The following summarizes the views of HR Policy Association Chief Human Resource Officers (CHROs) regarding the impact of the Affordable Care Act on the health care programs sponsored by their companies.

This summary is the product of six, separate all-day meetings conducted with over 250 members of the Association during the summer of 2010, numerous informal meetings and conference calls, and a formal membership survey conducted in September, 2010.

The purpose of the document is to give policy makers the perspectives generally held by large employers regarding the new law. As such, it contains commentary on both the statutory and regulatory aspects of the legislation.
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Overview of the Impact of the Affordable Care Act

The HR Policy Association membership consists of the chief human resource officers of more than 300 large employers who collectively spend more than $80 billion annually providing health insurance to millions of American employees, their dependents and retirees.

Before the debate over the Affordable Care Act (ACA) began, the Association published a comprehensive position statement laying out a roadmap for what they see as true reform. This position statement represented over three years of meetings, discussions, and debate among the members. In it, the Association called for reform of the health care system in the United States because of the strong belief that it was on an unsustainable path.¹

Large employers doing business in the United States want their employees and retirees to have access to affordable, high-quality health care. However, on the whole, large employers believe the ACA broadens access while failing to make any meaningful changes in the way health care is delivered by the health care supply chain, and then places the primary burden for paying for this broadened access on employers and employees. At the same time, many employers worry that passage of the ACA represents the first major step down a path that, within ten years, will result in health care no longer being provided through the employment relationship as it is today. They see the incentives in the law pushing employers to drop coverage, coupled with the ACA’s financing mechanisms, resulting in the system created by the law eventually collapsing, an event which will force Congress to draft the next version of health care reform.

Our members believe the ACA will, with each passing year encourage more employers to drop employer provided care and prompt their employees to seek coverage through exchanges. Employers may continue providing employment-based coverage in the near term, but once a few large employers begin dropping coverage, other employers are likely to follow their example as health care costs accelerate because of cost-shifting. While there are a variety of opinions within the large employer community as to whether it would be good or bad for employers to drop coverage and for employees to receive insurance through health insurance exchanges, there is general agreement that the trend will be away from employer-sponsored coverage over the next ten years.

<table>
<thead>
<tr>
<th>How likely is your company to provide employer-sponsored coverage in 2020?</th>
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<tbody>
<tr>
<td>34% Likely</td>
</tr>
<tr>
<td>19% Not likely</td>
</tr>
<tr>
<td>47% Not sure</td>
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HR Policy Association Membership Survey September 2010

The membership believes that true health care reform requires changes in access, efficiency, funding, and delivery. They are pleased, therefore, that the ACA does contain the following measures which are badly needed to improve our nation’s health care system and are consistent with the Association’s health care reform objectives:

- Insurance market reforms giving everyone access to coverage regardless of health status;
- Subsidies to help low income Americans buy health insurance;
- Mandates requiring individuals to maintain health insurance;
- Investment to strengthen primary care;
- Reforms of the provider payment system;
- Provisions to strengthen employer wellness programs;
- Comparative effectiveness research to help patients make informed decisions; and
- Steps to improve transparency of the cost and quality of health care providers and facilities.

Believing that many of their concerns were not addressed fully during the first round of the legislation, employers will be strongly motivated to insist that Congress tackle these issues in Version 2 of health care reform. In this second round, delivery system reforms to reduce costs will be of paramount importance to the payer community.

While the ACA was intended to give small employers many of the advantages that are currently available to larger companies, the new law will actually increase costs for both small and large employers because of new benefit mandates, taxes, cost-shifting, and adverse selection caused, in part, by a relatively weak penalty for people who fail to comply with the individual mandate. Ultimately, this could lead to more and more employers choosing to drop coverage and having their employees seek coverage through the exchanges.

<table>
<thead>
<tr>
<th>Will the ACA increase your company's health care costs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>96% Yes</td>
</tr>
<tr>
<td>0% No</td>
</tr>
<tr>
<td>4% Not sure</td>
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HR. Policy Association Membership Survey September 2010

<table>
<thead>
<tr>
<th>How much is the ACA likely to increase your company's health care costs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>56% 0 - 5%</td>
</tr>
<tr>
<td>26% 6 - 10%</td>
</tr>
<tr>
<td>18% more than 10%</td>
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HR. Policy Association Membership Survey September 2010
At the same time, companies which are self-insured are beginning to consider ways to be involved in ensuring that their employees have appropriate health care, other than simply sponsoring self-insured health plans. For example, they would like to move beyond just paying the claims presented to them and shift towards:

- Doing far more to ensure appropriate care;
- Promoting the development of effective and efficient integrated health care systems;
- Encouraging employees to save for future health care costs;
- Demanding transparency of quality and cost information;
- Placing a higher priority on wellness and productivity; and
- Fundamentally reforming the payment system so that it moves away from the fee-for-service reimbursement model.

Virtually all CHROs want to change the conversation with employees about health care. The vast majority of Americans receive health insurance through the employer-based system, and employees are very concerned about the coming systemic changes that will result from the new law. Health care has been a defined benefit for tens of millions of American employees for the past several decades. However, both the legislation and the health care industry generally are moving the nation to a defined contribution model.

If the ACA implemented as designed in 2014, how likely is your company to consider fundamental changes to long term benefit strategy for active employees?

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Somewhat likely or very likely</td>
<td>79%</td>
</tr>
<tr>
<td>Not likely</td>
<td>13%</td>
</tr>
<tr>
<td>Not sure</td>
<td>9%</td>
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For companies considering fundamental changes, which changes are most likely?

<table>
<thead>
<tr>
<th>Change</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Continue to offer defined benefit plan with caps</td>
<td>19%</td>
</tr>
<tr>
<td>Continue to offer defined benefit plans without caps</td>
<td>14%</td>
</tr>
<tr>
<td>Not sure</td>
<td>49%</td>
</tr>
</tbody>
</table>

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Thus far, dialogue with employees about the coming changes in their health care benefits has just begun with the beginning of open enrollment season and with the announcement to employees of the changes mandated by the ACA. This conversation is likely to become more intense in 2012 as employers look to the March 2013 deadline for informing employees about new health insurance exchanges.

The ACA provides some needed initial steps toward reforming our health care system. However, the Association membership still believes that subsequent legislation will be needed to achieve true reform. At this point, no one has a clear idea of all the implications of the ACA, and it will be years before major elements take effect. The implementation process will be challenging for the federal government, states, employers, and individuals. Going forward, the Association's
members continue their willingness to partner with government agencies on the complex issues that are likely to be raised throughout the regulatory process. We share a common objective of implementing the ACA in a manner that provides affordable and quality coverage for all Americans and ensures America can remain a leading global competitor.

<table>
<thead>
<tr>
<th>Your perspective on future of health reform law?</th>
</tr>
</thead>
<tbody>
<tr>
<td>56%</td>
</tr>
<tr>
<td>32%</td>
</tr>
<tr>
<td>3%</td>
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<td>3%</td>
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HR Policy Association Membership Survey September 2010

The New Relationship Between Employers and Employees Regarding Health Care

One of the overarching issues raised by the law is the new understanding between employers and employees regarding their health care and the employer’s role in the health of its workforce. For decades, the provision of health care by employers to employees has been an integral part of the employment relationship. However, passage of the ACA signals that Congress intended for that relationship to be changed.

