Supreme Court Decision on the Affordable Care Act

July 2, 2012
CHA Web Seminar
Anne O’Rourke is senior vice president for Federal Relations for the California Hospital Association. Based in Washington, DC, Ms. O'Rourke manages CHA’s Federal Relations office in Washington and represents the CHA membership before Congress and the White House, and serves as the liaison to other state and national health organizations.
Program Overview

Anne O’Rourke
California Hospital Association
Speaker Introductions

William Bernstein
Partner, Chair, Healthcare Division
WBernstein@manatt.com

- Bill Bernstein is chair of the firm’s healthcare division and a member of the firm’s Executive Committee.
- Mr. Bernstein’s practice concentrates on providing strategic, business and legal advice to clients in the healthcare industry, including provider organizations, managed care companies, emerging companies and financial institutions.
- He began his healthcare career working for the U.S. Department of Health, Education and Welfare.

Joel Ario
Managing Director, Manatt Health Solutions
JArio@manatt.com

- Joel Ario is a managing director of Manatt Health Solution and has over 30 years of experience helping to shape and implement public policy in the healthcare industry, including more than a decade devoted to leading insurance reform efforts at the state and federal government levels.
- Mr. Ario previously served as Director of the Office of Health Insurance Exchanges at the U.S. Department of Health & Human Services (HHS). Prior to his federal service, he was the Pennsylvania Insurance Commissioner (2007-10) and Oregon Insurance Administrator (2000-07).

Melinda Dutton
Partner, Healthcare Division
MDutton@manatt.com

- Melinda Dutton serves as a partner within the firm’s healthcare division and plays a leadership role within Manatt Health Solutions.
- Ms. Dutton has extensive experience working with public health insurance programs and the healthcare safety net, and represents a broad array of healthcare clients in navigating the legal, regulatory and political challenges of Medicaid, SCHIP and other public programs.
- She has written extensively on the laws and systems that govern public health insurance programs, particularly as they relate to eligibility, benefit delivery and reimbursement, and is currently advising foundations, state governments and provider groups on the implications of health reform.
The Supreme Court Decision on Healthcare Reform

Manatt Health Solutions

July 2012
Agenda

Impact of & Progress Implementing Affordable Care Act

Supreme Court Decision

Looking Ahead: Insurance Exchanges

Looking Ahead: Medicaid
Impact of & Progress Implementing Affordable Care Act
Nearly a Trillion Dollars in New Spending on Coverage

Estimated Federal Spending, in billions, 2014-2019

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Medicaid Expansion/</td>
<td>$38.8</td>
<td>$62.9</td>
<td>$78.7</td>
<td>$72.2</td>
<td>$76.3</td>
<td>$81.2</td>
<td>$410.1</td>
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<td>CHIP Funding</td>
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<td>Individual Premium</td>
<td>$38.4</td>
<td>$54.2</td>
<td>$68.3</td>
<td>$88.6</td>
<td>$98.7</td>
<td>$103.0</td>
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<tr>
<td>Individual Cost</td>
<td>$5.5</td>
<td>$7.2</td>
<td>$8.0</td>
<td>$10.5</td>
<td>$11.6</td>
<td>$12.5</td>
<td>$55.3</td>
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<td>Sharing Reductions</td>
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<tr>
<td>Small Employer</td>
<td>$5.7</td>
<td>$6.2</td>
<td>$1.6</td>
<td>$0.0</td>
<td>$0.0</td>
<td>$0.0</td>
<td>$13.5</td>
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<tr>
<td>Tax Credits</td>
<td></td>
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<tr>
<td>Total</td>
<td>$88.4</td>
<td>$130.5</td>
<td>$156.6</td>
<td>$171.3</td>
<td>$186.6</td>
<td>$196.7</td>
<td>$930.1</td>
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</tbody>
</table>

