LABOR, IMMIGRATION & EMPLOYEE BENEFITS DIVISION
U.S. CHAMBER OF COMMERCE

2017 HEALTH CARE POLICY RECOMMENDATIONS

U.S. Chamber Staff Contacts

- Randel Johnson, Senior Vice President, Labor, Immigration & Employee Benefits rjohnson@uschamber.com
- Katie Mahoney, Executive Director, Health Policy kmahoney@uschamber.com

The Chamber has long championed the invaluable benefits that the employer-sponsored health care system provides to both employees and employers alike. More than 177 million Americans currently rely on the health coverage and benefits offered by employers. The employer-sponsored system must be permitted to allow employers to customize the benefits offered to best serve the needs of their workforce and appropriately manage cost growth in health care. The Chamber will educate stakeholders, the administration and Hill staff about the innovative developments that are occurring in the private sector. Our focus will remain on promoting and advancing thoughtful legislative and regulatory changes to permit greater flexibility in benefit design and coverage that will improve health, reduce unnecessary costs, and reward high-value care.

I. CORRECTING THE HEALTH POLICY MISTAKES OF THE PAST EIGHT YEARS: AFFORDABLE CARE ACT (ACA) REFORMS

This section outlines different health policy mistakes that have been made in the past eight years and suggests opportunities and ways to correct these mistakes.[1]

[1] As when Bush succeeded Clinton, the Trump win opens the door to rolling back many of Obama's regulations. The press is very focused on these possibilities but keep in mind that this effort will vary depending on the underlying regulation in question, a fact lost on the press. Many were issued under executive orders and thus can be eliminated swiftly through repeal of the relevant executive order by the new president, which provided the underlying authority for the regulations, followed by procedural repeal of the regulations themselves. But others will have to be repealed and/or modified through notice and comment rulemaking. This can be done relatively quickly, but the courts have made clear that this must be a reasoned and deliberative process and not based simply on a change in the presidency. Another option is repeal through the Congressional Review Act (CRA) depending on when the underlying regulation was issued and when this Congress adjourns. In sum, we have huge opportunities here, which we are already working, but each has their own nuances. Ongoing court cases must also be calculated into the strategy.

REPEAL THE CADILLAC TAX

Issue: The Affordable Care Act (ACA) includes a 40 percent tax on group health coverage that exceeds $10,200 for self-only coverage and $27,500 for other than self-only coverage. The purpose of the tax on "high cost employer-sponsored health coverage" was to discourage employers from offering exceedingly generous health plans that would insulate consumers from the cost of services and drive up unnecessary utilization. However, because of the way this so-called "Cadillac Tax" provision was drafted, the tax will eventually affect all plans and essentially fine employers for offering health coverage to their employees – which is particularly ironic given that the law also fines employers for failing to offer health coverage to their employees. The Chamber filed comments in response to Notice 2015-16 issued in February 2015, as well as comments in response to Notice 2015-52 issued in July 2015.

Current Status: As part of the 2015 year-end budget deal, a combined tax extenders and omnibus appropriation package (H.R. 2090) was signed into law on December18, 2015, delaying the effective date of the 40 percent excise tax and making the tax deductible. Instead of applying to employer-sponsored coverage with plan years beginning on or after January 1, 2018, the tax will now apply to employer-sponsored coverage with plan years beginning on or after January 1, 2020. Applicable rulemaking is underway.

Steps Requested:

- The tax must be repealed as soon as possible. A myriad of bills have been introduced to repeal the tax – H.R. 879; H.R. 2050; S. 2045 and S. 2075. These bills are similar but reflect the political divide on whether repealing this provision is messaged as repealing part of the ACA or as fixing the ACA. Despite the delayed effective date, businesses are already modifying health coverage offerings.
- Additionally, rulemaking efforts should consider the desired purpose of the tax – mitigating overutilization of unnecessary services – and any rules promulgate should encourage employers to offer and employees to leverage benefits that will reduce unnecessary costs.
- Further, the rules must recognize the conflicting requirements in the law and create a safe-harbor that exempts employers merely offering the minimum coverage required under the employer mandate from the Cadillac Tax.

Rationale: Over 177 million Americans enjoy health care coverage through their employer and this tax will force businesses to first reduce that coverage and then potentially stop offering coverage. The "Cadillac Tax" is not indexed to inflation and will therefore, impact an increasing number of health plans over a long period of time. Contrary to economic theory, employers will, in all likelihood, not increase wages as a result of this tax or to off-set benefit reductions. Instead, in order to avoid the tax, employers may either cut benefits or shift more of the costs onto the worker in the form of higher deductibles, or co-pays.

REPEAL THE EMPLOYER SHARED RESPONSIBILITY PROVISION

Issue: Under the ACA, employers with more than 50 "full-time equivalent" employees that do not provide "affordable" health care coverage that meets the "minimum value" threshold to "all full-time employees" "(and their dependents)" may be assessed a penalty, if at least one full-time employee qualifies for a premium tax credit and purchases coverage in the health insurance exchange. In order for employer-sponsored coverage to be deemed "affordable," the employee's portion of the premium for self-only coverage cannot exceed 9.5 percent of the employee's household income.

This statutory obligation includes several different terms that were further fleshed out in regulation. Regulations were promulgated before the provision's effective date (originally January 1, 2014) to detail how to determine: 1.) if an employer has 50 or more "full-time equivalent" employees; if coverage is "affordable;" 2.) if coverage meets the "minimum value" requirement; 3.) if an employee is a "full-time employee;" and 4.) what is intended by the parenthetical "(and dependents)."