The law has created the unintended consequence of encouraging employers who offer very generous benefits to discontinue offering those benefits. By adding costly mandates and requirements to these already generous programs, many companies will reexamine the value proposition for providing benefits that go beyond what is required under the ACA.

Illustrations of the ACA’s ability to curtail benefits can be envisioned in at least three areas – benefits for part-time workers, supplemental benefit programs, and retiree coverage. For example, there is no penalty under the law for not offering benefits to part-time workers, but all new mandates apply if an employer offers coverage to these workers. The likely result is that many employers will consider dropping coverage for part-time workers to avoid additional costs of benefits that they previously provided.

In addition, the ACA provides a disincentive for employers to offer special supplemental benefit programs for their employees if these programs are deemed to be subject to new mandates under the law. Take the case of an employer who offers up to $50,000 benefits (lifetime cap) for employees with children who have special developmental, occupational, and physical needs. If these benefits are deemed to be essential medical benefits, caps would not be permitted under the law, and most companies would discontinue offering these benefits.

Finally, some companies have continued to offer retiree benefits despite the high cost. In many cases, employers accomplish this by including their retirees in the same plan as their employees, which creates administrative efficiency and economy of scale. Because the law places significant new mandates and prohibits caps on
benefits unless they are stand-alone retiree-only plans, employers are likely to respond by 1) ceasing to mix actives and retirees and creating stand alone retiree-only plans, which will drive up costs for retirees, or 2) discontinuing the provision of retiree benefits all together.

One of the talking points heard continually during the debate over the legislation was that for those Americans who currently had health care through the employment based system, nothing would really change. Employees would be able to keep their same plan and keep their same doctor, and the cost of utilizing both would decrease. The reality of the new law is that it will force employers to change their health plans, it will increase the cost of employer-based care beyond the costs they had already anticipated, and it will result in some employees receiving coverage through other means and thereby having to select new doctors and health care providers. And ultimately, millions of employees are likely to move from employment-based to exchange-based health care in the coming five years.

<table>
<thead>
<tr>
<th>What action are you likely to take in response to increased costs?</th>
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<tbody>
<tr>
<td>64% Split costs between company and employees, dependents, and retirees</td>
</tr>
<tr>
<td>19% Pass costs on to employees, dependents, and retirees</td>
</tr>
<tr>
<td>6% Have company absorb costs</td>
</tr>
<tr>
<td>11% Not sure</td>
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HR Policy Association Membership Survey September 2010

Developing New Health Care Strategies in Implementing the New Law

Employers are still in the early stages of working through the complex provisions of the law, digesting the equally complex regulations as they are being promulgated, and putting together their strategies to address the law’s requirements and obligations over the next decade. Further, the impact of the ACA on large employers will vary depending on whether they are labor or capital intensive, whether they use full-time or part-time employees primarily, whether they have collective bargaining agreements and/or provide retiree health care, the age and income level of their workforces, and the type of business in which their companies are involved. Therefore, impacts and strategies will vary substantially depending upon the industry in which a company operates.

Impact of New Mandates and Regulatory Burdens

A key point to keep in mind is that with each new administrative burden, each new direct and indirect tax, each new mandate, and with each piece of added complexity, employers are nudged in the direction of dropping coverage altogether. If policy makers and regulators wish to keep employers involved in the business of providing coverage, careful consideration needs to be given to the consequences of the regulations that are being promulgated under the ACA.
Health Care as a Differentiator and a Point of Competitive Advantage

For the past several decades, many large employers have viewed health care as part of the total compensation package that employers offer employees to attract them to their companies and retain them as employees. While the ACA seeks to ensure that all Americans have appropriate health care, it also turns health care into more of a commodity with federal mandates becoming both a floor and a ceiling. Employers, therefore, are struggling to figure out whether there is still a way they can use health care as a point of competitive advantage.

Control Over Health Care Costs

For years, large employers have sought to use their leverage as major purchasers of health care to make changes in plan designs and institute programs that, to some extent, lowered the cost of health. However, the significant federal oversight of health care plans that will occur under the ACA will limit employers’ ability to make such changes in the future, and most employers see themselves in the coming years losing the limited leverage they once had over the health care supply chain.

Impact on Retirees

Employers view improved coverage in the prescription drug donut hole, exclusion of retiree-only plans from the ACA’s numerous benefit mandates, and the temporary reinsurance pool for early retirees as positive features of the law. Guaranteed issue and means-tested subsidies for early retirees after 2014 are also viewed as positive developments as they will give all retirees guaranteed access to coverage through the individual market after insurance reforms take effect in 2014.

However, like active employee plans, employers offering group retiree benefits believe their costs will increase substantially due to increased cost-shifting and new supply chain taxes in the coming years as the ACA is fully-implemented. The change in tax status for the retiree drug subsidy has already had a major impact on costs for employers who are receiving federal subsidies for qualified Medicare prescription drug plans. Significant funding cuts to Medicare Advantage plans will likely result in reduced benefits and increased premiums for retirees enrolled in those plans.

Employers are concerned that the increase in the Medicare payroll tax is being used to fund a new entitlement, when it would be wise to use any increased revenue from the Medicare payroll tax to address long-term Medicare solvency issues if needed. The relatively weak Medicare payment reforms are also of concern. Employers want the federal government to focus first and foremost on addressing Medicare’s existing structural and financing issues.

The cumulative impact of all these changes is that while retirees will have better access to guaranteed coverage, more and more employers will likely encourage their retirees to seek coverage through health insurance exchanges. Those continuing to offer group plans will likely see their costs increase, and this will result in added costs for retirees in those plans.
Shifting From Employment Based Coverage to Exchange-Based Coverage

From discussions with the membership, a major consideration is whether, and how long, their companies should continue providing employment-based coverage. It is our impression that some companies are in the early stages of evaluating whether it is in the best interest of their competitive position and their employees to discontinue offering employer-based coverage and allow their employees to obtain coverage through the exchanges in the future. This is not to say that they have made a final decision to make the shift; rather, that they are currently exploring the pros and cons of their future options in light of the ACA. These evaluations must take into account a variety of factors, including the impact on a company’s ability to recruit and retain employees, the effectiveness of exchanges and ability of their employees to obtain access to care through them, the ability of employees to obtain subsidies through exchanges, and tax consequences for employees who would lose their income tax exclusion for employer-provided health insurance.

Employers with richer plans are looking at 2018 when the excise tax takes effect, and our impression is that 2018 may become a seminal date for employer-provided care. Our discussions indicate that by that date, far more private sector employees will be enrolled in exchanges than those receiving their health care through their employer compared to today. It is not only the tax issues that will move employers towards exchanges. As health care becomes more of a commodity in the employer-employee relationship and less of a tool that employers can use to attract and maintain quality employees, employers will be more inclined to shift to exchange-based coverage. However, their future actions will depend on whether the exchanges available to their employees are operating effectively and providing timely access to appropriate care and quality providers.

