-expands-simplifies-small-business-he.

[21] *Id.*

Medical Expense Deduction Floor Increases to 10% -- Under current law, out-of-pocket medical expenses are deductible if they exceed 7.5% of adjusted gross income (AGI). Beginning in 2013, only medical expenses that exceed 10% of AGI will be deductible.

Tax Increase on Medical Device Manufacturers, Health Insurance Plans, and Manufacturers and Importers of Brand Name Prescription Drugs – Beginning in 2013, the law includes a 2.3% tax on the first retail sales of medical device manufacturers.[22] Beginning in 2014, the law imposes an annual fee on health insurance plans of $8 billion in 2014, which rises to $14.3 billion in 2018, and thereafter increases by the rate of premium growth.[23] Beginning in 2011, the law imposes an annual fee of $2.5 billion on branded prescription drug manufacturers and importers, increases to a maximum of $4.1 billion in 2018, and then set at $2.5 billion per year in 2019 and thereafter.[24] The Chief Actuary of the Centers for Medicare and Medicaid Services has stated that he believes these tax increases would generally be passed along to health consumers in the form of higher costs.[25]

Tax on Indoor Tanning Services – In effect since July, 2010, this 10% tax on the use of indoor tanning services is estimated to raise $2.7 billion.

VI. Legal Challenges to the Law

Lawsuits

There have been almost two dozen legal challenges to the health care law to date.[26] Most of the lawsuits question whether the government can require citizens to purchase a commercial product; in this case, health insurance. According to the Commerce Clause of the Constitution,[27] the government may regulate "activities that substantially affect interstate commerce." The question before the courts in these cases is the definition of "activities."

The U.S. Supreme Court will hear arguments on the constitutionality of the health care law in March, 2012. This means its decision is likely to be delivered by next summer. The 11th Circuit Court of Appeals in Atlanta struck down the individual mandate but left the remainder of the law standing.

In August, a three member panel of the court ruled that Congress overstepped its authority in passing the law. Other federal courts that have decided the case have been split.

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[22] Memorandum on Financial Impact of Patient Protection and Affordable Care Act from Richard Foster, Centers for Medicare and Medicaid Services (April 22, 2010) *available at* http://www.politico.com/static/PPM130_oact_memorandum_on_financial_impact_of_ppaca_as_enacted.html.

[23] *Id.*

[24] *Id.*

[25] *Id.*

[26] Kevin Sack and Robert Pear, *Health Law Faces Threat of Undercut from Courts*, N.Y. TIMES (November 29, 2010), *available at* http://www.nytimes.com/2010/11/27/us/politics/27health.html?_r=1&hpw.

[27] U.S. Const. art. I, §8, cl. 3.

The Court of Appeals for the 6th Circuit in Cincinnati upheld the individual mandate.[28] The Court of Appeals for the 4th Circuit in Richmond ruled that courts do not have the authority to decide the case until 2015, when the penalties for failure to comply with the individual mandate become effective.[29]

Appropriations Process

Some Members of Congress have proposed legislation to de-fund certain provisions of the health care law, particularly the Internal Revenue Service's enforcement of the individual mandate to maintain health insurance, in an attempt to prevent its implementation. The Department of Health and Human Services may redirect money from other operations to cover implementation of the law.

Congressional Review Act

Other Members of Congress have pledged to challenge the law's regulatory provisions using the Congressional Review Act (CRA).[30] The CRA was enacted in 1996 to ensure that Congress retained some authority over rulemaking. Under the CRA, an agency must submit all of its covered final rules to both houses of Congress and the Government Accountability office before they can become effective. Within 60 days of the Administration sending the rule to Congress or a rule's publication in the Federal Register, Congress may hold an up-or-down vote on a resolution disapproving of it. If Congress passes the disapproval resolution and the President signs it, the rule is repealed, and the Administration may not issue a rule that is substantially similar to the disapproved rule. The CRA has only been used to disapprove one rule in the 14 years since its enactment.[31] Of course, there is little likelihood that President Obama would sign a resolution disapproving a rule his own administration promulgated.

Repeal Legislation

The House voted to repeal PPACA on January 19, 2011. The Senate has no plans to take up the legislation. As a result, small businesses are faced with a health care landscape where the Administration is continuing to release regulations pursuant to the law, and a Congress that may not fund their implementation.

VII. Effect of PPACA on Small Firms' Employer-Provided Coverage

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[28] *Thomas More Law Center et al v. Barack Hussein Obama et al, available at* http://www.ca6.uscourts.gov/opinions.pdf/11a0168p-06.pdf.

[29] 26 U.S.C. § 5000A.

"Kevin Sack, *Judge Voids Key Element of Health Care Law*, N.Y. TIMES, December 11, 2010, *available at* http://www.nytimes.com/2010/12/14/health/policy/14health.html?_r=1&scp=1&sq=health%20care%20law&st=cse.

