Critical Employer Issues in the Patient Protection and Affordable Care Act

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U.S. Chamber of Commerce

Table of Contents

Foreword

Businesses, large and small, have many questions regarding the 2400-page Patient Protection and Affordable Care Act (PPACA). This complex legislation has made sweeping changes to our country's health care system and will impose many new requirements and mandates for employer-sponsored health care coverage.

We at the Chamber therefore felt it necessary to commission this white paper to help serve as a handbook for the business community on how to navigate and comply with the new law. Employers also need to be aware of several taxes and penalties that can be levied against them if they are unable to provide minimum health care coverage levels that have yet to be determined.

Every employer faces unique circumstances and challenges; understanding and complying with the PPACA will be no exception. While this primer is an attempt to shed light on pieces of the new law, it is not intended to be a substitute for the legal counsel, benefits consultants, or in-depth analysis that individual businesses will need to ensure compliance.

The Chamber will continue examining the legislation to provide employers with the best information possible. We will also remain an active voice on the regulatory front where much of the law will be fleshed out.

I would like to give special thanks to the primary author, Joel White, and his staff Jennifer Bernstein and Drew Kent for drafting this primer. Also, many thanks are due to Chamber staff James Gelfand, Michael Billet and Walter Mullon for their help, as well as to Andy Anderson of Morgan, Lewis & Bockius for his advice and counsel on this primer.

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A. Introduction

No law since perhaps the creation of the Medicare and Medicaid programs or the Employee Retirement Income Security Act (ERISA) has more fundamentally shifted the health care landscape than the recently enacted Patient Protection and Affordable Care Act (P.L. 111-148, as modified by H.R. 4872, the Health Care and Education Reconciliation Act of 2010). Many of the provisions are geared toward expanding access to health care coverage through a mix of incentives for private insurance and a dramatic expansion of public programs.

Overview

In general, the law requires individuals to purchase health coverage and for some employers to provide it or face penalties. The law sets out standards for essential health benefits for plans available through exchanges, and provides premium and cost sharing assistance to individuals with incomes below 400% of poverty. The law also provides small business tax credits for certain small businesses. It raises taxes and cuts Medicare and other spending to finance the new entitlement to premium and cost sharing subsidies.

Coverage

The Congressional Budget Office (CBO) estimates 32 million of an estimated 54 million uninsured Americans will obtain coverage as a result of the law. This is due largely to an expansion of Medicaid, new health insurance subsidies, and creation of new health insurance exchanges through which individuals will purchase insurance and access premium credits. These changes will have a profound impact on employers and their employees. The total number of covered lives in employer plans is expected to decrease under the law, from 162 million to 159 million in 2019 (CBO, March 20, 2010).

Table 1 presents a breakdown of where individuals gain coverage, where they lose coverage, and how many remain uninsured.

Table 1. Change in Coverage by Category, in 2019

Coverage Category	Pre-Law	Post-Law	Change in Lives (Millions)
Employer	162	159	-3
Individual/Other	30	25	-5
Exchanges	0	24	24
Medicaid/CHIP	35	51	16
MA	14	7	-7
Medicare FFS	46	53	7
Uninsured	54	23	-32

Source: CBO and staff of the Joint Committee on Taxation
Notes: CHIP = Children's Health Insurance Program
MA = Medicare Advantage
FFS = fee for service

Premium Impact

Because the law requires some employers and insurers to cover a robust set of benefits and limits the flexibility for some employers to tailor benefit packages to their and their employees' needs, health insurance premiums will likely increase. The CBO, in a letter to Senator Evan Bayh[i], estimates that in 2016 premiums in the non-group, small-group, and large-group markets would increase or stay about the same prior to premium subsidies, as outlined in table 2.

Table 2. Premium Impact by Group

Market	Premium Impact
Non-group	+10 to 13%
Small Group	+1 to -2%
Large Group	0 to -3%

Source: CBO, Letter to Senator Bayh, November 30, 2009

It can be reasonably assumed health premiums may increase even more than CBO estimates. The Centers for Medicare and Medicaid Services (CMS) Office of the Actuary estimates that total health expenditures will increase by about $311 billion over the 10-year period,[ii] largely as a result of coverage expansions and increased demand for health services by the newly insured. Because the bill does little to address underlying medical costs, it is likely the increased demand for health services will drive premiums up. After premium subsidies are applied, net premium contributions, particularly in the non-group market, will decrease for individuals and families, with the cost borne by taxpayers and employers for more expensive insurance plans.

Cost

The CBO estimates the gross cost of the law at $940 billion over 10 years. Because tax increases and spending cuts offset new entitlement and other spending programs, CBO estimates the law reduces the deficit by $143 billion over 10 years.

According to a report released by the Office of the Actuary of the Centers for Medicare and Medicaid issued on April 22, 2010, entitled "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act, as Amended," it is explicitly stated that with respect to the estimated savings in Medicare, "trust fund accounting considers the same lower expenditures and additional revenues as extending the exhaustion of the HI (Hospital Insurance) Trust Fund. In practice, the improved HI financing cannot be simultaneously used to finance other federal outlays (such as the coverage expansions) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions." Savings accrued by the Medicare program cannot be also used to offset the premium assistance credits, or any other expansion of coverage. Therefore, the approximately $500 billion in Medicare savings cannot be used to both extend the life of the Medicare Trust Fund and to pay for subsidies, so in essence this money was double-counted for accounting reasons, and the costs of the bill may not be accurately reflected in the CBO report.[iii]

Cost Shifting

Medicare and Medicaid reimbursement and coverage changes will be dramatically altered as a result of the law, reducing projected Medicare spending by about $500 billion over the 10-year period (Lewin Group, June 12, 2009). When provider payments are cut in Medicare or Medicaid, the reimbursement differential is often shifted onto private plans and health premiums. For example, the Lewin Group estimates current Medicare payments for hospitals at 68% of private-plan rates, and Medicare payments for physicians at 81% of private-plan rates (Lewin Group, June 12, 2009). Providers make up this differential by demanding higher payments from private plans. These costs are borne by employers and other purchasers. The new law reduces reimbursement for Medicare providers, so there is a suggestion that this trend of cost shifting will continue.

Overview of Changes

Reforms made across the health system have interactive effects, and none will be felt more acutely than in the employer market. Small and large employers can expect systemic transformation over the next few years that will likely limit their options, increase benefit costs for many, reduce benefit costs for some, raise compliance costs, and change how health care is financed for all.

Some of the changes in the immediate and near term are outlined in table 3. A timeline of major provisions is provided in appendix A. A glossary of terms is included in appendix B.

Table 3. Major Provision by Impacted Group

Impacted Group	Provisions
Employers	• Mandate to provide coverage or pay fines (firms with less than 50 employees not subject to mandate) • Mandate to cover specific benefits in the small group market • New small business tax credit to purchase coverage • New insurance exchanges for small-group and individual markets • Limits on underwriting • Elimination of tax deduction for retiree drug subsidies to employers • Restrictions on Flexible Spending Account (FSA) salary deferral contributions • Existing plans grandfathered as of date of enactment from some, but not all, of the new plan requirements
Individuals	• Mandate to purchase coverage or pay fine • New mandated benefits/limits on choices • Subsidies to purchase coverage in an exchange • Limits on cost sharing • Limits on underwriting • Increase in floor for itemized medical deduction from 7.5% to 10% • Restrictions on use of Health Savings Accounts, FSAs, Health Reimbursement Arrangements for over the counter drugs

Medicare	• Part D coverage gap closed over time • Payment reductions to hospitals, physicians, etc. • Payment reductions to Medicare Advantage plans • Does not address physician payment issue • New rebates on drugs
Medicaid	• Expansion of coverage to 133% of poverty for all Americans • Temporary enhanced federal payments to states • Enhanced rebates on drugs
Taxes	• Medicare payroll tax increased by 0.9% for upper income • New 3.8% tax on investment for upper income • $1 then $2-per-life tax on all insurance policies to fund research • High-cost plan tax of 40% for plans above $10,200 individuals/$27,500 families • New fees on drug, device manufacturers • New fees on health insurers

Source: P.L. 111-148

As the partial list above indicates, these changes are both sweeping in scope and dramatic in volume. Simply understanding and then complying with the changes will be a task. Capitalizing on the incentives and new costs imposed by the law will be a more formidable challenge.

Conclusion

The basic premise of the law fundamentally shifts the foundation of employer-sponsored benefits in America. What has been a voluntary and flexible system will now be a one-size-fits-some landscape. Employers will be required to offer health benefits or face a penalty. Some small employers can also choose to offer coverage through an exchange rather than sponsor their own plan. Individuals must purchase coverage or pay a fine. Without adequate incentives to address steeply rising medical costs, insurance is likely to become more expensive. Because of the mandatory nature of the law, employers may find it more difficult to offer affordable coverage, may become competitively disadvantaged, and may drop coverage altogether in an effort to stay in business.

Employers and their employees and families are entering a confusing and uncertain time regarding their health security. Clear and understandable guidance is required to assist job creators in this new era in employee benefits. Unfortunately, complexity breeds confusion, and the new law is anything but simple. This paper outlines the changes and challenges and provides a basic outline of the new health reform law.

B. Employer Mandate and New Employer Penalties

Employer-sponsored health insurance is the predominant source of coverage for individuals and families, with more than 160 million people, or more than 60% of nonelderly Americans, receiving health coverage through their employer.[iv] Prior to enactment of the health reform law, there was no federal requirement that employers offer health insurance coverage. Employer coverage was voluntary, and employees could choose whether to enroll in that coverage.

The benefits of the employer-based structure are well known, including: risk pools that are not formed on the basis of health status; ease of acquisition by workers; better negotiating power than individual consumers; economies of scale that breed administrative efficiencies; and covered workers are more likely to be healthy and productive.[v] The Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code (Code) combined uniform regulation and flexibility with tax incentives to encourage employer-sponsored health insurance. Under the Code, the cost of employer-sponsored health coverage is excluded from taxable income for the employee and deductible for the employer. ERISA provides a framework that permits employers who have employees residing in multiple states to offer and administer their health plans uniformly under a single set of federal rules that also allows them to respond quickly to the changing needs of the labor force. This type of system gave businesses the flexibility to design health plans which maximize tax benefits while meeting the unique needs of their employees.

The recently enacted health care reform legislation moves away from the voluntary, flexible, employer-sponsored health insurance system. The legislation imposes a mandate that many employers provide health insurance and effectively forces some employers to change what the coverage must cover. This includes a minimum package of benefits determined by the law. Failure to comply with the new requirements will lead to employer penalties.