Companies struggling for survival are likely to be among the first to drop coverage and have their workers obtain coverage through exchanges. So too are those that use large numbers of younger workers, such as retailers and restaurants, because younger workers see relatively little value in health care coverage compared to older employees. As the exchanges become fully operational, it is likely that some employees may prefer obtaining coverage through the exchange which will be fully portable and able to be maintained as they change jobs throughout their careers. Given the tax premium credits and cost-sharing subsidies for lower wage workers under the ACA, the fact is that some employees may be able to get more affordable care through the exchanges, and these employees will be motivated to seek coverage through exchanges. This is why some employers with large numbers of lower paid, less skilled workers are giving serious consideration to how the establishment of exchanges will figure into their future health benefits strategy.

As more and more employees shift to exchanges, a tipping point is likely to be reached that will result in an avalanche of employers seeking to have their employees covered in the exchanges. Employers realize that a large scale shift to exchanges will create significant problems for policymakers, because the ACA and its financing scheme do not contemplate a massive shift away from the employment based system of care.
**Initial Rulemaking Activity**

Below are issues for which the federal government has already initiated rulemaking under the ACA, as well as related issues that may require legislative changes to address employer concerns.

**Grandfathering**

Virtually all CHROs believe the new health care law will substantially increase their costs, and their primary concern right now is figuring out how to minimize the impact of those costs on their businesses. At the same time, they believe that the interim final grandfathering rules would significantly limit their ability to effectively manage their plans to deal with the coming cost increases. Most, therefore, have decided that they cannot retain their grandfathered status. They believe that the necessity to maintain the discretion to change their plans to control costs trumps the advantages of grandfathering. Plus, in the contemporary business environment, companies frequently change forms through reorganizations, mergers, acquisitions, and divestitures, and companies changing form will often lose their grandfathered status.

Those that have decided to seek grandfathered status (a distinct minority) are committed to doing so only temporarily, through 2011 in most cases. They are concerned about hidden issues that might appear later this year or in 2011 as the law is digested and regulations are promulgated.

**Fully-Insured and Self-Insured Collectively Bargained Grandfathered Plans**

The ACA provides that health insurance coverage maintained pursuant to a collective bargaining agreement (CBA) is grandfathered until the CBA in effect on March 23, 2010 terminates. The interim final regulation on grandfathered fully-insured CBA plans provides that such plans enjoy a complete safe harbor in maintaining their grandfathered status during the life of a contract that was in effect on March 23, 2010. In other words, there is virtually no limit on the extent to which a health insurance carrier can make design changes in the plan during the life of the agreement. Following the termination of the CBA in effect on the date of enactment, fully-insured CBA plans are then subject to the same rules that govern whether health plans lose their grandfathered status.

By contrast, self-insured plans maintained pursuant to a CBA do not enjoy the same safe-harbor which the regulators have applied to fully-insured CBA plans. Self-insured CBA plans are subject to the same rules and treated like any other grandfathered group health plan, and the termination of the CBA in effect on the date of enactment will have no impact on the self-insured CBA plan status.

**Drug Formularies and Grandfathering**

Regulations on grandfathering rules sought public comment on the degree to which health plans should be able to make changes to drug formularies without losing their grandfathered status. Employers seek to design their benefit programs to ensure
that their employees, families, and retirees have access to the most cost-effective, clinically appropriate drug therapies available. As such, they often establish drug formularies that encourage the use of generic drugs by requiring plan participants to pay a higher fee for brand name drugs as generics become available. They also frequently change drug formularies as new medical evidence and treatment alternatives become available. Employers should be able to change coverage for a given prescription drug and/or treatment with new alternatives without losing grandfathered status.

**Internal Claims and External Review Processes**

One of the most significant consequences of an employer’s plan losing its grandfathered status is that benefit claim submissions and denials would be subject to the new internal claims procedures and external review process imposed by the ACA. This is an area of concern for employers. Under the new law, the benefit determinations of self-insured non-grandfathered plans will not only be subject to ERISA’s current claims procedures (and any regulatory changes to those procedures), but also such determinations will be subject to a new federal external review process. The external review process provides for review of a plan’s internal adverse benefit decision by an independent review organization (IRO), and the IRO’s decision will be “binding.”

The interim final rule regarding internal claims determinations and the new external review process were issued near the end of the Association’s regional meetings. Even so, several concerns have been raised.

**Internal Claims & Appeals.** The proposed regulations direct self-insured plans to continue to follow the existing regulatory regime governing the internal claims and appeals of ERISA plans. However, the proposed regulations included several significant revisions and additions to these requirements. For example, the time period in which plans must notify enrollees of urgent care benefit determinations (adverse or not) was reduced from 72 to 24 hours of a claim being submitted. This drastic reduction of time for plan administrators to receive, process, decide a claim and then notify a claimant will pose significant administrative problems. The proposed regulations also expand the definition of “adverse benefit determination,” and the notice required to be provided to an enrollee was also significantly broadened. The Departments of Labor and Treasury recently released sub-regulatory guidance explaining that the reduced time frame to provide notice of benefit determinations to urgent care claimants and some of the expanded notice requirements will be granted an enforcement grace period until July 1, 2011.

**Federal External Review Process.** Although the proposed regulation notes that further guidance will be issued “in the near future” setting forth the details of the federal external review processes, there are some general statements of rules and principles in the interim final rule that do provide some indication of where the administration is likely to go.
The federal external review process will be similar to state external appeals rules that, to date, have generally applied to fully-insured plans because of ERISA preemption. However, self-insured plans will not be subject to a state-by-state approach and will be subject to the single uniform federal review process. While employers appreciate that this standard will be uniform across the nation, they are concerned about the additional costs, administrative burdens, and uncertainty associated with the new process. For example, the regulations provide that an enrollee may file an urgent care claim simultaneously under a plan’s internal claim procedure and with an external review board. Given the new rule that plans must issue a benefit determination within 24 hours, the need for providing a simultaneous filing option does not appear necessary and will only drive up costs. The regulations contemplate two different bodies making a decision over the same set of issues at the same time.

Moreover, the proposed regulations provide that the external review determination will be “binding” on both the claimant and the employer, except to the extent that other remedies are available under federal or state law—such as a denial of benefit claim under ERISA. It is our understanding that the regulatory agencies believe this provides a claimant the right to contest a plan’s adverse benefit decision through the external review process and then (or even concurrently) challenge the adverse decision in federal courts under ERISA. Permitting claimants to pursue claims in such a manner makes the external review process an unnecessary additional layer of administration that will increase costs and complexity. Moreover, employers need clarification that they also will be able to challenge external review determinations that overturn the initial claim determination. Also, under the regulations it is clear that a claimant has right to bring an action in federal district court to contest an adverse ruling, but, in what has been seen thus far, it is not clear that the employer is given that same right.

Although the regulating agencies have yet to issue detailed regulations regarding the federal external review process, the Labor and Treasury Departments recently issued sub-regulatory guidance establishing very specific requirements that, if followed, would provide an interim enforcement safe harbor. These rules create significant administrative burdens, which do not currently exist and will be costly and difficult to implement. Overly prescriptive rules will make it more difficult for employers to offer or to continue to offer efficient, effective, and affordable health coverage to employees, their dependents, and retirees.

Annual and Lifetime Limits on Essential Benefits

The ACA requires all health plans to phase out annual dollar limits on essential benefits by 2014 and places a prohibition on lifetime dollar limits for essential benefits for plans that take effect after September 23, 2010. The interim final regulations that have been released on annual and lifetime limits have yet to define “essential benefits.” They simply advise employers to make a good faith effort to comply with a reasonable definition based on statutory language. Employers need clarity around the definition of “essential benefits” as soon as possible. They are concerned that, with time, the definition will expand as a result of intense lobbying.
from provider and advocacy groups, which will increase the cost of benefits for employers going forward.

