OVERVIEW OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT:

What Small Business NACS Members Need to Know About Obamacare

NACS® The Association for Convenience & Fuel Retailing

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I. Overview

This document is designed for small employers, that is, employers who are certain that they employ less than 50 full-time equivalent employees. NACS members are urged to use the companion document entitled *Am I a "Large Employer" under Obamacare?* to determine their employer size. If the result of that process clearly shows that you are a "small employer", then you should continue using this document. If the result shows that you are close to the "large employer" threshold or over it, then you should consult the document entitled *What "Large Employer" NACS Members Need to Know About Obamacare.*

While small employers are not required to offer coverage under Obamacare, this document addresses the issues and concerns relevant to employers that nonetheless choose to do so. Briefly, this document covers:

- issues related to whether a plan can maintain its "grandfathered" status;
- the Obamacare insurance market reform provisions that will affect most small employers offering coverage;
- new employer notice and reporting obligations such as the duty to inform employees of the option to purchase health care coverage through an Exchange;
- a brief overview of the different types of Exchanges, including SHOP exchanges (which will be utilized by small employers) and how they will function;
- the "nuts and bolts" of employee wellness programs and how you can use them to foster improved employee health and decreased premiums;
- the availability of a small business tax credit for employers who offer coverage and have less than 25 employees; and
- several related miscellaneous issues of which small employers should be aware.

II. Market Reforms

Obamacare contains a number of insurance market reforms applicable to all plans employers offer. Obligations can vary based on whether the plan is a "grandfathered" or "non-grandfathered" plan.

A. What is a "Grandfathered Plan?"

Obamacare provides that group health plans and health insurance coverage in existence as of March 23, 2010 are exempt from some of the law's market reform provisions. It is important for all employers to determine whether or not the plan(s) they offer employees are grandfathered in order to ensure compliance with the law.

1. What exactly can a "Grandfathered Plan" do and not do in order to stay a "Grandfathered Plan"?

Grandfathered plans CANNOT:

- Eliminate all benefits to diagnose or treat a particular condition;
- Increase % co-insurance charges;
- Increase co-pays, fixed amount cost-sharing "significantly" (med. infl. + 15%);
- "Significantly" (> 5%) reduce their employer contribution rate;
- Implement new or decreased annual limits;
- Change carriers (for insured plans);
- Switch employee's plans or undertake corporate mergers or sale to avoid compliance

Grandfathered plans CAN (pending future final rules):

- Change premiums;
- Make structural adjustments;
- Change provider networks;
- Change the prescription drug formulary;
- Add new employees, enrollees, and dependents to the plan; and
- Make "normal adjustments" to comply with Obamacare or other applicable state laws

B. *Are there other obligations applicable to employer plans?*

Yes. The following new plan obligations apply to all employer plans:

- New summary disclosure rules governing the summary of benefits and coverage;
- For insured plans, non-discrimination in favor of highly compensated employees. (This requirement does not apply to the few "grandfathered" plans currently in the market;
- No lifetime coverage limits for "essential health benefits";
- No annual coverage limits on "essential health benefits";
- No pre-existing condition exclusions;
- A ban on policy rescissions (except in cases of fraud);
- Extension of dependent coverage until the dependent turns 26 years old; and
- A bar on imposing waiting periods on plan participation in excess of 90 days.

Non-grandfathered plans are subject to mandatory compliance with the following ten new requirements imposed on new plans under Obamacare:

- Mandated offering of free preventative services;
- Out-of-pocket limitations (equal to the out-of-pocket limits for high deductible health plans for Health Savings Accounts);
- Primary care physician designation right for plan participants;
- Clinical trial participation right;
- Mandatory appeals process rights/notice;
- Premium increase reviews (does not apply to self-insured plans);
- Plan quality reporting obligation to enrollees/HHS;
- A ban on discrimination in favor of highly compensated employees (applies to insured plans only and is not effective until rules are issued);
- All non-grandfathered small group (<100) and individual plans also must comply with the following two new requirements:
    - Provide an "essential health benefits" package and 60% minimum plan value, and

- "Community Rating" – Issuers may use only the following variances in formulating rates:
    - whether the coverage is for an individual or a family;
    - whether the geographic rating area established by the state meets the standard under the rule, meaning there is either one rating area for the entire state or there are no more than seven total rating areas based on counties, zip codes, or metropolitan areas in a state;
    - age: a prescribed rate variance of not more than 3:1 for like individuals of different age who are aged 21 years and older, and any variation must be actuarially justified for individuals under age 21. The age bands are: a single uniform age band for children (0-20 years old); one-year age bands for adults 21-63 years old; and a single age band for older adults (64 years and older); and
    - tobacco use: a rate variance of 1.5:1 for like individuals.

States are permitted to impose narrower ratios for age and tobacco than those stated above. HHS believes the community rating will promote the transparency, predictability, and accuracy of risk adjustment because the risk adjustment methodology would account for rating as it is applied by issuers.

C. What are "Essential Health Benefits"?

Under Obamacare, issuers offering coverage in the individual and small group markets must ensure coverage includes statutorily defined essential health benefit ("EHB") items and services. Importantly, grandfathered plans are not required to cover the ten benefit categories Obamacare requires EHB to include. (Such plans may not, however, impose lifetime or annual limits on any EHB they offer.)

Beginning in 2014, plans offered in the individual and small group markets must cover essential health benefits as determined by each state in accordance with rules yet to be issued by the Department of Health and Human Services. HHS required that states select a benchmark plan from the following four options:

1. The largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;
2. Any of the largest three State employee health benefit plans by enrollment;
3. Any of the largest three national Federal Employee Health Benefits Program plan options by enrollment; or
4. The largest insured commercial non-Medicaid Health Maintenance Organization ("HMO") operate in the state.

For states that have not made a selection, HHS selected the largest small-group product in the state as the default benchmark.

III. Reporting and Notice Obligations

Under Obamacare, employers face a host of new reporting requirements in order to (1) demonstrate the value of coverage offered to employees, (2) communicate to employees their coverage options, and (3) certify compliance with the employer coverage provisions. Below is a general overview of these obligations.

