Small Business and PPACA

Testimony before the United States House of Representatives
Committee on Small Business
Subcommittee on Healthcare and Technology

Douglas Holtz-Eakin
President, American Action Forum*

July 28, 2011

*The views expressed herein are my own and do not represent the position of the American Action Forum.

Chairwoman Ellmers, Ranking Member Richmond, and Members of the committee, thank you for the privilege of appearing today. In this written statement, I hope to make the following points:

1. The Patient Protection and Affordable Care Act (PPACA) raises the overall cost of operating a small business and undermines job growth in the United States;

2. The PPACA's new taxes will dramatically increase the cost of insurance premiums and force small insurers out of business; removing insurance options for small business owners and hastening the decline in employer sponsored insurance;

3. The small business tax credits and the grandfathering health insurance provisions included in the PPACA provide offer false promises to small business owners and create disincentives for future job growth; and

4. Ultimately, the PPACA will lead to a dramatic decline in employer sponsored insurance; meaning as many as 35 million Americans will not be able to keep their insurance if they like it and the federal government will need to substantially increase spending projections for the state exchange subsidies.

Let me discuss each in turn.

1. The Patient Protection and Affordable Care Act (PPACA) raises the overall cost of operating a small business and undermines job growth in the United States.

The PPACA is a threat to the health of small businesses. Its heavy dosage of mandates and penalties will be a financial burden, and the law is riddled with hidden barriers to stronger job growth.

The small business implications of the legislation are important because data from the ADP National Employment Report shows that since January 2001 companies with one to 49 employees were responsible for 36 percent of job growth, while those with 50 to 499 workers accounted for 44 percent of new jobs.

Small business vitality is crucial to the economic fortunes of U.S. workers, and substantial new costs that curtail their hiring should be of concern to companies, workers and policymakers alike.

Sadly, the new health-care law is an assault on small business, beginning with the 3.8 percent Medicare tax on net investment income – a direct tax on many business owners. Of even greater concern is the law's most celebrated feature – the mandate to cover full-time employees with health insurance. For businesses with more than 50 workers, this means paying a penalty if any full-time workers receive subsidized coverage.

The mandate creates a tremendous impediment to expansion. Suppose for example that a firm does not provide health benefits. Hiring one more worker to raise employment t o 51 will trigger a penalty of $2,000 per worker multiplied by the entire workforce, after subtracting the first 30 workers. In this case the fine would be $42,000 to hire an additional worker. How many firms will chose not to expand?

The authors of the health-care law reflect liberal indifference to the climate for business, perhaps believing that businesses have a hidden well of resources or an infinite ability to evade the burdens placed on them. Businesses will try to shift costs. But their ability to push the burden on customers with higher prices is quite circumscribed.

Instead, we would expect that the effective burden will be borne by workers in the form of lower wage growth, fewer hours and reduced job growth. The only other avenue is for business owners to pay the costs out of scarce capital, raising the prospect of increased failure rates.

2. *The PPACA's new taxes and onerous regulations will dramatically increase the cost of insurance premiums and force small insurers out of business; removing insurance options for small business owners and hastening the decline in employer-sponsored insurance*

As businesses juggle new direct operating costs, they will face higher insurance premiums. The law levies roughly $500 billion in new taxes that will enter the supply chain for medical services, revealing themselves as higher medical costs.

Specific to health insurers, the PPACA imposes a fee that amounts to a *de facto* "health insurance premium tax" that will raise the cost of health insurance by an additional 3 percent for American families and small employers. Under the law, an annual fee will apply to any U.S. health insurance provider, with the intent of raising nearly $90 billion over the budget window. As shown in Table 1, the aggregate annual fee for all U.S. health insurance providers begins at $8 billion in 2014 and rises thereafter.