In addition, employers design their benefits to create incentives for employees to use providers that deliver the most effective and high value care by requiring employees to pay more for choosing lower value providers. To that end, employers would like to retain the flexibility to place annual and dollar limits on essential benefits delivered out-of-network. The agencies recognized the value of driving patients to high value providers in regulations that were recently released on preventive coverage, and applying this same principle to the annual and lifetime limits is consistent with this approach. At a minimum, employers should be permitted to impose out-of-network limits for essential benefits that are not for urgent and/or emergency care.

Employers would also like to see essential benefits limited to medically necessary services as they have been historically defined in summary plan descriptions by employers, and not expanded to include new technologies, drugs and services that have not proven to deliver greater effectiveness beyond existing approaches. Services such as cosmetic surgery and Lasik surgery should be excluded.

Age 26 Dependent Coverage

The ACA generally provides that a health plan or insurer that makes available dependent coverage of children must make such coverage available for children until attainment of age 26. The statute provides limited relief for grandfathered plans, allowing them to withhold dependent coverage if the child has access to other employer-based coverage, but only until 2014. After that point, employers must extend dependent coverage to children up to age 26, even if the child has access to other employer-based coverage. The policy rationale for this mandate is counter-intuitive given that health insurance exchanges will be operational beginning in 2014. After January 1, 2014, employers should no longer be required to cover an adult child who not only has access to his or her own coverage through his or her employer, but also has access to coverage through an exchange. Moreover, employers seek clarification of interim final rules that after January 2014, in the case of a grandfathered health plan, an employer is not required to offer dependent coverage up to age 26 if the child has access to other employer-sponsored coverage through the child’s spouse.

Employers have been pleased that sub-regulatory guidance has provided clarification about the children and/or dependents who are required to be covered under the new dependent coverage requirement for children up to age 26. The interim final rules did not provide a definition of “child.” Employers sought clarification that “child” as used under the ACA and interim final rules has the same meaning as under section 152(f)(1) of the Internal Revenue Code (i.e., sons, daughters, stepchildren, adopted and foster children). Some employers generously make coverage available to children related to employees under certain circumstances such as nieces, nephews, grandchildren, or other relations who do not fall under the 152(f)(1) definition of child. Interim final rules on dependent coverage appeared to require employers that offer this type of coverage to non-152(f)(1) individuals to continue to offer such coverage until the individual turns 26, regardless of whether
that individual continues to meet eligibility requirements set out under an employer’s plan. However, guidance released by the Departments of HHS, Labor, and Treasury on September 20, 2010 clarified that a plan may limit dependent coverage to children defined under 152(f)(1), and may impose other conditions on eligibility for dependent coverage on individuals who fall outside of that definition.

**Prohibited Cost-Sharing for Preventive Coverage**

A significant consideration leading some employers to consider maintaining grandfathered status is to avoid new requirements that recommended preventive care be provided to employees with no cost-sharing. While many employers support preventive care and include substantial benefits in their plans, the added cost of requiring these services without consideration of the provider that delivers the service is contrary to the philosophy that employers should be promoting responsible consumerism among their employees. Many employers currently do this by designing their benefits to create incentives for employees to use providers that afford the best outcomes and offer the most effective treatments. For example, employers may require employees to pay more if they choose to use health care providers that have not demonstrated they operate using high quality and cost-effective care. In addition, with this new infusion of mandated funding, there is concern by employers that the medical community will aggressively lobby to expand the definition of covered preventive services, further increasing the cost of this mandate.

Employers were pleased that interim final regulations addressed some employer concerns by permitting employers to encourage employees to use in-network providers to deliver preventive services, and that the agencies are considering further guidance that will facilitate employer use of value-based design to provide information and incentives to use higher value providers. In addition, employers appreciate that the interim final rule provides health plans one year to comply after new preventive guidelines are issued. This will facilitate the transition of meeting new guidelines as they are developed. However, employers remain concerned that the definition of mandated preventive care services does not become expanded beyond the scope of appropriate services in reaction to pressure from providers to adopt a broad definition of what constitutes mandatory preventive care services. Employers hope that further regulations in this area will continue to address the concerns described above.
Future Rulemaking Activity

Wellness Programs and the Genetic Information Non-Disclosure Act

Going forward, employers see wellness and disease management programs as critical areas in which they are able to influence the direction of health care costs and the quality of their employees’ coverage. They are likely to focus on wellness benefits as both a differentiator and as a means of coping with the cost increases that will result from the new law.

Nevertheless, as large employers consider placing far greater emphasis on wellness programs, they find that they are being bombarded with significant amounts of information about the subject while receiving little solid information available about what has actually worked. They are seeking hard data on cost savings that can be achieved through wellness programs, and they want a database of information that can be easily accessed.

Further, companies now have more of an incentive to care for the health of their employees than employees do. They believe that true reform means that employees should have the same incentives for wellness as employers. Regardless of whether employers elect to continue providing employer-sponsored health insurance, all companies will continue to have a sustained interest in wellness because they want to ensure they have a productive workforce. As such, large employers have a vested interest in healthy employees who have access to timely and appropriate care for themselves and their families.

In order to operate effective wellness programs, employers need to be able to offer incentives for participating. Employers are very pleased that the ACA will permit wellness incentives in group health plans to increase from 20 percent to 30 percent of plan costs, and permit those incentives to increase up to 50 percent in the future if determined to be appropriate. Yet, recent interim final regulations issued under the Genetic Information Nondiscrimination Act (GINA) prohibit employers from offering any benefit to individuals for participating in wellness programs that ask about family medical history—something that is a critical element of any effective wellness program. This is one area where hard data is available to show that employees are more likely to participate in health risk assessments when offered some financial incentive for doing so. Ironically, the GINA regulations are hampering employer efforts to use and expand these programs.

Long term, there is concern that once the nation shifts from employer-based to exchange-based health care, employers will lose the ability to build and manage effective wellness programs. Although employers who discontinue providing coverage through self-insured plans will no longer be impacted directly by the cost of medical claims, they will always be concerned about the wellness and the productivity of their employees. This is of significant concern for employers as the nation’s population ages and becomes more obese.
Employer Interest in Successful Health Insurance Exchanges

The ACA establishes two ways for employees of large companies to receive health care coverage—through their employers or through state exchanges. The state health insurance exchanges are to begin operating by January 1, 2014. By March of 2013, employers must provide their employees with notice if they are being shifted to an exchange. That means employees and employers will want to be sure that the state exchanges are fully operational by January 1, 2014. Creation of 50 state agencies and the federal entities to manage them along with all the vendors who will be participating in these exchanges is a massive undertaking, and early signs that the government will, in fact, be able to cope with the requirements of the new law would be reassuring to both employers and employees.

Large employers are vested in the success of health insurance exchanges and want to engage in the establishment of exchanges for several reasons.

First, the manner in which the ACA expands coverage to 32 million people will have a profound impact throughout the entire health care system. Providers are already wondering how they will be able to handle the coming demands for their services. Employers want to be sure that their own employees’ health care needs are not negatively impacted during the transition.