- The Treasury Department (Treasury) and the Internal Revenue Service (IRS) issued a notice and request for comments to initiate and inform the process of developing regulations regarding the shared responsibility provision of 4980H as added by the ACA. The Chamber filed comments on June 17, 2011.
- The Treasury Department and the IRS issued a notice of proposed rulemaking regarding the health insurance premium tax credit and the Chamber filed comments on October 31, 2011.
- The Treasury Department and the IRS issued a request for comments on health coverage affordability safe harbor for employers under the employer shared responsibility and the Chamber filed comments on December 13, 2011.
- The Treasury Department and the IRS issued Notice 2012-31 regarding the minimum value of an employer-sponsored health plan and the Chamber filed comments on June 11, 2012.
- The Treasury Department and the IRS issued a final rule on the Health Insurance Premiums Tax Credit and the Chamber filed comments on August 21, 2012.
- The Treasury and the IRS issued Notice 2012-58 to provide temporary guidance on how employers may determine which employees are treated as full-time employees for purposes of the shared responsibility provision. The Chamber filed comments on September 30, 2012.
- The Treasury and the IRS issued a notice of proposed rulemaking on the shared responsibility for employers regarding health coverage and the Chamber filed comments on March 18, 2013.
- The Treasury and the IRS issued a notice of proposed rulemaking on the determination of whether health coverage under an eligible employer-sponsored plan provides minimum value. The Chamber filed comments on July 2, 2013.
- The Treasury and the IRS issued a notice of proposed rulemaking on the minimum essential coverage requirements and other rules regarding shared responsibility payments. The Chamber filed comments on April 28, 2014.

- The Tri-Agencies issued an FAQ on May 26, 2015, reiterating and clarifying their interpretation that an individual with non-self-only coverage (i.e. family coverage) must only be subjected to the individual out-of pocket (OOP) limit which statutorily applies to self-only coverage. This interpretation had been included in the preamble of the proposed rule on the notice of benefit and payment parameter for 2016, where the Chamber also identified the interpretation as problematic and disputed in our comments on December 22, 2014. The Chamber coordinated a letter from the National Coalition on Benefits to strongly dispute the Agencies authority and decision to interpret that the statute required embedded deductibles for individuals covered under a non-individual plan. Instead, we reaffirm that the statute provides one OOP limit for ***self-only*** coverage, and one OOP limit for ***family*** coverage.
- The Treasury and the IRS issued a supplemental notice of proposed rulemaking on minimum value of eligible employer-sponsored health plans and the Chamber filed comments on November 2, 2015.

Current Status: Originally, the shared responsibility provision was to go into effect for months beginning after December 31, 2013.

However, on July 2, 2013, a Treasury blog post announced the delay of the employer mandate requirements for the 2014 calendar year – including the requirement to offer affordable minimum value coverage under 4980H as well as the information reporting requirements for insurers, self-insuring employers and other providers of minimum essential coverage under §6055, and the information reporting requirements imposed on applicable large employers under §6056. This delay was formalized several days later with the issuance of Notice 2013-45.

In the final rule published on February 12, 2014, Treasury delayed the application of the shared responsibility requirement to the smallest of the applicable large employers that had not previously offered coverage or had not previously offer affordable minimum value coverage. Those "applicable large" businesses with fewer than 100 full-time equivalents were granted another transition year for 2015, meaning that application of the employer mandate to these employers did not go into effect until 2016. The final rule also allows applicable large employers with more than 100 full-time equivalents to have satisfied the requirement to offer minimum essential coverage if coverage was offered to "substantially all" of their full-time employees, defined as 70 percent in 2015. In the years following, all applicable large employers are deemed to satisfy the requirement to offer minimum essential coverage if it is offered to substantially all full-time employees, defined as 95 percent for 2016 and beyond.

Step Requested:

- Congress should pass legislation to repeal the employer shared responsibility requirement. Several bills have been introduced over the past six years to repeal (or modify) the shared responsibility requirement – including H.R. 1744 and S. 20; S. 1049.

Rationale: Complying with the requirement to offer affordable minimum value coverage to substantially all full-time employees is difficult. However, the reporting requirements have proven far more challenging.

The offer and take-up rates of employer-sponsored insurance coverage have remained unchanged among nonelderly workers from June 2013 through March 2015. These rates remained stable for workers in both small and large firms, as well as for workers with higher and lower incomes.

If the employer mandate were to be repealed, the Urban Institute has estimated that only about 200,000 fewer people would get health coverage, a relatively small decrease compared to the millions expected to get insurance under the ACA. The Urban Institute noted that most big businesses already cover workers – and they have done so voluntarily, with no mandate. And the Institute has said that's unlikely to change.

Further, eliminating the employer mandate could allow employers to provide a wider range of offerings including more affordable plans for part-time employees or in industries with high turnover.

REPEAL THE HEALTH INSURANCE TAX

Issue: Starting in January 2014, the ACA began imposing a fixed dollar tax on health insurance providers in the fully-insured market based on net premiums written. Because small businesses generally offer fully-insured coverage to their employees, this tax disproportionately harms small businesses.

The Chamber commented on the proposed rule in June 2013 and a final rule was issued in November 2013 to implement this tax, after which the tax was collected for plan years 2014, 2015 and 2016 in the amounts of $8 billion, $11.3 billion and $11.3 billion respectively as prescribed by statute.

Current Status: As part of the 2015 year-end budget deal, a combined tax extenders and omnibus appropriation package (H.R. 2090) was signed into law on December18, 2015, which suspended the health insurance tax for the plan year beginning January 1, 2017. The tax will resume for the plan year beginning on or after January 1, 2018.

Step Requested:

- Congress should pass legislation (S. 183 and H.R. 928) to repeal this health insurance tax.

Rationale: The impact of the health insurance tax is expected to raise premiums as the amount of the tax will be subsequently passed on to policyholders. This new tax falls solely on the fully insured market, the market from which 88 percent of small business owners purchase health insurance for their employees and themselves.

Additionally, because of the way the regulations have been promulgated to implement this provision, the health insurance tax will cost employers offering these plans between $45 billion and $70 billion more over the next decade than the amounts statutorily prescribed to be collected. The regulations subject all premiums collected by the health insurers to federal income tax, including the amount that is collected to be passed onto the IRS to pay the tax. Therefore, in order to pay the IRS the statutorily dictated amount, even more must be collected in premiums before the insurers pay income tax on that amount.

According to an analysis by Quantria, in order to cover federal income taxes due under the statute, taxable health insurers will need to collect $1.54 from customers for each $1 of premiums attributable to the health insurer fee. The health insurer tax contained in the ACA will increase costs of taxable health insurers by $175-200 billion over the 2014 -2023 period, assuming current market shares. This includes $130 billion attributable to the statutory fees plus $45 billion to $70 billion from the federal income tax treatment of the health insurer tax.