Table 1: Aggregate Insurance Fees[1]

Year	Fee
2014	$ 8 billion
2015	$11.3 billion
2016	$11.3 billion
2017	$13.9 billion
2018 & Beyond [2]	$14.3 billion
Total through 2020	$87.4 billion

To see the implications for insurance costs, one must examine how it affects individual insurers. Each firm will be liable for a share of the aggregate fee that is calculated in two steps. First, each company will compute the total premiums affected by the law using the formula outlined in Table 2. For example, an insurer with net premium revenues of $10 million is unaffected. In contrast, an insurer with net premiums of $100 million will have $62.5 million ($12.5 million from the 50 percent component between $25 million and $50 million, and $50 million from the remainder).[3] The aggregate fee is apportioned among the insurers based on their shares of the affected premiums. Importantly, the fees are not deductible for income tax purposes.

Table 2: Fraction of Premiums Counted

Annual Net Premiums	Fraction
Less than $25 million	0 percent
$25 million to $50 million	50 percent
$50 million or more	100 percent

Taken at face value, insurers have to pay this new "health insurance premium tax." Unfortunately, this ignores the influence of market forces. For any company, as it sells more insurance policies it will incur a greater market share, and thus a greater share of the $87 billion. That is, with each policy sold, the firm's total tax liability rises; precisely the structure of an excise tax. And as with any excise tax, firms don't really pay taxes; they are shifted to suppliers, workers, or customers. Thus, it is important to distinguish between the *statutory incidence* of the premium tax – the legal responsibility to remit the tax to the Treasury – and the *economic incidence* – the loss in real income as a result of the tax.

Insurance companies will have to send the premium tax payments to the Treasury, so the statutory incidence is obvious. However, a basic lesson of tax policy is that people pay taxes; firms do not. Accordingly, the economic burden of the $87 billion in premium taxes must be borne by individuals. Which individuals will bear the economic cost?

The imposition of the premium tax will upset the cost structure of insurance companies, raising costs per policy and reducing net income (or exacerbating losses). Some might argue that the firms will simply "eat the tax" – that is simply accept the reduction in net income. For a short time, this may well be the case. Unfortunately, to make no changes whatsoever will directly impact companies' abilities to make investments in health IT programs, wellness initiatives and disease management tools. Ultimately, this hurts individuals and small employers who won't have access to the types of tools and programs that can improve the quality of care and lower costs. Trying to retain the *status quo* also hurts the return on equity invested in the firm. Because insurance companies compete for investor dollars in competitive, global capital markets, they will be unable to both offer a permanently lower return and raise the equity capital necessary to service their policyholders.

Importantly, these impacts will be felt equally by the not-for-profit insurers. Non-profits have comparable resource needs for disease management, wellness efforts, or IT equipment. They also have equity capital demands, as they rely on retained earnings as reserves to augment their capital base. Bearing the burden of the tax means lower access to these reserves and diminished capital, harming their ability to continue to serve policyholders effectively.

In short, all insurers – for profit and non-profit alike – will seek to restructure in an attempt to restore profitability, with the main opportunity lying in the area of labor compensation costs. To the extent possible, firms will either reduce compensation growth, squeeze labor expansion plans (or even lay off workers), or both. However, there are sharp limits on the ability of companies to shift the effective burden of excise taxes on to either shareholders (capital) or employees (labor). Moreover, their ability to do so diminishes over time as capital and labor seek out better market opportunities.

The only other place to shift the tax cost is onto customers – i.e., families and small businesses. This economic reality is reflected in the Congressional Budget Office and Joint Committee on Taxation revenue estimating procedures. Specifically, they apply a 25 percent "offset" to the estimated gross receipts of any excise tax. In terms of the premium tax, this convention has two important implications. First, if the aggregate fee were recognized as a premium excise tax that carried incentives to shift some of the burden via lower dividends, capital gains, and wages, then the aggregate fee will overstate the net budget receipts. To the extent this happens, receipts of income-based taxes will fall; hence the need for an offset to the gross receipts of the excise tax.

The second implication is that the remainder of the tax is passed on to consumers. That is, the offset is not 100 percent meaning that the non-partisan consensus-based revenue estimators have concluded that the vast majority of the burden of excise taxes will *not* be borne by shareholders or workers.

