

HEALTH LAW ADVISORS, P.L.L.C.

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UPDATE ON THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (“ACA”)

As 2014 approaches, the implementation of the Patient Protection and Affordable Care Act (“ACA”) looms closer than ever. The likelihood of repeal, even if possible, is diminishing. ACA is premised on several concepts:

- Expand covered lives. The notion is that the fewer uninsured there are, the greater the pool to share risks, leading to lower costs.
- States were to be the big players by establishing state exchanges to provide a market place for the individual and small employer markets.
- As it stands, the Federal government is establishing exchanges that it will be operating in the majority of states.

While the concept of absolute equality in access and affordability of health care is honorable, it is an insurmountable task to accomplish with the design of ACA. It occurred to me that many employers are struggling with the decisions that need to be made regarding the impending implementation of ACA in 2014.

**The ACA is to healthcare what
Dodd-Frank is to banks, but
for opposite reasons and with
opposite goals.**

The proposed regulations and notices to implement ACA are pouring out of the various government entities. I thought it would be worthwhile to give you an update and some things to think about.

First, consider that ACA is to healthcare what Dodd-Frank is to banks but for *opposite* reasons and with *opposite* goals.

- Dodd-Frank was passed to solve the problem that banks were issuing credit without properly evaluating the credit risk.
- Dodd-Frank is premised on the notion that no business should be too big to fail.
- Dodd-Frank established a myriad of rules and regulations that are going to keep financial institutions “healthy and afloat.”

ACA on the other hand offers the following:

- Exchanges require that the insurance companies that offer products CANNOT evaluate risk to determine who gets coverage or how much it will cost. Individuals or groups are to be added without regard to any risk assessment, no pre-existing conditions, no age consideration, no evaluation of future medical needs. Whereas Dodd-Frank purports to ensure financial institutions adhere to stringent criteria regarding the underlying credit risks, ACA requires insurers to disregard risk.
- Exchanges are to be available state wide at least one per state. To date there are 34 states with no plans to start a state exchange. The federal government is developing the vehicle by which it will operate exchanges by January 1,

2014 in all these states. Whereas Dodd-Frank seeks to curtail mammoth entities, ACA is creating a federally administered health program of a size never before seen. It will be larger than any institution that the federal government would consider too big to fail.

- The exchanges are designed to be the marketplace for small groups and individuals to purchase health care. The federal government has indicated to whom policies are to be made available, what the policies must include and how they are to be offered. But as of today, nothing has been issued to determine the cost of these products. Pricing is for the future.
- The fee to fund the federal reinsurance program will be \$9.25 per employee per month. That’s \$111 per employee each year. Understanding that the cost of the products in the exchanges will be high, the federal government has a federal reinsurance program through which it will give insurance companies rebates. Regulations were issued on December 7, 2012, that indicate the federal government will collect all amounts for reinsurance programs. States can have their own reinsurance programs, but the federal government will implant its own program and charge fees on its own. States that have such programs will need to charge and collect their own fees. Funds will be collected from all insurers and self-funded plans, but the federal government will distribute its collections based on where it determines the funds are needed not where they are sourced. Oklahoma will be used to subsidize other states. Too big to fail applies in the market place, but the federal government will create one entity to handle the entire United States.

The one thing that Dodd-Frank and ACA have in common is the multitude of regulations being promulgated. Davis Polk maintains a tracker on the Dodd-Frank regulations and noted that as of December 3, 2012, a total of 237 Dodd-Frank rulemaking requirement deadlines have passed. One third of these have final rules, one third have rules that have been proposed. The final third has no rules yet proposed. ACA is not much different. As the regulations have been pouring out this year, there is so much more that has yet to be written. For the ACA regulatory writers, much of what is to be written has to be created as the statute left most of the details to the regulatory writers. Thus, it is not even predicable at this stage.

OKLAHOMA ACTIVITY

Recent activity in Oklahoma indicates that Blue Cross Blue Shield (“BCBS”) is poising itself to be the healthcare provider for the small markets which generally take groups of fifty or less. It is no secret that BCBS has offered pricing to member banks that defies logic; large rate reductions to groups that have incurred more in claims than they have paid in. The only explanation is that BCBS is accumulating bodies. The more bodies, the greater the pool to share risks, the more the federal subsidy will be. Growth based on risk analysis is not part of ACA.

