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August 26, 2021

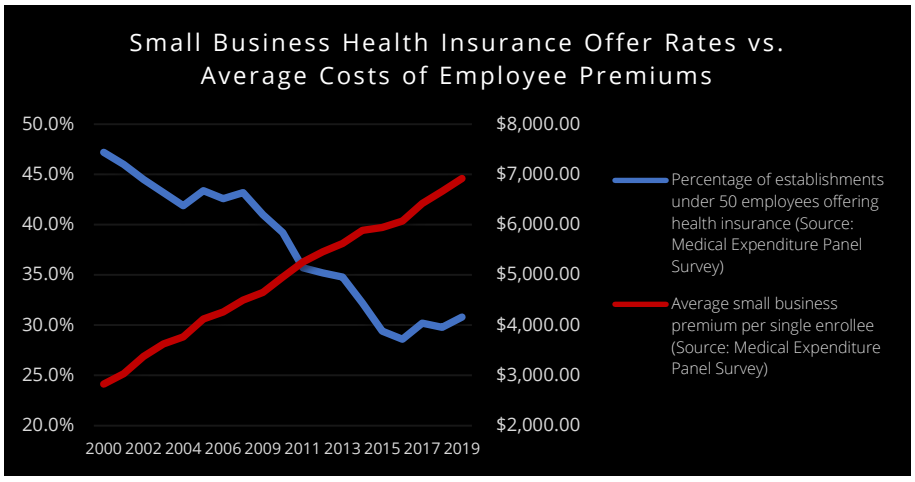
The Honorable Brett Guthrie
U.S. House of Representatives
2434 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Devin Nunes
U.S. House of Representatives
1013 Longworth House Office Building
Washington, D.C. 20515

Dear Representatives Guthrie and Nunes:

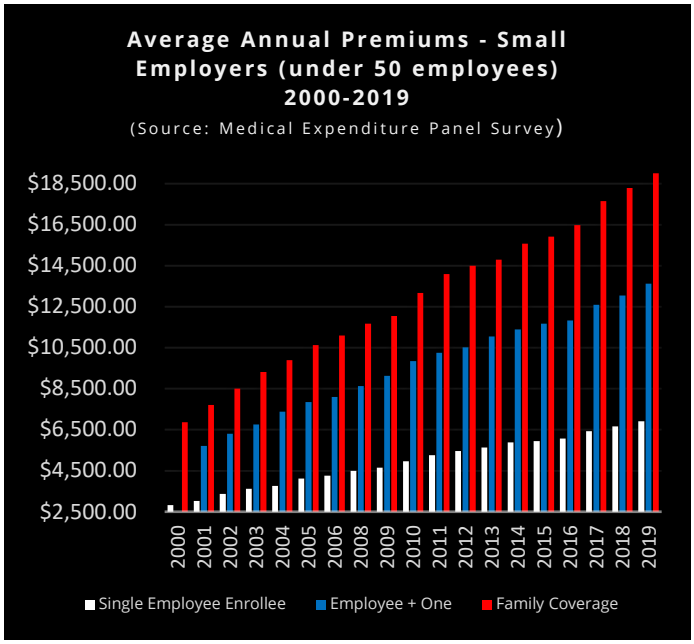
On behalf of NFIB, the nation's leading small business advocacy organization, I write to offer a small business prospective in response to Leader McCarthy's *Healthy Future Task Force*.

For over 30 years, NFIB members have identified the cost of health insurance as the number one small business problem with 50% ranking it as a critical problem.[1] Unfortunately, the problem continues to grow worse each year. Twenty years ago, almost half our nation's small businesses with fewer than 50 employees offered health insurance to their employees.[2] When the Affordable Care Act (ACA) passed in 2010, that number had fallen to just under 40%.[3] Today, it stands at just 30%.[4] As the below chart demonstrates, the strong relationship between cost increases and offer rates declining is easy to quantify.



[1] Holly Wade & Andrew Heritage, NFIB Research Center, *Small Business Problems and Priorities*, 2020, https://assets.nfib.com/nfibcom/NFIB-Problems-and-Priorities-2020.pdf.
[2] Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), *Percent of private-sector establishments that offer health insurance by firm size and selected characteristics: United States,* 2000, https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2000/tia2.htm.
[3] *Id.* (2010), https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2010/tia2.htm.
[4] *Id.* (2019), https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2019/tia2.htm.

Small business owners and their employees continue to struggle with expensive coverage options in both the small group market and the individual market.[5] For small businesses who can afford to offer coverage to their employees, obtaining coverage is complex and expensive with limited choices in insurance offerings.[6] Small business owners, who generally lack HR and compliance professionals, must navigate a maze of regulation and requirements.[7] Worse, due to increased mandates in the small group market, an uneven playing field, and a lack of bargaining power, small employers often pay more than their large employers to provide similar coverage.[8] This is a heavy burden on the very employers who can least afford it.



