

## Health Care Reform as It Relates to AAHSA Members

	<b>House Bill, HR 3962</b>	<b>Senate Bill, HR 3590</b>	<b>AAHSA's Position</b>
<u>CLASS Provisions</u>	Creates national insurance program for long-term services and supports, financed by premiums, offering cash benefit based on ADL needs. Administered through HHS.	Same	AAHSA supports! This is the legislative vehicle for the financing model that AAHSA developed and has championed for the past 4 years.
<u>Market Basket</u>	Market Basket CUT, effective January 1, 2010.  SNFs will only get the market basket increase for the first quarter of the calendar year (Oct 1 2009 – Dec 31, 2009), which represents a market basket loss for FY 2010 of \$517M.	No Market Basket cut for FY 2011.  The Senate bill preserves the market basket update for the entire FY 2010, 2011.	CMS provided a market basket update for the FY 2010 of 2.2%, or \$690M  AAHSA supports the Senate provision to preserve the SNF market basket for FY 2010 and 2011, as it is based on changes in the process of inputs ((labor, materials, capital) to providing SNF care. The rationale, that SNFs have sufficient margins to withstand elimination of the market basket update, does not apply to not-for-profits.
<u>Non-therapy Ancillary and Outlier Provisions</u>	Shift in payment from therapy to nursing services; separate payment for NTAs; and separate outlier policy for NTAs and therapy services.  <u>10% Increase in NTA payment and 5.5% Decrease in Therapy Payment:</u>  Effective January 2010. The changes in payments in this provision are budget neutral, reallocating payment from therapy services to nursing services.  <u>Separate Payment for NTAs:</u>  Effective FY 2011, CMS required to do a study and implement a new way of paying for NTAs, ensuring accurate reimbursement for NTAs, which may	The Senate Bill does not address NTA or outlier policies.	AAHSA supports the provisions on the House Leadership Bill.  <u>NTA/Therapy changes</u>  AAHSA supports. This is a step in the right direction, and an acceptable temporary solution to inadequate payment for NTAs. This provision may help the many non-profit facilities who disproportionately care for residents in need of more medically-complex care that require higher nursing services.  <u>Separate Payment for NTAs:</u>  Separate NTA payments: AAHSA supports the House effort to make CMS finally fix the problem of underpaying for NTAs. A MedPAC study showed that if MedPAC's model were implemented, nonprofit rates would increase

	<p>include a separate component for NTAs, as early as Oct 1 2010;</p> <p>During the development stage, the Secretary shall consult with MedPAC and other stakeholders to identify important predictors of NTA costs.</p> <p><u>Outlier policy for NTA and Therapy:</u> Effective FY 2011.</p> <p>The outlier policy for NTA and therapy is intended to account for unusual high costs of medically necessary care.</p> <p>The adjustment amount for outlier payments should not exceed 2% of total payment projections.</p>		<p>by about 7%.</p> <p>Outlier policy:</p> <p>AAHSA has long supported an outlier system for the SNF PPS. This is another piece of the MedPAC proposal that we have supported. The MedPAC study shows that under their model, the majority of non-profits would benefit. CMS and MedPAC are working together on this effort. This provision essentially lets CMS know that they would have to address important problems that have been lingering for far too long.</p>
<p><u>Productivity Adjustment</u></p>	<p>Apply a “productivity adjustment” on the market basket update.</p> <p>Effective Jan 1, 2010, CMS would be required to incorporate a productivity adjustment into the market basket update for skilled nursing facilities every year after that. In essence, this productivity adjustment nicks the yearly basket by about 1%.</p>	<p>Apply a “productivity adjustment” on the market basket update.</p> <p>Effective Jan 1, 2013</p>	<p>Both bills apply productivity factor to Medicare market basket update for ALL Medicare providers. AAHSA supports the Senate provision, because it provides breathing room to address concerns around appropriateness of applying productivity factors to LTC providers. High quality nursing home care is labor intensive, and output per labor hour does not change significantly as to improve productivity. As such, nursing homes may not be subject to normal “productivity” assumptions.</p>
<p><u>RUGs IV</u></p>	<p>Secretary to implement RUGS IV in FY 2011 (Oct 1, 2010).</p> <p>Rugs IV include exceptions (i.e. concurrent therapy, look back period, and estimated therapy) that will no longer be allowed to be used by nursing homes when classifying patients to RUG groups.</p>	<p>RUGs IV implementation postponed to FY 2012 (Oct. 1, 2011), but eliminates exception rules previously allowed in RUGs III (i.e. concurrent therapy, look back period, and estimated therapy).</p>	<p>AAHSA supports the House provision;</p> <p>The exceptions that will be eliminated have all been legal, and nearly all homes have used them to some extent. The new RUGS IV rates are set such that if your home has been using an “average” amount, you will not lose on the change to the new RUGs IV. The “average” amount for each exception is</p>