ACA by the Numbers

→ $4 billion: Additional federal revenue from mandate by 2017

→ Over $80 billion: Additional annual Medicaid spending by 2019 due to expansion

→ 50-83%: Fraction of state Medicaid costs that feds currently pays for

→ 90%: Fraction of state Medicaid costs that feds will pay for Medicaid expansion population at full implementation

State Investments in Coverage Reform to Date

Exchange Funding* | Medicaid Systems Funding | Exchange & Medicaid Systems Funding
---|---|---
States that have been awarded funding for Exchanges only | States that have applied for or been awarded funding for development of ACA-compliant Medicaid eligibility systems | States that have applied for or been awarded funding for both Exchange and development of ACA-compliant Medicaid eligibility systems

*$ Exchange funding includes Exchange Planning, Establishment and Early Innovator Grants awarded as of May 16, 2012 and net of any returns.

$1.13 billion
In Exchange funding

$1.07 billion
In Medicaid systems funding
### California Coverage Expansion Projections

<table>
<thead>
<tr>
<th>Type of Coverage for Californians Under Age 65 in 2019, in millions</th>
<th>Without ACA</th>
<th>Enhanced Scenario*</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>With ACA</td>
</tr>
<tr>
<td>Employer Sponsored Insurance</td>
<td>19.8</td>
<td>19.1</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>5.9</td>
<td>7.5</td>
</tr>
<tr>
<td>Healthy Families**</td>
<td>0.8</td>
<td>0.7</td>
</tr>
<tr>
<td>Other Public</td>
<td>1.3</td>
<td>1.3</td>
</tr>
<tr>
<td>Exchange with Subsidies</td>
<td>-</td>
<td>2.1</td>
</tr>
<tr>
<td>Individual Market / Exchange without Subsidies</td>
<td>2.3</td>
<td>2.2</td>
</tr>
<tr>
<td>Uninsured – Eligible for Coverage</td>
<td>4.7</td>
<td>2.0</td>
</tr>
<tr>
<td>Uninsured – Not Eligible for Coverage</td>
<td>1.1</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Notes: *Enhanced scenario based on a robust enrollment & retention strategy planned by state coverage programs. **Healthy Families to be folded into Medi-Cal. ^Change is less than 100,000.

In 2019, 1.6 M Californians are expected to be newly enrolled in Medi-Cal. 2.1 M Californians are expected to receive subsidized coverage via the exchange.

Source: [http://www.healthexchange.ca.gov/BoardMeetings/Documents/June19_2012/UCLA_UCB_9outof10CAsWillBeInsuredWhenACAFullyImplemented_June2012.pdf](http://www.healthexchange.ca.gov/BoardMeetings/Documents/June19_2012/UCLA_UCB_9outof10CAsWillBeInsuredWhenACAFullyImplemented_June2012.pdf)
# Federal ACA Funds For California

<table>
<thead>
<tr>
<th>Funding Area</th>
<th>Funding Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal Expansion</td>
<td>$43 B - $50 B between 2014-2019</td>
</tr>
<tr>
<td>Subsidies to Purchase Coverage through the Exchange</td>
<td>$4.8 B annually at full implementation</td>
</tr>
<tr>
<td><em>For low- and middle-income residents who buy subsidized insurance via the Exchange</em></td>
<td></td>
</tr>
<tr>
<td>Exchange Establishment Grants</td>
<td>$39 M (2011 grant)</td>
</tr>
<tr>
<td><em>Funds Exchange operations during a planning period</em></td>
<td>$188.2 M (to be requested)*</td>
</tr>
<tr>
<td>Medicaid Eligibility &amp; Enrollment Funds</td>
<td>$1.07 B (all states awarded to date)</td>
</tr>
<tr>
<td><em>CMS funds to support Medicaid’s share of cost associated with streamlined eligibility and enrollment systems</em></td>
<td></td>
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</table>

*Note: This amount is the request as presented to the California Health Benefit Exchange Board on June 12, 2012.*

Sources: Kaiser Family Foundation, Urban Institute, California Healthline, California Health Benefit Exchange website.
Supreme Court Decision
Overview of Decision

A divided Court ruled that:

- The ACA requirement for individuals to have insurance or pay a tax penalty is constitutional.

