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What just happened?: Obama's anti-religious liberty shell game

What just happened? That's what many asked after watching President Obama's February 10, 2012 announcement that he will be "accommodating" religious organizations that object to purchasing contraceptive and abortifacient coverage for their employees.
Hours later, the Administration released the final rule that contains the narrow waiver for churches.

In a separate document, the administration has issued a one-year "safe harbor" waiver for non-exempted religious organizations.

Then, in a scheme akin to a shell game, instead of requiring non-church religious organizations to purchase contraceptive coverage, the Obama Administration says that in a future regulation it will require the organization's insurance company to pay for the coverage.

But the U.S. Conference of Catholic Bishops is not fooled by the Administration's slight of hand.

[In] the case where the employee and insurer agree to add the objectionable coverage, that coverage is still provided as a part of the objecting employer's plan, financed in the same way as the rest of the coverage offered by the objecting employer. This, too, raises serious moral concerns.[1]

But the administration's "accommodation" solution does nothing to address the concerns of self-insured religious organizations. The Administration recognizes this problem in its final rule, promises a solution, but gives no details. It merely says,

The Departments intend to develop policies to achieve the same goals for self-insured group health plans sponsored by non-exempted, non-profit religious organizations with religious objections to contraceptive coverage.[2]

As if only non-profit organizations could have religious opinions, no exemptions, waivers, accommodations, or safe harbors are given to business owners who may object to providing such coverage on religious grounds. The bishops argue that,

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Update on State Options for Choosing an EHB Definition

In our January 2012 issue we reported on the Department of Health and Human Service's (HHS) bulletin on Essential Health Benefits (EHB). The bulletin outlined the Obama Administration's strategy to avoid inevitable controversy by shifting to the states its responsibility to define health benefits that will be required for many plans under Obamacare.

The bulletin seemed to suggest that it might be possible for a state to add additional mandates by July 1st of this year without having to reimburse health insurers for the costs of those mandates come 2014 as Obamacare requires.

But in further guidance issued on February 27, 2012, HHS clarified that: "any State-mandated benefits enacted after December 31, 2011 could not be part of EHB for 2014 or 2015, unless already included within the benchmark plan regardless of the mandate."[1]

[1] Centers for Medicare & Medicaid Services, "Frequently Asked Questions on Essential Health Benefits Bulletin," (Feb. 17, 2012) *available at* http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf.

Obama's anti-religious liberty shell game (continued)

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[T]he mandate would impose a burden of unprecedented reach and severity on the consciences of those who consider such "services" immoral: insurers forced to write policies including this coverage; employers and schools forced to sponsor and subsidize the coverage; and individual employees and students forced to pay premiums for the coverage. We therefore urged HHS, if it insisted on keeping the mandate, to provide a conscience exemption for all of these stakeholders—not just the extremely small subset of "religious employers" that HHS proposed to exempt initially.[3]

So, where exactly is the accommodation? Where exactly is the respect for religious liberty?

What just happened?

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[1] News Release, U.S. Conference of Catholic Bishops, "Regulation changes limited and unclear; Rescission of mandate only complete solution; Continue urging passage of Respect for Rights of Conscience Act (Feb. 10, 2012)(emphasis in original), available at http://usccb.org/news/2012/12-026.cfm.

[2] Group Health Plans and Health Insurance Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, (to be codified at 29 C.F.R. § 2590 and 45 C.F.R. § 147), pages 13-14 available at http://www.ofr.gov/OFRUpload/OFRData/2012-03547_PI.pdf.

[3] *Supra* note 1.

Affordable Care Act makes high deductible, low cost health plans, LESS affordable

A new study, released February 13, 2012, confirms what we've known for a while, the Affordable Care Act's Medical Loss Ratio (MLR) rule instead of making plans more affordable will make affordable plans more difficult to find.

The study conducted by Milliman, Inc, found that the MLR calculation is biased against high deductible plans (HDPs) such as those that offer Health Savings Accounts (HSAs). This bias will create disincentives for insurance companies to offer these low premium plans, and thus will reduce their availability to consumers.

