

The PPACA: A Critical Analysis of its Under-Funding,
Preexisting Condition Exclusion Ban, and
Individual Mandate

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I. INTRODUCTION

The Patient Protection and Affordable Care Act (PPACA) has initiated the implementation of sweeping changes to the general structure of the American healthcare system.¹ However, the PPACA has not been without controversy, as it received both praise and condemnation from both sides of the political aisle. This is largely because of three of its controversial components. Specifically, (1) the mandatory purchase of insurance by individuals, (2) the inability of a private insurer to deny an applicant based on a preexisting condition, and (3) the projected impact on premiums and cost of care.² Although independent to some extent, these provisions are inextricably connected to one another and affect both the insurer and insured. A major component of the structural changes to health care brought about by the PPACA involves the insurance industry and has resulted in the creation a number of obstacles insurers will need to confront and overcome. This text seeks to address the nature of these changes and their short and long-term impact on the cost of healthcare to insurers and individuals alike. This article will begin by discussing the basic framework of the insurance industry. It will then address the changes imposed on insurance markets via the PPACA. The article will

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1. Patient Protection and Affordable Care Act, Pub. L. No.111-148, 124 Stat. 461 (2010) [hereinafter PPACA]. It is important to note, however, that the constitutionality of this Act has been successfully challenged in a Florida District Court and the Supreme Court has yet to hear this issue or their opinion. *See Florida ex rel. Bondi v. U.S. Dept. of Health & Human Servs.*, 3:10-CV-91-RV EMT, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011), *order clarified by* 3:10-CV-91-RV/EMT, 2011 WL 723117 (N.D. Fla. Mar. 3, 2011).

2. *See HINDA CHAIKIND ET AL., CONG. RESEARCH SERV., R40942, PRIVATE HEALTH INSURANCE PROVISIONS IN PPACA (P.L. 111-148) (Apr. 15, 2010).*

primarily focus on two components of the PPACA: (1) the insurance mandate, and (2) the elimination of pre-existing injury discrimination. I will then conclude by arguing that these changes will lead to higher premiums and an infringement on private markets.

II. INSURANCE IN A NUTSHELL

Insurers normally categorize their customers between two segments: the self-insured market, which is largely employer-based plans, and the small-group/individual market.³ In the self-insured market, employers bear the financial risk for an employee's health and the insurer usually assumes the role of a third-party administrator.⁴ The federal Employment Retirement Income Security Act (ERISA) primarily governs this market.⁵ Conversely, in the small group and individual markets, insurers take on a more traditional role in assuming the financial risk of the insured's illnesses and are governed by state insurance regulations.⁶

At its most basic level, health insurance spreads the cost of health care across a pool of individuals to maintain solvency through using premium revenue from those currently without medical expenses to pay for those in the plan whose incurred expenses at the time are above their individual premium payment.⁷ Participants in the same insurance plan are said to be in the same "risk pool."⁸ These risk pools are only functional if they include enough healthy individuals to keep aggregate healthcare expenditures lower than premium costs in order to cover those who are ill.⁹ Generally, the larger the population in the pool, the more predictable and stable premiums are because the high outlier costs of a few are spread out across many individuals.¹⁰ To ensure reasonably predictable and stable costs, insurers attempt to maintain risk pools of individuals with health needs similar to or better than that of the general population.

3. Troyen A. Brennan & David M. Studdert, *How Will Health Insurers Respond to New Rules Under Health Reform*, 29 HEALTH AFF. 1147, 1147 (2010).

4. *Id.*

5. *Id.* Self-insured markets are comprised of companies that bear a lot of the risk of the healthcare payment for employees and limit the liability and exposure of an insurance corporation. Individual markets are built of those who privately seek insurance for themselves and do not obtain it through work.

6. *Id.*

7. Lawrence O. Gostin & Elenora E. Connors, *Health Care Reform in Transition- Incremental Insurance Reform Without an Individual Mandate*, 303 JAMA 1188, 1188 (2010).

