

**Testimony of Todd McCracken**  
**President**

**On behalf of the National Small Business Association**



**House Committee on Ways and Means Subcommittee on Oversight**

**Hearing:**

“The Implementation and Effectiveness of the Small Business  
Health Insurance Tax Credit.”

**November 15, 2011**

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Chairman Boustany, Ranking Member Lewis and members of the Committee, on behalf of the 150,000 small-business owners represented by the National Small Business Association (NSBA), I would like to thank you for the opportunity to appear today to discuss the implementation and effectiveness of the Small Business Health Insurance Tax Credit created by the Patient Protection and Affordable Care Act (PPACA).

NSBA is the nation's oldest small-business advocacy group representing employers in every state. As a strictly non-partisan organization, we reach employers in all sectors and industries of the U.S. economy from retail to trade to technology—our members are as diverse as the economy that they fuel. NSBA's policy positions and priorities are strictly formulated through robust volunteer leadership, communicated by NSBA staff, and reflective of our nation's 29.6 million small businesses. Indeed, health care reform has dominated the member-driven legislative priority agenda at NSBA for years, and NSBA has been an outspoken leader on the topic.

In fact, according to NSBA's Mid-Year Economic Report, released late-July, the cost of health care continues to be an issue with 44 percent of small-business owners who provide health insurance experiencing a premium increase of 11 percent or more. To address these costs, small businesses have implemented the following changes: 50 percent increased the deductible, 50 percent held off on employee compensation increases, 46 percent increased the employee share of the premium, 42 percent reduced employee benefits, 28 percent switched insurance carriers, 32 percent held off on hiring a new employee, and 24 percent held off on implementing new growth strategies.

These costs are coming to a breaking point where employers have fewer and fewer benefit design options and are increasingly forced to make difficult employment decisions as a result. There also was an increase in those who reported they were forced to lay off an employee due to health care costs.

NSBA has invested in the health care reform debate for decades. NSBA's volunteer leadership, with guidance from several experts, published *Small Business Health Care Reform—A Long-Term Solution for All* in 2004. This proposal sought to achieve universal coverage, focus on individual responsibility and empowerment, create the right market-based incentives, and a relentless focus on improving quality while driving out unnecessary, wasteful, and harmful care.

While PPACA attempted to address many of these goals, it failed to sufficiently achieve the most important factor for small businesses in health care reform; that is, to bring down the cost of health care and lower insurance premiums for all individuals. Thus, despite the extraordinary needs of small businesses for a sustainable health care system, NSBA opposed PPACA. However, the flaws of PPACA do not obviate the ongoing small-business need for health care reform and cost containment.

More specifically, we are here today to discuss the effectiveness of a provision in PPACA that includes a recently implemented limited-time tax credit to encourage small businesses to provide health care coverage to employees. The Small Business Health

Insurance Tax Credit (Small Business Tax Credit) is available to certain small businesses and covers some of the cost of employee health insurance.

### **What Are the Tax Credits?**

The tax credits are available to small businesses in two phases. To be eligible for both phases of the tax credits, employers must have 25 or less full-time equivalent employees with average wages of \$50,000 or less and provide at least 50 percent of the total premium costs. In the first phase of the tax credit—tax years 2010-2013—employers meeting the criteria can receive a tax credit worth up to 35 percent of the employer's contribution toward the employee's health insurance.

The second phase begins in 2014 when the Exchange is created. The credits are available for two years once the employer purchases a group policy through the Exchange (important to note: phase II credits are available strictly through the Exchange).

Employers meeting the criteria can receive a tax credit worth up to 50 percent of the employer's contribution toward the employee's health insurance during this time. The full tax credit for both phases is available only to employers with 10 or less employees who have average salaries of \$25,000 or less. The credit phases out for businesses between 10-25 full-time equivalent employees with average wages between \$25,000 -- \$50,000. Tax exempt employers meeting the aforementioned criteria get a 25 percent credit for tax years 2010-2013 and a 35 percent credit for the two years in the Exchange.

For-profit employers can capture the tax credits by deducting it against their federal income tax liability. The credit is not refundable, but it can be carried back one year and forward 20 years. Tax-exempt employers can deduct it against their payroll taxes.

The self-employed are not eligible because the credit is only available to those businesses with employees. The only health insurance premium self-employed individuals will qualify for are federal premium subsidies, assuming they meet the low-income criteria through the Exchange. This inequity should be remedied by allowing sole proprietors to be eligible for the tax benefits afforded to other small businesses.

### **NSBA Data**

Since the passage of the health care reform law small-business owners have expressed significant confusion about how the new health care law will impact their business. Today, however, there appears to be a slight increase in their understanding of the new law.