Second, employers want to ensure that the benefits offered through the exchanges are value-based and move our health care system away from the predominant fee-for-service model.

Third, some employees of large employers will be covered through health insurance exchanges either because employees will opt out of the employer’s coverage or because the employer will decide not to offer health benefits. Employers, therefore, want to ensure that their workforce and their employees’ families are able to gain access to affordable, evidence-based medicine, regardless of how and where their employees are insured. Congress chose to implement the exchanges at the state level, which opens the process to a high degree of variability for employers who have employees in multiple states.

Employers will be assessing the viability of exchanges that will have different carriers and plans in each state. Companies seek some assurance that offerings, requirements and administration will be as uniform as possible in order for their employees living in different states to be able to access equal coverage.

Because of the inevitable shift away from employment-based health care, most CHROs have a strong interest in ensuring that the exchanges are operated as efficiently as possible and provide the highest possible quality care. They would like to have the federal government as well as state governments partner with employers during the creation of exchanges, so that potential problems with employees accessing their health care through the exchanges can be minimized. Large employers have operated health insurance programs for millions of their employees, dependents and retirees on a large scale for decades. They can serve as a valuable resource for the federal government and states as exchanges are established.
Employers were pleased that in August 2010, the Department of Health and Human Services published a solicitation for feedback from stakeholders, including employers, on the establishment of health insurance exchanges. The Association has provided initial comments and urges the Administration to provide future opportunities for employer input throughout the exchange development process.

**Delivery System and Payment Reform Projects**

For years, employers have been encouraging carriers and providers to use financing models that shift away from fee-for-service systems and focus instead on promoting health using evidence-based medicine. This was the most important reform element sought by the payer community during the health care debate. The final legislation includes several pilot and demonstration projects in the Medicare and Medicaid program. It will be of vital importance to pursue these projects and expand approaches that demonstrate improved quality and cost control as quickly as possible. Employers are very concerned that implementation of these projects may be delayed and that they will not be expanded, even if they demonstrate the potential to improve care and lower costs.

The payment and delivery system reform projects in the ACA include the following:

- **Value-Based Purchasing and Piloting of New Programs.** These include rapid testing and, as proven, expansion of programs that use payment redesign to encourage better quality while lowering costs.

- **CMS Innovation Center.** The establishment of an Innovation Center with the capacity to implement innovations program-wide that require review and assessment by the Office of the Actuary.

- **Independent Payment Advisory Board.** Creation of a new board which includes reporting on cost and quality trends in Medicare and the private sector as well as making recommendations regarding policies in the private sector.

- **Alignment between Public and Private Payers.** The ACA includes multiple provisions that advance the goal of aligning payment between public and private payers.

- **Medical Home.** The ACA creates a medical home pilot program for Medicare and Medicaid beneficiaries. The medical home model has potential to be an effective strategy for delivering effective coordinated care to patients while minimizing unnecessary costs for specialty care.

These programs hold great promise and make important strides away from rewarding health care providers for the volume and intensity of services that they deliver, and towards reimbursing providers for delivering high quality and efficient care. The Association understands that the federal government is poised to move quickly to implement an initial set of these reforms and actively seeks employer
recommendations for individuals to represent the employer community to sit on boards and bodies established under the ACA. The Association stands ready to partner with the federal and state governments and insurers to aggressively implement these programs, and will make recommendations for good candidates as soon as possible.

**Transparency**

For the past two decades, employers have been engaged in discussions with the health care supply chain regarding the need for transparency in the pricing of health care services and the quality of those providing the services. However, very few, if any, elements of the discussion have been translated into action. Employers want carriers and providers to fully disclose the quality and price of health care services. They want hard data in a common format acceptable to the community of those purchasing health care, including consumers. Other industries use common coding systems that all those in the industry embrace. Employers believe the health care system should do the same.

In an ideal world, employers would like performance measures based on three forms of data from providers and doctors—patient satisfaction data, clinical data, and administrative (claims) data. During the ACA debate, the employer community sought a requirement that the government release Medicare claims data, a key source of administrative data, to private payers and consumer organizations. We are pleased, therefore, that the ACA provides for the release of Medicare claims data effective 2012. This data should provide a wealth of information to help consumers and payers identify the relative cost and quality of health care providers.

The Association would like this information publicly disclosed as soon as possible. It is concerned that doctor and provider organizations will seek to limit the availability of this information during the regulatory process. We understand that the Administration will be holding listening sessions on release of this data very soon and targets having rules in place by the fall of 2011. We welcome this speedy timeline and look forward to working with the federal government to ensure the data is released in a way that is useful for the payer community and consumers.

In addition, CMS should consider more aggressive requirements conditioning participation in Medicare that are linked to providers and insurers producing data to support performance measurement from clinical and patient derived sources.

**Medical Malpractice Reform**

The Congressional Budget Office estimates that medical malpractice reform would save $54 billion over the next ten years. The ACA appropriates a very modest sum—$50 million for five years—for state demonstration programs to evaluate alternatives to the current medical tort system. States can use the funds to develop, implement and evaluate alternatives for settling disputes over injuries caused by health care providers and promote the reduction of medical errors by facilitating the collection and analysis of patient safety data. There are considerable requirements and reporting obligations placed on states receiving the funds. The ACA further establishes a review panel of between 9 and 13 members, appointed by the
Comptroller General, to consult with the Secretary in reviewing the proposed alternatives received from the states, which will add considerable time to release of the funding. Because of the lengthy review process, prerequisites for receiving funds and the short time frame in which the funds will be available, employers are concerned that the process for releasing the funds may get bogged down in bureaucracy. Employers are pleased that $25 million in grant funds have already been released to states and health care systems, and urge the federal government to release the remaining half of funds as soon as possible as a means of exploring options to lower medical malpractice costs.

**Comparative Effectiveness Research**

The ACA will provide for comparative effectiveness research that clinicians, patients, and others can use to improve care and facilitate better clinical decision making. Among other things, the law creates a new independent entity to support and oversee comparative effectiveness research. Employers want to ensure that effective conflict of interest protections are in place to guard against self-interested individuals and entities unduly influencing comparative effectiveness research processes. In addition, is it vitally important that comparative effectiveness research include an analysis of the cost-effectiveness of new drugs and procedures? We must ask the question: if a new drug or procedure is effective, and has some advantage over existing alternatives, then does the incremental benefit justify the likely additional cost? Ignoring the issue of cost in comparative effectiveness research discounts an important element for the health care delivery system and its consumers and purchasers.

**Definition of Part-Time and Full-Time Workers**

Employers with large numbers of part-time employees who work varied schedules are very concerned about pending regulations defining what constitutes part-time employment for the purposes of the new health care law. Most retailers and other employers who employ part-time workforces currently use a 32 hour workweek for their part-time employees. According to Applied Economic Strategies, 6.9 percent of employees in the private sector have variable hours of work with the transportation and warehousing industry (11.1 percent) and the accommodation (lodging) and food service industry (10.6 percent) having the highest numbers.