The MLR simply determines what percentage of every insurance premium dollar is spent on health benefits. Under the regulation health insurers must spend no less than 80% to 85% of every premium dollar on "health improvement activities."

But the MLR calculation is biased against HDPs because it does not take into account health claims paid by individuals and employers.

Recent articles have claimed that the Medical Loss Ratio rule would make it difficult[1] or impossible[2] for HDPs to operate in Obamacare's Health Insurance Exchanges.

While the Milliman study does not paint the picture quite that bleak,[3] it does make several observations about the negative impact of the MLR on HDPs. Here's our summary of three of the reports major points:

1. The MLR makes it harder for HDPs to compete against higher-cost low-deductible plans. The MLR does not consider funds from a HSA as health improvement activities. This makes it harder for HDPs to meet the required minimum 80%-85% ratio compared to low-deductible plans. According to Milliman,

> For high-deductible and HSA plans to be viable, both from a consumer and carrier perspective under the PPACA, an adjustment to the MLR formula for the impact of HSAs may be necessary.[4]

2. The MLR makes it difficult for HDPs to build reserves in low-claim years to balance out unexpected high-claim years. Because HDPs have high deductibles they may pay fewer claims, but when they do pay claims, they are higher-than-average in cost. The net effect is that HDP plans are more volatile than low deductible plans. Before the MLR, the "fat," lower-than-average health claim years under HDP plans would make up for the "lean," higher-than-average health claim years. Now, the MLR will make it more difficult for HDPs to prepare for the "lean" years because it will have to issue rebates in the "fat" years.[5] The report states,

> This is of particular concern for the year 2011 MLR rebate determination because the calculation includes only one year of experience. This is also true in 2012 for larger plans. In year 2013, three-year averaging takes place, which will help reduce, but not eliminate, this fluctuation rebate risk for high-deductible plans.[6]

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LESS affordable health plans (cont.)

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3. The MLR creates disincentives for insurance companies to continue offering low cost HDPs. For the simple reason that HDP premiums are lower, HDP plans take in fewer dollars. This also means fewer dollars for administrative costs. The Milliman study demonstrates that the higher the deductible the more difficult it is for HDPs to maintain the mandated 80%-85% MLR standard. According to the report,

> Under normal market conditions . . . total dollars of expenses are already lower for [high deductible] plans than for more expensive (i.e., higher-premium) plans. The MLR requirement results in the need to cut these expenses even more, which **may create disincentives to offer such lower-cost plans**, particularly if the insurer cannot generate reasonable risk margins.[7]

Interestingly enough Milliman also says that because deductibles are not indexed to medical inflation, HDP premiums will rise faster than those of low deductible plans. It argues that prior to the MLR, insurance companies had a mechanism to stabilize their loss ratio. But Obamacare's "unreasonable" rate increase provisions and "the MLR one-sided rebate formula" make it more difficult for HDPs to maintain MLR stability than for low-deductible plans.

What all of this means for consumers is that, ironically, while the "Affordable Care Act" was sold to the public on the premise that it would lower the price consumers pay for insurance, it instead appears that it will make it difficult for affordable HDPs and HSAs to compete with higher-premium plans.

[1] David Hogberg, "Obamacare Rule May Bar HSAs, Low-Cost Health Plans," *Investor's Business Daily*, (Dec. 7, 2011) *available at* http://news.investors.com/Article/594079/201112071853/obamacare-rule-hits-hsa-high-deductible-plans.htm.

[2] See Dan Perrin, "The New Medical Los Ratio Rule means No Bronze Plans, and No HSAs in ObamaCare Exchanges," *REDSTATE*, (Dec. 5, 2012) *available at* http://www.redstate.com/dan_perrin/2011/12/05/the-new-medical-loss-ratio-rule-means-no-bronze-plans-and-no-hsas-in-obamacare-exchanges/. This article seems to indicate that it will be impossible for HSA plans to meet the MLR standards. We are not yet convinced that this is the case. And it remains to be seen whether HSA plans will be able to exist in the Health Insurance Exchanges. Much depends on how employee and employer contributions are treated in calculating the "actuarial value" of the plans. (The actuarial value of a plan tells us the percentage of healthcare costs paid for by the health plan).

