

Good Morning:

My name is Mike Ripley I am the Vice President of Health Care Policy at the Indiana Chamber of Commerce. The Chamber of Commerce represents a wide variety of Industry Sectors totaling approximately 5,000 employers that employ about 800,000 employees.

On behalf of those employers and their employees, I would like to thank the Interagency State Health Reform Task Force and the Daniels Administration for conducting this forum and providing the opportunity to comment on federal health care reform (PPACA).

David Wulf has provided you with specific concerns that he has from his perspective at Templeton Coal. I will attempt to provide general comments that I have received from our diverse group of employers.

The concerns over PPACA are numerous. As David previously mentioned we have members that believe there are too many things wrong with the legislation and support repeal. Others recognize that repeal may not be possible and support neutralizing any and all negative aspects of the legislation.

While businesses support PPACA's attempt to increase the number of insured individuals it is the increase in insurance premiums that reflect the underlying costs of care that employers are most concerned. With the exception of some Medicare cost containment provisions within the Act, businesses believe there is relatively little that contains costs for those who ultimately pay the freight for health care. Subsequently, the increased costs are passed along to our employees either through increased contribution participation or in higher deductibles and co-pays and in some cases not being able to provide coverage at all.

As David mentioned his company will see potential increases of more than 3% above normal trends. Generally companies are being informed by insurers to increase their trend lines 3-5 % among larger group markets and self-insured plans. The Small Group market will be exposed to the greatest increases in premiums. The 26<sup>th</sup> largest insurance agency in the United States located here in Indianapolis has indicated that based upon their book of business that impacts for Small Groups due to the extension of the dependant age 26 coverage and the prohibition of lifetime or annual coverage limits will require additional costs in the range of 7-15% to small group fully insured plans.

Accompanied with the concern of increased premiums is the notion that employers might find it less expensive to pay the per employee penalty than to continue offering health insurance to their employees. When you factor in that potential increase in premiums, additional administrative costs related to the W-2

minimum essential reporting provisions, any actuarial assessments of benefit values and presumable DOL and/or IRS audits that might potentially occur, the requirements that employers that have over 50 employees could be subject to fines if their employees elect to purchase from the Exchange; could ultimately lead to Cost Benefit Analyses' where employers throw their hands up and determine it's easier to pay the penalty. Granted the unknown factor in all of this is, will this put some employers at a competitive disadvantage with other employers because they do not provide coverage? However, from preliminary indications some employers have determined that they could discontinue providing coverage, pay the penalty, increase the employees wage and still be ahead on their bottom line. The CMS on page 7 of their April 22<sup>nd</sup> report indicated that even smaller employers would be inclined to terminate existing coverage and companies with low average salaries might find it to their—and their employees advantage to end their plans, thereby allowing workers to qualify for heavily subsidized coverage through the Exchange.

In addition to the cost increase for health insurance there are some concerns for Union shops. When a company enters into negotiations regarding benefits, PPACA has inserted a substantial amount of uncertainty into the bargaining process as a company's ability to project into the future for the next 3-4 years is greatly compromised. In the past one thing was certain price goes up every year. Now, in addition to that there is no ability to let the union know what will happen to plan design and the benefits included. It has been reported to me by companies employing union workers (assuming that the union will negotiate heavily to avoid the government system) that non-union domestic competitors may have the ability to develop a labor health care benefit cost advantage of between 60-75%. That could mean that union companies less profitable operations will be sent offshore or be closed down altogether because of that advantage.

When it comes to "Grandfathered Plans", some of our employers would question the veracity of the goal to preserve that "promise" of maintaining existing coverage balanced with the intent of expanding access. For some employers there are too many provisions that HHS has determined will knock them out of "Grandfathered status". Of course substantial changes to the plan will disqualify a plan for Grandfathered status. Likewise, in the updated regs HHS prohibits a company from maintaining its Grandfathered status, that might want to shop an existing plan with a new carrier. But as many employers view it, probably the most difficult provision will be to stay within the thresholds of cost-sharing requirements, co-pays and the contribution rates on their plans. Historically, it has been these kinds of cost shifting changes that have allowed some employers to maintain insurance for their employees.

