



PPACA:

**Inside the
Numbers; An
Inconvenient
Truth**

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Agenda

1. Review of Patient Protection and Affordable Care Act
2. Operation of Health Insurance Exchanges and Subsidies
3. Tax Changes
4. Massachusetts Experience with Health Insurance Reform
5. Review of State Litigation Against Federal Government



Overview

The Patient Protection & Affordable Care Act (PPACA) (Pub.L. 111-148):

- Requires most U.S. citizens and legal residents to have health insurance;
- Creates state-based health insurance Exchanges through which individuals and small businesses can purchase coverage with premium and cost sharing credits available between 133% to 400% of the federal poverty level;
- Requires employers to pay penalties for their employees who receive tax credits for health insurance through an Exchange with exceptions for small employers;
- Imposes new regulations on health plans operating through the Exchanges and the individual and small group markets; and
- Represents a major step in the commoditization of health insurance.
 - Commoditization - the process by which a product reaches a point in its development where one brand has no features that differentiate it from other brands, and consumers buy on price alone.



Overview (con't)

- On 3/20/2010 (before passage) non-partisan CBO estimated PPACA to cost over \$1 trillion but cut federal deficit by \$114 billion from 2010-2019.
 - Included \$70 billion positive contribution from Community Living Assistance Services and Supports (CLASS Act).
 - Estimate included assumption that Congress would enact “Doc Fix” to reduce Medicare fee-for-service rates by \$196 billion from 2010-2019.
 - Medicare payments to physicians have been scheduled to be cut each year since 2002, but these cuts have only been implemented once. Since 2003, Congress has taken action each year to prevent the cuts from going into effect. Medicare physician payments were scheduled to be cut by 21 percent starting April 1. Cut would be approximately 30 percent in 2011.
 - On 6/24/2010 Congress passed a 6-month freeze on enacting Doc Fix. Passed 417-1 in the House, and unanimously in the Senate. Congress will reconsider Doc Fix after the November elections.
- On 5/11/2010 CBO issued an estimate of an *additional* \$115 billion in discretionary government spending.
- In reality, PPACA is projected to add to the deficit from 2010-2019. Beyond 2019 – who knows....



Overview (con't)

- On 5/26/2010 Doug Elmendorf, Director of the CBO, made the following points in a presentation to the Institute of Medicine in a presentation entitled “Health Costs and the Federal Budget”:
 - Rising health costs will put tremendous pressure on the federal budget during the next few decades and beyond. In CBO’s judgment, the health legislation enacted earlier this year does not substantially diminish that pressure.
 - CBO has mis-estimated the effects of the changes in law.
 - Some observers think that subsidies will be more expensive than we project.
 - Budget conventions hide or misrepresent certain effects of the law.
 - The legislation will lead to an increase in discretionary spending, which is not included in the estimates mentioned earlier [projecting a decrease in the budget and now estimated at \$115 billion].
 - The law will be changed in the future in ways that will make deficits worse.
 - CBO estimates the effects of proposals as written and does not forecast future policy changes.
 - We have emphasized that the legislation maintains and puts into effect a number of policies that might be difficult to sustain over a long period of time. For example, the legislation reduces the growth rate of Medicare spending (per beneficiary, adjusting for overall inflation) from about 4 percent per year for the past two decades to about 2 percent per year for the next two decades.



Overview (con't)

- By 2019, CBO estimates that PPACA will reduce the number of nonelderly people who are uninsured by about 32 million.
 - 16 million people will be covered by Medicaid and CHIP – **total cost \$427 billion from 2014-2019**
 - 16 million people would purchase coverage or receive coverage through employer – **total cost \$459 billion from 2014-2019**
- 23 million nonelderly residents would still be uninsured (about one-third of whom would be illegal immigrants).
- The percentage of nonelderly residents with insurance would rise from 83 percent to 94 percent.



PPACA Is Over 2,700 Pages Long But Omits the Details

The devil is in the details,
The details are in the regulations,
The regulations (mostly) don't exist!





Timeline



Healthcare Reform Timeline

- Tax credits for small businesses
- Starts to close Medicare Part D Prescription "Doughnut Hole"
- Increases investment in primary care physician training programs
- Imposes indoor tanning service tax
- Funding will be available to establish a non-profit Patient-Centered Outcomes Research Institute.