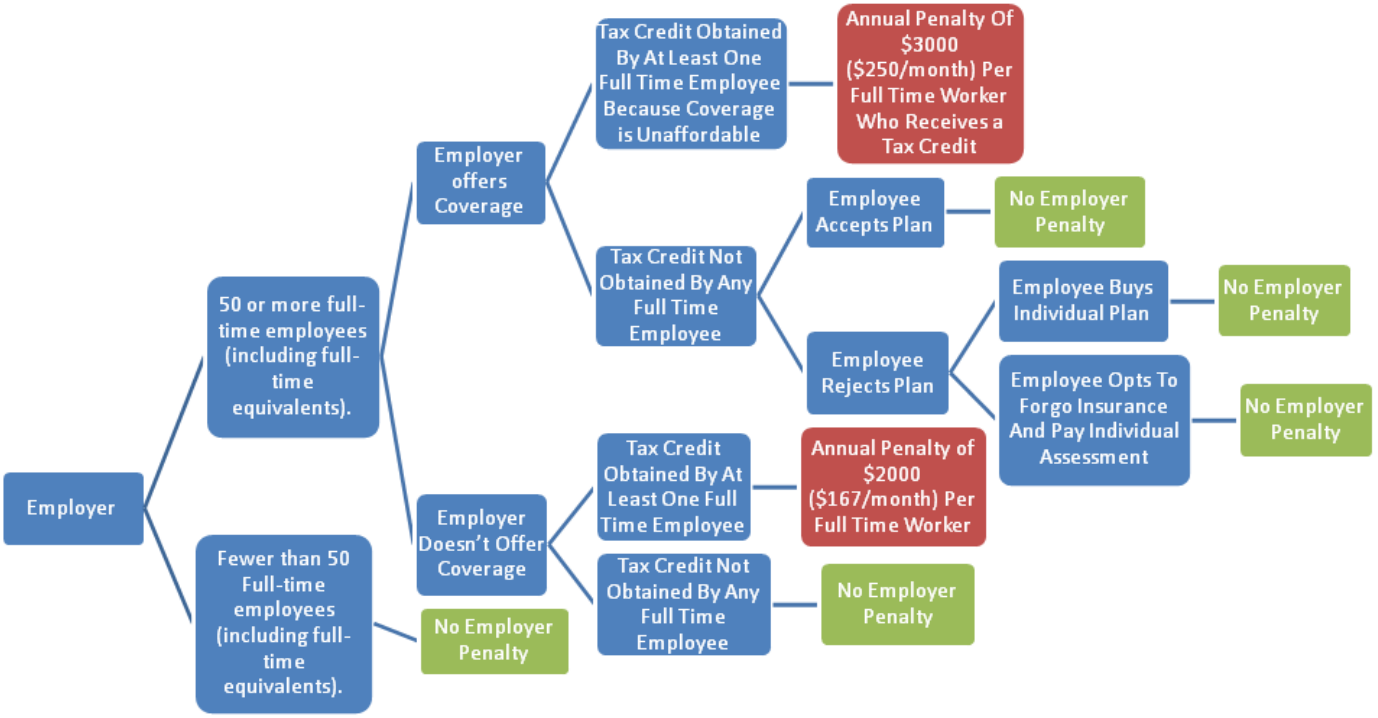
Some employers may weigh the cost of providing coverage against these penalties and decide to drop coverage altogether. Under this scenario, workers will suffer as flexible employer coverage is replaced by public programs.

Penalty for Employers Depending on Whether Coverage is Offered

Beginning in 2014, employers that employed an average of 50 full-time employees during the previous calendar year must offer health coverage that meets minimum essential coverage requirements or pay a fine. The one exception is for firms with more than 50 employees that have no employees receiving a tax credit for health insurance. For employers with more than 50 employees that offer coverage and have even one employee access a tax subsidy or cost-reduction benefit for health insurance, penalties are $3,000 per employee who receives the tax credit. Employers that do not offer coverage and have one employee receiving the tax credit in an exchange must pay $2,000 per full time employee after exempting the first 30 full-time equivalents.

The Joint Committee on Taxation estimates employers will pay $52 billion over 10 years in penalties for noncompliance (CBO, March 20, 2010).

The following flowchart outlines the employer mandate and penalties.

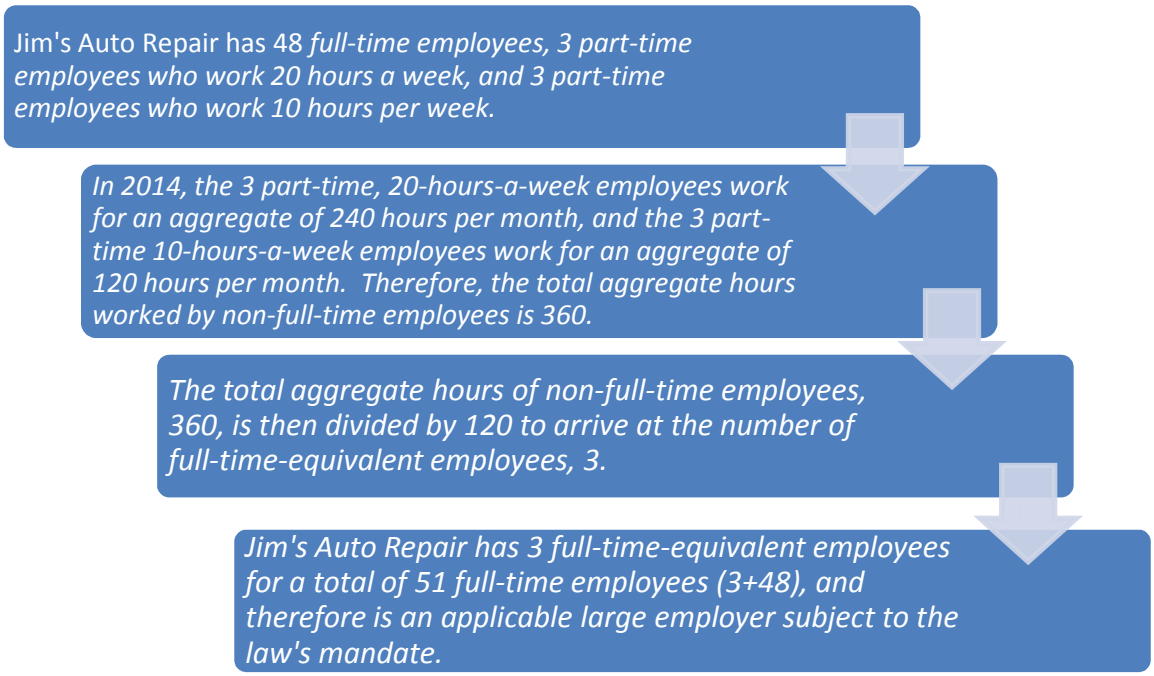


Note: This chart is for illustrative purposes only.

An employer is not considered an "applicable large employer" if the employer's workforce exceeds 50 full-time employees for 120 or fewer days during the calendar year and the employees in excess of 50 during that period were seasonal workers. A full-time employee is defined as someone who is employed on average at least 30 hours per week.

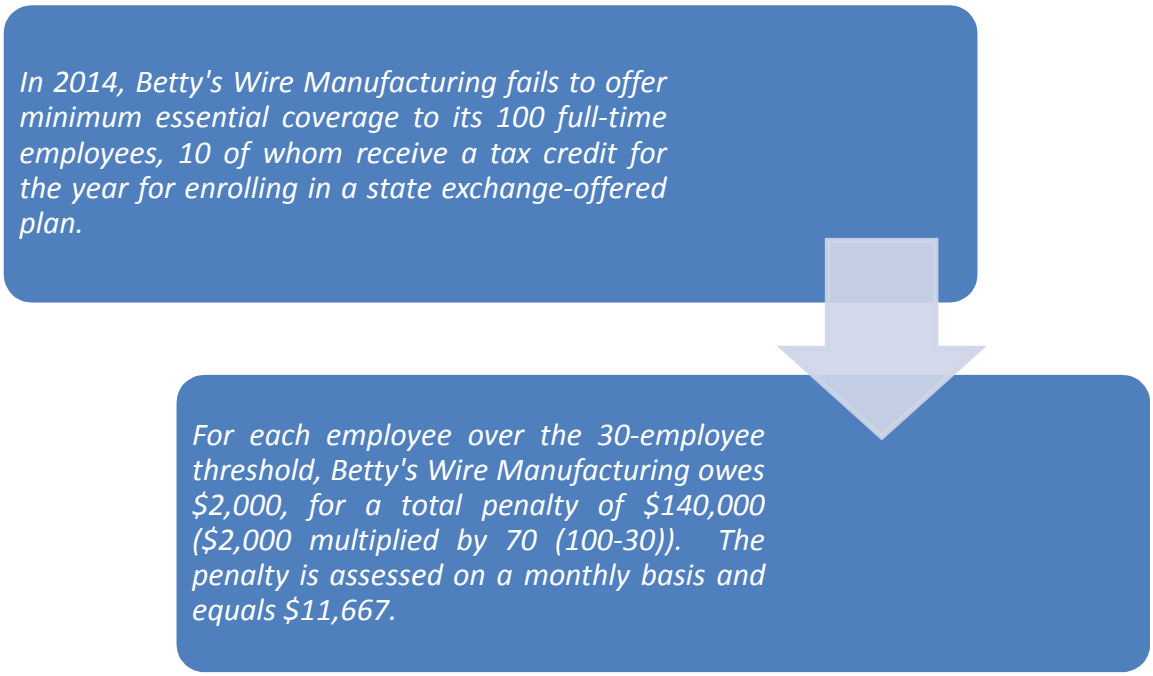
Part-time employees are taken into account as full-time equivalents for purposes of the 50 employee threshold (but not for penalty calculation purposes) by dividing the total number of hours worked by non-full-time employees during the month by 120.

Example 1. Calculation of Full-Time Equivalents



As noted above, the penalty for failure to offer coverage is an excise tax equal to the number of full-time employees over a 30-employee threshold during the month multiplied by 1/12 of $2,000 ($167). Note that for the purposes of determining penalties, part-time employees are not included in the calculation (they are included only in determining whether an employer is an applicable large employer).