Effective 2014, large employers must offer full-time employees and their dependents access to affordable coverage that meets a minimum actuarial value or pay a penalty when employees receive subsidized coverage through a health insurance exchange. However, this pay or play penalty does not apply to part-time employees. Under the ACA “the term ‘full-time employee’ means, with respect to any month, an employee who is employed on average at least 30 hours of service per week.” This approach appears fairly easy to apply with employees who work predictable consistent work schedules such as a 40, 32, or a 20 hour week. But the statute does not provide an effective way to determine the average hours of service of an employee who works a variable hour work week. Employers with large numbers

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2 Internal Revenue Code § 4980H(c)(4)(B).
of employees who work variable schedules are very concerned that future regulations being considered by the IRS and DOL to determine the method used for defining whether an employee has 30 hours or more of service per week may inappropriately categorize many part-time employees as full-time workers.

Agencies should take careful consideration to avoid continuity of coverage issues for part-time employees, and significant administrative burdens and confusion for employees and employers. Tracking these hours on a weekly or even a monthly basis would create an incredible administrative burden. For example, some part-time workers may work 50 hours in one pay period and 32 in another for one month, but work less than 10 hours per pay period for the remainder of the year. Should the regulations categorize these workers as full-time employees, a likely result would be that many employers with large numbers of part-time workers who work varied schedules would limit part-time workers to a flat 29 hours a week at all times. These employees would no longer be able to work heavy shifts during peak business periods, such as the Holiday season for retailers.

There is also the issue of access to the exchanges. An individual’s ability to enroll in health insurance exchanges and receive federal subsidies is dependent upon his or her eligibility to gain access to affordable employer-based coverage. Because part-timers are typically lower wage workers, many of them will be able to obtain subsidized coverage through the exchanges, thus receiving more affordable or better coverage than they would receive through their employers. Therefore, a broad interpretation of full-time employees could limit the ability of many employees to become eligible for subsidized coverage through a health insurance exchange.

A recommended approach for regulations in this area would be to assess an employee’s hours over a sufficient “look back” period (e.g., 90 days). This would provide a reasonable time to assess whether an employee is working on average more than 30 hours per week and would help avoid the improper categorization of part-time employees who have variable work schedules as full-timers. In addition, employees would be able to maintain continuous coverage without risk of having to go back and forth between eligibility for employer coverage and exchange coverage.

There are additional concerns regarding part-time employees discussed below with the application of the ACA’s provisions dealing with free choice vouchers and the automatic enrollment of employees in the employer’s health plan.

Clinical Trials, Internal and External Appeals, No Cost-Sharing for Preventive Care

Of the limited protections grandfathered status offers, those that employers believe would be most beneficial are exemptions from complying with:

- A requirement to cover approved clinical trials;
- New appeals processes; and
- A prohibition against cost-sharing for preventive care (see above).

Required Coverage of Approved Clinical Trials. A company losing its grandfathering status will be subject to new requirements regarding coverage for clinical trials for experimental procedures and medical devices. Employers are concerned that these regulations will be written in a way that will result in employers
being required to fund experimental medical research. This would in turn incentivize drug and device companies to expand the number of products being tested because they will be able to shift the cost of testing to employers. Physicians and other providers may also increase utilization and costs by delivering services which would not otherwise be covered by employer-sponsored plans.

**Dependent Coverage**

The ACA requires employers that do not provide access to coverage for full-time employees and their dependents to pay a penalty when certain employees receive subsidized coverage through a health insurance exchange. Employers are concerned that this requirement will be interpreted as calling for a minimum contribution for dependent coverage. Large employers want to limit mandates that will increase the cost of providing health benefits overall, and they especially want to limit any new mandates under the law to benefits for their employees as opposed to expanding new mandates for individuals who do not work for their companies (e.g. spouses and dependents). Given that the reform law was structured to create options to fill gaps in affordable coverage for people without access to employer-based coverage, our members believe it is appropriate that the regulations facilitate the use of health insurance exchanges to cover dependents, instead of placing additional cost burdens on employers.

**Concerns About Using Employee’s Household Income as a Basis for Penalty and Voucher Determinations**

Employers have expressed confusion about how data will flow between federal and state governments and employers regarding individuals’ incomes in relation to the penalty and voucher requirements under the ACA. The law imposes these requirements on employees in circumstances when an employee contribution for employer-based coverage exceeds a certain percentage of the employee’s household income. We understand from conversations with agency officials that the primary responsibility for determining household income and exchanging data between agencies, individuals and employers will rest with the health insurance exchanges. Employers look forward to working with the federal government and health insurance exchanges to minimize administrative burdens and privacy concerns for employers and employees, and enhance employers’ ability to strategically plan for health care related costs and penalties.

**Excise Tax on High Cost Plans**

CHROs are concerned about the 40 percent excise tax on so-called “Cadillac Plans” which will be effective for tax years after December 31, 2017. Under this provision, employers will be responsible for paying a tax of 40 percent on any health benefit in excess of $10,200 for individuals and $27,500 for family coverage. At a minimum, employers would like to see final regulations on this tax no later than January 1, 2013, so that they can plan their long term strategies.
This requirement creates very real incentives for employers to reduce the value of the benefits offered under an employer-sponsored plan so that the Cadillac tax will not be triggered, which we understand was the purpose of the provision and hence its nickname. During our regional meetings, we asked how many companies would take steps to avoid the Cadillac tax. At each meeting, nearly all the participants raised their hand.

In creating their long term health care strategies, many employers are beginning to view these numbers as eventual caps on what employers would be willing to contribute towards employee health care. This provision, therefore, is likely to result in employers reducing their plan design to avoid the Cadillac tax while trying to maintain a high enough actuarial value in the plan to avoid having to pay a penalty. As this corridor narrows over time, it would not be surprising if some employers decided that it is better to simply pay the penalty and move employees into the exchanges. It is significant to note how few employers plan to continue offering benefits above the Cadillac tax threshold after 2018 because the financing of the ACA depends, in part, on revenue derived from the excise tax.

There is also a distinct disparity in favor of multiemployer (i.e., Taft Hartley) health plans. Employees covered under a multiemployer plan will be treated as having family coverage regardless of whether it is simply the employee receiving coverage or the entire family. In other words, the $10,200 threshold does not exist for union plans, and the 40 percent excise tax is only triggered if the value of the benefits provided exceeds $27,500. In sum, the union plan must only pay a 40 percent excise tax when the health care coverage exceeds $27,500. There is simply no legitimate policy reason for the distinction between union and non-union employer-sponsored plans. Employees who have elected not to be represented by a union should not face disparate consequences under the ACA compared to workers who are represented by unions.

**Free Choice Vouchers**

The ACA requires employers who offer coverage to provide cash vouchers to qualified employees who opt out of the employer-sponsored plan to get coverage through health insurance exchanges. An employee would qualify for this voucher if his or her required contribution under the employer’s plan would be between 8.0 and 9.8 percent of household income and his or her income was under 400 percent of the federal poverty level. Although initial estimates were that the provision would affect relatively few employees, some employers are now concerned that a larger number of employees may be eligible for the vouchers, which could lead to significant adverse selection for employers’ plans, with lower income and healthier individuals allowed to take employer dollars for use in buying less expensive, individual coverage through exchanges. These employers are currently conducting analyses to determine what the impact might be, and hard data will be available in the coming months. In addition, it is unclear whether part-time employees are eligible for Free Choice Vouchers but there is nothing in the ACA that appears to limit this mandate to full-time employees. If so, employers would be very concerned about the scope of the types of employees to which the requirement would apply.
Automatic Enrollment Rules

Another area of the ACA that raises concerns because of considerable ambiguity is the automatic enrollment provision, which amends the Fair Labor Standards Act (FLSA). The automatic enrollment is a two-part mandate and in order for an employer to be subject to either requirement it must 1) be subject to the FLSA, 2) have more than 200 full-time employees, and 3) sponsor one or more health benefit plans.