Failure to reform healthcare policy relating to small employers has major public policy implications. Small businesses account for 44% of the U.S. GDP, create two-thirds of net new jobs, and employ almost half of the American workforce.[9] Ever rising healthcare costs hurt small business growth and often limit employee compensation increases.[10] Further, employees of small businesses who cannot afford coverage often end up on Exchange Marketplace subsidized coverage, increasing costs to taxpayers and eroding employer sponsored coverage (ESI) as the bedrock of the American health insurance system. In many cases, small employers must also go to extraordinary lengths to make the current system work, such as staying under the ACA Employer Mandate threshold or finding employees who can obtain affordable health insurance from a secondary source, such as a spouse. All of these factors frequently put small employers at a competitive disadvantage as compared to their large peers both in hiring and employee retention.

Polling has consistently shown that Americans like their ESI coverage.[11] However, this support should not be confused with sustainability. Failure to control health insurance costs is pricing small businesses out of offering ESI, and high costs are driving significant and serious frustration among small business

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[5] 34% of small business owners are covered by an employer plan, 41% are covered by an individual market health plan, and 17% are covered through their spouse's plan. Holly Wade, NFIB Research Center, *Small Business's Introduction to The Affordable Care Act* (2015), https://strgnfibcom.blob.core.windows.net/nfibcom/nfib-aca-study-2015.pdf.

[6] *See* Kaiser Family Foundation, *Market Share and Enrollment of Largest Three Insurers – Small Group Market* (2019), https://www.kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-small-group-market/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[7] *See* Wade, *supra* note 5.

[8] *See* National Conference of State Legislatures, *Small and Large Business Health Insurance: State & Federal Roles* (Sept. 12, 2019), https://www.ncsl.org/research/health/small-business-health-insurance.aspx (noting that "on average, small businesses paid about eight to 18 percent more than large firms for the same health insurance policy.")

[9] SBA Office of Advocacy, *Small Businesses Generate 44 Percent of U.S. Economic Activity* (Jan. 30, 2019), https://advocacy.sba.gov/2019/01/30/small-businesses-generate-44-percent-of-u-s-economic-activity/.

[10] *See* Wade, *supra* note 5.

[11] *See* AHIP, *Employer Provided Coverage: A Consumer Perspective, Consumer Satisfaction Survey 2021*, https://www.ahip.org/wp-content/uploads/Value-of-EPC-Survey-Presenters-Deck-0321.pdf (finding 67% of Americans with ESI report overall satisfaction with their health coverage).

owners. This is leading proponents of single-payer and a federal public option to actively court small business owner support.[12] Although small business owners tend to be free market and private sector oriented, absent serious reform, the unsustainability of the current system has reached a point that the potential for growth in support of government solutions by small business owners should be taken seriously. Now is the time to act on reform to preserve the viability of the ESI system.

In short, NFIB believes strongly that providing stability and affordability to the small group and individual market as well as easing the healthcare regulatory burden must be a top goal of your task force. Small businesses deserve health insurance that is affordable, flexible, and predictable. We offer the following suggestions to help address these concerns:

Enhance the Ability of Small Employers to Offer and Afford Coverage

Promote the Continued Growth of Health Reimbursement Arrangements (HRAs)

Health Reimbursement Arrangements (HRAs) allow employers the ability to make tax-advantaged, defined contributions for employees to purchase their own health insurance or pay for medical expenses. This important policy, while still in its infancy, is an immediate solution to many of the core problems that small businesses face in offering employer sponsored health insurance benefits. Unlike a traditional group health insurance product, with an HRA, costs are generally predictable to employers, administration is relatively simple, and decisions about coverage and insurance carrier are put in the hands of the employee.

In 2013, the Obama Administration ruled that such arrangements were unlawful under the Affordable Care Act's prohibition on annual caps of benefits and threatened to fine employers $100 per day per employee for providing this avenue to affordable coverage.[13] Fortunately, in 2015, Congress came together in a bipartisan manner to reverse this decision with Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs) as part of the 21st Century Cures Act.[14] QSEHRAs give employers with fewer than 50 employees the ability to offer HRAs subject to maximum contribution caps.[15] Employees receiving an QSEHRA may still receive an ACA Exchange Advance Premium Tax Credit (APTC); however, it is reduced by the employer's QSEHRA contribution.[16] Thus, QSEHRAs offer an advantage to taxpayers who would often otherwise cover a larger share of the employee's coverage through APTCs. In short, this law protected small employers from draconian penalties and offered a new and flexible health insurance option. However, it contained limitations based on number of employees, capped contribution amounts, and provided limited flexibility to customize benefits based upon different types of employees.