- Employees and New Hires – Exchange and Subsidies Notice

    - Obamacare amended the Fair Labor Standards Act ("FLSA") to require employers to inform employees of the existence of an Exchange, including a description of the services provided by such Exchange, and the manner in which the employee may contact the Exchange to request assistance. It also requires employers inform employees that employees might be eligible for premium assistance tax credits and cost-sharing subsidies for exchange coverage if the employer plan covers less than 60% of the total allowed costs of benefits (*i.e.*, does not provide "minimum value"). The notice also must inform employees that if they purchase Exchange coverage, they may lose the employer contribution (if any) to any health benefits plan the employer offers and that all or a portion of such contribution may be excludable from income for federal tax purposes.

    - Employers are required to provide the notice to current employees by 10/1/2013. For new hires on or after 10/1/2013, employers have 14 days from the hire date to provide the notice. Employers are only required to provide the notice to employees—not to dependents or any other individuals that may be eligible for coverage. In addition, notice must be provided regardless of full-time or part-time status, and regardless of plan enrollment status.

- Cadillac Taxes – Report Amounts To Carriers & HHS (2018)

    - Employers with self-insured plans will have to pay an excise tax of 40% on any "excess benefits" provided to its employees. The tax is triggered when the excess benefits for self-only or family coverage exceed the cost of coverage that the employer would charge for the same coverage under COBRA.

- Self-insured employers must also comply with the following notice obligations:

    - Notice of summary of benefits and coverage ("SBC") to employees that provides a basic outline of the employee's coverage.

    - 60-Day advance notice to employees of any material plan changes not reflected in the most recently provided SBC and not in connection with coverage renewal.

    - Notice to employees of the plan's appeals process and contact information for the state's consumer assistance office. This requirement does not apply to grandfathered plans, however.

- Notice to HHS and employees about quality of care measures and wellness programs used by the plan. This requirement does not apply to grandfathered plans, however.

- Data privacy compliance certification to HHS (two times: in 2013 and in 2015).

- IRS regulations implementing 26 USC § 6055 and 6056 require all large employers and most entities that provide minimum essential coverage – including self-insured group plans – to report annually to the IRS and to covered individuals certain information regarding that coverage.

  Information reporting to the IRS is intended to facilitate administration of the employer mandate, individual mandate, and premium assistance tax credits under the ACA. As a general matter, large employers must file a return with the IRS and provide a statement to each full-time employee with information regarding the offer of employer-sponsored health care coverage. Large employers generally must begin collecting information on January 1, 2015, to report to employees and the IRS beginning in January 2016. The final 6055 and 6056 regulations exempt from the reporting requirements employers with between 50 and 99 FTEs for calendar year 2015, consistent with the one-year delay in employer mandate obligations for such employers.

IV. Exchanges

A health insurance exchange is a government-regulated insurance marketplace akin to an on-line health insurance mall. The exchanges are intended to offer a menu of standardized health care plans for individuals to choose from and, depending on different factors, the individual may be eligible for subsidies to help pay for their exchange coverage. Exchanges in Obamacare fall into three categories:

- Federally-facilitated exchange ("FFE");
- State-based exchange; or
- Federal-State partnership exchange.

A. What are the differences between these exchanges?

In an FFE, the federal government assumes all control for implementing and running the exchange in a particular state. This occurs when a state has not met requisite deadlines for establishing its own exchange. HHS has allowed several states that defaulted to an FFE, however, to retain authority for certain plan management functions in their respective FFE, including the ability to review and approve qualified health plans sold in the exchange.

In a state-based exchange, the state retains all authority for running its own exchange. With Federal-State partnership exchanges, the federal government ultimately will be responsible for exchange implementation and operations, but states will have the option of managing certain limited functions. HHS, as the party responsible for exchange implementation, will hopefully provide as much flexibility as possible; however, HHS will need to ratify "inherently governmental" decisions made by the state partner.

B. Do the exchanges have any features designed specifically for small businesses?

Obamacare requires states to set up a Small Business Health Options Program, more commonly referred to as a "SHOP" Exchange. The SHOP Exchange is designed to assist small employers (≤100 for purposes of the SHOP Exchanges, but the exact number may vary in each state) in facilitating coverage in their respective state's small group health insurance market. (Note, that in the context of determining whether an employer is subject to the employer mandate, small employers are defined as those with less than 50 employees.)

The type of exchange each state selects will dictate the contours of how each SHOP Exchange will operate.

- State Exchanges
    - For 2014, the HHS rules require a state exchange to allow employers to offer either:
        - all plans at the selected level; or
        - any other selection method, including a single plan at the level of coverage the employer selects.

- Beginning January 1, 2015, state exchanges must allow employers to offer all plans at a given level, and may allow (or not allow) employers to offer only one plan at a given level.

- States may also elect to maintain responsibility for their SHOP exchange while the federal government simultaneously maintains overall responsibility for that state's individual market exchange. This is often referred to as a "SHOP-only" exchange.

- Federally-Facilitated SHOPS

  - For 2014, FF-SHOPs must limit employers' options to offering a single plan at a given level.