Effective Date of Auto-Enrollment. The automatic enrollment provision does not have a specific effective date, so it is presumed that both the provision’s requirements are effective on the date of enactment, which was March 23, 2010. However, Administration officials have indicated that the regulating agencies will not enforce the auto-enrollment provision until they have released regulations. Even so, the agencies should release written guidance memorializing a policy of non-enforcement.

Requirement to Continue Enrollment of Current Employees. The first requirement of the auto-enrollment provision requires employers with more than 200 full-time employees to automatically “enroll new full-time employees” in one of the employer’s health benefit plans. This requirement appears pretty straightforward. However, the second part of the automatic enrollment provision, which is often overlooked, requires employers to “continue the enrollment of current employees.” One concern regarding the continuation of enrollment is that the mandate does not appear to be limited to full-time employees. Thus, under this provision, large employers must continue to offer enrollment to part-time employees if the employer currently does so.

Concerns Regarding the Continuation of Enrollment Rule. The ACA’s requirement that employers “continue the enrollment of current employees” in a health plan sponsored by the employer raises numerous concerns. Employers need clarity from the DOL, which is the agency responsible for providing guidance with respect to the automatic enrollment provision, as soon as possible. For example, the DOL should clarify whether the continuation of enrollment is meant to apply to all employees including part-time workers or just those who were automatically enrolled. The agency should clarify whether the rule imposes any limits on an employer’s ability to modify or terminate a health plan. In addition, under what circumstances, if any, an employer can discontinue coverage.

New Administrative Requirements

The ACA imposes significant administrative burdens on employers who continue to offer coverage to employees through group health benefit plans. For example, employers must:

- Provide each affected employee, dependent, and retiree 60-day advance notice of material modifications to plans, including notice of the modifications made to current plan documents to reflect the new insurance and market reforms;
• Provide notice to both current and new employees regarding the tax credit premium and cost-sharing subsidies for which an employee may be eligible, a statement whether the employer coverage is unaffordable and detailed information on state exchanges, including services provided and how to enroll in them. Regarding the exchanges, this information must be provided 9 months before the exchanges are to be up and running;

• File returns with the IRS and information statements to participants after the individual mandate becomes effective;

• Engage in substantial information sharing with state exchanges; and

• Potentially restate FAS 106 liabilities to reflect increased costs of new mandates.

Not only will the new administrative schemes be burdensome, but a few of them require employers sponsoring plans to provide participants and beneficiaries with the same information which employers are already providing under ERISA. For example, the ACA requires that employers sponsoring health plans begin providing plan participants with a summary of coverage and benefits. In addition to prescribing the length of document at four pages and mandating that no font smaller than 12 point may be used, the law requires the summary of coverage and benefit to contain almost all of the information that is currently provided in ERISA mandated summary plan descriptions (SPDs). Yet, employers sponsoring plans must ensure that participants would receive both a summary of coverage and benefits and an SPD.

Another example is the information flow between employers, employees, the federal government, state governments and the state exchanges. For example, the new law requires employers providing “minimum essential coverage” to any individual to file IRS returns certifying the name and identification of covered individuals, dates of coverage during the calendar year, whether coverage is through a qualified plan offered through an exchange, the amount of any advance cost-sharing or premium tax credit received by the individuals, the identity of the employer maintaining the plan, and the portion of the premium paid by the employer. The reporting employer must then send a written statement to each individual who was included on the return, providing each individual with the information which was reported to the IRS. Much of the same information must also be reported to the relevant exchanges by offering employers. The Administration could be of great help to employers if it could design implementing regulations for all the administrative requirements in a way that avoided duplicative requirements and met the objective with the least amount of paperwork required.
Regulatory and Programmatic Issues That Members of HR Policy Association Recommend The Administration Address

Regulations That Have Been Released

Age 26 Dependent Coverage [Sec. 1001]

1. Permitting Higher Premium for Adult Children. Health plans should be permitted to charge “adult children” up to age 26 a higher rate than dependent children for coverage.

2. Clarity on Definition of a Child. Sub-regulatory guidance released after interim final rules were released provided clarity around the definition of a child for purposes of the requirement to cover children up to age 26.

3. Clarity Regarding Requirements for Children with Access to Other Employer-Sponsored Coverage. Employers need to have regulators answer the question about whether employers need to cover children with access to other employer-based coverage up to 2014. Does this apply when the adult child is an employee of another employer or when the child has access through his or her spouse’s employer?

Grandfathering Regulations [Sec. 1251]

1. Clarity Around Extension of CBAs. Employers need clarity around what happens when a CBA is extended but doesn’t terminate. The statute and regulations only refer to CBA terminations, but in many cases, employers and labor unions agree to extend existing agreements.

2. Grandfathering Rules for Railway Labor Act CBAs. Related to the point above, employers need clarity around what happens to agreements under the Railway Labor Act since those agreements don’t actually terminate, but are constantly extended.

3. Grandfathered Status Should Extend to Plan Year Under CBA. The termination of a CBA may not coincide with the plan year under the CBA. Grandfathered status should extend to the end of the plan year referenced under the CBA as opposed to the termination of the agreement. Otherwise, it creates problems when the agreement terminates before the end of a plan year.

4. Changing Insurance Companies Under Grandfathering Rules. Employers should be able to change insurance companies without losing grandfathered status. A practical example of how this would impact employers is a case in which a company with 30,000 employees offers one HMO plan and the plan is dropped by the insurer or the company due to low enrollment. When those workers are put into another plan option, the entire plan with 30,000 enrollees would lose its grandfathered status.
5. **Consider Some Form of Actuarial Value Approach to Grandfathering.** Instead of requiring employers to maintain prescriptive limitations for changes to co-insurance, copayments, and cost-sharing, employers should be allowed the flexibility to make plan changes that do not exceed the actuarial value of the benefits offered. We consider this to be the most important change that needs to be made to the Interim Final Regulations.

6. **Employers Should Be Permitted to Change Drug Formularies and Provider Networks Without Losing Grandfathered Status.** Employers seek to design their benefit programs to ensure that their employees, families, and retirees have access to the most cost-effective, clinically appropriate drug therapies available and that they use high value providers who deliver good outcomes. As such, they often establish drug formularies that encourage the use of generic drugs by requiring plan participants to pay a higher fee for brand name drugs as generics become available. In addition, they develop provider networks based on effectiveness and efficiency. They also frequently change drug formularies as new medical evidence and treatment alternatives become available. Employers should be able to change coverage for a given prescription drug and/or treatment with new alternatives and change provider networks to give their employees access to the most high value providers without losing grandfathered status.

**Annual and Lifetime Limits on Essential Benefits [Sec. 1001]**

1. **Essential Benefits Should Be Limited to Medically Necessary Services.** Regulations should provide a clear definition of the term “essential benefits” as soon as possible so that employers are clear on which benefits can and cannot have annual and lifetime limits imposed on them. The term “essential benefits” should be limited to medically necessary services as they have been historically defined in plan documents by employers and not expanded to include such services as fertility treatments, bariatric surgery, cosmetic surgery, or Lasik surgery. Employers were pleased that the agencies are providing good faith relief until the regulatory process is complete.

