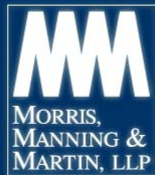




2011 Gulf States
Education Day



PPACA:

The Violent Torpedo of Truth/Defeat is Not an Option Presentation

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Agenda

1. Overview of the Patient Protection and Affordable Care Act and Associated Costs
2. Operation of Health Insurance Exchanges and Subsidies
3. Review of HHS Rate Review Regulation
4. Review of State Litigation Against Federal Government
5. 2011 to 2012: What Will Happen to PPACA?



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 March 20, 2010, (before passage) non-partisan CBO estimated PPACA to cost over \$1 trillion but “cut” federal deficit by \$138 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.
 - Included \$136 billion in cuts to Medicare Advantage.
- On May 11, 2010 CBO issued an estimate of an *additional* \$115 billion in discretionary government spending.



Overview (con't)

CBO Estimate [*fantasy*]:

\$138b deficit reduction

Minus [*reality*]:

\$70b CLASS Act

\$196b Doc Fix

\$136b Medicare Advantage

\$115b discretionary spending

*Total \$449b **increase** in the deficit from 2010-2019.*

Beyond 2019 – it only gets worse....



Overview (con't)

- On May 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.



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**
 - 24 million people would purchase coverage through an Exchange or receive coverage through employer – **total cost \$459 billion from 2014-2019**
 - CBO estimate revised August 2010 to **\$576 billion from 2014-2020**
 - CBO estimate revised March 2011 to **\$783 billion from 2014-2021**
 - 8 million people would no longer receive coverage through employer
- 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.



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 January 1, 2014, HHS will establish and operate the Exchange.



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)

- **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 2011).
- **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. In 2019 indexing also takes into account premium growth in excess of CPI-U.
- 2011 Federal Poverty Level (FPL) = \$10,890 for an individual, \$22,350 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.

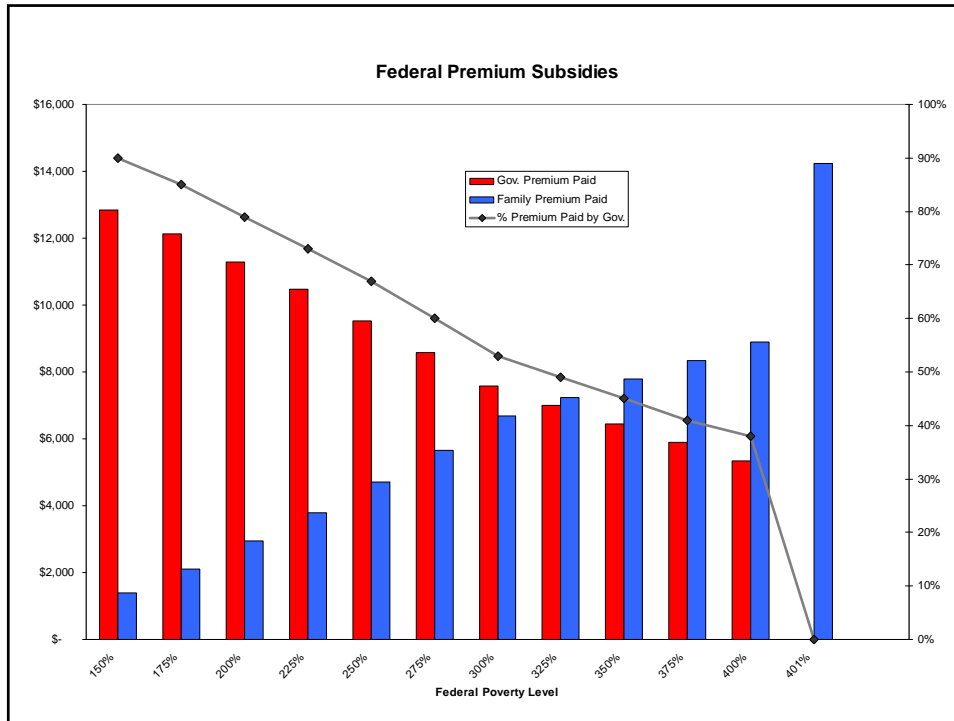


Subsidies in Health Insurance Exchanges (cont'd)

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 employer sponsored coverage in an 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 \$783 billion from 2014-2021 – *over \$7,000 per subsidized enrollee per year by 2021!*
- Given the limited cost to employers for dropping coverage and the generous subsidies, these costs may be drastically underestimated. (avg. non-elderly household income in 2009 was \$73,895; median income \$55,821 (45.5 million); 2/3 of households (66.8 million) had income under \$75,000).



