# Aggregation Aggravation

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Obamacare has a provision that will hand an untold number of businesses a deeply unpleasant surprise between now and Tax Day, 2015.

Very likely, most business owners understand that the health care law contains an employer mandate. Businesses with 50 or more full-time employees (FTs) or full-time-equivalent part-timers (FTEs) must either purchase health insurance for their FTs or pay a large fine for failing to do so. No surprise there.

Some business owners, however, are just realizing (or haven't realized yet) that the employer mandate net also scoops up quite a few businesses with *fewer* than 50 FTs or FTEs. This happens when the smaller businesses are deemed part of a "controlled group" or part of an "affiliated service group," due to common ownership interests. In such a case, the employees of the separate businesses will be aggregated into a larger employee count, with the mandate and penalties applying to all.

The easiest case to understand would be one where one household owns 100% of multiple businesses.

> Suppose a husband's auto repair shop has 20 FTs; his wife's greenhouse has 15 FTs; and they own a fast-food franchise with 20 FTs. Even if the three businesses are separate corporations, with no connections other than ownership, the IRS would almost certainly treat them as a single entity with 55 FTs (for purposes of the employer mandate). If so, the owners would have to offer insurance coverage to all 55 FTs or else face an employer mandate penalty of $50,000 per year ($2,000 for every FT, excluding the first 30).

For some, these penalties can decimate or even totally wipe out their profits.

The story gets even more complicated when the households have partial interests in multiple businesses. Involvement in multiple businesses is extremely common among entrepreneurs. This situation doesn't mean they're rich or high-income. In fact, quite often, owners invest in multiple businesses and live Spartan lifestyles while hoping that just one of their businesses will prove successful. According to an NFIB survey, around one-in-four small-business owners also own at least a 10% interest in one or more other businesses. Of those, 56% have interests in at least three businesses. Here's an example:

> Suppose there's a married couple, filing a joint tax return. Jim owns 90% of a dry cleaner with 17 full-time employees. (His cousin, who helped him start the business, owns the other 10%.) Jim also has an ice cream shop with 6 employees, each working half-time. Jim's wife Mary owns a landscaping business with 21 full-time employees and 12 part-timers working 20 hours a week. Jim and Mary together own 40% of their son's strawberry farm, which has 5 year-round full-time employees and, in the summer, employs 25 full-time seasonal employees. In addition, each of the three has a 15% interest in Mary's friend's delivery service, which has 6 full-time drivers. Will this family be subject to Obamacare's employer mandate?

With the patchwork of partial ownership, will John and Mary fall under the employer mandate? If so, that will mean obligations in the tens of thousands of dollars per year. If not, they owe nothing. And the

answer may well depend on the opinion of a paid expert and concurrence by the Internal Revenue Service or some other agency. Unfortunately, it would be difficult to write down a complete set of rules that yields a simple "yes" or "no" to whether or not one of these situations exists.

These multi-business definitions extend far beyond just family relationships. In a "parent-subsidiary" relationship, one business has total ownership, or at least 80% ownership, of other businesses (including subsidiaries of those other businesses). A "brother-sister" relationship is one where several businesses are owned by five or fewer common owners. An "affiliated service group" is one where the controlled-group relationships are absent, but where multiple companies in some sense act "as if" they were a controlled group.

The rules for these relationships come from the Employee Retirement Income Security Act of 1974 (ERISA). Determining whether any of these conditions exists can be mathematically and legally complex and requires a sophisticated understanding of the rules. Small businesses generally have no legal or human resources departments to work on such questions, so this means paying an expert for advice. In some cases, the complexities may require the business to seek an opinion from a public agency like the IRS.

For a business owner trying to plan for the next couple of years, it may be expensive and cumbersome to determine whether his multiple businesses will be rolled into a larger group for purposes of the mandate's employee count. Of course, any changes in ownership structure, a frequent occurrence with small businesses, complicate things still further.

For some businesses, this confusion, this uncertainty can mean the difference between growing and shrinking – or between remaining open and shutting their doors.

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# SHOP Chopped: Opt Dropped

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Three years into Obamacare, the federal government has quietly announced another major operational failure in its implementation. The SHOP exchanges will be barely functional through at least 2014. These were supposed to be bustling new shopping centers where small businesses and their employees could purchase health insurance loaded with options. Instead, SHOP exchanges in 2014 will be more like half-boarded-up strip malls.

The federal government's website describes SHOP as follows:

"Beginning in 2014, Exchanges will also operate a Small Business Health Options Program – or SHOP – that offers small businesses and their employees new choices. Through the SHOP, employers can offer employees a variety of Qualified Health Plans (QHPs), and their employees can choose the plans that fit their needs and their budget."

Virtually none of this will be true in 2014. SHOP was supposed to be a Travelocity-like website where a small business could effortlessly compare insurance policies, narrow down choices, choose several plans and allow each employee to pick the one best suited to his or her wishes. If the business had questions, a helpful exchange employee would be ready to answer. Once the business downloaded its payroll information into the system, the exchange would act as a virtual HR department – managing the flow of paperwork, prompting employees to send in their checks, handling employee claims, etc. The exchange would aggregate all the employees' premiums over all the different plans.

Now for the reality: Assuming the SHOP exchanges actually open in 2014, employers will not be able to choose multiple plans and offer employees a choice. It's one plan only – take it or leave it. No multiple plans. No premium aggregation. Furthermore, policies purchased in the exchange will carry a sizable surcharge and will impose high minimum participation rates.

Beginning in 2014, SHOP exchanges will be the only place that small businesses can claim the much-heralded, but low-performing small business health insurance tax credits. For the relatively small number of businesses claiming those credits, SHOP may still be the best option in 2014.

But it's now hard to imagine why any other small business would want to use SHOP in 2014. Brokers in the current health insurance market can already offer a higher level of service to small businesses than the SHOP exchanges will be able to offer in 2014. This is a failure of the highest order. It is being lamented by friends of Obamacare, as well as by foes.

Will the software and websites and data interfaces be up and running when enrollment time arrives this October 1 – less than six months from now? Will the exchanges have staff ready to answer the phone calls and chatlines? Ask the state and federal officials.

Will insurers bother to offer policies through the SHOP exchanges in 2014? To do so will require significant effort and costs for the insurers. Will they spend that treasure if they don't think anyone will use the SHOP exchanges? Will exchanges open with only one or two insurers offering plans? Ask the insurers.

Employers are likely to respond to all this in several ways. Some will simply stick with their existing brokers outside of the SHOP exchanges. Brokers, after all, can already do some of the things that SHOP will not offer in 2014. Other employers will throw in the towel and stop offering insurance coverage altogether. Employees, after all, are supposed to be able to go into the other new exchanges – the individual exchanges – where many should qualify for subsidies. Once employers drop coverage, will they resume it once the SHOPs are functional in 2015 or 2016 or whenever? Doubtful.

Does the failure of the SHOP exchanges bode ill for the individual exchanges, as well? SHOP exchanges were supposed to be an improved model of what brokers and private exchanges like esurance.com were already doing. SHOPs were not a massive departure from existing institutions. Still, with three years lead time and huge amounts of money spent, the federal government could not get the job done. [For an entertaining exercise, go on esurance.com to see how easily a small business can already get multiple quotes from an existing, private quasi-exchange.]

The individual exchanges are vastly more complex than SHOP exchanges and are unlike any institutions that have ever existed anywhere. They, too, are scheduled to open October 1, and in most cases, there is scant evidence that they are remotely near readiness. The failure of the SHOP exchanges is a disappointment. Failure of the individual exchanges would be a catastrophe. Simply put, if the individual exchanges are not fully functional, Obamacare cannot work.

Why? The central mechanism of the law is a three-legged stool. Almost all Americans must have health insurance or pay a tax for failure to do so. Those without "affordable" employer coverage can receive subsidies – sometimes in five figures per year. And "large" employers who have even a single subsidized employee must pay fines of thousands of dollars (or tens or hundreds of thousands) per year. Coordinating all these flows may constitute the single largest information technology project in computer history. And it all has to be fully tested and fully functional by October 1. Some are skeptical, and the warnings have been out there for years.

The much simpler SHOP exchanges have proven beyond the federal government's capacity. What if the individual exchanges fail similarly? Will the individual mandate still be in effect on January 1 – with no ability to offer subsidies? Will the employer mandate somehow live on, even without the subsidies? Individuals and businesses need answers now.

Sen. Jay Rockefeller, a strong supporter of Obamacare just said, Obamacare is "so complicated and if it isn't done right the first time, it will just simply get worse." Secretary of Health and Human Services Kathleen Sebelius admitted that many will see their insurance costs rise significantly. Small businesses and their employees have hundreds of questions about what Obamacare means to them in 2014 and thereafter, and there is no one they can call or write for answers. Meanwhile, all of this must come together in less than 180 days.

One final thought: In this instance, a significant benefit of Obamacare has been pushed down the road for at least a year, and this will not be the last such delay. And yet, there are no moves afoot to delay the crushing taxes that come from the law. Here's a suggestion: if you're going to delay the benefits that employers and employees were promised, then delay the costs that fall on them, as well.

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# End the Employer Mandate

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Obamacare's employer mandate must go. Now. Clean and neat. Straight repeal. Just do it.

If you're an Obamacare supporter, this is the biggest favor you can do for the health care law. If you're an Obamacare opponent, this is the biggest favor you can do for the country.

The American economy didn't grow slowly last quarter. It shrank. If that happens again this quarter, its official – we are back in recession, and the country's leadership can once again wear a scarlet "R" on their clothing. If so, the employer mandate may well be what earns Washington that shame.

Tellingly, the employer mandate warnings are coming from Obamacare friends and foes alike. With the U.S. economy one quarterly datum away from recession, employers are not seeking ways to maintain what they have, much less to innovate or expand or hire. Instead, we see frenzied efforts to restructure organizations in ways that make no sense whatsoever – other than to avoid the mandate. Employers exploring these options are small and large, for-profit and not-for-profit, private and public.

Just to recap, the mandate applies to employers with 50 or more full-time employees or full-time equivalents. It requires them to offer affordable coverage to substantially all full-time employees, with "affordable" determined by a complex formula. They must pay a large penalty if they fail the test with even a single full-timer. To avoid that possibility, they're exploring a number of possibilities:

**CUT SOME HOURS:** In a previous column, I mentioned that the Community College of Allegheny County (PA) slashed its adjunct professors' hours to avoid what would have been a budget-busting employer mandate penalty. In that story, an adjunct lamented that his pay was shrinking at the very moment he is being commanded by Obamacare to purchase expensive insurance. A number of restaurants had been considering the same move.