- No pre-existing coverage insurance exclusions for children
- Increases dependent coverage
- Eliminates lifetime caps on coverage
- Protects insurance rescission
- Bans new physician-owned hospitals in Medicare, requiring hospitals to have a provider agreement in effect by December 31, 2010 and limits the expansion of grandfathered physician-owned hospitals

- Allows providers organized as accountable care organizations (ACOs) to share in cost savings
- Establishes a hospital value-based purchasing program
- Reduces Medicare payment for hospitals with excess readmission rates
- Establish Medicare pilot program to evaluated bundled payments
- Creates the Medicare Independence at Home demonstration program

- Prohibits health plans from denying coverage to anyone with a preexisting condition
- Expands Medicaid to 133% of the FPL
- Opens health insurance exchanges in states that have none.
- Provides Individual health care tax credits for people between 100% and 400% of the FPL
- Individual insurance mandate penalties begin
- Employers with more than 50 employees insurance penalties begin
- Limits any waiting periods for coverage to 90 days
- Reduces Medicare Disproportionate Share Hospital (DSH) payments
- Imposes fees on the health insurance industry
- Permits employers to offer employees rewards for participating in a wellness program

2010
Effective Immediately

September 2010-December 31, 2010
Effective 6 months after Implementation

2012

2014

June 2010
Effective 90 days after Implementation

- Implements temporary affordable coverage for the uninsured with pre-existing conditions
- Provides re-insurance for retiree health benefit plans

2011

- Imposes new fees on the pharmaceutical manufacturing industry
- Awards five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations
- Provides grants to small employers that establish wellness programs
- Provides 10% Medicare bonus for primary care physicians and general surgeons. (2011-2015).
- Develops a national quality improvement strategy
- Establishes a new trauma center program

2013

- Begins phasing-in federal subsidies for brand-name prescriptions filled in the Medicare Part D "doughnut hole"
- Requires disclosure of financial relationships between health entities and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies
- Increases the Medicare tax rate on "high-income" earners by 0.9%
- Imposes an excise tax of 2.3% on medical devices

2015 and later

- Creates physician value based payment program
- Establishes Independent Payment Advisory Board
- Implements high cost "Cadillac" plan tax (2018)



Operation of Health Insurance Exchanges

- Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges.
- Exchanges are administered by a government agency or non-profit organization through which individuals and small businesses with up to 100 employees can purchase qualified coverage.
- Beginning in 2017, states can open the SHOP Exchanges to businesses with more than 100 employees.
- If a state fails to set-up the Exchanges by 1/1/2014 HHS will establish and operate the Exchange.
- Insurers may be required to participate in the Exchanges – waiting for further rule making.



Operation of Health Insurance Exchanges (cont'd)

Exchanges will:

- be funded by assessments or user fees on participating insurers;
- certify whether health plans are qualified to be offered in the Exchange, including examining their premium increases - \$250 million allocated for grants to states for premium increase reviews; 46 states received \$1m grants to review “unreasonable premium increases.”
- require of plans and make public disclosure of the following information in plain language: claims payment policies and practices; periodic financial disclosures; data on enrollment, denied claims, and rating practices; information on cost sharing and payments for out-of-network coverage; and enrollee and participant rights;
- require qualified health plans to make available timely information about the amount of cost sharing for specific items or services;



Operation of Health Insurance Exchanges (cont'd)

Exchanges will (cont'd):

- operate a toll-free telephone assistance hotline;
- maintain an Internet website where enrollees can obtain standardized comparative information about the health plans offered through the Exchange;
- assign a rating to each health plan in the Exchange based on the relative quality and price of their benefits;
- use a uniform enrollment form and a standardized format for presenting health benefit plan options;
- inform people about the eligibility requirements for the Medicaid, CHIP or other State or local public programs and coordinate enrollment procedures with them; and
- make available an electronic calculator to determine the actual cost of coverage after any premium tax credit and any cost-sharing reduction has been applied.



Operation of Health Insurance Exchanges (cont'd)

- Public Plan Option
 - Office of Personnel Management is required to contract with insurers to offer at least two multi-state plans in each Exchange.
 - At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law.



Operation of Health Insurance Exchanges (cont'd)

- Consumer Operated and Oriented Plan (CO-OP)
 - Creates the CO-OP program to foster the creation of non-profit, member run health insurance companies in all 50 states to offer qualified health plans.
 - \$6 billion has been allocated to finance the program and award loans and grants to establish co-ops by 7/1/2013.