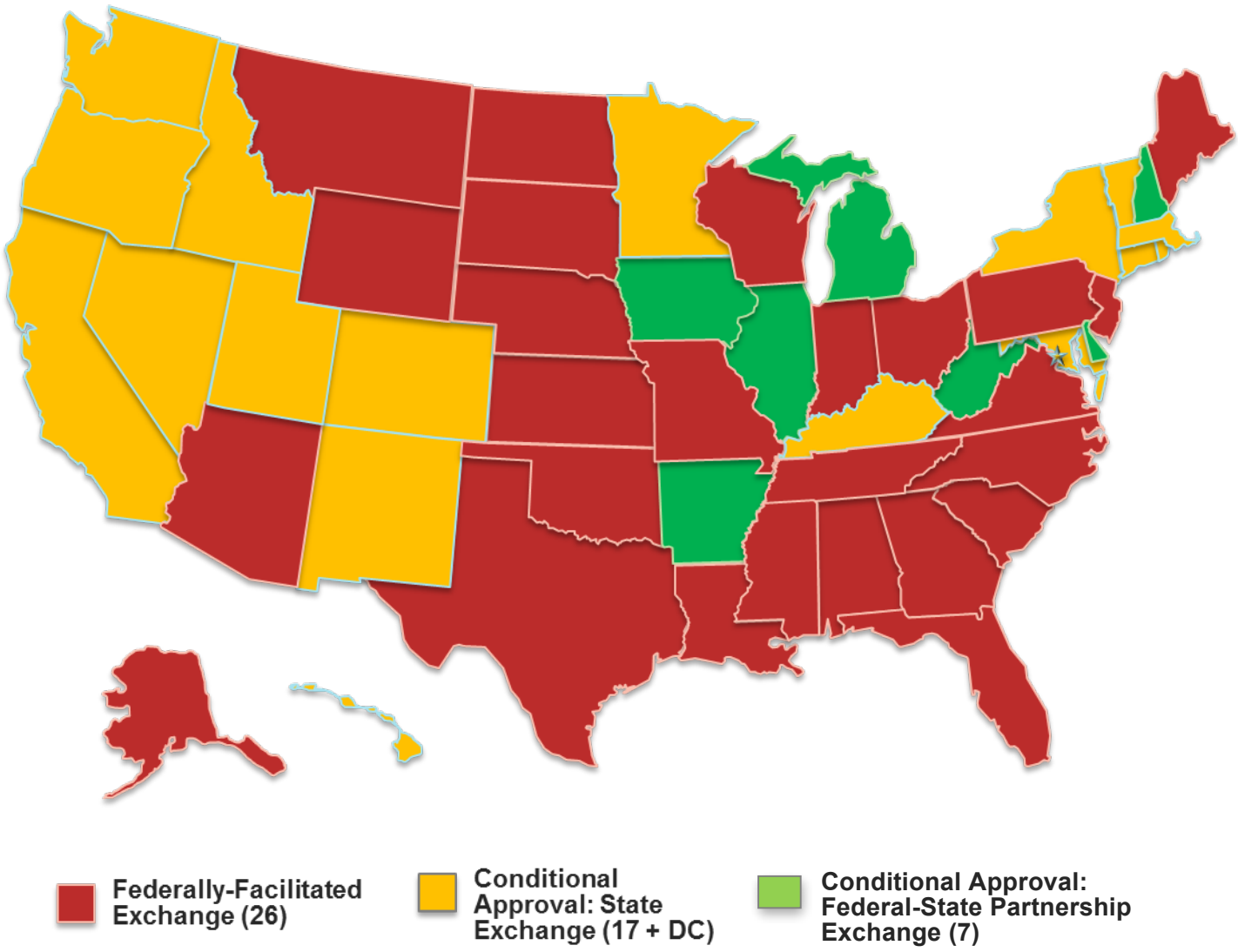
  - Beginning January 1, 2015, FF-SHOPs must allow employers to select:

    - a metal level and allow their employees to select any health plan offered on the exchange at that level; or

    - a single health plan at a given level for its employees.

C. *How can I determine which state has implemented which type of exchange?*

The following exchange implementation map details each state's current exchange selection. Currently, about half of the fifty states have defaulted to an FFE. Unsurprisingly, most of these states have Republican governors that have staunchly opposed PPACA and its implementation. Another seven states have received conditional approval to run a state-partnership exchange. The remaining states either have operational state-based exchanges or have received conditional approval from HHS to do so.


Federally-Facilitated Exchange (26)
Conditional Approval: State Exchange (17 + DC)
Conditional Approval: Federal-State Partnership Exchange (7)

V. Wellness

Wellness programs present an opportunity for employers to save money on health coverage costs. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") generally prohibits group health plans from charging employees different premiums based on their health status. However, it allows employers to establish such discounts and financial incentives if the employer only offers the incentives to employees who participate in wellness programs. Obamacare further encourages employer wellness initiatives in a number of ways. For example, it increases the permissible reward employers can offer employees from 20% of coverage costs to 30%. Further, if the wellness program is designed to reduce or prevent tobacco use, this number can jump to 50%. Note that the wellness rules can operate as a carrot or a stick, in that employers can both *reward* employees for more positive health choices, and *punish* (via higher costs) employees for less positive health choices.

A. What types of wellness programs can I offer?

Wellness programs are divided into two general categories: Participatory programs and health factor-based programs.

1. Participatory Programs

Participatory programs are programs made available to similarly situated individuals and that do not provide a reward based on a health factor. Common examples of these programs include:

- programs that reimburse all or part of the cost for fitness club memberships;
- diagnostic testing programs that provide a reward for participation but do not base any part of the reward on outcomes;
- programs that encourage preventative care (e.g., prenatal care or annual physicals) through waiver of the copayment or deductible requirement for such care; and
- programs that provide a reward to employees for attending a monthly health seminar.

2. Health Factor-Based Programs

HIPAA generally prohibits group health plans from discriminating on the basis of health factors, which would appear to preclude a wellness program from providing discounted copays for non-smokers or participants with a particular cholesterol level because these standards relate to the participant's medical status. HIPAA's non-discrimination provision, however, contains a specific exception for health factor-based wellness programs. This type of wellness program will comply with the HIPAA exception if it meets all five of the following criteria:

1. The reward for all applicable health-contingent wellness programs with respect to a plan must not exceed 30 percent of the total cost of employee-only coverage under the plan, or 50 percent if the program is designed to prevent or reduce tobacco use;
2. The program must be reasonably designed to promote health and prevent disease, and not appear to be a pretext for discriminating against employees based on health factors. This means

the program must have a reasonable chance of improving the health of, or preventing disease in, participating individuals, and not be overly burdensome, not be a subterfuge for discriminating based on a health factor, and not be highly suspect in the method chosen to promote health or prevent disease.;

3. The program must give participants at least one chance per year to qualify for the reward;

4. The program must provide a reasonable alternative means to obtain the reward for those who cannot meet the program's standard due to a medical problem or condition, or it must allow waiver of the standard for such people; and

5. The plan must disclose in all plan materials describing the terms of the program the availability of other means of qualifying for the reward or the possibility of waiver of the otherwise applicable standard.

In addition, health factor-based programs must be offered to all similarly-situated individuals.

Perhaps the most significant requirement listed above is that health factor-based programs provide "reasonable alternatives" to obtain the reward for individuals who are medically unable to satisfy the program's standards. Wellness regulations issued pursuant to Obamacare provided much-needed clarity as to when individuals are entitled to be offered a reasonable alternative, and what such alternatives should be.

Whether an alternative standard is "reasonable" is a facts-and-circumstances test that will look at the specific context of a given situation. The final rule sets forth four criteria that will be considered:

1. If the reasonable alternative standard is completion of an educational program, the plan or issuer must make the educational program available or assist the employee in finding such a program (instead of requiring an individual to find such a program unassisted), and may not require the individual to pay for the cost of the program.

2. The time commitment required must be reasonable (for example, requiring attendance nightly at a one-hour class would be unreasonable).

3. If the reasonable alternative standard is a diet program, the plan or issuer is not required to pay for the cost of food but must pay any membership or participation fee.

