Statement of
Mr. Raymer M. Sale, Jr.
President
E2E Benefits Services, Inc

before the
Committee on Oversight and Government Reform
U.S. House of Representatives

November 25, 2013

Good Morning.

My name is Raymer Sale and I am a small–business owner from a suburb of Atlanta called Duluth. I own an insurance agency called E2E Benefits Services, Inc. with a staff of 9. I am here to share with you the issues my clients are facing as they strive to comply with healthcare reform.

I would like to thank the House Committee on Government Oversight and Reform and Chairman Issa for inviting me here today and for electing to hold this public hearing. The impact of the Patient Protection and Affordable Care Act (PPACA) and the new costs it will impose on small–business owners and individuals will be profound.

Only now is the public beginning to see the intended and unintended consequences of the Patient Protection and Affordable Care Act. It wasn't until October 1 that consumers began to receive cancellation notices and were exposed to the higher cost of purchasing health insurance. The problems with Healthcare.gov only added fuel to the fire.

The insurance community has known from the very beginning that prices were expected to increase because of the required additional benefits; however, talking about the prospective increase in the cost of health insurance pales in comparison to showing someone the real numbers. These numbers weren't available until recently.

When an insurance company is required to add a benefit there is a cost associated with that new benefit. The mandated wellness benefits were responsible for a 1% to 2% increase in the cost. The contraceptive benefits were added, followed by the Minimum Essential Benefits. These are followed by the PCORI, Reinsurance and Health Insurance Taxes, which are being passed through to the consumer adding an additional 3% to 4% to the premiums. Our largest client saw their premium increase by over $10,000 per month due to the added tax burden alone. The costs directly tied to mandated benefits have

resulted in an overall increase of approximately 10%. Employers, both large and small, and individuals are seeing these increases in their premiums.

Since 2014 rates became available last month, we have quoted both 2013 and 2014 rates to our individual clients. In almost every case, the 2014 rates have been 50–100% higher. Although the ability to obtain coverage for previously uninsurable conditions is a good thing, it comes at a sometimes steep price. The bottom line is there is no free lunch.

In addition to the points above, since 2010, my agency has spent thousands of dollars to purchase the tools and modify software to help our clients weave through the compliance requirements of PPACA. Additionally, we have spent countless dollars and hours on education, so we could better understand a very complicated law.

This law is heavy with penalties and opportunities for the employer to be fined for failure to comply. The first such opportunity came in 2010 with the Age 26 notice to employees, and many more such requirements continue to appear. Making things even more complicated and costly, requirements have frequently changed, often at the last minute. After many advisors, including my agency, invested significant capital in software to prepare for the "Play or Pay" mandate, that mandate was delayed. Similarly, we spent several days preparing the October 1 notice to employees concerning the existence of the Marketplace. This notice included information about the projected penalties. We didn't send this notice until late September to hopefully incorporate any changes that might be made, but the same day we sent it the information came down that there would be no compliance penalty. When you add to issues such as these the confusion and misunderstanding of the law and its requirements, the costs continue to add up. All of this takes time, and time is money.

For the employer, the associated costs are even greater. The insurance companies began this past summer to offer employer groups the opportunity to renew their existing policies early in order to keep their current benefits and rating structures. These renewals were offered primarily for December 1, 2013 to extend through December of 2014. Maintaining the current policies also gives the government time to see what will and what will not work as the law is implemented and its real world effects become apparent. These early renewals have just served to further confuse employers and have resulted in higher administrative expenses. The end result has been that employers are seeking every possible way to avoid the financial impact of the law and many of them have been successful, but they are really just postponing the inevitable. When they are finally faced with these costs, it is certain that jobs will be affected. Even now, we are seeing a few employers drop coverage altogether, some because of the uncertainly and some because of a prevalent misunderstanding that their employees can now go to the exchange and get "free" coverage.

One of the most costly administrative expenses added to an employer involves the way a group client is now billed. Prior to 2014 companies were usually billed in four tiers – employee only, employee/spouse, employee/child(ren) or employee/family. Unless they had less than 10 covered employees (and sometime even then), the rates would be the same for any employee falling into a given tier. PPACA is now requiring that the community rates mandated for small business be age–billed. Each and every participant in the plan, the employee, the spouse and each child, must have their own line item billing rate. Therefore a group of 45 covered employees may go from 45 billing lines to be reconciled to well over 100. Additionally, much more information including Protected Identity Information, must be gathered, maintained and secured.

Another unintended consequence is that of participation. The reason many employers don't currently offer coverage is that they cannot get enough of their employees to purchase coverage to meet participation requirements. These requirements are not going away and with many employees dropping coverage to try to purchase subsidized coverage or just because the rates have increased so much they will only get that much harder to meet. This will cause more employers to drop coverage altogether, again increasing rather than decreasing the number of people uninsured.