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[12] *See, e.g.* Biden-Harris, *Protect and Build on Obamacare*, https://joebiden.com/healthcare/ (noting that a public option "will bring relief to small businesses struggling to afford coverage for their employees.").
[13] Internal Revenue Service, Notice 2015-17, *Guidance on the Application of Code § 4980D to Certain Types of Health Coverage Reimbursement Arrangements*.
[14] 21st Century Cures Act, Public Law 114–255, Section 18001.
[15] In 2021, the contribution caps are $5,300 for individual coverage and $10,700 for family coverage. *See* Healthcare.gov, *Health Reimbursement Arrangements (HRAs) for Small Employers*, https://www.healthcare.gov/small-businesses/learn-more/qsehra/.
[16] An exception to this rule is if the QSEHRA constitutes affordable coverage. *See* IRS, *Questions and Answers on the Premium Tax Credit,* Q19, https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit.

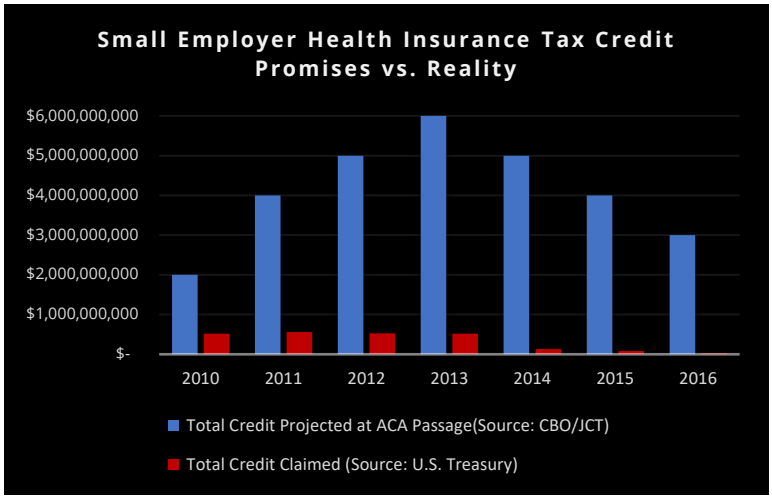
In 2020, the Trump Administration greatly expanded on QSEHRAs by issuing the Individual Coverage Health Reimbursement Arrangement (ICHRA) rule.[17] Under ICHRA, employers of all sizes may now offer HRAs at unlimited contribution amounts and comply with the ACA Employer Mandate as long as the offer is deemed sufficient to purchase affordable coverage. This regulatory change has the potential to revolutionize employer sponsored health insurance in the same manner that the 401k changed employee retirement. However, the policy needs time to grow as it became effective right as the COVID-19 pandemic began, and businesses need confidence that it will not be eliminated or substantially revised regulatorily.

Congress can help by codifying the ICHRA rule, which will provide the assurance of long-term stability to this important policy and will allow additional flexibility unavailable regulatorily in the rule making. Additionally, Congress can better harmonize QSEHRAs and ICHRAs, which have different rules and characteristics based upon their different origins.

Recommendation: Congress should provide long term stability to HRA policy by codifying the ICHRA rule. Additionally, Congress should continue to work with HRA administrators and business users to provide additional HRA flexibility and better harmonize ICHRAs and QSEHRAs.

Rewrite the Small Employer Healthcare Tax Credit to Make it Usable and Workable

The supposed cornerstone of help for small businesses to offer coverage in the ACA was the Small Business Healthcare Tax Credit.[18] Proponents of the ACA claimed the credit would assist millions of small businesses in offering affordable coverage to their employees. CBO estimated that the credit would peak at $6 billion in utilization.[19] Unfortunately, the promises of this benefit never came to fruition. Despite the affordability crisis growing worse after ACA passage, data on the credit from the IRS shows that utilization peaked at around $555 million in its early implementation before steadily declining to just $30 million in the last year data is currently available from Treasury.[20]



[17] Health Reimbursement Arrangements and Other Account-Based Group Health Plans, 84 Fed. Reg. 28888, Jun. 20, 2019, https://www.govinfo.gov/content/pkg/FR-2019-06-20/pdf/2019-12571.pdf.

[18] *See* Committee on Ways & Means, *Report to Accompany H.R. 3200*, https://www.congress.gov/congressional-report/111th-congress/house-report/299/2?overview=closed (noting "providing health insurance coverage is particularly challenging for . . . small business employers", "the cost of health insurance may be disproportionately large as a portion of payroll expenses [for small employers]," and that the tax credit was "designed to make the provision of health insurance coverage by small business employers of low-wage employees more affordable.")

[19] Congressional Budget Office, Letter to the Hon. Nancy Pelosi, *An Estimate of the Direct Spending and Revenue Effects of H.R. 4872,* (March 20, 2020), https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf.