Example 2. Calculating the Penalty



Penalty for Employers That Offer Coverage but Whose Employees Receive Government Subsidies

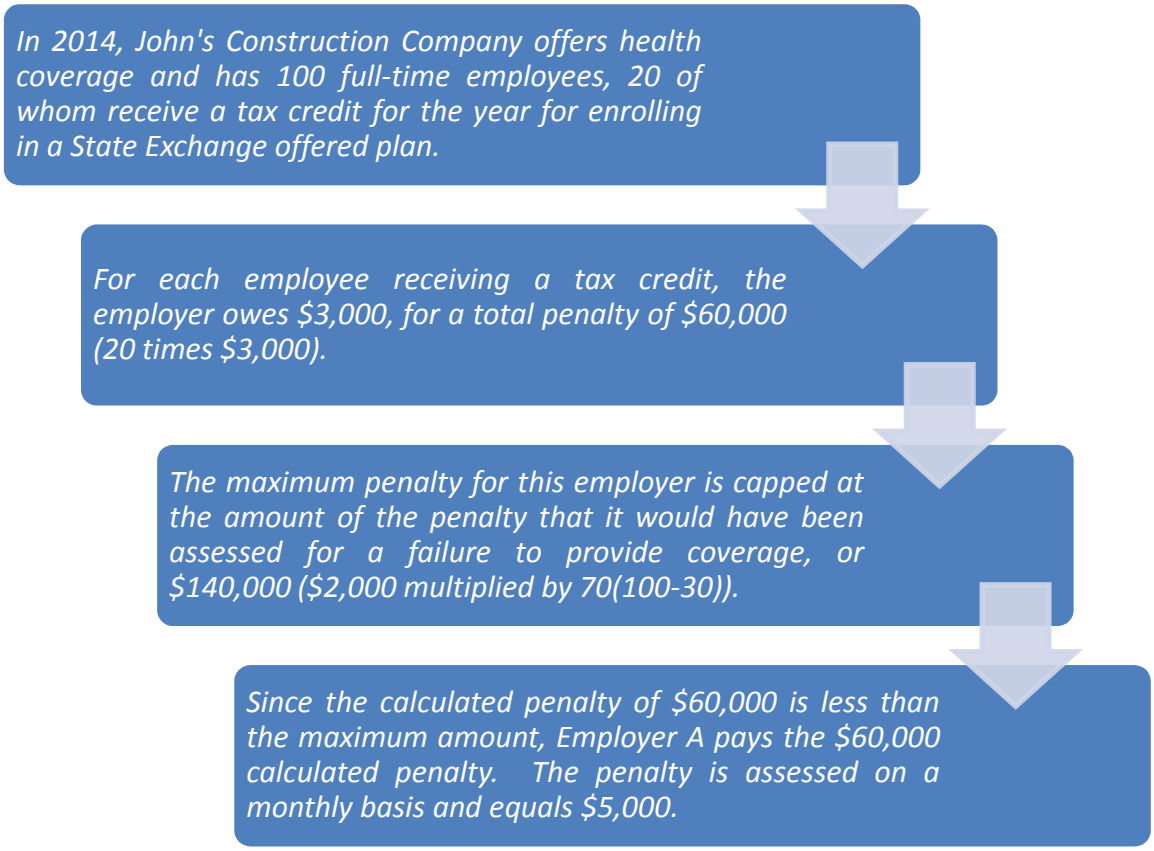
Beginning in 2014, if an applicable large employer offers employer-sponsored coverage to its full-time employees for any month, but one or more of the employees has enrolled in health insurance coverage through an exchange and receives a premium tax credit or cost-sharing reduction because the employer-sponsored coverage is unaffordable or fails to pay at least 60% of covered claim costs, the employer is subject to a penalty. Under the new law, employer sponsored coverage is unaffordable if the employees share of the premium exceeds 9.5% of the employee's total household income.

While this formula allows an employer a great deal of flexibility, it should be noted, however, that the law does state that an employer must provide "minimum essential coverage" as part of covered health care coverage. This concept is undefined and will need to be fleshed out in regulation or other subsequent guidance.[vi]

The term of "minimal essential coverage" should not be confused with another term used in the law, "essential health benefits package", which is only applicable to qualified health plans, and plans in the individual and small group market.

The penalty is a nondeductible excise tax on the employer that equals 1/12 of $3,000 for each full-time employee who receives a tax credit or cost-sharing subsidy through the exchange, calculated on a monthly basis. The total penalty under this section is capped at the maximum penalty amount an employer would face if the employer did not offer any coverage at all (the number of full-time employees over a 30-employee threshold during the applicable month multiplied by 1/12 of $2,000).

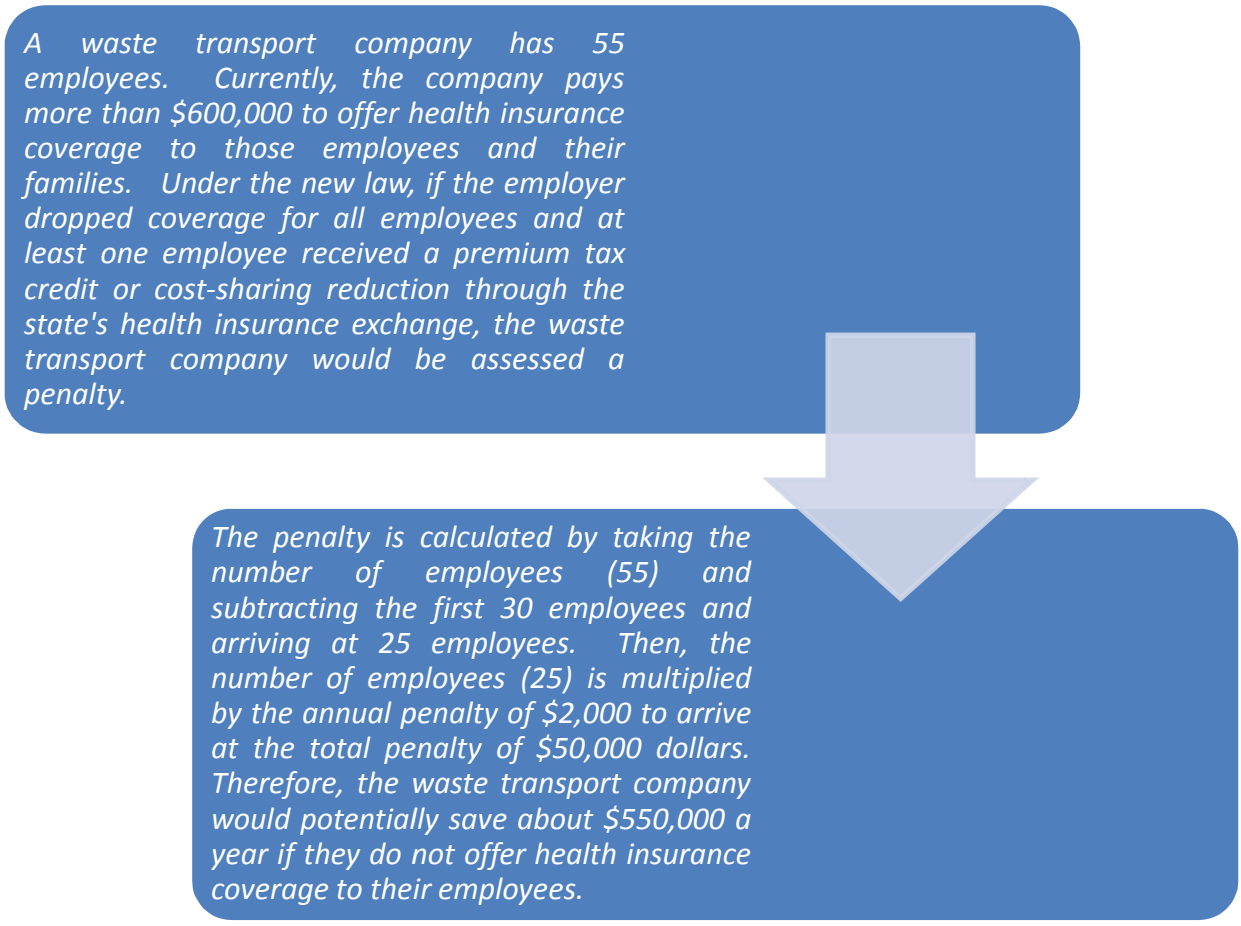
Example 3. Calculating the Penalty for an Employer That Offers Coverage, but Has At Least One Employee Receiving Coverage and Tax Credits through an Exchange



Economic Choice

Some employers may weigh the costs of providing coverage against the new penalties and determine ending coverage is a better decision to keep the company competitive or in business. Example 4 is a real life example based on an existing company located just outside of Philadelphia.

Example 4. Employer weighs decision whether to keep or drop coverage.



Note: This example is for illustrative purposes only. If the employer decides to increase their worker's wages, however, they would face increased liability with respect to their employment taxes.

Free Choice Voucher Program

Beginning in 2014, an employer that offers health coverage to its employees must provide free choice vouchers to each qualified employee. Qualified employees for the purpose of this program are employees who do not participate in a health plan offered by their employer, whose share of the premium costs required under the employer-sponsored plan exceeds 8% but is less than 9.8% of their household income (consistency would seem to cap this at 9.5%--Congressional action may be necessary), and whose household income is less than 400% of the federal poverty level (currently $88,200 for a family of four).[vii]

The amount of the voucher is equal to the largest portion of what the employer would have paid to provide health coverage to the employee under the employer-sponsored plan. The voucher amounts paid by the employer are tax deductible as compensation and are excluded from income for the employee. Employers that provide free choice vouchers are not subject to penalties for employees who receive premium tax credits or cost-sharing reductions for coverage in an exchange. Employees may keep any difference between the voucher and the cost of coverage (which is treated as taxable income), possibly encouraging employees to move out of employer plans.

Other Employer Requirements

Large Firm Automatic Enrollment Program

Employers with more than 200 full-time employees and that offer enrollment in one or more health benefit plans are required to automatically enroll new full-time employees in a health benefits plan after enabling regulations are released. Furthermore, the automatic enrollment must include adequate notice to the employee of the right to opt out of the coverage.

Employee Notification Requirements

The new law requires all employers to provide each employee written notification of the existence of health insurance exchanges and subsidies. The required notice must include: (1) the existence of the exchange; (2) a description of the services provided by the exchange; (3) how the employee may contact the exchange for assistance; (4) that the employee may be eligible for a premium tax credit for a qualified health plan purchased through an exchange if the employer's health benefit plan's actuarial value is less than 60%; and (5) that the employee will lose the employer contribution toward health coverage, and that all or a portion of the contribution may be excludable from federal income taxes, if the employee purchases a qualified health plan through an exchange. These new notification requirements will take effect on March 1, 2013.

Large Employer Reporting Requirements

Applicable large employers are subject to increased reporting requirements to the Secretary of Treasury. The required information includes: (1) details about the employer (name of business, employer identification number); (2) whether full-time employees are offered coverage through an employer-sponsored plan; (3) details regarding the employer-sponsored plan (waiting period, availability, premium costs, applicable large employer's share of costs of benefits); (4) number of full-time employees for each month during the year; and (5) the name, address, and the tax

identification number of each full-time employee during the year, and the months during which the employee was covered under the employer-sponsored health benefit plan.

