



The Congressional Health Care Caucus

Congressman Michael C. Burgess, MD, Chairman

The mission of the Congressional Health Care Caucus is to serve as resource for both Members and staff and present them with accurate and timely information on all issues surrounding health policy, and offer support in equipping them with resources to guide and educate the American people.

About the Caucus

Since its foundation at the start of the 111th Congress by Representative Michael C. Burgess, M.D. (R-Texas), the Congressional Health Care Caucus has been aggressive in educating Republican Members and staff about targeted issues of health care policy. Through events, resources, and information, the Health Caucus has fostered a more informed health care debate.

The Health Caucus' signature event is the Policy Forum, which brings important thought leaders together to discuss a wide array of topics. Policy Forums are always open to the public and are webcast live via the Internet. These events have highlighted everything from the process and likelihood of budget reconciliation in the Senate to the options for making health care better and more affordable.

In addition to Policy Forums, the Health Caucus hosts Member Briefings. These briefings cover a variety of topics and were moderated by authors, former Administration officials and think tank executives. Each of these briefings are off-the-record and allow Members to brainstorm new ideas and ask questions of other Members without the media present.

While the majority of the Caucus' activity occurred in Washington, DC, Chairman Burgess does not want the message to end once it has reached the boundaries of the Beltway. He also traveled back to Texas and hosted several events with business owners and physicians. In addition, he hosted business roundtables with local business leaders to discuss their questions and concerns regarding the changes they will face under the law. These events highlighted the complexity of the law and the detrimental side effects many provisions of the law can have.

In addition to our popular events, the Health is an indispensable resource to staffers, providing up-to-the-minute information on legislation or one-on-one assistance. Similarly, the Caucus' website has become a destination for tens of thousands of Americans seeking to learn more about health care policy and the debate inside the Beltway.

This Year in Health Care

December 19, 2009

Senator Reid secures his 60th vote to ensure health care passage in the Senate

December 24, 2009

The Senate passes H.R. 3590 on Christmas Eve

January 19, 2010

Scott Brown is elected in a special election erasing the Democrats supermajority

February 25, 2010

President Obama hosts a televised health care summit at Blair House

March 11, 2010

Senator Reid announces his decision to use reconciliation to pass the health care bill

March 21, 2010

By a vote of 219-212 the House passes H.R. 3590

March 23, 2010

The *Patient Protection and Affordable Care Act* is signed into law by President Obama

An Overview of Events in 2010

1-20-2010 Member only briefing

Bob Moffit, *The Heritage Foundation*

2-23-2010 Member only briefing

Rep. Darrell Issa

3-9-2010 Policy forum

Jim Frogue, *Center For Health Transformation*
Dennis Smith, *Former Director of Medicaid for CMS*
Dr. Chris Kryder, *CEO, Verisk Health*

3-16-2010 Member only briefing

Senator Tom Coburn
Senator John Barrasso

4-20-2010 Policy forum

James Gelfand, *U.S. Chamber of Commerce*
Michelle N. Dimarob, *Manager of Legislative Affairs for NFIB*

4-27-2010 Member only briefing

Dr. Robert Hertzka, *Former President of the California Medical Association*
Dr. Peter Lavine, *Medical Society of the District of Columbia*

5-4-2010 Policy forum

Linda Fishman, *Senior Vice-President, Public Policy Analysis & Development, American Hospital*
Leigh Burchell, *Director of Government Affairs for Allscripts*

5-12-2010 Member only briefing

Mark Pauly, Ph.D., *Professor and Author, Health Reform Without Side Effect*

6-9-2010 Republican Thought Leaders Series (public forum)

Governor Mitch Daniels

6-15-2010 Member only briefing

Peter J. Hansen, *Put the Patient in Charge. Repeal Obamacare, level the playing field, and bend the cost curve (really!)*

7-13-2010 Policy forum

John O'Shea, *The Heritage Foundation*
Peter Lavine, *DC Medical Society*

7-19-2010 Policy forum

Merrill Matthews, *Institute for Policy Innovation*
Dr. Craig Kessler, *Professor of Medicine and Pathology, Georgetown University*
Dr. Marc Cohen, *Chief of the Division of Cardiology, Newark Beth Israel Medical Center*