The Milliman report that indicates additional State Medicaid cost of upwards of \$3.6 billion for a 10 year period is of considerable concern to employers, particularly, in how the State will pay for this potential cost. Employers would not

support a reduction in Medicaid reimbursement rates for providers to help for these increased costs. Historically, those cost cutting measures result in cost shifting to private payers. Likewise, any new taxes generated to provide for these Medicaid increases could potentially fall upon the shoulders of employers ultimately impacting the job market. We highly support the administrations' attempts to make the Healthy Indiana Plan (HIP) the model for new Medicaid enrollees. If CMS does not approve of that request we would suggest that the State take a look (where legislatively possible) the benefit package for Medicaid in comparison to private plans and also take a look at small co-pays and deductibles for the many benefits provided. Business does not intend to injure or be unsympathetic to the Categorically Needy, but when there are increasingly limited resources it makes sense to investigate this issue. It might be suggested to put together an additional task force among interested stakeholders to look at plan design.

There has been healthy discussion about the tax-credits that are available to smaller employers that elect to provide health insurance coverage for their employees. At first glance it would appear (based upon early IRS marketing tools) that many employers with under 25 employees and less than an average annual FTE employee wages of \$50,000 would qualify for the tax-credits up to 35% of their annual insurance premium costs. However, upon further investigation credits are deducted rapidly as the employers numbers increase from 10 employees to 25 and from average annual wage of \$25,000 to \$50,000. As an example a company that has 20 employees and average annual wages of \$36,000, has employee family coverage costs of \$13,000 per employee and pays 75% or \$9,750.00 of that employee cost would not qualify for any tax credits. What we have been telling employers with under 25 employees that provide health insurance coverage; go to the IRS website and at least calculate because you may qualify for a credit most likely you will not but you don't want to miss out on the credit if you qualify. As far as the attempt to actually incentivize companies that do not provide insurance to do so; we are not sure how many will actually take the federal government up on the credit. It appears that restaurants and the retail sector along with maybe some lower income paying manufacturers would be the ones most likely eligible for the credits. However, many of these businesses are operating on relatively low profit margins and this may not be enough to encourage them to purchase health insurance for their employees.

The Chamber along with IMA has previously submitted comments on the Exchange to the Department of Insurance. We would have two additional points to add to those comments. We originally envisioned the Exchange as being an arm of the DOI, but because of the need to determine eligibility up to 400% of FPL for those individuals that qualify for the premium subsidies and in that FSSA is already determining eligibility for Medicaid and will be for the new enrollees it would make sense to further enable FSSA to make that determination for those individuals in the Exchange. Any rating, marketing or purview related to insurance would be under the authority of the DOI. If the State acquires a grant

for the study of the Exchange then this could assist in determining what ultimately this structure between the two entities would look like. The other comment that we would like to add is that as you look at the Exchange you should take into consideration the valuable role that Health Insurance Producers/agents/brokers provide to the consumer. While some would like to cut them out of the picture altogether (suggesting an Orbitz type portal) they provide information and resources, knowledge on products, make recommendations, assist and advocate through the claims process and provide benefit packages to employers and employees. Careful consideration should be given to them as the Exchange is developed.

While I recognize this topic does not fall under the bailiwick of either FSSA or the DOI I do want to bring this to your attention. The Medical Device Industry would like to make comment that the 2.3% tax on all domestic sales could significantly cut into profits of many of these companies. This industry is already facing competitive pressures to lower prices for hospitals that are being squeezed. PPACA requirements will add to these pressures. The Accountable Care Organization—bringing physicians, clinics and hospitals together to focus on reducing costs and rewards them for doing so could have an impact as well. It is expected that as a result of the ACO there will become a demand for lowest cost devices possibly regardless of quality. While Competitive Effectiveness Research prohibits decisions on Medicare coverage it is anticipated that the private sector will change coverage based upon these studies and shift some products out of the market. Ultimately, all of these pressures along with the tax could force some manufacturers to conduct business overseas, thus impacting jobs here in Indiana.

That concludes my remarks. Again, thank you for providing this opportunity to provide you with our comments.