C. Individual Mandate

Beginning in 2014, most U.S. citizens and legal residents are required to maintain qualifying health insurance coverage that includes minimum essential coverage or a benefits package offered by a grandfathered plan. Qualifying health coverage includes employer-sponsored plans in the individual market, government-sponsored programs, grandfathered group health plans, and other coverage recognized by the Secretary of Health and Human Services. Individuals who fail to maintain coverage are faced with a penalty in the form of an excise tax phased in from 2014 to full implementation in 2016. The penalty is equal to the greater of a flat fee or a percentage of a taxpayer's household income.

Table 4. Individual Penalties

Year	Flat Fee	Percentage of Income
2014	$95	1.0%
2015	$325	2.0%
2016 and beyond	$695*	2.5%

*The penalty will be increased annually by the cost-of-living adjustment

The Internal Revenue Service (IRS) cannot impose criminal or civil penalties for noncompliance. The Joint Committee on Taxation estimates individuals will pay $17 billion in penalties as a result of not purchasing qualified health coverage (CBO, March 20, 2010).

D. Essential Health Benefit Package

An essential health benefits package refers to coverage that provides for essential health benefits, limits the cost sharing for such coverage, limits the deductible for small group plans, and provides benefits that are at least actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan.

Essential health benefits must be included as part of any qualified health plan made available through an exchange or offered by an employer in the small group market. The scope of the essential health benefits is intended to be equal to the scope of benefits provided under a typical employer plan and may be further expanded by the Secretary of HHS.

Table 5 outlines the mandated benefits required to be covered by non-grandfathered plans.

Table 5. Minimum Essential Health Benefits Package

	Required Services
Covered Services	• Ambulatory patient services • Emergency services • Hospitalization • Maternity and newborn care • Mental health and substance use disorder services • Prescription drugs • Rehabilitative services • Laboratory services • Prevention and wellness services and chronic disease management • Pediatric services, including oral and vision care

An essential health benefits package also must limit total out-of-pocket spending for covered benefits in new plans to no more than the limits for health savings accounts. The Committee on Ways and Means estimates these amounts will be $6,200 for an individual and $12,300 for a family in 2014 (House-Senate Comparison of Key Provisions, January 6, 2010).

For health plans offered in the small group market, the deductible for essential health benefits is limited to $2,000 for single coverage, $4,000 for family coverage, increased by employer contributions to a flexible spending account, indexed after 2014.

E. Individual Premium Assistance, and Cost Sharing Assistance

Tax credits and reduced cost sharing are available for certain individuals with incomes less than 400% of poverty. Tax credits will limit the amount an individual must pay for health premiums for essential health benefits from 2% of income up to 133% of the federally defined poverty level to 9.5% at 400% of poverty. The credits are tied to the second-lowest-cost plan in the individual market where the person resides. Cost sharing is also reduced by credits, limiting the amount a person pays based on a sliding scale of income and phasing out at 400% of poverty.

Table 6 outlines the limits on premiums and cost sharing as a percentage of income.

Table 6. Premium and Cost Sharing Assistance

Income Range (as % of Federal Poverty Level)	Credit Equals Cap on Insurance as % of Income
Up to 133%	2%
133-150%	3-4%
150-200%	4-6.3%
200-250%	6.3-8.05%
250-300%	8.05-9.5%
300-400%	9.5%

Income Range (as % of Federal Poverty Level)	Limit on Cost Sharing
100-150%	94%
150-200%	87%
200-250%	73%
250-400%	70%

F. Market Reforms

Table 7 outlines the insurance market reforms that apply to non-grandfathered plans and that must be a part of any qualified health benefits plan offered through an exchange. Only coverage through a qualified health benefits plan is eligible for tax credits and cost sharing reduction assistance.

Table 7. Market Reforms Applicable to Non-Grandfathered Plans

	Provision
First Plan Year On or After September 23, 2010	• Prohibits exclusions based on pre-existing conditions for children to 19 • No lifetime limits on the dollar value of benefits for any beneficiary or any unreasonable annual limits on the dollar value of benefits as defined by the Secretary (2010) • No coverage rescissions (retroactive policy cancellations) except in the case of fraud or misrepresentation • Plan must cover certain preventative health services with no cost sharing • Extend coverage to dependent adult children up to age 26 • Uniform explanation of coverage • Notice of material modifications • Non-discrimination requirements for insured plans • An internal and external appeals process • No prior authorization for emergency services • Plans must allow designation of a primary care provider

2014	• No preexisting condition exclusions for all participants
	• Guaranteed issue
	• Guaranteed renewability
	• Must cover minimum benefit package
	• Allows HIPAA wellness discount up to 30% (50% at Secretaries' discretion)
	• Limits on out-of-pocket cost sharing, maximum deductibles
	• Coverage of routine costs associated with clinical trials
	• Prohibition on waiting periods more than 90 days
	• Must provide a minimum actuarial value for benefits
	• File an annual report with HHS on employer and plan information
	• Eliminate annual limits on benefits.
	• Limits premium underwriting. Permits variation of premiums only by individual and small group plans:
	  • Individual or Family status;
	  • Geographic area (each state must establish 1 or more rating areas);
	  • Age (restricted to a variance of no more than 3 to 1);
	  • Tobacco use (1.5 to 1).
	• Plan disclosure of claims payment policies and rating practices.

G. Status of Grandfathered Plans

Grandfathered health plans are group health plans, including self-insured plans, or individual health insurance coverage in which an individual was enrolled on the date of enactment of the health care law (March 23, 2010). Family members are allowed to subsequently enroll in a grandfathered plan. Furthermore, new employees and their dependents will be permitted to enroll in a grandfathered group health plan without jeopardizing its grandfathered status.

It is not clear when grandfathered plans will no longer be considered exempt from the law's requirements on new plans. Any change in benefits covered or changes to cost sharing obligations would change the underlying structure of a benefit plan, and might result in all the new requirements for plans (coverage of all minimum benefits, cost sharing limits, etc.) to be provided by the previously grandfathered entity. Congressional staff have noted this ambiguity in the law, and it will be resolved through regulation / guidance later in 2010.

Collective Bargaining Agreements

Heath insurance coverage maintained pursuant to a collective bargaining agreement that was ratified before March 23, 2010, may not be subject to the new requirements of the health reform law until the date of termination of the last of the collective bargaining agreements relating to the coverage. The exact scope and intent of the collective bargaining rules will be clarified by regulations. However, a voluntary amendment of the collective bargaining agreement to conform to some of the new health law's requirements will not be treated as a termination of the agreement that might otherwise subject the plan to an earlier full-compliance deadline.

Timeline of Provisions That Are Applicable to Grandfathered Health Plans

While grandfathered plans are exempt from many of the law's new requirements, grandfathered plans are not exempt from all of the requirements. Table 8 outlines the mandates that will apply to grandfathered health plans and the effective dates of the provisions.

Table 8. Provisions Applicable to Grandfathered Health Plans

First plan year on or After September 23, 2010	• Prohibits exclusions based on pre-existing conditions for children to 19 • No lifetime limits on the dollar value of benefits for any beneficiary or any unreasonable annual limits on the dollar value of benefits as defined by the Secretary (2010) • No coverage rescissions (retroactive policy cancellations) except in the case of fraud or misrepresentation • Extend coverage to dependent adult children up to age 26 • Uniform explanation of coverage • Notice of material modifications
2014	• Prohibition on waiting periods more than 90 days • No preexisting condition exclusions for all participants • File an annual report with HHS on employer and plan information Eliminate annual limits on benefits

Sources: Information taken from H.R. 4872, the Health Care and Education Reconciliation Act of 2010; *Health Reform Implementation Timeline*, The Henry J. Kaiser Family Foundation; and *Health Care Reform Has Arrived*, "Grandfathered Plans," Proskauer Rose LLP.

Other Notable Provisions That Are Not Applicable to Grandfathered Health Plans

Although the provisions listed in table 8 apply to grandfathered health plans, there are a number of notable provisions that are not required. These provisions include (but are not limited to): no discrimination based on health status, mandated cost sharing limits, mandated coverage for clinical trials, and annual reporting requirements regarding quality of care.

H. Health Insurance Exchanges

In 2010, the U.S. Department of Health and Human Services (HHS) must publish standards to create portals so consumers may compare health plans based on benefits offered and premiums charged. By 2014, state-based health insurance exchanges that are built off the portals would be established for individuals and small groups to assist in the selection and enrollment in a health plan. States may form regional exchanges or allow more than one exchange to operate in a state, and may merge the individual and small-group exchanges into one exchange. States are permitted to allow businesses with more than 100 employees to participate in an exchange beginning in 2017.

Table 9 outlines the benefit categories available through the 2014 exchanges.

Table 9. Health Benefits Plan Options in Exchanges

Plan	Description
Bronze	• Provides essential health benefits package and covers 60% of the benefit costs of the plan.
Silver	• Provides essential health benefits package and covers 70% of the benefit costs of the plan.
Gold	• Provides essential health benefits package and covers 80% of the benefit costs of the plan.
Platinum	• Provides essential health benefits package and covers 90% of the benefit costs of the plan.
Catastrophic	• Available to those younger than age 30 or to those exempt from the mandate to purchase coverage. Plan available only in the individual market.

Source: P.L. 111-148

Small Business Health Options Program (SHOP) Exchanges

No later than 2014, states are required to set up Small Business Health Options Programs, or SHOP exchanges, in which small businesses would pool together to purchase insurance. If a state fails to establish a SHOP exchange by 2014, the federal government would provide one of its own.

Small businesses are defined as having fewer than 100 employees, although states would have the option of limiting pools to companies with 50 or fewer employees through 2016. Companies expanding beyond the size limit would be grandfathered in.

I. Reinsurance and Risk Corridors

For the individual market, each state must establish by January 1, 2014, a three-year reinsurance program to collect payments from and make payments to health insurers that provide coverage to high-risk individuals based on their risk profile. The reinsurance program will redistribute $25 billion in funds from insurers that cover low-risk enrollees to plans that cover high-risk enrollees.

In addition, the law creates risk corridors for the individual and small-group markets. The risk corridors, which will begin in 2014 and end in 2016, operate similarly to the Medicare Part D risk corridors. For plans with high medical costs over a percentage threshold, the HHS Secretary would pay plans a fraction of the proportion over the threshold. For plans with low medical costs, the plans would pay the Secretary a fraction of the proportion below the threshold.

The intent of both the reinsurance program and the risk corridor program is to stabilize the market as new exchanges are established and to smooth out medical costs and premiums through 2016.