According to the NSBA Mid-Year Report, nineteen percent of small businesses—up from 15 percent in December 2010—said they have a clear understanding of how the new law will impact their business. Meanwhile, 63 percent, up from 53 percent, said they have a limited understanding and 18 percent, down from 32 percent, said they do not understand at all how their business will be impacted.

## **Complexity of Tax Credit**

Most business are not sure if they qualify primarily because it is fairly complex and the tax credit appears to be an administrative quagmire for small business owners. According to the pages and pages of questions answered on the Internal Revenue Service (IRS) website on the credit—which essentially proves the complexity of it—business owners have to calculate their average annual wage, figure out the premiums they paid for eligible employees, figure out the average premium for the small group market in which they offered health insurance coverage, deal with various phase-outs and limitations that start at 10 employees or more and figure out their full-time equivalent employees (FTEs) in order to determine eligibility **and** then seven worksheets must be completed in association with claiming the credit.

Complying with IRS rules and regulations is not a new burden for small businesses. They tend to be an easy target since unlike big corporations—which have hordes of accountants, benefits coordinators, attorneys, personnel administrators, etc. at their disposal—small businesses often are at a loss to keep up with, implement, afford, or even understand the overwhelming regulatory and paperwork demands of the federal government.

Approximately 36 percent of NSBA members have fewer than 5 employees—few, if any, of whom is a tax specialist—leaving business owners with no other choice but to hire outside help to keep track of all their additional reporting and filing requirements, which means even more paperwork.

According to the recently released Treasury Inspector General for Tax Administration (TIGTA) report titled *Affordable Care Act: Efforts to Implement the Small Business Health Care Tax Credit Were Mostly Successful, but Some Improvements are Needed* taxpayers have been slow to claim the credit, and both taxpayers and tax practitioners are making mistakes on Form 8941 in spite of the extensive outreach and education efforts made by the IRS to inform taxpayers and the tax preparer community about the credit and how to claim it. Clearly compliance is expensive and determining eligibility and planning is proving to be extremely difficult.

## **Low Volume of Participation**

Despite IRS efforts to inform four million employers who would be eligible for the credit, the TIGTA report states the volume of claims for the credit have been low. As of mid-May 2011, only 228,000 taxpayers took advantage of the credit for a total amount of more than \$278 million.

Certainly, it seems likely that the number of small firms utilizing the credit is likely to rise somewhat as outreach efforts continue and as awareness continues to build. However, it is also not particularly surprising to NSBA that participation by small employers is much lower than had been anticipated.

As designed, the tax credit is most valuable to very small, very low-wage companies. However, very few of these companies are able to offer health benefits at all, for myriad reasons. When those companies are able to offer coverage, their low-wage employees

typically decline it, since they are unable to afford their own share of the premium. In such a case, there is no employer-paid premium against which to claim the tax credit, even for a small, low-wage company identified as “offering” health insurance to its employees. A number of factors heighten this effect.

### **High Morbidity in Small Groups**

While I am not an actuary, it is well-known in actuarial circles that morbidity (a measure of poor health) is much higher in the very small group insurance market than in the rest of the market. Of course, it is not generally the case that workers in small firms are sicker than other workers. However, it is the sicker employees who are willing to make the financial sacrifices to obtain and retain coverage in the very small group market, a fact which drives up average premiums in this sector. Those higher premiums, in turn, reduce the number of healthy low-wage workers willing to pay for health insurance, driving the premiums yet higher.

### **Family Members as Employees in Small Groups**

In many small companies (again, especially under ten employees, where the credit in question is most valuable) multiple family members may serve as employees of the company. Small low-wage companies that employ family members are the ones most likely to offer employer-sponsored health insurance, since that plan also provides coverage for the owners own family. While there is not good available data, based on our experience, we strongly believe that these businesses account for a very substantial portion of the smallest companies that still offer health insurance to employees. However, those family employees are ineligible for this tax credit and many of the other employees may have declined the coverage because of high cost.

### **The Tax Credit is Non-Refundable**

Because the tax credit is nonrefundable, some employers will not be able to take full advantage of it even if they meet all the criteria. If the small business has no taxable income in the year in which it wishes to receive the credit, it may carry the credit forward for 20 years or backwards one year (after 2010). Tax-exempt organizations may use the credit to offset withholding and Medicare taxes that they owe on behalf of their employees.

### **Cost Containment**

Health care spending in the United States has increased from 12.5 percent of GDP in 1990 to 13.8 percent in 2000 to 17.6 percent in 17.6 percent in 2009. Nearly one in six dollars spent in the U.S. are spent on health care. This makes our country’s health care system uniquely expensive. By almost any metric (life expectancy at birth or age 65, infant mortality, etc.), our system does not deliver materially better results than other advanced countries’ health care systems.