8. *Id.*

9. *Id.*

10. *Id.*

Insurance companies often have difficulty with stabilization because, as expected, those needing health care are more likely to seek insurance than those with a low risk of need. This is commonly known as “adverse selection” and results when there is a surplus of people with poorer-than-average health in a given pool.¹¹ Insurers combat these issues with techniques such as rescission or cancellation of policies, lifetime limits on payments, and medical underwriting.¹² A lifetime limit, which varies by plan, serves to cap the amount of money an insurer will pay out to a given insured. Additionally, the method of regulating these defenses and insurers in general varies from state to state and there is no uniform system of evaluation.¹³

III. PPACA CHANGES TO THE EXISTING HEALTHCARE SYSTEM

Section 1513 of the PPACA requires all Americans to obtain insurance via one of the various outlined methods or face a penalty tax as a result.¹⁴ A penalty tax is a tax incurred by an individual not based on income, but instead as a result of an action, or inaction, on something that the government wishes to encourage, or discourage, through the use of tax consequences.¹⁵ The PPACA further utilizes tax incentives to facilitate its goals in several ways. For instance, employers with a staff of over fifty will be required to provide insurance to their employees or face fines and tax penalties.¹⁶ By contrast, employers with a staff of less than twenty-five will receive a tax credit for providing insurance.¹⁷

Aside from the impact on consumers and employers, insurers will also see sweeping changes to markets in 2014. To begin, the PPACA implements statewide insurance,

11. Brennan & Studdert, *supra* note 3, at 1147-48.

12. *Id.*; Mark V. Pauly, *Avoiding Side Effects in Implementing Health Insurance Reform*, 362 *NEW ENG. J. MED.* 671, 671 (2010).

13. Brennan, *supra* note 3, at 1148; Ilya Shapiro, *State Suits Against Health Reform Are Well Grounded In Law- and Pose Serious Challenges*, 29 *HEALTH AFF.* 1229, 1230 (2010).

14. PPACA, *supra* note 1, at § 1513.

15. See Bruce J. Douglas & Kelly M. Burke, *Patient Protection And Affordable Care Act - How it Will Be Funded*, LARKIN & HOFFMAN ATT'YS (Apr. 22, 2011, 6:39PM), http://www.larkinhoffman.com/news/article_detail.cfm?ARTICLE_ID=636; Subsidies have been made available to assist low income individuals with this tax. Scott E. Harrington, *U.S. Health-Care Reform: The Patient Protection and Affordable Care Act*, 77 *J. RISK & INS.* 703, 704 (2010).

16. For employers not offering insurance, they will pay \$2000 per employee not receiving a premium credit (subsidy), excluding the first 30 employees. Employers that offer coverage with one or more employees receiving premium tax credit will pay specified fees. *Id.* at 704.

17. Provided the average wages are not greater than \$50,000. *Id.*

which will act as a “one stop shop” for health insurance.¹⁸ Additionally, states will have the option to create joint exchanges with each other as well.¹⁹ Insurers participating in the exchanges, and those offering coverage outside of an exchange, will be restricted to offering four coverage tiers (bronze, silver, gold, and platinum), along with a catastrophic plan for young adults.²⁰ Applicants will be guaranteed insurance, and insurers will have to accept all applicants regardless of health status.²¹ Premium rates will be allowed to vary only by coverage tier, number of dependents, geographic region, age (3:1 ratio), and tobacco use (1.5:1 ratio).²² Thus, preexisting condition exclusions and rates based on health status (underwriting) will no longer be allowed in policy determinations. There will also be an excise tax on high-end, or “Cadillac,” insurance plans beginning in 2018.²³

Insurers will be required to report medical loss ratios and spend a minimum of 85 percent of premiums for large group coverage and 80 percent for individual and small group coverage on medical care, rather than overhead costs, etc.²⁴ They must issue rebates if they do not meet these requirements.²⁵ States are to establish a process of reviewing health insurance rate increases and requiring insurers to justify the increases they deem to be unreasonable.²⁶ Alongside mandating a review process, the PPACA established the Office of Consumer Information and Oversight to assist the states in their review of rates.²⁷

The PPACA further establishes various insurance market changes to become effective during 2010 and 2011, including: (1) the creation of temporary high-risk pools to provide subsidized coverage to individuals with preexisting medical conditions who have been

18. PPACA, *supra* note 1, at §§ 1301-04.

19. Linda J. Blumberg, *Timely Analysis of Immediate Health Policy Issues*, ROBERT WOOD JOHNSON FOUND. (April 2011), available at www.rwjf.org/files/research/72109multistateexchanges201104.pdf.