J. Tax Provisions

The new law makes a host of changes to the Code outside of the new employer penalties for not offering coverage and new premium subsidies for individuals, many of which could negatively impact employers small and large. In total, the revenue provisions raise a net $437.8 billion over 10 years (JCT Report, JCX-17-10). This does not include the tax credit program for small businesses that is estimated to provide $37 billion in tax relief for the costs of coverage in small firms (JCT Report, JCX-17-10).

Table 10 highlights the revenue provisions of the law, the effective date and the revenue impact.

Table 10. Revenue Provisions

Provision	Effective Date	Revenue Impact ($Billions)
40% excise tax on high-cost plans	2018	$32.0
FSA, HSA, HRA definition of medical expenses	2011	5
Increase to 20% penalty for non-health withdrawals from an HSA or Archer MSA	2011	1.4
Limit salary deferrals to FSAs to $2,500, indexed to inflation after 2013	2013	13.0
Require information reporting on payments to corporations	2012	17.1
Fee on drug manufacturers	2011	27.0
Fee on insurance providers	2014	60.1
2.3% tax on manufacturers and importers of medical devices	2013	20.0
Eliminate deduction for Medicare Part D employer subsidy	2013	4.5
Raise 7.5% adjusted gross income (AGI) floor on medical expense deduction to 10%	2013	15.2
$500,000 deduction limit on compensation of insurance providers	2013	0.6
Increase Medicare payroll tax by 0.9% on earned income in excess of $200,000/$250,000 (unindexed); impose new 3.8% investment tax on unearned income for taxpayers with AGI in excess of $200,000/$250,000 (unindexed)	2013	210.2
10% excise tax on tanning beds	2010	2.7
Exclude unprocessed fuels from biofuel credit	2010	23.6
Codify economic substance doctrine and impose penalties	2010	4.5
Impose fee on health insurance and employer plans to fund comparative effectiveness research	2012	2.6
Therapeutic discovery project credit	2010	-1
Other revenue provisions		25.9
Total		$437.8

Note: Excludes some provisions related to student loans and the adoption credit.
Source: JCX-17-10, Joint Committee on Taxation, March 20, 2010

Investment Tax

Perhaps less understood and not well known, the new tax on unearned income—known as the investment tax—is a massive revenue raiser that was added through the Reconciliation Act during the last week of consideration of the health reform package. Combined with the increase in the Medicare payroll tax, the provisions make up nearly half—$210.2 billion of $437.8 billion—of the increased taxes imposed by the bill.

The 3.8% tax would be levied on individuals, estates, and trusts based on certain net investment income over a dollar threshold amount. The tax is applied to investment income net of any deductions allowed for the investment. For individuals, the tax is applied to the lesser of net investment income or modified AGI over a threshold amount ($200,000 individuals, $250,000 married filing joint return, or $125,000 married filing separate returns). Modified AGI is AGI plus any foreign income typically excluded under section 911 of the Internal Revenue Code. For an estate or trust, the tax is 3.8% of the lesser of undistributed net investment income or the excess of AGI over the dollar amount at which the highest income tax bracket applies.

Net investment income includes gross income from interest, dividends, royalties, rents, and net capital gains. Investment income does not include interest on tax-exempt bonds, veterans' benefits, excluded gain from the sale of a principle residence, distributions from retirement plans, or amounts subject to self-employment taxes.

The tax applies to taxable years beginning after December 31, 2012.

The practical impact of the investment tax is that it will make capital more expensive and savings options less desirable. This will likely impact employers, particularly small businesses, that need capital to generate new jobs or projects, and will likely slow economic growth and hiring.

Medicare Payroll Tax

The new law raises the employee portion of the Medicare (the Hospital Insurance or HI) payroll tax by an additional 0.9% on wages above a dollar threshold. Unlike the existing 1.45% tax on wages, the additional tax is levied on the combined wages of the employee and the employee's spouse in the case of a joint return. The dollar threshold is $250,000 for a joint return and $200,000 for all other returns.

The employer is required to withhold the additional tax, as is the case for the existing HI payroll tax. If an employer fails to do so, the liability for the tax is on the employee, not the employer. The same additional tax applies to the HI portion for self-employed individuals. The dollar thresholds are the same, and no deduction is allowed for the additional Self Employment Contribution Act (SECA) tax. The provision applies to wages received after December 31, 2012.

Most economists agree that increased payroll taxes depress wages.

Excise Tax on High-Cost Plans

The law imposes a 40% excise tax on high-cost health plans, effective in 2018. Health plans for individuals and families with an actuarial value exceeding a dollar threshold ($10,200 for individuals and $27,500 for families) will be subject to a 40% tax on amounts exceeding the threshold. Higher thresholds ($11,850/$30,950) apply to retirees who are age 55 or older but who are not yet entitled to Medicare, or for high-risk professions such as construction, mining, forestry, agriculture, longshoremen, law enforcement, or fire protection. The dollar limits are indexed to inflation plus 1% in 2019. For 2020 and thereafter, the dollar value is increased by inflation. Benefits not counted against the threshold include vision and dental, long-term care, and accident and disability insurance.

The thresholds may be higher due to a little-noticed provision in the reconciliation package that changed the underlying Senate bill. Under that provision, the initial thresholds are adjusted upward if premium increases in the Blue Cross Standard Option plan under the Federal Employee Health Benefits Program are greater than 55% between 2010 and 2018. The thresholds would be adjusted upward to compensate for the excess cost growth. Premium increases in the Standard Option Plan over the last 10 years have been 8.6% for self and 8.7% for families, more than the 5.6% increase implied by the 55% factor. Thus, it is likely the initial dollar limits will be more than the dollar values suggested above.

The fee is paid by the insurance issuer or, in the case of a self-insured plan, by the employer or plan administrator. The tax is calculated on the total insurance premium paid by either the employer or employee, employee contributions to FSAs, and employer contributions to HRAs and HSAs. Because premiums are a reflection of medical costs, plans in high-cost areas may be impacted by the tax due to underlying medical costs, not the richness of a plan's benefits.

The total amount raised under the provision is estimated to be $32 billion from 2018 to 2019 (estimates not available after 2019).

According to a study by the Joint Economic Committee's Minority Staff, a family plan with the average national premium in 2010 would be subject to the tax in 2027, just eight years after the tax is implemented. Absent cost reductions in those plans, a majority of Americans would be subject to the tax in a relatively short amount of time.[viii]

Medicare Part D Retiree Subsidies

Employers currently receive a 28% subsidy (up to $1,330) for each qualifying covered retiree to help offset the costs of drugs and to incentivize employer-sponsored retiree coverage. The law eliminates the deduction of the 28% subsidy. The subsidy was created in 2003 and has been provided since 2006 as a way to keep retirees on their employers' plans and to prevent dumping retirees into stand-alone individual Part D drug plans.

Approximately 3,500 companies currently receive the subsidy.[ix] The provision eliminating the subsidy is expected to affect primarily industrial companies with retirees represented by collective bargaining pacts, as these benefits are more difficult for companies to reduce.

Accounting rules require publicly traded companies to restate their earnings to account for the present-day value of future tax liabilities, even though the start date of the provision is January 1,

2013. S&P 500 companies are expected to take a combined hit of $4.5 billion to first quarter earnings.[x] The following companies have already reacted to the change in the law:

- AT&T intends to take a charge of $1 billion in the first quarter of 2010 according to a March 26 filing with the Securities and Exchange Commission.[xi]
- John Deere issued a press release on March 25 noting the new provision would increase after-tax 2010 expenses by $150 million.[xii]
- Caterpillar stated that after-tax earnings for 2010 would decrease by $100 million.[xiii]

The Joint Committee on Taxation (JCT) estimates the provision would raise $4.5 billion over 10 years.[xiv] Because costs in Medicare Part D are greater than the value of the subsidy and the tax deduction, it is likely any private coverage dropped will cost taxpayers more than the subsidy or tax deduction as millions of retirees might be shifted to Part D[xv]. According to a recent report by the Moran Company, perhaps as many as 1.5 to 2 million retirees out of a total of about 7 million will shift to Part D.[xvi] Neither CBO's nor JCT's estimates take into account the spending impact on federal programs as retirees are shifted into Medicare Part D.

Health Industry Taxes

The law applies new taxes on pharmaceutical manufacturers and importers, health insurance companies, and device manufacturers and importers. These taxes will likely be passed through to consumers—employers and their employees and their families—in the form of higher premiums.

Pharmaceutical Manufacturers and Importers. Beginning in 2011, the law imposes a fee of $27 billion over ten years on drug manufacturers and importers based on their share of "covered" sales to government purchasers. Sales are adjusted to reflect any price concessions, including discounts and rebates. Covered sales exclude the first $5 million in sales, 90% of sales between $5 million and $125 million, 60% of sales between $125 million and $225 million, and 25% of sales between $225 million and $400 million. Companies will pay the fee by September 30 of each year. The fee is not deductible.

Health Insurance Companies. Beginning in 2014, the law imposes a fee on health insurance companies based on the value of net premiums for policies sold in the United States. The fee does not apply to self-insured plans. The value is calculated by determining each insurer's share of total premiums in a year and a year-specific aggregate. The share for each company is then determined as a percentage of the total market. The first $25 million in net premiums are excluded, and 50% of net premiums between $25 million and $50 million are excluded. Insurers must pay the fee by September 30 of each year. The fee is not deductible. Joint Tax estimates $60.1 billion in revenues over 10 years as a result of the provision (JCT Report, JCX-17-10).

Device Manufacturers and Importers. The law imposes a 2.3% tax on sales of medical devices after 2012. The tax does not apply to eyeglasses, contact lenses, hearing aids, and devices sold at retail establishments for individual use. JCT estimates $20 billion in revenues over 10 years from this provision (JCT Report, JCX-17-10).

Deduction Limit for Insurance Executives

The law imposes a $500,000 limit on the deduction for executive compensation (all officers, employees, directors, and other workers or service providers) paid by health insurance companies if at least 25% of the company's gross premium income is derived from insurance plans that offer qualified benefits plans. The provision does not apply to employers with self-insured plans.

The provision applies to compensation paid in tax years beginning in 2012 for services provided after 2009.

Tanning Salons

The law imposes a 10% tax on amounts paid for indoor tanning services. The tax is collected by tanning salon service providers and is effective for services provided on or after July 1, 2010. JCT estimates the provision will raise $2.7 billion over 10 years (JCT Report, JCX-17-10).

HSAs

Distributions from an HSA or Archer Medical Savings Account (MSA) must be used for qualified medical expenses, or they are subject to a penalty and income tax. Beginning in 2011, the penalty is increased from 10% to 20% for HSAs and from 15% to 20% for Archer MSAs. The provision raises $1.4 billion in revenues over 10 years (JCT Report, JCX-17-10).