Operation of Health Insurance Exchanges (cont'd)

- Insurer's rating flexibility is restricted in the Exchanges.
 - Rating variation based on age is limited to 3:1 and tobacco use is limited to 1.5:1 in the Exchange *and* in the individual and small group markets *outside* the Exchange.
 - Exchanges are required to offer four benefit categories plus a separate catastrophic plan available only to those individuals who are under 30 years old.
- Plans must include essential health benefits:
 1. ambulatory patient services
 2. emergency services
 3. hospitalization
 4. maternity and newborn care
 5. mental health and substance use disorder services (including behavioral health treatment)
 6. prescription drugs
 7. rehabilitative and habilitative services and devices
 8. laboratory services
 9. preventive and wellness services and chronic disease management
 10. pediatric services (including oral and vision care).



Operation of Health Insurance Exchanges (cont'd)

- Bronze Plan represents the minimum credible coverage and provides essential health benefits. It covers 60% of the expected benefit costs of the plan with an out-of-pocket limit equal to the HSA amount (currently \$5,950 for individuals and \$11,900 for families in 2010).
- Silver Plan provides the same benefits but covers 70% of the benefit costs with the HSA out-of-pocket limits.
- Gold Plan provides the same benefits but covers 80% of the benefit cost with the HSA out-of-pocket limits.
- Platinum Plan provides the same benefits but covers 90% of the benefit costs with the HSA out-of-pocket limits.
- Insurers participating in the Exchanges must offer at least a Silver and Gold plan.



Subsidies in Health Insurance Exchanges

- Premium tax credits to lower total cost of insurance. Credits are refundable and advanceable – calculated on second lowest cost Silver level plan:

Income Level	Premium as a % of Income
Up to 133% of FPL	2% of income
133-150% of FPL	3-4% of income
150-200% of FPL	4-6.3% of income
200-250% of FPL	6.3-8.05% of income
250-300% of FPL	8.05-9.5% of income
300-400% of FPL	9.5% of income

- Beginning in 2015 above percentages are increased to reflect the excess of premium growth over income growth.
- 2009 Federal Poverty Level (FPL) = \$10,830 for an individual, \$22,050 for a family of 4.



Subsidies in Health Insurance Exchanges (cont'd)

- Provide cost-sharing subsidies to eligible individuals and families. The cost-sharing subsidies reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of a Silver benefit plan to the following percentages for the specified income level:

Income Level	Actuarial Value
100-150% of FPL	94%
150-200% of FPL	87%
200-250% of FPL	73%



Subsidies in Health Insurance Exchanges (cont'd)

- The out-of-pocket limits are reduced for those with incomes up to 400% of the FPL and who enroll in a Silver level plan:

Income Level	Reduction in Out-of-Pocket Liability to:
100 - 200% FPL	One-third of the HSA Limits (\$1,983 individual and \$3,967 family)
200 - 300% FPL	One-half of the HSA Limits (\$2,975 individual and \$5,950 family)
300 - 400% FPL	Two-thirds of the HSA Limits (\$3,987 individual and \$7,973 family)

- The out-of-pocket reductions are applied within the actuarial limits of the plans and will not increase the actuarial value of the plan.
- Current HSA limits are \$5,950 single / \$11,900 family.



Subsidies in Health Insurance Exchanges (cont'd)

Following is an example of how the Exchange subsidies will work for a family of four with a household income of 250% of FPL (\$58,562 in 2014):

- Average Silver plan (70%) annual plan premium: **\$14,245**
- Cap on premiums as a % of income: **8.05%**
- Adjusted family premium payment: **\$4,714 (\$393 month) / gov. subsidy of \$9,531 (\$794 month) or 67% of premium.**
- Cost sharing subsidy would raise actuarial value to **73%** (plan would pay a higher share of covered benefits)
- Annual out of pocket limit: **\$6,250** (50% of HSA limit – est. \$12,500)

Source: <http://healthreform.kff.org/SubsidyCalculator.aspx>



Subsidies in Health Insurance Exchanges (cont'd)

- CBO estimates that approx. 24 million people will purchase coverage through an Exchange and be eligible for subsidies.
 - An additional 5 million people will buy coverage in the exchange but will not be eligible for subsidies.
- CBO estimates that 5 million people will leave individual market to purchase through an Exchange; that 8-9 million people will no longer get coverage through their employer; and that 6-7 million people will be added to employer coverage.
 - Companies are already considering the benefits of dropping coverage (AT&T, Caterpillar, Verizon).
- CBO estimates premium and cost sharing subsidies to cost \$459 billion from 2014-2019 - \$6,000 per subsidized enrollee per year!
- Given the limited cost to employers for dropping coverage and the generous subsidies, these costs may be drastically underestimated. (avg. household income in 2008 was \$68,424; 2/3 of households had income under \$75,000).