REPEAL THE MEDICAL DEVICE TAX

Issue: Beginning in January 2013, the ACA imposes a 2.3 percent tax on the sale of medical devices.

Current Status: As part of the 2015 year-end budget deal, a combined tax extenders and omnibus appropriation package (H.R. 2090) was signed into law on December18, 2015, which suspended the medical device tax for 2016 and 2017. This tax will resume in 2018.

Steps Requested:

- Congress should enact legislation (S. 149 and H.R. 160) to repeal the medical device tax or, in the interim, extend the suspension of this tax.

Rationale: The Chamber has argued that the ACA's new 2.3 percent medical device tax, which is imposed on medical device manufacturers whether or not they make a profit, will lead to increased health care costs, undercutting one of the primary goals of health care reform. Furthermore, by driving up the cost of medical technology, this tax undermines America's global leadership position in product innovation, clinical research, and patient care. The tax weakens the medical device industry's ability to create and maintain well-paying jobs in the United States and hinders the development of breakthrough treatments.

According to a survey by the Advanced Medical Technology Association (AdvaMed), two-thirds of the companies surveyed reported that they have had to "slow or halt U.S. job creation as a result of the tax." This survey found that 53 percent of respondents have reduced research and development as a result of the tax. Additionally, 75 percent of respondents said they have deferred or cancelled capital investments and plans to open new facilities, reduced investment in start-up companies, found it more difficult to raise capital, and reduced or deferred increases in employee compensation.

Similarly, a survey by the Medical Device Manufacturers Association (MDMA) of 100 industry executives found that 72 percent "slowed or halted job creation" to pay for the tax, and 85 percent would hire more workers if the tax were repealed. If not repealed, this tax will continue to weaken the industry's ability to create and maintain well-paying jobs in the United States and hinder the development of breakthrough treatments.

PERMIT STAND-ALONE HEALTH REIMBURSEMENT ARRANGEMENTS (HRAS)

Issue: The administration has issued multiple guidance documents articulating their interpretation that stand-alone Health Reimbursement Arrangements (HRAs) violate the insurance market reform rules and that therefore employers offering these stand-alone HRAs for

their workers will be fined $100 per day, per employee. As a result, employers will face significant fines should they provide tax-preferred dollars in these tax-preferred accounts to help their employees pay for either premiums or other qualified medical expenses. Transition relief was provided for small employers until July 1, 2015, which essentially deferred the imposition of the fine.

- On January 24, 2013, the Departments of Labor (DOL), Health and Human Services (HHS) and Treasury (collectively the Tri-Agencies) issued Frequently Asked Questions (FAQs) Part XI, indicating that the administration interprets the ACA's §2711 prohibition on imposing annual or lifetime limits on the dollar value of essential health benefits as prohibiting an employer from the offering tax-preferred funds to employees through a stand-alone HRA.
- The Chamber filed comments on May 20, 2013, and met with officials in an effort to encourage Treasury to revise this interpretation and to permit employers to offer HRAs.
- On September 13, 2013, the DOL's Technical Release No. 2013-03 and the IRS's Notice 2013-54 were issued, both of which were reiterated by HHS's September 16, 2013 guidance.
- Over a year later, on November 6, 2014, the DOL issued FAQs Part XXII to further clarify the administration's position on HRAs.
- On February 18, 2015, the IRS's Notice 2015-17 provided transition relief for failure to satisfy the market reforms in certain circumstances. As a result, Notice 2015-17 provided temporary relief for failure to satisfy the Affordable Care Act market reforms. Under the notice, small employers get relief for 2014 and up to July 1, 2015. Small employers are employers that are not "applicable large employers" under §4980H (generally defined as employing less than 50 full-time equivalent employees per month).
- On March 4, 2016, the IRS's FAQs specifically said that if an employer does not establish a health insurance plan for its own employees, but reimburses those employees for premiums they pay for health insurance, that arrangement fails to satisfy the market reforms and may be subject to a $100 per day excise tax, per applicable employee (which is $36,500 per year, per employee) under section 4980D of the Internal Revenue Code.

Numerous subsequent sub-regulatory guidance documents, as detailed above, specifically stated that any business offering HRAs on a stand-alone basis to their employees would be fined at a rate of $100 a day per employee beginning July 1, 2015.

Current Status: Bipartisan legislative language was included and enacted with the December 2016 passage of the 21st Century Cures Act which would create an exception to qualified small employers to offer stand-alone HRAs, on a limited basis. The bipartisan compromise included in the Cures Act allows businesses that are not applicable large employers to offer stand-alone HRAs. However, the contribution made to the HRA by the employer cannot exceed $4,950 (or $10,000 if the HRA also provides for reimbursements for an employee's family members), indexed for inflation. While this exception will be helpful for small businesses once enacted, it is likely that additional flexibility may be achievable through regulatory changes in the next administration.

Steps Requested:

- Revise regulatory guidance documents to reinterpret the application of the insurance market reform rules for HRAs or pass broader legislation that permits all employers to offer a stand-alone HRA, regardless of size or coverage obtained.

Rationale: Prior to enactment of the ACA, employers were able to provide their workers with tax-free money to help their employees purchase health care coverage, subsidize premiums, or pay for qualifying medical expenses. Employers of all sizes should have the flexibility to offer a variety of different benefits to their employees.

STREAMLINE EMPLOYER REPORTING REQUIREMENTS

Issue: In order to determine coverage offerings and enrollment as required by the employer mandate and individual mandate, the ACA requires employers and insurers to gather a tremendous number of data points on a monthly basis and submit them to the IRS and individuals. The challenge of collecting this information and submitting it successfully has been costly and burdensome to employers and insurers alike.

The Chamber has responded to numerous regulatory materials published to implement these requirements.