International Comparison of Health Expenditures (Public and Private), 2008<sup>1</sup>

United States	16.0%
Canada	10.4%
France	11.2%
Germany	10.5%
Italy	9.1%
Netherlands	9.9%
Switzerland	10.7%
United Kingdom	8.7%

Rising health costs consume most of the real wage increases that ordinary Americans receive. They impose a huge expense on business and harm our international competitiveness. They will make our state and federal budget difficulties nearly intractable.

Restraining rising health costs will:

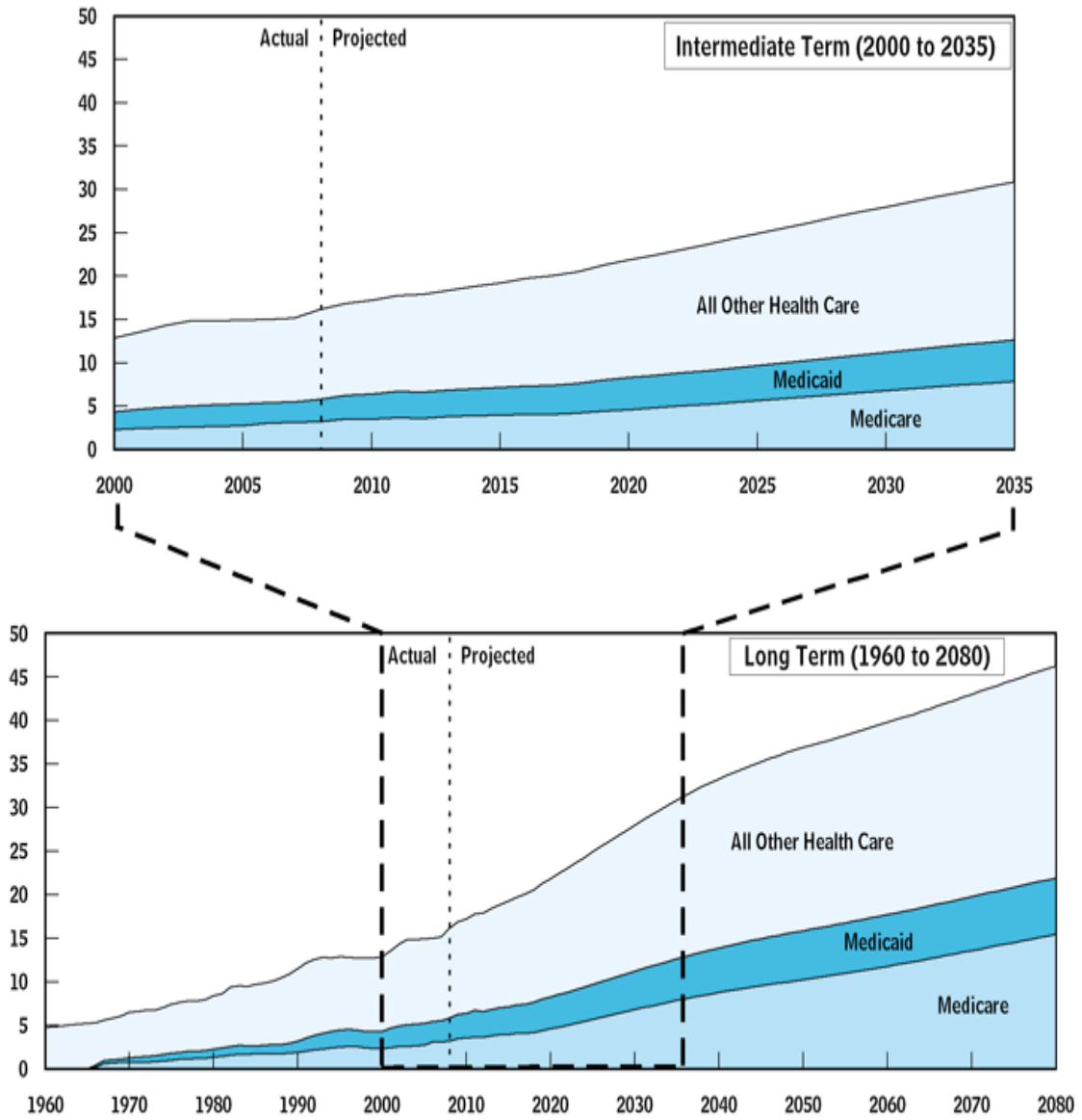
- Dramatically improve federal and state budgetary situation;
- Dramatically improve the cash compensation of working Americans; and
- Substantially improve the international competitiveness of U.S. businesses.

