



Statement of the U.S. Chamber of Commerce

ON: The Challenges Facing America's Businesses under the Patient Protection and Affordable Care Act

TO: The House Energy and Commerce Committee
Subcommittee on Oversight and Investigation

BY: Katie Mahoney
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The Chamber's mission is to advance human progress through an economic, political and social system based on individual freedom, incentive, initiative, opportunity and responsibility.

The U.S. Chamber of Commerce is the world's largest business federation representing the interests of more than 3 million businesses of all sizes, sectors, and regions, as well as state and local chambers and industry associations. The Chamber is dedicated to promoting, protecting, and defending America's free enterprise system.

More than 96% of Chamber member companies have fewer than 100 employees, and many of the nation's largest companies are also active members. We are therefore cognizant not only of the challenges facing smaller businesses, but also those facing the business community at large.

Besides representing a cross-section of the American business community with respect to the number of employees, major classifications of American business—e.g., manufacturing, retailing, services, construction, wholesalers, and finance—are represented. The Chamber has membership in all 50 states.

The Chamber's international reach is substantial as well. We believe that global interdependence provides opportunities, not threats. In addition to the American Chambers of Commerce abroad, an increasing number of our members engage in the export and import of both goods and services and have ongoing investment activities. The Chamber favors strengthened international competitiveness and opposes artificial U.S. and foreign barriers to international business.

Positions on issues are developed by Chamber members serving on committees, subcommittees, councils, and task forces. Nearly 1,900 business people participate in this process.

Statement on
“The Challenges Facing America’s Businesses
Under the Patient Protection and Affordable Care Act”
Submitted to
THE HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATION
By
Katie Mahoney
Executive Director, Health Policy
U.S. Chamber of Commerce
on behalf of the
U.S. CHAMBER OF COMMERCE
June 26, 2013

The U.S. Chamber of Commerce would like to thank Chairman Murphy and Ranking Member DeGette, and other members of the subcommittee for the opportunity to participate in today’s hearing. We appreciate this hearing’s focus on the challenges facing America’s businesses under the health reform law; it has been our focus for quite some time, dating back in fact to the legislative debate that began over 4 years ago. Indeed, it is critical that we understand how the law is affecting companies across the board – large and small – and that we do all we can to help business deal with the challenges.

I am Katie Mahoney, Executive Director of Health Policy at the U.S. Chamber of Commerce. I have more than 13 years of health care experience in hospital and health plan operations, as well as health policy. At the Chamber, I am responsible for developing and advocating the organization’s policy on health and working with members of Congress, the administration, and regulatory agencies to promote the Chamber’s health policy.

The U.S. Chamber of Commerce is the world's largest business federation, representing more than three million businesses of every size, sector and region. More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 71 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. We are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large.

The Chamber opposed the Patient Protection and Affordable Care Act ("PPACA") during the legislative debate because it does very little to control the rise of unnecessary health care spending. Instead, the law imposes benefit mandates, requirements, taxes and penalties that not only will increase the cost of coverage, but will also limit the flexibility that employers and employees alike need to choose coverage options that they can afford. Perhaps ironically, it was four years ago this month that the Chamber testified before both the House Committee on Ways and Means and the Senate Health, Education, Labor and Pensions Committee as to our significant concerns on these very points.^{1,2}

However, as we all know, the law's implementation continues. And as it does, it will be increasingly important to monitor and highlight whenever possible the effect the law is having on businesses and employees, as well as to the extent possible search for opportunities to provide relief. To be sure, the health care system was and continues now more than ever to be in dire need of reform. Our vision of reform continues to be one focused on improving the ability of all

¹ "Health Reform in the 21st Century: Proposals to Reform the Health System," The House Committee on Ways and Means, June 24, 2009.

² "Roundtable Discussion – Health Care Reform Legislative Options," The Senate Health, Education, Labor and Pensions Committee, June 11, 2009.

Americans: to access affordable health care coverage; to receive innovative and high-quality care; and to realize better health.

I would like to take this opportunity to reiterate our view that reform must not end here. While we continue to struggle with the implementation of the PPACA, we must also look to the future and strive to achieve true reform. Tomorrow, the Chamber will be releasing a report with proposals to advance access to affordable coverage and to improve health care value. While this will outline what needs to be done to improve the system, today's hearing focuses on the system created by the PPACA under the auspice of "reform." And that is where I will focus my remarks.