These are some of the issues facing most of our clients. Following are real life scenarios involving actual individual clients:

1. An employer group of 49 FTEs received an offer of early renewal. This client has three separate plans for employees to choose from and the offer called for 11–26% increase in premium to early renew these plans. In comparing this to what the renewal would be if they waited for their scheduled February 1, 2014 renewal, we found that some of the employees would receive a decrease beginning February 1, 2014 but some would receive a much greater increase. There were two employees particularly whose rates would increase from approximately $591 per month to over $1,018 per month, a 72% increase.

2. A rural Georgia client has reluctantly accepted the early renewal offer even though it carried a significant increase in premium. This decision was based partly on the fact that they like their current benefit structure, which was chosen to best serve the needs of their particular employees, and wanted to keep it. This employer has more than 50 FTEs and will be faced with "Play or Pay" in 2015. This employer is in the nursery business and pays approximately 75% of the employee premium. Many of the employees chose not to be covered due to the cost. Beginning in 2015 the employer will be required to offer coverage that is affordable. The law requires employees to either accept this coverage, or to purchase coverage from another source. So, let's look at an example of offering affordable coverage. Let's assume the employee is making $8.00 and

works a minimum of 40 hours per week. This employee will receive a gross income of $1,387 per month. 9.5% is $132 per month the employee can be charged for employer offered group medical insurance. This is more than he would pay for the current coverage and yet he's opting out. I expect he is making a financial decision to house and feed him family instead of purchasing coverage, but in 2014 he will be mandated into coverage. Now let's assume the employee has a spouse and dependent children. The employer's offer of coverage only has to meet the affordability test of offering the employee coverage that doesn't exceed 9.5% of the employee's income without taking into account how costly it may be for the employee to find additional coverage for his spouse and child. The employer is not required to offer "affordable" coverage to spouses or dependent children, and that coverage can lawfully be at a cost well above 9.5% of the employee's income.

3. A roofing contractor has 42 full-time employees and no part-time. This is down from 49 full-time employees 2 months ago. They are not replacing employees who leave because they don't want to run the risk of reaching 50 employees. Rather than become subject to "Play or Pay", they have already decided that they will supplement their labor force with part-time helpers and apprentices whose hours will be strictly monitored not to exceed 30 hours a week. Their first thought was to pay $200 month for each employee to purchase coverage through the exchange, where many would qualify for a subsidy. However, IRS Ruling 2013-54 removed that option for assistance when it clarified that an employer can only help an employee with individual health insurance premium if that contribution is treated as salary in every way, including paying FICA and other taxes, being figure into COLA increases, etc. So their hands are tied when it comes to helping their employees obtain health insurance.

4. A client in the entertainment retail industry has converted a significant portion of their staff to part-time to avoid having to offer them coverage.

Some of the situations our individual clients find themselves in are even more alarming, as evidenced here:

1. We have had numerous clients come to us seeking individual health insurance because they were covered as retirees by a former employer who is now dropping retirees from coverage.

2. A large national company who has multiple franchise-model offices throughout the country announced that effective January 1, 2014 they will no longer allow the franchise-employed personnel access to their health insurance plan, which in turn caused the franchise owners to cease to offer coverage since most are fewer than 50 FTEs. This left thousands

of previously–insured individuals without coverage.

3. A client is seeking individual coverage because the husband's employer, in another state, has about 100 FTEs, and is choosing to drop coverage. They are going from paying the full cost of family coverage to paying $400 per month in salary increase on the mistaken belief the employee can go the exchange and purchase coverage easily for that. We do not believe they are aware of the fine for each employee who accesses exchange coverage, nor are they aware of what the true costs are for an employee such as this one who earns slightly over 400% of FPL.

4. Many more individuals are losing coverage and would qualify for a subsidy to ease the cost burden, but they are terrified they will be uninsured January 1, 2014 because they can't afford the high 2014 premiums and cannot access the subsidy due to the numerous glitches in the healthcare.gov site. These are responsible individuals who want coverage and are willing to pay as much as they can for it but they are being left without viable options.

The examples cited here are not unique. These are the kinds of issues we are facing every day as Americans struggle to understand and comply with the changed world of purchasing health insurance. I truly appreciate the opportunity to appear before this committee and provide testimony. I consider it an honor to be here and a privilege to be able to help our elected representatives become more informed about how healthcare reform is impacting business owners and individuals in our state. If you have any questions, or I can be of additional assistance to you please do not hesitate to contact me.

Thank you.