[30] P.L. No. 104-121, 5 U.S.C. §§ 801-808 (1996).

[31] CURTIS W. COPELAND, CONGRESSIONAL RESEARCH SERVICE, INITIAL FINAL RULES IMPLEMENTING THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 21 (December 10, 2010), *available at* http://www.crs.gov/pages/Reports.aspx?PRODCODE=R41346&Source=search.

Several recent studies have heightened the debate over the effect of PPACA on employer-provided coverage of small firms. A Robert Wood Johnson Foundation study found that most Americans will still get their health insurance through employers, although fewer than in previous years. The study showed about 61% of the non-elderly received health insurance through employers in 2009, down from 69% in 2000. Those most likely to be affected by the loss of employer coverage were low and moderate income workers and those employed by small firms. A June 2011 study by the Urban Institute[32] predicted that the health care reform law will increase small firms' coverage of employees.[33]

These studies counter a McKinsey study[34] that found that 30% of respondents whose companies provided health insurance would definitely or probably end coverage after 2014, when the bulk of PPACA's provisions become effective. Senator Max Baucus (D-MT), among others, challenged McKinsey's methodology. A PWC survey[35] indicated that almost half of companies surveyed were likely to change subsidies for employee medical coverage, and 51% would not maintain grandfather status under PPACA. Douglas Holtz-Eakin's study[36] found that up to 35 million workers could lose employer-provided health insurance.

VIII. The Near Term Landscape: PPACA Provisions Affecting Small Businesses

The health care law is unlikely to be fully repealed. As a result, some Members are concerned not only with the ability of small businesses to comply with the law, but also with the new regulations that are being issued pursuant to it. These new regulations are remarkable in their number and also in their sweeping scope.[37] Efforts have been made to repeal, or grant waivers from, several regulations. Outlined below are some of the regulations that are expected to be particularly burdensome for small businesses:

Medical Loss Ratio (MLR)[38] -- Beginning on January 1, 2011, this provision requires insurers to spend between 80% and 85% of premiums on direct care for patients and efforts to improve care quality, placing a cap on administrative costs. There is some concern about how to define "health care." In addition, the *Wall Street Journal* raised questions about the ability of smaller insurers to meet the new targets and could fail as a result.[39] On November 22, 2010, HHS issued guidance on what insurers may count as health care, including a guide for how state insurance regulators may apply for an MLR adjustment, indicating that insurers may spend less than 80% if they can demonstrate a reasonable likelihood that market destabilization will occur. On December 1, 2010, HHS issued its interim final rule on MLR.[40]

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[32] STACEY MCMORROW, LINDA BLUMBERG AND MATTHEW BUETTGENS, URBAN INSTITUTE, THE EFFECTS OF HEALTH REFORM ON SMALL BUSINESSES AND THEIR WORKERS (2010), *available at* http://www.urban.org/publications/412349.html.

[33] Id at 1.

[34] MCKINSEY QUARTERLY, available at http://www.mckinseyquarterly.com/Health_Care/Strategy_Analysis/How_US_health_care_reform_will_affect_employee_benefits_2813

[35] PWC, HEALTH AND WELL-BEING TOUCHSTONE SURVEY (2010), *available at* http://www.pwc.com/us/en/hr-management/publications/health-wellness-touchstone-survey.jhtml.

[36] DOUGLAS HOLTZ-EAKIN AND CAMERON SMITH, AMERICAN ACTION FORUM, LABOR MARKETS AND HEALTH CARE REFORM: NEW RESULTS (May 2010), *available at* http://americanactionforum.org/files/LaborMktsHCRAAF5-27-10.pdf.

[37] *See generally*, CQ WEEKLY, A GAME OF RULES 28 (December 13, 2010).

[38] 45 CFR Part 158, available at http://www.ofr.gov/OFRUpload/OFRData/2010-29596_PI.pdf.

[39] Editorial, WALL ST. J., *Postponing ObamaCare* (November 26, 2010), available at http://integrate.factiva.com/en/search/article.asp.

[40] 45 CFR Part 158, *available at* http://edocket.access.gpo.gov/2010/pdf/2010-29596.pdf.

Waivers -- Hundreds of companies, organizations and unions that provide limited benefit plans not meeting the new medical loss ratio requirements are being granted temporary waivers from compliance with PPACA's minimum benefits. These waivers will expire at the end of 2014.

Minimum Essential Benefits -- Beginning in 2014, new insurance plans must include a "minimum essential benefit" package[41] that will include ten categories of services such as hospitalization, prescription drugs, rehabilitative services. The Department of Health and Human Services has asked the Institute of Medicine (IOM) to recommend the specific services that must be covered. IOM is expected to provide its recommendations this fall.