**CUT SOME MORE:** Now, Ohio's Stark State College has written its adjuncts: "in order to avoid penalties under the Affordable Care Act … employees with part-time or adjunct status will not be assigned more than an average of 29 hours per week." A hard-working, low-paid adjunct told the press, "In education, we're working for the public good, we are public employees at a public institution; we should be the first ones to uphold the law, to set the example." Unfortunately for this fellow, his college IS upholding the law – in this case, they're upholding the parts he doesn't like so much. The college is setting an example that will be replicated across the country. The employer mandate pits employer against employee. In this battle, the college won a Pyrrhic victory – no doubt in the name of the "public good" – and the adjunct and his family lost. In a larger sense, both lost, as did the students and the community and the country; all will pay a price. Following suit, the state of Virginia will now restrict over 37,000 state employees – those paid by the hour – to no more than 29 hours per week. For some Virginia adjunct professors, this could mean a one-third cut in pay.

**CUT DEPARTMENTS:** Entrepreneur Paul Christiansen suggests that businesses go "protean." The employer mandate only penalizes employers with 50 or more employees, so Christiansen suggests that businesses cut themselves up into tiny entities, each below the 50-employee threshold. Take your human resources department, spin it off, incorporate it, and deal with it as an independent vendor

rather than as a set of employees. Do the same with accounting, sales, whatever. Will this strategy pass legal muster? No doubt, an army of attorneys will work furiously to answer the question.

**TEMPS GALORE:** Then there's this strategy: lay off an employee, tell her to go to a temp agency, and then tell the temp agency, "I'd like her back, but as your employee, not mine." The IRS has warned employers not to try such strategies – that it will issue an "anti-abuse" regulation. The law says employers are only responsible for their own employees' health insurance, but the IRS comment suggests that they will simply declare non-employees to be employees. Time will tell whether an already over-stretched IRS can put muscle behind its order. No doubt, this will be a big job-creator for litigators.

**KICK YOUR WORKFORCE:** None of this should be a surprise. Economist Casey Mulligan wrote in his *New York Times* blog that when the government hands each employer its own personal fiscal cliff, the employer will go to extraordinary lengths to avoid that cliff. He shows, as does *Business Week*, that France has 2.4 times as many businesses with 49 employees as it has with 50 employees, thanks to mandate-like obligations that kick in at 50. You don't even have to leave the U.S. to witness this phenomenon. Hawai'i has had a health insurance employer mandate since 1974. For a given employee, that mandate kicks in at 20 hours, and in 2009, a Federal Reserve Bank of San Francisco study showed that the result is an unusually high number of employees working 19 or fewer hours per week. Businesses are already cutting employees or dropping expansion plans.

**KICK YOURSELF:** Labor unions were among the biggest backers of Obamacare, but now, some have realized that the employer mandate will bite them back. The *Wall Street Journal* reports that buyer's remorse is setting in. Obamacare will make union health insurance policies more expensive and will make it more difficult for union members to compete with employees working for businesses with fewer than 50 employees. The article reports that some unions are lobbying for subsidies to which they are not currently entitled.

**KICK THE CHILDREN:** One of the more surprising rules to emerge from the federal agencies may hang employees' families out to dry. The law says employers with 50 or more employees will pay penalties if: (1) they fail to offer health insurance to all full-time employees and their families and (2) the insurance is not "affordable" (according to calculations described here). A recent rule clarified, however, that while the employer must offer health insurance to employees' dependents, the affordability standard applies only to the *employee's* insurance – not to the *dependent* coverage. Thus, employers are now free to offer bargain-basement insurance to employees, but charge their families a king's ransom for their coverage. Just last month, a clarification of the clarification clarified that the families will be eligible for subsidies in the exchanges, but the clarification of the clarification makes it harder for the families to get those subsidies. Is that clear? Timothy Jost, a law professor and prominent Obamacare backer described the bottom line: "Employers can offer unaffordable family coverage and avoid a penalty. The federal government will pay less for premium tax credits as fewer people will be eligible. And hundreds of thousands, probably millions, of children (and spouses) will remain uninsured."

**BREAK THE SHELF:** The fastest-running assembly line in America these days is the one rolling out Obamacare regulations. Shelves are bowing under the weight of a 1,000-page law and over 10,000 pages of regulations. The employer mandate occupies 3½ pages or so of the law, and it has now been "clarified" by a 144-page proposed regulation, including 44 definitions – many of them unprecedented. The regulations make a distinction, for example, between a "seasonal worker" and a "seasonal employee." A seasonal worker and a seasonal employee will affect the employer mandate penalty in very different ways. The difference? A seasonal worker, you see, is one who works up to 120 days or

four months per year. A seasonal employee, on the other hand, is … well, they'll be getting back to us on that one.

**MANDATE CRASHING:** This might be an opportune moment to go back a few years and remember what economist Martin Feldstein wrote in the *Washington Post* in November 2009 – four months before the law passed: "Obamacare could have the unintended consequence of raising health insurance premiums and causing a decline in the number of people with insurance." The official forecast was that Obamacare would add 30,000,000 people to the health insurance rolls. It also forecast that 4,000,000 small businesses would get the health insurance tax credit (only 170,000 did); they forecast that 375,000 people with pre-existing conditions would get insurance through the new temporary high-risk pools (only 45,000 did). This month, the Congressional Budget Office (CBO) predicted that 7,000,000 people would lose their employer-sponsored coverage (up from 4,000,000 six months ago). CBO also predicted that individual subsidies will cost the federal government close to 30 percent more than they had previously forecast – in part because of employers dropping coverage.

**TIME FOR TRASHING:** Timing is everything. The employer mandate, individual mandate, and individual subsidies are all supposed to kick in at the same moment – January 1, 2014. These three mechanisms cannot function unless the health insurance exchanges are ready to go on October 1, 2013 and fully functioning by January 1, 2014. It grows clearer by the day that the exchanges will not be ready this year, so now is the perfect time to end the employer mandate. For an example of exchange-related doom-saying, economist John Goodman predicts that only three to five states will have functional exchanges by New Year's Day. Employers were supposed to explain to employees on March 1, 2013, how they could sign up with exchanges to purchase health insurance. Since no one yet has a clue how that is to happen, the Administration gently laid that deadline to rest, at least until late summer or early fall.

With the exchanges flailing and the employer mandate scaring the wits out of employers, this is a perfect moment for bipartisanship. The employer mandate serves the interests of no Americans and of neither party. This word is spreading on both sides of the aisle and across the country.

The message is clear: end the employer mandate today.

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# Will PPACA Self-Repeal

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The Patient Protection and Affordable Care Act (PPACA, or "Obamacare") survived two potentially mortal challenges in 2012. The Supreme Court upheld the law in *NFIB v Sebelius*. And the American electorate preserved the political status quo. Now, the law will face its third and biggest challenge – itself. Or more specifically, the perverse economic incentives imbedded throughout the law's 900-plus pages and tens of thousands of pages of associated regulations.

Many of the unintended consequences of the law have lain dormant until recently. Businesses and others withheld unpleasant actions in hopes that the Court or the election would sweep PPACA into the dustbin. That didn't happen, so now the revelations have begun.

Several restaurant groups are exploring strategies for coping with the potentially ruinous effects of PPACA on their businesses. One strategy is to cut full-time employees back to part-time hours in order to avoid the financial consequences of PPACA's employer mandate. Another is to raise prices, thus passing the costs along to customers. Thus, just as the Great Recession threatens a return performance, PPACA is cutting incomes and raising food prices. And now that the first movers have gone public, expect the possibility of a cascade of announcements.

The restaurant announcements were greeted by a torrent of Web-based accusations that the businesses were driven by profit-driven greed. It didn't take long, however, to see the hollowness of that argument. On November 19, the *Pittsburgh Post-Gazette* showed that publicly-owned and non-profit organizations are following the restaurants' lead ("Health-care law brings double dose of trouble for part-time CCAC profs"). The Community College of Allegheny County (Pennsylvania) announced that it would cut back the hours of 200 adjunct professors and 200 other employees, thus assuring that under PPACA's rules, they will be classified as part-time. Otherwise, PPACA would force the college to either provide the adjuncts with health insurance or to pay thousands of dollars a year in penalties for each of them.

Doing a quick calculation here, without this action, the college would face at bare minimum a $2,000-per-year penalty for each of these 400 employees – an $800,000-per-year liability, and more if the college bought them insurance. Note that no profit motive is found anywhere in this story. But for many private businesses, these sorts of penalties would exceed annual profits.

A college spokesman said, "While it is of course the college's preference to provide coverage to these positions, there simply are not funds available to do so." Area unions urged the adjunct professors to unionize. The adjuncts may wish to investigate how that strategy worked out for Hostess employees and for the Twinkie.

One Allegheny adjunct said:

> "It's kind of a double whammy for us because we are facing a legal requirement [under the new law] to get health care and if the college is reducing our hours, we don't have the money to pay for it," said Adam Davis, an adjunct professor who has taught biology at CCAC since 2005."

Professor Davis actually faces a triple whammy, rather than double. Not only will he lose income and have to buy insurance, but the insurance he must now purchase will also become much more expensive because of PPACA. This is because his insurance provider must charge him enough to cover the cost of the underlying health care, including imbedded taxes. And PPACA is about to send the cost of doctors and hospitals through the roof.

PPACA supposedly adds 30 million new people to the insurance rolls, and these 30 million will want to consume health care. But PPACA produces no new doctors, nurses or hospitals – at least not for many years. From Econ 101, we know that greater demand and static supply add up to price increases and/or shortages.

In fact, the biggest increase in demand may come not from the 30 million newly-insured, but rather from the other 280 million. PPACA now requires insurers to pay 100 percent of the costs of a long list of preventive services – check-ups, screenings, counseling, etc. A 2003 Duke University paper has recently resurfaced in the blogosphere. That study asked what would happen if every American received the *minimum* level of preventive services recommended by the U.S. Government. The result was these services would consume roughly 7.5 hours per day for every primary care physician in America. Note that this would leave doctors with practically no time to treat sick people.

(And if you're thinking "maybe all these preventive services will lower overall costs," think again. The evidence says otherwise. See "The Problem with Prevention;" scroll down to 7/24/09 entry)

Brad deLong, a liberal Berkeley economist and well-known blogger asked in November,

> "What is your guess as to what will happen if [PPACA] works for access, works for quality, works for coverage--but the extra health care workforce needed isn't there, and the lines start to get longer?"