			<p>the following:  Concurrent therapy, around 30%;  -Lookback, CMS expects only about 10% of the patients previously in the rehab ultra will still be there after the change. So, if you can only keep 10% of your patients in the Ultra High category, you will still break even with RUGs IV;  -Not clear how much “estimated therapy” was being done.</p>
<u>Supplemental Payment for Medicaid Nursing Facilities</u>	Authorizes \$6B over 4 year period for providers w/ dual eligibles to address Medicaid underpayments for quality SNFs.	Not in Senate bill	AAHSA supports as recognizing importance of addressing Medicaid and Medicare together.
<u>Bundling pilots</u>	<p>By not later than January 1, 2011, the Secretary shall, for the purpose of promoting the use of bundled payments to promote efficient, coordinated, and high quality delivery of care--</p> <p>Convert the acute care episode demonstration program to a pilot program; and expand to include post acute services and such other services the Secretary determines to be appropriate, which may include transitional services.</p>	The Secretary shall establish a pilot program for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services under this title.	AAHSA prefers House version because it explicitly includes long-term care providers.
<u>Limited English Proficiency</u>	Addresses whether LEP is working; provides for IOM study; grants; etc.		AAHSA supports; this section recognizes cost to health care system.
<u>Therapy Cap extension</u>	Exceptions process extended to 12/31/2011	Exceptions process extended to 12/31/10	AAHSA supports House provision
<u>Accountable Care Org</u>	Creates ACOs as part of “bundling” concept; primarily acute-care oriented but can include other providers; PACE participants excluded	Community Based Transitions Care Program	Both provisions are OK, House provides more options for LTC.
<u>Transparency Act</u>	Similar to legislation previously introduced in Congress; includes a number of provisions that AAHSA has long supported, including separating out nursing costs on Medicare cost reports.	Same, includes GAO study on 5-Star; does not include increased penalties for CMPs	AAHSA supports Senate version because of the CMP increases, 5-Star study.

	Includes increased penalties for CMPs		
<u>Sense of Senate re LTC in 2010</u>		Urges Congress to address LTC comprehensively over the next year	AAHSA supports
<u>Reducing “wasteful” dispensing</u>	Requires the Secretary to establish utilization management techniques, such as daily, weekly, or automated dose dispensing, to apply to PDP sponsors and MA organizations to reduce the quantities of covered part D drugs dispensed to enrollees who are residing in long-term care facilities in order to reduce waste associated with unused medications.	The Secretary shall require PDP sponsors of prescription drug plans to utilize specific, uniform dispensing techniques, as determined by the Secretary, in consultation with relevant stakeholders (including representatives of nursing facilities, residents of nursing facilities, pharmacists, the pharmacy industry (including retail and long-term care pharmacy), prescription drug plans, MA–PD plans, and any other stakeholders the Secretary determines appropriate), such as weekly, daily, or automated dose dispensing, when dispensing covered part D drugs to enrollees who reside in a long-term care facility in order to reduce waste associated with 30-day fills.	AAHSA opposes any effort that will make it more difficult for our members to provide appropriate and adequate medications to our residents.
<u>Value-based purchasing (aka, pay for performance)</u>		Secretary shall develop VBP payment system for both home health and SNF, report to Cong 10/11;	AAHSA supports, so long as opportunity for comment and input available.
<u>Elder Justice Act</u>		Same as bill that passed Senate last Congress; includes individual mandate to report “reasonable suspicion of crime” against SNF residents, similar to child abuse	AAHSA supported when it was individual legislation, so continues to support
<u>Criminal Background Check</u>		Extends current pilot program nation-wide, optional for state to participate	AAHSA has supported principals behind national criminal background check legislation; grants to states to reimburse providers.
<u>Home Health Reimbursement</u>	Home Health payment update for 2010 (\$56.8 billion in cuts). Eliminate 2010 update with rebasing after 2011 Payment adjustment for case mix for home health- cut reimbursement by 5.46%- combines 2010 and 2011 case mix adjustments	Payment Adjustment for Home Health care- The outlier cap is expanded to 5% of the total payments. The provision adds a temporary 3% Medicare payment add on for rural home health agencies from April 1, 2010 to January 1, 2016. (\$43.2 billion cut)	AAHSA prefers the Senate bill because there is less of a cut and rebasing is spread over a four year period instead of one year. Also, the House bill does not include a 3% add on payment for rural home health agencies. Home health will receive a market basket update for 2010.

