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Mr. Chairman Brady, Ranking Member McDermott, members of the Subcommittee. Thank you for the opportunity to address you today.

On January 1, 2014, millions of otherwise uninsured or uninsurable Americans will become eligible for coverage under the Affordable Care Act. Among them will be my 23 year-old son, who has a chronic disease that would make him uninsurable in the individual market, but who is already covered today because of the ACA and who can be assured that he will remain covered for the rest of his life once it is fully in place. Among them also is a good friend from my church, also uninsured, who recently discovered a large growth on her shoulder and was told by a doctor that it may be cancer but that he would not operate unless she paid one quarter of his fee up front. She will also be able, on January 1, to obtain affordable health insurance—and more importantly, health care—despite her low income.

The ACA expands health coverage through five major mechanisms. First, and most important, are the premium tax credits, which will help make coverage more affordable for millions of uninsured Americans with incomes between 100 and 400 percent of poverty. This extends a benefit that virtually everyone in this room, including my fellow panelists, already enjoys—tax-subsidized health insurance.[1] Low-income individuals and families will also qualify for cost-sharing assistance to ensure that health care, as well as health insurance, is affordable.

Second, the ACA would have extended Medicaid to every American under age 65 with income below 138 percent of the federal poverty level.[2] However, as we all know, the Supreme Court in 2012, in a decision that was literally unprecedented, decided that Congress could not require states to expand Medicaid, even though the expansion is fully federally funded for the first three years. This decision—coupled with state inaction—is leaving millions of the poorest uninsured Americans without a right to health coverage. As of today, almost half the states have decided to move forward on January 1, 2014.[3] I believe more are likely to follow.

Third, the ACA protects people with pre-existing conditions by prohibiting insurers from refusing to cover them or charging higher premiums as a result of their health needs.[4] Thus my son, who will have a pre-existing condition for the rest of his life, can rest assured that he—and everyone else with pre-existing conditions—will never be turned down for insurance and that it will remain affordable to him.

Fourth, the ACA's individual responsibility provision requires all Americans who can afford health insurance to purchase it or pay a tax.[5] This provision, which has been bitterly contested but upheld by the Supreme Court, is necessary to ensure affordable coverage for all. Pooling risk—where both healthy and sick people are buying policies – is a basic requirement for providing insurance to all. Of course, few of us know when illness or accident will leave us in need of health care, and the individual responsibility provision ensures that we will not become a burden to others when we need expensive health care. After all, states generally require car insurance before you get on the road, even though it is safe to say most of us hope we will not need it. Likewise, banks and other mortgage issuers require homeowners' insurance, irrespective of anticipated losses. Why should health insurance be any different in this respect?

Finally, the ACA requires large employers to offer affordable and adequate coverage to their full-time employees or face a tax penalty to help offset inevitable costs of their employees who do not receive health benefits.[6] Since the 1940s, our health care system has been largely dependent on employer-sponsored coverage, which currently covers 55 percent of our population.[7] Currently, 98 percent of employers with 200 or more employees and 94 percent of employers with 50 to 199 employees offer health insurance to their employees.[8]

Under the ACA, an employer with at least 50 full-time employees who fails to offer any health insurance will face a penalty of $2000 for every full-time employee if any employee gets premium tax credits through the exchange.[9] While this penalty applies if even one uncovered employee obtains tax credits, the penalty only applies to the number of employees in excess of 30. This "discount" was created to mitigate against potential disincentives to grow a business above 50 workers. Alternatively, an employer that offers its full-time employees health insurance that is either "unaffordable" coverage (the employee share of premiums for self-only coverage is more than 9.5 percent of household income) or "inadequate" (its actuarial value is less than 60 percent) will instead face a penalty of $3000 for every employee who ends up getting premium tax credits through an exchange or marketplace.[10]

The employer responsibility provision was intended to build on the current employer-based system, minimize disruption, and help ensure a level playing field among businesses. No employer, of course, is likely to offer health insurance simply to avoid a $2000 or $3000 penalty—health insurance costs far more than that. But nearly all mid-size and large employers already offer health insurance without a penalty, and all of the reasons that they do so now—the ability to increase compensation through tax subsidies, recruitment and retention of employees, increased productivity and reduced absenteeism—will continue to exist in 2014 and beyond. The penalties are merely a marginal incentive, which might induce a few more employers to offer insurance and, more importantly, will keep a few others from dropping it.

