AMERICAN BENEFITS COUNCIL

November 30, 2009

PRIORITY EMPLOYER ISSUES FOR SENATE CONSIDERATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

PRIORITY HEALTH REFORM PROVISIONS

I. ERISA
(Retain exclusive federal regulation of self-insured employer plans)

Patient Protection and Affordable Care Act: Retains the ERISA regulatory framework for employer-sponsored health coverage.

Council Position: The regulatory framework established by the Employee Retirement Income Security Act of 1974 (ERISA) makes it possible for multi-state employers to provide uniform benefits to their employees and consistently administer these essential benefits without being subject to conflicting state or local regulations. All employers that offer health benefits to employees who live in different states -- and potentially every state -- consider the ERISA regulatory framework to be absolutely essential and vital to their ability to have a consistent benefits strategy for their entire workforce.

Recommendation: We urge that no amendments be adopted that would undermine the ability of employers to maintain and administer their plans as uniformly and efficiently as possible. We also urge that no provisions be included that would permit state waivers of ERISA since this would also lead to state-by-state regulation of employer-sponsored self-insured plans and would significantly increase the cost and complexity of health benefits sponsored by multi-state employers.

II. EMPLOYER "PAY OR PLAY" MANDATE
(Oppose possible Kerry employer mandate amendment)

Patient Protection and Affordable Care Act: Includes a modified version of the employer responsibility provisions from the Senate Finance Committee bill. Employers retain flexibility to design health plans that meet the needs of their workforce. However,

if any full-time employee declines employer-sponsored coverage either because their share of the cost for the employer plan is deemed unaffordable (exceeds 9.8 percent of income) or if the plan has an actuarial value below 60 percent, and if the employee obtains an income-based tax credit for coverage in a health insurance exchange, then the employer is subject to an assessment for each such employee. In addition, employers would be assessed for their total number of full-time employees if an employer does not offer health coverage at all.

Council Position: We recognize that health care reform will also involve new responsibilities for employers and we believe the employer responsibility provisions approved by the Senate Finance Committee struck an appropriate balance between establishing new duties for employers while recognizing that employers must have flexibility to design benefit plans that meet the unique needs of their workforce.

Recommendation: The Patient Protections and Affordable Care Act already goes farther than the employer responsibility provisions set forth in the Senate Finance Committee measure. We oppose the more costly, coercive and disruptive employer "pay or play" provisions that were included in both the Senate HELP Committee bill and the House-passed bill, and urge that amendments that seek to add such provisions to the Senate bill be rejected. These other approaches would penalize employers for not offering health coverage unless the coverage meets highly prescriptive, "one-size-fits-all" standards set by federal regulations and employers make minimum contributions for the mandated coverage.

We are very concerned that ultimately, if unintentionally, the cumulative effect of these much more rigid requirements will lead to a net <u>reduction</u> in employer-sponsored coverage by leading some companies to simply "pay" rather than "play. This would lower the level of active employer engagement and the important role employers play as innovative and demanding purchasers of health care services. Making health care coverage more affordable for employers of all sizes is the best way to ensure the continuation of the extremely high level of participation by larger employers in offering health coverage and increase the level of participation by smaller employers who are struggling to make health coverage a reality for their employees.

III. EMPLOYEE OPT-OUT FROM EMPLOYER PLAN (Oppose possible Wyden "Free Choice" amendment)

Patient Protection and Affordable Care Act: The version of the Patient Protection and Affordable Care Act proposed by Senate Majority Leader Reid on November 19 does <u>not</u> include provisions to require employers to provide vouchers for employees who opt-out of employer-sponsored health plans in order to obtain coverage in an insurance exchange. However, Senator Ron Wyden (D-OR) has indicated that he intends to offer an amendment to modify the Senate measure to compel employers to provide a

voucher – equal to the "largest portion" of any employer contribution to health coverage offered to employees – if an employee opts-out of an employer plan based upon an affordability standard. Employees who opt-out would be able to keep the amount of the voucher that exceeds the cost of the coverage in the exchange and not be taxed on this excess amount. Senator Wyden has also indicated that he intends to continue working, as the legislation proceeds, to provide similar options to other individuals with employer-sponsored coverage.