It's a good question, and it would have been nice for PPACA's authors to ask that question in early 2010. But here we are, almost three years later and the question is just coming over the horizon.

The current Congress is not going to have a change of mind and repeal PPACA voluntarily. But sometimes, laws effectively repeal themselves when their unintended consequences kick in. To get an idea of how this happens and how legislators react, try the following five Google searches:

TennCare failure

"Kentucky Kare" failure

"Keiki Care" failure

Dirigo failure

PacAdvantage failure

Click on some of the links that pop up. You'll find case after case of states in the 1990s and 2000s passing PPACA-like health care reforms to great fanfare, followed by whirlpools of unintended

consequences, and culminating with the same legislators who had written the laws rushing to undo their own self-destructing handiwork.

Will PPACA follow to same path to self-destruction? I think it's likely. Many disagree. We'll see.

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# PPACA for Employees: The Good, the Bad, and the Ugly

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*NFIB Healthcare Bulletin* (10/16/12)

There's only so much a small business employer can do to prepare for the massive changes in health insurance scheduled for January 1, 2014. My previous Altarum column listed 13 huge question marks hanging over the big day when the Patient Protection and Affordable Care Act (PPACA) hits insurance markets with full force. Many of the big rules that will govern markets after that day have yet to be written or released.

But business owners can do themselves one big favor: They can start preparing their employees for the changes and the uncertainties that PPACA is supposed to deliver on January 1, 2014. While employees will no doubt be pleased with some of PPACA's features, they are likely to experience new costs and other surprises.

For the sake of good employer/employee relations, it is crucial that employees understand that many of the less desirable features will be dictated by the law and not by employers. It is probably good for them to hear about these features now rather than later.

Toward this end, the National Federation of Independent Business's Research Foundation has produced an easily digestible two-page briefing document titled "PPACA: A Healthcare Law Guide for Employees." This guide gives a brief overview of the good, the bad, and the ugly of PPACA. It's formatted to make it quickly and easily digested by employees with no depth of knowledge on health care.

**The Good (new benefits)**

The guide begins with PPACA features that employees will probably view most favorably. Kids can stay on parents' policies until age 26. Going forward, W-2s must reveal the real cost of insurance. Insurers cannot refuse to sell a policy because the buyer has a preexisting medical condition. Premiums cannot be affected by health status. Subscribers can't lose coverage when they become ill. Some will get federally financed subsidies. And for older employees, Medicare's "donut hole" comes to an end.

**The Bad (higher costs)**

Employees will be less enamored of the increased costs resulting from a slew of new taxes and mandates. Most prominently, employees will face the individual mandate tax: a requirement to buy insurance or else pay a tax—a substantial tax in some cases. Some employers not currently offering coverage will have to purchase insurance or pay the employer mandate penalty, thereby leaving less money toward wages. There are new taxes on insurance, on drugs, on medical devices, and on over-the-counter health care purchases. In most cases, the employees will never directly see these costs; they will merely note the higher resulting premiums.

**The Ugly (other surprises)**

PPACA is loaded with complex mathematical formulae that sort people into different markets, treat similar people differently, and diminish previous benefits. Here are some examples:

A couple with income of $41,000 and *three* children can get employer-sponsored coverage. A couple with income of $41,000 and *four* children will have to drop the employer's coverage and go on Medicaid because the formula for Medicaid eligibility depends on both income and family size.

Some families with highly variable income (e.g., one spouse in sales or construction) may find themselves blown back and forth between Medicaid and private insurance, multiple times a year in some cases. This may disrupt continuity of health care.

Some employees will notice co-workers leaving the employer's insurance plan and heading into the insurance exchanges with the help of heavy subsidies. But they will learn that PPACA's formulae prohibit them from doing likewise because they have higher wages or fewer children.

Some people with high annual health-related expenditures will lose important tax breaks. Consider a family who spends $14,000 per year on tuition for a special-needs child. Pre-PPACA, it was possible to pay that amount with pretax dollars through a flex plan. Under PPACA, only $2,500 of the expense can be tax free; the remaining $11,500 must be paid with fully taxed dollars. Some have called this a "special-needs tax."

Employees have lost the ability to use a flex plan or health savings account to purchase over-the-counter health care products.

The guide mentions potential PPACA-induced shortages of doctors and other providers, the $700 billion reduction in Medicare payments to fund PPACA; the incentive for employers to replace full-time employees with part-timers, and the extra financial burdens that PPACA imposes on small business.

"PPACA: A Healthcare Guide for Employees" offers an easy way to begin educating employees about these complexities and the good, the bad, and the ugly of what is coming in 2014.

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## Small Business under PPACA: Behind the Eight-ball

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*NFIB v. Sebelius* is history. The Patient Protection and Affordable Care Act (PPACA) lives on – 1,000 pages of law and 10,000 pages (so far) of regulations. Small businesses ask what lies ahead, and the job-killing answer comes from the Magic 8 Ball®: "REPLY HAZY. ASK AGAIN LATER."

For decades, the high and erratically increasing costs of health insurance have throttled the capacity of small business to plan and grow. The Great Recession compounded that uncertainty. Now, a Supreme Court-altered PPACA thickens the haze.

An exchange-based health insurance market is scheduled to open on January 1, 2014. The exchanges are essential to other provisions that kick in the same day – individual mandate tax, employer mandate, health insurance tax (HIT),, essential health benefits, health insurance premium tax credits (i.e., subsidies), guaranteed issue, modified community rating, etc.

It's not hard to find descriptions and forecasts of where small businesses will buy health insurance after January 1, 2014, or how much that insurance will cost, or how many Americans will be covered. But for now, no forecast is worth the pixels it's written with. PPACA will make life worse for small business, but there are big reasons why no one can say how much worse or worse in what ways. This is because every small business has to ask the following baker's dozen of questions:

**[1] Will PPACA's key institutions be up and running by 2014?** The exchanges and other provisions will require a massive new information technology infrastructure that merges individual-level data (on all 310,000,000 Americans) from the U.S. Departments of Health and Human Services (HHS), Labor, Justice, Homeland Security, Treasury (and the Internal Revenue Service), plus Social Security, Medicare, Medicaid, 50 states, exchanges, and hundreds of insurers. Governors of both parties reported a year ago that HHS was missing crucial deadlines related to the construction of this IT infrastructure. Indeed, some skeptics (I am one) question whether this unparalleled IT integration will ever be feasible.

**[2] Who will establish my state's exchanges?** Most states have not yet decided whether to establish health insurance exchanges or whether to leave the task to HHS. Is HHS capable of running a multi-state array of exchanges? A recent paper has raised questions about whether individual subsidies and employer mandate penalties are applicable in states that have HHS-operated exchanges. Only time and courts will tell.

**[3] Will my state expand Medicaid?** In the original forecasts, half of those gaining insurance coverage would do so through Medicaid, partly thanks to heavy-handed federal incentives. NFIB v Sebelius, however, diminished the federal government's power to force states into complying. Some states are declining the expansion and others are thinking about doing so. This new question gives a small business yet another uncertainty: how many employees will be on Medicaid and not on its group plan or in the exchanges?

**[4] How many Americans will pay the individual mandate tax rather than purchase coverage?** Before NFIB v Sebelius, PPACA ordered Americans to purchase insurance and threatened them with penalties if they did not. After the ruling, PPACA offers Americans a choice: buy insurance or pay a tax. Choosing the

latter no longer implies a violation of the law. If a large percentage of Americans choose to pay the tax, health insurance premiums will spike, thanks to adverse selection.

**[5] How will the individual mandate affect wages?** Whether or not a business offers coverage, many or most of its employees will now be required to either purchase health insurance or pay the individual mandate tax. A business will have to pay sufficient wages for employees to meet this obligation. But until we know how many states expand Medicaid and how many opt for the individual mandate tax, we can't estimate the impact on wages with any confidence.

**[6] How many employers will choose to pay the employer mandate penalty rather than provide coverage?** For any small business, bottom line calculations will be complicated by how their competitors react to PPACA. Will a large percentage of businesses offer employees insurance coverage, or will they send employees instead into the exchanges (when and if the exchanges open)? Both employees and employers stand to gain financially from the exchange-based individual subsidies.

**[7] Which services must my insurance policy cover, and who decides?** Every insurance policy purchased in the small-group and individual markets must cover PPACA's Essential Health Benefits (EHB) package – a menu of mandates. An expansive EHB package will increase the cost of insurance. PPACA stipulated that the U.S. Secretary of HHS would define EHB, but this role was shifted to the states, at least temporarily.

**[8] Will I be able to self-insure?** Some small businesses find they can control costs better by self-insuring, rather than by purchasing a commercial policy in the fully-insured market. But some in Congress and in state legislatures would like to deny small businesses this option. (See the 5/31/10 entry here.)

**[9] Is my businesses "small" or "large" with respect to the employer mandate?** When and if the exchanges open, businesses with 50 or more full-time employees (FTs) or full-time equivalents (FTEs) will be subject to potentially massive employer mandate penalties each year. Calculating FTs and FTEs is not simple; the employee count will depend on whether a particular individual is considered full-time, part-time, seasonal, or temporary, and the distinctions are not always clear. In addition, multiple businesses with a common owner – even unrelated businesses – may be interpreted by the IRS as a single business.

**[10] How expensive and time-consuming will PPACA's paperwork requirements be?** Some businesses are already experiencing a cascade of paperwork thanks to the Medical Loss Ratio (MLR) provision. MLR sets a benchmark for when an insurer has "overcharged" a business. When this occurs, the insurer sends the employer a rebate check which the employer may have to refund, in turn, to employees who received health insurance during the previous plan year. This can entail complex calculations and may require the employer to track down former employees and send them checks, often for trivial amounts of money.

**[11] Which insurers will still be around once the exchanges open?** Some insurers have already been driven out of certain markets. It is already true, for example, that insurers cannot refuse to cover children. The result has been the virtual disappearance of child-only policies nationally. Similarly, the market for student health insurance plans at colleges is also drying up. Other insurers in other markets may follow.

**[12] Will provider shortages drive up costs?** PPACA supposedly brings complete insurance coverage to perhaps 35 million Americans. It promises free services to just about all 310,000,000 Americans. Yet there is no near-term increase in the number of doctors, nurses, hospitals. The result will be shortages, and the response should be higher costs. Here's a back-of-the-envelope calculation: Suppose the new provisions lead Americans to spend one extra hour a year with a doctor. With just under 1 million doctors, that's around 300 extra hours of demand per year for each doctor.

