ACA—
Where Are We Now?

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Today’s Agenda

- Implementation and Lessons Learned
- Latest Regulatory Guidance
  - Cadillac Tax
  - Section 1557 Non-Discrimination Rules
- The New Administration: What to Expect
ACA Implementation

Implementation Timeline

2010-2014: Insurance Market Reforms

2014: Structural Reforms

2014-?: Continuation of Structural Reforms
Lots Can Happen in Six Years!

2010

2016
Implementation Issues

• “Insurance Market” Reforms
  – Cost impact on employer-sponsored plans (including multiemployer and public plans)
    • Grandfather status challenges
    • Age 26 dependent coverage
    • Preventive services without cost-sharing (for non-grandfathered plans)
    • Out-of-network emergency room coverage
    • Penalties for non-compliance
Implementation Issues

• “Structural Reforms” faced significant implementation challenges
  – Rollout of healthcare.gov
  – Extension of non-ACA compliant plans after 2014
  – Individual mandate
  – Employer mandate
Implementation Issues

• ACA “Marketplace” still faces significant challenges
  – Sub-optimal enrollment numbers
  – Heavy utilization of healthcare services
  – Increasing premiums/cost-sharing
  – Decreasing insurer participation
ACA Accomplishments: Decrease in Uninsured Population

Uninsured Rate Among the Nonelderly Population, 1972-2016

Share of population uninsured:

Note: 2016 data is for Q1 & Q2 only.
Source: CDC/NCHS, National Health Interview Survey, reported in
http://www.cdc.gov/nchs/health_policy/trends_hc_1968_2011.htm#table01 and
ACA Accomplishments: Minimal Displacement of Employer-Sponsored Health Plans

Exhibit 2.1
Percentage of Firms Offering Health Benefits, 1999–2016

* Estimate is statistically different from estimate for the previous year shown (p < .05).

NOTE: As noted in the Survey Design and Methods section, estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

### Exhibit 2.2
Percentage of Firms Offering Health Benefits, by Firm Size, 1999-2016

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>3-9 Workers</td>
<td>55%</td>
<td>57%</td>
<td>58%</td>
<td>58%</td>
<td>55%</td>
<td>52%</td>
<td>47%</td>
<td>49%</td>
<td>49%</td>
<td>45%</td>
<td>50%</td>
<td>47%</td>
<td>59%</td>
<td>48%</td>
<td>48%</td>
<td>48%</td>
<td>44%</td>
<td>47%</td>
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<tr>
<td>10-24 Workers</td>
<td>74%</td>
<td>80%</td>
<td>77%</td>
<td>70%</td>
<td>76%</td>
<td>74%</td>
<td>72%</td>
<td>73%</td>
<td>76%</td>
<td>78%</td>
<td>72%</td>
<td>76%</td>
<td>71%</td>
<td>73%</td>
<td>68%</td>
<td>64%</td>
<td>63%</td>
<td>61%</td>
</tr>
<tr>
<td>25-49 Workers</td>
<td>86%</td>
<td>91%</td>
<td>90%</td>
<td>87%</td>
<td>84%</td>
<td>87%</td>
<td>87%</td>
<td>83%</td>
<td>90%</td>
<td>87%</td>
<td>92%</td>
<td>85%</td>
<td>87%</td>
<td>87%</td>
<td>85%</td>
<td>83%</td>
<td>82%</td>
<td>80%</td>
</tr>
<tr>
<td>50-199 Workers</td>
<td>97%</td>
<td>97%</td>
<td>96%</td>
<td>95%</td>
<td>95%</td>
<td>92%</td>
<td>93%</td>
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<td>95%</td>
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<td>91%</td>
<td>91%</td>
<td>92%</td>
<td>91%</td>
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<tr>
<td>All Small Firms (3-199 Workers)</td>
<td>65%</td>
<td>68%</td>
<td>67%</td>
<td>65%</td>
<td>65%</td>
<td>62%</td>
<td>59%</td>
<td>60%</td>
<td>59%</td>
<td>62%</td>
<td>59%</td>
<td>68%*</td>
<td>59%*</td>
<td>61%</td>
<td>57%</td>
<td>54%</td>
<td>56%</td>
<td>55%</td>
</tr>
<tr>
<td>All Large Firms (200 or More Workers)</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>98%</td>
<td>97%</td>
<td>98%</td>
<td>97%</td>
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<td>99%</td>
<td>98%</td>
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<td>98%</td>
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<tr>
<td>ALL FIRMS</td>
<td>66%</td>
<td>68%</td>
<td>68%</td>
<td>66%</td>
<td>66%</td>
<td>63%</td>
<td>60%</td>
<td>61%</td>
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<td>63%</td>
<td>59%</td>
<td>69%*</td>
<td>60%*</td>
<td>61%</td>
<td>57%</td>
<td>55%</td>
<td>57%</td>
<td>56%</td>
</tr>
</tbody>
</table>

* Estimate is statistically different from estimate for the previous year shown (p < .05).

