A Brave New World: Health Insurance Regulation and Litigation After *National Federation of Independent Business v. Sebelius*

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About the Author

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I. Introduction

The American health insurance industry is changing in multiple and significant ways. Many of those changes were directly imposed by legislation. Others are being prompted by implementing regulations. Still others are the result of market forces which are, themselves, attributable to changes in health care delivery systems and the mechanisms through which Americans pay for health care.

By upholding the constitutionality of the *Patient Protection and Affordable Care Act (PPACA)*, the Supreme Court virtually ensured that many of those changes will be lasting. Similarly, the outcome of the 2012 presidential election suggests many of those changes now can be considered permanent. Nevertheless, the ultimate impact of those changes is uncertain, and the policy choices they represent continue to be debated.

Only time will reveal the new shape into which the American health care and health insurance industries are being contorted. In the meantime, health insurers are adapting, and health care providers are reacting; states are preparing, and employers are planning. As explained herein, new battles also are being fought in American courtrooms that present some chance that judicial intervention

will lead to additional changes. For the foreseeable future, then, the only constant for the health insurance industry may be that more changes are coming.

II. Update on *PPACA* Litigation

PPACA became law on March 30, 2010, when President Obama signed the *Health Care and Education Reconciliation Act of 2010.* Together, the two pieces of legislation use nearly 1000 pages of text to call for numerous reforms in pursuit of several objectives. Given the nature and scope of *PPACA*'s many provisions, the public always has been sharply divided in its support for *PPACA*. In turn, at least 8 lawsuits challenging *PPACA*'s constitutionality were filed in the week before its passage, and dozens more were filed in the months that followed.

On June 28, 2012, the Supreme Court issued its decision in three of those cases. Ultimately, a majority of the justices concluded that *PPACA*'s "individual mandate" was not authorized by the Commerce Clause. U.S. Const. Art. I, §8, cl. 3. At the same time, a different majority of the justices concluded that the provision was within Congress' power to "lay and collect taxes." U.S. Const. Art. I, §8, cl. 1. To many, the Supreme Court's decision in *National Federation of Independent Business v. Sebelius* therefore signaled that *PPACA* had survived its primary constitutional challenge.

However, *PPACA* has been (and is being) challenged on other constitutional grounds.

One challenge involved those portions of *PPACA* which called on states to expand the *Medicaid* programs they administer to include persons whose annual income is not more than 133 percent of the federal poverty level. No fewer than 26 states joined in a lawsuit which objected that a related provision allowing the Department of Health and Human Services to withhold *all* funding for *Medicaid* from states which declined to participate in that expansion was unconstitutionally coercive. The Supreme Court agreed, explaining in its June 28, 2012 opinion that:

> "The Court today limits the financial pressure the Secretary may apply to induce States to accept the terms of the Medicaid expansion. As a practical matter, that means States may now choose to reject the expansion; that is the whole point."

Roberts, C.J., p. 57. Since then, 17 states have committed to participate in the expansion of *Medicaid*, while 9 have elected not to do so.

Another challenge involved the "employer mandate" – a collection of provisions in *PPACA* which provide financial incentives for certain employers to make health insurance coverage more available (and affordable) in the workplace.

In *Liberty University v. Geithner*, the district court held the employer mandate to be constitutional under the Commerce Clause because it "regulat[es] the terms of the employment contract." On appeal, the Fourth Circuit simply concluded that the *Anti-Injunction Act* deprived it of jurisdiction to proceed. One day after issuing its opinion in *National Federation of Independent Business v. Sebelius*, though, the Supreme Court formally denied *certiorari* in that case. By doing so, it effectively rejected any claim that *PPACA*'s employer mandate is unconstitutional.

As explained elsewhere in this paper, a final set of challenges involves religious objections to those provisions in *PPACA* which require group health plans to provide no-cost coverage for preventive care and screening for women. However, none of the litigants in those cases has asserted that the preventive care coverage mandate is so inextricably entwined with *PPACA*'s remaining provisions as to justify striking the entire law as unconstitutional. Absent some new and compelling constitutional challenge, then, *PPACA*'s fate as an ambitious and enduring piece of legislation may effectively be sealed.

III. Assessing the Impact of *PPACA*'s Earliest Changes

By design, *PPACA* did not impose the many changes for which it calls e*n masse*. Instead, it generally directed that those changes designed to liberalize health insurance coverage become effective immediately, while directing that those which promise to change the marketplace and those involving taxes needed to help pay for new government benefits become effective later. Perhaps for that reason, many of *PPACA*'s changes which already are effective have garnered popular support. At this point, however, the success of those measures appears to be mixed.

A. Dependent Coverage

According to some estimates, young adults between the ages of 19 and 29 made up 13 million of the 47 million Americans who had no health insurance when *PPACA* became law. To make coverage more available to that group, the *PPACA* required that health plans allow parents to keep children under the age of 26 covered by their family coverage. In December 2011, the National Center for Health Statistics at the Centers for Disease Control and Prevention (CDC) released a report which suggested 2.5 million more Americans within that age group have health insurance as a result of that measure.

B. Pre-Existing Conditions

According to the CDC, the percentage of children (under age 18) who were uninsured remained relatively stable between 2004 and 2010, ranging from 10.9 percent to 13.3 percent. To make coverage more available to that group, *PPACA* prohibited health plans from denying coverage or limiting benefits for a

child (under age 19) because the child has a pre-existing condition. In its report, the CDC indicated that just 7 percent of children (under age 18) lacked health insurance in 2011.