20. PPACA, *supra* note 1, at §§ 1301-04.

21. PPACA, *supra* note 1, at §§ 1201, 2702 (adding new Public Health Service Act).

22. Harrington, *supra* note 15, at 704.

23. “Cadillac” plan is defined as a plan that charges greater than \$27,500 for families and \$10,200 for individuals, excluding vision and dental. Also, 80-85% of revenue generated by insurance companies must be used for actual patient care and profits will be capped at 15-20%. Peter R. Orszag & Ezekiel J. Emanuel, *Health Care Reform and Cost Control*, 363 NEW ENG. J. MED. 601, 602 (2010); Joseph P. Newhouse, *Assessing Health Reform’s Impact on Four Key Groups of Americans*, 29 HEALTH AFF. 1714, 1718 (2010).

24. PPACA, *supra* note 1, at §§ 1331, 1342.

25. Phased in between 2010 and 2011. Harrington, *supra* note 15, at 704.

26. PPACA, *supra* note 1, at § 1311.

27. Harrington, *supra* note 15, at 704 (the law does not provide the federal government with the authority to regulate rates or require prior approval of rates by the states).

uninsured for 6 months; (2) the prohibition of preexisting condition exclusions for children under the age of 19; (3) extension of coverage to adult children up to age 26; (4) regulation of annual and lifetime benefit limits prior to their elimination in 2014; and (5) prohibition of policy rescissions absent fraud. Existing conditions will be grandfathered in subject only to changes to conform to the new laws.²⁸

These changes have shifted the very foundation of the insurance industry. While the PPACA in certain regards seeks to help insurers, its regulation of pre-existing injuries, premium control, and medical-loss ratios present hurdles to sustainability not easily overcome.²⁹ The inability to base premium coverage on the health characteristics of applicants and to deny insurance to high-risk individuals will cause insurers to need to seek other methods of revenue generation, which will most likely come at a cost to consumers.³⁰

IV. THE INDIVIDUAL MANDATE

The individual mandate, a requirement that all consumers possess some level of health insurance, is a misleading term, and one that the government relied upon to justify prohibiting denials based on pre-existing injuries.³¹ While the mandate applies to most Americans, it exempts dependents, persons receiving coverage from Medicare, Medicaid, or their employer under a qualified plan, military families, persons living overseas, and persons with religious objection.³² A newly enacted portion of the Internal Revenue Code outlines the penalty for not complying with the mandate as an excise tax; the amount of which will prove largely insufficient to enforce widespread compliance.³³ This mandate serves as both the keystone to any plausible success of the PPACA as well as a controversial and arguably unconstitutional intrusion by the federal government into a citizen's fundamental liberties and freedom.

28. *Id.* at 706.

29. PPACA, *supra* note 1, at §§ 1201, 1331, 1342, 2702; Harrington, *supra* note 15, at 704.

30. *Health Reform Regulations on Preexisting Condition Exclusions*, HUB INTERNATIONAL (Aug. 9 2010), available at [http://www.hubinternational.com/uploadedFiles/Health_Care_Reform/Preex%20Conditions%20Exclusions\(2\).pdf](http://www.hubinternational.com/uploadedFiles/Health_Care_Reform/Preex%20Conditions%20Exclusions(2).pdf).

31. PPACA, *supra* note 1, at § 1501(a).

32. Jack M. Balkin, *The Constitutionality of the Individual Mandate for Health Insurance*, 362 NEW ENG. J. MED. 482, 482 (2010).

33. 26 U.S.C.A. § 5000A (2010).

The largest controversy surrounding the individual mandate involves the constitutionality of the provision. Shortly after passage of the PPACA, the Florida Attorney General, Bill McCollum, and 19 other Attorneys General, filed a lawsuit to overturn the law citing several constitutional arguments; namely that the Commerce Clause does not cover this regulation and therefore the matter should be left to the states.³⁴ Also, the lawsuit questioned the constitutionality of the penalties imposed on individuals who elect not to purchase insurance, suggesting that they are a direct tax in violation of Article I, sections two and nine, of the Constitution.³⁵

Additionally, in a recent Michigan decision, the court disagreed with both arguments and held that the federal government has broad power under the Commerce Clause to regulate insurance because the allocation of money away from the insurance market by individuals who did not purchase insurance would have widespread effects.³⁶ In addition, the court held the tax was allowable because its congressional intent was not to generate revenue but to serve as an incentive to buy insurance.³⁷

Aside from its constitutionality, it remains unclear whether the individual mandate will even work. Beginning in 2014, “both employer and individual mandates will be in place, and most medical underwriting will be eliminated.”³⁸ Health insurance exchanges will “demystify” the purchase of coverage and arguably dictate which products will be available and negotiate the rates that can be charged.³⁹ The problem here is that insurers will now have uniform prices comparable to plans offered by competitors in an exchange program and little to no influence over who purchases the plans. Under strong and tightly enforced mandates, insurers could possibly construct a reasonable risk pool assuming that

34. See Florida *ex rel.* Bondi v. United States Dept. of Health & Human Servs., 3:10-CV-91-RV EMT, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011), *order clarified by* 3:10-CV-91-RV/EMT, 2011 WL 723117 (N.D. Fla. Mar. 3, 2011).