EXCHANGES WILL HAVE ADVERSE SELECTION

Who will go to an exchange? Individuals who could not previously obtain coverage because of pre-existing conditions and employers who seek lower cost today even though their medical history indicates serious risks are included. But risk is not a factor for the exchanges. It's a body count. To the extent that the federal government subsidizes individuals on the exchange, BCBS will get its money. *But history shows that there is a point at which there is financial failure when the outgoings exceed the incoming funds.* One need only look to the current state of many European countries. If you want to look closer to home, all the commentaries indicate that neither Medicare nor Social Security can continue for the long term. The solution: reduce participants by imposing higher age limits, tax more wages to collect more revenue, or charge the users more money.

ACA intends to increase users and tax employers more

Why should the public healthcare system be different? ACA's stated goal is to lower the number of uninsured individuals in the United States. So more people are covered, the cost will decrease? Not if there is no underwriting of risk associated with those individuals! **It works only so long as the Federal government subsidizes the cost with your money.**

MASSACHUSETTS SIX YEAR LATER

If ACA is such a wonder, why aren't large employers ready, willing, and able to embrace the exchange products?

If past performance is indicative of future performance, one should look at the Massachusetts plan to find its success. The data presented was prepared by The Henry J. Kaiser Family Foundation, in May, 2012. The Foundation

is widely respected for its analysis of health care information. The Massachusetts' health care program has been touted as the basis for extending the concept outside of a single state to the entire United States. The Massachusetts "Connector" is the same as the exchanges. Their program provides subsidized costs though at levels *lower* than ACA.

The goal of Massachusetts was to cover more citizens and attain lower health costs. **So what do we know six years later?** Consider the following:

1. Massachusetts has the *lowest uninsured* population of any state.
2. Massachusetts has a per capita health spending that is **15% higher** than the national average. It continues to struggle with rising health care costs.
3. Affordability continues to be an issue. Massachusetts has the **highest individual market premiums** in the country.
4. Legislation is now focusing on comprehensive *provider payment reform* to reduce costs.

As with ACA, Massachusetts purposefully focused on expanding coverage to residents but it left the task of cost containment for future years. So now more people are covered, but the costs are higher than the national averages. That is not the result that was anticipated. Massachusetts is

turning its attention to providers to try to reduce their payments to curtail costs. Why? Dictating price controls is within government's realm, while **price transparency and efficiency of use are not.**

If ACA is modeled after the Massachusetts program, why should we expect the results to differ? ACA is more expansive. Why do people think that as more people have coverage, the cost of health care will decrease and that providers will be happy to take less for the same services?

Massachusetts has a per capita health spending that is 15% higher than the national average. It continues to struggle with rising health care costs.

That seems contrary to what history shows with Massachusetts or the federal Medicare system.

There is nothing to suggest that ACA has overcome the problems that Massachusetts experiences. The programs are similar. The only difference is that people think that ACA as implemented is too big to fail so we can't let it fail. Sound familiar?

TWO CLASS HEALTH SYSTEM

Ensuring access to health care is critical to health care reform. **Coverage without access is not valuable.** Massachusetts has experienced the problem related to access. Primary care providers are an issue. The Kaiser Report indicates that one in five adults have problems finding a doctor to see them either because the doctor is not taking new cases or because they don't accept the patient's insurance. Not accepting the patient's insurance means that the reimbursement is too low for the provider to accept for its services.

Many believe that the exchanges will create two classes of health care beneficiaries. The exchanges provide access to health insurance. But they do not guarantee accessibility of providers. Those of you who are familiar with Medicare will know that, in addition to lack of funding to sustain the program, its participants also encounter many issues with respect to access. Many providers limit Medicare participants or don't take them at all. This is not a coincidence. The Medicare payments are low. This causes many providers to refuse to take Medicare patients.

SELF-FUNDED PLANS IN THE AGE OF ACA

Approximately 70% of employees currently receive health care through self-funded plans offered by their employers. **AHP is self-funded** and allows the smaller employees to obtain coverage like a large employer by banding together. Recent activity in the market indicates that more employers are seeking to be self-funded rather than embrace the exchanges. IF ACA is such a wonder, why aren't large employers ready, willing, and able to embrace the exchange products? There are many reasons, but let me offer you a few.