		<p>Market basket updates for home health. Home health providers will receive the full market basket update for 2010 (2.2%). Home health will see the market basket for 2011 and 2012 reduced by 1%.</p> <p>Revisions of Market basket adjustments- Home Health – extends no market basket increase for 2012 and 2013.</p> <p>Home Health rebasing- rebasing starts in 2014 (over 4 years)- full rebased rate in 2017</p>	
<u>Hospice Reimbursement</u>	<p>Productivity adjustment for hospice. Updates market basket to include productivity adjustment- 1.6% cut for 2010</p> <p>Hospice Moratorium extension- till October 1, 2010- delays a 6.7% cut.</p>	Hospice- reduces market basket from 0.5 to 0.3	AAHSA supports the House bill that updates the market basket and delays the implementation of the budget neutrality adjustment factor phase out that would lead to a cut in payment.
<u>MedPAC study on Home Health</u>	MedPAC study on home health margins	Not in Senate bill	AAHSA supports MedPAC conducting a study on home health profit margins since we believe that MedPAC needs to look at the difference between for profit and not for profit as well as the inclusion of capital expenditures in the reporting of profit margins.
<u>Hospice Reform</u>	Not in House bill	Hospice Reform - adopts MedPAC Hospice eligibility recertification recommendations, mandates additional data collection requirements.	AAHSA supports the increase in data requirements that will demonstrate quality.
<u>Hospice Concurrent Care demonstration</u>	Not in the House bill	Hospice Concurrent care demonstration- 3 year, 15 hospice provider demonstration	AAHSA supports funding for demonstrations that utilize innovation in providing hospice services.
<u>Personal Care services under Medicaid state plan option</u>	Community First Choice- Option to provide Medicaid coverage of community-based attendant services and supports.	Community First Choice Option- state plan option to provide Home and Community-based Attendant services and supports and the State would receive a 6% increase in FMAP for participating in the program- starts in 2010 and is a permanent option for states.	AAHSA supports. This provision is better than the House version because it is a permanent option.

<u>Medicare Advantage cuts and P.A.C.E.</u>	PACE Carve out under Medicare Advantage cuts- same as Senate version	PACE Carve out under Medicare Advantage cuts.	AAHSA supports exempting Programs of All inclusive Care for the Elderly from Medicare Advantage cuts
<u>Independence at Home</u>	Independence at Home- same as the Senate bill	Independence at Home Demonstration Program- payment incentive and service delivery system that utilizes physicians and nurse practitioners based on a targeted spending level.	AAHSA supports this demonstration that will benefit older adults in senior housing, and home health providers interested in applying for the demo.
<u>ADULT DAY HEALTH CARE SERVICES in the Medicaid State plan coverage</u>	ADULT DAY HEALTH CARE SERVICES- 8 state Medicaid State plan coverage	Not in the Senate bill	AAHSA supports the provision in the House bill that would allow the 8 states ( NY, CA, MA, TX, NH, NJ, MD, ) that have their Adult Day Health programs in their state plan instead of a waiver to continue to offer these services in the state plan.
<u>Medicaid State Plan Amendment and Eligibility for HCBS</u>	Not in House bill	Removal of Barriers to Providing HCBS- amends 1915 (i) waiver to cover individuals up to 300% FPL, clarifies type, amount, duration and scope of HCBS and authorizes the use of the state option for targeted populations. There is a 5 year phase in for States. Eliminates option to waive state wideness.	AAHSA supports improving the 1915 (i) waiver by increasing eligibility
<u>Money Follows the Person Rebalancing Demonstration- extension</u>	Not in House bill	Money Follows the Person Rebalancing Demonstration – extends the program to 2016 and reduces the institutional residency period from 6 months to 3 months.	AAHSA favors extending the funding of the Money Follows the Person demonstration and improving eligibility
<u>Expand state aging and disability resource centers</u>	Not in House bill	Funding to expand state aging and disability resource centers (Single point of entry) - \$10 million for each year 2010 through 2014.	AAHSA supports funding to improve the system of referrals to needed long term services and supports
<u>National Family Caregiver Program/LTC workforce</u>	Creates Personal Care Attendant Workforce Advisory Panel to address personal care worker needs, core competencies; \$250 million authorized for 2011, 2012, 2013.	\$260 million for the National Family Caregiver Program	AAHSA supports improving the funding of the National Family Caregiver program that funds adult day service and in-home services; and supports the personal care attendant workforce panel and mission.
<u>Medicaid to the states</u>	Medicaid program. The coverage expansions (except the	Medicaid to the states Beginning in 2017,	AAHSA supports the House bill that provides more funds for a longer period of time to cover