THE FACTS

First, let's consider the facts and statistics of employer-sponsored coverage prior to the enactment of the PPACA:

- Prior to the enactment of the PPACA, more than half of all Americans received health insurance benefits voluntarily provided by their employers.
- The employer-based system voluntarily provided health benefits to over 178 million Americans.
- Overwhelmingly, employees were satisfied with these benefits and want their employers to continue providing it to them.
- Further, employers were spending over \$500 billion on health benefits each year.

Recent analyses indicate that despite the goal of the employer mandate – ostensibly to increase employer-sponsored coverage – the PPACA is eroding the employer-sponsored system. There

are several work-force changes that employers are now being forced to make because of the law. These changes include not hiring new employees, canceling expansion plans, reducing employees' hours, and dropping health care coverage for their employees. In fact, when asked about these choices in a recent Gallup poll:

- 41% of small-business owners say they have held off on hiring new employees;
- 38% have pulled back on plans to grow their business;
- 19% have reduced their number of employees;
- 18% have cut employee hours in response to the health care law; and
- 24% have thought about eliminating healthcare coverage for their employees.³

In the same vein, the Chamber's Small Business Outlook Survey⁴ released in April 2013 found that:

- The requirements of the health care law are now the biggest concern for small businesses, having bumped economic uncertainty from the top spot which it had held for the last two years.
- Of small business respondents, 77% say the health care law will make coverage for their employees more expensive, and 71% say the law makes it harder for them to hire more employees.
- As a result of the employer mandate, 32% of small businesses plan to reduce hiring, and 31% will cut back hours to reduce the number of full-time employees.

³ Gallup, Half of Small Business Think Health Law Bad For Them, May 10, 2013, available at: <http://www.gallup.com/poll/162386/half-small-business-think-health-law-bad.aspx>.

⁴ U.S. Chamber of Commerce, "Q1 U.S. Chamber of Commerce Small Business Outlook Survey," April 2013, available at <http://www.uschambersmallbusinessnation.com/community/q1-2013-small-business-survey>.

To better understand precisely why employers are making these choices, which the Chamber and others forewarned about, there are still more statistics quantifying the underlying cause: the increasing cost of coverage.

- 55% of small-business owners expect the money they pay for healthcare to increase.⁵
- More than half of employers now feel that taxes on insurance companies and drug/medical devices will ultimately increase employer costs.⁶
- According to a survey of 996 individuals conducted in March 2013 by the International Foundation of Employee Benefit Plans, most organizations estimating costs associated with the ACA (88.3%) expect the law will increase their organization's health care costs this year.⁷
- The Diamond/Willis Health Care Reform Survey 2012-2013 (survey of more than 1,200 employers): 61% of survey respondents indicate that the total impact of all health care reform changes has increased costs.⁸

REAL-LIFE EXAMPLES

And these are not just statistics – we are hearing this from our member companies and have been for the past three years. In fact, we have had nine member companies testify on how the law will harm their business. These businesses run the gambit in size and industry ranging from a company with 10 employees to one with 1,000 employees, and include restaurants, service companies, entertainment companies, construction suppliers and remodeling companies.

⁵ Gallup, May 10, 2013.

⁶ Diamond Willis Health Reform Survey, 2012-2013, page 12, available at:

http://www.willis.com/documents/publications/Industries/Healthcare/HealthCareReformSurvey_2012_2013.pdf

⁷ International Foundation of Employee Benefits Plans, 2013 Employer Sponsored Health Care: ACA's Impact, Survey Results, March 2013, [http://op.bna.com/dlrcases.nsf/id/kpin-97vt56/\\$File/2103ACAImpactSurvey.pdf](http://op.bna.com/dlrcases.nsf/id/kpin-97vt56/$File/2103ACAImpactSurvey.pdf)

⁸ Diamond/Willis, The Health Care Reform Survey 2012-2013, February 2013,

http://www.willis.com/documents/publications/Industries/Healthcare/HealthCareReformSurvey_2012_2013.pdf

Individuals representing Chamber member companies that have testified in the House and the Senate since the enactment of the PPACA include:

1. Mary Miller, the owner of a Cincinnati based janitorial company with 320 full-time employees;⁹
2. Arnold Baker, the owner of a New Orleans concrete supply company with 60 employees;¹⁰
3. Dan Withrow, the executive of a Kentucky pallet distribution company with 10 employees;¹¹
4. Brian Vaughn, a Georgia franchisee owner of 4 Burger King restaurants with 182 employees;¹²
5. Phil Kennedy, the owner of an Oklahoma lumber company with 45 employees;¹³
6. Brett Parker, the executive of a bowling alley company with 6 locations in 4 states and 538 employees;¹⁴
7. Bill Feinberg, the owner of a kitchen and bath remodeling company in Fort Lauderdale with 40 employees;¹⁵
8. Scott Womack, a Ohio IHOP franchisee owner of 12 restaurants in Ohio and Indiana and 1,000 employees; and¹⁶

⁹ “Examining the Impact of ObamaCare on Job Creators and the Economy.” House Committee on Oversight & Government Reform, July 10, 2012.

¹⁰ “What Would the APA Do?” The House Committee on Judiciary, October 25, 2011.

¹¹ “Health Reform and Health Insurance Premiums: Empowering States to Serve Consumers, Senate Committee on Health, Education, Labor and Pensions, August 2, 2011

¹² “Small Businesses and PPACA: If They Like Their Coverage, Can They Keep it?” House Committee on Small Business, Subcommittee on Healthcare & Technology, June 28, 2011.

¹³ “True Cost of PPACA: Effects on the Budget and Jobs,” The House Committee on Energy and Commerce’s Subcommittee on Health, March 30, 2011.

¹⁴ “The Pressures of Rising Costs on Employer Provided Health Care,” The House Committee on Energy and Workforce Subcommittee on Health, Employment, Labor and Pensions, March 10, 2011.

¹⁵ “Putting Americans Back to Work: The State of The Small Business Economy,” The House Committee on Small Business, February 16, 2011.

9. James Wordsworth, the owner of a Virginia restaurant with 200 employees.¹⁷

To be sure – as the hearings’ titles suggest – these business owners know that:

- ObamaCare will have a detrimental impact on job creators and the economy;
- Regulations implementing PPACA are discouraging growth;
- Health reform is increasing health insurance premiums;
- Small businesses can’t keep their coverage, even if they like it;
- The true cost of the PPACA is having a damaging effect the budget and jobs;
- The law is increasing the pressures of rising costs on employer provided health care;
- The health reform law will curtail the ability to put Americans back to work and the small business economy;
- The health care law is negatively impacting jobs, employers, and the economy; and
- The small businesses consensus is that the PPACA is harmful.

And the feedback we have heard certainly doesn’t end there. My colleagues and I, both at the Chamber and in other employer associations, are constantly invited to talk with member companies, industry trade associations, and local and state chambers of commerce about the law. The appetite for accurate information continues to be voracious. What is perhaps most shocking during these speaking opportunities is the complete confusion around the country as to what the law will require of business. While we arrive ready to explain recent regulatory developments such as the affordability safe harbors and options for verifying minimum value, we find ourselves still explaining the basics of the law, such as what constitutes an “applicable large

¹⁶ “Health Care Law’s Impact on Jobs, Employers and the Economy,” The House Committee on Ways and Means, January 26, 2011.

¹⁷ “Common Ground: Finding Consensus on Health Reform, the Small Business Perspective,” The House Committee on Small Business, June 3, 2009.

business” and why in some states an applicable large business would be buying coverage in the small group market. Instead we focus on the bare basics which are still very confusing. As we try to explain, there are basically four scenarios that an employer could face:

- An employer falls under the 50 full-time equivalent employee (“FTE”) threshold and is not an applicable large employer.
 1. The employer is not required to offer coverage and doesn’t.
 2. The employer is not required to offer coverage but does. Unfortunately in order to offer coverage, they have to now purchase a plan that complies with a myriad of benefit requirements that make all coverage options in the small group market more expensive than the modest and affordable coverage options that were available in the past.
- The employer has more than 50 FTEs and has to offer coverage to all full-time employees and their children under 26 years of age.
 3. Employer offers affordable, minimum value coverage.
 4. Employer doesn’t offer affordable, minimum value coverage.

Despite these simple sounding scenarios – the outcome under each scenario is complicated by two subsequent factors: the penalty trigger and the penalty calculation.

Trigger: The penalty for an applicable large employer is triggered when one full-time employee, without access to affordable, minimum value employer-sponsored coverage who is not eligible for Medicaid, obtains a premium tax credit and uses it to purchase coverage on the exchange.