Council Position: While it is important to address the needs of those who may find their employer-provided coverage too expensive and who may not otherwise qualify for a federal subsidy, it is not appropriate to penalize employers for sponsoring generous plans by requiring them to provide a voucher equal to their largest contribution to any plan they sponsor. Also, allowing employees who opt-out of an employer plan to keep, on a tax free basis, the amount that the voucher exceeds the cost of the coverage they actually purchased would inappropriately reward a limited number of employees and misuse plan resources that are needed to pay claims of other employees.

Recommendation: Employers should not be required to subsidize employees who decline coverage under an employer plan and opt to obtain coverage elsewhere. Under this approach, employees who remain in the employer's plan would lose the value of the premium contributions from their co-workers who opt-out and obtain coverage in the insurance exchanges. This would result in higher costs for the plan sponsor as well as the employees who participate in the employer plan. This approach would also reduce the employer's purchasing leverage when negotiating with insurers or benefit administrators for the plans offered to their employees, resulting in added costs paid by employers and employees.

A much simpler and fairer alternative to Senator Wyden's proposal would be to allow employees who are unable to afford coverage under their employer plan to obtain low-cost catastrophic coverage with comprehensive preventive benefits and access to primary care services, as Senator Olympia Snowe (R-ME) proposed during consideration of health reform legislation by the Senate Finance Committee. These individuals should also qualify for premium subsidies in a health insurance exchange to help make these low-cost catastrophic plans affordable and to help ensure that they meet their coverage obligation.

IV. WAITING PERIODS AND DEFINITION OF FULL-TIME EMPLOYEES
(Allow up to a 90-day initial enrollment waiting period and do not include temporary or seasonal workers in the definition of "full-time" employees)

Patient Protection and Affordable Care Act: Penalizes employers for initial enrollment waiting periods that are longer than 30 days and includes an absolute prohibition on

any waiting periods longer than 90 days. Also, defines "full-time" employees as those who work 30 or more hours per week, but does not limit this definition to individuals who work on more than seasonal or temporary basis for an employer.

Council Position: Employers should be permitted to establish initial enrollment waiting periods up to 90 days without incurring a penalty. This is particularly important for restaurants, retailers, and other industries where there is very high turnover among employees. Similarly, the definition of a "full-time" employee should not include those who work only on a temporary or seasonal basis for an employer.

Recommendation: Delete penalties in the Senate measure that apply to waiting periods longer than 30 days and the higher penalties that apply to waiting periods above 60 days. Retain prohibition on waiting periods longer than 90 days. Also, amend definition of "full-time" employees to exclude individuals who work on a seasonal or temporary basis for an employer.

V. PUBLIC PLAN OPTION
(Oppose possible Rockefeller and/or Schumer public plan option amendments)

Patient Protection and Affordable Care Act: Includes a modified version of the public plan option from the health care reform bill approved by the Senate HELP Committee. Under this approach, a public plan would be required to negotiate reimbursement rates with health care providers, though not higher than the average reimbursement rates paid by private health plans offered in an insurance exchange. States may approve legislation to not include the public plan option in their insurance exchanges.

Council Position: We recognize that the public plan option issue and possible alternatives are still under consideration. Our view on this issue has consistently been that vibrant competition among private health plan options in a reformed market should be given every opportunity to succeed.

Transitioning from the market rules in place today to a reformed market with new insurance exchanges available in every state is a dramatic and positive change in current practices. Achieving a reformed and well regulated private market is essential and should be a central focus of health care reform. This core element of health reform will be challenging enough without attempting to introduce public plan options that risk destabilizing the insurance market at the same time it will be undergoing significant change and meeting demanding new standards.

If the public plan will operate under a different set of rules than the private market, then it will clearly have an unfair advantage. If it truly operates under the same set of rules (if that is even possible) then it is not needed at all, especially when the

government will have many other responsibilities to ensure that health reform is implemented appropriately.

