AFFORDABLE CARE ACT – DESTINATION UNKNOWN

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I. INTRODUCTION

The election of a new president brings uncertainty to health care compliance. Prior to the election, President-elect Trump and the Republicans in Congress talked about the total repeal of the Affordable Care Act. Now that President Trump is in office and the Republicans control both houses of Congress, the political realities are setting in.

The government health care marketplace where individuals can purchase subsidized health insurance is imploding. Due to the high level of claims by many people in the health care marketplace along with the lack of healthy young people, the insurance companies are incurring large losses. In many areas in the country, there will be one or no insurance companies offering coverage on the government health care exchange. With the uncertainties of the future of the Affordable Care Act, there will be additional companies pulling out of the government health care marketplace.

2017 and 2018 will be big years for additional changes in health care. Where the final destination leads us is unknown at this time.

II. SUMMARY OF WASHINGTON HEALTH CARE IDEAS

The House of Representatives passed the American Health Care Act of 2017 (AHCA) on May 4, 2017. The AHCA is a budget reconciliation bill that is part of the 2017 federal budget process; this status means that it cannot be filibustered in the Senate and can thus pass the Senate with a simple majority of votes. It would repeal the parts of the Affordable Care Act within the scope of the federal budget, including provisions contained within the Internal Revenue Code and also modifications to the federal Medicaid program.

The Senate has indicated that it will write its own version of the bill instead of voting on the House version. Ultimately, the House version and the Senate version will go to a conference committee where members of the House and Senate will come up with a final version for each body to vote on.

A. House of Representatives - Major Features of the AHCA.

1. Income-based subsidies would be replaced by an age-based tax credit.

2. The individual and employer mandates, along with the penalties associated for not adhering to those mandates, would be repealed.

3. Medicaid expansion would be eliminated by the start of 2020, and Medicaid disbursements would be given on a per-capita basis to the states. The AHCA cuts the Medicaid program for low income people and lets states impose work requirements on Medicaid recipients. It changes Medicaid from an open ended program that covers beneficiaries' costs to one with fixed amounts of money annually.

4. Older adults could be charged five times as much as younger adults for monthly premiums. The Affordable Care Act only permits three times.

5. $108 billion would be set aside to create a risk-pool fund for sicker patients.

6. Insurers could tack on a 30% surcharge to the premiums of consumers who did not have continuous coverage in the previous year.

7. Health savings accounts could see their annual contribution limits nearly double.

8. The net investment income tax and Medicare surtax would be repealed.

9. Children would be allowed to stay on their parents' plans until age 26, the same as under Obamacare.

10. The Affordable Care Act's 10 essential health benefit provisions stay, but the MacArthur Amendment would allow states to apply for a waiver to be excluded from this mandate.

11. Most of the provisions in the House Bill, by their terms, affect the individual and small group health insurance markets

The version of the AHCA as passed by the House would not repeal all provisions of the Affordable Care Act. Even if the AHCA provided for a total repeal of the Affordable Care Act, the Senate would not have the 60 votes needed to override a filibuster by Senate Democrats. The version of the AHCA as passed by the House would allow Republicans in the Senate to use the Senate reconciliation process to pass the House version.

B. Senate Discussions on Health Care Reform.

A Senate proposal is now being developed by a 12-member working group. It will attempt to incorporate elements of the House bill, but will not take up the House bill as a starting point and change it through the amendment process.

As of June 1, 2017, the U.S. Senate has not released its proposed legislation relating to the AHCA. All we currently know is:

1. Senate Republicans said they will not vote on the House-passed AHCA, but will write their own legislation instead.

2. To proceed under Senate budget reconciliation procedures, which limit debate and amendments and allow for passage with a simple majority, the Senate bill must reduce the federal deficit for the years 2017 through 2026 by $2 billion. The Senate's bill must also be free of "extraneous" material that does not affect federal revenues or outlays. Although no particular timeline has been announced for any Senate legislation, September 30, 2017 is the likely deadline for passage since that is when the current federal fiscal year will end. Any opportunity to pass a new health care bill using a simple majority under the budget reconciliation rules would expire.