35. *Id.*; Shapiro, *supra* note 2, at 1231; Brennan, *supra* note 3, at 1148.

36. Thomas More Law Ctr. v. Obama, 720 F. Supp. 2d 882 (E.D. Mich. 2010)

37. Order Denying Plaintiffs’ Motion for Injunction and Dismissing Plaintiffs’ First and Second Claims for Relief [Doc. #7] at 19, *Thomas More Law Ctr. v. Barack Hussein Obama, President of the United States*, No. 10-CV-11156 (E.D. Mich. Oct. 7, 2010), available at <http://www.justice.gov/healthcare/docs/thomas-more-v-obama-order-denying-motion.pdf>.

38. Brennan, *supra* note 3, at 1148; Harrington, *supra* note 15, at 704; *Preexisting Condition Exclusions & The New Health Reform Regulations*, NAT’L HEALTHCARE REFORM MAG., Aug. 03, 2010, <http://heathcarereformmagazine.com/article/preexisting-condition-exclusions-the-new-health-reform-regulations.html> [hereinafter *Health Reform Regulations*].

39. Brennan, *supra* note 3, at 1148.

they were able to keep premiums at a reasonable price for both them and those insured.⁴⁰ However, many insurers fear that the individual mandate's penalties are not adequate to force compliance.⁴¹

In the absence of functional and competently operated mandates, insurers would almost inevitably end up with uneven risk pools as the lower-risk insured individuals choose to partake in "gaming," rather than purchase insurance.⁴² The idea of gaming the system describes a trend among consumers to refrain from purchasing insurance and accept a tax penalty less than their premium would otherwise be, because economically it is a more prudent move to pay a lesser tax until medical costs rise, with the knowledge that insurance will be available when it is actually needed.⁴³ The absence of any underwriting or preexisting condition exclusion will allow those who have been injured to obtain the insurance when they require it, rather than before they need it.⁴⁴ Under the PPACA, for 2014, the penalties incurred in taxation will be the greater of \$95 or 1.0% of taxable income.⁴⁵ The tax increase in 2015 is the greater of \$395 or 2.0% of taxable income.⁴⁶ What this means is that it will be economically cheaper to forgo insurance and simply pay the penalty. Finally, in 2016 the penalty will fully mature to the greater of \$695 or 2.5% of taxable income.⁴⁷ Even under these circumstances, a majority of people faced with this decision will likely pay the tax penalty or look to government subsidized insurance rather than incur a private insurer premium.

PPACA advocates point out that in an effort to curb this, those who purchase insurance in a given year can pay to be shielded by subsequent yearly increases, meaning that you will pay less if you buy sooner. While this is a start, it is far from an answer. The mandate's success will make or break this reform, and until it is shown to be

40. *Id.* at 1148.

41. *Id.* at 1148; Deborah J. Chollet, *How Temporary Insurance for High-Risk Individuals May Play Out Under Health Reform*, 29 HEALTH AFF. 1164, 1165 (2010).

42. Brennan, *supra* note 3, at 1148; Newhouse, *supra* note 23, at 1717.

43. See generally PPACA, *supra* note 1, at § 1311; Dave Petno, *Game On! How guaranteed issue coverage and PPACA will cause employers and individuals to cancel their coverage, and join the ranks of the uninsured*, NAT'L HEALTHCARE REFORM MAG. (Aug. 3, 2010), <http://www.healthcarereformmagazine.com/article/game-on-how-guaranteed-issue-coverage-and-ppaca-will-cause-employers-and-individuals-to-cancel-their-coverage-join-ranks-uninsured.html>.

44. PPACA, *supra* note 1, at § 1201.

45. 26 U.S.C.A. § 5000A (2010).

46. *Id.*

47. *Id.*

effective there will continue to be doubt surrounding the ability of this bill to bring down premiums and equalize the insurance market.