Tax Changes

- Insurers are required to pay an annual fee based on market share:
 - \$8,000,000,000 in 2014
 - \$11,300,000,000 in 2015 to 2016
 - \$13,900,000,000 in 2017
 - \$14,300,000,000 in 2018

Non-profit plans only count 50% of premium. After 2018, the fee is based on the previous year's fee times the rate of premium growth. Expected to raise \$60.1 billion.

Smaller annual fees on drug manufacturers expected to raise \$27.0 billion.

- In 2008, health insurance industry was 86th in profit margin and earned about \$18 billion in profits.



Tax Changes (cont'd)

- Limit deductibility of executive and employee compensation to \$500,000 per applicable individual for health insurance providers - raise \$.6 billion. (effective 1/1/2009)
- Impose a 10% tax on the amount paid for indoor tanning services – raise \$2.7 billion. (effective 7/1/2010)
- Impose an excise tax of 2.3% on the sale of any taxable medical device – raise \$20.0 billion. (effective for sales after 12/31/2012)
- Require all businesses to issue a 1099 to any entity from whom they purchased more than \$600 of products or services in a year – raise \$17.1 billion. (effective 1/1/2012)



Tax Changes (cont'd)

- Impose an excise tax on insurers of employee-sponsored health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage indexed to the CPI-U for years beginning in 2020 (the so-called Cadillac tax) – raise \$32.0 billion. (effective 1/1/2018)
 - Taxes equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy which, in the case of a self-insured plan, is the plan administrator or in some cases the employer.
- Increases the Medicare Part A tax rate on wages from 1.45% to 2.35% on earnings over \$200,000 for individuals and \$250,000 for couples and imposes a 3.8% tax on unearned income for higher income taxpayers – raise \$210.2 billion. (*thresholds are not indexed* - effective 1/1/2013)



Tax Changes (cont'd)

- Small business tax credits provide a tax credit to employers with no more than 25 employees and average annual wages of less than \$50,000 that purchase health insurance for employees – cost \$37 billion.
 - Phase 1:
 - For tax years 2010 through 2013, provides a tax credit of up to 35% of the employer's contribution if the employer contributes at least 50% of the total premium.
 - Full credit is available to employers with 10 or fewer employees and average annual wages of less than \$25,000.
 - Phase 2:
 - For tax years 2014 and later, eligible small businesses that purchase coverage through an Exchange receive a tax credit of up to 50% of the employer's contribution if the employer contributes at least 50% of the total premium.
 - Full credit is available to employers with 10 or fewer employees and average annual wages of less than \$25,000.
 - Credit will be available for two years.
- Shareholders of 2% or more of an S Corp or 5% of a C Corp are excluded for purposes of calculating and determining the credit. Family members are also excluded.



Table I. Small Business Tax Credit as a Percent (Maximum of 35%) of Employer Contribution to Premiums, For-Profit Firms in 2010-2013 and Nonprofit Firms in 2014+

Firm size	Average wage					
	Up to \$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
Up to 10	35%	28%	21%	14%	7%	0%
11	33%	26%	19%	12%	5%	0%
12	30%	23%	16%	9%	2%	0%
13	28%	21%	14%	7%	0%	0%
14	26%	19%	12%	5%	0%	0%
15	23%	16%	9%	2%	0%	0%
16	21%	14%	7%	0%	0%	0%
17	19%	12%	5%	0%	0%	0%
18	16%	9%	2%	0%	0%	0%
19	14%	7%	0%	0%	0%	0%
20	12%	5%	0%	0%	0%	0%
21	9%	2%	0%	0%	0%	0%
22	7%	0%	0%	0%	0%	0%
23	5%	0%	0%	0%	0%	0%
24	2%	0%	0%	0%	0%	0%
25	0%	0%	0%	0%	0%	0%



Table 2. Small Business Tax Credit as a Percent (Maximum of 50%) of Employer Contribution to Premiums, For-Profit Firms in 2014+

Firm size	Average wage					
	Up to \$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
Up to 10	50%	40%	30%	20%	10%	0%
11	47%	37%	27%	17%	7%	0%
12	43%	33%	23%	13%	3%	0%
13	40%	30%	20%	10%	0%	0%
14	37%	27%	17%	7%	0%	0%
15	33%	23%	13%	3%	0%	0%
16	30%	20%	10%	0%	0%	0%
17	27%	17%	7%	0%	0%	0%
18	23%	13%	3%	0%	0%	0%
19	20%	10%	0%	0%	0%	0%
20	17%	7%	0%	0%	0%	0%
21	13%	3%	0%	0%	0%	0%
22	10%	0%	0%	0%	0%	0%
23	7%	0%	0%	0%	0%	0%
24	3%	0%	0%	0%	0%	0%
25	0%	0%	0%	0%	0%	0%

Source: CRS analysis of PPACA (P.L. 111-148).