[3] Perhaps, this is because Milliman does not examine the effect on HDPs that "actuarial value" minimums will have as will be mandated by the Health Insurance Exchanges.

[4] Mark E. Llitow, et al., "Impact of Medical Loss Ratio Requirements Under PPACA on High Deductible Plans / HSAs in Individual and Small Group Markets," (Jan. 6, 2012) 3, *available at* http://www.hsacoalition.org/wp-content/uploads/2012/02/Report-ABAImpactofMedicalLossRatioRequirements.pdf.

[5] Milliman makes it clear that the MLR makes an adjustment for small, but not large, HDPs.

[6] *Supra* note 4 at 3.

[7] *Id*. at 6 (emphasis added).

Obamacare's Medical Device Tax: The power to destroy affordable care

The power to tax is the power to destroy.[1]

On February 3, 2012, the IRS issued a proposed rule that implements Obamacare's tax on medical devices.

Yes, starting next year the "Affordable Care Act" will require drug manufacturers to pay a 2.3% excise tax on medical devices.

How does that make healthcare more affordable?

It doesn't.

Our forefathers understood that the power to tax was the power to destroy. Daniel Webster in the seminal case, *McCulloch v. Maryland*, stated, "An unlimited power to tax involves, necessarily, a power to destroy." In his opinion for the case, Chief Justice John Marshall agreed with Webster. He said, "That the power to tax involves the power to destroy … [is] not to be denied."

The medical device tax's potential to destroy is demonstrated by a recent Manhattan Institute economic study. The study says the medical device tax will "double the device industry's total tax bill" and will make the United States less competitive as a manufacturer of healthcare devices in the world market. This could mean "job losses in excess of 43,000 and employment compensation losses in excess of 3.5 billion."

But it's not just the founders of yesteryear and present-day conservatives who believe in the power of taxes to destroy. Liberals understand and use it. They know that if you tax something, its cost will go up and individuals will purchase less of it. Obamacare created a tax on indoor tanning salons. The purpose? To discourage the use of indoor tanning.

Obamacare's authors were deluded to think they could heal the healthcare system by taxation while at the same time using taxation to destroy the indoor tanning industry.

[1] *Respectfully quoted: a dictionary of quotations requested from the Congressional Research Service*, Suzy Platt, ed., (1989) number 1798, *available at* http://www.bartleby.com/73/1798.html.

[2] *Id*.

How to Comment on a Regulation

1. Go to the Regulations page at: ObamacareWatcher.org
2. Choose a regulation.
3. Click on the "Comment Now" link to be directed to the Regulations.gov website.
4. Click "Submit a Comment" which is located towards the top of the page.
5. Fill out the comment form.

Glossary of Agency Abbreviations

CMS: Centers for Medicare and Medicaid Services

DOL: Department of Labor

EBSA: Employee Benefits Security Administration

HHS: Department of Health and Human Services

HRSA: Health Resources and Services Administration

IRS: Internal Revenue Service

OIRA: Office of Information and Regulatory Affairs

OWCP: Office of Workers' Compensation Programs

TREAS: Department of the Treasury

The power to destroy (cont.)

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[3] *Id.*

[4] Diana Furchtgott-Roth and Harold Furchtgott-Roth, Employment Effects of the New Excise Tax on the Medical Device Industry, (Sept. 2011), 2 available at http://www.chi.org/uploadedFiles/Industry_at_a_glance/090711EmploymentEf... .

[5] *Id.*

Upcoming Regulations

Medicaid Eligibility Expansion Under the Affordable Care Act of 2010
RIN: 0938-AQ62 **Agency:** HHS-CMS
Status: Under review by OIRA.