- States can choose not to expand Medicaid to cover all state residents under 133% FPL, without risking federal funding for their entire Medicaid program.

“The Affordable Care Act’s requirement that certain individuals pay a financial penalty for not obtaining health insurance may reasonably be characterized as a tax. Because the Constitution permits such a tax, it is not our role to forbid it, or to pass upon its wisdom or fairness.”

– Chief Justice Roberts in Majority Opinion

“In this case, the financial ‘inducement’ Congress has chosen is much more than ‘relatively mild encouragement’—it is a gun to the head.”

– Chief Justice Roberts in Majority Opinion

With the exception of the ruling that states can forgo Medicaid expansion, the Court leaves intact the entire ACA.
Impact on ACA: With One Exception, All Provisions Stand

**Insurance Reforms**
- Insurance reforms, including guaranteed issue, pre-existing condition restrictions, premium increase review, premium rebates based on medical loss ratio, etc.

**Exchange Establishment**
- Federal funding for the creation of health insurance Exchanges in every state

**Affordability**
- Premium and cost sharing subsidies to those with incomes under 400% of FPL to purchase insurance through Exchanges

**Delivery System Redesign**
- Substantial payment and delivery reforms, including duals demonstration, patient centered medical home initiatives, accountable care organization pilots and support for primary care

**Eligibility & Enrollment**
- Redesigned eligibility and enrollment systems across insurance affordability programs
Reaction Among Insurers & Providers

“This ruling removes a distraction from the job that thousands of Californians have come together to address... The state is moving full-speed ahead...

We look forward to making the purchase of insurance through California's exchange as easy as buying a book on Amazon or shoes on Zappos.”

– Peter Lee, Executive Director of California Exchange

“The law expands coverage to millions of Americans, a goal health plans have long supported, but major provisions, such as the premium tax, will have the unintended consequences of raising costs and disrupting coverage unless they are addressed.”

– Karen Ignagni, America’s Health Insurance Plans’ President and CEO

“If states do not avail themselves of this opportunity . . . The federal money will go to other states, and hospitals will be left with large numbers of the uninsured.”

– Richard Umbdenstock, AHA President

"This is a very great day . . . California has been a leader in health care reform for a very long time. We've had many starts and stops, and we are now in the full go mode here.”

– Diana Dooley, California HHS Secretary
## Implications for Insurers

<table>
<thead>
<tr>
<th>Benefits &amp; Opportunities</th>
<th>Continuing Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MAINTAIN</strong> access to market expansion driven by Exchanges and premium tax credit subsidies</td>
<td><strong>#1 Issue:</strong> Limited ability to bend the medical cost curve</td>
</tr>
<tr>
<td><strong>RELY</strong> on the individual mandate to help stabilize risk pools</td>
<td><strong>Sufficiency of penalties to drive uptake of coverage among healthy populations</strong></td>
</tr>
<tr>
<td><strong>INTENSIFY</strong> efforts to drive delivery system reform, including collaborating with stakeholders to reduce the cost of health care delivery</td>
<td><strong>Potentially smaller market growth than expected if states do not opt-in for Medicaid expansion</strong></td>
</tr>
<tr>
<td><strong>EXERT</strong> pressure to leverage the ACA’s Medicaid expansion opportunity (Medicaid managed care carriers)</td>
<td><strong>Rate reviews</strong></td>
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<tr>
<td></td>
<td><strong>Potential for modifying specific ACA provisions related to:</strong></td>
</tr>
<tr>
<td></td>
<td>– Insurer tax – Expected to raise premiums by 2-3% for small businesses and individuals</td>
</tr>
<tr>
<td></td>
<td>– Open enrollment periods</td>
</tr>
<tr>
<td></td>
<td>– Ratio for rating variation based on age</td>
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</table>
Implications for Providers

The ACA has and will continue to support substantial payment and delivery reforms. Providers will continue to face a number of considerations.