[20] Internal Revenue Service, *Small Business Health Care Tax Credits Filed in Tax Years 2010–2016*, https://www.irs.gov/pub/irs-soi/17acasmallbusiness.xls.

As NFIB pointed out at passage of the ACA, the credit was poorly designed, being too short in duration and too restrictive in eligibility. The credit is only available for two years, meaning that every small business owner who takes advantage sees a large spike in their costs in year three. Furthermore, the credit phase outs (number of employees and salary limitations) are confusing and make projecting the effect of the credit difficult for small employers. Despite also having challenges, businesses with more than 25 employees were completely barred from participating. Finally, the credit is generally only available for plans purchased on the Small Business Health Options (SHOP) Exchange Marketplace, which has been extremely unpopular among small business owners[21] and is functionally non-operational in more than half of states.[22] All of these issues resulted in the vast majority of small business owners determining that pursuing the credit was too burdensome and not worth the benefit.

A better designed health insurance credit could provide an immediate source of relief to small employers struggling to maintain or afford coverage. Given the worsening of the situation, a workable Small Employer Healthcare Tax Credit is needed more now than it was in 2010. Unfortunately, while Congress has spent considerable time debating reforms to the individual market APTC program, little attention has been spent on the ACA's tax credit program designed for small businesses. If properly implemented, this credit could help keep small business employees on ESI and off the Exchange Marketplace, which should provide savings to the government in less APTC utilization.

An improved Small Business Healthcare Tax Credit could significantly aid millions of small businesses and their employees in the purchase and maintenance of ESI coverage. For this reason, Congress should revisit the Small Employer Healthcare Tax Credit and make it usable and workable.

Recommendation: Congress should rewrite the Small Employer Healthcare Tax Credit to make it widely available to small businesses under a simple formula and usable for plans on and off the SHOP Exchange Marketplace.

Level the Playing Field for Small Business Owners and Their Employees in the Purchase of Health Insurance

Equalize the Treatment of Small Employers with Large Employers in the Purchase of Health insurance

Small business owners and their employees face a competitive disadvantage to their large employer competition in the offering and purchase of insurance. Approximately 80% of large employers offer a self-insured group health product to their employees.[23] This allows large employers to generally escape regulation at the state level and under ACA coverage mandates. These large employers are thus able to better customize their insurance offerings, better manage their employee health risk pool, and offer a multistate insurance product.

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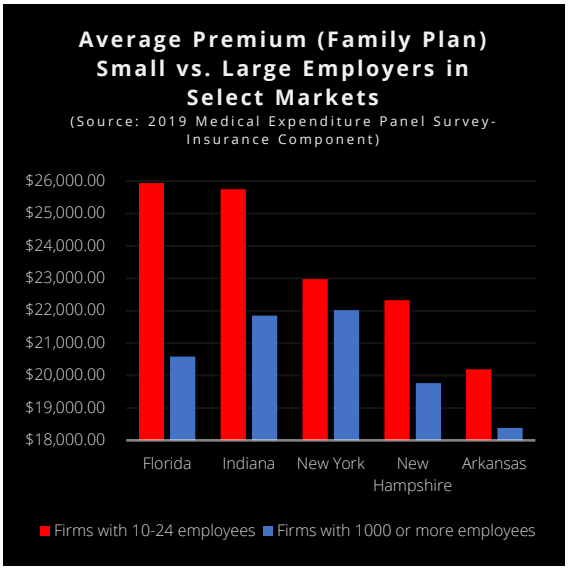
[21] *See* Government Accountability Office, *Private Health Insurance: Enrollment Remains Concentrated among Few Issuers, including in Exchanges* (March 2019), https://www.gao.gov/assets/gao-19-306.pdf (noting "SHOP exchanges in most states had little enrollment—that is, typically less than 1 percent of the overall small group market. For example, in 2016, Alaska's small group market had 17,257 covered life-years, while its SHOP exchange had 96 covered life-years (0.6 percent).").

[22] *See* Vanessa C. Forsberg, Congressional Research Service, *Overview of Health Insurance Exchanges*, (updated Fed. 16, 2021) (noting for plan year 2021 "there are no insurers offering medical plans in SHOP exchanges in more than half of states.").

[23] Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), *Percent of private-sector establishments that offer health insurance that self-insure at least one plan by firm size and selected characteristics: United States,* 2019, https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2019/tia2a.htm.