- On July 11, 2012, the Chamber filed:
  - Comments on (Notice 2012-32 on §6055).
  - Comments on (Notice 2012-33 on §6056).
  - Comments on Notice 2012-31on minimum essential coverage.
- On July 2, 2013, a Treasury blog post announced the delay of the employer mandate requirements for 2014. Several days later, the issuance of Notice 2013-45 formalized the delay.
- On November 8, 2013, the Chamber filed:
  - Comments on the proposed rule to implement §6055, which requires health coverage providers to report information on individuals enrolled in minimum essential coverage.
  - Comments on the proposed rule to implement §6056, which requires applicable large employers to report information on health insurance coverage offered, and the individuals to whom it is offered, under employer-sponsored plans.
- On March 10, 2014, a final rule was issued to implement §6055, which requires health coverage providers to report information on individuals enrolled in minimum essential coverage.
- On March 10, 2014, a final rule was issued to implement §6056, which requires applicable large employers to report information on health insurance coverage offered, and the individuals to whom it is offered, under employer-sponsored plans.
- On December 28, 2015, Notice 2016-04 extended the deadlines for the 2015 reporting requirements, employers and insurers submitted forms in the spring of 2016 to comply with these requirements to report on coverage offered and elected in 2015. Employers and insurers were required to send paper forms to individuals by March 31, 2016, and to the IRS by May 31, 2016. Employers and insurers were required to send forms electronically to the IRS by June 30, 2016.

Current Status: Bipartisan legislation has been introduced in the House (H.R. 2712) and Senate (S.1996). While not identical, Hill staff is working to create a redline version that would synchronize the bills and incorporate technical assistance from the IRS. While it is unlikely that this legislation will move in the short term, it may be reexamined when republicans pursue a replace proposal which is expected to also offer premium tax credits to individuals without an offering of employer sponsored coverage.

Step Requested:

- Enact legislation or issue regulations that would simplify the reporting requirements and permit employers to report on a prospective basis to mitigate the cost and complexity that results from retrospectively reporting on coverage offered over a year earlier.

Rationale: There are a host of problems that are expected to occur with the 2017 income tax deadline due to retrospective reporting on the part of employers and insurers, as well as the prospective application for Advanced Premium Tax Credits (APTCs) by individuals. The information required to be reported in these forms will be used by the IRS to determine which employers satisfied their obligation under the employer mandate to offer affordable minimum value coverage to their full-time employees (and dependents). The IRS will similarly determine which employers: 1.) failed to offer affordable minimum value coverage to their full-time employees; 2.) had an employee who received an APTC to purchase coverage in the exchange; and 3.) therefore, must be fined a tax.

The IRS will also use the information reported on these forms to assess which individuals satisfied their obligation under the individual mandate to have minimum essential coverage.

Finally, the IRS will also use this information to reconcile the APTCs that were given to help individuals purchase coverage on the exchange and ensure that those individuals provided with APTCs were in fact eligible for the amounts that were given. (Recall – to be eligible to receive an APTC, an employee has to fall within a certain income bracket and must not be offered affordable minimum value coverage from an employer.)

Because the administration requires employers to send notices to all employees informing them of the ability to purchase coverage on the exchanges and the availability of APTCs, it is expected that many full-time employees who were offered employer-sponsored coverage elected instead to go to the exchange and apply for an APTC. Since documentation from the employer as to which employees received an offer of minimum value affordable coverage is provided to IRS roughly a year and a half later, it is likely that thousands of individuals received these APTCs in error. In April 2017, it is expected that many individuals will receive notification from the IRS that they must repay the APTC they received in error to purchase coverage on the exchange in 2015.

When employees receive these tax notices, they are likely to complain to their employer – inquiring as to why the employer gave them a notice about the availability of the APTC to purchase coverage on the exchange when the employer's offer of affordable minimum value coverage would have rendered the employee ineligible for an APTC. It is also unlikely that the IRS will be able to recoup the improperly awarded APTCs since these funds were sent directly to the insurers through whom individuals enrolled in coverage on the exchange. Beyond this future

problem, employers already received multiple error messages in response to large batch submissions of thousands of forms that they submitted in advance of the 2016 filing deadlines. The IRS is currently unable to tell employers which form, much less which line item, contains the error. Finally, for employers with transient workers or high-turnover, ensuring that these forms are mailed to the employee's current address for work rendered a year and a half ago is highly problematic.

Employers provide information to the IRS regarding the number of workers and dependents enrolled in any of their health plans on a monthly basis, which is then matched against files provided by the exchanges. The IRS has been informing businesses that the information they are receiving is incomplete or the exchange has provided them with information that contradicts the information on the employer's forms. The IRS should continue to work with the business community while the agency improves system processing capabilities by providing businesses with a safe harbor until the underlying problems have been resolved.

MITIGATE THE ADMINISTRATIVE BURDEN OF §1557 NON-DISCRIMINATION COMPLIANCE

Issue: The ACA includes a provision that prohibits "covered entities" from discriminating on the basis of sex, race, color, national origin, age, and disability in any health program or activity. These discrimination prohibitions generally apply to "covered entities" that offer health care programs receiving federal funds and include covered entities' operations as health insurance issuers in Federally Facilitated Marketplaces or Exchanges ("FFMs") and State-Based Marketplaces or Exchanges ("SBMs"), health care providers, managed care providers, and even health insurance issuers acting in their capacity as third-party administrators for self-insured group health plans.

The Chamber filed comments on the proposed rule issued in November 2015, and a final rule was published by the HHS's Office of Civil Rights (OCR) on May 18, 2016.

Current Status: Concerns remain regarding the frequency and circumstances under which notice of these protections must be provided, as well as the requirement to have taglines on these notices provided in 15 different languages to indicate that language assistance is available. Outstanding questions remain as to how the OCR will assist with compliance efforts or pursue enforcement.

Steps Requested:

- The Chamber is working with a number of different stakeholders to recommend ways to streamline notice requirements and simplify the administrative requirements necessary for compliance.
- Several recommendations include allowing notices to include an icon indicating that language assistance is available, which would limit the need to translate the tagline informing consumers of this assistance into 15 different languages.
- Additionally, the notices of this protection should be only required on an annual basis – as part of open-enrollment (or special enrollment periods) or in conjunction with the documentation provided to satisfy the summary of benefit and coverage requirements.

Rationale: The expense of having to provide translations into 15 different languages and to provide multiple notices of these protections is significant and outweighs the benefit to consumers. It is expected that by providing these notices with such frequency, consumers will disregard the information rather than realize the protections afforded.