	optional expansions) and the enhanced provider payments will be financed with 100% federal financing through 2014 and 91% federal financing beginning in year 2015. (Effective January 1, 2013	financing for the newly eligible will be shared between the states and the federal government through an increase in the federal medical assistance percentage (FMAP). For states that already cover adults with incomes above 100% FPL, the percentage point increase in the FMAP will be 30.3 in 2017 and 31.3 in 2018. For all other states, the percentage point increase in the FMAP will be 34.3 in 2017 and 33.3 in 2018, except Nebraska, which will continue receiving 100% federal funding for newly eligibles after 2017. Beginning in 2019, all states will receive an FMAP increase of 32.3 percentage points for the newly eligible. Certain states not eligible for the enhanced federal funding because they had already expanded Medicaid to adults with incomes above 133% FPL will receive a 2.2 percentage point increase in their FMAP for parents and childless adults who are not newly eligible for 2014 through 2019 or a .5 percentage point increase in the FMAP for 2014 through 2016. (Effective January 1, 2014	the expansion of Medicaid in the states.
<u>Spousal Impoverishment Medicaid eligibility for HCBS</u>	Not in House bill	Protection for recipients of HCBS against spousal impoverishment- Starting in 2014, extends spousal institutional based income spousal Medicaid eligibility to HCBS (good for 5 years).	AAHSA supports because it increases access the long-term services and supports.
<u>Integrated Care demonstration</u>	Not in the House bill	Establishes a 5 year Medicaid demonstration on integrated care to prevent hospitalizations	AAHSA supports
<u>Hospital Readmission Reduction Program</u>	Not in the House bill	Hospital Readmission reduction program	AAHSA supports
<u>Community-based Transition Program</u>	Not in the House bill	Community-based Transitions program- hospitals can partner with community-based organizations to assist high risk	AAHSA supports

		Medicare beneficiaries to transition from acute care to the community.	
<u>Enhanced FMAP to promote HCBS</u>	Not in the House bill	Enhanced FMAP to promote HCBS- 5% increase in FMAP to encourage changes in systems that promote HCBS	AAHSA does not support this provision since it favors certain state over other states, and ultimately encourages states to cut provider reimbursement in order to meet FMAP requirements. We prefer using system change grants in order to promote needed changes that promote the use of HCBS.

## Provisions in Health Care Reform Bills that Affect Employers

	<b>House Leadership Bill HR 3962</b>	<b>Senate Leadership Bill HR 3590, as Amended Dec 19</b>
<u>Employer Mandate</u>	<p><u>Yes, for “larger” employers</u> Beginning in 2013. Most employers, with the exception of “small” employees (FT and PT), must offer health insurance for each employee and family or pay a payroll tax of 8% of the avg. salary to the Health Insurance Exchange Fund.</p> <p>Exempts the vast majority of “small” businesses: 87%</p> <p>“Small” Employers: annual payroll does not exceed \$500,000. These “small” businesses are exempt from mandate. “Larger” Employers: annual payroll exceeds \$500,000 - mandates that these employers offer coverage and automatically enroll employees into the employer’s lowest cost premium plan. If the annual payroll: \$0 - \$499,999 penalty = 0%; \$500,000 - \$584,999 , = 2% \$585,001 - \$669,999 , = 4% \$670,001 - \$749,000, = 6% Over \$750,000, = 8%</p> <p><b><u>Employer Contribution Requirements:</u></b> <u>FTE:</u> If an employer decides to offer coverage for their FTEs, then the employer must make a contribution of 72.5% of the premium for individual coverage and 65% of the premium for family coverage.</p>	<p>No Mandate, but penalty for “large” employers who do not offer coverage. Effective January 1, 2014</p> <p>“Large” Employers with more than 200 employees:</p> <p>Employers must automatically enroll new full-time employees in coverage with the opportunity for an employee to opt out of any coverage the individual or employee was automatically enrolled in.</p> <p><u>Definition of “Large” Employers</u> changed from employers with more than 50 employees to employers with at least 5 FTE and with an annual payroll in excess of \$250,000. All others are exempt from penalty (see below).</p> <p><u>Provision:</u> Requires a “large” employer who <i>does not offer coverage</i> and has at least one full-time employee receiving the premium assistance tax credit to make a payment of \$750 per full-time employee.</p> <p>A “large” employer who <i>does offer coverage</i> but has at least one full-time employee receiving the premium assistance tax credit will pay the lesser of \$3,000 for each of those employees receiving a tax credit or \$750 for each of their full-time employees total.</p>