Penalty Calculation: Once the trigger is tripped, the calculation determines the penalty. This is where we see lots of blank stares because there will be situations, where an applicable large employer is required to offer coverage and doesn't but is not penalized and where an applicable large employer is required to offer coverage and does but is penalized. There are two calculations that are used when the trigger is tripped which depend on the employer's decision on offering coverage.

- If an applicable large employer offers coverage (any coverage, not necessarily affordable or minimum value coverage) to all full-time employees and dependents, and the trigger is tripped, the calculation is:
 - \$2,000 x (total number of full-time employees minus the 30 full-time employees).
- If an applicable large employer doesn't offer coverage to all full-time employees and their dependents, and the trigger is tripped, the calculation is the lesser of:
 - \$3,000 x (number of full time employees receiving a premium tax credit) or
 - \$2,000 x (total number of full-time employees minus the 30).

All of this is even more complicated when you consider that the trigger requires an employee below 400% of federal poverty level ("FPL") to not only qualify but also use the premium tax credit to purchase coverage on the exchange. This may become increasingly less probable when the cost of coverage, even with the premium tax credit, is more than employees can afford.

WHAT ARE WE TO DO?

EDUCATE!

Clearly, the importance of this hearing is tremendous and while we will continue to speak with businesses in Washington and around the country about the new requirements that law imposes on employers, we are engaging in other ways too. With a law that has regulations that when

stacked reach 7 feet in height to date, the law itself is not *all* that you need to read to “know what is in it.” In several critical ways, we are striving to educate our members, regulators, legislatures and the public.

EDUCATING CHAMBER MEMBERS

First, for our members, we created a brand new website title “Health Reform Law 101” which has a variety of interactive resources. The website includes:

- “Employer Mandate” – an explanation of what the employer mandate is and how it works – including WHO has to offer coverage, WHAT is required to avoid the penalty, TO WHOM coverage must be offered, OR ELSE what could happen, followed by three example scenarios.¹⁸
- “Coverage or Penalty Chart” - a charted decision tree that outlines the employer mandate.¹⁹
- “Employer Mandate Calculator” - a two-step interactive calculator where businesses can assess their potential penalty under the employer mandate.²⁰
 - Step 1: Helps businesses assess if they are required to offer coverage.
 - A business enters the number of part-time hours worked in a month and the number of full-time employees to figure out how many FTEs they employ.
 - Step 2: Helps a business assess if they may have to pay a penalty.
 - If based on the calculation in Step 1, the business has more than 50 FTEs and is therefore an applicable large employer, the calculator begins a

¹⁸ https://www.uschamber.com/sites/default/files/file_attach/HealthcareEmployeeMandate_OnePager_Revised.pdf

¹⁹ https://www.uschamber.com/sites/default/files/file_attach/HealthcareEmployeeMandate_OnePager_Revised.pdf

²⁰ <http://www.uschamber.com/health-reform/calculator>

second step to help the business assess the potential penalty based on whether they offer coverage to all full-time employees and dependents and the number of full-time employees with household incomes between 100-400% of FPL who are not eligible for Medicaid.

- Clearly, it will be hard for many employers to know precisely how to answer each prompt on the calculator but it provides an educational resource and serves as a tool which businesses can use to run various scenarios and assess potential penalties.
- “Added Cost Table” – a chart that highlights the new taxes and effective dates to educate businesses on revenues raised by various tax provisions in the PPACA.²¹
- “Interactive Timeline” – a responsive tool that outlines when key provisions of the law will take effect and briefly describes each provision.²²
- “FAQ page” offers in depth answers and definitions to help business understand the nuances of the employer mandate.²³
- “Press Room and Video Pages” – provide links to Chamber publications and Chamber videos featuring members and chamber executives discussing health reform.^{24, 25}

These resources have been very well received. We have had 56,000 total views since the website was launched in October 2012. It is also worth noting that we have been working for nearly a decade now to educate our member companies on the benefits of workplace wellness programs and also have some material on this effort as well.