FSAs

Beginning in 2013, the law limits salary deferral contributions to an FSA to $2,500 annually. The limit is indexed to inflation after 2014. Currently the allowed contribution is unlimited. JCT estimates the provision will raise $13 billion over 10 years (JCT Report, JCX-17-10).

Excluding Over-the-Counter Drugs from HSAs, FSAs, HRAs, and Archer MSAs

Under the law, the cost of over-the-counter medicines may not be reimbursed with funds through an HSA, FSA, HRA, or Archer MSA, unless the medicine is prescribed by a physician (or unless it is insulin). The provision is effective beginning in 2011 and would raise $5 billion in revenue over 10 years (JCT Report, JCX-17-10).

AGI Floor on Medical Expenses

The law raises the AGI threshold for claiming an itemized deduction for medical expenses from 7.5% to 10.0% beginning in 2013. The 7.5% threshold is retained through 2016 for individuals who have reached age 65 or who have a spouse who attained age 65 before the end of a tax year. JCT estimates this provision will raise $15.2 billion in revenue over 10 years (JCT Report, JCX-17-10).

Biofuel Producer tax Credit

The law excludes certain byproducts of paper manufacturing—so-called "black liquor"—from the existing biofuel producer credit effective for fuels sold or used after 2010. The biofuel producer credit provides a nonrefundable credit of $1.01 per gallon of qualified cellulosic fuel. JCT estimates the provision will raise $23.6 billion in revenues over 10 years (JCT Report, JCX-17-10).

Investment Credit for Qualifying Therapeutic Discovery Projects

The law creates a two-year credit for new therapies for acute and chronic illness, particularly for products that show reasonable potential to result in new therapies that meet unmet medical needs. Qualifying investments made by companies with fewer than 250 employees are eligible for a 50% credit for investments made in taxable years 2009 and 2010. Funding for the program is limited to $1 billion and must be effective within 90 days of enactment. Qualified projects cannot also claim the orphan drug tax credit, the R&D credit, or bonus depreciation.

Funding for Comparative Effectiveness Research

The law creates a new trust fund financed by appropriations and a new tax on health insurance policies sold in the United States to support comparative effectiveness research that investigates clinical comparisons of the effectiveness of procedures, drugs, devices, and services. The tax is equal $2 per covered life ($1 for health policy years ending during fiscal year 2013) for issuers of insurance and for plan sponsors of self-funded plans. The dollar amounts are indexed to health cost growth and apply until 2019, when the tax ends. JCT estimates the provision will raise $2.6 billion in revenues over 10 years (JCT Report, JCX-17-10).

K. Small Employer Tax Credit

Beginning in 2010, employers with no more than 25 full-time employees and average wages of less than $50,000 purchasing health insurance for their employees and covering at least 50% of total premium costs are eligible for a tax credit. The full amount of the credit is available only to employers with 10 or fewer full-time employees and whose employees have average annual full-time-equivalent wages of less than $25,000.

For years 2010–2013 (Phase I), the tax credit equals up to 35% of the employer's premium cost based on the average premium contribution in the small-group market. Tax-exempt employers would receive up to a 25% credit. For years 2014 and beyond (Phase II), when exchanges are established, the tax credit equals up to 50% of the lesser of the employer's premium contribution toward insurance purchased through an exchange, or the average premium contribution in the small-group market. Tax-exempt employers would receive a credit up to 35%.

In determining full-time equivalents for this credit, the employer calculates the total number of hours of service for which wages were paid, divided by 2,080. No more than 2,080 hours may be counted for any individual employee.

The size of the credit is phased out based upon the number of employees and average wages. Beginning in 2014, the credit is available only for two years. An employer could qualify for the credit for a total of six taxable years—four years in the first phase and two years in the second phase.

The credit is available only to offset actual tax liability and is claimed on the employer's tax return. It is not payable in advance or refundable, so the employer must pay the employee premiums during the year and claim the credit at the end of the year.[xvii]

There are major concerns with the credit:

- The self-employed are excluded from the credit, yet they represent 78% of all small businesses in the United States. The earliest that the self-employed can receive assistance with affordability is 2014. However, they would qualify for the individual/family premium assistance only if they make below certain income levels (less than $43,320 for an individual or $88,200 for a family of four) *and* they purchase health coverage through the newly created exchanges.[xviii] .

- Only businesses with 10 or fewer employees that have average taxable wages of less than $25,000 *and* pay 50% of the cost of health coverage for their workers will qualify for the full credit. Those businesses with between 10 and 25 employees, with average taxable wages less than $50,000, and paying 50% of the cost of coverage for their workers will receive only a portion of the credit.

As of 2014, to continue to receive a tax credit for an additional two more years, small-business owners would have to drop their existing group coverage and purchase coverage in the newly created exchanges.

L. IRS Reporting Requirements

The health reform legislation creates a new mandate for the IRS to act as enforcer of some of the key provisions—including ensuring that employers offer health insurance and penalizing them for noncompliance. The IRS is expected to keep track of this through a series of reporting mechanisms established by the legislation.

Employers providing minimal essential coverage are required to file a report with the IRS no later than January 31 of the following year providing information about employees covered by the minimum essential coverage, the portion of the premium that is required to be paid by the employer, and any additional information required if the minimum essential coverage is offered through an exchange.

The employer must give each employee a statement showing information reported to the IRS regarding that particular employee. This reporting requirement is intended to aid the IRS as it determines whether individuals are meeting the coverage requirements and to determine their eligibility for the premium tax credit or cost sharing reduction.

Large employers are required to file a report with the IRS no later than January 31 of the following year certifying whether the employer offers full-time employees the option to enroll in minimum essential coverage through an eligible employer-sponsored health plan. Information on length of waiting periods, costs of premiums, total cost paid by the employer, number of full-time employees, and information on each full-time employee covered under the plan is required.

Additionally, employers are required to report the cost of employer-provided coverage on their employees' Form W-2.

Utilizing this reported information, the IRS will determine whether an employer falls under the mandate. If a business has failed to comply with this mandate for any month out of the year, it is required to pay a separate tax to the IRS.

The new responsibilities tasked to the IRS as enforcers of the individual and employer mandates have been estimated by the CBO to cost approximately $10 billion over 10 years.[xix] However, no money was provided for this dramatic expansion of IRS responsibility. Although assessable and collectable under the Code, the IRS authority to use certain collection methods is limited. Specifically, the filing of notices on liens and levies otherwise authorized for collection of taxes does not apply to the collection of this penalty. In addition, the statute waives criminal penalties for non-compliance with the requirement to maintain minimum essential coverage. However, the authority of the IRS to offset refunds or credits is not limited by this provision."[xx]

In other words, the IRS is severely limited in what it can do to enforce the fines imposed by the legislation. It appears the agency will have to rely on taxpayers either voluntarily obtaining or providing coverage or paying the penalty for noncompliance.

M. Changes to Retiree Health Insurance

Temporary Reinsurance Program

Effective 90 days after enactment, a temporary reinsurance program for employers offering retiree coverage is created until exchanges are available in 2014. However, only $5 billion has been allocated to the program, and the Secretary of Health and Human Services has the authority to stop taking applications for this program prior to the program's end date of January 1, 2014, based on funding availability.

Employment-based plans providing health benefits to early retirees (ages 55–64) and their dependents can apply to receive reimbursement for a portion of the cost of coverage. The program will reimburse employers or insurers for 80% of retiree claims between $15,000 and $90,000, adjusted each year based on Medicare percentage increases. Payments from the reinsurance program will be used to lower the costs for the employer and for enrollees in the employer plan and cannot flow directly to the plan sponsor. The payments may be used to lower:

- Premium costs
- Premium contributions
- Copayments
- Deductibles
- Coinsurance
- Other out-of-pocket costs

Elimination of Medicare Part D Coverage Gap

Since the inception of the Medicare Part D drug benefit in 2006, beneficiaries enrolled in certain Part D plans may pay 100% of prescription drug costs after total drug spending exceeds a certain statutory coverage limit until the beneficiary is eligible for catastrophic coverage.

Table 11. Part D Coverage

Drug costs	Cumulative Beneficiary Responsibility
0 to $310	100% of cost
$310 to $2,830	$310 plus 25% of total cost over $310
$2,830 to $6,440 (coverage gap)	$940 plus 100% of total cost over $2,830
More than $6,440 (catastrophic coverage)	$4,550 plus 5% of total cost over $6,440

Source: CMS

The newly enacted health reform legislation reduces the amount that Medicare enrollees are required to pay for their prescriptions once they reach the coverage gap, with different levels of subsidies for brand-name and generic drugs phased in beginning in 2011. The coverage gap will be eliminated by 2020.

- In 2010, Part D beneficiaries with spending in the coverage gap will receive a $250 rebate as early as June.
- In 2011, Part D beneficiaries who reach the coverage gap are eligible for a 50% discount on brand-name drugs, financed by the pharmaceutical industry. Government subsidies will provide 7% of generic drug costs, and the subsidies will increase yearly until 2020.
- Beginning in 2013, the government will begin providing subsidies for brand-name drugs for those who enter the coverage gap. The government's contribution will start at 2.5% and increase to 25% by 2020.
- By 2020, combined industry discounts and government subsidies will total 75% of brand-name and generic drug costs.
- The coverage gap will be eliminated by 2020.

In 2007 an estimated 3.4 million Part D enrollees (14%) reached the coverage gap.[xxi] CMS noted that additional enrollees spent enough to enter the "doughnut hole," but they did not pay out of pocket for their medications because they have low incomes and receive separate subsidies.[xxii]

A Kaiser Family Foundation study found that of beneficiaries entering the coverage gap, 15% stopped taking their medications altogether.[xxiii]

Elimination of the coverage gap, in combination with elimination of the tax deduction for the retiree prescription drug subsidy, may lead employers to seriously consider whether they wish to continue providing retiree prescription drug benefits. With the gradual elimination of the coverage gap, the actuarial value of the Part D benefit will significantly increase. As a result, employers that access the retiree drug subsidy would be forced to increase their retiree prescription drug benefits to keep up with the actuarial value of the Part D benefit in order to continue receiving the subsidy.

N. Wellness Program Initiatives

The wellness provisions included in the health reform legislation essentially codify the wellness regulations that were established by the Secretaries of Labor, Treasury, and HHS under the portability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that already applied to group health plans, and the current health reform law broadens the wellness provisions to include health insurance issuers.

Employers may establish wellness programs providing a minimum discount, rebate, or other reward for participation without violating rules that prevent discrimination in group health plans based on health status–related factors. These programs are allowed under the following circumstances:

- The reward is not based on the participant satisfying a certain health standard; the program is allowed if the reward is made available to all similarly situated individuals.