	<p><b>PTE:</b> If an employer has part time employees, the employer has an option of providing part-time employees with health coverage by contributing a share of the expense (an amount proportional to hours the employee worked) or contributing to the Exchange in order for PT employees to get coverage there. Contributions for part-time employees will be pro-rated based on the proportion of average weekly hours of employment and the minimum weekly hours for an employee (30 hours/week).</p> <p><b>Insufficient Coverage:</b> If an employer (unknowingly) offers coverage other than the “qualified” plan, they can be assessed a penalty of up to \$500,000 a year (\$100 per day). This tax would not apply for failures corrected within 30 days, in cases where the employer could not have reasonably been aware of the failure, and other exceptions. For failures due to a reasonable cause and not willful neglect, the tax would be limited to the lesser of 10% of the amount paid or incurred for the employment-based health plan for the prior year or \$500,000.</p> <p><b>Penalty for Denying Coverage:</b> If an employer with payroll taxes above \$750,000/yr decides not to offer coverage, then the employer would have to pay a penalty of 8% of the employer’s total payroll.</p> <p><b>Automatic Enrollment:</b> “Large” employers must automatically enroll their employees into the individual health plan offered with the lowest applicable employee premium.</p>	<p><b>New Amendment: Free choice vouchers:</b> (sec 10180, Senator Wyden Amendment) Effective Jan 1, 2014. Mandatory.</p> <p>The idea behind this is to allow low income individuals to have more options in purchasing insurance.</p> <p><b>Eligibility:</b> Workers who qualify for an affordability exemption to the individual responsibility policy but do not qualify for tax credits can take their employer contribution and join an exchange plan.</p> <p>“Qualifying employee”: whose required contribution for employer coverage is greater than 8% and less than 9.8% of household income; AND whose household income is less than 400% of the poverty line for a family; AND who does not participate in a health plan offered by the offering employer.</p> <p><b>Vouchers:</b> Employers would give these contributions in the form of vouchers to workers, and workers would use them to buy health insurance on the Exchanges. (No penalty for employers if employee decides to take insurance through the Exchange).</p> <p>Monthly portion of the amount the employer would have contributed to the employer-sponsored plan were the employee covered (for either self or family coverage).</p> <p>If amount of voucher is greater than amount of premium of the plan in Exchange, employees get to keep it</p>
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	<p><b>Opt Out:</b> Employees can opt-out of employer provided individual coverage (or choose another plan offered) if they make an affirmative election to do so. Employers shall provide employees a 30-day period to make such an affirmative election before auto-enrolling the employee in the individual plan with the lowest premium.</p> <p><b>Opt Out into Exchange:</b> An employee can also choose to opt out or des-enroll in the employer’s plan into a plan through the Exchange (although such individual may be responsible for all of the premium). Beginning in 2014, with respect to an employee who declines the employers qualifying coverage, employers with aggregate wages above \$750,000 would be assessed 8% of average wages - this payroll assessment would be limited, so that it could be no more than the contribution that the employer would have been required to make had the employee elected to enroll in a plan offered by the employer. This 8% payroll assessment would not be required for an employee who was not the primary insured individual but was covered as a spouse or dependent in an Exchange plan. The employer’s payroll assessment for this group of individuals would go into the Exchange but would not apply toward the individual’s premium. So, employers who do not offer qualified coverage contribute 8% of their payroll to help cover expenses of employees who seek coverage through the Exchange.</p> <p><b>Employee Option to Opt Out:</b> Full-time</p>	<p>(employers pay employees the excess). If more, employees have to pay the difference out of pocket.</p> <p>The voucher amount would be tax deductible to employees.</p> <p>“<u>Offering employer</u>”: defined as one who offers minimum coverage through an eligible employer-sponsored plan AND pays any portion of the costs of the plan.</p> <p><u>Waiting Period:</u> Changed with amendment. If the employer imposes a waiting period to enroll in coverage, the law would no longer require a payment from the employers for a waiting period between 30-60 days.</p> <p>The new waiting period would be extended to include on 60 days instead of starting with 30 days. A “large” employer requiring a waiting period before an employee may enroll in coverage of longer than 60 days will pay a fine of \$600 per FTE. (Effective January 1, 2014)</p> <p>Employees may opt out of coverage from employers.</p>
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<p><u>Tax Credit</u></p>	<p><b>Yes, but non-profits would <u>NOT</u> benefit.</b></p>	<p><b>Yes, but as tax-exempt entities, non profits <u>WOULD</u> benefit.</b></p> <p><u>Effective Date:</u> Amendment allowed for benefit to start an year earlier. Effective date would then be Jan 2010 instead of Jan 2011.</p> <p><u>Eligibility:</u> "Small" employers.</p> <p><u>Definition of "Small Employers":</u> amendment broadened definition of "small" employers to include those with average wages up to \$25,000 (instead of \$20,000) for full credit. IT also broadened the eligibility for partial credit (on a sliding scale) to other small firms with average wages up to \$50,000 (instead of \$40,000). This means that more small businesses would be able to qualify for the credit.</p> <p>Amendment allows eligible small</p>