In contrast, most small businesses offering group health insurance must enter the state-based, fully-insured small group market.[24] These plans are heavily regulated by state law and subject to ACA mandates, which have been cited as cost drivers, such as essential health benefits (EHBs) and community rating.[25] Additionally, small businesses lack leverage to negotiate lower insurance premiums, even in comparison to their large peers in the fully-insured market. Research suggests that this can significantly increase costs for small businesses in offering similar coverage to their large competitors.[26]

Congress can help address this imbalance in several ways. First, Congress should look to deregulate the small group market at the federal level, providing a level of parity with large employers with self-insured plans. Second, Congress should provide the ability for employers to purchase health insurance across state lines, allowing states and insurance carriers with the best regulatory systems and products to attract out of state small businesses. Finally, Congress should expand the ability of small employers to band together to form Association Health Plans[27] that mirror the benefits that large employers presently receive.

Recommendation: Congress should level the playing field for small business owners by rolling back unnecessary mandates, with policies such as allowing interstate health insurance sales, and by increasing the ability of small employers to pool their resources in Association Health Plans.

Provide Tax Parity to Small Business Owners for Purchasing Health Insurance

Under federal law, self-employed individuals and small business owners are barred from treating their health insurance premiums as an ordinary business expense. Instead, they are subject to a complicated system in the deduction of health insurance benefits.[28] Although small business owners can generally

[24] Less than 15% of small employers are able to offer a self-insured product to employees. *Id.*
[25] Centers for Medicare & Medicaid Services, Office of the Actuary, *Report to Congress on the impact on premiums for individuals and families with employer-sponsored health insurance from the guaranteed issue, guaranteed renewal,and fair health insurance premiums provisions of the Affordable Care Act* (Feb. 21, 2014), https://www.cms.gov/research-statistics-data-and-systems/research/actuarialstudies/downloads/aca-employer-premium-impact.pdf (estimating that 65 percent of the small firms are expected to experience increases in their premium rates due to certain ACA provisions); U.S. Senators Ron Johnson and Mike Lee, *Dear Colleague Letter* (Jul. 19, 2017), https://www.ronjohnson.senate.gov/public/_cache/files/2c915f24-f868-4207-85ed-4d0d319c45e8/johnson-and-lee-dear-colleague-july-19a.pdf (containing a McKinsey study presentation prepared for HHS).
[26] *See* National Conference of State Legislatures, *supra* note 8.
[27] In 2018, the Trump Administration sought by rule to expand the use of association health plans under existing ERISA statutory authority. Unfortunately, in an effort to comply with ERISA, the rule contained a narrow definition of the "commonality of interest" necessary for employers to join together to offer health care coverage to their employees. Under the rule, an association can show a commonality of interest among its members on the basis of geography or industry, if the members are either in the same trade, industry or profession throughout the United States. This essentially barred non-industry-based trade associations, such as NFIB, from offering an association health plan on the federal level. The Trump Administration rule is currently tied up in litigation and may be repealed by the current Administration. Rather than codify the narrow Trump rule, NFIB recommends revisiting a broad-based bill, similar to what was considered in the House on multiple occasions prior to the Trump Administration rule. *See, e.g.* H.R. 1101, the *Small Business Health Fairness Act* (115th Congress).
[28] *See* 26 U.S. Code § 162(l)(4).

reduce their taxable income by the cost of health insurance premiums, they still must pay self-employment tax on this amount. This results in a structural unfairness for many of our nation's small business owners.

Congress should simplify and standardize the tax treatment of health insurance regardless of how an individual obtains coverage by passing legislation such as the bipartisan *Tax Fairness for the Self-Employed Act*.[29] This will provide additional fairness to the system and promote portability in coverage.

Recommendation: Congress should provide tax parity in the deduction of health insurance benefits between wage earners receiving ESI benefits, small business owners, and employees of businesses not offering health insurance.

Lower the Compliance Burden for Small Businesses Relating to Healthcare

Raise the Employer Mandate Threshold to 100 Full-time Employees to Ease Compliance and Promote Small Business Growth

The ACA implemented a complicated employer mandate system, known as the Employer Shared Responsibility Provision, requiring all small businesses with 50 or more full-time employees (including "full time equivalent" employees (FTEs)[30]) to offer health insurance to 95% or more of its full-time workforce or face significant and often draconian fines.[31] Employers subject to the mandate are considered "Applicable Large Employers" (ALEs).[32]

If an ALE does not offer health insurance to its full-time employees and at least one full-time employee receives subsidized coverage in the form of an APTC through the Exchange Marketplace, the business must pay a fine ($2,700 in 2021)[33] per full-time employee minus the first 30 employees. For example, if a business crosses the 50-employee threshold without offering coverage in 2021 and only a single employee receives subsidized coverage on the Exchange Marketplace, the business could owe an annual fine of $54,000 = 2,700 x (50 – 30). Additionally, even if the employer offers insurance, if the offer does not meet the definition of "affordable" or "minimum essential coverage", the employer may be fined (4,060 in 2021)[34] for each full-time employee who receives subsidized coverage through the Exchange Marketplace. These provisions and the IRS's developed safe harbors are so complicated that most small businesses must rely upon their insurance broker or carrier to ensure they are in compliance.

