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Employers and Health Insurance Exchanges Have Shared Interests: Employers Should Care About Exchanges, States Should Care About Whether Employers Care

By Scott J. Macey and Kendra L. Roberson

I. Introduction

The Patient Protection and Affordable Care Act (PPACA) requires states to establish and implement health insurance exchanges by 2014.[1] Exchanges will serve as a marketplace for individuals and employers to purchase health insurance coverage. The design of exchanges is important to employers because it will affect whether exchanges are a viable option for providing health coverage to their employees and whether employers are appropriately subject to play or pay penalties. States, in turn, should consider how to make exchanges attractive to employers to improve the stability of insurance risk pools and to realize economies of scale in providing administrative services to individuals and employers through exchanges.

[1] To the extent that a state fails to properly establish an exchange by the required date (or to demonstrate sufficient progress in establishing one approximately a year in advance), the federal government will establish an exchange in that state. The statutory provisions dealing with health exchanges can be found primarily in PPACA, H.R. 3590 (P.L. 111-148, enacted March 23, 2010) §§ 1301-1321.

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Exchanges are required to perform several functions to ensure that health insurance plans offered on an exchange meet minimum quality requirements and that consumers have sufficient information to compare plans. In 2014, exchanges will be open to individuals and employers that employ an average of at least one but not more than 100 employees in the preceding calendar year ("small employers").[2] In 2017, exchanges can, if they choose, open their health insurance plans to large employers.

Individuals whose household income is between 100 percent and 400 percent of the federal poverty line are generally eligible for discounts on their premiums (in the form of premium tax credits) and cost-sharing reductions (such as lower deductibles and copayments) if they purchase coverage through an exchange and are not eligible for health coverage from an employer or through a public assistance program, such as Medicaid.[3] Exchanges play a key role in determining whether individuals are eligible for premium tax credits or cost-sharing reductions.

Many states are in the process of making significant decisions about the design and implementation of exchanges.[4] In addition, the federal government has re-

[2] Before 2016, states are permitted to define small employers as employers who employ 50 or fewer employees in the preceding calendar year.

[3] Premium tax credits are refundable tax credits that individuals receive for coverage they purchase for themselves or members of their family through an exchange. Code § 36B. The exchanges, based on information received from the U.S. Department of Treasury, will estimate the amount of the premium tax credit that an individual is likely to receive and the Department of Treasury will pay this amount to the issuer of the plan in which the individual enrolls. The issuer will then reduce the individual's premium payment by the amount of the federal payment. At the end of the tax year, individuals will determine the amount of the actual premium tax credit on their tax return. If the advance federal payments exceed the amount of the premium tax credit an individual should have received, the individual will be required to repay at least some of the overpayment to the federal government. If the advance federal payments are less than the amount of an individual's calculated premium tax credit, the individual will receive an income tax refund for the shortfall.

[4] Some states that oppose PPACA have decided not to work on the development of an exchange, in the belief that PPACA

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leased a series of proposed regulations that impose parameters on exchange designs.[5] The design and implementation of exchanges are important to employers in three significant respects:

- First, several decisions by exchanges will affect their ability to offer employers and their employees health insurance coverage at affordable, competitive rates. For example, a state's regulation of the insurance market and the resources that it devotes to promote participation in its exchange will have a significant impact on the health of the state's insurance risk pools.
- Second, decisions are being made now that will affect whether exchanges are a viable mechanism through which employers can offer health coverage to their employees. For example, employers could realize significant savings and be relieved of administrative burdens if exchanges perform administrative functions that are typically performed by the employer or outside vendors, such as eligibility determinations, enrollment, and COBRA administration. Exchanges are also making decisions that affect whether employers will have the same (or at least adequate) flexibility in designing or choosing the health coverage that they make available to their employees as the flexibility they enjoy today.
- Third, large employers will be subject to a penalty (sometimes called the ''shared responsibility penalty'') if their employees purchase coverage through an exchange and receive premium tax credits or cost-sharing reductions because the large employers fail to offer them affordable coverage that provides a specified minimum level of benefits. Accordingly, adjudications by exchanges regarding whether an employer's employees are eligible for premium tax credits or cost-sharing reductions will affect whether, and the extent to which, the employer must pay penalties for failing to offer appropriate health coverage to employees.