- If the reward is based on the participant satisfying a certain health standard, the program is allowed if:

    - The reward is not greater than 30% of the cost of the health plan's coverage (including both employer and employee contributions),
    - The program is designed to promote health or prevent disease,
    - The full reward is available to all similarly situated individuals, and
    - The availability of reasonable alternatives is disclosed in plan materials.

The wellness incentive limit has been increased from 20% under HIPAA to 30% of the cost of coverage and may be raised to 50% by regulation.

Issues not addressed in the wellness program language include compliance with the Genetic Information Nondiscrimination Act. Additionally, the Equal Employment Opportunity Commission may decide to weigh in regarding potential violations of the Americans with Disabilities Act when employers require employees to participate in medical exams or complete a health risk assessment as a condition of participation.

Grants to Small Employers

For fiscal years 2011–2015, $200 million has been appropriated for grants to small employers. HHS is authorized to award grants to eligible employers to provide employees with access to comprehensive workplace wellness programs. $200 million has been appropriated for grants to small employers for fiscal years 2011-2015. Eligible employers are those that have fewer than 100 employees working 25 or more hours per week and did not provide a wellness program prior to March 23, 2010.

O. Voluntary Employer Participation in CLASS Program Premium Collection

The Community Living Assistance Services and Supports (CLASS) Act is a national insurance program for purchasing community living assistance services and supports. Employers who choose to participate in CLASS must automatically enroll employees in the same manner that an employer automatically enrolls employees in a 401(k) or similar plan. Employees may opt out of the program. Employers enrolling employees in the CLASS program are responsible for making monthly payroll deductions for the premium applicable to each enrolled employee.

Benefits will be no less than $50 per day for qualifying individuals. A five-year vesting period exists, after which participants unable to perform at least two activities of daily living or with substantial cognitive impairment would be eligible to receive a cash benefit.

Lawmakers contend the program will be funded entirely by premiums with no federal subsidies, and CBO estimates the program will raise $70.2 billion from 2010 to 2019.[xxiv] However, much of the program's revenues are realized in the first five years and prior to any paid benefits.

Richard Foster, chief CMS actuary, expressed his concerns about the solvency of the CLASS Act program in an April 2010 memo. According to the memo, CMS estimates that 2.8 million people would participate in the program by the third year, which equates to about 2% of potential participants, compared with a participation rate of 4% for private long-term care insurance offered through employers. Foster notes that will be probable participation of a significant number of individuals who would already meet the functional limitation requirements to qualify for benefits, and would therefore begin to receive benefits in 2016. To keep up with demand, Foster estimates that an initial average premium of about $240 per month would be required to adequately fund this level of enrollment and participation.[xxv]

According to the memo, "Voluntary, unsubsidized and non-underwritten insurance programs such as CLASS face a significant risk of failure as a result of adverse selection by participants. Individuals with health problems or who anticipate a greater risk of functional limitation would be more likely to participate than those in better-than-average health. Setting the premium at a rate sufficient to cover the costs for such a group further discourages persons in better health from participating, which may lead to further premium increases. This effect has been termed the 'insurance death spiral' … There is significant risk that [this] would make the CLASS program unsustainable."[xxvi]

P. Conclusion

At the end of the day, this law is largely about the worthy goal of expanding access to coverage, rather than the pressing imperative of addressing explosive health care costs. While the law makes a number of changes to reduce spending, particularly in the Medicare program, several more provisions will actually increase health care costs over and above costs that would have happened without enactment of health reform. Therefore, at least from the perspective of controlling costs, the law is likely worse than doing nothing at all.

CMS Actuary Analysis

On April 22, the Chief Actuary from the Centers for Medicare and Medicaid Services released a comprehensive analysis of the health reform law[xxvii]. The CMS Actuary found that:

- Under the law, national health spending will increase by $311 billion, or 0.9%, over the 2010 to 2019 period.[xxviii]
- The increase in national health spending is mitigated by price reductions in Medicaid and provider reimbursement cuts in Medicare.
- The Actuary found that the Medicare reimbursement changes are unrealistic, unlikely to remain in effect and would create access problems if were implemented as intended throughout the period.
- Some of the cost containment provisions included in the law would likely lead employers to reduce benefits for their employees.
- Some employers would drop coverage altogether.

It is important to note that while a part of the Administration, the CMS Actuary is by law an independent, impartial cost estimator.

National Health Expenditures

In aggregate, the Actuary found national health costs will increase by 0.9% or about $311 billion over the 2010 to 2019 period. This is not surprising. The law extends coverage to an estimated 32 million individuals and requires many benefit plans to be robust, with maximum limits on out of pocket expenses and first dollar coverage for many services. The law also shields consumers from premiums (via the affordability credit up to 400% of poverty) and cost sharing (via the cost sharing credits that pay for a portion of out of pocket expenses up to 400% of poverty).[xxix] As consumers become less price and cost sensitive, they demand more services. This is simply Economics 101.

Price Reductions in Insurance and Medicaid

Increased costs would be partially offset by "sizeable discounts imposed on providers by State Medicaid payment rules and the significant discounts negotiated by private health insurance plans."[xxx] A significant portion of the newly covered under the law would receive benefits through Medicaid. Many current Medicaid enrollees are already witnessing problems in

accessing providers. It is difficult to understand how the law will not exacerbate these problems with more than 16 million new enrollees and a limited supply of health providers.

Some studies estimate only half of primary care physicians are accepting new Medicaid patients currently.[xxxi] This is partly a reimbursement issue as one study pegged Medicaid payment rates at half of commercial fee levels.[xxxii] According to the UnitedHealth Center for Health Reform and Modernization, 67% of primary care physicians think that new Medicaid patients will struggle to find a suitable primary care doctor, absent other policy reforms. The UnitedHealth survey found that "Absent broader changes to the health care system, only 6% of primary care physicians reported that they expected actively to increase their Medicaid patient roster beyond current levels, and 35% said they expected their number to decrease."[xxxiii]

While the health reform law increases payments to community health centers, and provides two years of increased primary care physicians' Medicaid reimbursement, the Center estimates ensuring access over the rest of the decade would require an additional $50 billion in funding.[xxxiv]

In addition, many have argued the new health insurance exchanges would enhance competition and force price concessions to the benefit of consumers, which is exactly what the Actuary is estimating. Unfortunately, the increased demand for health services would far overwhelm any negotiated price discounts and would result in bending the cost curve up by 3.4% in 2019.[xxxv]

Medicare Reimbursement Changes

The Actuary estimates net savings in Medicare under the law would total $575 billion over the ten year period.[xxxvi] A large portion of the savings ($233 billion) would result from adjusting provider payments by reducing payment updates for improvements in productivity gains.[xxxvii] These permanent adjustments to price updates for providers would create strong incentives for hospitals, skilled nursing facilities and home health agencies to improve efficiency. But the Actuary states that:

> [...]It is doubtful that many will be able to improve their own productivity to the degree achieved by the economy at large…Thus, providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and, absent legislative intervention, might end their participation in the program (possibly jeopardizing access to care for beneficiaries.[xxxviii]

Thus, it is unlikely Congress would allow the savings envisioned by the Medicare cuts to actually occur, raising national health expenditures even more than the current Actuary estimates.

Even if Congress allows the payment changes to stand through 2019, the reduced payments will likely increase employer costs. As noted in the introduction of this paper, the Lewin Group estimates there are substantial underpayments to Medicare providers when compared to commercial payment rates. This underpayment is shifted to employers and individuals in higher provider payments in commercial plans that are then reflected in higher plan premiums. We have

heard countless stories about providers citing low Medicare and Medicaid reimbursements in negotiating tactics with private plans. Exacerbating the payment disparity between Medicare rates and commercial rates will likely further shift costs on private plans.

Impact on Employers

The CMS Actuary estimates an additional 13 million workers and family members would be covered as a result of expanded employer coverage under the law. But this increase is more than wiped away by 14 million workers and their families losing employer coverage, according to the Actuary. [xxxix]

The reasons for this are multiple:

- Some currently covered workers would enroll in Medicaid or the subsidized exchanges.
- Some smaller employers would be inclined to terminate coverage to qualify for more generous subsidies through the exchanges.
- Some employers would weigh [relatively low] penalties against the [relatively high] cost of providing coverage and determine dropping employee benefits is more cost effective.

Regarding the impact of the high cost plan tax outlined in Section J of this paper, the Actuary found that the tax would force employers to consider a reduction in employee benefits. In 2019, 12% of workers would be in employer plans subject to the tax.[xl] According to the Actuary, the number of plans subject to the tax would increase rapidly thereafter because plan benefit values would increase faster than the threshold for determining the tax. If implemented as intended, workers would face reduced benefits or pay additional taxes.

Summing It Up

Our opinion is that the combination of reduced flexibility, new taxes, new penalties, new benefit mandates, new reporting requirements and uncertainty about implementation far outweighs the potential benefits to employers of the new law. We have significant work to do to educate policy makers, employees and their families to understand these negatives and to help effectuate positive change.

That is why the Chamber is working to blunt the costs of the massive new government health care law, while promoting strategies and solutions that can help businesses get health care costs under control, improve quality, and increase coverage of the uninsured.

We will aggressively pursue the Chamber's plan to control health care costs, improve quality, and increase coverage. Various aspects of the plan include:

- **Health Information Technology (HIT):** Widespread adoption of HIT—including electronic prescriptions and medical records—will improve quality, lower costs, reduce medical errors.
- **Consumer-Focused Health Care:** Congress should make account-based plans more attractive to small businesses by increasing flexibility and improving the transparency of cost and quality data.

- **Medical Liability Reform:** The Chamber supports health courts, caps on punitive damages and other medical liability reforms that ensure fair damage awards, eliminate frivolous lawsuits, and lower health care costs.

- **Purchasing Across State Lines:** Individuals and small businesses should be permitted to purchase plans that are not subject to onerous state mandates, forcing states to have more competitive regulatory environments. The CBO says this will lower health care costs while improving choice.

- **Small Business Health Plans:** Allowing businesses to freely pool together and negotiate with health insurers will lower costs for government as well as businesses, while improving choice and competition.

- **Payment Reform:** Congress should make it easier for employers and insurers to create insurance plans that pay for quality, not quantity, and reward doctors for keeping patients healthy.

- **Fraud & Abuse:** Medicare and Medicaid fraud are running rampant and costing the taxpayers tens of billions of dollars every year. A broad array of countermeasures should be enacted immediately.