**Payment Innovation:** Duals demonstration, Bundled Payments, ACOs, Innovation Center grants, advanced primary care demonstrations (i.e., PCMH), etc.

**The Drive Toward Transformation:** The demand for risk-based contracting is likely to increase. Providers will have to continue efforts to redesign systems, moving toward increasingly transparent and data-driven infrastructures.

**Temporary Increases in Primary Care Payment Rates:** Increase Medicaid rates for parity with Medicare (2013 – 2014), temporary 10% Medicare bonus (2011-2015).

**DSH & Payment Cuts:** In states that do not choose to expand Medicaid, hospitals will face both the cuts and the need to serve an uninsured population. The Medicare Independent Payment Advisory Board will also continue in its capacity of recommending spending cuts when Medicare exceeds certain growth targets.

**Focus on Workforce:** The ACA makes major investments in workforce expansion through scholarships, loan repayment, changes to graduate medical education, etc.

**Narrow Networks:** As Exchanges develop QHP selection criteria, providers will need to ensure inclusion in narrow network products.
Looking Ahead:
Insurance Exchanges
One Stop Shop for Health Insurance: How Health Benefit Exchanges Work

1. Apply for coverage
2. Select health plan
3. Enroll in health plan
4. Insured
Visions for California’s Exchange

**Price Leader**
A driver of lower premiums, focusing on the Exchange as primarily a cost-focused marketplace that offers competitively priced health plans

*Implications:* Could limit number of carriers to drive scale, preferring limited networks

**Service Center**
Consumer destination, focusing on providing customers with a best-in-class user experience and wide range of products and services

*Implications:* May attract larger non-subsidized membership

**Likely Exchange Focus**

**Change Agent**
Catalyst of finance and delivery reform, encouraging innovation and reducing costs, while improving quality, and efficiency

*Implications:* Likely to promote vertically integrated care systems and/or plans with non-overlapping competing provider systems

**Public Partner**
Support Medi-Cal in improving health status and outcomes of low-income, high-need individuals, focusing on enrollment, retention & care continuity

*Implications:* May yield smaller non-subsidized membership

# Five Core Functions of Exchanges

<table>
<thead>
<tr>
<th><strong>Consumer Assistance</strong></th>
<th>Consumer support assistors; education and outreach; Navigator management; call center operations; website management; and written correspondence with consumers to support eligibility and enrollment.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Management</strong></td>
<td>Plan selection approach (e.g., active purchaser or any willing plan); collection and analysis of plan rate and benefit package information; issuer monitoring and oversight; ongoing issuer account management; issuer outreach and training; and data collection and analysis for quality.</td>
</tr>
<tr>
<td><strong>Eligibility</strong></td>
<td>Accept applications; conduct verifications of applicant information; determine eligibility for enrollment in a Qualified Health Plan and for insurance affordability programs; connect Medicaid and CHIP-eligible applicants to Medicaid and CHIP; and conduct redeterminations and appeals.</td>
</tr>
<tr>
<td><strong>Enrollment</strong></td>
<td>Enrollment of consumers into qualified health plans; transactions with Qualified Health Plans and transmission of information necessary to initiate advance payments of the premium tax credit and cost-sharing reductions.</td>
</tr>
<tr>
<td><strong>Financial Management</strong></td>
<td>User fees; financial integrity; support of risk adjustment, reinsurance, and risk corridor programs.</td>
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Three Exchange Options for States

State-based Exchange
State operates all Exchange activities; however, State may use Federal government services for the following activities:
- Premium tax credit and cost sharing reduction determination
- Exemptions
- Risk adjustment program
- Reinsurance program

State Partnership Exchange
State operates activities for:
- Plan Management
- Consumer Assistance
- Both

State may elect to perform or can use Federal government services for the following activities:
- Reinsurance program
- Medicaid and CHIP eligibility: assessment or determination*

Federally-facilitated Exchange
HHS operates; however, State may elect to perform or can use Federal government services for the following activities:
- Reinsurance program
- Medicaid and CHIP eligibility: assessment or determination*

Partnership Exchange can be a way station to a State-based Exchange or a long term allocation of responsibilities.