This article explains some of the key determinations that states are facing concerning health exchanges—determinations that could affect how attractive state exchanges are to employers that are considering enrolling their employees in health insurance coverage offered through an exchange, the viability of purchasing health insurance for employees through exchanges, and the interactions of employers with exchanges for purposes of the shared responsibility penalty.

II. Health Exchange Structure and Operational Issues

States are permitted to establish a health insurance exchange in the form of a governmental agency, including an independent or quasi-governmental agency, or a nonprofit entity.[6] If the exchange is an independent agency or a nonprofit entity, the exchange must be governed by a board and the majority of the voting members of the boards must not have a conflict of interest.[7] Exchanges must regularly consult with stakeholders, including educated[8] health care consumers who are enrolled in exchange coverage, small and large employers, health insurance issuers, agents and brokers, and state Medicaid and Children's Health Insurance Program (''CHIP'') agencies.[9]

The principal purpose of an exchange is to make ''qualified health plans'' available to individuals and employers in a competitive marketplace. Qualified health plans are defined as health insurance coverage and group health plans that are sold by state-licensed

will be invalidated by the Supreme Court or repealed by Congress, or that it will be less expensive if the federal government establishes an exchange in their state. There are currently two appellate court decisions regarding the constitutionality of PPACA, and in particular, its requirement for individuals to purchase health insurance coverage or pay a tax penalty unless they qualify for an exemption (*i.e.,* the individual mandate). Code § 5000A. An appellate court decision in the U.S. Court of Appeals for the Eleventh Circuit upholds the law and a decision in the U.S. Court of Appeals for the Sixth Circuit invalidates the individual mandate requirement of the law. *Thomas More Law Center v. Obama,* 2011 WL 2556039 (6th Cir. 2011); *Florida v. HHS,* 2011 U.S. App. LEXIS 16806 (2011). On Sept. 28, President Obama asked the Supreme Court to review the Sixth Circuit's decision. If the Sixth Circuit's decision is ultimately upheld by the Supreme Court and the Court overturns the individual mandate, it is likely that PPACA would remain in effect. Nevertheless, if the individual mandate is ruled unconstitutional by the Supreme Court, exchanges may not attract enough consumers to be self-sustaining by 2015 because (1) individuals will not be required to purchase coverage, and (2) insurance premiums will be higher because PPACA also prohibits health insurance issuers from denying coverage based on health factors.

[5] Two sets of proposed regulations were released by the Department of Health and Human Services on July 11, 2011 and published in the Federal Register on July 15, 2011 at 76 Fed. Reg. 41866, available at http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf#page=1 and 76 Fed. Reg. 41930, available at http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17609.pdf#page=1. Additional proposed regulations were published in the Aug. 17, 2011 *Federal Register*. See Treasury regulations regarding premium tax credits at 76 Fed. Reg. 50931, available at http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20728.pdf#page=1 and HHS regulations regarding exchange functions, individual eligibility, and exchange standards for employers at 76 Fed. Reg. 51202, available at http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20776.pdf#page=1, and HHS regulations regarding Medicaid expansion at 76 Fed. Reg. 51148 available at http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20756.pdf#page=1. The first set of proposed HHS rules addressed two primary aspects of exchanges: (i) the requirements for the operation of exchanges, including standards for the selection and qualification of offered health plans; rules regarding employer eligibility for SHOP exchanges; and requirements for insurers that offer plans through exchanges and (ii) the requirements for states to establish a temporary federal reinsurance program and a permanent risk adjustment program to manage adverse selection. The second set of regulations released in August addressed: (i) the basic exchange functions for individuals and the eligibility provisions for employers in the SHOP exchanges; (ii) the operation of the individual health insurance tax credit for individuals, which can result in penalty assessments against employers (issued by Treasury and the IRS); and (iii) the Medicaid expansion provisions.

[6] PPACA § 1311(d)(1); Proposed 45 C.F.R. § 155.100(b) (76 Fed. Reg. at 41913).

[7] Proposed 45 C.F.R. § 155.110(c) (76 Fed. Reg. at 41914).

[8] ''Educated'' is the term used in PPACA § 1311(d)(6)(A). The proposed regulations do not expound upon what it means for a consumer to be educated. However, the regulations recommend that exchanges consult with individuals with disabilities. 76 Fed. Reg. at 41873 (July 15, 2011).

[9] PPACA § 1311(d)(6); Proposed 45 C.F.R. § 155.130 (76 *Fed. Reg.* at 41914).