To make this a baker's dozen, we can add one more element.

**[13] Will the U.S. head over the "fiscal cliff" in 2013?** If all of these issues were not complicated enough, decisions on most of these provisions will have to be made in 2013 – a year when the American economy may be heading over the fiscal cliff and potential disaster.

What To Do

Summing up, a business owner planning for the next year has to think the following: "Will the exchanges be ready in 2014? Will my state open one? How many of my employees will be on Medicaid? How many of my employees will opt out of insurance? What will PPACA do to wages? Will my competitors offer coverage? How generous will my health insurance policy have to be to attract employees? Will I be able to self-insure? Am I 'large?' How much paperwork will I have? Will my insurer still be around? How much will doctors charge for their services? And will the U.S. economy lie in a heap at the bottom of the fiscal cliff?" This mash-up of questions is not a strong incentive to create jobs.

To operate a small business in the PPACA era, the owner has no choice other than to become something of an expert in health care law. This means spending large amounts of time reading circulars from the IRS, other federal agencies, insurers, and other entities. But no owner can possibly grasp all the ways that PPACA will affect a business and its employees. Those of us who spend every working hour poring over this law discover new mysteries every week.

However, any business that tries to be its own health care consultant is likely to miss important requirements, impacts and opportunities. Trolling the Internet for advice will likely yield plenty of misinformation. Perhaps a small business owner should add an extra bedroom on his house. Going forward, he'll want his accountant available 24/7, and perhaps an insurance broker and tax attorney close by as well.

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## The Day After: Health Care Reform After *NFIB v Sebelius*

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*Altarum Health Policy Forum* (6/20/12)

The long process of health care reform will begin the day after the U.S. Supreme Court rules in the case of NFIB v Sebelius. No matter how the Court rules, we will still face the big problems that predated The Patient Protection and Affordable Care Act (PPACA) – high and rising costs, gaps in coverage, uneven quality and heavy red-tape burdens for individuals, providers and businesses. The Court may throw out all of PPACA, part of it, or none of it; but no matter which, health care spending will remain the single greatest fiscal threat to the federal government, state governments, businesses and individuals. Congress and the 50 state legislatures will have little choice but to revisit the topic.

What will be the elements of post-Supreme Court reform debates? In the text below, I'll outline two areas: small business issues and entitlement issues.

**Small business health care solutions**

Small business is the logical starting point for health care reform. In the lead-up to PPACA's passage in 2010, it was often said by parties on all sides of the debate that reform had to address the health care problems faced by small business. With no human resources departments, small businesses have great difficulty dealing with the administrative side of health care. The laws governing small-group insurance create special obstacles to purchasing coverage for employees. But most importantly, insurance costs are at their worst – high and volatile – in the small business sector.

In 2008, NFIB said, "When it's fixed for small business, it's fixed for America." Unfortunately, PPACA did not fix the problems for either small business or for America. Since the challenges have not lessened for small business, it's time, once again, to address the issues.

**If the Court upholds all or part of PPACA:** It's essential to deal with some of the law's provisions that are especially troubling to small business. Congress could start by repealing the health insurance tax and the employer mandate. Following those, there are some harmful taxes that discourage employers from hiring: the so-called Medicare wage and investment taxes, the medical device tax, the drug tax and so forth. (NFIB led the successful effort to repeal the infamous 1099 provision.) Of course, if the Court strikes down PPACA in its entirety, these questions will be moot.

**Regardless of how the Court rules:** NFIB has proposed a set of twelve health care solutions that would benefit small businesses. These include: (1) Equal tax treatment in the employer-sponsored and individual markets; (2) Tax parity between the self-employed and other small businesses; (3) Changes in tax and insurance laws so employers may offer insurance on a defined-contribution basis; (4) Information technology to make insurance prices and quality transparent; (5) Insurance exchanges to expedite insurance purchases by both employers and individuals; (6) Interstate health insurance markets for small business; (7) Options for developing larger insurance pools; (8) Access to insurance for those with pre-existing conditions; (9) Insurance portability for those whose residence or job situation changes; (10) Broader range of consumer-driven health insurance products (e.g., improvements in HSAs, FSAs); (11) Wellness and preventive options; (12) Medical malpractice reform. NFIB's website provides more information on this starter set of health care solutions.

On #3 (defined contribution), I'll note that while opposing PPACA in late 2009, NFIB avidly supported a bipartisan amendment, introduced by Sen. Ron Wyden (D-OR) and Sen. Susan Collins (R-Maine) that

would have enabled small businesses to offer health insurance on a defined-contribution basis. Unfortunately, the amendment was defeated. The basic framework of Wyden-Collins is a good starting point for new discussions, as is the Utah health insurance exchange, which includes a defined-contribution capability.

Solutions #8 (concerning pre-existing conditions) and #9 (concerning portability) are perhaps the most daunting challenges on the list. The individual mandate, the subject of NFIB's constitutional challenge, was meant to address these problems. The mandate, however, is not essential for these goals. By 2009, ways to achieve these goals without a mandate were already under discussion. Ed Haislmaier, a conservative scholar at the Heritage Foundation and Paul Starr, a liberal scholar at Princeton University suggested strikingly similar mandate-free proposals that would almost certainly have passed constitutional muster, for example.

**Entitlements**

NFIB focuses on issues that are of direct concern to small business. However, the "NFIB Healthcare Solutions" document acknowledges "meaningful reform" must also deal with entitlements.

**Entitlement reforms:** The most difficult long-term financial problem facing the federal government is how to make Medicare efficient and financially sustainable. For states, the biggest problems are Medicaid and CHIP (the Children's Health Insurance Program).

Medicare's reimbursement system is nearly 50 years old and fails to reflect underlying economic realities. There is a chain of arguments that goes something like this: (1) Medicare's reimbursement formulae overcompensate specialists and undercompensate primary care doctors; (2) thus, we have an overabundance of specialists and a shortage of primary care physicians; (3) Because Medicare is so big, the overcompensation and overabundance of specialists spills over into the private health insurance markets for people under 65 years of age; (4) The end result is to skew health care toward treating disease rather than toward preventing it.

Medicaid is a heavy financial burden on the states, as well as on the federal government. And, as with Medicare, part of the problem involves nearly-50-year-old financing formulae. In particular, the structure of Medicaid financing arguably rewards states that are profligate and punishes states that are prudent.

How should we change entitlements? That's the $60-trillion-dollar question. And we'll need answers in order to keep the federal government solvent and in order to deliver better care less expensively and more efficiently.

We can start the conversation on entitlements the day after the Supreme Court rules on NFIB v Sebelius. And Congress can begin pursuing those small business health care solutions that same day.

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## Health Care Law Blues: They Hear That Train a-Comin'

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*Altarum Health Policy Forum* (4/3/12)

For small business, the 2010 health reform law means higher costs, more red-tape and fewer choices. Some provisions are already in effect (e.g., coverage expansions, drug tax, FSA limits). Others start in 2013 (e.g., medical device tax, increased "Medicare" taxes on business owners' wages, a new "Medicare" tax on owners' investments). But the biggest provisions don't kick in until January 1, 2014 (e.g., individual mandate, employer mandate, health insurance tax, essential health benefits, exchanges, Medicaid expansion).

Hence a recurring question from journalists and others: "I understand that the provisions that go into effect in 2014 might hurt small business, but how is the health care law hurting small business TODAY?"

Let me offer an equivalent question:

"I realize you're worried about the freight train arriving in six minutes, but how is being tied to the railroad tracks adversely affecting you RIGHT NOW?"

Yes, the guy lying on the track may be hot, thirsty and itchy. But the approaching train is far more real to him than any heat, thirst or bugs. So it is with small business and the health care law.

Businesses are already smarting under the law's provisions currently in force. The coverage expansions, drug tax and FSA limits have driven premiums up for small business employers and employees. Insurance premiums rose 3 percent in the year before the law was passed (and 5 percent for the preceding few years), but have risen 9 percent in the year after its passage. The law's supporters claim that only 2 percent of the most recent rise is attributable to the law; opponents suspect it's greater.

But the 2014 freight train is already rumbling down the tracks and affecting small businesses. Any small business renewing its insurance policy has to buy it from an insurer who must price the uncertainty over 2014 into the premiums it charges. In some markets, insurers have withdrawn, leaving businesses with fewer choices—making a hash of the promise from the law's proponents who said, "If you like your insurance, you can keep it." (An NFIB survey reported that since enactment, 12 percent of small employers have had their health insurance plans terminated or been told that their plan would not be available in the future.)

No one knows how rapidly provider costs and premiums will rise in 2014 and thereafter, or whether the state health exchanges will actually function or how heavy the employer mandate penalties will be. An unknown number of small businesses are currently hesitating to hire new employees, to start new lines of business or to expand old lines.

The law makes it difficult to predict the costs of running a business. When a business reaches 50 full-time employees (or full-time equivalents), it may owe employer mandate penalties. The reaction of many small businesses has been to stay well below that 50 mark—even if there are potentially great expansion opportunities to be had. Typically, businesses can't (or won't) hire people and grow their businesses now and then shrink back down by January 1, 2014. This is one reason that small business growth has remained stagnant in recent years.

Oh, and after reading this analysis, some may be tempted to ask, "But what about the law's small business health insurance tax credit?" If you are tempted to ask this, please read my earlier post, "Cashews on the Hindenburg." Not much consolation for the guy on the tracks, I'm afraid.

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## Cashews on the Hindenburg

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*Altarum Health Policy Forum* (2/24/12)

The Patient Protection and Affordable Care Act (PPACA) has a thousand pages of moving parts, and the relatively few that have rolled out are shedding sprockets across the landscape. This is deeply worrying, given that the stability of the nation's health care system depends on the successful construction and launch of a vast fleet of new institutions before New Year's Day, 2014.

**Number-one selling point**

Consider the small business health insurance tax credit. For two years, PPACA supporters have trumpeted this small piece of the law as their number-one talking point toward small business. For some businesses, they note, the credit can offset up to 35 percent of employee health insurance costs and 50 percent beginning in 2014. "This year, up to 4 million small businesses may be eligible for tax credits, making it easier for them to provide coverage to their workers," says the White House website. "Health care reform saves small business owners money immediately through tax credits," proclaims another site. The credit is a "huge boon to small businesses," declares a recent newspaper column.