If market conditions make it impossible for insurers to absorb the economic burden of the premium tax, they will have no choice but to build the new, higher costs into the pricing structure of policies. In this way, the economic burden of the tax is shifted to the purchasers of health insurance. In particular, the more competitive are markets for equity capital and hired labor, the greater the fraction of the burden that will be borne by consumers.

The implications for purchasers of health insurance are obvious and unambiguously negative. In addition, as employers pay more for health insurance, they will have to shave back on cash wage increases, and thus taxable compensation. Thus the health insurance premium tax will have the perverse effect of lowering personal income and payroll taxes.

To top things off, the PPACA has an especially unpleasant feature for those facing higher premiums: the fees are not tax-deductible but higher premiums will be taxable.

This non-standard tax treatment matters a lot. If an insurance company passes along $1 of premium taxes in higher premiums and cannot deduct the cost (fee), it will pay another $0.35 in taxes. Accordingly the impact on the insurer is $0.65 in net revenue *minus* the $1 fee. Bottom line: a loss of $0.35. (The problem gets worse when you consider that the $1 of additional premium is also subject to other state-level premium taxes and in some cases a state income tax.)

To break even, each insurer will have to raise prices by $1/(1-0.35) or $1.54. If it does this, the after-tax revenue is the full $1 needed to offset the fee. This has dramatic implications for the overall impact of the premium taxes. Instead of an upward pressure on premiums of $87.4 billion in fees over the budget window, the upward pressure will be $134.6 billion.

The line of reasoning outlined above is sometimes met with skepticism, and countered with the notion that consumers will simply be unwilling to accept a higher price. Evidence suggests that this is not true, but suppose the counter-argument is taken at face value. To the extent that firms accept a lower rate of return, they will be unable to attract capital. Similarly, to the extent they reduce employment in response to the tax (or cut wages and lose skilled employees to better opportunities), they will again suffer in their ability raise their scale of operations. In short, for insurers that attempt to adjust entirely on the cost side will be unable to maintain their operations at a competitive level, and will lose market share or even depart the industry entirely. For health insurance markets as a whole, this reduces competition. The bottom line for consumers is the same: higher prices.

To gain a rough empirical feel of an average $87 billion health insurance premium tax, I employ publicly-available data on Yahoo! Finance.[4] Those data indicate that the earnings for the industry called "Health Care Plans" were roughly $16 billion. The average annual aggregate fee of $8.7 billion is a substantial impact on the cost structure and profitability of the companies; roughly one-half of the net earnings.

Could insurers absorb the fee and remain competitive in the market for equity capital? As a whole, the overall profit margin is shown as 4.2 percent.[5] Assuming no change in behavior, a 50 percent decline on a sustained basis would make it impossible to obtain the financing needed to compete. Accordingly, it will be a matter of competitive reality for the insurers to pass the fee to consumers in the form of higher health insurance premiums.

In short, the health insurance fee will likely quickly and nearly completely be incorporated into higher insurance premiums. To get a feel for the implications, I adopt the projected changes in insurance coverage by Medicaid and SCHIP; employers, and non-group and others contained in the Congressional Budget Office

letter to Nancy Pelosi on March 20 2010.[6] Using the rough assumptions that 55 percent of employer coverage is self-funded and that 66 percent of Medicaid and SCHIP is private coverage yields an estimate of the insured coverage in each year.

To compute the baseline premium income, I assume that premiums per person will grow at an average rate of 3 percent. When combined with the coverage growth implicit in the CBO projections, the result is projected growth in overall premium income. In 2009, overall premium income was $1.005 trillion, providing a starting point for a projection of premium income in each year.[7]

Table 3 shows the impact of the ACA on premiums. As shown at the bottom of the table, the premium tax in isolation will raise premiums from between 2.4 percent (in 2014) to over 3 percent (in 2015). If one factors in a second assessment on insurers that covers the transitional reinsurance program, the effect will be as large as 3.5 percent.