Rate Review Regulation

- Final regulation promulgated May 23, 2011
- Creates disclosure & review procedure to find an “unreasonable rate increase:”
 - Excessive
 - Unjustified
 - Unfairly discriminatory
- Starting September 1, 2011, rate increases of 10% or more are subject to enhanced review before rate is effective. New state specific thresholds will be introduced on June 1, 2012.
- CMS will review if a state does not have an Effective Rate Review Program



Rate Review Regulation (con't)

- What is an “unreasonable rate increase”?
 - Excessive
 - Projected MLR below 80/85%
 - One or more assumptions not supported
 - Choice of assumptions or combination of assumptions are unreasonable
 - Unjustified
 - Insurer uses incomplete or inadequate data or rate lacks a reasonable basis
 - Unfairly Discriminatory
 - Rate results in premium differences between insureds with similar risks that are:
 - Not permissible under state law; or
 - Do not reasonably correspond to differences in expected costs



Rate Review Regulation (con't)

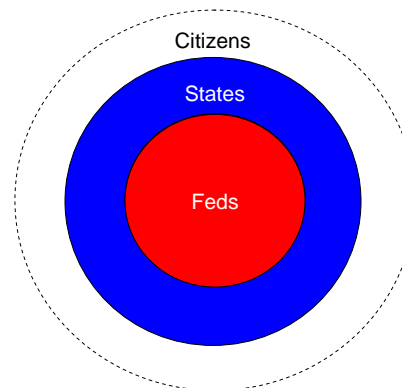
- You proposed an rate increase over 10%, so what?
 - Submit Preliminary Justification
 - Rate increase summary
 - Written description justifying the rate
 - If CMS is reviewing, also need to include rate filing documentation
 - CMS posts parts of Preliminary Justification on its website
- CMS says my rate is an “unreasonable rate increase”, so what?
 - Rate still goes into effect
 - Insurer submits Final Justification
 - Insurer posts rate filing information on its website for at least three years.



Litigation Status

- 27 States have sued the federal government alleging that PPACA violates the Constitution because Congress does not have the power to force individuals to buy insurance.
- 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 provides Commerce Clause examples and rationale.



Litigation Status (con't)

Guide to the Rulings

How the legal battle over the health-care law has played out, and how it is expected to advance.



FIRST ROUND

- Feb. 22, 2011**
District of Columbia
Democratic appointee
Mead v. Holder
Judge Kessler rules that it is “pure semantics” to argue that an individual who makes a choice to forgo health insurance is not making an economic decision.
- JAN. 31, 2011**
Northern District of Florida
Republican appointee
Florida v. Dept. of Health and Human Services
Judge Roger Vinson threw out the health law by declaring the individual mandate unconstitutional, saying the requirement is ‘not severable’ from the rest of the law.
- DEC. 13, 2010**
Eastern District of Virginia
Republican appointee
Virginia v. Sebelius
Judge Henry E. Hudson ruled that the individual mandate is unconstitutional, saying the provision ‘would invite unbridled exercise of federal police power.’
- NOV. 30, 2010**
Western District of Virginia
Democratic appointee
Liberty University v. Geithner
Judge Norman Moon ruled that by forgoing insurance, plaintiffs are ‘making an economic decision to try to pay for health-care services later, out of pocket.’
- OCT. 7, 2010**
Eastern District of Michigan
Democratic appointee
Thomas More Law Center v. Obama
Judge George Steeh found that the requirement to carry insurance or pay a fine was ‘essential to the larger regulatory scheme’ of the health overhaul.

SECOND ROUND

- Court of Appeals for D.C. Circuit (District of Columbia)
JUDGES:
3 Democratic appointees **6 Republican appointees**
 - 11th U.S. Circuit Court of Appeals (Atlanta)
5 Democratic appointees **6 Republican appointees**
 - Fourth U.S. Circuit Court of Appeals (Richmond, Va.)
9 Democratic appointees **8 Republican appointees**
 - Sixth U.S. Circuit Court of Appeals (Cincinnati)
10 Democratic appointees **19 Republican appointees**
- Note: Appeal first heard by three-judge panel, then possibly later by full state of judges; counts include judges with senior status.

THIRD ROUND

U.S. SUPREME COURT
Ruling not expected until 2011-12 term at earliest
4 Democratic appointees **5 Republican appointees**



Other lawsuits in district courts around the country may eventually go to other appeals courts and perhaps the Supreme Court.

Source: wsj.com



What Will Happen to PPACA

1. Hearings
2. Revisions
3. Delays
4. Defunding
5. Dismantling
6. Repealing