The employer mandate presents a number of serious challenges for small businesses. First, it fails to account for industry revenue differences, presenting a blanket idea that every employer with 50 or more full-time or FTE employees can afford to offer coverage. As a result, many small employers go to

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[29] H.R.4558, 117th Congress (Delgado/Salazar).
[30] An employer determines its FTEs by a complicated formula. It must combine the number of hours of service of all non-full-time employees (less than 30 hours) for the month but do not include more than 120 hours of service per employee. Then, it must divide that total by 120. Internal Revenue Service, *Determining if an Employer is an Applicable Large Employer*, https://www.irs.gov/affordable-care-act/employers/determining-if-an-employer-is-an-applicable-large-employer.
[31] 26 U.S.C. § 4980H.
[32] *Id.*
[33] Internal Revenue Service, *Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act*, Question 55, https://www.irs.gov/affordable-care-act/employers/questions-and-answers-on-employer-shared-responsibility-provisions-under-the-affordable-care-act.
[34] *Id.*

extraordinary lengths to keep their workforce under the 50-employee threshold to avoid the mandate. This unnecessarily holds back small business growth. Due to the complicated nature of the formula, other small employers are unwittingly snagged with massive fines. Often, IRS enforcement of the mandate can be delayed by years.[35] To make matters worse, the IRS is bad at administering the employer mandate, admitting that 82% of enforcement letters are resolved with the business owing nothing.[36]

The ACA instructed the IRS to begin enforcement of the employer mandate in 2014. However, given the massive burden of the statute on employers and the agency, the IRS did not enforce the mandate at all in 2014, enforced it only against certain employers with 100 or more FTEs in 2015, and provided additional transitional relief in 2016.[37] Congress should recognize that the employer mandate continues to pose numerous small business problems and challenges. To ease compliance and promote small business growth, the mandate should at a minimum be raised to only apply to businesses with 100 or more full-time employees.

Recommendation: Congress should raise the employer mandate requirement to apply to businesses with 100 or more full-time employees.

Define Fulltime Workers Subject to the Employer Mandate as those who work 40 Hours or More Per Week

As discussed above, the ACA requires employers with 50 or more full-time employees (including FTEs), to offer health insurance to their full-time workforce or face significant penalties. However, rather than use the traditional definition of 40 hours for full-time work, the ACA requires employees to use non-traditional definitions and complicated formulas to determine its full-time workforce and number of FTEs.

Under the ACA, a full-time employee is considered what most small businesses would traditionally call part-time. Specifically, a full-time worker is defined as an employee who has on average at least 30 hours of service per week or at least 130 hours of service during the calendar month.[38] A company must also determine its FTEs by combining the number of hours of service of all non-full-time employees for the month (but not including more than 120 hours of service per employee) and dividing the total by 120. However, the FTE calculation is only relevant to determining whether an employer is an ALE and subject to the mandate. Thus, an employer must calculate the number of FTEs it employs to determine if it is an ALE, but it only is required to offer coverage to its full-time workforce.[39]

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[35] *See Continued Oversight Over the Internal Revenue Service,* Committee on Oversight and Government Reform, 115th Congress 115-78 (2018), pg. 107-108 *(statement of Hon. David Kautter, Acting Commissioner, in response to questioning).*
[36] *See id.*
[37] *See* Valerie Jarrett, White House, *We're Listening to Businesses about the Health Care Law* (Jul. 2, 2013), *available at* https://obamawhitehouse.archives.gov/blog/2013/07/02/we-re-listening-businesses-about-health-care-law; Internal Revenue Service, *Shared Responsibility for Employers Regarding Health Coverage* (Feb. 2, 2014), https://www.federalregister.gov/documents/2014/02/12/2014-03082/shared-responsibility-for-employers-regarding-health-coverage; Congressional Research Service, *The Affordable Care Act (ACA): Notifying an Employer of a Potential Shared Responsibility Payment (ESRP)* (May 16, 2018).
[38] Internal Revenue Service, *supra* note 33.
[39] *Id.*

These definitions and formulas require small business owners, who often manage their own compliance work, to engage in complicated payroll decisions and calculations to stay under the employer mandate if they cannot afford to offer coverage or pay penalties. In many cases, small businesses can be forced to lessen employee hours in order to stay under the ALE definition. This can provide less work opportunity for small business employees both in available hours and job opportunities generally. Returning to the traditional definition of full-time work and eliminating the FTE definition or raising its hour threshold would greatly help with compliance and provide additional opportunities for small business employees. Legislation to this effect, the *Save American Workers Act*,[40] has passed the House on three occasions but unfortunately has never been considered in the Senate. Congress should again take up this important bill or similar legislation to help American workers and small business with ACA compliance.