Table 3: Impact of PPACA on Insurance Premiums

Year	2014	2015	2016	2017	2018	2019
Fees: Fully Insured Plans Only ($B)						
Premium Tax (PPACA Section 9010)	$8.0	$11.3	$11.3	$13.9	$14.3	$14.3
Reinsurance (PPACA Section 1341)	$2.0	$2.0	$1.0			
Fees: Fully Insured & Self-Funded ($B)						
Reinsurance Transition (Section 1341)	$10.0	$6.0	$4.0			
Total Fees and Assessments ($B)	$20.0	$19.3	$16.3	$13.9	$14.3	$14.3
Impact: Fully Insured Premiums (pct.)						
Premium Tax	2.40%	3.03%	2.69%	3.02%	2.98%	2.89%
Premium Tax and Reinsurance	3.16%	3.45%	2.96%	3.02%	2.98%	2.89%

Data from the Kaiser Family Foundation show that the average overall family premium in 2010 is $13,770.[8] Using this as a rough guide, the ACA premium tax will add as much as $475 to the costs, or nearly $5,000 per family over a decade.

The ACA contains insurance reforms, medical device taxes, pharmaceutical fees, and insurance company fees that will raise the cost of insurance for millions of individuals, small businesses and households. This analysis suggests that the insurance tax in isolation will raise premiums by roughly 3 percent. An important topic for future research is to perform similar analyses for the other cost-raising aspects of the ACA in order to assess the overall pressure on premiums.

3. *The small business tax credits and the grandfathering health insurance provisions included in the PPACA provide offer false promises to small business owners and create disincentives for future job growth.*

Proponents of the PPACA point toward the fact that small businesses will receive aid in the form of a small business tax credit, ostensibly offsetting the burdens outlined above. Unfortunately, the credit is available only for employers with fewer than 25 workers and those in which average earnings are under $50,000. Thus the cost and growth impacts for those with 26 to 50 employees remains unchanged. Moreover, the credit is not a permanent part of the small business landscape. An employer may receive the credit only until 2013 and then for two consecutive tax years thereafter. Thus, the credit is available for a maximum of six years.

Turning to the credit itself, to be eligible the employer must pay at least 50 percent of the premium. The credit is equal to 35 percent of employer contributions for qualified coverage beginning in 2010, increasing to 50 percent of the premium in 2014 and thereafter. The amount of the credit is phased-out for firms with average annual earnings per worker between $25,000 and $50,000. The amount of the credit is also phased-out for employers with between 10 and 25 employees.

The combination of requirements for premium contributions, limitation on employees, limitations on earnings, and phase-outs has surprised the small business community. IN particular, the reform's strict definition that a firm is only a small business if it has 25 or fewer employees proved convenient to the legislators who crafted the bill. This narrow definition has led to a number of studies that assert that more than 80 percent of small businesses will be eligible for the tax credit.

Even those studies that recognize the limitation imposed by the 25-employee limit tend to overstate the likely penetration of the tax credit. For example, the Small Business Majority and Families USA recently estimated that 84 percent of the nation's 4.8 million businesses that employ 25 or fewer employees will be eligible for the tax credit. Unfortunately, the net impact of the credit in offsetting the cost of the PPACA will depend not upon eligibility but rather on receipt of the tax credit. This distinction was noted early in the debate by the Congressional Budget Office (CBO). In November 2009 when the law was being considered before Congress, CBO found that, "A relatively small share (about 12 percent) of people with coverage in the small group market would benefit from the credit in 2016."

A more useful study focuses on the estimated number of small firms who would qualify for the small business health insurance tax credit. An analysis conducted by the National Federation of Independent Business (NFIB) found that the total number of firms that offer health insurance and pay more than half of their employees' premium costs, as mandated under PPACA, is more likely near 35 percent of all firms with less than 25 employees.

In the same way that the individual mandate provides an implicit tax on growth, the structure of the small business tax credit will raise the effective marginal tax rate on small business expansion. For this reason, the credit may discourage firms from hiring more workers or higher-paid workers. Consider two examples.

In the first, employers will have an incentive to avoid increases in the average rate of pay in their firm. Suppose that the average wage in a small (3 worker) firm is $25,000 and the owner decides to add a more highly paid supervisor being paid $50,000. This will raise the average wages in the firm to $31,250 thereby reducing the tax credit per worker from $2,100 to $1,596. In effect, the structure of the credit raises the effective cost of adding valuable supervisory capacity.