Recommendation: We urge Congress to reject the inclusion of a government-sponsored public plan in an insurance exchange. We also oppose any amendment that would permit a public plan to use Medicare payment rates -- even for a temporary start-up period -- as this will increase cost-shifting to private payers and give a public plan an unfair market advantage over private plan competitors. Employers will already be facing an increasing cost-shift burden under this legislation because of reductions in Medicare payments to providers and expansions in Medicaid eligibility.

VI. WORKPLACE WELLNESS PROGRAMS
(Retain Enzi/Harkin and Carper/Ensign provisions to encourage wellness program participation)

Patient Protection and Affordable Care Act: Includes the wellness program incentive provisions from the Senate HELP and Senate Finance Committee bills. These provisions permit employers to discount up to 30 percent of the premium or cost-sharing for employee-only coverage for participants in a workplace wellness program (with discretion given to the Secretary of Health and Human Services to permit discounts up to 50 percent). The provisions also codify current law protections in HIPAA regulations to safeguard the privacy of employee health information and to assure that wellness programs meet appropriate non-discrimination standards. For example, any rewards offered by the employer must be available to all "similarly situated" individuals. In addition, there must be a reasonable alternative available to those for whom medical conditions prevent them from achieving the reward, or for whom it is medically inadvisable to attempt to achieve the reward.

Council Position: Workplace wellness programs are an important component of health care reform and help to reduce health costs, improve productivity, and promote personal responsibility for achieving and maintaining a healthy lifestyle. Provisions were included in both the Senate HELP bill and the Senate Finance Committee bill, with bipartisan support, to allow employers to offer premium or cost-sharing discounts to encourage employer participation in workplace wellness programs.

Recommendation: We strongly support retaining the wellness program incentive provisions in the Patient Protection and Affordable Care Act that were previous approved on a bipartisan basis by both the Senate HELP Committee and the Senate Finance Committee.

VII. Individual Responsibility for Obtaining Coverage
(Establish adequate incentives for individuals to obtain and maintain coverage)

Patient Protection and Affordable Care Act: Starting in 2014, individuals would be required to obtain "minimum essential coverage" or pay a penalty of up to $95 in 2014, $350 in 2015, $750 in 2016 (and indexed annually in the following years). Also allows for young adults under age 30 to enroll in a low-cost catastrophic insurance policy that also provides three primary care visits a year and first-dollar coverage for preventive services. Individuals who are not able to afford the lowest cost comprehensive plan in a health insurance exchange (a "bronze" plan) may also enroll in the policy for young adults.

Council Position: A reformed and stable insurance market requires broad participation so that individuals do not wait to obtain health insurance only when they or a member of their family has an imminent need for medical services. Achieving broad participation in the marketplace requires a combination of minimum standards that assure the availability of affordable coverage and adequate financial incentives to encourage individuals to obtain and maintain coverage.

Recommendation: We support efforts to broaden the availability of low-cost coverage to satisfy the individual mandate requirement, particularly for individuals who are not able to afford "bronze" level health coverage (the lowest level coverage available in a health insurance exchange) because these individuals might otherwise remain uninsured entirely. We also believe that the penalties for not obtaining health insurance coverage under the Patient Protection and Affordable Care Act are very likely to be insufficient in their current form to encourage early and continuous enrollment in health coverage. Finally, the index for the assessment should keep pace with overall increases in health care costs.

VIII. CLASS Act
(Do not include CLASS Act in health reform legislation and instead direct appropriate committees and agencies to further examine CLASS Act and alternatives)

Patient Protection and Affordable Care Act: Establishes a new national insurance program for community living assistance services and support (CLASS Act), financed through voluntary payroll deductions. Working adults would be automatically enrolled in the program unless they elect to opt-out.

Council Position: The Council supports public and private efforts to better meet the long-term care needs of the elderly and disabled individuals, but believes that the CLASS Act and other approaches to meeting these needs should be more thoroughly

examined by Congress before the establishment of a major new entitlement obligation for the federal government. This is particularly important since Social Security and Medicare already face critical shortfalls and will likely compete for adequate resources with the new commitment in health reform legislation to adequately fund the premium subsidies needed to assist those with incomes up to 400 percent of the federal poverty level. In addition, there certainly has not been sufficient attention given to the structure of the benefit, financing or administration of the CLASS Act to conclude that it should be included as part of health reform legislation.