Note: As noted in the Survey Design and Methods section, estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

Marketplace Health Check
Figure 1
Nearly Two-Thirds of Non-Group Enrollees Have Marketplace Plans In 2016

AMONG TOTAL NON-GROUP HEALTH INSURANCE ENROLLEES: Percent whose plan is each of the following:

- Marketplace plan: 64%
- ACA-compliant, non-Marketplace plan: 19%
- Non-ACA-compliant plan: 12%
- ACA-compliant, unsure if Marketplace plan: 2%
- Unknown: 4%

Most Lack Access to Employer Coverage

Figure 2
Most Non-Group Enrollees Have No Access To Employer Coverage

AMONG TOTAL NON-GROUP HEALTH INSURANCE ENROLLEES:

- Self-employed 31%
- Employer offers a health plan 18%
- Employer does not offer a health plan 21%
- Not employed 28%
- Don’t know/Refused 2%

ASKED OF THE 18% OF NON-GROUP ENROLLEES WHO SAY THEIR EMPLOYER OFFERS A HEALTH PLAN: Which of the following is the main reason why you don’t participate in this health plan?

- It’s less expensive to buy your own coverage than to pay your portion for your employer’s plan: 6%
- You’re not eligible to participate: 5%
- You’re not happy with the plan your employer offers: 3%
- You’re not currently eligible, but will be after a waiting period: 1%

Marketplace Enrollees Have Moved to High-Deductible Plans

Figure 3
More Non-Group Enrollees Report Being in High-Deductible Health Plans in 2016 than in 2015

AMONG NON-GROUP ENROLLEES WITH ACA-COMPLIANT PLANS: Percent whose plan is:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-deductible</td>
<td>36%</td>
<td>49%</td>
</tr>
<tr>
<td>Not high-deductible</td>
<td>46%</td>
<td>35%</td>
</tr>
<tr>
<td>Undetermined</td>
<td>18%</td>
<td>16%</td>
</tr>
</tbody>
</table>

NOTE: High deductible defined as $1500 or higher for an individual or $3000 or higher for a family.
SOURCE: Kaiser Family Foundation Surveys of Non-Group Health Insurance Enrollees (Wave 2 & Wave 3)
### Premiums for Marketplace Plans Increasing

<table>
<thead>
<tr>
<th>Measure</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Increase for HealthCare.gov States</td>
<td><strong>25%</strong></td>
</tr>
<tr>
<td>Median Increase for HealthCare.gov States</td>
<td>16%</td>
</tr>
<tr>
<td>Average Increase for HealthCare.gov States and State-Based Marketplaces for Which Data are Available</td>
<td>22%</td>
</tr>
<tr>
<td>Average Premium Change for Returning Consumers IF All Consumers Shopped and Selected Lowest-Cost Plan in Metal Level</td>
<td>-20%</td>
</tr>
</tbody>
</table>

Insurer Participation Rates in Marketplace Declining

Figure 1
57% of exchange enrollees will have a choice of three or more insurers in 2017, down from 85% of exchange enrollees in 2016.

Source: Kaiser Family Foundation analysis of data from the 2017 QHP Landscape file released by healthcare.gov on October 24, 2016. Note: For states that do not use healthcare.gov in 2017, insurer participation is estimated based on information gathered from state exchange websites, insurer press releases, and media reports as of August 26, 2016. Enrollment is based on 2016 signups.
Competition Among Insurers Within Marketplace Declining

Figure 4

32% of counties will have one exchange insurer in 2017, compared to 7% of counties with one exchange insurer in 2016

Source: Kaiser Family Foundation analysis of data from the 2017 QHP Landscape file released by healthcare.gov on October 24, 2016. Note: For states that do not use healthcare.gov in 2017, insurer participation is estimated based on information gathered from state exchange websites, insurer press releases, and media reports as of August 26, 2016. Enrollment is based on 2016 signups.
High Utilization of Health Care Services

Figure 15: One-Third of Those Who Have Had ACA-Compliant Plans For at Least a Year Have Used Their Insurance More Than 10 Times

Among those with ACA-compliant plans who have had non-group coverage for at least 12 months: In the past 12 months, approximately how many times have you (and the other family members covered by your plan) used your insurance, such as to see a doctor or fill a prescription?