7-20-2010 Member only briefing

Roy Ramthun, *President of HSA Consulting Services, Former Health Care Policy Advisor to the White House under President Bush*

7-27-2010 Republican Thought Leaders Series

Representative Mike Pence

8-17-2010 Policy forum – Flower Mound

Bobby Hillert - *Executive Director at Texas Physician Hospitals Advocacy Center*
David May - *President of the American College of Cardiology, Texas Chapter*

8-18-2010 Policy forum – North Hills

Laura Stromberg, *National Federation of Independent Business*
Sally Bustamante, *Bates Containers*
Lisa Wilborg, *Peterbilt*

8-18-2010 Policy forum – Denton

Laura Stromberg, *National Federation of Independent Business*
Sally Bustamante, *Bates Containers*
Lisa Wilborg, *Peterbilt*

8-19-2010 Policy forum – Denton

Dr. Burgess at Denton Chamber of Commerce

9-28-2010 Policy forum

Janet Trautwein, *National Association of Health Underwriters*
Brian Webb, *National Association of Insurance Commissioners*

11-15-2010 – Policy forum

Ed Haislmaier, *The Heritage Foundation*
Brandon Clark, *FrogueClark*
Alissa Fox, *Blue Cross Blue Shield Association*

11-18-2010 – Grace Marie Turner

Grace-Marie Turner, *The Galen Institute*

Policy Forums and Member Only Briefing

Member Only Briefing: Implications of a health plan administered by the Office of Personnel Management (January 20)

Bob Moffit, *The Heritage Foundation and Reagan Administration OPM senior official*

Dan Blair, *Commissioner of the US Postal Regulatory Commission*

Bob Moffit, Director of The Heritage Foundation Center for Health Policy Studies, described how OPM's current role as manager of the Federal Employees Health Benefits plan, which allows plans to compete directly for consumers, differs greatly from the Senate's plan for OPM to administer health plans for private citizens. Under the Senate health bill, OPM would sponsor, and set rates, for two health plans to compete against private insurers.

Dan Blair, former OPM Deputy Director under President Bush, emphasized the importance of the current role OPM holds in managing the internal workings of the federal government. He cautioned that expanding the scope of OPM's obligation may diminish the already overburdened agency's capacity to serve federal agencies.

Policy Forum: Ranking Member Darrell Issa (R-California) on Medical Liability Reform (February 23)

Representative Darrell Issa, *Ranking Member Oversight and Government Reform*

Congressman Issa, Ranking Member of the Committee on Oversight and Government Reform came to present the report titled, "The Failure to Address the Costs of Defensive Medicine in the Health Care Legislation." This report proved what

Republicans have known all along- that defensive medicine is a significant factor that drives up the cost of delivering health care, and must be addressed in any real health care reform proposal.



Congressman Burgess and Issa at the Policy Forum

Policy Forum: Tackling Inefficiencies And Fraud In Government Health Care Systems (March 9)

This policy forum focused on examining existing problems within Medicare and Medicaid and proposing solutions. Health Caucus hosted Jim Frogue, Vice President of the Center for Health Transformation, Dennis Smith, the Managing Director at Leavitt Partners and former Medicaid director at CMS, and Dr. Christian Kryder, primary care physician and CEO of Verisk Health.

Jim Frogue discussed the enormous number of improper payments Medicaid makes annually, citing Government Accountability Office reports that outline thirty years of waste, fraud and abuse in Medicare and Medicaid. Jim provided several examples of extravagant abuse, showing that \$60 billion is stolen from Medicare, and ultimately the taxpayers, every year. One positive note, several solutions to Medicare abuse have gained bipartisan support. Dr. Kryder pointed out that increased oversight and management of Medicare, the type of bottom-

line driven management seen in the private sector, would prevent an enormous amount of abuse. Dr. Kryder proposed two solutions. First, move away from fee-for-service payments in order to shift risk away from providers and maximize care; and secondly, increase the transparency and scrutiny of Medicare claims by placing all claims online, removing only sensitive information.