V. PREEXISTING CONDITION

The PPACA has largely altered both the Health Insurance Portability and Accountability Act (HIPAA) definition of a “pre-existing condition” as well as the ability of a private insurer to deny coverage based on it.⁴⁸ This is a bold and aggressive governmental move that controversially crosses into the private sector and regulates the ability for insurers to select, and reject, plan participants. A “‘preexisting condition exclusion’ is a plan provision that limits or excludes benefits or plan coverage based on the fact that a condition was present before the effective date of coverage.”⁴⁹ It applies whether medical advice, diagnosis, care, or treatment that was recommended or received before the date or not.⁵⁰ Although insurers are generally still able to exclude conditions from plans regardless of when they were incurred, there are several regulations prohibiting aspects of this conduct.⁵¹ First, plans cannot exclude coverage for a condition caused by an injury because the injury occurred prior to the effective date of the policy.⁵² Second, plans cannot deny the individual’s application for coverage because a pre-enrollment physical reveals the person has an illness such as type-2 diabetes.⁵³ Essentially, a person cannot be denied coverage for a policy because of the existence of an illness covered under one of their plans, but they can wholly be denied coverage for specific illnesses by the insurance company not including it under their scope of coverage in that plan. To illustrate how little control over the acceptance of applicants this gives the insurer, insurers may no longer require pre-enrollment physicals to assess any risk involved with an applicant.

This change could be extremely problematic for many private insurers, as the potential for consumers to “game” the insurance company is high.⁵⁴ This trend would result in adverse selection as those without significant health expenses would delay the purchasing

48. 42 U.S.C.A. § 300gg-3 (2010) (Public Health Service Act “PHSA” § 2704).

49. *Health Reform Regulations*, *supra* note 30.

50. *Id.*

51. *Id.*

52. *Id.*

53. *Id.*

54. *See* Petno, *supra* note 43.

of insurance and the subsequent risk pool would be comprised of people who, on average, take out more than the premiums put in.⁵⁵ Insurance companies would bleed out slowly unless premiums were raised in the plan, or they spread out the expenses of the risk pool over its entire market segment. Also, those that were previously unable to afford insurance or who could only afford a government-subsidized insurance may now seek better insurance plans in times of need, rather than pay hospital bills for illness not covered under subsidies.

There is expected to be little impact on larger plans with this change. The primary plans that will be impacted are the small and individual plans.⁵⁶ Because underwriting and denials at the application stage will be eliminated, there could be a large expansion of coverage. Although consumers may have better access, premiums could be substantially higher due to a less stable risk pool that will no doubt continue to rise despite the efforts of oversight committees.⁵⁷

VI. EFFECTS ON PREMIUMS

Inside the scope of discussion regarding the curbing of insurance premiums from “unreasonable increases,” a major issue exists – the federal government does not have the ability to enforce such provisions, and many states are reluctant to police it themselves.⁵⁸ Nevertheless, the PPACA requires the Secretary of the Department of Health and Human Services (HHS), alongside individual states, to annually review any increases in insurance policies that could be deemed unreasonable.⁵⁹ In essence, HHS and the states will determine which increases are unreasonable, and it will then be up to the insurer to establish adequate justification for such increases.⁶⁰ The outlined review process has not been solidified and the HHS is soliciting ideas from various sources, institutions and experts to establish a method for deeming an increase “unreasonable” under federal law.⁶¹

55. *Id.*

56. *Health Reform Regulations*, *supra* note 30.

57. *Id.*

58. Ann Mills et al., *Truth and Consequences—Insurance-Premium Rate Regulation and the ACA*, 363 *NEW ENG. J. MED.* 899, 900 (2010).

59. *Id.* at 899.

60. *Id.* at 900.

61. *Id.*

It is unclear how this federal standard will actually prevent any increases, seeing as insurance regulation is primarily a state activity.⁶² Moreover, although the PPACA enables the oversight board to review proposed rate increases, it does not grant federal regulators power to deny increases they deem to be unreasonable.⁶³ Additionally, only 28 states have the power to exercise that authority, with enumerated powers varying greatly in scope and definition.⁶⁴ This lack of standardization in insurance regulation will allow insurers who are unhappy with a state's regulation to go to a state with more favorable treatment to accomplish their goals. The PPACA further allows for insurers in one state to conduct business in another. Conceivably, this forum shopping for favorable treatment will greatly affect the ability of HHS blocking unreasonable rate increases absent state power or assistance.⁶⁵