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health insurance issuers and are certified by the exchange as meeting certain requirements under federal and state laws.[10]

States must establish a program, called the Small Business Health Options Program (''SHOP'') to assist employers in selecting, and to facilitate the enrollment of employees in, qualified health plans.[11] A state can establish the SHOP as a separate exchange with a separate governance and administrative structure as long as the SHOP coordinates with the state's exchange; otherwise, the SHOP must be a program administered by the state's exchange.[12] An employer that wishes to enroll its employees in a health insurance plan through a state exchange must do so through the SHOP.

PPACA requires SHOP and non-SHOP exchanges to perform several functions, including the following:

- certifying whether health plans are ''qualified'' to participate on the exchange by evaluating compliance with federal and state standards;
- providing consumer assistance tools, including a web site that standardizes comparative information on each health plan, operating a toll-free call center, and establishing and making available a ''calculator'' to facilitate comparison of available plans;
- determining whether individuals, employers, and employees are eligible to participate in the exchange and whether individuals are eligible for premium tax credits or cost-sharing reductions;
- conducting an annual open enrollment and special enrollment periods for individuals and rolling enrollment for employers/employees (*i.e.,* 12 months after the effective date of coverage), and enrolling individuals in selected plans;
- providing employers with a single bill aggregating each of the premium payments due to the health insurance issuers offering each of the plans in which employees are enrolled; and
- evaluating the quality of available health plans (and rating them) and monitoring compliance by issuers with certification requirements.[13]

States are currently making decisions about SHOP and non-SHOP exchange designs that will affect how, and how well, the exchanges perform these functions. These design decisions will affect both large and small employers, directly and indirectly, whether or not the employer provides health benefits to its employees through a SHOP.

As discussed in more detail in Part III below, employers interested in making exchange coverage available to their employees should monitor, and seek input into, decisions that could affect a SHOP's ability to provide affordable, high quality health coverage to employees, in a manner that reduces the impact on employers' resources, such as:

- whether the exchange will perform administrative functions currently performed by employers (or their vendors), such as COBRA administration or billing services;
- whether employers can receive assistance from their agents or brokers in selecting plans for their employees and in interfacing with the exchange;
- whether employers will have any input in the design or choice of plans available to their employees;
- the effect of any merger of the individual and small group risk pools on insurance premiums in the small group markets; and
- the cost of the essential health benefits package that health insurance issuers will be required to offer in every qualified health plan available on an exchange.

Regardless of whether employers are able to, or interested in, offering coverage to their employees through an exchange, large employers will be required to interact with exchanges to verify whether individuals applying for premium tax credits have access to affordable employer-sponsored coverage that provides minimum value. This determination will also control whether employers must pay a penalty with respect to employees who purchase coverage through the exchange. As discussed in Part IV below, employers have an interest in ensuring that this verification does not impose undue administrative burdens and costs on them and that the determinations are accurate.

The resolution of these and many other detailed and inter-related issues will likely dramatically affect the ultimate operations and success of an exchange and their interaction with employers. Although subsequent positive or adverse experience can result in either reinforcing or suggesting changes to initial decisions, getting it right from the outset is, of course, the preferred course.

III. Participating Employers and Exchanges

Small employers can purchase coverage through a SHOP beginning in 2014 and states are permitted to open their SHOPs to large employers starting in 2017.[14] For this purpose, small employers are defined as employers who employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employ at least one employee on the first day of the plan year.[15] Employers

[10] PPACA § 1301(a); Proposed 45 C.F.R. § 155.20 (76 Fed. Reg. at 41913).

[11] PPACA § 1311(b)(1)(B); Proposed 45 C.F.R. § 155.700 (76 *Fed. Reg.* at 41918).

[12] Proposed 45 C.F.R. § 155.110(e) (76 *Fed. Reg.* 41914).

[13] PPACA § 1311(c).

[14] PPACA §§ 1312(f)(2) and 1304(b).