Dennis Smith agreed with Dr. Kryder's point to shift risk away from providers, and he emphasized that beneficiaries need to take on more risk. His main point was that low quality health care costs more. As Medicare currently functions, the beneficiary takes on zero risk, so they don't have an incentive to question improper payments to providers. Dennis called for increased review of submitted claims, saying that the states and federal government technologies are outdated and incapable of preventing abuse of the Medicare system.

From this forum, we learned that modernization of technology and oversight methods will bring Medicare oversight into the 21st century. Once improper Medicare payments have been made, even if fraud is detected, the funds are nearly impossible to recover. A successful Medicare system will anticipate problems and prevent abuse.

Member Only Briefing: Discussion with the Doctors (March 16)

Senator Tom Coburn, *Senator & Doctor*
Senator John Barrasso, *Senator & Doctor*

The Senators have more than 50 years of combined medical experience and were instrumental in offering Republican alternatives to the health care law. Each Senator was able to offer insight into the OPM administered exchanges, the Cadillac tax and the special deals and carve outs that plagued the health care bill.

Policy Forum: Side Effects of PPACA on Business (April 21)

James Gelfand, *U.S. Chamber of Commerce*
Michelle Dimarob, *National Federation of Independent Business*

After the passing of the Patient Protection and Affordable Care Act, businesses have been confused about how they will be impacted. With companies such as AT&T, Verizon, Caterpillar, and John Deere releasing reports of monetary losses in the millions, businesses both large and small have become nervous about the ramifications the new law will have on them.

James Gelfand, co-manager of the U.S. Chamber's Employee Benefit Committee, addressed the intricacies of the employer mandate and penalties assessed if a company does not provide qualified plans.

Michelle Dimarob, a legislative affairs manager from the National Federation of Independent Business, focused on small business and the forecasted monetary losses due to complicated and restrictive tax credits, increased paperwork and increases in Medicare taxes.



Member Only Briefing: The Patient Response (April 27)

Dr. Robert Hertzka, *Former President of the California Medical Association*

Dr. Peter Lavine, *Medical Society of the District of Columbia*

Dr. Hertzka and Dr. Lavine outlined the complaints and fears they heard from patients as well from other doctors after the passage of PPACA.

One specific concern was the lack of a permanent fix to the SGR. The continued use of “fix-it” legislation to postpone cuts to physicians creates uncertainty and risks access of care for seniors.

They mentioned a recent New England Journal of Medicine survey which revealed how America’s physicians feel about this health reform bill.

A majority of physicians said health-care reform would cause the quality of American medical care to “deteriorate.”

More than 29% of the nearly 1,200 doctors who responded to the survey said they would quit the profession or retire early if health reform legislation becomes law.

Policy Forum: Consumers, Providers, and Suppliers: Concerns over proposed implementation of HIT (May 4)

Don May, *Vice President for Policy at the American Hospital Association*

Leigh Burchell, *Director of Government Affairs for Allscripts*

Health Information Technology (HIT) is an efficient and reliable tool which provides high-quality care to patients and has been proven to reduce errors as well as costs. Specifically, HIT is used to store health information electronically, facilitate clinical decision making and simplify clinician workflow.

The American Reinvestment and Recovery Act (ARRA), also known as the stimulus, allocated money to be given to hospitals and doctors to implement HIT. To qualify, you had to be deemed a “meaningful users.”

The proposed criteria, put forth by CMS, for physicians and hospitals to become “meaningful users” was unrealistic, and the rule proposed an ambitious all-or-nothing approach

Member Only Briefing: Making Markets Work (May 12)

Mark Pauly, Ph.D., *Professor and Author, Health Care Reform Without Side Effects*



Congressman Burgess and Dr. Pauly

Dr. Pauly spoke to Members about alternatives to the *Patient Protection and Affordable Care Act*. He highlighted free market principles that could be implemented which would allow more Americans to become insured as well as bend the cost curve down.