Massachusetts Insurance Reform

- In April 2006 Massachusetts passed a law requiring residents to maintain health insurance or face significant penalties.
- Employers with 11 or more employees are required to provide insurance or pay an annual “Fair Share Contribution” of \$295 per employee.
- The law also included market reforms, such as:
 - Merger of the individual and small group markets
 - Creation of the Massachusetts Connector to facilitate purchase of policies
 - Elimination of waiting periods or pre-existing conditions
 - Creation of Commonwealth Care to facilitate premium subsidies up to 300% of FPL
 - Less than 150% FPL pay no premiums



Massachusetts – What Happened

- Positive Effects:
 - Increased adult non-elderly insureds from 87.5% in 2006 to 96.5% in 2009.
- Negative Effects:
 - Health care spending as a percentage of state budget:

1990	16%
2000	22%
2010	35%

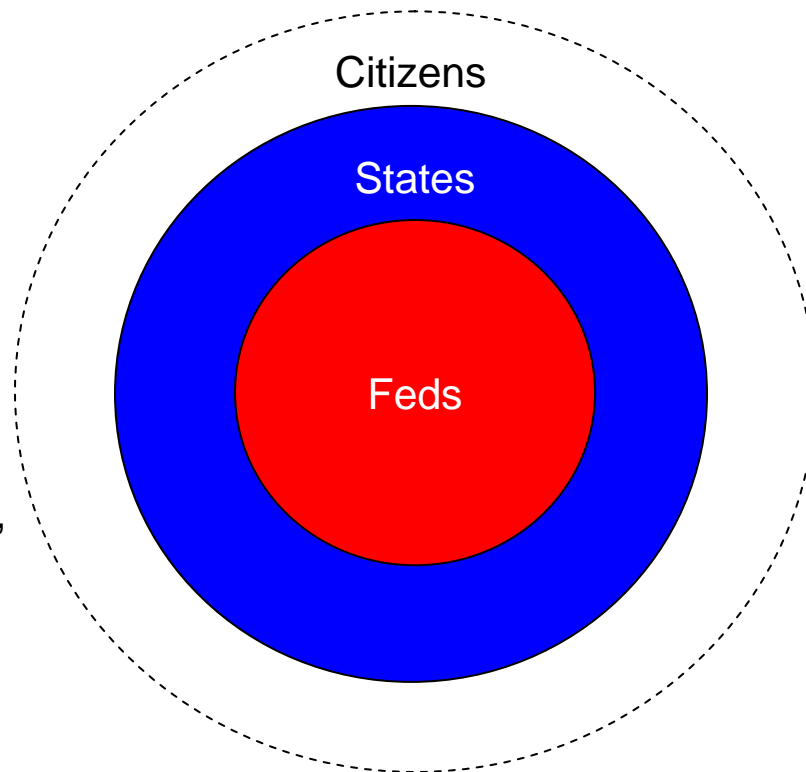
- Total cost is approx. 25% higher than estimated; revenue generated was below estimates.
- Strong evidence of adverse selection.
- 235 of 274 requests for rate increases rejected.
- Increase in physician wait times: shortage of primary care physicians.



Litigation Status

- 21 States have sued the federal government alleging that PPACA violates the Constitution:
 - Commerce Clause
 - Taxing power
 - Commandeers the States

- Federal Gov. has limited powers!
“The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.” 10th Amend. (1791).





Litigation Status (con't)

Commerce Clause

Congress has the power to “regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes.” Art. I, § 8(3).

- Historically has not reached commercial *in*activity
- Legislation is not regulating commerce but is compelling commerce
- The Court has broadly defined “commerce.” Only two favorable cases.
- Sec. 1501 of PPACA



Litigation Status (con't)

Taxing Power

There are only four types of taxes in the Constitution:

1. Duty – on imports.
2. Excise Tax – for the privilege of doing something.
3. Direct/Capitation Tax – each person in a state pays equally.
4. Income Tax – 16th Amendment (1913).