4. If an individual's personal physician states that a plan standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for that individual, the plan must provide a different reasonable alternative standard that accommodates the personal physician's recommendations with regard to medical appropriateness. (Plans may impose standard cost-sharing under the different reasonable alternative.)

Specifically, the new regulations divide health factor-based wellness programs into two categories and the category a program falls into impacts the type of "reasonable alternative standards" that must be offered.

- *Activity-Only Wellness Programs* – An activity-only wellness program requires an individual to perform or complete an activity related to a health factor in order to obtain a reward, but does not require the individual to attain or maintain a specific outcome. Activity-only programs can be distinguished from non-health factor programs because, with the latter, health conditions are not relevant. For example, a program that reimburses employees' gym memberships would be a non-health factor program because anyone, regardless of health condition, can belong to a gym, and the reward is not contingent upon exercising at the gym. In contrast, a program that provides lower premiums for individuals who walk for thirty minutes three days per week is an activity-only wellness program, because an individual's health condition (*e.g.*, being wheelchair-bound or physically unable to walk for thirty minutes) could preclude the individual from participating in the program.

- *Outcome-Based Wellness Programs* – An outcome-based wellness program requires an individual to attain or maintain a specific health outcome (such as not smoking or attaining certain results on biometric screenings) in order to obtain a reward.

Whether a health factor-based program is *activity only* or *outcome based* is significant with regard to the requirement that such programs offer "reasonable alternative standards" to certain individuals: For activity-only programs, the reasonable alternative standard requirement is triggered by a *medical need for an alternative*: it must be unreasonably difficult due to a medical condition to satisfy the standard, or medically inadvisable to attempt to satisfy the standard. Outcome-based programs, on the other hand, must offer a reasonable alternative to any individual who does not meet the initial standard *regardless of medical need*.

The wellness guidance has generally been favorably received. In addition to the host of participatory wellness programs that employers can offer, the increase in the reward or penalty amount for health factor-based programs means that employers can now offer stronger monetary incentives (or disincentives for their employees to participate in these programs. Because participation in these programs often correlates with an increase in employee health, employers are more likely to see a reduction in health costs for their participating employees. This may also benefit an employee that enjoys the program's reward and any corresponding health improvements.

B. *Examples*

Example 1 (Cholesterol screening with reasonable alternative standard to work with personal physician):

(i) Facts. A group health plan offers a reward to participants who achieve a count under 200 on a total cholesterol test. If a participant does not achieve the targeted cholesterol count, the plan allows the participant to develop an alternative cholesterol action plan in conjunction with the participant's personal physician that may include recommendations for medication and additional screening. The plan allows the physician to modify the standards, as medically necessary, over the year. (For example, if a participant develops asthma or depression, requires surgery and convalescence, or some other medical condition or consideration makes completion of the original action plan inadvisable or unreasonably difficult, the physician may modify the original action plan.) All plan materials describing the terms of the program include the following statement: "Your health plan wants to help you take charge of your health. Rewards are available to all employees who participate in our Cholesterol Awareness Wellness Program. If your total cholesterol count is under 200, you will receive the reward. If not, you will still have an opportunity

to qualify for the reward. We will work with you and your doctor to find a Health Smart program that is right for you." In addition, when any individual participant receives notification that his or her cholesterol count is 200 or higher, the notification includes the following statement: "Your plan offers a Health Smart program under which we will work with you and your doctor to try to lower your cholesterol. If you complete this program, you will qualify for a reward. Please contact us at [contact information] to get started."

(ii) Conclusion. The program is an outcome-based wellness program because the initial standard requires an individual to attain or maintain a specific health outcome (a certain cholesterol level) to obtain a reward. The program satisfies all the requirements for an outcome-based wellness program because 1) the cholesterol program is reasonably designed to promote health and prevent disease; 2) it makes available to all participants who do not meet the cholesterol standard a reasonable alternative standard to qualify for the reward; and 3) the plan also discloses in all materials describing the terms of the program and in any disclosure that an individual did not satisfy the initial outcome-based standard the availability of a reasonable alternative standard (including contact information and the individual's ability to involve his or her personal physician).

Example 2 (Tobacco use surcharge with smoking cessation program alternative):

(i) Facts. In conjunction with an annual open enrollment period, a group health plan provides a premium differential based on tobacco use, determined using a health risk assessment. The following statement is included in all plan materials describing the tobacco premium differential: "Stop smoking today! We can help! If you are a smoker, we offer a smoking cessation program. If you complete the program, you can avoid this surcharge." The plan accommodates participants who smoke by facilitating their enrollment in a smoking cessation program that requires participation at a time and place that are not unreasonably burdensome or impractical for participants, and that is otherwise reasonably designed based on all the relevant facts and circumstances, and discloses contact information and the individual's option to involve his or her personal physician. The plan pays for the cost of participation in the smoking cessation program. Any participant can avoid the surcharge for the plan year by participating in the program, regardless of whether the participant stops smoking, but the plan can require a participant who wants to avoid the surcharge in a subsequent year to complete the smoking cessation program again.

(ii) Conclusion. The program is reasonably designed because the plan provides a reasonable alternative standard to qualify for the reward to all tobacco users (a smoking cessation program). The plan also discloses, in all materials describing the terms of the program, the availability of the reasonable alternative standard (including contact information and the individual's option to involve his or her personal physician). Thus, the program satisfies wellness program requirement.

Example 3 (Activity-only Wellness Program):

(i) Facts. A group health plan provides a reward to individuals who participate in a reasonable specified walking program. If it is unreasonably difficult due to a medical condition for an individual to participate (or if it is medically inadvisable for an individual to attempt to participate), the plan will waive the walking program requirement and provide the reward. All materials describing the terms of the walking program disclose the availability of the waiver.

(ii) Conclusion. The program is reasonably designed to promote health and prevent disease. The program's reward is available to all similarly situated individuals and accommodates individuals for whom it is unreasonably difficult to participate in the walking program due to a medical condition (or for whom it would be medically inadvisable to attempt to participate) by providing them with the reward even if they do not participate in the walking program (that is, by waiving the condition). The plan also complies with the rule's disclosure requirement. It therefore meets all the requirements for activity-only wellness programs.