Payments for Primary Care Services Under the Medicaid Program
RIN: 0938-AQ63 **Agency:** HHS-CMS
Status: Under review by OIRA.

Establishment of Exchanges and Qualified Health Plans Part I
RIN: 0938-AQ67 **Agency:** HHS-CMS
Status: Under review by OIRA.

Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2013
RIN: 0938-AQ86 **Agency:** HHS-CMS
Status: Under review by OIRA.

Medicare and Medicaid Programs: Reform of Hospital and Critical Access Hospital Conditions of Participation
RIN: 0938-AQ89 **Agency:** HHS-CMS
Status: Under review by OIRA.

Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review
RIN: 0938-AQ83 **Agency:** HHS-CMS
Status: Under review by OIRA.

Long Term Care: Ethics and Compliance
RIN: 0938-AQ93 **Agency:** HHS-CMS
Status: Under review by OIRA.

Student Health Insurance Coverage
RIN: 0938-AQ95 **Agency:** HHS-CMS
Status: Under review by OIRA.

Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction
RIN: 0938-AQ96 **Agency:** HHS-CMS
Status: Under review by OIRA.

State Requirements for Exchange--Reinsurance and Risk Adjustments
RIN: 0938-AR07 **Agency:** HHS-CMS
Status: Under review by OIRA.

Health Information Technology: New and Revised Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology
RIN: 0991-AB82 **Agency:** HHS
Status: Under review by OIRA.

Regulations Implementing Amendments to the Black Lung Benefits Act: Determining Coal Miners and Survivors Entitlement to Benefits
RIN: 1240-AA04 **Agency:** DOL-OWCP
Status: Under review by OIRA.

Regulations Open for Comment

Ex Parte Cease and Desist and Summary Seizure Orders Under ERISA Section 521
RIN: 1210-AB48 **Agency:** DOL-EBSA
Status: Proposed rule. Public comments accepted through March 5, 2012.

Filings Required of Multiple Employer Welfare Arrangements and Certain Other Entities that Offer or Provide Coverage for Medical Care to the Employees of Two or More Employers
RIN: 1210-AB51 **Agency:** DOL-EBSA
Status: Proposed rule. Public comments accepted through March 5, 2012.

Administrative Simplification: Adoption of Standards for Electronic Funds Transfer (EFT)
RIN: 0938-AQ11 **Agency:** HHS-CMS
Status: Interim final rule with comment period. Public comments accepted through March 12, 2012.

Covered Outpatient Drugs
RIN: 0938-AQ41 **Agency:** HHS-CMS
Status: Proposed Rule. Comments accepted through 5:00pm, April 2, 2012.

Application for Recognition as a 501(c)(29) Organization
RIN: 1545-BK64 **Agency:** TREAS-IRS
Status: Notice of proposed rulemaking. Public comments accepted through April 9, 2012.

Reporting and Returning of Overpayments
RIN: 0938-AQ58 **Agency:** HHS-CMS
Status: Proposed Rule. Comments accepted through 5:00pm, April 16, 2012.

National Practitioner Data Bank
RIN: 0906-AA87 **Agency:** HHS-HRSA
Status: Notice of proposed rulemaking. Public comments accepted through April 16, 2012.

Taxable Medical Devices
RIN: 1545-BJ44 **Agency:** TREAS-IRS
Status: Notice of proposed rulemaking. Public comments accepted through May 7, 2012.

National Practitioner Data Bank
RIN: 0906-AA87 **Agency:** HHS-HRSA
Status: Notice of proposed rulemaking. Public comments accepted through April 16, 2012.

Medicare Program; Reporting and Returning of Overpayments
RIN: 0938-AQ58 **Agency:** HHS-CMS
Status: Notice of proposed rulemaking. Public comments accepted through 5pm, April 16, 2012.

For the latest status on these and other regulations, visit us at:

http://ObamacareWatcher.org

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