		<p>businesses access to up to six years of tax credits to purchase health insurance for their employees.</p> <p>Requires the Government Accountability Office (GAO) to review the impact of Exchanges on access to affordable health care for small businesses to ensure that Exchanges are indeed making a difference for small business owners.</p> <p>Modifies the definition of a full-time employee: 390 hours per calendar quarter (13 weeks) instead of the current definition of 30 hours per week on average. This would take into account fluctuation in employee hours, and reduce the impact of employer responsibility requirements for industries with high turnover and that rely on part-time employees to sustain their business.</p> <p>Phase I : For tax years 2011 through 2013, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. Full credit available to employers with 10 or fewer employees and average annual wages of less than \$20,000. The credit phases-out as firm size and average wage increases.</p> <p><u>Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium.</u></p> <p>Phase II : For tax years 2014 and later, for eligible small businesses that purchase coverage through the state Exchange,</p>
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		<p>provide a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium. Employer must contribute at least 50% of the total premium cost. Credit available for two years. Full credit available to "small" employers: 10 or fewer employees; and avg annual wages less than \$20,000. The credit phases-out as firm size and average wage increases.</p> <p><u>Tax-exempt (non-profit) small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium.</u></p>
<p><u>Health Insurance Exchange</u></p>	<p>Beginning 2013, <b>National</b> Health Insurance Exchange (with State option to create their own) with public plan option.  <b>Exchange Eligible Employers:</b>  →"Smallest": 25 or fewer employees will be eligible for coverage in the Exchange on the first year of the program, 2013.  →"Smaller": Employers with more than 10, less than 50 employees eligible for Exchange after the second year of implementation, in 2014.  →"Larger": Beginning with the third year of implementation, 2015, larger employers, (100 or fewer) that are not "smallest" or "smaller" are permitted to be Exchange-eligible employers. From the third yr forward, the Exchange will then be opened to larger employers as another choice for covering their employees. Once an employer is permitted to be an Exchange-eligible employer and enrolls employees through the Exchange, the</p>	<p><b><u>State-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges</u></b>, administered by a governmental agency or non-profit organization (starting 2017)</p> <p>Eligibility: small businesses with up to 100 employees can purchase qualified coverage.</p> <p>Permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP</p>

	<p>employer would continue to be treated as an Exchange eligible employer for each subsequent plan year regardless of the number of employees involved unless and until the employer meets the requirement to offer a group health plan (payment of required contributions). Medicaid-eligible individuals will be enrolled in Medicaid, not the Exchange. Requires that employers who offer coverage through the Exchange contribute at least the required contribution toward such coverage and permit their employees the freedom to choose any plan within the Exchange.</p>	
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