[15] In the case of plan years beginning before January 1, 2016, a state may elect to define a small employer by substituting 50 employees for 100 employees. PPACA § 1304(b)(3). For purposes of small employer status regarding exchange eligibility, the proposed rules require employers to count all employees (including part-time and seasonal). Proposed 45 C.F.R. § 155.20 (76 Fed. Reg. at 4187-88). Part-time workers are counted in the same manner as full-time employees while seasonal employees are counted in a manner proportionate to the number of days they work in the year. The determination is made with reference to the average number of employees on business days during the preceding calendar year. Thus, an employer that had more than 50 or 100 (depending on the state definition) total employees under the described test would not be eligible for SHOP exchange coverage even if it was going to offer coverage only to its full-time employees, the number of which was fewer than 50 or 100 (depending on the state definition of small employer). Additionally, once an employer is determined to be a qualified small employer, it can retain that

who wish to purchase coverage through an exchange must agree to offer the coverage to at least all of their full-time employees.[16] Employers can purchase coverage through the SHOP that serves their principal business address or from the SHOP that serves employees working at a particular location whom the employer wishes to enroll in the SHOP.[17]

The exchange is responsible for enrolling employees in qualified health plans.[18] Because employees may be permitted to select from among several qualified health plans available in the SHOP, the proposed rules require exchanges to provide employers with a single bill aggregating each of the premium payments due to the health insurance issuers offering each of the plans in which employees are enrolled.[19]

There are several reasons why an employer may want to consider purchasing coverage through an exchange. Exchanges are intended to offer less expensive health insurance coverage by providing a more transparent, competitive marketplace in which employers can shop for coverage. In addition, exchanges will absorb many of the costs borne today by insurers and employers in administering health insurance coverage, such as eligibility and enrollment functions, billing, and certain customer service functions. Employers who purchase coverage through an exchange can allow employees to pay for their exchange coverage through pre-tax salary deferrals under a Code section 125 cafeteria plan.[20] Moreover, an employer that purchases coverage for its employees through an exchange will be exempt from the shared responsibility penalty that might otherwise apply to an employer who employs an average of at least 50 full-time employees.[21] (If an employer does not purchase coverage through an exchange but merely directs employees to purchase individual coverage through the exchange, the employees could not purchase individual health coverage on a pre-tax basis under Code section 125(f)(3) and the employer might be subject to the shared responsibility penalty.[22])

There are additional reasons why *small* employers may want to purchase coverage through an exchange. PPACA requires a single risk pool to be established in 2014 to decrease the overall cost of coverage in the small group market and to put the small group market on more equal footing with the large group market.[23] Small employers that purchase coverage through an exchange will receive a partial tax credit for their contributions towards the cost of coverage for two years.[24]

Moreover, it is possible that some states will make exchanges the only marketplaces through which insurance coverage may be purchased. Nothing in PPACA prohibits states from requiring all health insurance to be sold only on a health insurance exchange.

A. Providing health coverage at competitive rates

Several decisions by exchanges will affect their ability to offer employers and their employees health insurance coverage at affordable, competitive rates.

1. *Maintaining a healthy risk pool.* It is important for exchanges to maintain a healthy risk pool in order to encourage health insurance carriers to participate in exchanges and offer employers a variety of choices on the exchange. PPACA includes some mechanisms to help prevent the exchange market from attracting a mix of participants that is less healthy on average than the non-exchange market. For example, PPACA provides a risk adjustment mechanism[25] that will shift money from insurers that enroll larger numbers of healthy people to insurers that enroll more of the least healthy people — *i.e.*, ''adverse selection.''

States have additional tools available to them to reduce adverse selection, such as requiring health insurance to be sold only on an exchange, imposing additional mandates on insured coverage offered outside of exchanges, requiring out-of-pocket limits that are lower than those in health benefit plans, and devoting resources to marketing programs to encourage participation in exchanges, particularly by employers that can bring groups of employees to exchanges.

Perhaps one of the most powerful tools available to the states in reducing adverse selection is to open their exchanges to the largest number of employers permissible under PPACA. In 2014, states must allow small employers to participate in SHOPs. However, states can choose whether to define small employers before 2016 as employers that employ an average of at least 50 employees or an average of at least 100 employees in the preceding calendar year. Defining small employers by reference to the 100 employee threshold would increase participation in exchanges. However, states that currently define small employers as those employing 50 or fewer employees are considering any negative impacts that expanding the definition would have on employers who employee between 51 and 100 employees. For instance, including these larger employers in the small group risk pool may increase premiums sufficiently to cause these employers to self-insure or drop their insurance coverage. States will undertake a similar cost-benefit analysis in deciding whether to allow employers who employ 101 or more employees to participate in exchanges in 2017.