STABILIZE THE INDIVIDUAL INSURANCE MARKET

Issue: The ACA imposed significant new insurance market rules on carriers offering plans in the individual and small group insurance markets. Under these rules, all plans offered in these markets must cover newly mandated benefits and also be priced based on new rating rules. Beginning in 2014, carriers were challenged with pricing insurance products in the individual market on and off the health insurance exchanges with very little information as to the cost of covering new enrollees.

There were several different provisions included in the law designed to mitigate negative financial risk for carriers. Three separate premium stabilization provisions (transitional reinsurance, risk adjustment and risk corridors) were incorporated to provide some financial protections to carriers. Several other provisions were intended to help sure up the viability of the individual market – including provisions around open enrollment and limitations as to when individuals could enroll in coverage at other times. The goal of these provisions was to discourage or even prevent individuals from improperly waiting to obtain insurance and only enrolling when, and for as long as, health care services were needed.

Many regulations have been issued by HHS on a litany of issues regarding the health insurance exchanges. On an annual basis, HHS issues a proposed notice of benefit and payment parameters which provides details and parameters related to "Risk adjustment, reinsurance, and risk corridor programs; cost sharing reductions; the advance payments of premium tax credit; and the medical loss ratio program." The Chamber has filed comments each year in response to these largely exchange focused proposed rules:

- On December 24, 2012, the Chamber filed comments in response to the proposed rule on the notice of benefit and payment parameters for 2014.
- On March 11, 2013, HHS issued the final rule for 2014.

- On December 26, 2013, the Chamber filed comments in response to the proposed rule on the notice of benefit and payment parameters for 2015.
- On March 11, 2014, HHS issued the final rule for 2015.

- On December 22, 2014, the Chamber filed comments in response to the proposed rule on the notice of benefit and payment parameters for 2016.
- On February 27, 2015, HHS issued the final rule for 2016.

- On December 21, 2015, the Chamber filed comments in response to the proposed rule on the notice of benefit and payment parameters for 2017.
- On March 8, 2016, HHS issued the final rule for 2017.

- On October 6, 2016, the Chamber filed comments in response to the proposed rule on the notice of benefit and payment parameters for 2018.
- The final rule on the notice of benefit and payment parameters for 2018 is expected to be released before the end of 2016.

Other improper action is destabilizing the individual market and the Chamber continues to weigh in with regulators to ensure that protections intended to be provided are in fact afforded to carriers. On such an issue, the Chamber has filed comments in response to a request for information about inappropriate steering of individuals eligible for Medicare and Medicaid benefits into the individual insurance market plans.

Current Status:
Amounts collected to help pay for the transitional reinsurance program have not been paid as promised to carriers:

- In 2014, a $63 per member, per year assessment was assessed to collect $12 billion ($10 billion for reinsurance payments to issuers and $2 billion for Treasury repayments). However, for 2014, the Centers for Medicare and Medicaid Services (CMS) collected only $9.7 billion of the statutorily required $12 billion.
- In 2015, a $44 per member, per year assessment was assessed to collect $8 billion ($6 billion for reinsurance payments to issuers and $2 billion for Treasury repayments). However, for 2015, CMS collected only $6.5 billion of the required $8 billion.
- In 2016, a $27 per member, per year assessment was assessed to collect $5 billion ($4 billion for reinsurance payments to issuers and $1 billion for Treasury repayments). We will know at the end of June 2017 how much will be collected for 2016.

With regard to the risk corridor payments, carriers have also not received the amounts promised:

- In 2014, carriers only received 12.6 percent of what was promised.
- In 2015, budget neutrality legislation was enacted for all three years of the risk corridor program to require that carriers that experience losses only receive an amount equal to what other carriers that experience profits pay in. Therefore, the amount of money promised will not be paid to insurers to cover their losses since more issuers lost money than received a profit.
- For 2015, CMS will owe health plans operating in the individual market $5.2 billion and those in the small group market $588 million, according to an announcement issued on November 18, 2016. But insurers won't see any of that money yet as the government still has to pay down its balance from 2014. Since CMS paid insurers only $362 million for 2014 when they were owed $2.87 billion, there is still a $2.5 billion balance on the government's 2014 obligation. Therefore, all 2015 benefit year risk corridor collections will be used to pay a portion of the balance on 2014 benefit year risk corridor payments. In total, the program will pay just $95 million toward the calculated 2014 benefit year payments.
- In 2016, it is again unlikely that any money will be paid to insurers to help cover their losses. Whatever is collected for 2016 will go towards the outstanding balances for 2014 and 2015.

The Chamber will continue to respond to regulatory inquiries and proposals on premium stabilization programs and improper manipulation of special enrollment periods. The Chamber

will oppose legislative efforts to defund or stop payments promised to carriers under these programs.

Step Requested:

- Oppose any efforts to reduce the payment of funds promised under these programs.

Rationale: Carriers priced premiums based on assurances that unexpected and unforeseen high risk claims and challenges estimating costs for a new population would be off-set by premium stabilization programs. As with any contractual arrangement, the government must uphold its side of the agreement.

ENCOURAGE WORKPLACE WELLNESS PROGRAMS

Issue: Despite a provision in the ACA that would strengthen incentives for employees participating in workplace wellness programs, a myriad of conflicting and confusing regulations issued by a variety of agencies over a four year period has limited the ability to leverage these programs.

The Chamber filed four comments letters to four different agencies:

- Comments on the Tri-Agencies' proposed rule issued in November 26, 2012.
- Comments for the record following an Equal Employment Opportunity Commission (EEOC) public meeting and request for comment held on May 8, 2013.
- Comments on the EEOC's proposed rule regarding restrictions on wellness program incentives under the Americans with Disabilities Act (ADA) issued in April of 2015.
- Comments on the EEOC's proposed rule regarding restrictions on wellness program incentives under the Genetic Information Nondiscrimination Act (GINA) issued in October 30, 2015.

On May 17, 2016, the EEOC's final GINA rule and the EEOC's final ADA rule were published nearly three years after the Tri-Agencies' final ACA rule which had been published June 3, 2013. There were significant areas of discrepancy between the EEOC's final rules and the earlier Tri-Agencies' final rule leading to tremendous confusion and uncertainty about how employers could vary premiums for employer-sponsored health coverage in response to employee (and employee family members) participation and engagement in workplace wellness programs.