This is equivalent to the statement, "Unlimited cashews offer huge boon to Hindenburg passengers."

A bowl of cashews is a tempting snack, but it's relatively unimportant to someone riding five million cubic feet of hydrogen toward an electrical source. Likewise, the incessantly-touted credit is a modest little windfall for a relatively few small businesses. It's not a bad thing in and of itself. But the credit is miniscule next to the heavy load of financial costs, red-tape, and uncertainty generated by PPACA. And the credit provides a cautionary tale for the rest of the law.

**The record**

The National Federation of Independent Business noted all along (see 4/3/11 and 5/13/10) that far fewer than 4 million businesses would qualify. Our warnings were greeted with rolling eyes, but even our most pessimistic forecasts weren't as bad as the actual numbers.

The U.S. Treasury Inspector General for Tax Administration said only 309,000 businesses claimed the credit for 2010—8 percent of that theoretical 4,000,000. Those 309,000 received, on average, only $1,346. Spread across the mythical 4,000,000 "potential" recipients, that's $103 apiece. To put this in perspective, in 2011 small-group insurance premiums averaged $5,328 for an individual employee and $14,098 for a family. So $1,346 per employer (not per employee) is not much of an inducement to offer insurance.

But as insignificant as the credit is for most businesses, it did cost the government $416,000,000 in 2010. Buried within a trillion-dollar deficit, something just under half-a-billion dollars isn't huge, but as the federal debt floats toward crisis, neither is it trivial.

The real reasons for the credit's failure were obvious from the start. It was terribly designed, relatively few businesses qualified, and many who did only qualified for a pittance. The 35 percent credit shrinks to nothing as a business grows beyond 10 employees, raises wages beyond $25,000, employs the

owner's relatives, uses part-time labor, or offers more-generous-than-average insurance. Once the exchanges open in 2014, the credit expires within two years. Some accountants have told business owners to forget about claiming the credit—that it costs more to calculate than it will pay out. (For the record, NFIB always suggested that employers take advantage of the credit if it were in their financial interests.)

**The excuse**

Why this failure? PPACA supporters give a troubling response. They did a survey purporting to show that 57 percent of business owners had never heard of the credit. Let's suppose they're correct and consider what that claim implies.

Advocates, from President Barack Obama on down, have continuously touted the credit. In 2010, the White House launched a "nationwide educational campaign for small businesses and tax preparers." According to the official website, this campaign included a special page on WhiteHouse.gov, millions of postcards mailed by the IRS to businesses, over 1,000 tax workshops and small business forums, email blasts to 175,000 tax professionals, and a special section on IRS.gov.

And yet after two years of this massive information campaign, PPACA supporters complain that a majority of business owners (and by extension, their accountants) remain unaware of a tax form that could potentially save an individual business thousands of dollars per year. Keep in mind that these are business owners who constantly navigate the more cumbersome and arcane corners of the U.S. Tax Code. If we believe the survey, in two years, all the resources of the federal government could not reach a small, targeted, well-educated, easily-identified segment of society.

Now, the same government has less than two years to acquaint 300 million Americans with the impenetrably complex workings of PPACA's individual mandate, premium credits, cost-sharing subsidies, exchange and non-exchange markets, employer mandate, essential health benefits, Medicaid qualification, actuarial values, myriad tax-code changes, benefit tiers, preventive service coverage and on and on.

**Beyond the credit**

PPACA's failures do not end with the credit. PPACA created high-risk pools so that Americans with pre-existing medical conditions could immediately gain access to insurance. The Congressional Budget Office estimated that perhaps 4 million Americans would be eligible. The Chief Actuary of Medicare and Medicaid estimated that 375,000 people would enroll by the end of 2010. By October 2011, only 41,000 had signed up nationwide—an 89 percent underperformance.

PPACA was sold as a way of lowering the cost of health insurance. And yet health insurance premiums rose 9 percent in the year following enactment, versus a 3 percent increase in the year before (and 5 percent between 2005 and 2010).

As the states scramble to establish the exchanges that must be operative by January 1, 2012, governors of both parties are warning that the law is a logistical nightmare (scroll to 9/28/11).

The list goes on.

The Supreme Court will decide in early 2012 whether to throw PPACA out. Whatever the court decides, it is time to rethink health care reform and to do it right this time. Here's a small starter set of ideas – twelve ways to begin genuine reform.

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## Small Business and Exchanges: SHOP Till You Drop

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*Altarum Health Policy Forum* (12/20/11)

Assuming the 2010 health care law survives through 2014, one of the big questions is the future of small-group insurance plans – those in which the employer chooses and administers a plan or plans for employees. The health insurance exchanges built into the Patient Protection and Affordable Care Act (PPACA) create mechanisms for small-group survival, but also powerful incentives for their dissolution. Following are some thoughts on the question.

**Small business and exchanges:** There is substantial support among small businesses for the idea of exchanges. My employer, the National Federation of Independent Business (NFIB), strongly opposed the Patient Protection and Affordable Care Act (PPACA), and is carrying that opposition to the Supreme Court in *NFIB v Sebelius*. However, thanks to dissatisfaction with the current small-group market, NFIB and its membership have cautiously encouraged health insurance exchanges, regardless of whether the law survives through 2014.

**Centripetal vs. centrifugal exchanges:** PPACA creates two kinds of exchanges, both due to open in 2014. Small employers can purchase group policies in Small Business Health Options Program (SHOP) exchanges. Some, but not all, employees can buy individual policies in the American Health Benefits (AHB) exchanges; these are open only to individuals whose employers do not offer coverage or to individuals whose employer-sponsored coverage is deemed inadequate or unaffordable.

SHOP exchanges ostensibly exert a centripetal force to group by making it cheaper and easier for employers to buy and administer group plans. AHB exchanges apply centrifugal force, giving businesses two powerful motives to break up their groups and send employees into the AHB exchanges. First, going the AHB route liberates a small business from the time and expense of choosing and managing a plan. Second, premium subsidies covering part or all of an employee's insurance premium are available in the AHB exchanges, but not in SHOP exchanges.

**Employer-sponsored insurance (ESI) has never worked well for small business:** Employer-sponsored insurance was designed to circumvent World War II wage-price controls. Tax laws reinforced the employer/insurance nexus; in the group market, employees can pay premiums with pre-tax dollars; in the individual market, this tax break vanishes.

Operationally, though, small employers were never well-suited for ESI. Unlike a large employer, a small business brings too few lives to the table to muscle insurers into granting price breaks. The typical small business has no human resources department to maintain expertise in insurance matters and manage the paper flows. In a small business, that burden falls to the owner, who generally has no special knowledge of insurance. Choosing and administering a plan carries a substantial administrative burden that distracts the owner from the core business.

Thus, small-group premiums are high and choices are few for employers and employees. Many small businesses maintain company plans so employees can take advantage of the tax breaks. But very likely, most small businesses would be delighted to wash their hands of the process.

**To succeed, exchanges have to provide value to small businesses:** For small businesses to choose SHOP over the drop-and-dump-into-AHB option, the SHOP exchanges will have to demonstrate greater value to businesses. If the answer to "Why should businesses choose SHOP over AHB?" is "because group policies have been the mainstay of private insurance since the 1940s," then prepare for wide-scale abandonment of group plans in 2014.

Adding value means dealing with the fact that for decades, health insurance costs have been the single biggest problem for small businesses. SHOP exchanges are supposed to give small groups some of the virtues of large-group plans. Exchanges are supposed to simplify the act of buying group insurance by creating a centralized market where plans compete transparently. Often compared to sites like Travelocity.com, the exchange is supposed to include a user-friendly computer portal that allows purchasers to easily compare the prices and qualities of different insurance plans, thus exerting downward pressure on prices.

Purchasing a group policy, however, is only one part of the problem. The plan still must be administered. Here, too, SHOP is supposed to simplify life by acting as a virtual human resources department, managing the plan's paper flows, alerting the business employees to deadlines, changes, etc.

But these features will not be enough. To succeed, SHOP exchanges can't just be better than current small-group markets. They have to be better than the alternative of dropping group coverage and sending employees into the AHB exchange. And, it's worth remembering that in many or most states, employers and employees will be able to sidestep both SHOP and AHB exchanges by buying insurance directly from brokers, as they do today.

On what criteria will they judge the exchanges? On whether they offer enough insurance carrier competition to drive down costs without compromising quality of care. On whether business owners spend less, rather than more, time dealing with insurance matters. On whether employers and employees are happy with the choices among plans.

**Exchanges can fail:** On the negative side, a number of features may drive businesses away from SHOP exchanges and/or employees away from AHB exchanges. If costs continue to rise rapidly. If the exchange is perceived as a heavy-handed regulator. If the computer portals are poorly designed and opaque to users. If the administrative functions of the exchange seem mired in red-tape. If phone calls and emails go unanswered. Ominously, the Internal Revenue Service, the National Governors Association, and others are already warning that parts of PPACA may be a logistical mire (see my PPACA: Five Layers of Uncertainty, 9/28/11).

**Small business does not exist to close the federal budget deficit:** PPACA supporters fear that small businesses will tilt heavily away from SHOP and drop employees into the AHB exchanges. If this happens, the federal budget deficit will swell as millions of individuals claim federal subsidies, further strengthening the argument that PPACA is costly and fiscally irresponsible.

However, small business isn't obliged to stanch PPACA's fiscal strain on the U.S Treasury. Congress designed the AHB subsidy scheme and aligned the incentive structure to small businesses. This may well be one of many ways in which Congress underestimated the law's costs. But that is a problem for Congress, not small business, to fix.

**Defined-contribution insurance could alter the equation:** As of now, two states, Massachusetts and Utah, have fully functioning exchanges up and running. Utah's is arguably more market-oriented and has included a feature that could go a long way toward keeping group coverage attractive. It does so by blending elements of the SHOP exchange and the AHB exchange into a "defined-contribution" option. Rather than choosing one or two plans and offering employees a take-it-or-leave-it choice, defined-contribution allows the employer to contribute a set amount that employees can use to purchase the policies of their choice within the SHOP exchange. There are still no subsidies. During the final days of the debate over PPACA, NFIB supported a defined-contribution plan offered by Sens. Ron Wyden (D-OR), Susan Collins (R-ME), and Evan Bayh (D-IN); the measure did not make it into the final bill. There are moves afoot in the current Congress to resurrect the idea.

**Conclusion**

Those designing and managing exchanges would do well to ask themselves the following question: "What will our state's exchange accomplish for small business that is not currently possible?" They would do well to resist the urge to corral small businesses into a particular scheme to serve some end such as minimizing the AHB subsidies. Like most other things, exchanges are best sold with carrots, not sticks.