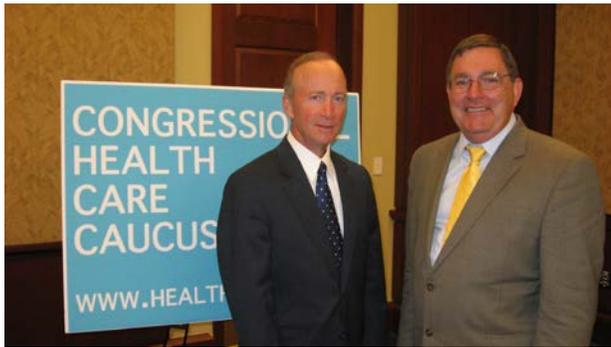
Alternatives like these presented by Dr. Pauly prove there are other ways to reform health care without a government take over.

Republican Thought Leaders Series: Governor Mitch Daniels (June 9)

Mitch Daniels, *Governor of Indiana*

The Republican Thought Leaders Series begun as an outlet to allow influential leaders to share their thoughts on health care and offer insight into how they would have handled it, had they been in charge.

Governor Daniels outlined his decision to implement Health Savings Accounts (HSA) in Indiana and highlighted the savings incurred by their state.



Governor Mitch Daniels and Congressman Burgess

He discovered when people were in charge of their health care, they were more conscious consumers – leading to savings for individuals and the state.

The state of Indiana is projected to save \$20 million in 2010 and see an 11% drop in health spending costs.

Unfortunately, the health care law places penalties on those with HSAs including no longer being able to purchase over-the-counter medicine with your HSA.

In addition, another negative side effect which has already been seen – the closing of nHealth, a health insurance company built around the HSA model.

nHealth cited uncertainties in the insurance market created by the federal health care legislation made the company unsustainable.

Members Only Briefing: Author and Health Care Commentator: Peter J. Hansen (June 15)

Peter J. Hansen, *Put the Patient in Charge. Repeal Obamacare, level the playing field, and bend the cost curve (really!)*

Mr. Hansen presented Members with a unique insight into how the cost curve can be bent down without creating a government takeover of health care. His critique of the *Patient Protection and Affordable Care Act* echoed what people around the country had feared: increased costs, access to care problems and widening the scope of the government.

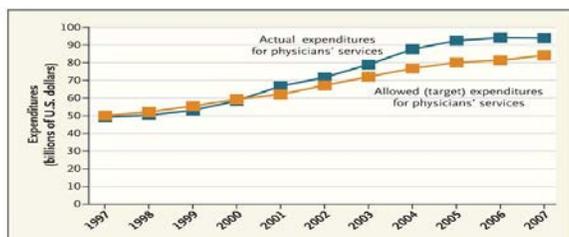
Policy Forum: Fixing the Sustainable Growth Rate (July 13)

John O'Shea, *The Heritage Foundation*
Peter Lavine, *DC Medical Society*

The Sustainable Growth Rate is putting physicians caring for Medicare patients in a terrible position, and without a permanent fix many doctors will be required to cut their number of Medicare patients or, in the most dire of circumstances, some might be forced to close their doors. This problem gets exponentially worse when a temporary fix is enacted instead of a permanent solution. The numbers speak for themselves: It will cost \$210 billion today for a 10 year freeze on payments, and if we wait another 5 years, costs could surpass \$500 billion for a complete overhaul.

Some are worried a permanent fix will increase the deficit too much; however, Chairman Burgess argues this money has already been spent, and it will take the leaders of 112th Congress to act boldly, and make it their priority to end SGR.

Dr. John O'Shea, a former Health Policy Fellow at The Heritage Foundation, suggests if this problem is not resolved, broader health reform initiatives would not be successful. He proposes that too many solutions focus solely on price. If you look at spending it is the cost of the services times the volume, and unless you control both, there will not be a workable solution. Trying to control only one of the factors has been attempted, and has not been successful. He also suggested quality measures to be instituted by the specialty societies or state medical societies, since the closer you can get to the people that will use them the more relevant it will be.