C. Small Business Tax Credit

To promote the availability of employer-sponsored coverage, *PPACA* created a small business tax credit which allows small employers (with fewer than 25 employees) to offset as much as 35 percent of the cost of providing health insurance. While the Congressional Budget Office had estimated that $2 billion in small business tax credits would be claimed after *PPACA* became law, Congressional testimony revealed that (as of October 2011) only 309,000 of the 4.4 million taxpayers believed to be eligible for the credit had applied for it. The total of all small business tax credits therefore was just $416 million.

That figure translates to an average of $1,346 for each small employer. Perhaps for that reason, the National Federation of Independent Business reported that the net number of small employers (with 50 or fewer employees) who provide coverage was largely unchanged in the year after *PPACA* was enacted, with 1 percent of small employers adding health insurance coverage to their benefit packages while 4 percent dropped it.

D. Early Retirement Reinsurance

PPACA also created an Early Retirement Reinsurance Program (ERRP) to help employers (and unions) maintain early retiree programs until the health benefit exchanges become available. Under the ERRP, employers (and unions) could be reimbursed for as much as 80 percent of medical claims costs (between $15,000 and $90,000 per year) for retirees who were 55 or older and not yet eligible for *Medicare*.

The ERRP went into effect on June 1, 2010 and was scheduled to end on the earlier of January 1, 2014 or when its $5 billion in funding is exhausted. In February 2012, the ERRP Center announced that it already had made $4.73 billion in payments and was processing reimbursement requests that would exhaust the balance of its funding. Additional funds could become available as a result of audits, the failure of plan sponsors to timely submit a full-replacement claim list, or other claim submission adjustments. For practical purposes, however, the ERRP will run out of funds – and therefore terminate -- before the health benefit exchanges become operational.

That fact is indicative of an important problem with which many employers are now struggling: the rising cost of insuring retirees. Some employers have addressed that problem by altering the terms of their retirement programs to minimize what they must pay for retirees' health insurance coverage. Predictably, though, such alterations have prompted litigation.

One such case -- *The Providence Retired Police and Firefighter's Association v. The City of Providence* -- involved a city ordinance enacted after the State of Rhode Island passed a law allowing municipalities to require retirees to enroll in *Medicare* as soon as they become eligible. A group of retired police officers and firefighters objected that a central element of their respective collective bargaining agreements with the city was to have a specific type and level of lifetime benefits at a set price. The city responded that it was facing a "fiscal crisis" and that transitioning eligible retirees into *Medicare* would save approximately $6 million annually. Despite that claim, the Court found the collective bargaining agreements gave the retirees a vested right to their existing coverage and that the ordinance must fail because the coverage available through *Medicare* was not comparable.

As the Court explained in *Aldo v. Raytheon Corp.* (9th Cir. 2012), the analysis in any given case may depend on "the language of the relevant documents, considered against the background of employee benefits law and labor law precepts." Thus, if the relevant documents indicate the employer reserved the right to amend or terminate its retirement plan, it may be free to change the terms on which it insures its retirees. See, *Kraft Foods v. Retail Wholesale and Department Store Union* (N.D. Ill. 2012). If not, the Court may conclude that the employer's "agreed-upon obligation could not be unilaterally abrogated." See, *Aldo v. Raytheon* (9th Cir. 2012).

E. Free Preventive Care

PPACA also sought to make coverage for all insured Americans more valuable by requiring that health plans cover certain preventive services without copayments, co-insurance or deductibles.

Although the implementing regulations exempt certain religious employers from compliance, several religious organizations, religiously-affiliated colleges and small employers have filed lawsuits objecting that a government-imposed mandate to pay for contraceptives violates their freedom of religion. Several of those lawsuits were dismissed because the court concluded the plaintiffs' claims were not ripe. In two others (*Korte v. DHHS* and *Grote Industries, LLC v. Sebelius*), the courts declined to provide injunctive relief to the plaintiffs, reasoning that they had not demonstrated a sufficient likelihood of success on the merits of their claims. In three of the cases (*Monaghan v. Seblius, Newland v. Sebelius* and *Sharpe Holdings, LLC v. DHHS*), though, courts reached a contrary conclusion and issued injunctions prohibiting the government from enforcing *PPACA*'s "preventive care coverage mandate."

On January 31, 2013, the government proposed an updated set of regulations in an apparent effort to address the several plaintiffs' concerns. Under the proposed regulations, employers who morally object to providing coverage for contraception could omit it from their health insurance plans. Nevertheless, the

proposed regulations still would require that insurers issuing policies to those plans inform employees that they are eligible for separate insurance plans that cover contraception with no additional premium or out-of-pocket expense. The proposed regulations also would require that insurers pay the costs for that coverage, while allowing them to offset those costs by reducing the user fee they must pay to sell policies through the health benefit exchanges.

F. Lifetime and Annual Limits

Six months after it was enacted, *PPACA* began prohibiting health plans from imposing lifetime limits on the cost of essential health benefits. It also began phasing-out annual limits by restricting them to $750,000 for plans beginning on September 23, 2010, to $1.25 million for plans starting on September 23, 2011, and to $2 million for plans starting on September 23, 2012. After January 1, 2014, annual limits will be prohibited for essentially all health plans.