The SHOP exchange option has considerable merit, but "option" should be the key word. It is fine if SHOP exchanges expedite group policies, but SHOP exchanges will have to earn the fealty of small businesses and of those employees who have the option to go into the AHB exchanges. Frankly, the subsidies in the AHB exchanges, which can be many thousands of dollars per employee, will make that difficult. That is a problem for Congress, not small business, to contemplate.

## Health Care Law Subsidies: A Tale of Two Cities

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*Altarum Health Policy Forum* (10/11/11)

The 2010 health care law will conjure up a strange brew of inequities as it comes to a boil in 2014. The mechanistic, one-size-fits-all health insurance subsidies, for example, will generate serious questions about the law's fairness. By ignoring the enormous regional disparities in cost of living, the subsidies effectively penalize those in more expensive localities and reward those in lower-cost areas. Additionally, the law biases the subsidies toward those with larger families.

This inequity arises because of a three-part structure at the core of the Patient Protection and Affordable Care Act (PPACA). First, PPACA requires individuals to purchase health insurance (or to pay penalties for not doing so). Second, another provision draws a mathematical line between those households with access to "affordable" insurance and those without such access. Third, the law offers premium tax credits (subsidies) to households lacking options meeting the affordability standards. To qualify for subsidies, the household's income must be below 400 percent of the Federal Poverty Level (FPL), and insurance premiums that the household pays must exceed 9.5 percent of the employee's income. A household meeting these two standards can obtain the subsidies and purchase insurance in the exchanges set to open in 2014.

To understand the problem, let's focus on two siblings – one in New York City and one in Abilene, Texas. Both own small businesses.

**New York sister, Texas brother**

The New Yorker is single and has a new business that earns her $45,000 in its first year of operation. To put this in perspective, this amount is almost exactly what a beginning schoolteacher earns in New York. With high taxes, food prices, and apartment rents, $45,000 in New York City only buys a Spartan life in a cramped apartment.

The Texan is married, has three children, and earns $100,000 a year at his 15-year-old business. He and his family live in a roomy house with a swimming pool. In Abilene, $100,000 buys a very cozy life. An unscientific Google search suggests that most of Abilene's attorneys earn less than our business owner.

In 2014, sitting at the Thanksgiving table, the sister complains to her brother about the heavy burden of health insurance. The brother mentions that he bought insurance in the new exchange and received federal subsidies because the law deems health insurance unaffordable for him and his family. The sister is surprised – and irritated – since she was told that her income is too high to qualify for subsidies.

Here's the explanation. To get a health insurance subsidy, a household's income must be less than 400% of FPL *for a given size of household*. The guidelines have separate dollar figures for Alaska and Hawaii, but no regional variation within the 48 contiguous states. In those 48 states, 400% of FPL for a household of one person is currently $43,560; for a household of five people, the figure is $104,680. The sister earns more than $43,560, so she cannot receive subsidies. Her brother earns less than $104,680, so he may qualify.

To obtain the subsidies, the Texan's insurance would have to cost more than 9.5 percent of household income – $9,500 in this case. An October 2011 Kaiser Family Foundation survey reported that, across the

U.S., average 2011 individual and family policies cost, respectively, $5,429 (up 8 percent from 2010) and $15,073 (up 9 percent from 2010). We can say with near certainty that the New Yorker's individual policy will cost more than 9.5 percent of her income ($4,275). It's not important to this blog piece, but given the high cost of health care in New York, the sister's unsubsidized individual policy might even cost more than her wealthier brother's subsidized family policy.

In a different context, New York Senator Charles Schumer recently declared a proposed income tax provision to be unacceptable because it effectively treats households across America as "rich" if they earn more than $250,000 a year. Schumer said, "$250,000 makes you really rich in Mississippi but it doesn't make you rich at all in New York and there ought to be some kind of scale based on the cost of living on how much you pay." One can apply Schumer's logic to PPACA's subsidies. Doing so, however, would open quite a few new cans of worms.

When families gather in 2014, PPACA's fairness will be questioned around many a dinner table. In that year, members of Congress from high cost-of-living areas are likely to hear quite a few of those questions from displeased constituents.

## PPACA and the Jobless Recovery

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*Altarum Health Policy Forum* (8/9/11)

Small-business owners are deeply concerned that the 2010 health-care law (PPACA) will prolong what has been described as America's "jobless recovery." Recent Congressional testimony and a new study by the NFIB Research Foundation (my employer) shed some additional light on this concern. It is worth noting that small businesses normally create around 65 percent of the country's net new jobs, but the sector has been shedding jobs almost continuously since early 2007.

Obviously, job-creation anemia did not begin with PPACA. But if small-business owners are correct, PPACA could prolong a situation that, in August 2011, is dire. For context: In June, the overall unemployment rate was 9.2**%;** add in discouraged and underemployed workers and the real rate is 16.2**%**. Since the second quarter of 2007, the small-business sector – normally the engine of job creation – has lost, not added, jobs in all but one quarter. Pre-PPACA, we can cite at least three contributory factors: Weak economic growth stripped businesses of the incentive to expand or hire. (The latest official data show 0.4**%** in the first quarter of 2011 and 1.3**%** in the second quarter.) Uncertainty over tax rates made it difficult for businesses to do even relatively short-term business planning. (2011's marginal income tax rates and estate tax rates were not known, after all, until days before the year began.) And the real estate collapse obliterated the collateral that many small businesses would have used to fund expansion and hiring. (Business owners own a lot of homes, offices, and investment properties.)

But recent information adds to the perception that PPACA has joined these other three anchors in discouraging growth and job creation. In late July, a panel of business owners expressed their fears before a subcommittee of the U.S. House Oversight Committee. One of the panelists, with 450 mostly blue-collar employees, was an NFIB member whose written and oral testimony walked members of Congress through the mechanics of his business and the options PPACA imposes on it in 2014. In his words, "this law will cost our company $1,000,000 or more no matter which option we choose. … Today, these estimates are more than the company makes. … These forecasts do not even consider the significant additional administrative costs we are incurring and will continue to incur managing the program, preparing mandated government reports, and tracking all [employees'] household dependents and earnings." He added, "[O]ur thirty-year business and the jobs of 450 employees are at risk of being legislated out of existence. … Our goals turn from 'hire-and-grow' to 'cut-and-survive.' " Other panelists expressed similar fears about the impact on their businesses. For those interested in a flesh-and-bones look at the law, their testimony is worth reading.

The panelists' testimony accorded with the new NFIB Research Foundation. In the study, by William J. Dennis, Jr., majorities of business owners familiar with the law said PPACA:

- won't reduce paperwork or simplify the provision of healthcare (79%);
- will increase taxes (77%);
- will increase federal budget deficits (71%);
- will infringe on the rights of Americans (65%);
- won't slow the rate of health insurance cost increases (65%);
- won't improve the overall health of the American public (59%);
- will lead to a government takeover of healthcare (58%); and

- will separate doctors and patients (50%).

In general, the negative sentiments were more widely held by those businesses currently offering insurance than by those who do not offer – similar to the findings in the McKinsey and Company report that made headlines recently by predicting that, "Overall, 30 percent of employers will definitely or probably stop offering insurance coverage in the years after 2014."

The Foundation study was based on a survey of 750 small businesses, chosen at random from Dun and Bradstreet. The survey of these companies was conducted by the nonpartisan Mason-Dixon polling organization.

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## The HIT Hit: PPACA's Health Insurance Tax

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The 2010 health care law, the Patient Protection and Affordable Care Act (PPACA), hits small business with a barrage of inequities. Among the most egregious is the health insurance tax (HIT) launched by the law's Section 9010. Ostensibly a tax on insurers, its real effect will be hundreds of billions of dollars of taxation on people who purchase coverage in the fully-insured market – mostly small business employers and employees and the self-employed. These are the people who usually generate around two-thirds of America's new jobs.

In contrast, the HIT bypasses those who have coverage through self-insured plans – mostly big business, labor unions, and governments. Like PPACA's essential health benefits and longstanding state benefit mandates, the HIT puts an anchor around the neck of small business while leaving larger organizations free to swim unburdened. And the anchor is a heavy one.

**Over the first decade, the HIT will hit the fully-insured market with an estimated $87.4 billion tab, but that figure greatly understates the long-run financial impact.** The tax is not implemented until the fourth year of the decade (2014) and is only fully implemented in 2018. The tax rises from $8 billion in 2014 to $14.3 billion in 2018 and in later years, even higher according to a complex (and at this point opaque) index, discussed below.

**To put this in perspective, that $14.3 billion equals around 15 percent of the total small business expenditures on employee benefits in 2007.** According to IRS data, proprietorships, partnerships, and corporations with up to $10 million in annual receipts deducted $96.8 billion that year for Employee Benefit Programs. An extra 15 percent or so constitutes an enormous blow to the ability of small businesses to compete against larger entities.

**The HIT's full magnitude will only become apparent in the second decade (2021-2030), when businesses and consumers experience 10 years of a premium-indexed, fully-implemented HIT.** The second-decade cost is difficult to forecast, but may exceed $200 billion or even $300 billion. It all depends on how rapidly the law's arcane index lifts the HIT beyond its $14.3 billion base in later years. There are two major sources of uncertainty in that index.

**First, after 2018, the size of the tax depends on how fast health insurance premiums rise, and no one can forecast that rate of increase with any confidence.** In Essential Health Benefits: The Secretary's Joystick, I explained the uncertainty that the essential health benefits structure poses for premium forecasts. PPACA was supposed to moderate the increase in health insurance premiums, but that talking point has been killed by pronouncements from the Congressional Budget Office, the Chief Actuary of Medicare and Medicaid, and a rash of private forecasters. Even a White House-sponsored teleconference in summer 2010 warned participants to stop arguing that PPACA would reduce costs. There are few reasons to think that premiums will rise more slowly, but many reasons to think they will increase more rapidly – the essential health benefits package, the health insurance tax, the slew of other new taxes imbedded in the premiums, elimination of coverage limits, mandatory preventive services, giving more people insurance while creating no new doctors or nurses, and demographic trends.

**Second, the precise mathematical structure of the index is uncertain.** The index consists of a complex set of equations that incorporate not only premium increases, but also each year's number of policyholders, size of U.S. gross domestic product, Consumer Price Index, and certain tax credits contained in PPACA. The provision says of the index (PPACA, Section 9010):

> "In the case of any calendar year beginning after 2018, the applicable amount shall be the applicable amount for the preceding calendar year increased by the rate of premium growth (within the meaning of section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986) for such preceding calendar year."