Dr. Lavine, the president of the DC Medical Society, advocates that the Medicare payment could be a floor or a base, and then physicians could privately contract with patients. They would bill each patient more or less than Medicare would allow based on a patient's need. Unfortunately, this is currently illegal in the Medicare system. He also acknowledges that engaging the patient in decisions is important, and assuring the patient knows the cost of each service would help deter unneeded and costly tests. Both panelists agree there is not one easy solution, and concluded Medicare is not getting cheaper and costs will not go down.

Policy Forum: Biosimilars and the Implications of Future Regulations (July 19)

Merrill Matthews, *Institute for Policy Innovation*
Dr. Craig Kessler, *Professor of Medicine and Pathology, Georgetown University*
Dr. Marc Cohen, *Chief of the Division of Cardiology, Newark Beth Israel Medical Center*

Merrill Matthews, along with contributing doctors, presented a paper on biosimilars and their impact on the future of medicine. They also addressed the process of approving biosimilars through the FDA. The *Patient Protection and Affordable Care Act* failed to address a clear path for biosimilars to move through the process to the market. The main concern is the safety of biosimilars since duplicating these drugs is much more complicated than commonly manufactured generic drugs.

Member Only Briefing: The Benefits of Health Savings Accounts (July 20)

Roy Ramthun, *President of HSA Consulting Services, LLC*

Roy Ramthun is an expert in Health Savings Accounts (HSA). He led the US Treasury Department in the implementation of HSAs after they were signed into law in 2003, as well served as health care policy advisor to the White House under President Bush. Members in attendance were very interested in continued action regarding HSAs. Mr. Ramthun highlighted the benefits of HSAs, including how cost effective they can be, and exhibited how contrary to popular belief, the majority of users are middle aged.

Concerns were raised about the harm HSAs could face during the regulation process of the *Patient Protection and Affordable Care Act* signed into law this past March. Many feared rules would be written to exclude HSAs as being considered a qualified plan under the individual mandate going into effect in 2014. Currently, the law has been written to prohibit HSAs from being allowed to be used on over the counter medicine. In order to use a HSA to purchase medicine, one would need to go to the doctor and obtain a prescription leading to more patients wanting to see their doctor more often.

Thought Leaders Series:

Representative Mike Pence (July 22)

Congressman Mike Pence, *Member of Congress from Indiana*

Congressman Pence, another in the Thought Leaders series, shared his ideas for health care reform. He emphasized that although the Democrats may have thought the reform debate was over, it wasn't. One provision that was left out from the law was the ability to purchase insurance across state lines. He pointed out that many small businesses would like to be able to cover their employees; however, they lack options in their area. By opening up the market place prices will fall and more people will be able to be covered.



He argued that Democrats solely focused on universal coverage, no matter the cost, while Republicans targeted lowering the cost of insurance to make it more accessible to Americans – ultimately covering more people without growing the government.

Moving forward he supported the repeal of the *Patient Protection and Affordable Care Act* and replacing it was a targeted reform which expanded health savings accounts and tort reform.

District Policy Forum: PPACA and the End of Physician Owned Hospitals (August 17)

Bobby Hillert, *Executive Director of Texas Physician Hospital Advocacy Center*

David May M.D., Ph.D, *President of the Texas Chapter of American College of Cardiology*

Texas Health Presbyterian Hospital Flower Mound hosted the Congressional Health Care Caucus to discuss the impact of health reform on physician owned hospitals. This law adversely impacted these hospitals, inhibited growth and, in some cases, halted construction leaving shells of buildings. PPACA mandates that the percent of physician ownership or investment in a hospital may not be increased at any time after March 23, 2010, and the number of operating rooms, procedure rooms and beds for which a hospital is licensed may not be increased at any time after March 23, 2010.

This hospital was at risk of not being able to open its doors since it did not have a Medicare provider number as of the signing of the law. Fortunately, CMS regulations extended the time period to obtain a Medicare provider number allowing the hospital to open its doors.