3. Some reports indicate Senate Republicans are weighing a two-step process to replace the Affordable Care Act that would postpone a partial repeal until 2020.

4. Reports also indicate that the Senate plan may first take action to stabilize premium costs in the Affordable Care Act's insurance-purchasing exchanges in 2018 and 2019.

5. The Senate plan is likely to continue subsidies that help low-income Americans with co-pays and deductibles.

6. Sometime in 2020 the Senate version would repeal various parts of the Affordable Care Act. A full repeal cannot occur without Senate Democrats also voting for the new law. This is an unlikely event. The law will have to be passed solely by the Republicans using reconciliation, a procedure used by the Senate Democrats in initially passing parts of the Affordable Care Act.

III. WHAT SHOULD EMPLOYERS/EMPLOYEES EXPECT?

A. Projected ACA Repeal Process and Timeline.

1. **May 4, 2017** – House Bill 1628 Passes – American Health Care Act of 2017.

2. **June 2017** – Senate will examine whether the AHCA (or its version) sets out the 6 requirements to meet the Senate reconciliation requirements to pass on a majority vote basis.

3. **June/July 2017** – Senate will negotiate its version of the AHCA bill and vote. This may require several attempts to pass.

4. **August 2017** – Congress goes on vacation.

5. **September 2017 through December 2017** – If the Senate passes its version of the AHCA it will go to a joint House/Senate Conference Committee to agree on a common bill.

6. **Sometime in 2018** – House and Senate vote on a combined bill.

With various transitional rules, expect effective dates for many provisions to occur in 2020 and later.

B. Employees who are currently receiving subsidies for health insurance on the government marketplace may lose all or a portion of the subsidies. Under House version, individuals would receive tax credits based on their ages. This may increase the cost of medical care for marketplace insurance. This may also decrease the cost differential of using the employer's health insurance.

C. Provisions of any new health care law will likely take some time to implement. It will take health insurance companies at least a year to get the approval of state legislators to make changes to health insurance policies offered in each state.

IV. WHAT SHOULD EMPLOYER BE DOING?

A. Employer Actions – ACA/AHCA.

1. Employers should continue with their normal open enrollments and compliance with the Affordable Care Act.

2. Employers should also start to look at the future. If the mandate for employers to provide health insurance is repealed, will employers drop health insurance for those non-full time employees who work 30 hours per week? Will the employers drop any subsidies for such insurance? What kind of employee backlash and negative employee relations are acceptable to the employer? Crunching the numbers now and analyzing the cost and benefits of maintaining the current program should be undertaken.

3. Repeal of the employer mandate gives employers more flexibility in deciding which employees should be eligible for coverage and how generous the coverage should be.

4. If states change the rules for their individual health insurance markets as the House Bill allows, inexpensive, narrow-scope plans could again become available. These types of health plans are attractive to healthier and younger people, particularly if employer coverage is more expensive. These employees could then return to the employer plan during open enrollment in a later year if they get sick and want broader coverage.

V. AHCA WILL NOT REMOVE ALL ACA REQUIREMENTS

A. ACA Section 1557 Requirements.

ACA Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in “health programs or activities”

any part of which receives federal financial assistance. It also applies to health program or activities administered by a federal executive agency (such as HHS) or any entity established under Title I of the ACA (including state-based Marketplaces).

B. Who is subject to Section 1557?

The Section 1557 regulations apply to any "health program or activity" any part of which receives "financial assistance" from HHS. A health program or activity is defined as the provision of health-related services, health-related insurance coverage or other health-related coverage and the provision of assistance to obtain such coverage. It also includes programs administered by HHS, including the Marketplace.