In this example, total credits to the firm are essentially unchanged ($6,300 to $6,384) by raising the average wage. If the new supervisor were paid $75,000 however, total credit payments would fall from $6,300 to $4,368. The lesion is clear in that the structure of the tax credit can impose large effective tax rates on raising the quality of the labor force for those receiving the small business credit.

Similar incentives affect the decision to hire additional workers because the overall tax credit falls by 6.7 percent for each additional employee beyond 10 workers. This is a very strong disincentive to expanding the size of the firm. Using the example above, suppose that the firm has 10 employees and total credits received were $21,000. The firm's total subsidy will peak at $21,840 with the hiring of the 13th worker. Thus, a firm employing 13 workers would get a total tax credit of $21,840 while a firm employing 24 workers would receive a total credit of only $3,360.

Ultimately, the small business tax credits will prove to be little more than a talking point for PPACA advocates. Relatively few small businesses will qualify for the credit and even fewer will be able to offset the cost of PPACA on small business health insurance premiums. For those that do qualify, receiving the tax credits will impose a new regime of hidden effective marginal tax increases on a small business owner's ability to increase employment and hire more qualified employees.

Whether they qualify for the tax credit or not, small business owners can expect to be re-working their benefits packages. Even though President Obama promised that, "If you like what you have you can keep it," most small business owners will need to find new health insurance plans to for their employees.

In June 2010, the Administration released interim final regulations defining grandfathered status for health insurance plans (75 Fed. Reg. 24538). To be eligible for grandfathered status, employers cannot raise deductibles or out-of-pocket limits by more than 15 percentage points beyond the increase in the medical inflation, nor can they raise co-pays by more than that amount, or $5 if that is more. They also cannot increase employee coinsurance percentages at all. In addition, a health plan or benefit package will lose grandfathered status if the sponsor cuts their contribution rate toward total coverage costs by more than 5 percentage points.

These regulations essentially undercut the stated intent of the law (Sec. 1251) that "nothing in this Act requires an individual to terminate coverage under a group health plan or health insurance coverage in which they were enrolled on the date of the healthcare reform law's enactment."

The Obama Administration's interim regulations for grandfathered plans estimate that 18 percent of large employer plans and 30 percent of small employers plans would lose grandfather status in 2011, increasing over time to 45 percent and 66 percent respectively by 2013. This is at best an overly optimistic estimate, especially in light of recent employer surveys that indicate between 63 percent and 88 percent of employers anticipate losing grandfathered status by 2013.

Hewitt Associates, a leading global health benefits consulting, conducted a survey of 450 employers representing 6.9 million employees that specifically focused on the grandfathered health plan rules. The survey found that 88 percent of self-insured medical plans and 81 percent of fully-insured medical plans expect to lose grandfathered status by 2014.

These results are corroborated by a similar study done by Mercer, another leading global health benefits consulting firm, 62 percent of small businesses have at least one red flag in their plan design that violates the new law's mandates, and 14 percent have two red flags.

Simply put the rules designed to determine grandfathered status undermine existing health insurance plans and contradict the stated intent of the bill as well as the promises made to the American people by President Obama. The grandfathered health plan rule erodes existing employer-based insurance plans, especially for small businesses.

4. *The PPACA will lead to a dramatic decline in employer sponsored insurance; meaning as many as 35 million Americans will not be able to keep their insurance if they like it and the federal government will need to increase spending projections for the federal government by $1.4 trillion.*

The PPACA will have profound implications for U.S. labor markets. Today about 163 million workers and their families receive health insurance coverage from their employers. While proponents of the PPACA insisted that a key tenet was to build on this system of employer-sponsored coverage, the healthcare law creates strong incentives for employers to drop employer-sponsored health insurance.

Roughly one-half of the $900 billion of spending in the PPACA is devoted to subsidies for individuals who do not receive health insurance from their employers. These subsidies are remarkably generous, even for those with relatively high incomes. For example a family earning about $59,000 a year in 2014 would receive a premium subsidy of about $7,200. A family making $71,000 would receive about $5,200; and even a family earning about $95,000 would receive a subsidy of almost $3,000.