Both Mr. Hillert and Dr. May stressed the importance of physician owned hospitals and their necessity as more people gain insurance coverage or qualify for Medicaid. They fear Americans will not be find care if hospitals like this one are not able to expand as need increases.

District Policy Forum: Local Response to Health Care Reform (August 18)

Laura Stromberg, *National Federation of Independent Business*
Sally Bustamante, *Bates Containers*
Lisa Wilborg, *Peterbilt*

Local small businesses and constituents were concerned about the health care law, how it will affect them, their families and their businesses.

Laura Stromberg discussed how various provisions of law will directly affect businesses. The 1099 form - requiring all businesses to complete a tax form for all transactions over \$600 - was widely discussed. The NFIB estimated it would cost small businesses an extra \$72 an hour to uphold this section of the law. She also discussed the employer mandate and how many businesses fear this could force them to close their doors due to steep costs.



Sally Bustamante and Lisa Wilborg both represented companies who have had to begin implementing certain provisions of the law to avoid receiving a penalty.

They stressed the extra man hours needed to scour details of the law and recent regulations as well as updating their insurance plans to ensure they comply with PPACA.

Each woman noted they will be forced to raise the premiums of their employees in order to keep up to day and in compliance.

District Policy Forum: Speaking to the Denton Chamber of Commerce (August 19)

Congressman Michael C. Burgess, M.D.

Congressman Burgess led a discussion with the Denton Chamber of Commerce on health care implementation. This candid conversation allowed local residents to express their approval of the law, disapproval, concerns and ask questions in an open setting.

Many constituents spoke out against the law and their disapproval of the way it was passed without any Republican support.

Congressman Burgess also displayed two visual aids that displayed the new federal agencies that will be created as well as a timeline of implementation. Most North Texans were outspokenly opposed the expanding federal bureaucracy and breadth of the government as a result of the PPACA.

Policy Forum: Medical Loss Ratio (September 28)

Janet Trautwein, *National Association of Health Underwriters*
Brian Webb, *National Association of Insurance Commissioners*

The medical loss ratio (MLR) is the formula that determines the percentage of health insurance premiums that insurers must use to provide health care to their customers versus the amount used to

pay expenses that do not directly benefit policyholders, such as salaries, administrative costs, advertising, agent commissions, and profits.

The *Patient Protection and Affordable Care Act* outlined guidelines for insurers that required large insurers to spend at least 85 percent of premiums on medical care, while smaller plans would have to spend at least 80 percent.

Brian Webb from the National Association of Insurance Commissioners worked in collaboration with the Department of Health and Human Services to determine which expenses constitute patient care, and which should be categorized as administrative expenses.



Congressman Burgess at the MLR forum

The debate surrounding MLR has focused on what costs should be classified as medical care and which are administrative.

Some are worried about this creating a superficial way to regulate care and expressed concern over how far the regulations will reach.

Policy Forum: The Implementation of State Exchanges (November 15)

Ed Haislmaier, *The Heritage Foundation*

Brandon Clark, *FrogueClark*

Alissa Fox, *Blue Cross Blue Shield Association*

The *Patient Protection and Affordable Care Act* mandates the creation of state exchanges by the year 2012.

Exchanges will not be insurers, but will provide qualified individuals and small businesses with access to insurers' qualified health plans in a comparable way and will be regulated by the government.

The Congressional Budget Office estimates 29 million Americans will be enrolled in the exchanges.

Alissa Fox from Blue Cross Blue Shield advocated for the state development of exchanges to facilitate coverage in a manner that makes it easy for consumers and small employers to shop, compare and enroll in coverage that best meets their needs.

Brandon Clark highlighted the ramifications of an expected 16 million people added to the Medicaid program. State exchanges are required to automatically enroll all Medicaid-eligible individuals into Medicaid.

The states face many choices when it comes to implementing their exchanges; however, not all the regulations have been written and have expressed concern that they will not be ready in 2012.

Member Briefing: Health Care in the 112th Congress (November 18)

Grace-Marie Turner, *The Galen Institute*

Grace-Marie met with current Members and recently elected Members to discuss the future of the health care debate under the majority Republican House. They debated strategy, future legislation, oversight and the funding of the law.