From an actuarial standpoint, those changes could have a significantly negative impact on the losses experienced by any health plan. To some extent, implementation of the "individual mandate" may help insurers offset those losses by prompting younger and/or healthier individuals to apply (and pay higher than actuarially-based premiums) for coverage. For employers who self-insure, though, the prospect of providing coverage to their employees without annual or lifetime limits is particularly troubling.

One response might be for employers who offer self-funded plans to limit their exposure by purchasing stop-loss insurance. However, the employer's plan may then be subject to state laws regulating insurance. Indeed, the Texas Supreme Court recently held that stop-loss insurance sold to a self-funded plan is not reinsurance, but direct insurance which is subject to state regulation. See, *Texas Department of Insurance v. American National Insurance Company* (Texas 2012).

At least one state already has signaled its plan to enact legislation which will impact an employer's ability to use stop-loss insurance to mitigate the risks associated with health insurance coverage. Specifically, the State of California introduced a bill (*S.B.1431*) in 2012 which would have required a stop-loss carrier to offer coverage to all of a small employer's employees and would have required that the "attachment point" – the figure at which the employer's responsibility ends and the carrier's begins -- be no less than $45,000 for each employee (or dependent). Although the California Senate passed that bill, it was replaced in February 2013 with a different version (*S.B. 161*) which would prohibit any individual attachment point that is less than $95,000.

As of this writing, it is too soon to know if that measure will become law. However, approximately 20 states already regulate stop-loss insurance that is sold

to small employers, and the California bills both were patterned after the NAIC's *Stop Loss Insurance Model Act*. Employers with self-funded health benefit plans therefore would be well-advised to carefully consider the impact of state law before making stop-loss insurance part of the mechanism by which they fund health benefit plans.

G. Insurance Practices

PPACA purports to reform the American health *care* system. However, several of its provisions mandate changes in certain health *insurance* practices about which the public had long been critical. Whether and how those provisions help Americans gain access to affordable health care remains subject to debate.

1. Rescissions

One such set of provisions serves to prohibit insurers from rescinding coverage in the absence of fraud. Predictably, those provisions already have substantially reduced the number of rescissions involving health insurance policies. As explained elsewhere in this paper, though, *PPACA* also calls for other changes – namely, "guaranteed issue" and "community rating" – that may prevent health insurers from rescinding on the basis of any misrepresentation involving the insured's health or medical history. Once those changes are implemented, health insurance coverage may only be subject to rescission for fraudulent misrepresentation of an employee's eligibility to participate in a health plan or of one of the four factors that can legitimately affect premiums: age, dependent status, residence and tobacco use. Under *PPACA*, nothing else could be material to the insurer's decision to issue a policy as applied for.

2. Internal Appeals

Another set of provisions expanded requirements for group health plans and health insurers to provide an internal claims and appeals processes. The new requirements apply to both group and individual insurance coverage, as well as to fully insured and self-insured plans.

As a threshold matter, group health plans were required to comply with all of the requirements currently applicable to *ERISA*-covered group health plans (29 C.F.R. 2560.503-1), regardless of whether the group plan is governed by *ERISA*. Similarly, insurers providing individual health insurance coverage were initially required to incorporate the internal claims and appeals processes mandated by applicable state laws. Under *PPACA*, though, group health plans and health insurers in the individual market also were required to update those processes as necessary to comply with standards to be established by the Department of Health and Human Services.

The Department of Health and Human Services announced those standards in a set of regulations it promulgated in July 2010. 75 Fed. Reg. 43330, 43334 (July 23, 2010). Among other things, those standards provide that:

a. The set of "adverse benefit determinations" which are eligible for internal claims and appeals now expressly include rescissions.

b. Notice of urgent care benefit determinations must be made "as soon as possible, taking into account the medical exigencies." In no event may the notice be provided more than 72 hours after receiving notice of the claim.

c. Claimants must be provided (free of charge) any new or additional evidence considered, relied upon or generated by (or at the direction of) a plan or issuer in connection with a claim, as well as any new or additional rationale for a denial at the internal appeals stage. They also must be afforded a "reasonable opportunity" to respond to any new evidence or rationale.

d. For persons charged with hearing a claim for benefits, hiring, compensation, termination, promotion or similar matters may not be based on their supporting (or the likelihood of their supporting) the denial of benefits. Likewise, the selection of an individual for such a position may not be based on his or her propensity to deny claims.

e. In certain cases, notices must be provided in a "culturally and linguistically appropriate" manner. This requirement applies to any plan that covers fewer than 100 participants if 25 percent or more of all plan participants are literate only in the same non-English language. It also applies to any plan that covers 100 or more participants and in which at least 500 participants (or, if less, at least 10 percent of all participants) are literate only in the same non-English language.

f. Any notice of an adverse benefit determination must include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. The plan or issuer must ensure that the reason(s) for an adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the plan's or issuer's standard, if any, that was used in denying the claim. In the case of a final internal adverse benefit determination, this description also must include a discussion of the decision.

g. Coverage must be provided pending the outcome of an appeal.

The regulations further require that the plan or issuer provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal. In addition, the plan or issuer must disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman.