By 2018, subsidy amounts and the income levels to qualify for those subsidies would grow substantially: a family earning about $64,000 would receive a subsidy of over $10,000, a family earning $77,000 would receive a subsidy of $7,800 and families earning $102,000 would receive a subsidy of almost $5,000.

An obvious question is how employers will react to the presence of an alternative - subsidized source of insurance for their workers - which can be accessed if they drop coverage for their employees. The most simple calculation focuses on the tradeoff between employer savings and the $2,000 penalty (per employee) imposed by the PPACA on employers whose employees move to subsidized exchange coverage. Consider a $12,000 policy in 2014, of which the employer would bear roughly three-quarters or $9,000. A simple comparison of $9,000 in savings versus a $2,000 penalty would seemingly suggest large-scale incentives to drop insurance.

Caterpillar for instance noted that it could save 70 percent on health care costs by dropping coverage and paying the penalties; AT&T's $2.4 billion cost of coverage would drop to just $600 million for the penalties. And the list could go on.

Unfortunately, the economics of the compensation decision are a bit more subtle than this simple calculation. Health insurance is only one portion of the overall compensation package employees receive as a result of competitive pressures. And the evidence suggests that if one portion of that package is reduced or eliminated – health insurance – another aspect – wages – will ultimately be increased as a competitive necessity to retain and attract valuable labor. Thus, the key question is whether the employer can keep the employee "happy" – appropriately compensated and insured – and save money.

Table 4: Health Care Reform and Employer-Sponsored Insurance in 2014
(Employer Health Plan =$11,941)

Percent of Federal Poverty Level	Income[1]	Tax Bracket[2]	Wage Equivalent of Employer Health Plan[3]	Federal Subsidies[4]	Required Pay Raise[5]	Employer Free Cash Flow[6]	Employer Drop Decision[7]
133%	$31,521	15%	$14,048	$14,176	-$128	$9,941	Drop
150%	$35,550	15%	$14,048	$13,385	$663	$9,941	Drop
200%	$47,400	25%	$15,921	$10,985	$4,936	$9,941	Drop
250%	$59,250	25%	$15,921	$7,530	$8,391	$9,941	Drop
300%	$71,100	25%	$15,921	$5,187	$10,734	$9,941	Keep
400%	$94,800	28%	$16,585	$2,935	$13,650	$9,941	Keep

Notes:
1. Income calculated based on 2009 FPL for a family of four of $22,050 (HHS), indexed to CPI projections (CBO)
2. Tax bracket calculated based on 2010 tax brackets, indexed to CPI projections (CBO)
3. Computed as CBO estimate of Silver Plan in 2016, indexed to 2014 ($11,941), and divided by (1-Tax Rate)
4. Estimated federal insurance subsidy
5. Wage equivalent minus subsidies
6. Value of insurance plan minus $2,000 penalty
7. Drop if required pay raise is greater than free cash flow

As Table 4 outlines, the answer is frequently "yes" – thanks to the generosity of federal subsidies. To see the logic, consider the first row of the table, which shows the implications for a worker at 133 percent of the Federal Poverty Level (FPL) or $31,521 in 2014. We project that this worker will be in the 15 percent federal tax bracket, which means that $100 of wages (which yields $85) is needed to offset the loss of $85 dollars of untaxed employer-provided health insurance. Consider now a health insurance policy worth $15,921, of which the employer picks up 75 percent of the cost. The employer's contribution to health insurance of $11,941 is the equivalent of a wage increase of $14,048 to the worker.

Do the economics of PPACA ever suggest that employer's could drop? Yes. The employee would receive $14,176 in federal subsidies – more than the value of the lost health insurance. On paper, they could take a pay cut and be better off. Clearly, the employer comes out way ahead – $11,941 less the penalty. Obviously, there is

room for the employer to actually improve the worker's life by having a small pay raise and the same insurance and still save money. This is a powerful, mutual incentive to eliminate employer-sponsored insurance.