Health Insurance Company Price Controls – Beginning July 1, 2011, this HHS proposed rule will require insurers to post justifications online when they propose raising premiums more than 10%. The rule sets a clearer definition of an "unreasonable" rate increase (presumably those over 10%). An HHS formal review process will determine whether an increase is unreasonable.[42] Smaller insurers may have difficulty complying with the additional burdens of posting online rate justifications.

Indoor Tanning Excise Tax Guidance – On June 15, 2010, the IRS published a final rule providing guidance on the PPACA's indoor tanning 10% excise tax,[43] specifically the manner in which indoor tanning businesses should remit the additional tax. This rule took effect on the day the guidance was published, and is estimated to affect up to 19,000 small businesses.[44]

Prohibition of Preexisting Condition Exclusions; Lifetime Dollar Limits on Benefits; Prohibition of Rescissions On June 28, 2010, the Internal Revenue Service, Employee Benefits Security Administration, and HHS jointly issued a final rule implementing new sections of the Public Health Service Act that were added by the PPACA. The final rules were effective on August 27, 2010, and apply to group health plans and group health issuers, some of whom are small businesses, for plan years beginning on or after September 23, 2010.

IX. Economics of Implementation

It is uncertain how the health care law will affect small businesses in the long term. Many of the new law's provisions have not yet become effective. However, the law will impose new regulations, mandates, taxes and indirect costs on small- and medium-sized small businesses. These provisions may affect their ability to create jobs, invest and promote economic growth.

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[41] 42 U.S.C. § 18001 (2010).
[42] 45 CFR Part 154, *available at* http://www.ofr.gov/OFRUpload/OFRData/2010-32143_PI.pdf.
[43] 42 U.S.C. § 10907 (2010).
[44] Press Release, Indoor Tanning Association, By the Numbers: The Indoor Tanning Tax, *available at* http://www.theita.com/resource/resmgr/press_releases/by_the_numbers_suntan_tax_fi.pdf.

Health Insurance Costs – Supporters of the law claim that when all of its provisions become effective, it will help to control health care costs and reduce the cost of health insurance. Others say that the law's provisions will increase the cost of health care, increasing premiums, and that compliance with the law will be burdensome and costly for small firms, forcing them to drop coverage, pay the penalty and even reduce their payrolls.

Small Business Tax Credit – Some small business owners have said the credit may spur them to offer insurance.[45] The Congressional Budget Office estimates that the credit will impact up to 12% of businesses with 25 or fewer workers and will expire after 2014.[46]

Companies With Fewer than 50 Employees – Small businesses are exempt from the law's mandate to provide health insurance by 2014 or pay a penalty. However, this 50 employee limit may discourage growing firms from exceeding the threshold. The owners may decide to split the company into smaller divisions or hire only part-time workers.

Medicare Tax Increase and Tax Increase on Unearned Income – The new non-payroll or "investment tax" will apply to "flow through income," business income that is reported on individual tax returns. Increasing taxes on flow-through income will capture an increasing number of small businesses.[47] The effect of imposing additional taxes on job creators may be reduced hiring, reduced wages to current employees, hiring of temporary rather than permanent employees, or job losses.

Increased Paperwork, Regulatory and Compliance Costs – According to the Small Business Administration's Office of Advocacy, it already costs small companies $2,830 more per employee to comply with regulations than larger firms.[48] Adding more regulations, mandates and paperwork burdens to small companies may further increase their costs.

X. Keeping Your Current Coverage under PPACA

Richard S. Foster, the Chief Medicare Actuary for the Centers for Medicare and Medicaid Services, projected that following the passage of PPACA, "some smaller employers would be inclined to terminate their existing coverage and companies with low average salaries might find it to their -- and their employees' – advantage to end their plans, thereby allowing their workers to qualify for heavily subsidized coverage through the Exchanges."[49]

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[45] Karen Klein, *How Health-Care Reform Will Affect Small Business*, BUSINESSWEEK, April 13, 2010, *available at* http://www.businessweek.com/smallbiz/content/apr2010/sb20100413_125807.htm.

[46] CONGRESSIONAL BUDGET OFFICE, AN ANALYSIS OF HEALTH INSURANCE PREMIUMS UNDER THE AFFORDABLE CARE ACT (November, 2009), *available at* http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf.

[47] Individuals earning $200,000 or more annually and families earning $250,000 or more annually. *See* JOHN LIGON, THE HERITAGE FOUNDATION, OBAMACARE: IMPACT ON BUSINESSES (April 27, 2010), available at http://www.heritage.org/research/reports/2010/04/obamacare-impact-on-businesses.