- Not at all (13%)
- More than 20 times (13%)
- Between 11 and 20 times (20%)
- Between 1 and 10 times (54%)
- "Heavy" Utilizers (33%)

Stabilization of Risk Pool Needed

- Issuers exiting the Marketplace
- Lack of SEP verification has the effect of year-round open enrollment
- Risk mitigation programs
  - Risk adjustment is the only permanent program
  - All three programs (risk adjustment, reinsurance, and risk corridors) have had challenges
Risk Corridors

- Congress has limited risk corridor payments to receipts.
- All payments for 2014 and 2015, plus some/all for 2016 will be used to make payments for 2014 obligations.
- Issuers face significant shortfalls.
- Some issuers (including many CO-OPs), have filed suit for these amounts.
- CMS recently indicated a willingness to settle these claims and make payment out of the Judgment Fund.
- There is already significant political blow back, and further legislative/legal action is likely.
Risk Adjustment

- Risk adjustment transfer methodology tends to reward plans with better data capture methodology (i.e., bigger issuers)
- Payments into the risk adjustment program may endanger smaller issuers and new entrants to a particular market
- Any reduction in “payments in” has a corresponding reduction in “payments out”
- CMS had done little to prevent solvency, etc., but states have taken significant action
  - IL Department of Insurance prevented the Land of Lincoln CO-OP from making payments into the risk adjustment program that threatened the CO-OPs solvency/receivership
  - New York Dep’t of Fin. Servs. issued emergency regulations permitting it to effectively unwind risk adjustment payments after the fact by taxing issuers in receipt of risk adjustment payments, and then reapportioning amounts to issuers that owed risk adjustment payments
Improving the Risk Pool

- SEP verification system needed
- Federal regulation and oversight too onerous
- Proposed changes to risk adjustment will help, but will they be implemented soon enough?
Regulatory Update

- Cadillac Tax
- Section 1557
Cadillac Tax

• 40% excise tax located in new IRC Section 4980I
• Purpose of excise tax:
  – Reduce tax preference for employer-provided health benefits;
  – Reduce excess health care spending by employees and employers, hopefully lowering the general cost of health care;
  – Encourage employers to shift expenditures on health benefits to other forms of employee compensation (e.g., wages and salaries); and
  – Help finance the expansion of health care coverage under the ACA
Cadillac Tax

- Originally set for collection in 2018, but delayed by Congress for two years.
- Hence, **tax not effective until 2020**
  - Tax is now deductible for employers
Cadillac Tax—Annual Limitation—i.e., When the Tax Applies

<table>
<thead>
<tr>
<th>Type</th>
<th>Threshold</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-only</td>
<td>$10,200 (2018 only)</td>
<td></td>
</tr>
<tr>
<td>Other-than-self-only</td>
<td>$27,500 (2018 only)</td>
<td></td>
</tr>
</tbody>
</table>

- Base limits will be adjusted by various factors (e.g., inflation) over time
  - Plans that disproportionately cover females and/or older individuals will have increased thresholds
  - Different thresholds apply for certain “high risk” professions
Cadillac Tax—What Gets Counted?

- Applies to “applicable employer-sponsored coverage”
  - Generally any group health plan made available to an employee by an employer that is excludable from the employee’s gross income under Code section 106, or would be so excludable if it were employer-provided coverage (within the meaning of Code section 106)
## Cadillac Tax—What Gets Counted?

- **Health FSAs**
- **HSAs** and Archer MSAs—employer contributions and employee pre-tax contributions by payroll deductions
  - Except for after-tax contributions by account holder where deducted on Form 1040
- **Governmental plans**
  - Except military coverage
- **On-site medical clinics**
  - Except if clinic provides *de minimis* medical care
- **Retiree coverage**
  - Even though such coverage may not be subject to ACA market reforms
- **Multiemployer plans**
- **Coverage for specified disease or illness or fixed indemnity insurance**
  - Only if payment for insurance is excluded from income or deducted from income; otherwise not counted
- **Executive physical programs**
- **HRAs**
Many Plans Will Be Hit With Cadillac Tax

Share of Employers with at Least One Plan Hitting Threshold by Firm Size

<table>
<thead>
<tr>
<th>Year</th>
<th>Self-Only Threshold</th>
<th>Premium, HSA, HRA and FSA</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Small Firms (3-199 workers)</td>
</tr>
<tr>
<td>2018</td>
<td>$10,200</td>
<td>25%</td>
</tr>
<tr>
<td>2023</td>
<td>$11,800</td>
<td>29%</td>
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<tr>
<td>2028</td>
<td>$13,500</td>
<td>41%</td>
</tr>
</tbody>
</table>

SOURCE: Kaiser Family Foundation analysis
Cadillac Tax—What To Do?