If a plan or issuer fails to strictly adhere to all the requirements of those regulations, the claimant will be deemed to have exhausted the plan's or issuer's internal claims and appeals process. Regardless of whether the plan or issuer asserts that it has substantially complied, the claimant will then be free to initiate any available external review process or pursue any remedies that are available under *ERISA* or state law.

The Department of Labor acknowledged that group health plans and health insurers would need time to comply with certain portions of those regulations and, in September 2010, issued Technical Release 2010-02 to clarify that its enforcement of certain regulations would be deferred until July 1, 2011. In March 2011, the Department of Labor issued Technical Release 2011-01 to further extend that grace period until plan years beginning on or after January 1, 2012. At this point, then, the Department of Labor, the Department of Health and Human Services, and the Department of the Treasury are enforcing all of *PPACA*'s regulations concerning internal appeals.

3. Independent External Review

Under *PPACA*, group health plans and health insurers in both the individual and group markets must provide for an independent external review of certain adverse benefit determinations. At present, the implementing regulations limit the scope of claims eligible for external review to those involving medical judgment or a rescission of coverage. Beginning on January 1, 2014, though, any adverse benefit determination that does not relate solely to eligibility will be subject to external review.

The precise nature of that external review will be governed by either a state process or a federal process, depending on the type of coverage and whether a state process that meets certain minimum standards is available. For example, self-insured plans that are subject to ERISA must comply with the federal external review process. Self-insured plans that are not subject to ERISA are instead subject to state external review processes.

Under a transition rule, health insurers in the group and individual market must comply with the state external review process if the state had such a process in effect on September 23, 2010. According to federal regulators, all but three states -- Alabama, Nebraska and Mississippi -- have external review processes in place. Except in those states, then, group and individual health insurers currently must comply with state external review processes.

As of the first day of any plan year that began on or after December 31, 2011, though, an insurer's obligation to comply with a state external review process depended on whether that process includes at least 16 consumer protections set forth in the NAIC's *Uniform Health Carrier External Review Model Act*. If so, the plan may continue to use the state external review process. If not, it must instead choose between the review process currently administered by the Department of Health and Human Services and a federal external review process that will be supervised by the Departments of Labor and Treasury.

In all cases, the independent external review process generally will involve a review by an independent third party, who then makes a "binding" decision. However, the term "binding" has been defined to mean only that the plan or insurer must provide benefits pursuant to the external reviewer's final decision, regardless of whether the plan or insurer intends to seek judicial review of the decision. 76 Fed. Reg. 37217 (June 24, 2011). In that way, the regulations appear to preserve some right for plans and insurers to seek a refund of any benefits a court later concludes were not payable.

H. Medical Loss Ratios and Rebates

Other provisions in *PPACA* purport to serve the end of making insurance coverage more affordable. One such set of provisions established medical loss ratios (or "MLRs") which require that insurers in the individual market spend at least 80 percent of premium dollars on medical claims and quality improvement. Group insurers must spend at least 85 percent of premium dollars on medical claims and quality improvement. A related set of provisions required that, beginning in August 2012, insurers who failed to meet those standards must issue rebates to policyholders.

According to the Department of Health and Human Services, approximately 80 million people were covered by insurance plans subject to the MLRs in 2011. Of that total, about 66.7 million were insured by companies that met the MLR standards. In turn, more than 12.8 million people (or 14% of the insured population) were entitled to rebates. Collectively, those rebates totaled $1.1 billion. The average award therefore was $151 per qualifying household.

In a report prepared for Congress in September 2012, the Congressional Research Service explained that compliance with the MLRs was higher for companies serving the small and large group markets than for those offering individual policies. It also hypothesized that one reason for that difference was the fact insurers in the individual market have higher non-claims expenses. Indeed, such expenses include fees and commissions paid to brokers and agents which cannot be deducted from insurers' administrative expenses.

To that end, the NAIC initially encouraged "HHS to recognize the essential role served by producers (i.e., agents and brokers) and accommodate

producer compensation arrangements in any MLR regulations promulgated." In response, the Department of Health and Human Services merely allowed any state that was concerned for the stability of its individual insurance market to seek waivers from the requirement that broker and agent compensation be included as part of an insurer's non-claims expenses. Congress separately introduced two measures (H.R. 1206 and S.B. 2288) to expressly exclude brokers' commissions, fees or rebates from the MLR calculations. However, the NAIC subsequently withdrew its support for the measures, and both bills died in committee.

As a result, the MLR provisions may be having an unintended impact on agents and brokers who market health insurance policies. Indeed, an April 2012 survey conducted by the National Association of Insurance and Financial Advisors indicated that 70 percent of that organization's members who sell health insurance had seen a decrease in commissions. The survey also revealed that, of those agents and brokers seeing reductions, more than half (53 percent) reported that their commissions decreased by at least 25 percent, while 18 percent said their commissions were cut by at least half.

At the same time, agents and brokers are preparing for new competition with "navigators" who, beginning in 2014, will market coverage through the health benefit exchanges. Because *PPACA* allows it, some agents and brokers may elect to become navigators themselves. In any given state, though, navigators might not be paid by commission. In addition, *PPACA* expressly prohibits a navigator from receiving any direct or indirect compensation from a health insurance company. For those reasons, agents and brokers are closely following each state's development of the rules under which its health benefit exchange will operate.