Current Status: The EEOC's final rules further limit the application of these incentives and create different standards for compliance.

Steps Requested:

- Oppose additional regulations that would make the administration of workplace wellness programs more challenging and burdensome.
- Smooth inconsistencies among the EEOC's final ADA rule, the EEOC's final GINA rule and the Tri-Agencies' final ACA rule.

Rationale: Although there is no silver bullet for controlling health care costs, well-designed workplace wellness programs reduce costs while improving the quality of lives. Legislation should further encourage adoption of these types of programs. Confusion with conflicting

regulations will reduce the use of financial incentives that are known to be critical in encouraging participation and improving health.

II. PROMOTE PRIVATE SECTOR INNOVATION

This section details positive policy proposals that go beyond correcting the record of the last eight years. Note that this list will evolve as circumstances dictate and additional proposals are vetted by Chamber members. Obviously, there will be opportunity to explore more far-reaching proposals, as we get a better grasp on what is actually doable.

PROTECT THE EMPLOYER-SPONSORED COVERAGE: PRESERVE THE CURRENT TAX-TREATMENT AND EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) PRE-EMPTION OF EMPLOYER-SPONSORED COVERAGE

Issue: Over 177 million Americans receive health care coverage through their employer based on the framework of the Employee Retirement Income Security Act (ERISA). Employers operating in and/or employing individuals in multiple states rely on ERISA pre-emption protection in order to offer and administer uniform benefits. Several potential efforts at the federal and state level could disrupt this highly-valued source of coverage either by changing the current tax-treatment of the benefit, or by piercing the ERISA pre-emption veil.

The Chamber filed comments on a proposed rule published on March 14, 2011, regarding the application, review and reporting process for waivers for state innovation. A final rule was issued by the Departments of Treasury and Health and Human Services on February 27, 2012, and FAQs as well as a fact sheet were issued on July 22, 2015. Finally, guidance was published on December 16, 2015, detailing the additional requirements that must be met for approval.

Current Status: States have started applying for §1332 state innovation waivers and several are exploring taxes on claims, a creation of the public option, and other proposals that may threaten the ability of employers to offer and administer uniform benefits across different states.

Steps Requested:

- Urge Congress not to dismantle the ERISA framework.
- Fight efforts to change the current tax-treatment of employer-sponsored health coverage.
- Oppose state and local efforts to circumvent ERISA pre-emption and interfere with self-insured plans.

Rationale: The employer-sponsored health care system is not only where the majority of Americans receive private health care coverage, but it is also where innovation in benefit and plan design are advancing, where chronic disease management and population health efforts are improving productivity and wellbeing, and where unnecessary health care costs are being reduced. Further, recent surveys show that this benefit remains paramount to employees. Millions of Americans like the plans they have through the employer-sponsored system. According to the Employee Benefit Research Institute 2015 Health and Voluntary Workplace Benefits Survey:

- Eighty-eight percent of workers report that employment-based health insurance is extremely or very important, far more than for any other workplace benefit.
- More than one in five workers report accepting, quitting or changing jobs because of the benefits, other than salary or wage level, that an employer offered or failed to offer.
- Eighty-five percent of workers take the health insurance coverage they are offered through their employer.

Employers depend on the ERISA framework to ensure that they can offer plans nationwide, providing fairness to all employees regardless of where they live, work, or receive medical care. Any attempts to erode ERISA would make it more difficult for businesses to offer health plans as businesses would face additional reporting and paperwork requirements.

ADVANCE HEALTH INFORMATION TECHNOLOGY

Issue: For years now, efforts have been underway to encourage the adoption of health information technology both to facilitate the adoption and use of electronic medical records (EMRs) and to permit the use of technology in delivering treatment through telemedicine.

Current Status: While the use of EMRs continues to increase and become more widely adopted, the advent and wide use of telemedicine remains elusive. One main reason for this may be the challenge in reimbursing providers for services rendered through this modality.

Step Requested:

- Support legislation that would further accelerate the use of health information technology, such as permitting the use of telemedicine across state lines.

Rationale: Health information technology has the potential to lower costs, improve quality, reduce medical errors, and promote continuous care.

ENACT MEDICAL MALPRACTICE REFORM

Issue: The threat of lawsuits forces doctors to practice defensive medicine and order medically-unnecessary tests that needlessly drive up health care costs. Also, medical liability has forced doctors in high-risk fields like obstetrics and neurology to either quit or limit their practices, reducing the availability of their services and access to treatment. The ACA did very little to reform our medical liability system. With health care costs continuing to rise, we can't ignore this cost driver.

Current Status: Efforts to cap non-economic damages and impose a statute of limitations have been unsuccessful. Various proposals have been put forth over the years, including one supported by Dr. Tom Price (R-GA), chairman of the House Budget Committee in H.R. 2300, which would change the burden of proof based on compliance with clinical practice guidelines and provide a safe harbor for physicians following the recommended protocols of the professional specialty association.

Steps Requested:

- Support reforming the medical tort system to reduce the perverse incentive for providers to perform unnecessary tests which increase costs needlessly.
- Medical malpractice cases could be tried in special administrative health courts, similar to bankruptcy courts, which may reduce the cost of litigation.

Rationale: The medical liability system costs the U.S. health care system over $50 billion annually. Defensive medicine coupled with additional care given by providers to protect against lawsuits diminishes provider accountability while adding to the total cost of care.

DRIVE PAY-FOR-PERFORMANCE & DELIVERY SYSTEM REFORM

Issue: Our health care system should reward providers for the health outcomes achieved. To do this, our payment systems should transition away from simply rewarding providers for each service rendered and move beyond the traditional fee-for-service construct.

Current Status: The ACA began to encourage this transition through the development of Accountable Care Organization (ACO) demonstrations, the Medicare Shared Savings Program (MSSP), and other alternative payment program demos. Additional work has been done by the Center for Medicare and Medicaid Innovation (CMMI) which has set the goal of tying 50 percent of Medicare fee-for-service payments to quality or value through alternative payment models (APMs) by 2018. While efforts to advance delivery system reform are laudable, questions remain about the precise payment methodologies and lack of progress made by CMMI.