²¹ <http://www.uschamber.com/health-reform/added-costs>

²² <http://www.uschamber.com/health-reform/timeline>

²³ <http://www.uschamber.com/health-reform/frequently-asked-questions>

²⁴ <http://www.uschamber.com/health-reform/press>

²⁵ <http://www.uschamber.com/health-reform/video>

EDUCATING THE REGULATORS

Second, we have been heavily involved in educating the regulators by submitting comments and meeting with the Administration to highlight problems with the regulations promulgated to implement the law. We have filed 62 comments to date in response to regulatory materials ranging from 8 Interim Final Rules, 3 Final Rules, 20 Requests for Comments, 21 Proposed Rules, 1 Information Collection Request, 2 Amendments to the Interim Final Rules, 6 Requests for Information and 1 Frequently Asked Question. It is important to mitigate implementation burdens at every opportunity. For example, one key point that we are focused on now is encouraging the Treasury to use its discretion to not “tax the tax” but exclude the portion of premiums collected to pay for the health insurance providers fee from gross income for reporting purposes.²⁶ This important and feasible modification would save small businesses unnecessary premium increases of between \$45-70 billion over ten years.²⁷

EDUCATING MEMBERS OF THE HOUSE AND SENATE

Third, we have been educating members of the House and Senate about the impact of a number of provisions and are pushing for relief on several critical provisions. First and foremost, for business – our focus is on the employer mandate and how it will hurt employees, as well as employers. Particularly in this economy, employees want jobs and wages; they want to be able to earn a living. Instead, to avoid a penalty that will - for many - bankrupt the business, businesses are reducing their employee’s hours and therefore overall wages. The result, employees are not only not receiving health care coverage, they will now in many cases be losing full-time wages.

²⁶ Skadden, Arps, Slate, Meagher & Flom, “Annual Fee Imposed on Health Insurance Providers under Section 9010 of the Patient Protection and Affordable Care Act: Exclusion from Gross Income of Recoveries of the Fee from Policyholders,” page 1.

²⁷ Quantria Strategies, LLC, Prepared by Mary M. Schmitt and Judy Xanthopoulos, “Effect of the Health Insurer Fee in the Affordable Care Act (ACA) on Health Insurance Premiums” June 3, 2013.

To rectify this, we continue to push for changes to the employer mandate and believe that restoring the definition of full-time employment to what was commonly accepted before PPACA's enactment is a critical step.

EDUCATING THE PUBLIC

Fourth, our efforts to educate the public are likely going to be even more important in the coming months as the Administration begins its PR campaign. Instead of promising free care, we need to have an honest discussion about what the law does and does not do. Yes, an individual will no longer have to pay a copayment when they see a physician for preventive services but that does not mean the service is free. And to say that it is, is simply dishonest. Individuals will still pay for these services when they purchase health insurance to cover these services and in fact – the premiums to pay for the health insurance to cover these services with no copayments is likely to be higher. *Selling* the law to the public instead of *educating* the public about the law is going to lead to further confusion.

Beyond educating the public about the health reform law, we also need to have an honest conversation about the state of our country's entitlement programs. Medicare and Medicaid are on an unsustainable trajectory. Last week the Chamber began a national campaign to educate the public about the future of these programs face if we do nothing. Before we can even begin to talk about a solution, we must all recognize that there is a problem. To retort, as some did, that "the American people really do not want to cut benefits for Social Security, Medicaid and Medicare" is to further deny the problem. If the American people don't want to cut benefits, we need to address this problem proactively and rationally now.

PARTICULARLY PROBLEMATIC PROVISIONS

While the list of problematic provisions is long, there are a number that consistently rank as the most dire for business. These provisions each increase the cost of coverage and limit flexibility, contributing to the one-size fits all vision of health care coverage under PPACA. It is like requiring that all car manufacturers only build and sell cars with leather seats, DVD players, GPS systems, sunroofs, and seat and steering wheel warmers when many people prefer more modest cars at a lower price. I am not sure that people fully realize that the law places specific requirements as to what coverage can be sold in the individual, small group and even to some extent the large group market. There will no longer be plans for sale that cover a more modest list of benefits, and have varying deductibles. Depending on whether we are talking about the individual, small group or large group market, many of the plans that people liked are not or will not be available in 2014.²⁸ And clearly, as car-manufacturers know, the more comprehensive and extensive a product is, the more it will cost. Some of the provisions that are of particular concern to the business community, regardless of whether they purchase coverage in the small group or large group market include:

1. Essential Health Benefits: While all plans in the individual and small group market have to cover the essential health benefits (“EHBs”), plans in the large group market cannot include annual or lifetime dollar limits on any essential health benefits. Broad requirements for EHBs could inhibit the strategies that employers and plans are using to