For readers who enjoy solving puzzles, I suggest that they turn to Section 36B(b)(3)(A)(ii) of the Internal Revenue Code and try to figure out how the IRS will calculate the post-2018 tax increases. With the help of some taxation and insurance industry experts, I think I have it figured out. But we'll see. Meaningful forecasts will have to await future IRS rulings and other regulatory interpretations.

**Nevertheless, we can explore some plausible scenarios.** Health insurance premiums for the average family grew by around 5 percent between 2005 and 2010 (see Exhibit 1.1 here.). If the HIT were to rise by 5 percent per year after 2018, the tax would total $208 billion between 2021 and 2030. Family premiums rose by over 10 percent between 2000 and 2005. If the HIT were to rise by 10 percent per year, the second-decade cost would be $303 billion.

**In addition, the HIT will cascade on itself.** Insurers will pass the HIT along to purchasers in the form of higher premiums. In turn, those premium increases will enter into the index and raise the tax in later years, and insurers will have to pass those increases along to purchasers, as well. So the HIT violates a common principle of fairness in taxation – that one should not be taxed on a tax.

**And interactions between the HIT and the corporate income tax will augment the total effect by over 50 percent.** Former Congressional Budget Office Director Douglas Holtz-Eakin explained how the first-decade costs will actually be $134.6 billion, rather than $87.4 billion ("Higher Costs and the Affordable Care Act: The Case of the Premium Tax," available on the web.) By the same logic, a $208 billion second-decade HIT would really mean a $320 billion impact on health insurance consumers.

**Finally, the impact on those in the fully-insured market is likely to be even worse because of the peculiar structure of the HIT.** If some businesses switch from the fully-insured market to self-insured plans, those remaining in the fully-insured market will have to pick up the tax bill for those who have switched to self-insurance. And because of the inequity of the tax, it will certainly drive some businesses to self-insure – even if such a switch may be imprudent from a risk standpoint.

**In short, this tax will bludgeon small business.**

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## Essential Health Benefits: The Secretary's Joystick

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Beginning in 2014, the Patient Protection and Affordable Care Act (PPACA) hands the Secretary of the U.S. Department of Health and Human Services a joystick – the Essential Health Benefits package – with the potential to rocket small-business health insurance premiums skyward. EHB is the menu of goods and services that must be covered under all exchange-purchased insurance plans and non-grandfathered small-group and individual insurance plans. By vesting one set of hands with control over EHB, small business faces permanent administrative uncertainty. At the same time, the brunt of EHB appears largely to bypass big business, unions, and governments.

**EHB, Ban on Limits, Actuarial Value**

Beginning in 2014, PPACA (§1302) makes EHB a mandatory feature of most insurance plans purchased by America's 6 million small businesses and 15 million self-employed individuals. Exceptions initially include businesses with more than 100 employees and those with grandfathered policies. The EHB requirements apply to policies purchased both in exchanges and in non-exchange small-group or individual markets.

In the small-group and individual markets, annual or lifetime coverage limits on all EHB items are forbidden. And plans must have an actuarial value (AV) of at least 60 percent, meaning the plan's total reimbursements must be at least 60 percent of the total qualifying health care costs incurred.

Section 1302 empowers the Secretary of HHS to define EHB, but gives little specificity beyond requiring that EHB include 10 general categories (e.g., ambulatory patient services) and "the items and services covered within the categories;" the Secretary is to also assure that EHB includes "benefits typically covered" by a "typical employer plan." The meaning of these words in quotation marks is left to the Secretary (and future Secretaries) to define and redefine. The fluid definitions and concentrated discretion mean uncertainty, which carries a financial cost for small business.

**State Mandates as Precedent**

The Council for Affordable Health Insurance lists 2,156 state mandates in 2010. These included benefit mandates (e.g., reimbursement for smoking cessation), provider mandates (e.g., reimbursement for services provided by acupuncturists), and covered-person mandates (e.g., inclusion of stepchildren under family policies).

Some mandates are less controversial than others. But every mandate benefits some patients. The problem is that mandates, no matter how well-intentioned, mean higher costs.

At least with state mandates, the legislative process restrains proliferation. Typically, a new mandate has to wend its way through a state legislature, with attendant impact estimates, public hearings, recorded votes, and so forth. Disease groups and provider groups can lobby for additional covered benefits, but so can groups representing consumers and taxpayers. In the end, legislators have to weigh both costs and benefits of mandates or else incur the wrath of financially pressed voters. Importantly, with state mandates, cross-state comparisons provide evidence of how the mandates affect costs and

health outcomes. One can measure the difference in costs between Rhode Island's 69 mandates and Idaho's 13 mandates.

For small business, a perpetual irritation is the fact that state mandates apply mostly to small businesses and individuals (including the self-employed). Most big businesses, labor unions, and governments are self-insured, and, therefore, exempt under ERISA. EHB appears to compound this inequity.

**Federal Mandates under PPACA**

Effectively, §1302 creates national benefit mandates. Most small-group and individual policies must cover the entire EHB package, with no coverage limits and an AV of 60 percent or higher. States will still have the discretion to add additional mandates on top of the EHB package. In contrast, plans obtained in the self-insured and fully-insured large-group (over 100) markets apparently do not have to include all EHB items. They can't impose annual or lifetime coverage limits on any EHB services that they do cover, but it appears that they can omit EHB items from their coverage. This would seem to create a powerful motive to omit EHB items that are rare, but terribly expensive – a luxury small business will not share.

Unlike most state benefit and provider mandates, designing and altering the EHB package will require no legislative action. PPACA specifies simply that the Secretary of HHS "shall define the essential health benefits" after commissioning some data collection from the Labor Department. (In the current process, HHS also turned to the Institute of Medicine for advice in crafting the EHB.) Since EHB is national, there will be no cross-state comparisons of costs and health effects of the actual EHB with any other design. According to the law:

> "The Secretary shall ensure that the scope of the [EHB] is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary." … In defining [EHB], the Secretary shall … ensure that such essential health benefits reflect an appropriate balance among the categories … so that benefits are not unduly weighted toward any category."

The Labor Department's survey of April 2011 cites problems with employer plan data. The document notes, for example, variation in how plans define items such as "infertility treatments." The report warns: "Unfortunately, this review indicated that it is not possible to produce reliable data for many of the services due to the lack of detail that characterizes many plan documents. Services may or may not be covered when they are not mentioned in plan documents." Hence, the Secretary will have to layer subjective judgment on top of inadequate data.

But even if the data were adequate, the vagueness of PPACA's instructions creates considerable uncertainty for small business. How is the Secretary to define a "typical employer?" Should a shoe store's employee plan depend on the "typical" coverage offered by an investment bank, a white-shoe law firm, a federal agency, or a union shipyard? Or, since EHB affects small businesses most directly, should the shoe store's requirements square with other small firms in the fully insured market? The Secretary's thoughts apparently carry the day.

What are "benefits typically covered?" Suppose 1/3 of the employers surveyed offer "Cadillac" coverage (high-end), while 1/3 offer what we can call "Corolla" coverage (middle-of-the-road), and 1/3 offer "Kia"

coverage (bare-bones, but decent). Does the Secretary decide that since 2/3 of employers offer Corolla coverage or better, then that should define the EHB? Businesses with Cadillac or Corolla plans will be relatively unaffected. Only those companies with the Kia policies will see their premiums rise, and it's likely that these will include many small businesses and perhaps especially start-ups. In other words, those hardest hit will be the incubators of America's job growth.

How finely will the Secretary define the required benefits? The Secretary's wide discretion is described in a bulletin from the American Cancer Society:

> "While it requires coverage for each of [ten] categories of benefits, the law does not name the specific services that must be covered or the amount, duration, and scope of covered services. The Secretary will define the specific benefits within each of the categories and will update the package to address gaps or to respond to changing medical practices. … [W]ill the Secretary determine how many counseling sessions are covered for smoking cessation, or whether medications are included, and which ones? Or will a plan be permitted to decide the number of covered sessions and medications? The Secretary will need to make critical decisions about the level of discretion to leave to health plans. … While the law enumerates certain considerations that must be taken into account, the Secretary retains wide authority in making determinations on covered services. And while the law requires an opportunity for public comment, it does not define a procedure for involving stakeholders like cancer patients, clinicians, or experts in cancer care. Advocates, therefore, will need to seek out opportunities to weigh in to make sure important benefits are included."

As an example of the lobbying to come, a Cancer Society spokesman wrote, "If a patient requires chemotherapy every week for a year… they should not be hindered by an arbitrary rule about only getting 35 visits." In contrast, America's Health Insurance Plans urged HHS not to get into "the details of each category of care" and suggested that HHS permit restrictions on the number of visits in certain situations to hold down costs. Medical merits aside, these two policies have very different cost impacts. And small business shares the Cancer Society's concern that the law defines no procedure to involve stakeholders – including small business.

Section 1302 also requires the Secretary to update the EHB at least annually. When a new benefit is added, will outstanding insurance contracts have to comply immediately? If so, then insurers are going to have to build extra margins of safety into their premiums, and costs will rise.

**Conclusion**

The Essential Health Benefits package is a ganglion of uncertainty for small business. Disease and provider lobbies, with admirable intent, will tout the benefits of expanded coverage and ignore the costs. Small business will wonder how "typical coverage" is defined and who the "typical employers" are against whom they are measured. The jobs and the wages of their employees will depend on the whims of whoever happens to be Secretary of HHS at the time. They will look with envy as big business, labor unions, and governments go unscathed. And with certainty, their premiums will rise.

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## Small Business Health Care Wish List: Repeal and Replace

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*Altarum Health Policy Forum* (2/8/11)

For small business to flourish the Patient Protection and Affordable Care Act (PPACA) must go away, and—equally importantly—the status quo that preceded it must never return. The laws of physics do not limit American health care to those two unacceptable choices. And, unfortunately, productive discussion of health care reform ends whenever a PPACA supporter begins a sentence with, "Does that mean you want to go back to the days when… ?" The answer is almost certainly "No," and the question itself distracts us from more fruitful discussion.

To start a real dialogue that leads to real reform, here's the small business position: The past was awful, the present lies somewhere between no-better and much-worse, and the future can be bright if sensible replace follows blessed repeal.