C. Are there any wellness incentives designed specifically for small businesses?

The federal government has the authority to award comprehensive workplace wellness grants to small employers that employ less than 100 employees that work 25 hours a week or more. To be eligible for the grant, however, the employer must not have had a wellness program in place as of March 23, 2010. While HHS has not issued regulations governing this grant program, these programs must include:

- Health awareness initiatives (such as health education or preventive screenings);
- Mechanisms to encourage employee participation; and
- Supportive environments (such as workplace policies designed to encourage healthy lifestyles).

VI. Small Business Tax Credit

Under Obamacare, small businesses with fewer than 25 full-time employees whose individual average wages are less than $50,000 per year will be eligible for a tax credit if they contribute a uniform percentage of at least 50% towards their employees' health insurance costs. Because the tax credit comes in the form of a general business credit, generally any unused credit could be carried forward for up to 20 years. The below tables illustrate how the credit will apply based on the number of employees and the employees' average annual wages. Essentially, as your business adds employees and/or your employees' average wages increase, the credit tapers off and eventually goes away.

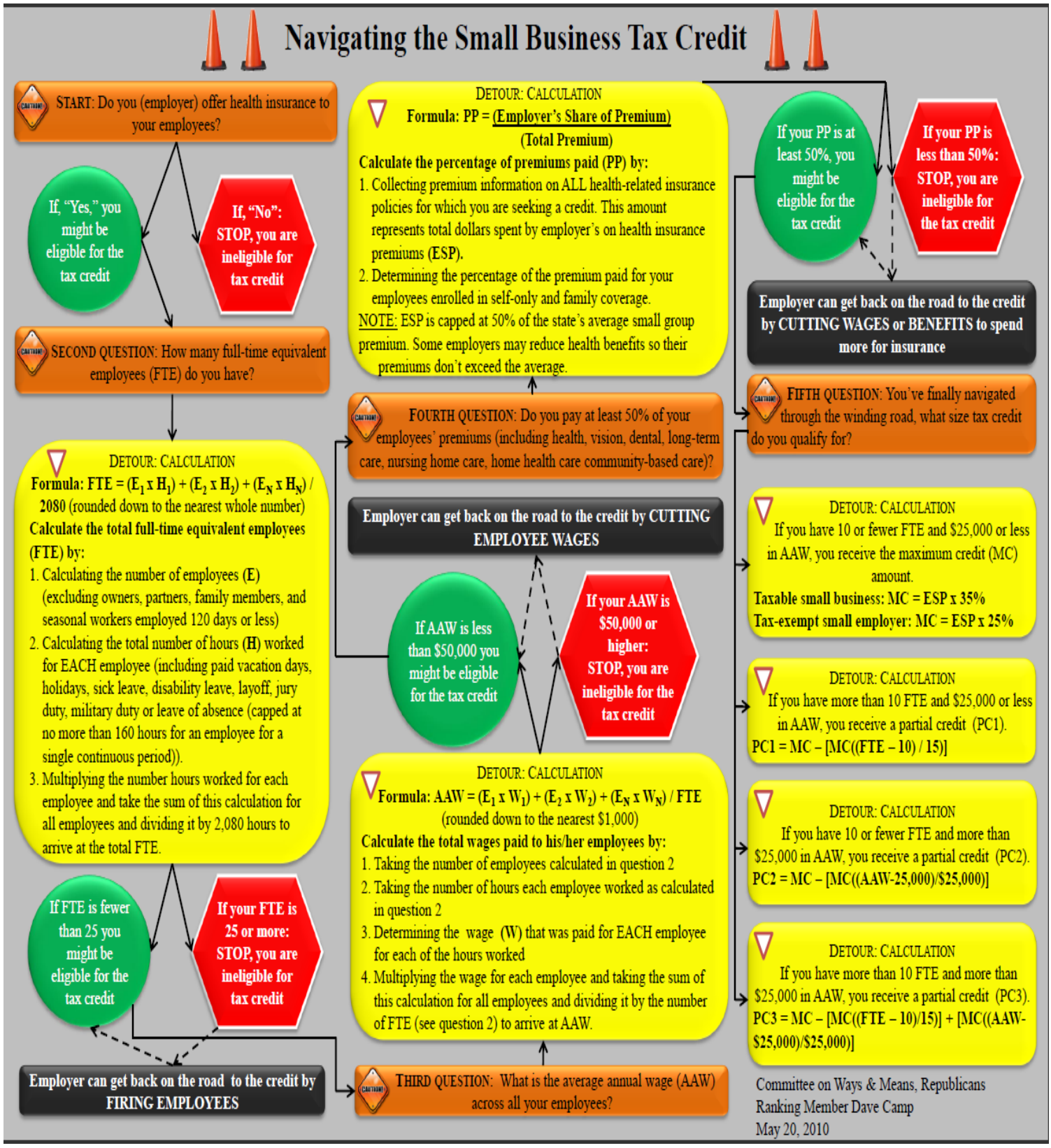
Table 1. Small Business Tax Credit as a Percent (Maximum of 35%) of Employer Contribution to Premiums, For-Profit Firms in 2010-2013 and Nonprofit Firms in 2014+

	Average wage					
Firm size	Up to $25,000	$30,000	$35,000	$40,000	$45,000	$50,000
Up to 10	35%	28%	21%	14%	7%	0%
11	33%	26%	19%	12%	5%	0%
12	30%	23%	16%	9%	2%	0%
13	28%	21%	14%	7%	0%	0%
14	26%	19%	12%	5%	0%	0%
15	23%	16%	9%	2%	0%	0%
16	21%	14%	7%	0%	0%	0%
17	19%	12%	5%	0%	0%	0%
18	16%	9%	2%	0%	0%	0%
19	14%	7%	0%	0%	0%	0%
20	12%	5%	0%	0%	0%	0%
21	9%	2%	0%	0%	0%	0%
22	7%	0%	0%	0%	0%	0%
23	5%	0%	0%	0%	0%	0%
24	2%	0%	0%	0%	0%	0%
25	0%	0%	0%	0%	0%	0%

Table 2. Small Business Tax Credit as a Percent (Maximum of 50%) of Employer Contribution to Premiums, For-Profit Firms in 2014+

	Average wage					
Firm size	**Up to $25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
Up to 10	50%	40%	30%	20%	10%	0%
11	47%	37%	27%	17%	7%	0%
12	43%	33%	23%	13%	3%	0%
13	40%	30%	20%	10%	0%	0%
14	37%	27%	17%	7%	0%	0%
15	33%	23%	13%	3%	0%	0%
16	30%	20%	10%	0%	0%	0%
17	27%	17%	7%	0%	0%	0%
18	23%	13%	3%	0%	0%	0%
19	20%	10%	0%	0%	0%	0%
20	17%	7%	0%	0%	0%	0%
21	13%	3%	0%	0%	0%	0%
22	10%	0%	0%	0%	0%	0%
23	7%	0%	0%	0%	0%	0%
24	3%	0%	0%	0%	0%	0%
25	0%	0%	0%	0%	0%	0%

Source: CRS analysis of PPACA (P.L. 111-148).