[48] OFFICE OF THE CHIEF COUNSEL FOR ADVOCACY, U.S. SMALL BUSINESS ADMINISTRATION, THE IMPACT OF REGULATORY COSTS ON SMALL FIRMS (September 2010), *available at* http://www.sba.gov/advocacy/853/2016.

[49] MEMORANDUM ON ESTIMATED FINANCIAL EFFECTS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT FROM RICHARD S. FOSTER, CENTERS FOR MEDICARE AND MEDICAID SERVICES, (April 22, 2010), *available at* https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf.

PPACA contains provisions[50] that allow health insurance plans that were in effect on March 23, 2010[51] to be "grandfathered," or exempt from certain requirements of the law. But PPACA requires that even grandfathered plans must meet certain PPACA provisions, including: 1) prohibition on annual or lifetime limits; 2) Medical Loss Ratio reporting (must spend 80 percent of their premium income on medical claims for the individual and small group markets, and 85 percent in the large group market); 3) uniform explanation of coverage documents; 4) prohibition on rescissions; 5) dependent coverage for children under 26 years of age; 6) prohibition on excessive waiting periods; and 7) coverage for preexisting conditions.

The Interim Final Rule published on June 17, 2010[52] by the Departments of Health and Human Services, Department of the Treasury and Department of Labor outlined several changes to health insurance that could cause the loss of grandfathered status: 1) a plan that did not have continuous enrollment (does not need to be the same enrollee); and 2) termination of an existing collective bargaining agreement under which the grandfathered health insurance was provided. Finally, the rule includes transitional rules that allow flexibility in changes made to the terms of health insurance that do not cause the loss of grandfathered status. The Interim Final Rule was effective on June 14, 2010. Comments were accepted until July 12, 2010.

On November 17, 2010,[53] the Departments of Health and Human Services, Department of the Treasury and Department of Labor published an amendment to the Interim Final Rule on grandfathered health insurance. The amendment allows group health plans to change insurance carriers and still retain grandfathered status for its policies. The amendment to the Interim Final Regulations was effective on November 15, 2010. Comments were accepted until December 17, 2010.

XI. Potential Impact of Grandfathering Rules on Small Businesses

In its June 17, 2010 Interim Final Rule, the Departments of Health and Human Services, Treasury and Labor estimated that by 2013, about 50 percent of employer-sponsored plans will no longer qualify as grandfathered. For larger employer (with 100 or more employees) plans, about 45 percent would lose grandfathered status by 2013. For smaller employer (3-99 employees) plans, about 66% would no longer qualify.[54] The amendment to the Interim Final Rule allowed plans to switch insurance carriers and remain grandfathered, so the Departments predicted a small increase in the number of plans that will retain grandfathered status.[55]

Some health insurance companies that serve the small group market may not be able to meet PPACA's Medical Loss Ratio (MLR) requirements. Insurers may be forced out of the

[50] 124 U.S.C. § 1251 (2010).
[51] The date that the Patient Protection and Affordable Care Act was signed into law.
[52] 75 Fed. Reg. 116 at 34,541, *available at* http://www.gpo.gov/fdsys/pkg/FR-2010-06-17/pdf/2010-14488.pdf.
[53] 75 Fed. Reg. 221 at 70,114, *available at* http://www.gpo.gov/fdsys/pkg/FR-2010-11-17/pdf/2010-28861.pdf.
[54] 75 Fed. Reg. 116.
[55] *Id.*

market, leaving consumers with fewer options or without coverage. A Congressional Budget Office report[56] noted that "[w]hether insurers serving the individual and small-group markets could increase their loss ratio simply because they were required to do so is not clear, so the effects of such requirements on those markets is hard to predict. If the MLR requirement was set too high, insurers would probably exit the market."[57]

PPACA does not address the point at which changes to a group health plan or health insurance coverage in which an individual was enrolled on March 23, 2010 are significant enough to cause the plan or coverage to cease to be grandfathered. The Departments said in the June 17, 2010 Interim Final Rule that the Interim Final Rule was an attempt to "ease the transition of the healthcare industry into the reforms established by the Affordable Care Act by allowing for gradual implementation of reforms through a reasonable grandfathering rule."[58] However, some small businesses are concerned about uncertainty surrounding the implementation of PPACA. Some have said they are unsure about whether the mandates will allow them to continue offer health insurance or whether they should, or will be able to, pay the penalty.

XII. Conclusion

This hearing will provide Committee Members with the opportunity to hear testimony about whether small business owners will be able to keep their current health insurance coverage under PPACA, or offer alternative coverage, and whether it may affect the ability of small firms to grow, invest and create jobs in the future.

[56] CONGRESSIONAL BUDGET OFFICE, KEY ISSUES IN ANALYZING MAJOR HEALTH INSURANCE ISSUES (December 2008), *available at* http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf.
[57] *Id.* at 71.
[58] 75 Fed. Reg. 116 at 34,531.