Steps Requested:

- Support transition from fee-for-service to pay-for-performance. Provider-led ACO demonstrations have shown that when patients are actively cared for under a robust primary care provider network which is reimbursed under prospective payments, patients receive exceptional quality care at a lower cost and ultimately lower spending.
- Assess CMS and CMMI's efforts to shift providers to alternative payment models that: 1.) reimburse providers under prospective down-side risk; and 2.) reward providers based on transparent quality metrics that are scalable and transferable to the private sector.

Rationale: Transitioning to pay-for-performance reimbursement models reward quality over quantity, and promotes cross-collaboration between and among providers as well as health insurance issuers. Ultimately, reforming payment systems will drive delivery system reform and lead to better patient outcomes as well as reduced unnecessary procedures and health care costs.

EXPAND CONSUMER-DIRECTED ACCOUNTS/VALUE-BASED INSURANCE DESIGN SAFE HARBOR

Issue: There are a number of limitations and restrictions on the use of Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs) that are hindering their use and unnecessarily limiting benefit design innovation.

The Chamber filed comments in response to a request for information published on December 28, 2010, regarding value-based insurance design in connection with preventive care benefits.

Current Status: Some of these restrictions have existed since HSAs were created by the Medicare Modernization Act of 2003 (MMA) and others are more recent. Two such issues that should be tackled are: 1.) the inability of employers or issuers to offer secondary preventive services to enrollees in high deductible health plans either before the deductible is met and/or on a zero dollar cost sharing basis; and 2.) the inability to use HSA/FSA funds to pay for over-the-counter items without a prescription.

Steps Requested:

- Support changes to HSAs that make the accounts more flexible and appealing to consumers and plan sponsors.
- Repeal limitations that require a prescription for individuals to use HSA and FSA funds to purchase over-the-counter (OTC) items.
- Encourage the IRS to expand the HSA preventive care safe harbor to permit for value-based insurance design.

Rationale: Consumerism depends on placing health care spending decisions back into the hands of individuals. To achieve this goal, employers and workers need health plan options that meet their needs and give them personal ownership of their health care dollars. An expansion of the HSA preventive care safe harbor would enable individuals to receive the right care at the appropriate time.

STOP DRUG IMPORTATION

Issue: Repeatedly, members of Congress have tried to change federal law to allow individuals to import price-controlled foreign prescription drugs into the United States. However, allowing individuals to import prescription drugs from foreign countries where they are available at a lower cost is dangerous in two ways: 1.) allowing personal importation of drugs into the U.S. could create a gateway for unsafe, substandard or counterfeit drugs to enter our prescription drug supply; and 2.) allowing individuals to purchase prescription drugs from countries where the cost is lower will cut off the research funding that drug laboratories need to develop the next generation of treatments.

Current Status: Senators and Congressmen frequently introduce amendments and legislation to permit individuals to import drugs from other countries. While there is nothing currently expected on this issue, we remain vigilant on any efforts to permit this legislative change.

Step Requested:

- Oppose proposals that permit importation of drugs.

Rationale: The Food and Drug Administration (FDA) cannot guarantee the efficiency or safety of drugs that re-enter the United States. Such drugs may be adulterated or counterfeit, and jeopardize patient safety.

One of the reasons countries like Canada can impose price controls on their drugs is that much of that multi-billion-dollar investment is made back in the American market. A wave of drug importation would make pharmaceutical investment far less attractive, choking off funding for

researchers who work to develop the next generation of treatments for diseases like cancer and Alzheimer's.

PRESERVE THE NON-INTERFERENCE CLAUSE IN MEDICARE MODERNIZATION ACT (MMA)

Issue: When the Medicare Modernization Act (MMA) was enacted to create a Medicare prescription drug benefit (commonly referred to as Medicare Part D), it included a provision known as the non-interference clause, which prohibits the Secretary of Health and Human Services from interfering in the private price negotiations between Medicare Part D plans and drug manufacturers and pharmacies in the program. Despite numerous claims that repealing the non-interference provision will save money, the nonpartisan Congressional Budget Office (CBO) continues to say that: 1.) private Medicare Part D plans can effectively negotiate savings on Medicare drug costs; and 2.) striking the non-interference clause is not likely to achieve any significant savings unless the government also restricts beneficiary access to prescription drugs or fixes prices.

Current Status: Various members of Congress frequently offer amendments or legislation to repeal the non-interference clause. While nothing is currently expected in the next few weeks, we remain vigilant on any efforts to advance this change.

Step Requested:

- Oppose proposals that would attempt to remove the non-interference clause from Part D.

Rationale: The CBO has stated that even if the Secretary of Health and Human Services had the authority to negotiate drug prices, there would be no discernable savings. The Medicare Part D program is a success because the program relies on free market principles such as choice and competition, which has led to lower prices than originally projected.

DEFEND MEDICARE ADVANTAGE (MA)

Issue: Medicare Advantage (MA) reimbursement rates must be stabilized to preserve a program valued by seniors and employers alike. The Chamber opposes reimbursement cuts to the MA program. Every February, the administration issues an annual call letter and notice outlining possible changes in reimbursement or methodology to MA plans for the following plan year. After a public comment opportunity, the administration issues a final notice in April detailing MA changes for the upcoming calendar year.

The Chamber has filed multiple comments on an annual basis in response the Center for Medicare and Medicaid Services' proposed advance notice of methodological changes:

- In response to the annual notice of methodological changes for calendar year 2017:
    - The Chamber filed comments.
    - The Chamber spearheaded comments signed by employer organizations after the notice was issued.
    - The Chamber spearheaded comments signed by state and local Chambers.
    - The Chamber spearheaded comments signed by employer organizations before the advance notice was issued.

    - On April 4, 2016, the administration announced the annual rates and changes for Calendar Year 2017.
- In response to the annual notice of methodological changes for calendar year 2016:
    - The Chamber spearheaded comments signed by employer organizations.
    - The Chamber spearheaded comments signed by state and local Chambers.
    - On April 6, 2015, the administration announced the annual rates and changes for Calendar Year 2016.
- In response to the annual notice of methodological changes for calendar year 2015:
    - The Chamber filed comments.
    - On April 7, 2014, the administration announced the annual rates and changes for Calendar Year 2015.
- In response to the annual notice of methodological changes for calendar year 2014:
    - The Chamber filed comments.
    - On April 1, 2013, the administration announced the annual rates and changes for Calendar Year 2014.