Navigating the Small Business Tax Credit
START: Do you (employer) offer health insurance to your employees?
If, "Yes," you might be eligible for the tax credit
If, "No": STOP, you are ineligible for tax credit
SECOND QUESTION: How many full-time equivalent employees (FTE) do you have?
DETOUR: CALCULATION
Formula: FTE = (E1 x H1) + (E2 x H2) + (EN x HN) / 2080 (rounded down to the nearest whole number)
Calculate the total full-time equivalent employees (FTE) by:
1. Calculating the number of employees (E) (excluding owners, partners, family members, and seasonal workers employed 120 days or less)
2. Calculating the total number of hours (H) worked for EACH employee (including paid vacation days, holidays, sick leave, disability leave, layoff, jury duty, military duty or leave of absence (capped at no more than 160 hours for an employee for a single continuous period)).
3. Multiplying the number hours worked for each employee and take the sum of this calculation for all employees and dividing it by 2,080 hours to arrive at the total FTE.
If FTE is fewer than 25 you might be eligible for the tax credit
If your FTE is 25 or more: STOP, you are ineligible for tax credit
Employer can get back on the road to the credit by FIRING EMPLOYEES
THIRD QUESTION: What is the average annual wage (AAW) across all your employees?
DETOUR: CALCULATION
Formula: AAW = (E1 x W1) + (E2 x W2) + (EN x WN) / FTE (rounded down to the nearest $1,000)
Calculate the total wages paid to his/her employees by:
1. Taking the number of employees calculated in question 2
2. Taking the number of hours each employee worked as calculated in question 2
3. Determining the wage (W) that was paid for EACH employee for each of the hours worked
4. Multiplying the wage for each employee and taking the sum of this calculation for all employees and dividing it by the number of FTE (see question 2) to arrive at AAW.
If AAW is less than $50,000 you might be eligible for the tax credit
If your AAW is $50,000 or higher: STOP, you are ineligible for the tax credit
Employer can get back on the road to the credit by CUTTING EMPLOYEE WAGES
FOURTH QUESTION: Do you pay at least 50% of your employees' premiums (including health, vision, dental, long-term care, nursing home care, home health care community-based care)?
DETOUR: CALCULATION
Formula: PP = (Employer's Share of Premium) / (Total Premium)
Calculate the percentage of premiums paid (PP) by:
1. Collecting premium information on ALL health-related insurance policies for which you are seeking a credit. This amount represents total dollars spent by employer's on health insurance premiums (ESP).
2. Determining the percentage of the premium paid for your employees enrolled in self-only and family coverage.
NOTE: ESP is capped at 50% of the state's average small group premium. Some employers may reduce health benefits so their premiums don't exceed the average.
If your PP is at least 50%, you might be eligible for the tax credit
If your PP is less than 50%: STOP, you are ineligible for the tax credit
Employer can get back on the road to the credit by CUTTING WAGES or BENEFITS to spend more for insurance
FIFTH QUESTION: You've finally navigated through the winding road, what size tax credit do you qualify for?
DETOUR: CALCULATION
If you have 10 or fewer FTE and $25,000 or less in AAW, you receive the maximum credit (MC) amount.
Taxable small business: MC = ESP x 35%
Tax-exempt small employer: MC = ESP x 25%
DETOUR: CALCULATION
If you have more than 10 FTE and $25,000 or less in AAW, you receive a partial credit (PC1).
PC1 = MC – [MC((FTE – 10) / 15)]
DETOUR: CALCULATION
If you have 10 or fewer FTE and more than $25,000 in AAW, you receive a partial credit (PC2).
PC2 = MC – [MC((AAW-25,000)/$25,000)]
DETOUR: CALCULATION
If you have more than 10 FTE and more than $25,000 in AAW, you receive a partial credit (PC3).
PC3 = MC – [MC((FTE – 10)/15)] + [MC((AAW-$25,000)/$25,000)]
Committee on Ways & Means, Republicans
Ranking Member Dave Camp
May 20, 2010

VII. Miscellaneous Issues

A. 90 Day Waiting Period

Under Obamacare, if employers offer healthcare coverage to their employees, then employers are not allowed to impose a waiting period of more than 90 days before coverage becomes effective. This means that eligibility conditions that are based solely on the lapse of a time period are permissible for no more than 90 days. Other conditions for eligibility under the plan's terms (such as being in an eligible job classification or fulfilling job-related licensure requirements specified in the plan) are generally permissible unless the condition is designed to avoid compliance with the 90-day waiting period limitation. For example, employers may utilize a cumulative hours of service requirement of no more than 1,200 hours for part-time employees before the 90-day waiting period applies. Furthermore, if under the terms of a plan, an employee may elect coverage that would begin on a date that does not exceed the 90-day waiting period limitation, the 90-day waiting period limitation is considered satisfied. Accordingly, a plan or issuer will not be considered to have violated the 90 day waiting period limitation merely because employees take additional time to elect coverage. (Notably, regulators have proposed a rule that would allow employers to require that new employees complete a bona fide orientation period not to exceed one month prior to the beginning of the 90 day waiting period.)