Source: CCIIO, Draft Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges.
Current State Exchange Positioning

- **Leading states**: States best positioned to achieve certification of a State-Based Exchange (SBE)
- **Federal exchange states**: states that have indicated they are not pursuing an SBE or a partnership exchange (subject to change)
Implications: States’ Exchange Development

- **20 States With Chance of Certifying State-Based Exchange by End of Year**
  - Intensify efforts to submit state-based exchange application by November 16
  - Submit partnership application if not ready or as back up

- **24 States Conflicted Over Exchange Implementation**
  - Accelerate agency level work to submit "robust" partnership application
  - Remain in holding pattern but keep option open to submit "bare-bones" partnership application

- **6 States Most Likely to Default to Federally-Facilitated Exchange**
  - Default to FFE by state choice or HHS decision

**State-Based Exchange**

**Partnership**

**Federally-Facilitated Exchange**
California Exchange: Key Dates

**Sept 30 2012:** Deadline to select benchmark Essential Health Benefits plan.

**Nov 16, 2012:** Request federal certification for Exchange operations.

**Nov 2012:** Execute agreements with DHCS (Medi-Cal) & MRMIB (CHIP) agencies to define eligibility and enrollment responsibilities and cost allocation of federal funds.

**Dec 31 2014:** Exchanges must be self-sustaining.

**March 2013:** Complete business rules and workflow for all eligibility & enrollment operations.

**July 1 2013:** Finalize QHP contracts.

**Jan 1 2013:**
- Receive conditional or full exchange certification from Secretary.
- QHP solicitation bids due.
- Initiate marketing & outreach campaign.
- Launch assisters training program.

**Jan 1 2014:** Exchange goes live.

**Oct 1 2013:** Proposed open enrollment begins.

**Oct 1 2013:**
- Proposed open enrollment begins.

**Jan 1 2014:** Exchange goes live.

**Feb 1 2014:** Exchange Operations initiated.

**June 29 2012:** Apply for Establishment Level 1.2 Grant.*

**Aug or Nov 2012:** Apply for Establishment Level 1.3 Grant.

**Sept 30 2012:** Deadline to select benchmark Essential Health Benefits plan.

**Nov 16, 2012:** Request federal certification for Exchange operations.

**July 1 2013:** Finalize QHP contracts.

**Jan 1 2013:**
- Receive conditional or full exchange certification from Secretary.
- QHP solicitation bids due.
- Initiate marketing & outreach campaign.
- Launch assisters training program.

**Nov 1 2014:** Last Exchange Establishment application deadline.

Key Challenges Facing Exchanges

Can the Exchange achieve enough scale to have large and balanced risk pools?

→ California has sufficient population to give it a leg up on the “large” part

→ The “balance” part depends, in part, on the effectiveness of the mandate and that is iffy given the small penalties/taxes and continued controversy

Can the Exchange be ready for certification as an SBE by the end of 2012?

→ California is leading state but still challenged to be ready this year

→ Fallbacks are “conditional certification” or temporary partnership

→ Partnership depends on Federally-facilitated Exchange (FFE) being ready

What contracting approach should the Exchange use to best serve consumers?

→ National trend, including FFE, is to start with “open marketplace” approach

→ California considering its options under selective contracting authority
Looking Ahead:
Medicaid
Medicaid: Adult Expansion Now State Option

The Supreme Court’s reasoning:

- Congress can attach conditions to federal programs, but cannot coerce states to participate

- The adult expansion constitutes “a shift in kind, not merely degree” in the Medicaid program, changing its fundamental nature in a way not predictable to states, and thus constituting a new program

- Conditioning existing Medicaid funds on implementation of new adult expansion constitutes a coercion of states to participate in the new program
  - “The threatened loss of over 10% of a State’s overall budget ... Is economic dragooning that leaves the states no real option but to acquiesce in the Medicaid expansion.”