The remaining rows of Table 4 repeat this calculation for workers at ascending levels of affluence. For example, at 200 percent of the FPL, the "surplus" between the pay raise required to hold a worker harmless ($4,936) and the firm's cash-flow benefit from dropping coverage ($9,941) has narrowed, but the bottom line decision in the final column is the same. Indeed, the incentives are quite powerful up to 250 percent of FPL, or $59,250. Only for higher-income workers do the advantages of untaxed health insurance make it infeasible to drop insurance and re-work the compensation package. Appendix Table 1 repeats this analysis and checks the robustness of this conclusion if one assumes that health care costs are significantly higher and the employer's contribution to the insurance plan rises to $15,000. In this instance the decision holds for up to 200 percent of FPL.

How big could this impact be? In round numbers, at present there are 123 million Americans under 250 percent of the FPL. Roughly 60 percent of Americans work (the employment-population ratio is 58.8 percent) and about 60 percent of those receive employer- sponsored insurance. This suggests that there are about 43 million workers for whom it makes sense to drop insurance if the health plan costs the employer $11,941.

CBO estimated that only 19 million residents would receive subsidies, at a cost of about $450 billion over the first 10 years. This analysis suggests that the number could easily be triple that (19 million plus an additional 38 million in 2014) – the gross price tag would be roughly $1.4 trillion[3].

In contrast, the CBO predicted that only 3 million individuals who previously received coverage through their employers will get subsidized coverage through the new exchanges. One mechanism that would reduce employer drop is if high-wage workers continue to receive insurance and non-discrimination rules force employers to offer insurance to all workers – even those for whom it makes sense to drop coverage. For those firms dominated by lower-wage workers this is unlikely to succeed as it will be possible to use the accumulated savings to retain the few high-wage workers. Or, there may be incentives for firms to "out-source" their low-wage workers to specialist firms (that do not offer coverage) and contract for their skills. In any event, the massive federal subsidies are money on the table inviting a vast reworking of compensation packages, insurance coverage, and labor market relations.

This analysis has been recently corroborated by employer surveys conducted by McKinsey & Company and PricewaterhouseCoopers (PwC). The McKinsey survey of more than 1,300 employers across industries, geographies, and employer sizes found:

- Overall , 30 percent of employers will definitely or probably stop offering employer-sponsored insurance in the years after 2014

- Among employers with a higher awareness of reform, this proposition increases to more than 50 percent, and upward of 60 percent will pursue some alternative to traditional employer-sponsored insurance

As part of its annual report, PwC surveyed employers about changes they are making in their benefits plans. The survey found:

- Overall, 86 percent of employers are likely to re-evaluate their overall benefits strategy

- One-half (50percent) of employers are considering significantly changing or eliminating company subsidies for dependent medical coverage.

With each passing day the impact of the PPACA grows clearer. The healthcare law harms small businesses and will have profound implications for U.S. labor markets. It must be repealed and replaced with real healthcare reforms that encourage providers to offer higher-quality care at lower costs; reduce the cost pressures that underlie the bankrupt Medicare and Medicaid entitlements; and give every American access to more options for quality insurance.

Thank you and I look forward to answering your questions.

---

[1] The non-deductibility of the Insurance fees raises their economic impact. See text for discussion.

[2] The statute provides that after 2018 the insurance fee is equal to the amount of the fee in the preceding year increased by the rate of premium growth for the preceding calendar year.

[3] There is some ambiguity as to whether the reduced percentages to the first $50 million apply to all firms. If it applies only to those with revenue below the threshold, the overall analysis is little changed, but the premium pressures will differ across market segments and products.

[4] See http://biz.yahoo.com/p/522qpmd.html.

[5] See also, "Health Care-Managed Care," Barclays Capital, November 19, 2009 which indicates an overall profit margin of 4.42 percent.

[6] See http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.

[7] See also, "Health Care-Managed Care," Barclays Capital, November 19, 2009 which indicates an overall profit margin of 4.42 percent.

[8] http://ehbs.kff.org/pdf/2010/8085.pdf .