B. Employee Additional Medicare Tax

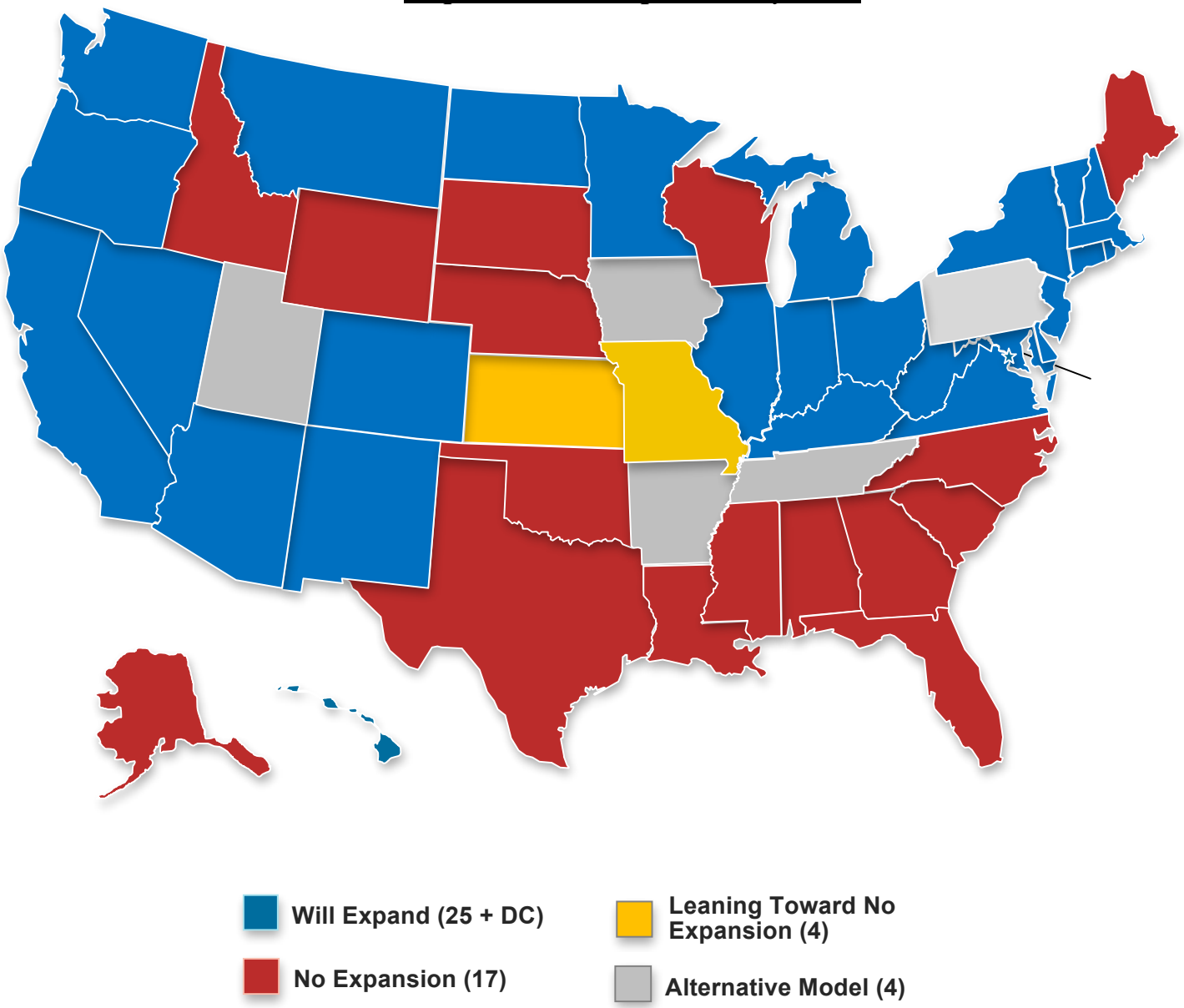
Under recently released IRS guidance, individuals that earn more than $200,000 and married couples filing joint tax returns that earn more than $250,000 will be subject to a new 0.9% annual tax. Similar to employer requirements to withhold Social Security and other Medicare taxes, employers will be required to withhold this additional 0.9% from its employees' paychecks. It is anticipated that the IRS will finalize this requirement in 2013 or early 2014.

C. Medicaid Expansion

Obamacare dramatically expanded the Medicaid program, which addresses the health care needs of the poor. Beginning in 2014, the law extends Medicaid coverage to all individuals between ages 19 and 64 with incomes up to 133 percent of the federal poverty level, or $11,490 for an individual and $23,550 for a family of four (based on the 2013 federal poverty level). For example, an uninsured 55-year old clerk with no children that works at a convenience store where insurance is not offered could qualify for Medicaid under this provision if he earns less than $11,400 in a year.

Under the Supreme Court ruling upholding Obamacare against a constitutional challenge, states are not *required* to participate in this expansion of the program, and some have already announced that they will not. The Medicaid expansion issue is significant because employees eligible for Medicaid are not eligible for a subsidy to purchase coverage on an exchange. Therefore, employers will be less exposed under the employer mandate because they are only penalized when employees receive a subsidy for exchange coverage.

Map: Medicaid Expansion By State



VIII. APPENDIX - GLOSSARY OF KEY HEALTH CARE TERMS

Affordable Care Act (a/k/a The Patient Protection and Affordable Care Act or "Obamacare"):
The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

Affordable Coverage (as it relates to Premium Tax Credit):
Employer coverage is considered affordable if the employee's share of the annual premium for self-only coverage is no greater than 9.5% of annual household income. Starting in 2014, individuals offered employer-sponsored coverage that's affordable and provides minimum value won't be eligible for a premium tax credit.

Benefits:
The health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents. In Medicaid or CHIP, covered benefits and excluded services are defined in state program rules.

Children's Health Insurance Program (CHIP):
Insurance program jointly funded by state and Federal government that provides health insurance to low-income children and, in some states, pregnant women in families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage.

Community Rating:
A rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status or other factors.

Cost Sharing:
The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums.

Deductible:
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Dependent Coverage:
Insurance coverage for family members of the policyholder, such as spouses, children, or partners.

Disability:
A limit in a range of major life activities. This includes activities like seeing, hearing, walking and tasks like thinking and working. Because different programs may have different disability standards, please check the program you're interested in for its disability standards. The list of activities mentioned above

isn't exhaustive. A legal definition of disability can be found here: http://www.ada.gov/pubs/ada.htm. For the proposed EEOC ADA Amendments Act regulations, and related resources, *see* http://edocket.access.gpo.gov/2009/E9-22840.htm.

Employer Shared Responsibility Payment:
The Affordable Care Act requires certain employers with at least 50 full-time employees (or equivalents) to offer health insurance coverage to its full-time employees (and their dependents) that meets certain minimum standards set by the Affordable Care Act or to make a tax payment called the ESRP.

Essential Health Benefits:
A set of health care service categories that must be covered by certain plans, starting in 2014. The Affordable Care Act ensures health plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges (Exchanges), offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Insurance policies must cover these benefits in order to be certified and offered in Exchanges, and all Medicaid state plans must cover these services by 2014. Starting with plan years or policy years that began on or after September 23, 2010, health plans can no longer impose a lifetime dollar limit on spending for these services. All plans, except grandfathered individual health insurance policies, must phase out annual spending limits for these services by 2014.