Recommendation: Do not include the CLASS Act provisions as part of health reform legislation. Instead, direct the committees with jurisdiction over these issues and the secretaries of Health and Human Services, Labor and Treasury to examine the CLASS Act and other alternative approaches to improve access and financing for the long-term care needs of the elderly and disabled individuals.

PRIORITY REVENUE PROVISIONS

I. HIGH COST PLAN EXCISE TAX (Make Further Changes to the Tax Thresholds, Indexing and Benefits Subject to the 40 Percent Excise Tax)

Patient Protection and Affordable Care Act: Includes a 40 percent excise tax to be assessed on the aggregate cost of insured and self-insured group health coverage that is above a threshold of $8,500 for singles and $23,000 for family plans. For retirees age 55 and older and those in certain high risk occupations, the thresholds would be $9,850 for singles and $26,000 for families. The tax would apply to the amounts above the thresholds. Thresholds would be indexed each year by CPI plus 1 percent. Tax would be effective in 2013.

Council Position: While we commend the increases made in Patient Protection and Affordable Care Act in the thresholds for the high cost plan excise tax, we believe that these changes do not go far enough. Large numbers of employer plans (both public and private) are certain to exceed the new tax thresholds, not because they offer "Cadillac" or "gold-plated" benefits, but simply because health care costs are increasing by an average of 7 or 8 percent a year while the tax thresholds would be indexed to CPI + 1 percent and therefore will increase at a much lower rate than health care costs. Health plan costs may also be higher than average because of geographic variations, the average age of the workforce and for health benefits offered to retirees. Because of these factors, eventually a large number of employers could face payment of the 40 percent excise tax unless significant benefit changes are made to avoid these costs.

Recommendation: The Council strongly urges that additional changes be made in the high cost plan excise tax to make it fairer, less disruptive and less likely to result in diminished coverage for employees and retirees, including:

- Increase the tax thresholds so that fewer plans would face immediate taxation in 2013;
- Provide a multi-year transition rule for plans already above the thresholds in tax year 2010;
- Index the tax thresholds by the medical component of CPI, or at a minimum, by a blend the CPI and the medical component of CPI;
- Adjust the tax thresholds to reflect difference related to the average age of the workforce;
- Establish a "safe harbor" for plans that would not be subject to the excise tax, such as plans that do not exceed the actuarial value of a "silver" plan in the health insurance exchanges;
- Do not count employee contributions to health care in determining the amounts applied toward the thresholds. In particular, amounts paid by employees on an after-tax basis should not be included in the thresholds since these employee payments have already been taxed;
- Exempt retiree health plans from the excise tax so that employers who offer these valuable plans are not penalized for doing so and so that the tax does not further contribute to the costs of these benefits or employers' liability for sponsoring them
- Do not count contributions to flexible spending arrangements, health savings accounts, dental, vision or other supplementary benefits in determining amounts applied toward the thresholds since health reform efforts have never been about concerns associated with these benefits;
- Maintain the initial year increase in the thresholds for high-cost states on a permanent basis; and
- Exempt employers from the excise tax if they offer multiple plan options that have an aggregate average value below the tax thresholds.

II. ANNUAL "FEES" ON SELF-INSURED PLANS AND OTHER HEALTH INDUSTRY STAKEHOLDERS

(Reduce or Eliminate "Fees" that Will Increase Employer and Employee Costs)

Patient Protection and Affordable Care Act: Includes a total of over $100 billion in "fees" over the next ten years to be paid by insurers, third-party administrators of self-insured health plans, and pharmaceutical and medical device manufacturers. These amounts would initially apply to revenues received in 2009, significantly enhancing their short-term disruptive effect in the marketplace.

Council Position: The Congressional Budget Office (CBO) has correctly advised Congress that any annual "fees" on insurers, third-party administrators of self-insured

health plans, and pharmaceutical and medical device manufacturers are highly likely to be passed along in the form of higher prices paid by employers, employees and other purchasers and consumers of health care services, increasing their costs.