1. Study IRS Notices issued to date
   - Describes the approaches Treasury is considering with regard to a number of issues and requests comments on a number of approaches
   - Particularly focuses on how employers will determine the cost of coverage (generally in accordance with COBRA principles)

2. Consider if benefit programs may need restructuring to avoid the excise tax
   - Many employers are already trying to determine whether their benefit programs will be in excess of annual limitation
   - If concerned about exceeding annual limits, consider viability of a “glide path” over the next few years to reduce costs
     • This glide path to compliance will avoid a significant change in coverage in 2020
Responses to Cadillac Tax

• Employers and other plan sponsors are considering:
  – Increasing deductibles and other cost sharing;
  – Eliminating covered services;
  – Capping or eliminating tax-preferred savings accounts like FSAs, HRAs and HSAs;
  – Eliminating higher-cost health insurance options;
  – Using less expensive (often narrower) provider networks; or
  – Offering benefits through a private exchange (which can use all of these tools to cap the value of plan choices to stay under the thresholds).

• These changes will generally result in employees paying for a greater share of their health care out-of-pocket.
ACA Section 1557 Extends Nondiscrimination Laws to Health Programs or Activities Receiving Federal Financial Assistance

Except as otherwise provided for in title I of the ACA . . . an individual shall not, on the grounds prohibited under:

- Title VI of the Civil Rights Act of 1964 (race, color, national origin),
- Title IX of the Education Amendments of 1972 (sex),
- The Age Discrimination Act of 1975 (age), or
- Section 504 of the Rehabilitation Act of 1973 (disability),

be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any:

- Health program or activity, any part of which is receiving Federal financial assistance;
- Program or activity administered by an Executive Agency; or
- Entity established under ACA title I (or its amendments)
Final Rule Effective Dates

- The rule is generally effective July 18, 2016
- The rule’s **notice requirements**, specifically the posting of a nondiscrimination notice and statement and taglines, are effective **October 16, 2016** (within 90 days of the effective date of the final rule)
- If provisions of the rule require changes to health insurance or group health plan **benefit design**, the rule will be effective on the first day of the first plan/policy year beginning on or after **January 1, 2017**
  - Benefit design changes include cost sharing, covered benefits, or benefits limitations or restrictions
The Final Rule Has a Broad Reach Over Health Programs or Activities

The final rule applies to the following covered entities:

1. All health programs or activities, any part of which receives Federal financial assistance from HHS;
   - The term “covered entity” is defined broadly to include the receipt of any **Federal financial assistance**; however, the regulation states it applies only to a health program or activity administered by recipients of Federal financial assistance **from HHS**

2. Health programs and activities administered by HHS, including the Federal Marketplaces; and

3. Health programs and activities administered by entities under title I of the ACA, including the State Marketplaces
Federal Financial Assistance Is Broad

Federal Financial Assistance

IRC 36B Premium Tax Credits and CSRs
Medicaid/CHIP
HHS Grants
RDS Funds
EGWP Funds
Medicare (except Part B)
Government Contracting $
Many Health Insurers—Including Their TPA or ASO Operations—Are Subject to 1557

- If a health insurance issuer operates one entity that receives federal financial assistance from HHS, then the nondiscrimination requirements apply to all of the issuer’s operations
  - HIPAA excepted benefits are not excepted from the scope of the final rule
- If HHS receives a complaint against a TPA or ASO provider, HHS will determine whether the allegedly discriminatory decision or action rests with the TPA or the employer
  - If the conduct is related to plan administration, HHS will process the complaint against the TPA
  - If the conduct is related to a decision or action by an employer, HHS will proceed against the employer
    - If HHS does not have jurisdiction over the employer, it may refer the matter to other Federal agencies that may have jurisdiction over the employer (e.g., EEOC)
Final Rule Is Applicable to Group Health Plans Receiving Federal Financial Assistance

• HHS includes a group health plan as an example of a health program or activity “principally engaged in providing or administering health services”

• Therefore, an employer plan sponsor could be considered liable for the employer’s group health plan if the plan or plan sponsor receives Federal financial assistance (such as Part D subsidy money)
Prohibited Discrimination for Protected Classes