The Congressional Budget Office (CBO) projections below show this problem getting steadily worse, with total health care spending reaching an absurd 25 percent of GDP by 2035. It is a problem that simply must be addressed. And one thing is certain. Simply making adjustments around the edges of the current system will not solve the problem.

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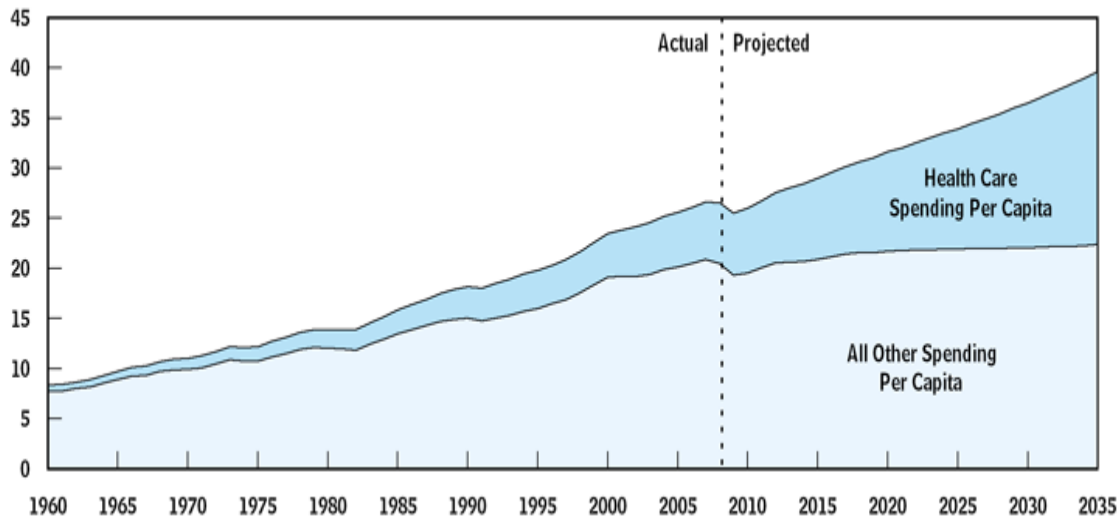
<sup>1</sup> Statistical Abstract of the United States, 2012, Table 1346.

Total Spending for Health Care Under CBO's Extended-Baseline Scenario  
(Percentage of Gross Domestic Product)



Source: Congressional Budget Office, Long-Term Outlook for Health Care Spending, 2009.

Total Health and Nonhealth Spending Per Capita  
Under CBO's Extended-Baseline Scenario  
(Thousands of 2009 dollars)



Source: Congressional Budget Office, 2009

### Principles of Health Care Cost Constraint

The current health care marketplace is thoroughly broken and bears no resemblance to a normal market. There is virtually no competition on the basis of price. Information about quality regarding providers is very difficult to obtain. Neither providers nor consumers have a meaningful incentive to economize and a third party pays for the decisions made by consumers and providers of health services. In fact, almost all of the incentives in the current system are to spend more money.

Consumers, although they have some first dollar cost-sharing, have no incentive at the margin to economize on health care costs. Generally, the marginal cost to consumers under private insurance and under Medicare and Medicaid is zero. This must change. We must move the private and government health systems toward positive marginal costs to consumers. As has been almost universally understood by economists since the 1870s, it is at the margin that decisions are made. If there is a marginal cost to the consumer of ordering an additional test or choosing a more expensive treatment, then consumers will have some incentive to economize. The current flat deductible and flat co-pay system means that there is no marginal costs to consumers for electing more expensive health care.

Another reason for high hospital costs are mandates on hospitals to treat those that arrive at the emergency room for free if necessary. By this mechanism, a large number of uninsured persons received free medical care. Providing this care, however, is not free and the hospitals recover it in the end by higher bills to paying patients.

Moreover, the employer-provision of health insurance (driven by the tax exclusion for employer provided health insurance) further breaks the link between health care expenditures by consumers and the cost of providing those expenditures. Generally, a consumer's health care costs consist of a deductible (which is so low it is almost always exceeded) and minor co-payments. There is little to no variance in a consumer's health care costs depending on the degree to which health care services are used.

Providers, meanwhile, have every incentive to provide more health care because by providing more services they make more money. They are under no pressure to compete on the basis of price because the health care consumer generally faces a zero marginal cost. Very little information is available or provided regarding quality. Artificial limits are placed on the number of newly minted doctors each year. Medicare, Medicaid and private insurers are under tremendous pressure to simply pay the medical bills presented to them and are treated as pariahs by politicians and the media if they attempt to push back on health care provider costs.