I. Premium Rate Increases

At least in the short term, *PPACA*'s mandate of richer benefit plans that offer additional services to more insureds – sometimes without co-pays and deductibles – necessarily will cause the cost of health insurance to escalate. In 2011, the Congressional Budget Office (CBO) therefore projected that PPACA would have a modest impact on small and large employer plans, resulting in premium increases of "somewhat less" than 10-13 percent. Nevertheless, the CBO also projected that premiums for large-employer group health insurance would be slightly lower and that many people in the individual insurance market "will end up paying less for health insurance."

To guard against a different outcome, *PPACA* directed the Department of Health and Human Services to establish a process for the annual review of "unreasonable" increases in premium rates for health insurance coverage. The implementing regulations separately require that any rate increase of 10 percent or more must be approved by the Centers for Medicare and Medicaid Service (CMS). 45 CFR § 154.200. They also clarify that CMS will deem a health

insurance rate increase to be unreasonable if it is excessive, unjustified, or unfairly discriminatory. 45 CFR § 154.205(a).

The regulations define an "excessive" rate increase as one that "causes the premium charged for the health insurance coverage to be unreasonably high in relation to the benefits provided under the coverage." 45 CFR § 154.205(b). To make this determination, CMS will consider how the proposed rate increase is projected to affect the insurer's compliance with the medical loss ratio. CMS also will consider whether the proposed rate increase is based on assumptions that are not supported by substantial evidence or otherwise are unreasonable.

Under the regulations, CMS will deem a rate increase to be "unjustified" if the insurer fails to provide a basis upon which the reasonableness of the increase may be determined, or if the information provided is incomplete or inadequate to establish such reasonableness. 45 CFR § 154.205(c). CMS also will find a rate increase to be "unfairly discriminatory" if it "results in premium differences between insureds within similar risk categories" that are either "not permissible under applicable State law" or "do not reasonably correspond to differences in expected costs." 45 CFR § 154.205(d).

Since that time, CMS has completed approximately 28 rate reviews. In 20 of those reviews, it found that the proposed rate increases were unreasonable. The most common reason for that determination is that the proposal would result in projected medical loss ratios below the 80 percent applicable threshold.

On September 1, 2011, the Department of Health and Human Services separately announced the nationwide implementation of state-based programs to conduct reviews. Since that time, 27 of the 35 states receiving rate review grants have reduced (or outright rejected) proposed rate increases. At least two states (Oregon and Nevada) also responded to proposed rate increases (respectively, 9.83 percent and 16.55 percent) by approving only a *decrease* in health insurance premiums (respectively, 0.53 percent and 1.66 percent).

While insurers may challenge those outcomes by litigation, their efforts to do so often are complicated by the deference which must be given to the entity reviewing a proposed rate increase. See, e.g., *Kirsch v. Department of Consumer and Business Services* (Oregon 2012). Except when the approved rate results in a premium decrease, they also may be frustrated by the fact that the insurer "will earn a profit on the rates approved." See, e.g., *Anthem Health Plans of Maine, Inc. v. Superintendent of Insurance*, 40 A.3d 380 (Maine 2012). In many cases, then, insurers may be forced to absorb both the increasing costs of the health care services provided to their insureds and the increased tax burdens imposed by *PPACA*, with only limited ability to offset those expenses through premium rate increases.

IV. Changes in the Health Insurance Marketplace

By many accounts, several of the earliest provisions in *PPACA* to become effective were immediately popular with the American public. Indeed, even while *PPACA*'s constitutionality remained in doubt, several insurers announced plans to retain certain features (e.g., dependents eligible to age 26 and rescissions limited to fraud) – regardless of how the Supreme Court ruled. What hung in the balance at the Supreme Court, though, was not limited to the potential repeal of the changes which already had been implemented. Rather, it included several prospective changes which had not yet become effective but promised to change the health care system, health insurance industry, employer obligations and millions of American lives in significant ways.

A. The Individual Mandate

The "individual mandate" is a set of provisions which (with some exceptions) requires that all citizens obtain and maintain "minimal essential coverage" –a package of benefits within ten broad categories of health services -- by January 2014. Beginning in 2014, anyone who does not have minimum essential coverage in place will be required to make a "shared responsibility payment" as part of their federal income tax return.

As outlined in Congressional testimony (and later explained in the Supreme Court's decision), Congress reasoned that the individual mandate was made necessary by a pair of significant limitations on insurers' ability to underwrite health insurance applications which also are scheduled to become effective in 2014. One – known as "guaranteed issue" -- prohibits health insurers from denying coverage to people for any reason, including their health status. The other – known as "community rating" -- prohibits health insurers from charging people more because of their health status and gender. Instead, premiums will be allowed to vary only on the basis of geographic area, age (by a 3 to 1 ratio), tobacco use (by a 1.5 to 1 ratio), and the number of family members.

The Supreme Court acknowledged that, without the individual mandate, those provisions raised a genuine risk of "adverse selection." As Chief Justice Roberts explained:

> "The guaranteed-issue and community-rating reforms do not . . . address the issue of healthy individuals who choose not to purchase insurance to cover potential health care needs. In fact, the reforms sharply exacerbate that problem, by providing an incentive for individuals to delay purchasing health insurance until they become sick, relying on the promise of guaranteed and affordable coverage. The reforms also threaten to impose massive new costs on insurers, who are required to accept unhealthy individuals but prohibited from charging them rates

> necessary to pay for their coverage. This will lead insurers to significantly increase premiums on everyone."