States failure to expand Medicaid to all adults under 133% FPL cannot result in a loss of existing federal Medicaid funds
Medicaid Expansion under the ACA

Covers qualified adults <65 with incomes up to 133% FPL

Provides “benchmark” benefits to new coverage group

Enhanced federal funding
  - 100% federally funded 2014-16
  - Gradually reducing to 90% in 2020 and thereafter
Medicaid Expansion: FPL & Federal Match Timeline

In 2014, four “Insurance Affordability Programs” will be available to individuals with incomes below 400% FPL.

<table>
<thead>
<tr>
<th>Year</th>
<th>State Share</th>
<th>Federal Share</th>
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<tbody>
<tr>
<td>2014</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>2015</td>
<td>0%</td>
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<td>7%</td>
<td>93%</td>
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<tr>
<td>2020</td>
<td>10%</td>
<td>90%</td>
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</table>
The Rest of the ACA’s Medicaid Provisions Stand

**Maintenance of Effort** provision requiring states to keep current eligibility levels/procedures the same for Medicaid & CHIP until 2014 for most adults and 2019 for children.

**Modified Adjusted Gross Income (MAGI)** a standardized definition of income to determine program eligibility.

**DSH Reductions** of $14.1 billion between 2014 and 2019.

**Streamlined Eligibility and Enrollment**, including consumer-friendly, streamlined systems to determine eligibility for insurance affordability programs and to enroll and re-enroll persons eligible for these programs.

**Primary Care Payment Increases**, for parity with Medicare payment rates (in 2013 and 2014 only).

**Benchmark Coverage or Benchmark-Equivalent Coverage** must cover Essential Health Benefits and meet mental health parity requirements.
Implications: Medicaid Expansion Still Attractive

Richest federal match available in the history of the program

60% of current Medicaid funds are used for optional populations or services.

100% federal funding for the first 3 years, leveling off at 90 cents on the dollar in 2020 and beyond.

Optional programs with lower federal matching rates, including CHIP, have been implemented in most states.

Opportunity for federally financed coverage to displace state-funded services and programs

While politically awkward for some, the adult Medicaid expansion will be difficult for most states to refuse.
Medicaid Expansion: What’s at Stake for Declining States?

States choosing not to expand must consider:

40% of the uninsured have incomes below 133% FPL

Tax credits are not available to most individuals below 100% FPL under the ACA

Providers are facing a dramatic decrease in DSH funds traditionally used to cover the uninsured
Open Questions

Is the adult expansion an “all or nothing” choice?
- Will states be allowed to expand adult coverage to levels less than 133% and receive the enhanced match?

When will states need to make a decision?
- With Blueprint submission?
- Will states be able to opt in and out of the adult coverage option over time?

Are enhanced matching funds for systems upgrades/operations tied to the expansion?
- Is the 90/10 match for Medicaid systems upgrades available to non-expansion states?
- Is the 75/25 match for operating costs available in non-expansion states?

How will the Medicaid/Exchange interface work in non expansion states?
- What are the issues for the FFE?
- In non-electing states, will some individuals overstate their incomes to access PTCs? What are the federal cost implications? Adverse selection implications?
ACA Medicaid Changes: Key Dates

Develop business rules and workflow for all eligibility & enrollment operations.

Q3 - Q4 2012

Q1 – Q2 2013

Q3 – Q4 2013

Q1 – Q2 2014

Q3 – Q4 2014

Q1 – Q2 2015

Q3 – Q4 2015

CalHEERS solicitation is awarded. Vendor begins work on streamlined eligibility and enrollment operations.