- **Long-Term Care:** The CLASS Act will clearly never be adequately funded. The program should be eliminated and real long-term care reform should be enacted so Americans can use pre-tax dollars to buy coverage from private plans.

For those provisions included in the new law that will harm employers and their workers, we will work to repeal them. For those changes that require refinement to work well, we will work to change them. For those provisions that require clarity to be implemented optimally, we will work with the Administration to educate all stake holders.

Our goal should be to promote expanded coverage and hold costs down. Doing one without the other makes little sense. While challenging, this combined task is not impossible.

We have outlined common sense solutions, and look forward to working with the Administration and Congress to undo some of the damage that has been done by the health reform law. Many of the reforms will not take effect until 2014, so there is some time to make adjustments. Together we can effect change that will promote a high value, efficient health system. In this conclusion we have outlined some common sense value-driven health care solutions to achieve our shared goals of increasing coverage while truly controlling costs. The Chamber is committed to advancing these ideas while both addressing some of the law's negative aspects and building upon some of the beneficial changes it will make.

About the Author and Staff

Joel White

The Founder and President, Joel White, spent twelve years on Capitol Hill as professional staff, where he helped enact nine laws, including the Medicare Modernization Act, the Trade Act, the Administrative Simplification Compliance Act, and the Children's Health Act.

Joel spent six years as staff on the Committee on Ways and Means, first as Professional Staff and then as Staff Director of the Health Subcommittee.

As Staff Director, Joel had responsibility for advising Members of Congress, developing strategy, holding hearings and negotiating and helping to enact legislation into law. Joel helped to produce more than 100 hearings on various issues while working for the Committee.

He was the lead staff negotiator on health issues for the Deficit Reduction Act and the Tax Reform and Health Care Act, which were signed into law. He also worked on the MMA, the Trade act and 5 other laws while at the Committee.

Prior to his work on the Ways and Means staff, Joel worked for Congressman Jim Greenwood (PA) for two years and Congressman Chris Shays (CT) for four years.

He is currently the Executive Director of the Health IT Now Coalition (www.healthitnow.org), a diverse group of 58 organizations representing patients, health providers, health insurers, agents, and brokers, employers and unions that have come together to help integrate information technology into health care. He is also the Executive Director of the Coalition for Affordable Health Coverage (www.cahc.net), a group of 20 organizations that promotes affordable health coverage and that has played an active role in the health reform debate.

Joel has been a member of the National Economist's Club for nine years and is a member of the Industry Advisory Panel of the American Society for Health Information Managers. He is the co-author of the book, Facts and Figures on Government Finance, which brings together data on public finance at all levels of government, with comparisons of taxing and spending levels spanning a half century.

Joel graduated from American University with a degree in International Relations and Economics.

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Jennifer joined JC White Consulting in December 2008 as Vice President, focusing on legislative and regulatory developments within the pharmaceutical, biotechnology and medical device sectors.

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Jennifer also spent several years on Capitol Hill as a legislative assistant to former Congressman James Greenwood (PA), with an emphasis on issues under the jurisdiction of the Energy and Commerce Committee.

Jennifer received her Bachelor of Arts in Political Science and History from Millersville University, and Master's Degrees in American Government and International Relations from Temple University. She holds the following securities licenses: Series 7 (General Securities Representative), Series 65 (Uniform Investment Advisor) and Series 87 (Registered Research Analyst).

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Drew joined JC White Consulting in December 2009 after spending 5 years on Capitol Hill serving as Senior Legislative Assistant to Congressman Louie Gohmert (TX-01). In this capacity, Drew assisted in strategizing and implementing the Congressman's health, tax, budget, energy, environment, transportation, appropriations and water resources agenda.

Drew received his Juris Doctor from the Catholic University of America, Columbus School of Law. He received his Bachelor of Arts in Political Science from Boston College.

ENDNOTES

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Appendix A

Health Reform Implementation Timeline: Employer Provisions
Immediate
• Provide tax credits to certain small employers with no more than 25 employees and average annual wages of less than $50,000 that provide health insurance for employees.
• Create temporary reinsurance program for employers providing health insurance coverage to retirees older than age 55 who are not eligible for Medicare.
• Limit the tax deductibility of executive compensation to $500,000 per individual employed by health insurance providers.
First Plan Year Beginning On Or After September 23, 2010
• Require individual and group policies to provide coverage for adult children up to age 26.
• Prohibit individual and group policies from imposing lifetime annual limits on insurance coverage, although certain annual limits may be imposed, as determined by the Secretary of Health and Human Services, on coverage until 2014.
• Prohibit rescission of health insurance coverage, except in cases of fraud or misrepresentation.
• Grandfather existing individual and group plans with respect to new benefit standards, but require grandfathered plans to adhere to some new conditions, including extension of dependent coverage and prohibition of restriction on coverage.
• Require employers (after enabling regulations issued) with more than 200 employees to automatically enroll employees into employer-offered health insurance plans. Employees may opt out.
2011
• Establish a national, voluntary insurance program for purchasing long-term care insurance, known as the Community Living Assistance Services and Supports (CLASS) program.
• Provide grants for up to 5 years for small employers (employers with fewer than 100 employees who work 25 hours per week,) that establish a wellness program.
• Initiate five-year state demonstration programs to address alternative approaches to existing medical malpractice litigation.
2013
• Create Consumer Operated and Oriented Plan (CO-OP) program to aid development of nonprofit, member-run health insurance companies to offer qualified health plans.
• Eliminate the tax deduction for employers receiving Medicare Part D retiree drug subsidy payments.
• Increase the itemized medical expense deduction threshold from 7.5% to 10% of adjusted gross income. Temporarily (2013-2016) exempt individuals 65 years or older.
• Limit flexible spending account (FSA) salary deferral contributions to $2,500 per year, indexed for inflation.
• Impose 2.3% excise tax on medical devices.
2014
• Establish state-based health insurance exchanges through which individuals may purchase qualified health insurance coverage.
• Create Small Business Health Options Program (SHOP) exchanges where small businesses (up to 100 employees) may purchase qualified health insurance coverage.
• Require individuals to have qualifying health insurance coverage or face a penalty, which is phased in over time.
• Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee receiving a premium tax credit a fee of $2,000 per full-time employee (excluding the first 30 employees from the assessment).
• Penalize employers that offer coverage having more than 50 employees with at least one full-time employee receiving a premium tax credit $3,000 for each employee receiving a premium credit. The total penalty amount is capped at the amount an employer would have to pay if no insurance coverage were offered.
• Create essential health benefits package providing a comprehensive set of services covering at least 60% of the actuarial value of the covered benefits and limit the cost sharing such that the out-of-pocket expense does not exceed that applicable to health savings account (HSA)–related coverage.

• Allow employers to offer employees premium discounts, waivers of cost-sharing requirements, or benefits that would not otherwise be provided (up to 30% of the cost of coverage) for participating in a wellness program and meeting standards. The Secretary of HHS may increase the discount to 50%.
2018
• Impose an excise tax on insurers of employer-sponsored health plans with aggregate values exceeding $10,200 for individual coverage and $27,500 for family coverage.

Appendix B – Glossary of Terms Used in Report

Actuarial Value: The ratio of benefit cost to allowed cost. It represents the portion of the total cost of covered benefits that are paid by a health insurance plan.

Continuation of Participation for Growing Small Employers: A qualified employer that is a small employer and that makes enrollment in qualified health plans offered through the group market available to its employees through an exchange. If the employer ceases to be a small employer because of an increase in the number of its employees, the employer will continue to be treated as a small employer for the period beginning with the increase and ending with the first day on which the employer does not make such enrollment available to its employees.

Cost-Sharing Reduction: A reduction in the cost-sharing amounts for benefits applicable to subsidy-eligible low-income taxpayers. The reduction is not available to any taxpayer eligible for minimum essential coverage outside of the individual market except for certain circumstances, including if the actuarial value of the eligible employer-sponsored plan is less than 60%.

Eligible Employer-Sponsored Health Plan: A group health plan offered by an employer to an employee.

Employment-Based Plan: A plan maintained by a current or former employer.

Essential Health Benefits: Benefits required in any qualified health plan made available through an exchange. Items and services required to be covered include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative services
- Laboratory services
- Prevention and wellness services and chronic disease management
- Pediatric services

Essential Health Benefits Package: A group health plan that:

- Provides essential health benefits

- Limits out-of-pocket spending by participants to the limits on health savings accounts, indexed after 2014
- Limits the deductible to $2,000 for single coverage, $4,000 for family coverage, increased by employee and employer contributions to a flexible spending account, indexed after 2014

Exchange: A governmental agency or a nonprofit entity designated by states for making qualified health plans available to qualified individuals and qualified employers.

Grandfathered Plan: A grandfathered plan is a group health plan in effect on March 23, 2010. Grandfathered plans retain grandfathered status even if:

- Family members of a participant enrolled on March 23, 2010, enroll in the plan after March 23, 2010; and
- New employees and their families enroll in the plan after March 23, 2010.

Grandfathered plans also include any coverage maintained pursuant to a collective bargaining agreement that was ratified before March 23, 2010.

Large Employer: In connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employees at least 1 employee on the first day of the plan year.

Minimum Essential Coverage: With respect to the fulfillment of the individual mandate, **c**overage provided under Medicare, Medicaid, CHIP, TRICARE, the VA, Peace Corps, and eligible employer sponsored plan, health plan offered in the individual market, Grandfathered plan or state health benefits risk pool.

Premium Tax Credit: A credit available to taxpayers with income below 400% of poverty who purchase health coverage in the individual or small group market through an Exchange. The credit is not available to any taxpayer eligible for employer sponsored coverage unless the required contributions under the employer sponsored plan equals or exceeds 9.5% of household income, or the actuarial value of the employer sponsored plan is less than 60%.

Qualified Employer: A small employer that elects to make all full-time employees eligible for 1 or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans.

Qualified Health Plan: a health plan that:

- Has in effect a certification that such plan meets necessary criteria, issued or recognized by each Exchange through which the plan is offered;
- Provides the essential health benefits package; and
- Is offered by a health insurance issuer that is licensed and in good standing to offer insurance coverage in each State where offered and agrees to at least one qualified health plan in the silver level and gold level in each Exchange. Additionally, the issuer must

agree to charge the same premium rate for each qualified health plan without regard to whether the plan is offered through an Exchange or directly from issuer through an agent.

Qualifying Covered Retiree**:** An individual eligible for Medicare but not enrolled in either a Medicare Part D prescription drug plan or a Medicare Advantage prescription drug plan but is covered under a qualified retiree prescription drug plan, such as through an employer.

Seasonal Worker: A worker who performs labor or services on a seasonal basis, and retail workers employed exclusively during holiday seasons.

Small Employer: In connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

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