1. Self-funded plans have more freedom to design plans to accommodate their employees. Employers prefer to not have cookie cutter type of plans.
2. Most employers seeking self-funded plans look to history to try to understand what the future of the exchanges will

be. To date, little is settled. It is clear that there will be a mammoth federal type of program because so many states opted to not institute their own exchanges.

3. The federal government is designing itself to create the largest entity ever that will "oversee" all the intricacies of the exchanges.
4. Government run plans are not known for their efficiencies. Quite to the contrary. The spending generally far outweighs early predictions.

The recent editorial in the Oklahoman on December 11, 2012, says it best:

A newly released Oliver Wyman study conducted for America's Health Insurance Plans analyzes the impact of a new Obamacare tax on insurance. From 2014 to 2023, the report determined the tax would, averaged nationally, increase the cost of premiums by an aggregate \$2,171 to \$2,794 for single contracts and \$5,140 to \$7,186 for family contracts.

The report includes calculations for two scenarios. One model assumes the tax does not cause more businesses to become self-insured, which would avoid the tax, and the other assumes a shift occurs.

In Oklahoma, the report predicts the aggregate tax will total roughly \$1.2 billion from 2014 to 2023. It would boost Oklahoma small-group family policies as much as an aggregate \$7,748 during that time frame. About 40 percent of state policies would be impacted by the tax, based on current figures.

Insurance Commissioner Doak was quoted in the Tulsa World on December 12, 2012 as stating:

"Unfortunately, thanks to Obamacare, the recent rate increases are only the beginning of the price hikes," Doak said in a prepared statement for the Tulsa World. "The mandates that kick in next year will continue to raise costs, especially for younger adults."

This update is intended to be informational and does not constitute legal advice regarding any specific situation. Should you need specific information as to how these provisions may apply to you, you should seek legal counsel.

By 2014, health insurance rates could increase an additional 30 percent to 40 percent because of new premium taxes, underwriting reforms, reinsurance costs and benefits mandate increases, he said.

"This forecast is definitely a bad omen of what's to come with respect to affordable health insurance," Doak said.

Perhaps it really is not so far-fetched to think the whole thing will collapse under its own weight. But if it is designed to be too big to fail, the repercussions will not end in the near future.

Some things are a given:

- The IRS will get bigger and bigger as they are the collection agency.
- The federal government will continue to grow as the need to administer these national programs expands on a daily basis.
- Health care costs will increase.
- Access will decrease.

CONCLUSION

So as you look at Advantage Health Plans for your bank, keep the following in mind:

- The program will continue to provide access to providers.
- AHP will continue to address costs now and work at cost containment to ensure quality care at prices that are transparent.
- AHP has a track history.

If you choose to get cheaper healthcare today, AHP may no longer be an option for you in the future. You may be required to remain with whatever the exchanges offer you and your employees.

AHP will comply with Federal laws. A list of the key provisions as they will apply in 2013 and 2014 is attached. Only time will tell if managing AHP by understanding risks and costs will prove successful.

ADDENDUM

ACA PROVISIONS THAT WILL DIRECTLY IMPACT YOU:

- 2012 - Employers pay \$1.76 per employee
- 2013 - Flexible spending accounts limited to \$2,500
 - Additional Medicare tax on wage earners over \$200,000
 - 2.3% tax on medical devices
 - Limited itemized deductions for medical expenses
- 2014 - Federally run exchange to be in Oklahoma and Texas
 - Employer penalties if no coverage offered to full time employees
 - Employer penalties if coverage is offered but is not "affordable"
 - Employer tax on employees for reinsurance, approximately \$111 per employee for AHP

A. ACA FEES THAT IMPACT YOU DIRECTLY NOW

The "Patient Centered Outcomes Institute Fee" will be assessed to all employers for plan years ending on or after **October 1, 2012**. The initial fee is \$1.76 per employee per year and should be \$3.52 in the following year.