- Discriminatory actions include:
  - Denying or limiting health coverage
  - Denying a claim
  - Employing discriminatory marketing or benefit designs
  - **Imposing additional cost sharing on certain individuals**

- Covered entities may use *reasonable medical management* techniques and must apply **neutral, nondiscriminatory standards** to health-related coverage
Final Rule Prohibits Discrimination Based on an Individual’s Sex

• The rule does not define benefit design or provide examples of discriminatory benefit designs

• However, the rule specifies:
  – Individuals cannot be denied health care or coverage based on sex, including gender identity
  – Individuals must be treated consistent with their chosen gender identity, including in access to facilities
  – Sex-specific health care cannot be denied or limited only because the person seeking the services identifies as belonging to another gender
  – Explicit categorical exclusions for all health services related to gender transition are facially discriminatory
    • OCR suggests blanket exclusions categorizing all transition-related treatment as “cosmetic” or “experimental” are “outdated and not based on current standards of care”
Examples of Discrimination Claims/ Lawsuits Under 1557

- Gender Dysphoria and Transgender Claims
  - Exclusion of coverage for any expenses related to treatment of gender dysphoria
  - Refusal to cover hysterectomy/mastectomy for female transitioning to male
  - Refusal to cover breast augmentation for male transitioning to female
  - Refusal to cover hormone therapy
Examples of Discrimination Claims/ Lawsuits Under 1557

- Prescription Drug Formulary Design Issues
  - Placement of all HIV/AIDS medications at high-level of formulary, with highest cost-sharing requirements
  - Requiring mail order pharmacy for all HIV/AIDS medications
Examples of Discrimination Claims/ Lawsuits Under 1557

- Other Benefit Design Issues
  - Refusal to cover gastric bypass surgery (disproportionate impact on women and obese individuals)
  - Refusal to cover pregnancies of females covered as dependents
1557 Enforcement

- HHS enforces (or may refer)
- Private cause of action also available
  - Lawsuits filed in federal court
  - No requirement to exhaust internal or external administrative procedures
- No requirement to prove *intent* to discriminate—disparate impact is sufficient
- Back pay, denied benefits, and “compensatory damages” available
Presidential Election
Health Care Platforms
House GOP Health Proposals

- Contents of House task force report
  - Cap on employer-provided exclusion
  - Individual tax credit
  - HSA/consumer-driven proposals
  - Changes to insurance market reforms
  - Maintain stop loss insurance
  - Wellness plan clarifications
  - Pooled arrangements and purchases across state lines
Trump Health Care Reform Proposals

- Complete repeal of “Obamacare”
  - But keep ban on pre-existing conditions?
- Allow sales of health insurance across state lines
- Deduction for individual health insurance premiums
- Increased incentives for HSAs
- Price transparency for health care providers
- Block grants for Medicaid
- Allow importation of prescription drugs
Clinton Health Care Reform Proposals

- Defend the ACA
- Tax credits to reduce the cost of purchasing ACA exchange coverage
- Repeal of “Cadillac Tax”
- New incentives for all states to expand Medicaid
- Invest in navigators and exchange advertising
- Support a “public option”
- Lower out-of-pocket costs
- Reduce prescription drug costs
Challenges in the “Marketplace” means group coverage will continue to be critically important.

Plans continue to face pressures:
- Medical costs continue to rise
- **Cadillac Tax** poses significant threat to plans and sponsors
  - Must evaluate likelihood of exceeding annual limit
  - Must evaluate benefit design changes to get under threshold
- Section 1557 requires reexamination of plan benefits
  - Exclusions of coverage for gender reassignment/dysphoria may have to be removed
  - Careful vetting of prescription drug formularies is required

Website Resources
2017 Educational Programs
Health and Welfare

63rd Annual Employee Benefits Conference
October 22-25, 2017
Las Vegas, Nevada
www.ifebp.org/usannual

Certificate Series
February 27-March 4, 2017
Lake Buena Vista (Orlando), Florida
July 24-29, 2017
Denver, Colorado
www.ifebp.org/certificateseries

Health Care Management Conference
May 1-3, 2017
New Orleans, Louisiana
www.ifebp.org/healthcare

Certificate of Achievement in Public Plan Policy (CAPPP®)
Part I and Part II, June 13-16, 2017
San Jose, California
Part II Only, October 21-22, 2017
Las Vegas, Nevada
www.ifebp.org/cappp

Related Reading
Visit one of the on-site Bookstore locations or see www.ifebp.org/bookstore for more books.

Self-Funding Health Benefit Plans
Item #7563
www.ifebp.org/SelfFunding