PPACA also includes rules designed to encourage the availability of affordable health coverage to small employers. Many small businesses are currently not able to offer health coverage to employees at all because of market conditions, higher costs due to adverse risk evaluation, and a variety of other significant concerns. A significant portion of the country's uninsured are the

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status even though it subsequently grows into a larger business (as long as it continuously maintains SHOP coverage).

The definition of ''small employer'' is not the same for all purposes under PPACA. For example, it is defined differently for purposes of determining (1) employers eligible to participate in exchanges or for the employer tax credit and (2) employers subject to the shared responsibility penalty.

[16] PPACA § 1311(f)(2); Proposed 45 C.F.R. § 155.710 (76 *Fed. Reg.* at 41919).

[17] Proposed 45 C.F.R. § 155.710(b) (76 Fed. Reg. at 41919).

[18] Proposed 45 C.F.R. § 155.720 (76 Fed. Reg. at 41920).

[19] Proposed 45 C.F.R. § 155.705(b)(4) (76 Fed. Reg. at 41919).

[20] Code § 125(f)(3)(B).

[21] Code § 4980H(c)(2).

[22] The Department of Treasury has not yet issued guidance regarding whether contributions to a health plan by, or reimbursements from, an employer that does not participate in an exchange will constitute employer-sponsored coverage for purposes of the shared responsibility penalty.

[23] PPACA § 1312(c)(2).

[24] Code § 45R(e)(2).

[25] PPACA § 1343.

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owners or employees (and their families) of small businesses.

One of the ways that PPACA intends to encourage the expansion of affordable small business health coverage is to require issuers to adopt a community rating for participating employers under which the risks of individuals from all small participating businesses are aggregated. This may allow some small employers to get more favorable premium rates than under an experience rating system.

PPACA also gives states the authority to decide whether to merge the risk pools of the individual and small group markets.[26] States are considering whether such a merger would cause the small group market to subsidize the cost of individual insurance policies in the exchange and whether the benefits of any subsidy justify the corresponding premium increases in the small group market.

2. *Managing the cost of the essential health benefits package.* One of the principal factors that will dictate the cost of coverage available in exchanges is the cost of the essential health benefits package. PPACA requires that all health insurance coverage sold in the individual and small group markets include essential health benefits (regardless of whether they are sold on a health insurance exchange).[27] Moreover, PPACA prohibits employer and other health plans, including large group health plans, whether insured or self-insured, grandfathered or not, to set annual or lifetime dollar limits on any essential health benefits that are covered under the plans.

The cost of the essential health benefits package will be heavily influenced by the final rules issued by the federal agencies defining the term ''essential health benefits.'' The statute sets out ten categories of benefits that must be included in essential health benefits, but left it up to regulators to define and prescribe the details of what must be included.[28] There are already concerns among some that if the definition of essential health benefits is too broad it could result in significant increases in plan costs and price many individuals (especially healthy and young people) and small companies out of the exchange and general health coverage marketplace.[29] This concern arises because PPACA prohibits its pricing based on health status and restricts the ability of issuers in the individual and small group markets to vary rates based on factors other than whether the plan covers an individual or family, rating area, age (and the rate cannot vary by more than a 3 to 1 ratio for adults) and tobacco use (and the rate cannot vary by more than a ratio of 1.5 to 1).[30]

The Institute of Medicine (IOM) has issued a report recommending a process for the Department of Health and Human Services to use in defining the essential health benefits package.[31] The IOM report recommends that the Department use a typical small employer plan as the starting point for the package and ensure that the package does not exceed the estimated average cost of a typical small employer plan in 2014 if PPACA had not been enacted. The report also recommends that the Department strive to reduce the cost of the essential health benefits package over time by refining the package to include more evidence-based, value-added services.

B. Decisions by exchanges affecting whether they will provide attractive services to employers

Several decisions by exchanges will affect how attractive they are to employers as a mechanism for employers to purchase health insurance coverage for their employees.

1. *Offering Employers Multiple Ways to Choose Plans.* The proposed rules allow exchanges to offer employers multiple ways to offer one or more qualified health plans to their employees.[32] Exchanges will offer plans at four coverage levels— bronze, silver, gold, and platinum— with each level of coverage providing a richer level of benefits. Exchanges are required to allow employers to choose at least one level of coverage from which employees may select a qualified health plan.[33] In addition, exchanges may also choose to offer employers the following ways to make coverage available to their employees:

- allow employees to choose *any qualified health plan* offered in the SHOP *at any level*;
- allow employers to select *specific levels* from which an employee may choose a qualified health plan available *within those levels*;
- allow employers to *select specific qualified health plans* from different levels of coverage from which an employee may choose a qualified health plan; or
- allow employers to *select a single qualified health plan* to offer employees.