Roberts, C.J., pp. 16-17. The Congressional testimony had painted a far more desperate picture, suggesting that such a circumstance would cause the financial foundation supporting the health care system to fail, "in effect causing the entire health care regime to 'implode'." See, *Virginia v. Sebelius*, 728 F.Supp.2d 768 (E.D.Va. 2010). Most insurers therefore had anxiously awaited the Supreme Court's decision.

Ultimately, the Supreme Court upheld the constitutionality of the individual mandate. In turn, many Americans simplistically believe that, beginning in 2014, they must either have health insurance coverage or be prepared to make a "shared responsibility payment" as part of their federal taxes. However, the individual mandate does *not* apply to everyone. To the contrary, *PPACA* exempts several classes of individuals from the individual mandate, including illegal aliens, members of recognized Indian tribes and certain religious sects, incarcerated people and anyone with a coverage gap of fewer than three months. It also provides for a hardship exemption.

At the same time, *PPACA* contains other provisions which effectively limit the impact of the individual mandate to high-income individuals.

For example, individuals who make less than 133 percent of the federal poverty level (FPL) are exempt from the individual mandate. *PPACA* instead addressed their need for health coverage by expanding *Medicaid* to include persons who make no more than 133 percent of the FPL. However, the Supreme Court's decision preserved the states' ability to choose whether to participate in that expansion of *Medicaid*. In those states which choose not to participate, individuals who make between 100 percent and 133 percent of the FPL may be left without coverage.

Individuals who make between 133 and 400 percent of the FPL will be eligible to obtain coverage through the health benefit exchanges that are scheduled to be created in 2014. They also will be eligible for premium subsidies which are designed to ensure that their cost of doing so does not exceed 9.5 percent of their income.

In 2011, the FPL for a family of four was $23,050. If that figure increases by just 4 percent per year, a family of four which makes 400 percent of the FPL will have an income of $112,176 in 2016. That family of four's cost of obtaining coverage through the health benefit exchanges therefore will be capped at $10,657 per year. The rest will be paid by premium subsidies, but their alternative is to make a shared responsibility payment of just $2,085.

Although the numbers are different, families which earn less than 400 percent of the FPL will face similar choices. Indeed, while subsidies will ensure that families do not use more than 9.5 percent of their income to pay for health coverage, the alternative always will be to make a shared responsibility payment of no more than 2.5 percent of their income (capped at $2,085).

Individuals who make more than 400 percent of the FPL will be subject to the individual mandate unless the cheapest plan available in a health benefit exchange costs more than 8 percent of their income. The Congressional Budget Office has estimated that the cheapest plan available through a health benefit exchange (providing "bronze" level coverage) will cost a family between $12,000 and $15,000 per year. If the lower of those figures proves to be accurate, a family of four that makes no more than $150,000 in 2016 also would be exempt from the individual mandate.

As a practical matter, then, the individual mandate may apply only to individuals with substantial income. Logically, many of those individuals will already have health insurance through employer-sponsored group plans. For the rest, they will face a choice between paying something more than $12,000 per year for health insurance and making a shared responsibility payment of not more than $2,085. Whether (and to what degree) the individual mandate actually drives more Americans into the health insurance marketplace therefore is a debatable proposition.

B. The Employer Mandate

To make "minimum essential coverage" more available to working Americans, *PPACA* contains a set of provisions which sometimes has been referred to as the "employer mandate." Technically, those provisions do *not* require that employers offer health insurance coverage to their employees. Rather, they provide that large employers (with 50 or more full-time employees) will be assessed an annual fee of $2,000 per full-time employee (in excess of 30 employees) if they do not offer "minimum essential coverage."

Large employers who choose to offer coverage will be required to automatically enroll employees in the employer's lowest cost premium plan if the employee does not sign up for employer coverage or opt out of coverage. However, they will be required to pay an annual fee of $3,000 for each employee who has an annual income below 400 percent of the FPL and opts out of the employer's plan.

Many large employers therefore may currently be reviewing which alternative is most economical: offering minimum essential coverage to their employees or paying penalties for not doing so. Since the employer mandate applies only to large employers, some also are considering the possibility of limiting their workforce to fewer than 50 full-time employees.

Researchers have used various types of studies to predict the effect of *PPACA* on employer-sponsored health insurance, including microsimulation models, other analytic approaches, and employer surveys. In August 2012, the Government Accounting Office (GAO) reported that "[m]icrosimulation studies generally predicted little change in employer-sponsored health coverage in the near term, but results of studies using other analytic approaches and employer surveys varied more widely." Specifically, the microsimulation studies provided near term estimates ranging from a decrease of 2.5 percent to an increase of 2.7 percent in the number of individuals with employer-sponsored coverage. According to the GAO, some studies that used other analytic approaches predicted a net increase of 6 percent, while others predicted a net decrease of between 2 and 3 percent. The estimates provided by employer surveys uniformly projected a net decrease in the number of individuals with employer-sponsored group coverage, with estimates ranging from 2 to 20 percent.