Frequently Asked Questions

The *Patient Protection and Affordable Care Act* contained over 2000 pages of technical legislation and contained mandates that could change the health care Americans receive. The Congressional Health Care Caucus is dedicated to providing straight forward and accessible answers to Americans and help them answer challenging and complex questions. Below are frequently asked questions which have stemmed from the signing of the law.

What if I am uninsured?

Is there a way to receive free insurance under the law?

No – However, there are expanded options - most not beginning until 2014 - for those who qualify, through Medicaid and tax credits available through Insurance Exchanges that can help the uninsured purchase coverage

January 1, 2014 – States must expand Medicaid eligibility to all individuals under 65 with family incomes below 133% of the Federal Poverty Level - 14,404 for individuals and \$29,326 for a family of four, according to current poverty guidelines

January 1, 2014- States must have created at least one insurance “American Health Benefits Exchange,” which would sell health insurance to individuals and small employers regardless of preexisting conditions

- Policy prices only may vary due to family structure, geographic location and tobacco use

I am uninsured, what are the ramifications for remaining uninsured?

January 1, 2014 – Individuals must maintain qualified insurance coverage for themselves and their dependants or pay a new penalty. Those who fail to comply will pay a fine each month they are in non-compliance

- Penalty can be up to \$695 or 2.5% of income, whichever is greater

I am uninsured due to a preexisting condition.

June 21, 2010 – Deadline for the Secretary of Health and Human Services (HHS) to establish a \$5 billion high risk pool that will work in conjunction or alongside current state high risk pools to provide coverage to people who had been without coverage due to a preexisting condition. To qualify a person must:

- Have been without coverage for more than 6 AND
- Have a preexisting condition as defined by HHS

July 1, 2010 – Deadline for the Secretary of Health and Human Services (HHS) establish a web site through which you can search health coverage options including private insurance, Medicaid and State high-risk pools

September 23, 2010 - Insurers may not deny coverage to a dependent child under age 19 because of preexisting condition

January 1, 2014 – Insurers cannot deny coverage due to a preexisting condition

I have been kicked off my parent’s insurance plan due to graduation from college, age, ineligibility, etc.

September 23, 2010 – All insurance companies must allow “children” to stay on their parent’s health plan until age 26. Be aware your premiums may increase as well as:

- A child cannot be eligible if they are offered an employer sponsored health plan (until 2014)
- A company must have previously offered coverage to dependants
- Not eligible if married and insurance is offered through the spouse's place of employment

My employer does not offer insurance due to the cost.

January 1, 2010 - A tax credit may be available for some employers from 2010-2013; however, they must qualify under specific guidelines. It is estimated that only 12% of businesses will qualify

- To get the maximum 35% credit, the employer must:
 - Have 10 or fewer employees
 - Pay 50% of the premium of the insurance
 - Average annual income of \$25,000 or less
- Smaller tax incentives are for companies who:
 - Have less than 25 employees
 - Pay 50% of the premium of the insurance
 - Average annual income of \$50,000 or less

January 1, 2014 – Employers with more than 200 full-time employees who offer health benefits must automatically enroll new employees into an offered plan. The employee must opt themselves out

- Companies may find they will pay less by paying the penalty than by providing coverage

Does this law apply to illegal immigrants?

Section 1312 of the *Patient Protection and Affordable Care Act* limits enrollment to those who are lawful residents. Those who are not qualified individuals cannot qualify to purchase insurance from the State Exchanges or receive tax credits. Those who are here without documentation (unqualified aliens) already do not qualify for Medicare or Medicaid*.

* Under the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), unqualified aliens may qualify for limited emergency Medicaid benefits, such as in the case of childbirth and only if they would otherwise qualify for the program if not for their citizenship status. The Deficit Reduction Act of 2005 established guidelines which required Medicaid applicants to show proof of citizenship and identity with the intent to enforce standing law; unfortunately, the Democratic controlled Congress has consistently modified this provision allowing a social security number to suffice as burden of proof