On July 2, 2013, the Treasury Department and White House announced that they were delaying for one year the reporting requirements that the ACA had included to help the IRS enforce the law's employer responsibility provisions.[11] According to Administration

officials, they had heard from businesses that the reporting requirements were too complicated, and that businesses needed more time to comply. Because Treasury concluded that it would be impractical to enforce the employer responsibility provision without the reporting requirement in place, it was also delayed until 2015.

The Administration did not ask for my opinion on this issue. They never do. I did not find out about it until a reporter called me during dinner for my reaction. My initial response was shock and disappointment, which is reflected in statements I made to the press and on my Health Affairs blog post immediately following the announcement. But as I have had time to reflect on it further, I am not sure that it was such a bad decision. It seems to me that the decision raises four issues, which I would like to discuss today.

The first is whether it is legal. The employer responsibility provisions of the ACA, like many of its other provisions, have an effective date of January 1, 2014.[12] Arguably this is not true of the reporting requirements under sections 6055 and 6056, which apply "at such time as the Secretary may prescribe," although the ACA seems to say that the reporting also must begin for 2014.[13] I am informed that Treasury believes that it has authority to offer transition relief under its general rulemaking power under IRC § 7805(a). Also, the ACA requires the IRS to assess and collect in the same manner as penalties under subchapter B or chapter 68 of the Internal Revenue Code, and the IRS frequently abates penalties assessed under chapter 68.[14] Under this analysis, Treasury has the authority to delay the reporting requirement and thus their enforcement of the employer responsibility provision.

However, even if one disagrees with that analysis, there is in fact a long history, going back at least to Marbury v. Madison,[15] of both Republican and Democratic administrations failing to comply promptly, or even refusing to comply at all, with laws passed by Congress. Sometimes this failure has been due to disagreements about policy. The George W. Bush administration, for example, refused to enforce certain requirements of the Clean Air Act.[16] Sometimes, it has been due to simple inability to comply in a timely manner with all of the demands made by Congress and in the context of given resource constraints.[17] This is presumably the case with this situation.

Between competing obligations and scarce resources, it appears that the Administration has concluded that employers cannot practically implement these requirements of the law at this point and instead opted to delay enforcement for one year. The Supreme Court in Heckler v. Chaney held that "an agency's decision not to prosecute or enforce . . . is a decision generally committed to an agency's absolute discretion."[18] Arguably the Administration's decision to delay enforcement of the employer responsibility provision is within its discretion. But if it is not, a delay in enforcement is certainly not without precedent, and arguably delayed enforcement is better than non-enforcement, a policy that has been pursued by other administrations in other contexts.

A second question is whether delay jeopardizes the implementation of other ACA requirements, particularly provisions dealing with eligibility for premium tax credits and the individual responsibility provisions. The Administration's statements say that

implementation of the rest of the ACA, including the launch of marketplaces or exchanges and the availability of premium tax credits, is going forward on schedule. From all appearances this is true.

Advance premium tax credits, however, are only available to employed individuals who are either not offered health coverage by their employers or are only offered employer coverage for which "self-only" coverage costs more than 9.5 percent of household income or that fails to offer "minimum value" —covering 60 percent of health care costs. Also, taxpayers are subject to the individual mandate penalty if they fail to accept coverage from their employer that meets the minimum value requirement and costs 8 percent or less of household income.

It had never been intended that the exchanges would rely on employer and insurer reporting to determine the existence and scope of an applicant's employer coverage. Employer and insurer reports are not filed until the next reporting year. Indeed, the premium tax credit eligibility provisions of the ACA itself require that applicants, not employers, provide information on employer coverage.[19] Under the final rule on premium tax credit eligibility verification, released on Friday, July 5, an applicant for premium tax credits will be required to attest as to whether or not he or she has employer coverage, its cost, and extent.[20] The application form includes an appendix for this information.[21] The applicant can, but is not required to, ask the employer to provide information to fill out this form. The employer is not required to help, but it is hoped that employers will help their employees fill out these forms and make pre-populated forms available to employees.