²⁸ Of course in a superficial way it may be easy to blame the insurance companies for premiums increasing but it is important to acknowledge that these companies are having to comply with new benefit mandates and rating restrictions which will necessitate higher premiums. These new requirements include: no pre-existing condition exclusions, no annual or lifetime dollar limits on essential health benefits, no recessions, when children are covered on their parents’ plans they must be offered coverage until the age of 26, in the small group and individual markets plans must cover the essential health benefits. New rating restrictions prohibit plans from varying premiums: based on health status; beyond the age rating band of 3-1; beyond prescribed geographic rating bands and beyond a 1-1.5 variation for tobacco use.

support high-value care. For example, if EHBs are interpreted to include generous coverage for costly services where less expensive but effective alternative treatments or providers exist, premiums will rise significantly. Even though this provision most directly affects plans in the individual and small group markets and the individuals or businesses that buy them, there is an increasing ripple effect on plans and businesses purchasing coverage in the large group market not only as they struggle with how to control costs when they choose to cover essential health benefits but also as the regulations specify how minimum value is assessed.²⁹

2. Deductible limits: The law limits the size of deductibles that plans in the small group market can impose to \$2000 per individual and \$4000 per family which could severely limit some plans offered in conjunction with health saving accounts.
3. Out-of-pocket limitations: A uniform *cap on out-of-pocket maximums* potentially applies to all plans and will inhibit the ability of many plans with tiered networks to impose higher out-of-pocket costs when an individual receives treatment from a lower-quality provider.
4. Health insurance providers fee: The health insurance tax, as it is commonly referred to, will only be passed onto consumers in the form of higher premiums according to both the Congressional Budget Office and the Joint Tax Committee.
5. Transitional reinsurance fee: The transitional reinsurance fee is a fee imposed on all group health plans to stabilize the individual market for years 2014, 2015 and 2016. Regulations clarified the size of this fee would be \$63 per covered life, which is significantly higher than many businesses anticipated when the law was enacted.

²⁹ The minimum value NPRM issued on May 3, 2013 indicates that several methods are available to determine whether a plan meets the 60% minimum value requirement: the minimum value calculator; if the plan design mirrors the safe harbors in terms of deductibles cost-sharing and out-of-pocket limits; and certification by an actuary.

As a Chamber board member with a 30-year-old small business recently told me –

We have been providing health insurance for our 20 employees and their families at no cost to the employee, but our company-paid insurance premiums have gone up 96% over the past 4 years. I am concerned that the increased cost of the PPACA will require us to start passing on some of the cost to our employees and/or reduce other benefits like dental, vision, and life insurance and pay increases. I am concerned that the increase in essential benefits, the lowering of deductibles and out of pocket expenses, along with the many taxes (especially the Health Insurance Tax) will increase costs to a point that prevents us from continuing to pay the total cost of health insurance for our employees.

Then there are the continuously nagging concerns that persist not because the law dictates changes but because of indications that regulators and states may choose to require certain changes anyway:

1. Regulation of stop-loss: Because the law imposes many more new requirements on fully-insured small group plans, there is speculation that some small employers may choose to self-insure their group plans. There have been reports that the administration plans to potentially regulate stop loss coverage at the federal level by establishing minimum attachment points, prohibiting the sale of stop-loss policies to small businesses, or regulating stop-loss policies in the same way as small-group health insurance.
2. Challenges to ERISA pre-emption: Many states are considering legislation that would impose state fees, taxes, and administrative burdens on self-insured plans that have

historically held ERISA preemption from state mandates. This will only add additional confusion and costs to employer-sponsored coverage and should be prohibited.

CONCLUSION

Despite many promises that health reform would lead to lower premiums, improve access to affordable coverage and allow people to keep the plans that they have if they like them, we are continuing to learn the true ramifications of the law. While many predictions of how the law would work have not been met, we must all move forward – business, the regulators, members of Congress and the public to do what we can to mitigate the harm. Clearly, the law and the implementing regulations are very complicated regardless of whether you supported or opposed the law. What we must do is engage in an honest discussion to educate our country about the law and take every opportunity – regulatory, legislative, and educational – to reduce administrative burdens, preserve flexibility, and reduce premium increases. To that end we urge the regulators to adopt a compliance assistance approach as opposed to strict enforcement. We urge Congress to pass legislation that would restore common business standards for the definition of a full-time employee. We urge the public to be inquisitive and cautious as they assess the information available to understand the law. We urge business to continue to innovate and work within the confines of the laws to develop and offer coverage options that serve their employees.