There is one obvious exception to the forgoing analysis: the case of elective procedures such as corrective eye laser surgery or cosmetic surgery. In these medical fields, competition on the basis of price and quality is commonplace. The reason, of course, is that the consumer is footing the bill.

Neither does the current system possess the cost containment features of a government run system. The government is not in a position to dictate prices and salaries to health care providers. It cannot use monopoly power to dictate to suppliers.

In short, we have the worst of both worlds. A private market without any of the normal market mechanisms that lead to efficiency, cost control and quality gains. A government insurance system that has almost none of the cost containment features that a single-payer, monopoly, socialized system would have. Thus, we have the most expensive health care system in the world. We cannot afford it.

The health care system must be changed so that:

- Consumers have substantial marginal costs when consuming health care services;
- Consumers benefit financially when they economize on health care services;
- Health care providers compete on the basis of price;
- Health care providers compete on the basis of quality and outcomes;
- Health care providers have a substantial incentive to economize; and
- Genuinely unwarranted medical malpractice claims or excessive awards are limited.

Maintaining the present system will accomplish none of these goals. Both President Obama's PPACA and Rep. Paul Ryan's Medicare reform proposal move towards a premium support system (where government subsidizes the purchase of private insurance). They retain the basic structure of the current health care system with no

meaningful consumer costs at the margin and little incentive for consumers or providers to economize. In Rep. Ryan's case, the plan may succeed in shifting costs from government onto private citizens, but it can be expected to do little to reduce overall health care costs.

Ensuring that consumers bear meaningful marginal costs and that therefore providers in competing for those consumers have a reason to compete on the basis of price and quality can be accomplished without harming the poor or lower middle class. Instead, however, of subsidizing insurance premiums, government funds could be used to provide individuals with a stipend for health care expenses that if not used for health care expenses because the consumer effectively economized can eventually be used by the consumer for whatever they want. In this way, there is a real incentive for everyone involved in the system to economize.

Tort reform can also contribute to health care cost containment. The CBO estimates that a modest medical malpractice reform law would save over \$50 billion through 10 years. However, those savings would continue to increase as the cost of medical malpractice litigation in the U.S. continues to grow, steadily increasing at almost 12 percent annually since 1975. Moreover, according to the Harvard School of Public Health, 40 percent of malpractice suits filed in the U.S. are "without merit." In general, studies place the direct and indirect costs of malpractice between 5 percent and 10 percent of total US medical costs.

Beyond traditional medical malpractice laws, NSBA supports some kind of safe harbor for physicians, as well as the use of health courts. Any safe harbor rule would have to be in conjunction with federally-defined, evidence-based medical procedures. Physicians, who abide by those standards and report outcomes, would be allowed a certain level of protection from medical liability. Health courts would allow for the establishment of specialized courts for dealing with medical malpractice claims. NSBA surveys show 83 percent of small businesses support monetary caps in medical malpractice cases. That survey also found that a majority support addressing the issue federally. Tort reform traditionally has been dealt with at the state level; however, the National Conference of State Legislatures cites 17 states where there are no stipulations whatsoever on medical malpractice lawsuit caps. The broad variance in states' laws encourages attorneys to forum shop, which simply increases the need for a federal solution.

## **Conclusion**

This tax credit is only temporary—it expires after five years—and given the failure of PPACA to contain costs even those few small-businesses able to utilize this credit will be left without any kind of support and a very expensive benefit that is difficult to take away once they offer it to employees. Tax credits are neither the cure-all for small businesses' health insurance woes nor a replacement for good policies on cost-containment that make health care more affordable.

The number of uninsured in the United States is a big problem that needs to be addressed, but the uninsured are not a homogeneous group and they are uninsured for several different reasons. However, one common element that runs through the entire health care

system, for those insured or not, is the cost of health care. In fact, the impetus for health care reform was sold on the need to address spiraling cost by altering the increasing health care cost trend.

Unfortunately, this founding tenet of reform has been lost through deliberations. The CBO has reported that PPACA does not alter the unsustainable long-term health inflation trends to the level needed to make a significant enough difference in premiums five, 10 or 15 years down the road.

I would like to thank Chairman Boustany for holding this hearing, and appreciate the opportunity to provide a small-business perspective to the Small Business Health Insurance Tax Credit. We hope to continue to work with you and your staff as a constructive participant as the implementation of this proposal continues to be at the forefront, and will gladly provide additional information or insight into the health care challenges faced by our nation's small businesses.