Under ERISA, employers are permitted to design their health plans with relatively few parameters, and few employers will be willing to forego this flexibility in order to purchase health insurance through an exchange. Accordingly, state exchanges have a strong interest in providing similar options to employers who might be eligible to purchase insurance through the exchanges, and employers will want to monitor closely whether exchanges provide the same tractability they have enjoyed until now.

2. *Allowing employers to provide input on plan designs.* Exchanges must establish a process for certifying health plans as qualified health plans.[34] Exchanges must regularly consult with stakeholders to the ex-

[26] PPACA § 1312(c)(3).

[27] Public Health Service Act § 2707 as added by PPACA § 1201.

[28] The ten categories include 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. PPACA § 1301(b)(1).

[29] In other words, the cost of coverage could exceed the penalty an individual would pay under the individual mandate for declining to enroll in health insurance coverage.

[30] PPACA § 1201.

[31] *Essential Health Benefits: Balancing Coverage and Cost* available at http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx.

[32] 76 Fed. Reg. at 41886.

[33] PPACA § 1302(d).

[34] PPACA § 1311(d)(4)(A).

changes, including small and large employers. Thus, employers should be given the opportunity to provide input regarding the requirements that health plans in the small and large group markets must meet in order to be certified. For example, employers have an interest in ensuring that plans certified to be offered on the SHOP comply with the Employee Retirement Income Security Act (''ERISA''), the Internal Revenue Code, COBRA, and other laws that typically apply to employer group health plans.

Employers that purchase insurance coverage for their employees are often given the ability to customize health insurance plans. For example, employers may be permitted to adjust cost-sharing amounts, add or remove certain benefits, and adjust limitations on benefits. Employers may also want the ability to customize qualified health plans that they select for their employees. It may be possible for exchanges to allow certified health plans to accommodate these requests within certain limits or undergo a streamlined certification process to obtain approval for a customized plan.

3. *Providing additional administrative services to employers.* Exchanges will likely help employers realize savings by performing administrative functions, such as enrollment and billing, some of the costs for which are currently passed on to employers by insurers in the form of higher premiums and some of which are borne directly by employers. Accordingly, employers have an interest in ensuring that SHOPs provide administrative services such as COBRA administration, customer assistance (for example, to assist employees with enrollment and addition of dependents), and perhaps providing financial assistance to employers purchasing coverage through an exchange by offsetting some portion of an agent or broker's fee.

Small employers also have an interest in obtaining assistance from exchanges in applying for and determining the amount of a temporary tax credit for coverage arranged through an exchange.[35] The tax credit is available for any two consecutive years after 2013. For these purposes, a small employer is an employer that employs no more than 25 full-time equivalent employees, with a phase-out for employers that employ between 11 and 25 employees or if average wages are in excess of $25,000 (with a full phase out at $50,000). The credit is 50 percent of the employer costs of coverage (or, if lesser, the average costs of small business coverage at the average premium level in the exchange) as long the employer pays at least 50 percent of the total premium or coverage costs.

4. *Providing customer service to employers.* Employers will need assistance in understanding plans available to them on the SHOP, accessing the SHOP, and resolving any questions or concerns as they interact with the exchange to purchase coverage for their employees. Employers that currently provide insured health coverage usually obtain assistance from a broker who helps to locate available coverage and negotiate the best pricing and appropriate policy provisions. Exchanges are permitted to allow agents and brokers to assist employers in purchasing coverage through an exchange.[36] Because agents and brokers have a wealth of experience in customizing plans for employers and assessing employer's needs, exchanges may wish to allow brokers to assist employers in purchasing coverage through an exchange.

In today's market, insurers typically designate a contact person to whom employers can address questions and concerns. Because (1) exchanges will perform many administrative functions that have traditionally been performed by insurers, such as enrollment and billing, and (2) an employer's employees may enroll in health plans provided by many different insurers, employers will need a central contact at the exchanges to receive and address their questions and concerns. Although a customer service call center might be adequate, employers may prefer that they be assigned one or two persons within the call center who can become familiar with the employer and the plans available to their employees.