Recommendation: NFIB supports legislation to define full-time work under the ACA as 40 hours per week and reform or eliminate the definition of full-time equivalent employees.

Eliminate or Reform Unnecessary Paperwork Requirements under the ACA

The ACA created a complicated paperwork and reporting system, primarily to enforce the individual and employer mandates, that is not useful and is outdated. Section 1514 of the ACA added sections 6055[41] and 6056[42] to the Internal Revenue Code, which require certain small businesses and ALEs to track multiple sources of information regarding employees and employees' health insurance coverage on a monthly basis and requires retroactive reporting of this information to the IRS on an annual basis. The ACA also requires employers of all sizes to provide a notice to employees about the availability of insurance through the ACA's health insurance Exchange Marketplaces, regardless of whether the employer offers affordable coverage to its employees.[43]

The paperwork imposed by sections 6055, 6056, and other ACA provisions consumes substantial amounts of the time, labor, and money of small business owners, diverting time, labor, and money from more productive activities and investment. Worse, employers continue to waste significant time on IRS and employee reporting to implement the individual mandate, which is effectively no longer applicable now that the individual shared responsibility provision has been eliminated.

Congress should take steps to examine the massive paperwork burden placed on small businesses by the ACA and should streamline the collection of information to the IRS and employees to ensure it is relevant and necessary for proper tax administration.

Recommendation: Congress should examine and overhaul the reporting and paperwork requirements of the ACA to ease compliance burdens on small businesses.

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[40] H.R.2575, 113th Congress (Rep. Todd Young); H.R.30, 114th Congress (Rep. Todd Young); H.R.30, 115th Congress (Rep. Jackie Walorski).

[41] 26 U.S.C § 6055 (requires self-funded employers – including small businesses with fewer than 50 full time employees – to file information returns to the IRS and provide each covered individual with a statement of coverage).

[42] 26 U.S.C § 6056 (requires ALEs to file returns with the IRS and provide each covered full-time employee with a statement of coverage).

[43] 29 U.S.C. § 218b. The Department of Labor has never enforced penalties for failure to comply. *See* Department of Labor, *Notice of Coverage Options FAQs*, https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/notice-of-coverage-options.

Promote Reforms to the Healthcare System to Lower Costs

Provide for State Innovation and Stabilization to Control Small Group and Individual Market Costs

The United States regulatory system of state-based health insurance markets has made control of the rapid cost growth in insurance premiums a challenge. While cost growth is universally a problem, the situation is worse in certain states and driven by different factors depending on the state market. Congress should provide solutions that empower individual states to address unique challenges in their small group and individual markets.

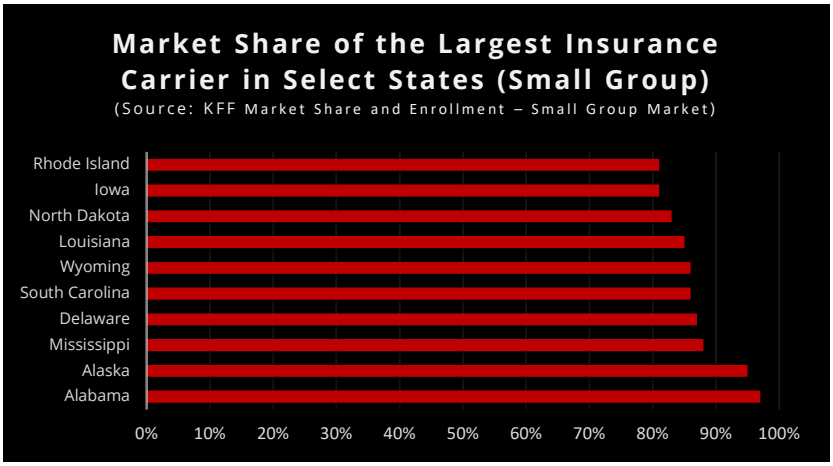
When Congress last considered broad reforms to the ACA in 2017, Republicans sought to address different state needs with proposals such as *Graham-Cassidy*, which would have block granted federal funds to states to allow individual states to design their own programs for state-based coverage assistance and stabilization. *Graham-Cassidy* and the *American Health Care Act* further proposed to increase the ability of states to apply for waivers of provisions of the ACA shown to increase costs.[44]

Congress should build upon this type of approach. Providing flexibility and resources to the states would address unique challenges, help the best ideas come forward, and allow new adaptable innovations to emerge. That said, Congress should recognize the individual market and the small group market both share many of the same problems in excessive costs, expensive mandates, and lack of competition. Consequently, new authority and any grant funding should provide maximum flexibility and should not overly limit states in addressing specific markets or issues.

Recommendation: Congress should provide for state innovation and stability programs that allow individual states to meet their unique challenges, both in the individual and small group markets.