Ultimately, PPACA's true impact on the availability of employer-sponsored group coverage cannot be known until the employer mandate becomes effective in 2014. However, the baseline year for calculating an employer's obligations under *PPACA*'s employer mandate is 2013. The employer mandate's pending implementation therefore presents a time-sensitive opportunity to help large employers identify and evaluate their options.

C. Health Benefit Exchanges

PPACA also created a new Pre-Existing Condition Insurance Plan (PCIP) program to make health insurance available to Americans who lack coverage because of a pre-existing condition. As of April 30, 2012, twenty-three states and the District of Columbia had elected to have their PCIP program administered by the federal government, while the remaining twenty-seven states had chosen to run their own programs. By design, though, the PCIP program is temporary. Indeed, it is scheduled to terminate in 2014, when the health benefit exchanges will become effective. 42 C.F.R. § 152.45.

To that end, *PPACA* provides for funding to assist the states in establishing health benefit exchanges. It also directs the Department of Health and Human Services to establish an exchange (directly or through agreement with a not-for-profit entity) in any state that fails to establish its own. As of the date of the Supreme Court's decision, forty-nine states (i.e., all but Alaska) and the District of Columbia had applied for and received up to $1 million in Exchange Planning Grants. However, only thirty-two states and the District of Columbia had applied for and received Level 1 Establishment Grants, and just two states had applied for and received Level 2 Establishment Grants.

A number of the states that challenged *PPACA*'s constitutionality decided to wait for the Supreme Court's decision before spending time or money to create exchanges. Recognizing that circumstance, the federal government extended until

February 15, 2013 the date by which each state was required to announce its intention to create a state-run health benefit exchange. Four days later, the Department of Health and Human Services announced that a total of 24 states (plus the District of Columbia) were on track to run exchanges, either on their own or in partnership with the federal government. The remaining 26 states have opted to rely solely on the federal government to establish and operate exchanges.

Although the exchanges are scheduled to become operational when calendar year 2014 begins, substantial questions remain about many states' ability to meet that deadline. It also is unclear whether those exchanges can truly be functional on January 1, 2014, whether they will be adequately prepared to handle a substantial number of new enrollments, and (in the long term) whether they can do so in a fiscally sound manner that serves *PPACA*'s goal of making health care *affordable*. Nevertheless, open enrollment for all exchanges is scheduled to begin in October 2013. For that reason, the Department of Health and Human Services (and numerous states) already are preparing to make concerted efforts at promoting their exchanges and attracting enrollees.

D. The Expansion of *Medicaid*

To make coverage available to Americans who have neither private nor employer-sponsored health insurance coverage and who do not have the means to obtain coverage through the exchanges, *PPACA* also calls for an expansion of *Medicaid* to include all individuals under age 65 with incomes up to 133 percent of the FPL. Initially, the federal government will fully fund the cost of covering those who become newly eligible for *Medicaid*. Beginning in 2017, though, the states which administer coverage to those newly eligible participants will be required to fund some portion of the associated costs.

The Congressional Budget Office has projected that, by 2015, those provisions in *PPACA* will increase *Medicaid* enrollment by 24 million people. CMS separately estimated that the expansion of *Medicaid* will impose between $20 and $42 billion in additional costs on the states by 2020 -- even after counting the federal financing. The Supreme Court's holding that individual states could elect not to participate in PPACA's expansion of *Medicaid* without jeopardizing their funding for their existing *Medicaid* programs therefore has become a lightning rod for both opponents and supporters of *PPACA*.

According to an analysis by the New England Journal of Medicine, at least 13 states have indicated they will not participate in *PPACA*'s expansion of *Medicaid*. Given that 26 states participated in the related constitutional challenge, still more states may elect to forego participation before the expansion goes into effect. Either way, there will be large portions of low-income adults in some states that are ineligible for any publicly subsidized health insurance (i.e., *Medicaid*) and unable to afford coverage through other means.

V. **Changes in Health Care Delivery**

As explained previously, *PPACA*'s ability to achieve its goal of providing more Americans with access to mechanisms for paying the cost of any health care they need is unclear. To the extent it does, though, *PPACA* will create upward pressure on health insurance premiums. It also will impose new financial burdens on *Medicare*, *Medicaid* and the other government programs on which many Americans will rely.

Those circumstances will, by their very nature, complicate any effort to achieve *PPACA*'s other goal: making health care more affordable. To offset many of its anticipated costs, PPACA therefore makes numerous changes to the tax laws. Several of those changes (e.g., a new tax on innovator drug companies, an increase in the tax on early withdrawals from health savings accounts, and codification of the "economic substance doctrine") already are in place. Others (e.g., a reduction in the allowable medical expenses for taxpayers who itemize, a new 3.8 percent tax on investment income, an increase in the *Medicare* payroll tax, and an annual tax that will be imposed on the entire health insurance industry) have yet to be implemented.

As taxpayers, many consumers will soon feel the effects of those changes. As the Supreme Court explained in its recent decision upholding *PPACA*'s constitutionality, consumers also can count the shared responsibility payments that must be made for a failure to comply with *PPACA*'s individual mandate among *PPACA*'s new tax burdens. Employers, too, may be required to make penalty payments to the IRS for a failure to comply with *PPACA*'s employer mandate.