Presumably, states are reaching out to businesses and their advisors to understand and evaluate their interests and concerns in structuring the SHOP and establishing its key policies. If the SHOPs are established on a sound structural, operational and financial basis employers may find an exchange to be a practical, efficient and cost effective vehicle for offering health coverage to their employees.

IV. Shared Responsibility Penalty and Exchanges

Large employers are subject to the shared responsibility penalty if they either (1) do not offer health coverage to full time employees (and their dependents) and at least one full-time employee enrolls in a qualified health plan through an exchange and is eligible for a premium tax credit or cost-sharing reduction or (2) offer coverage to their full-time employees (and their dependents) that is either considered **unaffordable** or fails to provide **minimum value** and one or more full-time employees enrolls in a qualified health plan through an exchange and is **eligible for a premium tax credit or cost-sharing reduction (as explained below)**.[37] Large employers are beginning the process of determining whether to continue sponsoring health plans, to modify their plans to avoid the penalty, to join an exchange, or to stop providing health coverage. The penalty is intended to encourage employers to maintain existing health coverage for their employees. However, there is some evidence that the penalty is not large enough to prevent some employers from dropping their health coverage.[38]

For this purpose, a large employer is an entity that employed at least an average of 50 full-time employees

[35] Code § 45R. There is a temporary tax credit arrangement available for small employers for years prior to 2014. This credit is 35 percent of costs of coverage although the credit is phased out for employers with more than 10 employees and is eliminated entirely for those with more than 25.

[36] Proposed 45 C.F.R. § 155.220 (76 Fed. Reg. at 71916).

[37] Code § 4980H.

[38] Recent survey results from several benefit consulting firms have indicated that six percent to 20 percent of medium and large employers are considering or have decided to terminate employee health coverage in 2014 when exchange coverage becomes available. *Health Care Changes Ahead: Survey Report*, Towers Watson (October 2011), available at http://www.towerswatson.com/assets/pdf/5622/TW-survey-report_HC-Changes-Ahead_101411.pdf; *US health plan enrollment up 2% under PPACA's dependent eligibility rule*, Mercer (August 2011), available at http://www.mercer.com/press-releases/1421820.

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in the prior calendar year.[39] All full-time employees in the entity's controlled group must be included in the count. Full-time employees include (1) those who work at least 30 hours per week (on average) and (2) full-time equivalents determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120. If the employees who cause an employer to have more than 50 full-time employees are seasonal employees and work for no more than 120 days during the calendar year, the employer will not be subject to the shared responsibility penalty.

A. Affordability

An employer's coverage is **unaffordable** if the employee's required contribution for the lowest-cost, single-only option exceeds 9.5 percent of the employee's household income.[40] Because household income takes into account amounts that are generally not known to employers (such as spousal or child support payments), the Department of Treasury expects to propose a safe harbor whereby affordability of an employer's coverage would be measured by reference to the wages reported for an employee in Box 1 of Form W-2.[41]

B. Minimum Value

An employer's plan does not provide **minimum value** if the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of the costs.[42] The agencies have indicated that employers will not be required to provide essential health benefits (described in the ''Providing health coverage at competitive rates'' section, above) in order to satisfy the requirement for providing ''minimum value,'' however, employers will be required to provide some minimum level of benefits.[43]

C. Eligibility for Premium Tax Credits or Cost-Sharing Reductions

If the employer's coverage is either unaffordable or does not provide minimum value, an employee will generally be eligible for premium tax credits if he (1) purchases coverage through an exchange and (2) his household income for the calendar year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for his family size. An employee will generally be eligible for cost-sharing reductions if his household income for the year exceeds 100 percent of the federal poverty line but does not exceed 250 percent of the federal poverty line.[44] Conversely, an employee is not eligible for premium tax credits or cost-sharing reductions if he enrolls in employer-sponsored coverage, regardless of whether it is affordable or provides minimum value, or he is eligible for affordable employer-sponsored coverage that provides minimum value.

D. Amount of Penalty

If an employer is subject to the penalty because it fails to offer its full-time employees (and their dependents) health coverage for any month, the penalty is equal to $2,000 times the number of full-time employees employed that month reduced by 30.[45] If an employer is subject to the penalty because it provides coverage that is not affordable or does not provide minimum value, the penalty is equal to $3,000 times the number of full-time employees eligible for a premium tax credit or cost-sharing reductions for the month, provided that the aggregate penalty cannot exceed the penalty the employer would have paid if it did not provide any coverage at all (*i.e.,* $2,000 times the number of its full-time employees reduced by 30).