Exchange:
See Health Insurance Marketplace.

Federal Poverty Level ("FPL"):
A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits.

Flexible Spending Account ("FSA"):
An arrangement you set up through your employer to pay for many of your out-of-pocket medical expenses with tax-free dollars. These expenses include insurance copayments and deductibles, and qualified prescription drugs, insulin and medical devices. You decide how much of your pre-tax wages you want taken out of your paycheck and put into an FSA. You don't have to pay taxes on this money. Your employer's plan sets a limit on the amount you can put into an FSA each year. There is no carry-over of FSA funds. This means that FSA funds you don't spend by the end of the plan year can't be used for expenses in the next year. An exception is if your employer's FSA plan permits you to use unused FSA funds for expenses incurred during a grace period of up to 2.5 months after the end of the FSA plan year.

(Note: Flexible Spending Accounts are sometimes called Flexible Spending Arrangements.)

Full-Time Employee
An employee who works an average of at least 30 hours per week (so part-time would be less than 30 hours per week).

Grandfathered:
As used in connection with the Affordable Care Act: Exempt from certain provisions of this law.

Grandfathered Health Plan:
As used in connection with the Affordable Care Act: A group health plan that was created – or an individual health insurance policy that was purchased – on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions. (Note: If you are in a group health plan, the date you joined may not reflect the date the plan was created. New employees and new family members may be added to grandfathered group plans after March 23, 2010).

Health Insurance Marketplace (the Exchanges):
A new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. The Marketplace will offer a choice of health plans that meet certain benefits and cost standards. Starting in 2014, Members of Congress will be getting their health care insurance through the Marketplace and you will be able buy your insurance through the Marketplace too.

Health Maintenance Organization ("HMO"):
A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Health Reimbursement Account ("HRA"):
Health Reimbursement Accounts (HRAs) are employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the account. Health Reimbursement Accounts are sometimes called Health Reimbursement Arrangements.

Health Savings Account ("HSA"):
A medical savings account available to taxpayers who are enrolled in a High Deductible Health Plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses. Unlike a Flexible Spending Account ("FSA"), funds roll over year to year if you don't spend them.

High-Cost Excise Tax ("Cadillac Tax"):
Under the Affordable Care Act starting in 2018, a tax on insurance companies that provide high-cost plans. This tax encourages streamlining of health plans to make premiums more affordable.

Individual Responsibility:
Under the Affordable Care Act, starting in 2014, you must be enrolled in a health insurance plan that meets basic minimum standards. If you aren't, you may be required to pay an assessment. You won't have to pay

an assessment if you have very low income and coverage is unaffordable to you, or for other reasons including your religious beliefs. You can also apply for a waiver asking not to pay an assessment if you don't qualify automatically.

Medicaid:
A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies by state and may have a different name in your state.

Medicare:
A Federal health insurance program for people age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Minimum Essential Coverage:
The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

Minimum Value:
A health plan meets this standard if it's designed to pay at least 60% of the total cost of medical services for a standard population. Starting in 2014, individuals offered employer-sponsored coverage that provides minimum value and that's affordable won't be eligible for a premium tax credit.

Navigators
An individual or organization that's trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms. These individuals and organizations are required to be unbiased. Their services are free to consumers.

New Plan:
As used in connection with the Affordable Care Act: A health plan that is not a grandfathered health plan and therefore subject to all of the reforms in the Affordable Care Act. In the individual health insurance market, a plan that your family is purchasing for the first time will generally be a new plan. In the group health insurance market, a plan an employer offers for the first time will generally be a new plan. Please note that new employees and new family members may be added to existing grandfathered group plans – so a plan that is "new to you" and your family may still be a grandfathered plan. In both the individual and group markets, a plan that loses its grandfathered status will be considered a new plan. A plan loses its grandfathered status when it makes significant changes to the plan, such as reducing benefits or increasing cost-sharing for enrollees. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions.

Nondiscrimination:

A requirement that job-based coverage not discriminate based on health status. Coverage under job-based plans cannot be denied or restricted. You also can't be charged more because of your health status. Job-based plans can restrict coverage based on other factors such as part-time employment that aren't related to health status.

Out-of-Pocket Costs:
Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

Plan Year:
A 12-month period of benefits coverage under a group health plan. This 12-month period may not be the same as the calendar year. To find out when your plan year begins, you can check your plan documents or ask your employer. (Note: For individual health insurance policies this 12-month period is called a "policy year").

Pre-Existing Condition (Job-based Coverage):
Any condition (either physical or mental) including a disability for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on your enrollment date in a health insurance plan. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition. Pregnancy cannot be considered a pre-existing condition and newborns, newly adopted children and children placed for adoption who are enrolled within 30 days cannot be subject to pre-existing condition exclusions.

Premium Tax Credit:
The Affordable Care Act provides a new tax credit to help you afford health coverage purchased through the Marketplace. Advance payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit payments to apply to your premiums each month, up to a maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

Qualified Health Plan:
Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Exchange in which it is sold.

Seasonal Employee:
The Employer Mandate final regulations define a "seasonal employee" as an employee who is hired into a position for which the customary annual employment is six months or less.

Seasonal Worker:
The Employer Mandate final regulations define a "seasonal worker" as a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including (but not limited to) workers

covered by 29 CFR 500.20(s)(1), and retail workers employed exclusively during holiday seasons. Employers may apply a reasonable, good faith interpretation of the term seasonal worker and a reasonable good faith interpretation of 29 CFR 500.20(s)(1).

Self-Insured Plan:
Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third party administrator, or they can be self-administered.

Summary of Benefits and Coverage ("SBC"):
An easy-to-read summary that lets you make apples-to-apples comparisons of costs and coverage between health plans. You can compare options based on price, benefits, and other features that may be important to you. You'll get the "Summary of Benefits and Coverage" ("SBC") when you shop for coverage on your own or through your job, renew or change coverage, or request an SBC from the health insurance company.

Waiting Period (Job-based coverage):
The time that must pass before coverage can become effective for an employee or dependent, who is otherwise eligible for coverage under a job-based health plan.

Wellness Programs:
A program intended to improve and promote health and fitness that's usually offered through the work place, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships, and other incentives to participate. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs, and preventative health screenings.

**** Source: U.S. Department of Health and Human Services' HealthCare.Gov website. These are not intended as formal, legal definitions of the foregoing terms.*

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