B. ACA PROVISIONS THAT MAY IMPACT YOU DIRECTLY EFFECTIVE DURING 2013

1. Flexible Spending Account **Limited to \$2,500**
2. Medicare Tax Increase on wages by 0.9% (from 1.45% to 2.35%) on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly **and imposes a 3.8%** assessment on unearned income for higher-income taxpayers.
3. **Tax on Medical Devices 2.3%** - though there is talk in Congress of delaying this effective date as the new tax is likely to increase costs and eliminate jobs!
4. **Itemized Deductions for Medical Expenses** - increases the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income; waives the increase for individuals age 65 and older for tax years 2013 through 2016
5. The Federal government will establish an exchange in Oklahoma and more than 30 other states. A fee of 3.5% of premiums will be charged on each policy for their administrative services. It is to be seen how the exchange will work. The Federal government intends on side stepping states to get the plan in place.

Other ACA Provisions to implement national healthcare

1. State Notification Regarding Exchanges must be completed. Most states have opted out.
2. Closing the Medicare Drug Coverage Gap - Begins phasing-in federal subsidies for brand-name prescriptions filled in the Medicare Part D coverage gap (reducing coinsurance from 100% in 2010 to 25% in 2020, in addition to the 50% manufacturer brand-name discount)
3. Medicare Bundled Payment Pilot Program
4. Medicaid Coverage of Preventive Services
5. Medicaid Payments for Primary Care
6. Employer Retiree Coverage Subsidy
7. Financial Disclosure
8. CO-OP Health Insurance Plan
9. Extension of CHIP
10. Medicare Disproportionate Share Hospital Payments
11. Medicaid Disproportionate Share Hospital Payments

3. ACA PROVISIONS EFFECTIVE DURING 2014

Provisions that may impact you directly:

1. Individual Requirement to Have Insurance - Requires U.S. citizens and legal residents to have qualifying health coverage. This is the **MANDATE!** Enforceability is a major problem
2. **No Annual Limits** on Coverage (theoretically the waivers expire)
3. Employer Requirements - **provide affordable coverage to full time employees (30 hours or more) or pay**. Assesses a fee of \$2,000 per full-time employee, excluding the first 30 employees, on employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee, excluding the first 30 employees
4. Health Insurance Premium and Cost Sharing Subsidies Provides - refundable and advanceable **tax credits and cost sharing subsidies to eligible individuals**. Premium subsidies are available to families with incomes between 133-400% of the federal poverty level to purchase insurance through the state sponsored

Exchanges, while cost sharing subsidies are available to those with incomes up to 250% of the poverty level. IRS indicates it applies to any state. Oklahoma has challenged this provision.

5. **Wellness Programs** in Insurance - Permits employers to offer employees rewards of up to 30%, potentially increasing to 50%, of the cost of coverage for participating in a wellness program and meeting certain health-related standards; establishes 10-state pilot programs to permit participating states to apply similar rewards for participating in wellness programs in the individual market.
6. **Temporary Reinsurance Program for Health Plans – this is where the “\$63” fee will go – annualized cost per employee is approximately \$111.**
7. Health Insurance Exchanges
8. Basic Health Plan.
9. Essential Health Benefits - Creates an essential health benefits package that provides a comprehensive set of services, limiting annual cost-sharing to the Health Savings Account limits (\$5,950/individual and \$11,900/family in 2010). Creates four categories of plans to be offered through the Exchanges, and in the individual and small group markets, varying based on the proportion of plan benefits they cover.
10. Guaranteed Availability of Insurance - Requires guarantee issue and renewability of health insurance regardless of health status and allows rating variation based only on age (limited to a 3 to 1 ratio), geographic area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchanges.

Other ACA Provisions:

1. **Expanded Medicaid Coverage** - Expands Medicaid to all individuals not eligible for Medicare under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL and provides enhanced federal matching payments for new eligible.
2. Presumptive Eligibility for Medicaid - Allows all hospitals participating in Medicaid to make presumptive eligibility determinations for all Medicaid-eligible populations.
3. Multi-State Health Plans - Requires the Office of Personnel Management 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.**
4. Medicare Advantage Plan Loss Ratios.
5. **Fees on Health Insurance Sector - Imposes new fees on the health insurance sector.**
6. Medicare Payments for Hospital-Acquired Infections - Reduces Medicare payments to certain hospitals for hospital-acquired conditions **by 1%.**