E. Role of Exchanges

As explained above, an individual is not eligible for premium tax credits if he is eligible for affordable coverage from his employer that provides minimum value, even if he enrolls in coverage through an exchange. Exchanges are responsible for determining whether an individual is eligible for premium tax credits or cost-sharing reductions. If an exchange determines that an individual is eligible for premium tax credits because the individual's employer did not offer qualifying coverage to the individual, the exchange must notify the employer.[46] Because these determinations will affect whether an employer must pay shared responsibility penalties, the statute requires exchanges to provide a process through which an employer would be permitted to appeal the determination.[47]

In proposed federal regulations, the Department of Health and Human Services states that it is considering establishing a process to help exchanges verify whether an employer offers affordable coverage that provides minimum value.[48] The first method would require exchanges to provide a template that employers and employees could use to capture required information, such as whether the individual is a full-time employee, whether the employer provides minimum essential coverage and if so, the lowest cost option available to the

[39] Code § 4980(H)(c)(2).

[40] Thus, an employer's coverage will be considered affordable even if the employer's family coverage option is unaffordable for an employee.

[41] The Department of Treasury has issued a request for comments on the safe harbor in Notice 2011-73. Comments are due Dec. 13, 2011.

[42] This does not mean that every charge must be paid at 60% or greater, but that the expected coverage for all charges for all participants must be 60% or greater. There is not yet any guidance on how the actuarial test is to be performed. Code § 36B(c)(2)(C)(ii).

[43] Future regulations by the Department of Health and Human Services ''will seek to further the object of preserving the existing system of employer-sponsored coverage, but without permitting the statutory employer responsibility standards to be avoided.'' 76 *Fed. Reg.* at 50936. Employers are concerned that any minimum value requirements preserve and be compatible with their ability to use reasonable medical management techniques (such as requiring participants to use less costly but effective medical treatments before using more expensive and less evidence-based treatments) to control the costs and quality of health care provided under their plans.

[44] Code § 36B(c)(1)(A); PPACA § 1402(b) and Proposed 155.305(g) (76 Fed. Reg. at 51230).

[45] Code § 4980H. Treasury Department officials have informally indicated that if an employer does not offer coverage to full-time employees' dependents (*i.e.,* provide family coverage), the employer is subject to the penalty of $2,000 times the number of full-time employees.

[46] Proposed 45 C.F.R. § 155.310(g) (76 *Fed. Reg.* at 51231).

[47] PPACA § 1411(f)(2); 76 *Fed. Reg.* at 51223 (noting that the Department of Health and Human Services depends to propose an appeals process in future rulemaking).

[48] 76 *Fed. Reg.* at 51217.

employee and the employee's required contribution for that option. The second method would require exchanges to establish a central database that employers could voluntarily populate as a resource for the verification process. It may generally be more cost-effective for employers that experience higher turnover in their workforces, such as in the retail and food service industries, to populate a central database once a year rather than provide a separate document to each worker. In contrast, it might be less expensive for employers in industries that typically experience lower turnover to complete a template for individuals upon request or provide the template to their workers as part of the hiring process or during periods of open enrollment.

Accordingly, employers may want the Department to make both verification methods available and allow employers to choose which method they prefer to use. In any event, employers will want exchanges to provide a process for them to interact with exchanges in a way that does not impose undue administrative burdens and costs on employers. Employers may also want the federal government to require all exchanges to use the same process so that employers with employees residing in many different states are not burdened with potentially 50 different verification processes.

V. Conclusion

The overall objectives of PPACA are to expand access to health coverage while arresting the increasing costs of this coverage and improving the general health of Americans. It attempts to do this through interlocking concepts of health insurance exchanges, providing incentives for employers to provide health coverage, and requiring individuals to purchase coverage with federal assistance (if necessary).

- Decisions by exchanges will affect their ability to offer employers and their employees health insurance coverage at affordable, competitive rates.
- In addition, decisions are being made now that will affect whether exchanges are a viable mechanism through which employers can offer health coverage to their employees, including whether employers will have the same (or at least adequate) flexibility in designing health coverage offered by them to their employees as the flexibility they enjoy today.
- Finally, adjudications by exchanges regarding whether an employer's employees are eligible for premium tax credits or cost-sharing reductions will affect whether, and the extent to which, the employer must pay penalties for failing to offer appropriate health coverage to employees.

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