2. **Ensure Certain Supplemental Plans are Not Considered Essential Benefits.** The definition of “essential benefits” should exclude certain supplemental benefits that may or may not be considered “excepted benefits.” For example, some employers may offer benefit plans to help employees who have children with physical or developmental disabilities, and those plans usually have a lifetime cap. If the benefits are deemed essential and annual and lifetime limits are prohibited, then employers are likely to discontinue these plans.

3. **Permit Employers to Provide Incentives to Use High Value Quality Providers When Offering Essential Benefits.** Regulations that prohibit annual and lifetime limits for essential benefits should permit employers the flexibility to provide these services through value-based plans by encouraging the use of higher value providers, including allowing employers and health plans to impose limits on essential benefits that are delivered via lower value health providers.
4. **Permit Limits on Essential Benefits that Are Provided Out-of-Network.** Regulations should follow the approach taken in preventive care regulations of recognizing the value of driving patients to high value by permitting employers and health plans to impose out-of-network limits for essential benefits that are not for urgent and/or emergency care.

**Preventive Coverage [Sec. 1001]**

1. **Allowance for Value-Based Designs.** Regulations that require no cost-sharing for preventive services should permit employers the flexibility to provide these services through value-based plans, including allowing employers and health plans to impose cost-sharing on preventive services that are delivered via lower value health providers.

2. **One Year to Comply with New Preventive Recommendations.** Employers are pleased that the interim final rules provide one year to comply after new preventive guidelines are issued in order to facilitate administrative transition.

3. **Expansion of Recommended Preventive Services.** Regulations should balance coverage of preventive services against concerns that the definition of mandated preventive care services does not become too expansive due to pressure from providers to adopt a broad definition of what constitutes mandatory preventive care services.

**Internal Claims and Appeals and External Review Process. [Sec. 1001]**

1. **24 Hour Response for Urgent Care Claims.** Regulations requiring a plan’s claim procedure to receive, process, decide, and notify urgent care claimants of the decision should not be reduced from 72 to 24 hours. Regulations should balance the requirement realizing that plans must have at least 48 hours to complete such a process.

2. **Concurrent Filing of Urgent Care Claims.** Regulations should require an urgent care claimant to complete and receive notice through a plan’s internal claims procedure before seeking review through federal external review. Concurrent filing, which has been adopted by the Agencies, seems unnecessary, particularly given the shortened time period under which plans have to make benefit decisions and notify participants. The requirement will increase costs and administrative burdens.
Summary of CHRO Concerns

3. **Binding Nature of Federal External Review Decisions.** The proposed regulations suggest that external review decisions are “binding” unless other remedies are available under federal or state law. Employers need clarification of the meaning of “binding” if the claimant can simply file an ERISA denial of benefit claim if they are unsatisfied with the federal external review process. Would the federal external review determination receive any type of deference or would courts apply the concept res judicata to such decisions? Similarly, employers need clarification that plan fiduciaries would be permitted to sue under ERISA for injunctive relief or restitution of improperly awarded benefits by a federal external review decision.

4. **Selection of Processes.** Clarification is necessary as to whether the Agencies have adopted the position that a claimant has a right to contest a plan’s adverse benefit decision through the federal external review process and then (or even concurrently) challenge the plan’s adverse decision in federal courts under ERISA. Regulations should provide that claimants should be required to choose either a review through the federal administrative process or file an ERISA claim in federal court, but not both. At a minimum, however, claimants should have to await the determination of the federal review board before filing a claim in court.

**Longer Term Regulatory Issues**

1. **Wellness Programs and the Genetic Information Nondiscrimination Act.** Consistent with the intent of the ACA, GINA regulations should permit employers to provide financial incentives to employees for participating in wellness programs that ask for family medical history. Regulations should enable employers to provide incentives up to the maximum (50 percent of plan costs) permitted under the ACA as soon as possible.

2. **State Health Care Exchanges.** The regulations creating the exchanges should ensure that the employer community is involved in the process used to set up and implement state health care exchanges under Section 1321.

3. **Delivery System and Payment Reform Projects.** The government should establish an aggressive timeline for development, rollout, and implementation of the delivery system and payment reform projects authorized by the ACA, including the value-based purchasing programs (Sec. 3002), the CMS Innovation Center (Sec. 3201), the Independent Payment Advisory Board (Sec. 3403), the provisions dealing with the alignment between public and private payers (Secs. 3021, 3023, 3012), and the medical home pilot project (Secs. 3021, 2703, 5405). In establishing these programs, they should be done so in a way that the interests of those paying for medical services are not outweighed by the interests of those providing such services.

4. **Release of Medicare Claims Data.** The government should establish an aggressive timeline for the development of regulations setting up the process for the release of Medicare claims data in order that the statutory deadline established in the ACA (Sec. 10332) is met.
5. **Medical Malpractice Reform.** The government should establish an aggressive timeline to begin the process of developing the program authorized by the ACA (Sec. 6801) to create state demonstration programs to address medical malpractice reforms.

6. **Comparative Effectiveness Research.** The government should ensure that the program or programs set up to implement the comparative effectiveness research provisions of the ACA (Sec. 6301) contain effective conflict of interest protections to protect against self-interested individuals and entities unduly influencing comparative effectiveness research processes. In addition, it should ensure that the research includes an analysis of the relative cost-effectiveness of various drugs and treatments.

7. **Definition of Part-Time Workers.** The regulations implementing Section 1513 should take into account part-time employment in which employees work variable schedules throughout the year (e.g., weekly hours may exceed 30 hours per week on occasion, seasonally, or during peak times) to ensure that the definition of full-time employment is not overly broad, resulting in inappropriate categorization of part-time employees as full-timers. Accounting for these hours over a reasonable period of time (e.g., 390 hours per quarter or examining hours over a 90-day period) will ensure part-time workers are appropriately categorized and are able to maintain consistent coverage.

8. **Coverage of Approved Clinical Trials.** Regulations under Section 10103 of the ACA should balance the requirements of the law with employer concerns about protecting patient safety and shielding their benefit plans from extraordinarily expensive experimental treatments. Clinical trial coverage should be predicated in an exhaustion of all recommended treatments and approved clinical trials should be narrowly confined.

9. **Employer Penalty for Not Providing Dependent Coverage.** Regulations implementing Section 1513 of the ACA should not require employers to provide a minimum contribution for dependent and spouse coverage.

10. **New Administrative Requirements.** Regulations should minimize the administrative burdens under the ACA and eliminate redundant administrative requirements where permitted by statute.
Conclusion

Employers have a vested interest in successful reform of the nation’s health care system. Transforming our health care system is critical if America is to maintain its position as a global leader in an increasingly competitive world market. In addition to addressing the issue of the uninsured, they want to see reform that transforms our health care system into one that delivers higher quality and greater value, focuses on prevention and wellness, and contains health care costs. As companies that provide health insurance for millions of employees, retirees, and their families, our members can provide valuable insight to practical problems and answers for questions arising under the health reform law. We stand ready to work with the federal government as it implements the ACA and to work with Congress on future legislative changes that may be needed.