Despite much speculation, the basic principle that an increased overhead will lead to increased prices still exists. While there are many issues with the "cost bending" ability of the PPACA, such as the grossly underfunded interim high-risk pools that the Office of the Actuary has estimated will be exhausted in less than two years,⁶⁶ the insurance companies are still for-profit enterprises that will adjust as necessary to maintain profit. The entrance of such a large number of participants in the risk pools that will require assistance, coupled with the unknown number of low-risk participants who will drop health insurance expecting that it will be there when they need it, will lead to an adverse selection that will necessitate the raising of premiums to cover the cost. This, in turn, could force consumers out of the commercial market into government-subsidized plans

62. Amanda Cassidy, *Health Policy Brief: 'Unreasonable' Insurance Rate Increases*, HEALTH AFFAIRS (Mar. 31, 2011), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=43

63. *Id.*

64. *See* Mills, *supra* note 58, at 900.

65. *See* Cassidy, *supra* note 62 ("Although some states may have the authority to reject unreasonable increases, under the Affordable Care Act and other laws, HHS does not. If HHS finds a rate increase to be unjustified, excessive, or unfairly discriminatory, it will be considered unreasonable. In that case, the insurer might choose to withdraw or reduce the requested rate increase, or it might choose to go ahead with it. If an insurance company decides to proceed with a rate increase that has been determined to be unreasonable, the company must publicly disclose the increase on its own website and provide a final justification to HHS. State laws and regulations may affect what an insurer is permitted to do in response to a determination that a rate increase is unreasonable.").

66. Memorandum from Richard S. Foster, Chief Actuary, Dep't of Health & Human Serv. Ctr. for Medicare & Medicaid Serv., *Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended* (April 22, 2010), available at https://www.cms.gov/ActuarialStudies/. . ./PPACA_2010-04-22.pdf (By 2011 and 2012 the initial \$5 billion in Federal funding for this program would be exhausted, resulting in substantial premium increases to sustain the program).

where taxpayers bear the cost. In any event, those that seek private insurance can expect a rise, not decline in premiums.⁶⁷ While advocates definitively assert that the insurance exchange will reduce premium prices, previous unsuccessful attempts to establish similar exchanges have demonstrated that the slim margin for success is largely dependent on the successful avoidance of adverse selection, maintaining the exclusive source of coverage for defined population groups, inclusion of health plans charging the same inside as outside the exchange, and allowing only a limited number of standardized benefit packages - all which contain risk-adjustment mechanisms.⁶⁸

VII. CONCLUSION

Substantial skepticism exists over whether the health care reform law will significantly slow the growth in health care costs. The Office of the Actuary of the Center for Medicare and Medicaid Services predicts that the law will increase total health-care spending by \$311 billion over 10 years due to the greater utilization of health care services by the American public.⁶⁹ While the PPACA will give broader access to health care for those who don't currently have it, it will come at the cost of higher insurance premiums for those already in the market.⁷⁰

67. *Heath Insurance Costs Jump for Employers and Employees*, BUSINESSNEWSAILY.COM (Apr. 25, 2011, 11:03AM), <http://www.businessnewsdaily.com/health-care-claims-cost-employer-premiums-1221/>

68. Meena Seshamani, MD, PhD, Director of Policy Analysis, Dep't of Health & Human Serv. Office of Health Reform, *Lower Premiums, Stronger Businesses: How Health Insurance Reform Will Bring Down Costs for Small Businesses*, HEALTHREFORM.GOV, <http://www.healthreform.gov/reports/smallbusiness2/index.html> (last visited Apr. 28, 2011) (advocating that the increased purchasing power of the insurance exchanges will make premiums more affordable); *see contra* Elliot K. Wicks, Ph.D., *Building a National Insurance Exchange: Lessons From California*, CALIFORNIA HEALTHCARE FOUNDATION, available at www.chcf.org (last visited Apr. 28, 2011) (explaining the failure of the California insurance exchange and the overwhelming difficulty inherently associated with insurance exchange sustainability).

69. *See* Memorandum from Richard S. Foster, *supra* note 66.

70. Gregory Herrle & Thomas Snook, *Healthcare reform: Strategic considerations for 2011*, MILLIMAN INSIGHT (Jan. 18, 2011), http://insight.milliman.com/article.php?cntid=7490&utm_campaign=Insight%20Promos&utm_medium=web&utm_source=health&utm_content=7490 (Although the PPACA allows the Government the ability to declare premium increases unreasonable, it lacks the ability to police such activity. Further, there is a wide-latitude amongst the individual states as to their ability to actually control premium increases).