Current Status: The Chamber expects to comment before and again following the February 2017 issuance of an advance notice of methodological changes for calendar year 2018. Our comments will focus on the importance of preserving the ability of MA plans to continue to offer highly valued coverage to Medicare beneficiaries.

Step Requested:

- Stop additional reimbursement cuts and changes to methodology that will undermine the ability of MA plans to continue to provide highly valued coverage.

Rationale: MA plans such as coordinated care plans (e.g., Health Maintenance Organizations, Preferred Provider Organizations), private fee-for-service plans, and/or special needs plans provide for an expanded set of option for beneficiaries. MA plans promote continuity of care and are highly valued by consumers and employers alike.

III. REAUTHORIZE LAWS

Several programs and amendments are up for reauthorization in 2017, which the Chamber expects to support generally. Our role in these reauthorizations has generally consisted of high level support and we expect that will be the case this year as well.

REAUTHORIZE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Issue: The Children's Health Insurance Program (CHIP) is a partnership between the federal government and states and territories to help provide low income children with the health insurance coverage they need. The program improves access to health care and the quality of life for millions of vulnerable children less than 19 years of age. In general, CHIP reaches children whose families have incomes too high to qualify for Medicaid, but too low to afford private health insurance.

Current Status: Originally created under the Balanced Budget Act of 1997, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended funding for the program through FY 2017.

Step Requested:

- Support reauthorization of the Children's Health Insurance Program.

Rationale: The Children's Health Insurance Program has reduced the number of children that are uninsured.

REAUTHORIZE PRESCRIPTION DRUG USER FEE ACT (PDUFA), MEDICAL DEVICE USER FEE AMENDMENTS (MDUFA), GENERIC DRUG USER FEE AMENDMENTS PROPOSALS

Issue: The Prescription Drug User Fee Act (PDUFA) was created by Congress in 1992 and authorizes the Federal Drug Administration (FDA) to collect fees from companies that produce certain human drug and biological products. Since the passage of PDUFA, user fees have played an important role in expediting the drug approval process.

PDUFA must be reauthorized every five years, and was renewed in 1997 (PDUFA II), 2002 (PDUFA III), 2007 (PDUFA IV), and 2012 (PDUFA V). On July 9, 2012, the president signed into law the Food and Drug Administration Safety and Innovation Act (FDASIA), which includes the reauthorization of PDUFA through September 2017. PDUFA V will provide for the continued timely review of new drug and biologic license applications.

Current Status: The current legislative authority for PDUFA expires in September 2017. At that time, new legislation will be required for the FDA to continue collecting prescription drug user fees in future fiscal years. Following discussions with the regulated industry and periodic consultations with public stakeholders, the Federal Food, Drug, and Cosmetic Act directs the FDA to publish the recommendations for the reauthorized program in the Federal Register, hold a meeting at which the public may present its views on such recommendations, and provide for a period of thirty days for the public to provide written comments on such recommendations. The FDA will then consider such public views and comments and revise such recommendations as necessary.

Step Requested:

- Respect the negotiated deals between pharmaceutical industry and the Food and Drug Administration.

Rationale: The FDA and the pharmaceutical industry have thoughtfully reached agreement on a set of principles spelled out in the Prescription Drug User Fee Act, Medical Device User Fee Amendment, and Generic User Fee Amendment frameworks. Any proposals to further reopen negotiations would jeopardize these agreements and lead to delays in drug market approval.

IV. REFORM UNSUSTAINABLE ENTITLEMENT PROGRAMS

The Chamber has been campaigning for years to tell the truth to the American people about the unsustainability of our country's entitlement programs. Government agencies from the Social Security Trustees to the General Accountability Office have been sounding the alarm for many, many years. Think tanks and academic researchers have done so as well. Some members of Congress have occasionally and courageously added their voices to the chorus, much to the dismay of some of their colleagues.

The Chamber understands that the Social Security, Medicare, and Medicaid programs, all of which we strongly support, have complicated problems, both structurally and politically. We understand the problems with these programs go beyond setting them on a sound financial footing for future generations. We understand these problems have been allowed to build and fester over many years and so correcting them all in a single Congress is probably beyond a reasonable expectation. However, we expect to see real progress in the coming Congress.

REFORM MEDICARE & MEDICAID

Issue: The Congressional Budget Office in its regular updates to the economic and budget forecast and in its annual long-term budget update have told the tale of fiscal imprudence repeatedly and well for years. The federal government's fiscal policies are simply not sustainable, largely because the entitlement programs are not sustainable in their current form. Mandatory spending currently comprises about 70 percent of the federal budget. If overall spending levels hold, entitlement spending and interest on the debt will account for 98 percent of all federal revenue by 2026. This leaves only 2 percent for discretionary spending without running a deficit, according to Congressional Budget Office projections. Absent a change in policy, the CBO predicts a return to trillion-dollar deficits, almost entirely because of an aging population, rising health care costs, and projected interest rate hikes.

Current Status: According to the 2016 Centers for Medicare and Medicaid Services (CMS) Trustees' report, Medicare spent $647.6 billion on medical services for America's seniors but only collected $323.7 billion in payroll taxes and monthly premiums. Medicaid expenditures including additional items such as administrative costs, accounting adjustments, or the U.S. Territories, totals $552 billion in FY 2015.

Steps Required:

- Advance advocacy efforts that reflect our general health policy priorities such as broader choice and competition, greater quality and efficiency in care delivery and financial sustainability.
- Push for broader entitlement reform more generally, in order to preserve the system's long-term viability, and supporting a new reimbursement model that rewards quality and efficiency.

Rationale: As the Chamber has historically done, we recommend that our focus with regard to entitlement reform remain on advancing general goals to: preserve choice and competition for beneficiaries, reduce unnecessary costs, and improve quality of care and outcomes. Efforts at the highest levels of the Chamber to address entitlement reform have focused and should continue to focus on the need for a holistic conversation *after* consensus is reached that the programs are not sustainable. Any efforts to advance reform priorities before this consensus will be futile.