California Exchange

CA HBE executes working agreement with MRMIB and DHCS

Affordable Care Act Provisions

Primary care payment increases (100% federally funded)

Medicaid expansion to 133% FPL (100% fed. funds)

DSH reductions begin

Redesigned eligibility & enrollment systems launch

Basic Health Plan launches (for states opting in)
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C. Duane Dauner was appointed president/CEO of the California Association of Hospitals and Health Systems (CAHHS) in November 1985. On Jan. 1, 1996, CAHHS transformed into the California Hospital Association (CHA) and Mr. Dauner was appointed president/CEO of this new organization, as well. CHA is devoted to statewide representation and advocacy for California’s health care organizations and is one of the nation’s largest state health care associations, representing nearly 400 hospitals and health systems.
Supreme Court Affordable Care Act Decision & The Political Landscape

Duane Dauner
California Hospital Association
Political Messages

- Waited months for the SCOTUS Decision
- House will vote (again) to repeal
  - Senate will not bring it up
- Conventional wisdom
  - Win at the Court; lose the political message
- With Chief Justice Roberts writing the decision, may not play out that way
- Next chapter is the November elections
Campaign 2012

- Expect to see the Republicans focus on the “tax” label for the penalty, cuts in Medicare
- Expect to see the President and his allies focus on the popular components of the law
  - Guaranteed issue
  - Ban on pre-existing conditions
  - Coverage for young adults
  - Quality improvements
- Long overdue education campaign
  - President failed at this before
Fate of ACA Rests on the Outcome in November

- Repeal is possible
- Reconciliation – DC-speak for a process to circumvent the 60-vote requirement in the Senate
  - Live by the sword – die by the sword
- **IF** the Republicans gain a simple majority in the Senate they could repeal the financial components of the ACA
- **IF** the Republicans retain control of the House and Romney wins the White House
Regardless of the Election Outcome

End of this year …

- Moratorium on Medicare physician cuts expires
- Payroll tax cut expires
- Bush & Obama tax cuts expire
- Sequester scheduled to kick in
- Debt ceiling will need to be extended

EXPECT DELAYS
Five Months From Now

If Congress doesn’t act significant savings to the federal treasury will accrue:

- Letting sequester kick in $-1.2$ trillion
- Letting Bush/Obama tax cuts expire $-4$ trillion

Medicare and Medicaid Payments won’t be spared if efforts to block sequestration or extend the tax cuts must be offset with federal savings.
California is Moving Forward

California’s officials continue to implement:

- Young adults to remain on parents health plans
- Block insurers from setting lifetime caps on benefits
- Established the California Health Benefit Exchange
- Prohibit insurers from denying coverage to children with pre-existing conditions
California is Moving Forward

California’s officials continue to implement:

- Medicaid expansion to cover 1.5 to 2 million people
- 47 counties participating in “Bridge to Reform” waiver
- About 2 million expected to buy through the Exchange
- “Full-go mode” (Secretary Dooley)
Thank you

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Questions

Online questions:
Type your question in the Q & A box, hit enter

Phone questions:
To ask a question hit 14
To remove a question hit 13
2012 Publications

- California Hospital Survey Manual (New publication)
- California Hospital Compliance Manual
- Consent Law
- Principles of Consent and Advance Directives
- Minors and Health Care Law
- Mental Health Law (Available July 2012)
- California Health Information Privacy Manual (Available Summer 2012)

Learn more at www.calhospital.org/publications
Upcoming Programs

- Licensing and Certification Survey Basics
  *August 21, 2012, Web Seminar*

- Disaster Planning for California Hospitals
  *October 15 – 17, 2012, Sacramento*

- Behavioral Health Care Symposium
  *December 3 – 4, 2012, Huntington Beach*

- Post-Acute Care Conference
  *January 31 – February 1, 2013, Huntington Beach*

- Rural Health Care Symposium
  *March 13 – 15, 2013, Sacramento*
Thank you for participating in today’s program. An online evaluation will be sent to you shortly.

For education questions, contact Liz Mekjavich at (916) 552-7500 or lmekjavich@calhospital.org.