If an entity is principally engaged in the provision or administration of health services, health insurance or health coverage, all of the entity's operations are considered part of the health program or activity. Such entities would include health insurance issuers, hospitals and group health plans. HHS also defined "employee health programs," which is a subset of health programs or activities, as a group health plan, wellness program and/or employer-maintained onsite health clinic.

C. Does the rule apply to employers who sponsor or participate in group health plans or employee health benefit programs?

HHS views the employer who sponsors the plan separately from the plan or employee health benefit program it sponsors; however, there are three instances in which the employer entity itself can be liable for violations of Section 1557:

1. The entity is principally engaged in the provision or administration of health services.

2. The entity receives financial assistance from HHS and the primary purpose of the assistance is to fund an employee health benefit program. In that case, the employer's provision or administration of that employee health benefit plan would be subject to Section 1557.

3. The entity operates a health program or activity that receives HHS assistance but is not principally engaged in the provision of health services and has an employee health benefit program that does not receive HHS assistance. In this case, the employer is liable for a Section 1557 violation only for health benefits provided to employees who participate in the health program or activity that receives HHS assistance. For example, a state government may need to comply with Section 1557 for its employees who participate in the state Medicaid program (or another program that receives HHS funding) but would not be required to comply overall, and not for its health benefit plan for employees outside of the Medicaid (or other HHS-funded) operations.

The plan receives the retiree Part D (RDS) subsidy or is an employer group health waiver plan (EGWP).

The employer receives the retiree Part D (RDS) subsidy whose primary purpose is to fund a group health plan.

The employer that sponsors the health plan is an entity principally engaged in the provision of health services, health insurance or health coverage that maintains a health program or activity that receives HHS assistance. This would include hospitals and physician's offices.

D. Prohibitions.

Under Section 1557, a covered entity may not:

1. Segregate, delay or deny services or benefits based on an individual's race, color or national origin. For example:

    a. A covered entity may not assign patients to patient rooms based on race.

    b. A covered entity may not require a mother to disclose her citizenship or immigration status when she applies for health services for her eligible child.

    c. Delay or deny effective language assistance services to individuals with limited English proficiency (LEP).

2. The term "national origin" includes, but is not limited to, an individual's, or his or her ancestor's, place of origin (such as a country), or physical, cultural, or linguistic characteristics of a national origin group.

3. Section 1557 protects individuals in the United States, whether lawfully or not, who experience discrimination based on any of Section 1557's prohibited bases.

E. Requirements for communicating with individuals with limited English proficiency (LEP).

1. A covered entity must take reasonable steps to provide meaningful access to each individual with LEP eligible to be served or likely to be encountered in its health programs and activities. Reasonable steps may include the provision of language assistance services, such as oral language assistance or written translations.

2. A covered entity must publish taglines, which are short statements in non-English languages, in significant publications and post in prominent locations and on its website, to notify the

individual about the availability of language assistance services.

3. A covered entity must offer a qualified interpreter when oral interpretation is a reasonable step to provide an individual with meaningful access.

4. Where language services are required, they must be provided free of charge and in a timely manner.

5. A covered entity must adhere to certain quality standards in delivering language assistance services. For instance, a covered entity may not:

    a. Require an individual to provide his or her own interpreter.

    b. Rely on a minor child to interpret, except in a life threatening emergency where there is no qualified interpreter immediately available.

    c. Rely on interpreters that the individual prefers when there are competency, confidentiality or other concerns.

    d. Rely on unqualified bilingual or multilingual staff.

    e. Use low-quality video remote interpreting services.

F. Covered entities must:

1. Provide equal access to health care, health insurance coverage, and other health programs without discrimination based on sex, including pregnancy, gender identity, or sex stereotypes.

2. Treat individuals consistent with their gender identity, including with respect to access to facilities, such as bathrooms and patient rooms.