**The Past: Unmourned**

Small business holds little nostalgia for the status quo that went on life support March 23, 2010, and is now drawing to an unmourned close. For a full generation, the rising financial costs of health insurance have strained the capacity of small business to grow and create jobs. The administrative burdens of purchasing and managing policies are a serious distraction. The small-group insurance market is inefficient, and in many states, there is little competition or choice. (Several states have near-monopolies in the small-group market.) Tiny risk pools mean that small-group premiums can go through the roof if a single employee becomes ill.

Small businesses generally don't have human resources departments, so the burden of decisions usually falls on the owner who, in most cases, has no special understanding of insurance. Between renewals, problems with employees' coverage fall on the employer, distracting attention from running the business.

The small-business market is dynamic and depends heavily on the ability to find and hire good employees when the time is right. The old status quo limits this ability. A prospective employee may refuse an offer because changing jobs means leaving a trusted family doctor or giving up an important benefit in the prospect's current policy.

In answer to the question (hopefully unasked): Small business does not wish to return to the days when (fill in the blank).

**The Present: Unaffordable**

The hopes of small business were dashed when PPACA headed from the Capitol to the White House. The past year has shredded claims that the new law would rein in health care costs—especially for small business. New administrative burdens (e.g., 1099s, employer mandated documentation, etc.) are suffocating. Competition and choice in the insurance markets began to decline almost immediately.

Portability will remain limited for most small-business employees purchasing in the group market—impacting the employers' ability to hire the employees they need. In 2014, they'll have access to

coverage, but a change of jobs may still mean changing doctors, hospitals, etc. For people with pre-existing conditions, the good news is that they'll have access to coverage; the bad news is that they may not be able to afford that coverage, and their employers may not be able to afford them.

The idea that PPACA will cut costs is dead. A month after the bill became law, the Congressional Budget Office issued caveats about pre-passage forecasts. Soon thereafter, the Centers for Medicare and Medicaid Services warned that: (1) Supposed Medicare savings were double-counted; (2) The long-term finances of the Community Living Assistance Services and Supports Act (CLASS Act) were financially unstable from the outset; and (3) Another round of "doc-fix" is likely to overturn implied Medicare savings. In January 2011, the CMS Actuary reiterated and amplified these concerns.

PPACA drops new costs directly or indirectly on small business. Multi-billion-dollar brand-name drug tax. A 2.3 percent medical-device tax. A 0.9 percent "Medicare" payroll tax. A 3.8 percent "Medicare" investment tax. A 10 percent tanning tax. An undetermined number of new federal benefit mandates are overlaid on existing state mandates (estimated at 2,156 in 2010). Perhaps 80 percent of small businesses (by administration calculations) will lose their current coverage because of hair-trigger grandfathering regulations. And nothing in the bill touches our ineffective, inefficient, intrusive malpractice system.

The infamous 1099 provision has now been decried by business owners, the IRS Tax Advocate, Republican members of Congress, Democratic members of Congress, and the President. The employer mandate even penalizes some employers who provide coverage. All Americans face the unprecedented individual mandate. Employee subsidies will trigger employer penalties and in the process, violate the financial privacy of both.

The fabled small business tax credit can, as advertised, offset "up to 35 percent" of a small firm's insurance costs. But only the smallest, lowest-paying businesses will get 35 percent. Most will get nothing. Those who get something will likely get less—perhaps much less—than 35 percent. The percentage erodes if a company hires more employees, pays more generous wages, uses part-timers, hires family members, or offers more- generous-than-average coverage. (e.g., 18 employees, average wage + average wage of $38,000 = zero credit.) Most importantly, the credit automatically repeals itself by 2016.

Together, these shortcomings encourage businesses to downsize, to lay off employees, to shift from full-timers to part-timers, and to avoid hiring individuals who are likely to obtain subsidies and trigger penalties on the employer (a single mother for example?). Repeal is a necessity.

**The Future: Undeterred**

So how do we begin to make things better? We could start with items that small business asked for in the years leading up to PPACA and then add some new ones.

Begin by leveling the tax treatment of people buying insurance in the group and individual markets. The current tax code effectively locks individuals into employer-based plans, limits their portability, and disadvantages them when they become unemployed. It lessens the incentive for individuals to become smart, well-informed shoppers in insurance and provider markets.

Reduce the benefit mandates that drive up the cost of insurance. PPACA makes the problem worse by empowering the federal Department of Health and Human Services to lay an extra layer of mandates on top of the state-level mandates.

Enable employers to shift from defined-benefit to defined-contribution health insurance—similar to the shift from traditional pensions to 401(k)'s. Under a defined-contribution plan, employers could contribute tax-free toward their employees' health insurance purchases on the new health insurance exchanges. This would give employees the motive and power to apply competitive pressures on insurers.

Allow individuals to purchase health insurance across state lines, forcing insurers and regulators to compete against other states. Opponents of this idea fret about a "race to the bottom." Those making this argument assume, rather than demonstrate, that people will opt to save a penny rather at the expense of their health. And they can't cite any state that represents the dreaded bottom to which reckless consumers will race. Idaho and Utah have few benefit mandates but excellent health care.

Fix medical liability laws. Our tort system fails to punish doctors who truly commit malpractice, and it punishes many who practice excellent medicine on patients who happen to suffer adverse events. This increases costs, pushes doctors into defensive mode, and frays doctor-patient trust.

Enable those who depend on the individual market (the self-employed, for example) to get insurance, even when they have pre-existing conditions. The PPACA accomplishes this by bludgeoning employers and individuals with mandates. There are less intrusive ways to accomplish this goal.

These ideas are just a start. We just saw Democrats and Republicans seated together at the State of the Union. Perhaps it's time that they do the same with health care.

**Conclusion**

The wheels began to fall off of PPACA as soon as it left Union Station in Washington. Big companies prepared for billions in new costs and revealed drawing-board plans to drop coverage. CBO and CMS undermined the law's numbers. Grandfathering became moot for most small businesses. Child-only policies vanished. A White House teleconference was warned "Don't … say the law will reduce costs and deficit." Some providers began layoffs. It is in the interest of both political parties now to devise a better choice than either PPACA or the pre-PPACA status quo. The challenge is to get it done—and soon.

## Health Reform — New Burdens for Small Business

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Health care reform is now the law of the land, and the rollout has begun. If the law stands without major revision, only time will tell how it ultimately affects health care costs, coverage, and quality. Like everyone else, I have my own thoughts, but opinion and forecast must give way to reality. Congressional Budget Office and Centers for Medicare & Medicaid Services scores prepared before the reform legislation passed are now museum pieces. Without a doubt, however, the new law radically alters the environment for small business, and some firms will struggle to survive the changes.

The new law complicates small firms' administrative burdens, their access to capital, and their capacity to estimate input costs. Few of the smallest firms have human resources, accounting, or legal departments to help them adapt. Hence, they rely heavily on outside advisors: brokers, CPAs, attorneys, and others. Time will also tell whether this network of outside advisors is up to the task at a price that small businesses can afford. If not, this shortcoming will have serious macroeconomic ramifications given the immense role that small business plays in job creation.

Like all firms, small businesses will face a heavy dose of new reporting requirements. But again, most will do so without the benefit of specialized departments to handle the load. The best example concerns Internal Revenue Service Form 1099. At present, if a firm pays $600 or more for services from an unincorporated vendor in a year, it must mail the vendor and the IRS a Form 1099. At present, purchases from corporations are exempt from this requirement; in 2012, the new law drops the exemption.

So, if Sue's Flower Shop pays $25 for supplies from two locations of a chain hardware store every other week ($25 x 26 = $650), Sue has to obtain a taxpayer ID number, aggregate her purchases over a year, and mail the store and the IRS the 1099. But what if the hardware store fails to send her their taxpayer ID? What if the ID number is typed incorrectly? If the two locations are franchises, are they still considered part of the same corporation? How much time must she devote to tracking down this information from her many vendors? How difficult will it be to aggregate hundreds, even thousands of payments each year by vendor? Who is at risk when errors are made? These and hundreds of other questions will be subject to years of regulation writing, interpretation, education, and enforcement. Those who have not worked in a small business may not adequately understand how disruptive and expensive these microscopic reporting requirements will be.

The new law also exacerbates the difficulty that small firms are encountering in accessing credit. Small firms have relied heavily on real property equity for collateral, and much of that equity has been consumed by declining property values. Beginning in 2013, individual filers earning more than $200,000, and joint filers earning more than $250,000, will be subject to an additional 3.8 percent tax on investment income (such as dividends from the business or gains on the sale of capital assets). This additional tax will induce an indeterminate number of potential investors to place their capital elsewhere.

The new health insurance exchanges will offer firms opportunities and risks. Their subsidy structures are complex and, in a number of ways, will make it difficult to predict the cost of labor inputs. Here's an example: When a firm goes from 50 to 51 employees, it runs up against the law's employer mandate

and its arcane rules. Suppose a firm with 80 employees does not offer health insurance but instead sends its employees into the new health insurance exchanges to purchase coverage. As long as none of the employees' household income falls below 400 percent of the federal poverty level, the company incurs no fines. Now suppose one employee's wife loses her job at another firm, so the family's combined income drops below that roughly $88,000 mark. At that moment, the company incurs a $100,000-per-year fine ($2,000 x 50 of the 80 employees). This employer's annual profit will now depend heavily on the employment and wage decisions of some other firm and on whether an employee is married. (The potential employee privacy issues are troubling. In effect, your employer now gains the right and need to know personal information about your family status and your spouse's income.) One way for a firm to avoid these complications is to simply avoid growing past the 50-employee mark—not a useful incentive for hiring given today's high unemployment.

The 1099, the payroll and investment taxes, and the subsidy structure are only a few of the myriad complications that the health care law brings to the life of a small-business owner. Notice that the potentially disruptive changes described here have little or nothing to do with improving health care or business efficiency. At the very least, small businesses will need a whole new information infrastructure to deal with all of these issues. For some, the cost will be too much; they and the jobs that they provide will simply be lost.

Finally, it's worth noting that many physician offices, laboratories, and other health care providers are themselves small businesses. The increase in administration, taxation, and uncertainty will affect these businesses as well. Like other small businesses, some will not survive the changes. And that will occur at the very moment that an estimated 30 million people gain health insurance and, hence, access to health care. Supply-side constraints could push costs upward; for small businesses, high costs were the problem in the first place.

Small businesses can be fragile things. For many of our least advantaged residents, they are the entry point into the American economy. These firms will be severely tested as the new health reform law unfurls.