Once the exchange receives this information, it will check available databases to verify the information, including Office of Personnel Management data for federal employees and the state's SHOP exchange data.[22] If the exchange finds information incompatible with the applicant's attestation, it will ask the applicant to provide evidence to resolve the inconsistency. In most instances, however, there will be no electronic data available to confirm the attestation. In these cases, the exchange will select a statistically significant random sample of cases in which it only has the attestation and, after notice to the applicant, contact the employer to verify the information. If the employer provides information incompatible with the applicant's claims, the exchange will ask for further proof. In cases where the employer does not respond, however, or cases that are not a part of the random sample, the exchange will rely on the applicant's attestation. HHS will offer to perform this verification procedure for the states when requested, but will not be able technically to take this task on until 2015. Because some states were relying on HHS being able to do this for them, the states are excused from conducting the sampling procedure until 2015 as well although the federally facilitated exchanges will do it for their own enrollees. The exchanges will rely on the same procedures for verifying lack of employer coverage for exemption from the individual responsibility provision.

Some commentators have claimed disparagingly that this approach effectively creates an honor system for applicants. In many respects, however, our income tax system relies on

the honor system. Like others on this podium today, I receive from time to time payment for speaking engagements or articles I publish. Unlike the other speakers, the amounts are often small enough that I do not receive a 1099. I am on my honor to report this income to the IRS when I file my taxes, and I do. While some of the income reported to the IRS each year is backed up by reporting from third parties, much is not.

For example, another provision of the ACA that would have required businesses to file 1099s reporting purchases of goods in excess of $600, was repealed in 2011.[23] It was expected by the CBO to produce $22 billion in revenue over 10 years because otherwise unreported income would be uncovered. Apparently, however, Congress believed businesses could be trusted to self-report their income. Does anyone here believe that low-income Americans are categorically less trustworthy than businesses? If so, where is your evidence?

There are, moreover, serious consequences for applicants who misrepresent their employer-sponsored coverage. The exchange must still notify employers every time one of their employees receives premium tax credits.[24] Applicants who receive tax credits for which they are ineligible will have to pay them back when they file their taxes, and the exchange will inform applicants of this fact if it provides the applicant with tax credits pending verification of information provided by the applicant. Negligent misrepresentation of eligibility information can result in a $25,000 fine, while knowing and willful violations are punishable by a $250,000 penalty.[25]

A third question is whether the delay is justifiable from a policy perspective. It is ironic that many of those most critical of the delay are also those who have been complaining most loudly about the employer responsibility provision, or about the ACA in general. The reason that the Administration gave for the delay makes some sense. The approach that Treasury had contemplated for implementing the employer reporting requirements was quite complex and if taking a little more time could result in simplification, that should relieve a burden on American businesses. The announcement was greeted favorably by a wide range of business and insurance interests, including the National Association of Health Underwriters, America's Health Insurance Plans, the American Benefit Counsel, the National Business Group on Health, and the ERISA Industry Council.[26]

The moratorium should allow employers and insurers to adjust their IT systems to make reporting possible for 2015. In the meantime, employers will know how many of their employees, if any, are getting premium tax credits and will have time to adjust their coverage offerings to make sure they are in compliance by 2015.

As I said earlier, there is little evidence that employers will rush to exit employee coverage in the meantime. Employers have, of course, been dropping employee health coverage for some time, and this is likely to continue. But a recent survey by the International Foundation of Employee Benefit Plans found that the vast majority of employers intended to continue to offer health insurance once the ACA was implemented.[27] Less than 1 percent of large employers stated that they were very likely

to or would definitely drop coverage in the next year. Most importantly, 70 percent of employers said they offered health insurance to retain current employees and 65 percent to attract future talent. This will not change, regardless of when enforcement of the mandate begins. Further, if the mandate influences employer choice at all, an employer would be silly to drop coverage for 2014 realizing that enforcement will begin a year later.