However, *PPACA* also attempts to generate a reduction in the costs of health care by stimulating innovations in the ways it is delivered. Whether, when and on what scale those innovations succeed in reducing the costs of health care cannot yet be known. In the meantime, insurers, managed care organizations, health maintenance organizations, medical groups and physicians are actively realigning themselves to create an infrastructure for the new health care delivery system *PPACA* is trying to promote.

A. Health Information Technology

PPACA contains provisions which allow health care providers to receive federal incentive payments for a "meaningful use" of health information technology. Many hospitals and health care providers therefore have started using electronic medical records systems and e-prescribing.

However, the costs of these technologic transitions are substantial and often are not affordable for many small group practices. There is, therefore, some risk that the costs of implementing health information technology systems will

force physicians into employment within large group practices or financially secure hospital systems. Indeed, practice groups that cannot afford to implement their own systems will be unable to compete for new government funding based on meaningful use of health information technology. They also will also be poorly equipped to take advantage of clinical research that will be built around the ready accessibility of clinical data – a factor which will determine a significant component of their reimbursement under *PPACA*.

B. Value Based Purchasing

PPACA mandates certain changes to the way in which hospitals will be paid for services they provide to *Medicare* participants. It does so by establishing (or expanding) three provisions to promote "value based purchasing." – a model that increases the focus on patient outcomes.

First, beginning in 2013, hospitals will receive increased base rate payments for each discharged patient if they meet certain clinical quality measures for specified conditions. Beginning in 2014, the Department of Health and Human Services must ensure that the payment formula includes efficiency measures, such as *Medicare* spending per beneficiary. Funding for these payments will be generated through reduced inpatient payment per service (PPS) payments to hospitals.

Second, beginning in 2013, inpatient payments will be reduced if a hospital has "excess readmissions" for heart attack, heart failure, and pneumonia. Beginning in 2015, the Department of Health and Human Services will have authority to expand the list of medical conditions to be included in those calculations.

Third, reimbursement will be reduced based on a hospital's acquired condition (HAC) rates. Beginning in 2015, hospitals will face an additional 1 percent reduction in *Medicare* inpatient payments if they fall into the top 25 percent of national risk-adjusted HAC rates for all hospitals in the previous year.

C. Patient Centered Medical Homes

Statistically, American medical schools are producing fewer primary care physicians. At the same time, access to primary care physicians appears to have a positive effect on patient outcomes. To help refocus the health care system on the benefits of primary care physicians, *PPACA* authorized the Department of Health and Human Services to test Patient Centered Medical Homes (PCMHs) as a new care-delivery model.

In general, PCMHs combine an emphasis on prompt access to primary care through a patient's ongoing relationships with a primary care provider

or team. The PCMH is charged with coordinating care with and for patients, then using the results of good care coordination to develop appropriate care plans. The PCMH will be responsible for partnering with all professionals and teams that participate in a given patient's care. It also will have some role in connecting patients with community resources.

D. Accountable Care Organizations

PPACA also establishes the Medicare Shared Saving Program (MSSP), the stated goal of which is to achieve better care for individuals, better health for populations, and slower growth in costs through improvements in care. Under the program, an Accountable Care Organization (ACO) must assume responsibility for the care of a clearly defined population of *Medicare* beneficiaries. If it succeeds in delivering high-quality care while reducing costs, it will share in the cost savings with *Medicare*.

While the PCMH model is centered around a single practice, the ACO model typically involves multiple practices within one organizing entity. Thus, a single ACO could be quite large and cover thousands of patients.

The American Hospital Association estimated that it will cost between $11.6 million and $26.1 million to build the ACO infrastructure and run it for the first year. In contrast, CMS estimated those costs to be only $1.8 million. Regardless of which estimate is more accurate, many hospitals and large medical groups already are merging and/or acquiring smaller medical practices as part of their efforts to create an ACO infrastructure.

VI. Conclusion

In a best case scenario, the individual mandate will prompt more Americans to purchase health insurance before they need it. In turn, health insurers will be able to use premiums collected from a new set of healthier individuals to offset the costs of providing guaranteed coverage and greater benefits to more people. The employer mandate will make coverage more available to working Americans, the health benefit exchanges will reach those who do not have employer-sponsored coverage, and the *Medicaid* expansion will ensure that consumers with lesser means have some mechanism to pay for the health care they need. At the same time, *PPACA*'s insurance reforms will make coverage more affordable, while – over time -- its modifications of the health care delivery system both improve patient outcomes and substantially decrease the costs of health care.

In a worst case scenario, the individual mandate proves to be ineffective, making the threat of adverse selection more real for insurers. The employer-sponsored group market for health insurance contracts, the health benefit exchanges are unable to function in a fiscally sound manner, and many states elect

not to make *PPACA*'s expansion of *Medicaid* available to some of their most impoverished citizens. In addition, the substantial costs associated with *PPACA*'s modifications of the health care delivery system make the costs of health care higher, perhaps even prompting systemic changes which jeopardize all Americans' access to the health care they need.

In all likelihood, the reality will fall somewhere in the middle. For now, though, there are substantial changes taking place in both the health insurance and health care industries. Thus far, Americans have experienced only some of the most consumer-friendly changes mandated by *PPACA*. However, new tax obligations, new marketplace choices and new relationships with health care providers are on the horizon. Whether they ultimately benefit consumers – or serve as a rallying cry for still further changes – can only be known with more time.