Recommendation: The Council supports amendments to reduce or eliminate the health industry "fees" that will inevitably result in increased costs for employers and employees who are already struggling to maintain affordable health coverage. If these provisions are retained, at a minimum, we strongly urge that the annual amounts be reduced, third-party administrators be exempted (as they had been under the Senate Finance Committee bill), later effective dates be established (e.g., 2014) and the provisions should sunset after 2019.

III. ADDITIONAL PREMIUM TAXES ON EMPLOYER PLANS
(Eliminate New Federal Premium Taxes on Employer Plans)

Patient Protection and Affordable Care Act: Includes new premium taxes on fully insured and self-insured health plans to fund comparative effectiveness research and a reinsurance program for individuals in the non-group insurance market.

Council Position: Health care reform legislation should not include new premium taxes that will directly increase the cost of health coverage for employers and employees.

Recommendation: The Council strongly supports the worthwhile objectives of the comparative effectiveness program and the reinsurance programs for the individual insurance market. We urge that the premium taxes for funding these programs be eliminated and recommend that these be funded in the same manner as all other new requirements in the legislation. Premium taxes are an inappropriate financing solution for these programs because they will directly increase employer and employee costs for health coverage and establish an inappropriate precedent for meeting future revenue needs by increasing these taxes, or establishing new ones, on employer-sponsored health coverage.

IV. TAXATION OF RETIREE PRESCRIPTION DRUG SUBSIDIES
(Continue to Exclude Retiree Prescription Drug Subsidies from Taxation)

Patient Protection and Affordable Care Act: Eliminates the tax exclusion for retiree drug subsidy payments received by employers who provide prescription drug coverage to retirees that is at least the same value as the drug coverage available under Medicare Part D. The provision would be effective in 2011.

Council Position: The Medicare Modernization Act of 2003 provided subsidies to encourage employers to maintain retiree drug coverage for their Medicare-eligible

retirees and excluded these subsidies from taxation so that as many employers as possible would continue this valuable benefit for their retirees. Employers who retain this benefit save federal funds since it costs more for Medicare to provide the same benefits to its beneficiaries than what it spends to encourage employers to maintain this coverage.

Recommendation: The Council strongly recommends that retiree drug subsidy payments to employers who maintain prescription drug coverage for their Medicare-eligible retirees continue to be excluded from taxation. Taxation of these amounts will lead to more Medicare-eligible retirees obtaining coverage in the Medicare Part D program rather than through their employer, resulting in unnecessarily higher and avoidable costs to taxpayers. In addition, under Financial Accounting Standard (FAS) rules, if employers are subject to taxation for retiree drug subsidy payments, they will be required to immediately restate their financial liabilities as of the date of enactment of health reform legislation to reflect the discounted present value of the loss of the favorable tax treatment for these subsidies. This single tax change will result in a significant and unintended increase in liabilities for these companies, and a commensurate loss in earnings. Therefore, it would likely result in immediate efforts by many companies to have Medicare-eligible retirees obtain drug coverage under the Part D program, at a higher cost to the government.

V. CONTRIBUTION LIMITS ON FLEXIBLE SPENDING ACCOUNTS (Increase and Index Contribution Limits to FSAs)

Patient Protection and Affordable Care Act: Includes an annual $2500 limit on contributions to a health flexible spending account (FSA), effective 2011. Unlike a comparable provision in the House-passed health reform bill, the Senate bill limit is not indexed in future years, so the value of an employee's $2500 contribution to an FSA would diminish over time.

Council Position: Limiting contributions to employee flexible spending accounts (FSA) will raise health care costs for individuals with high unreimbursed health care expenses, including chronically or seriously ill individuals with costly prescription drug or medical equipment needs.

Recommendation: We support amendments that would both increase and index the $2500 annual FSA contribution limit included in the Patient Protection and Affordable Care Act. We also urge that any limit be accompanied by a report by the appropriate agencies to determine the impact of contribution limits on individuals with chronic illness or other serious health conditions. This report should also include recommendations to Congress on how to mitigate such adverse impact.