Finally, there is the question of what the delay says about timely implementation of the rest of the ACA. Critics of the ACA have been proclaiming for some time that implementation is shaping up to be a disaster. A GAO report last month raised reason for concern that some regulatory deadlines that the administration had set earlier had been missed, although it concluded that timely implementation was still feasible.[28]

It was never going to be easy to restructure our private health care financing system in less than four years to make it work for all Americans. But the premise of the Act was to build on current coverage, rather than starting from scratch.

In addition, Congress, which in this case is to say the Senate, made the task infinitely harder by asking the states to take on much of the responsibility for implementation. This body had the good sense to leave more of the task to the federal government. Asking the states to help was done in good faith—it was an effort to maintain state sovereignty over insurance markets and ensure flexibility for the states. But even before the ACA was adopted, the law had become intensely political, and with a dramatic shift in control over state governments in 2010, most states opted out of taking responsibility for implementation.

That left the Administration with a massive task—setting up exchanges for two-thirds of the states and enforcing all of the insurance market reforms in over one-fifth of them. The federal government must run the reinsurance and risk adjustment premium stabilization programs in virtually all of the states. It will also have to enforce the individual responsibility requirement and issue premium tax credits and cost-sharing assistance to millions of Americans.

The Administration continues to assert that the central ACA reforms will be implemented on time. It will have the Federally-facilitate exchange up and running by October 1, 2013 and start issuing premium tax credits by January 1, 2014. I expect that there will be disruptions and glitches, like there were in implementing the Part D prescription drug program in 2006, the CHIP program before that, and countless other policy changes.[29] But I continue to expect that my friend from church will be able to get covered on January 1, 2014, and hope that coverage will come in time for her.

If further delays become necessary, however, the blame lies entirely with those in Congress who refuse to accept the law of the land and provide adequate resources for its implementation. It is simply not possible for a program of this magnitude to be implemented without substantial resources. The ACA appropriated $1 billion for initial implementation efforts, but I do not believe that it was the expectation of Congress that

this would be enough to get us to 2014. The amount is certainly inadequate to implement the law given the unexpected increase in federal responsibilities, especially in light of the Supreme Court's decision and the political intransigence of a number of states. Of course, sequestration has only made a bad situation worse.

If you actually care about implementation of the ACA—if you actually care about my son and my friend from church—take action immediately to appropriate the money needed to get the job done. If you are not willing to help with ACA implementation, you have no standing to complain about any delay on the Administration's part.

References

[1] See Affordable Care Act (ACA) § 1401.
[2] ACA, § 2001.
[3] http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/
[4] ACA §§ 2700, 2701, 2705.
[5] ACA § 1501.
[6] ACA §1513.
[7] De-Navas Walt, et al., Income, Poverty, and Health Insurance Coverage in the United States, 2011 (Census Bureau, 2012), at 23.
[8] Claxton, et al., Employer Health Benefits Annual Survey, 2012 (Kaiser Family Foundation, Health Research and Educational Trust, 2012), at 34.
[9] ACA § 1513, adding IRC § 4980H(a).
[10] ACA § 1513, adding IRC § 4989H(b).
[11] http://www.treasury.gov/connect/blog/Pages/Continuing-to-Implement-the-ACA-in-a-Careful-Thoughtful-Manner-.aspx.
[12] ACA § 1513(d)
[13] ACA §§ 1502(e), 1514(d).
[14] ACA § 1513(d).
[15] 5 U.S. 137 (1803).
[16] See, Deacon, Deregulation Through Nonenforcement, 85 N .Y.U.L. Rev. 2795 (2010).
[17] See, e.g., Belleview Hospital Center v. Leavitt, 443 F.3d 163 (2nd Cir. 2006).
[18] 470 U.S. 821, 831 (1985).
[19] ACA § 1411(b)(4).
[20] ACA § 155.320(d).
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[22] ACA § 155.320(d).
[23] ACA § 9006(b)
[24] 45 CFR § 155.310(h).
[25] ACA § 1411(h)(1).
[26] http://www.lifehealthpro.com/2013/07/03/5-industry-reactions-to-the-ppaca-delay-that-might
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[29] http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/06/launching-the-medicare-part-d-program--lessons-for-the-new-healt.html