Increase Competition, Transparency, and Marketplace Innovation in Healthcare

Small business owners continue to be frustrated by a healthcare system that offers limited choices, is opaque in pricing, and lacks the type of innovative offerings that lower costs in other types of markets. In many areas across the country, competition in health insurance carriers is almost non-existent with a single carrier dominating the small group and individual market.[45] This, combined with excessive state and federal regulation and limited bargaining power, can provide small businesses little choice other than to accept a small range of health insurance offerings that continue to grow in cost each



[44] Bill Cassidy, U.S. Senator for Louisiana, *Read About Graham-Cassidy-Heller-Johnson,* https://www.cassidy.senate.gov/read-about-graham-cassidy-heller-johnson; H.R.1628, *American Health Care Act of 2017*, 115th Congress.
[45] *See* Kaiser Family Foundation, *supra* note 6.

year. Problems in competition are not, however, limited to insurance providers. Often to improve their leverage in negotiation with dominate insurance carriers, health provider consolidation, particularly among hospitals, has rapidly increased over the last several decades.[46] Studies show that this consolidation has driven up costs without meaningful gains in quality of care.[47]

In addition to limited competition, price transparency in health insurance, provider services, and drug costs has traditionally been almost non-existent. Small business owners and their employees are often provided little information beyond the basic price of health insurance offerings and what providers, procedures, and prescription drugs are covered by their plan. This opaque system leads to unnecessary costs that wildly fluctuate depending upon the payer, prevents smart consumer shopping, and hinders market innovations and corrections in healthcare costs.

Fortunately, the Trump Administration made important strides in health price transparency with bipartisan support. In late 2019, the Administration finalized its *Hospital Price Transparency Rule*, which requires hospitals to make public a list of all the standard charges for all items and services and to display charges for the hospital's 300 most shoppable services in a consumer accessible format. Hospitals are further required to make public the gross charges, the discount cash price, the payer-specific negotiated charges, and the de-identified minimum and maximum negotiated charges for all items and services.[48] Data from this rule has already been illustrative, showing that hospitals in some cases are charging 10 times difference for the same procedure, depending upon the payer.[49]

The Trump Administration also finalized its *Transparency in Coverage Rule* in 2020, which requires health insurance companies in the individual and group markets to disclose cost-sharing information to a participant, beneficiary, or enrollee including an estimate of such individual's cost-sharing liability for covered items or services furnished by a particular provider. The rule requires most private health insurers to begin posting their negotiated rates by 2022.[50] Both rules should have a lasting effect upon the healthcare system.

Congress should continue to support additional competition, transparency, and innovation in healthcare in order to drive down costs and provide better value. This should include large scale changes, such as interstate insurance sales to increase competition and lower regulation, and smaller initiatives such as codifying the Trump Administration transparency rules to decrease legal uncertainty and obstinacy in compliance.[51] Congress should also continue work to bring better value, transparency, and pricing in the purchase of prescription drugs, a major cost driver.

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[46] *See* Karyn Schwartz, *What We Know About Provider Consolidation,* KFF, Sep. 2, 2020, https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/view/footnotes/#footnote-481999-26.
[47] *Id.*
[48] Department of Health and Human Services, Medicare and Medicaid Programs: *CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public*, 84 Fed. Reg. 65524 (Nov. 27, 2019).
[49] Anna Wilde Mathews*, How Much Does a C-Section Cost? At One Hospital, Anywhere From $6,241 to $60,584,* Wall Street Journal (Feb. 11, 2021), https://www.wsj.com/articles/how-much-does-a-c-section-cost-at-one-hospital-anywhere-from-6-241-to-60-584-11613051137?st=f9bjsgytcae3k5j&reflink=desktopwebshare_permalink&mod=article_inline.
[50] Department of Health and Human Services, *Transparency in Coverage*, 85 Fed. Reg. 72158 (Nov. 12, 2020).
[51] Morgan Henderson & Morgane C. Mouslim, *Low Compliance from Big Hospitals On CMS's Hospital Price Transparency Rule*, Health Affairs (Mar. 16, 2021), https://www.healthaffairs.org/do/10.1377/hblog20210311.899634/full/.

Recommendation: Congress should focus on additional health insurer and provider competition, codify the Trump Administration's regulatory price transparency efforts, continue to require additional healthcare transparency, and focus efforts to stimulate healthcare competition, curtail healthcare cost drivers, and promote innovation.

In closing, thank you again for the opportunity for NFIB to share our vision for a healthcare system that is more affordable, flexible, and predictable for small business owners. As you continue the important work of the *Healthy Future Taskforce*, NFIB looks forward to working with you to provide a small business prospective.

Sincerely,

Kevin Kuhlman
Vice President, Federal Government Relations
NFIB

cc: Members of the *Healthy Future Task Force*.