3. Health care providers cannot deny or limit sex-specific health services based solely on the fact that the gender identity or gender recorded for an individual does not align with the sex of individuals who usually receive those types of sex-specific services (e.g., denying a transgender male a pap smear or denying a transgender woman a prostate exam).

4. Sex specific programs are allowed only if a covered entity can show an exceedingly persuasive justification for the program. That means the sex specific nature of the program must be substantially related to an important health-related or scientific objective.

   For example, a breast cancer program cannot refuse to treat men with breast cancer solely because its female patients would feel uncomfortable.

G. Federal Enforcement.

The U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR) enforces Section 1557 as to programs that receive funding from HHS.

When OCR finds violations, a covered entity will be required to take corrective actions, which may include revising policies and procedures, and implementing training and monitoring programs. Covered entities may also be required to pay compensatory damages.

When a covered entity refuses to take corrective actions, OCR may undertake proceedings to suspend or terminate Federal financial

assistance from HHS. OCR may also refer the matter to the U.S. Department of Justice for possible enforcement proceedings.

Section 1557 also provides individuals the right to sue covered entities in court for discrimination if the program or activity receives Federal financial assistance from HHS or is a State-based Marketplace.

H. Federal Court Injunction.

On December 31, 2016, the U.S. District Court for the Northern District of Texas issued a nationwide injunction in *Franciscan Alliance, Inc. v. Burwell*, N.D. Tex., No. 16-cv-108, holding that portions of the final rule issued by the HHS Office for Civil Rights (OCR), which sought to operationalize Section 1557 of the Affordable Care Act (ACA), violated the federal Administrative Procedures Act.

The court did not strike down the entire rule. Entities covered under Section 1557 will still be required to provide assurances and notices of nondiscrimination on the basis of sex. However, the Section 1557 protections against discrimination on the basis of gender identity or termination of pregnancy are subject to the nationwide injunction.

The court also found that Title IX of the Civil Rights Act of 1964, which is incorporated by ACA Section 1557 statute, only prohibits discrimination on the basis of biological sex. The court also noted that the government's own health insurance programs, Medicare and Medicaid, do not mandate coverage for transition surgeries. The court also noted that the military's health insurance program, TRICARE, specifically excludes coverage for transition surgeries.

I. What to Do?

Compliance with the transgender requirements of ACA Section 1557 are on hold due to the federal court injunction. All other requirements

are operational. OCR has already announced that it intends to enforce the rest of the rule, including "its important protections against discrimination on the basis of race, color, national origin, age, or disability and its provisions aimed at enhancing language assistance for people with limited English proficiency, as well as other sex discrimination provisions." OCR will also continue to enforce other requirements such as notice and taglines. Also, the HIPAA Notice of Privacy Practices for covered entities should still be updated to include additional language provided by HHS.

The injunction prohibits OCR from enforcing, for example, the transgender services requirements in the regulation, but would not prevent an individual from bringing a private lawsuit to enforce those requirements. As such, at least for the time being, issuers and plan sponsors should exercise caution in changing plan designs based on the decision.

The District Court's decision distinguished between sex discrimination under Title IX and sex discrimination under Title VII. This may be important to employers, because the Equal Employment Opportunity Commission ("EEOC") has taken the position that sex discrimination includes discrimination against transgender individuals under Title VII, which prohibits employers from discriminating, among other things, in the provision of fringe benefits (like health coverage).

VI. U.S. DEPARTMENT OF LABOR CLAIMS PROCEDURES

A. The U.S. Department of Labor ("DOL") has issued final regulations with respect to their claims and appeals procedures under ERISA for employee benefit plans providing disability benefits.

The final regulations apply to all disability benefit claims filed on or after January 1, 2018. ERISA plans providing disability benefits and

associated documentation (including any ERISA wrap plans, Code Section 125 cafeteria plans, and claims denial forms) should be reviewed and updated to ensure legal compliance with the requirements for claims filings beginning January 1, 2018.

B. Retirement Plans Must Also Comply.

Generally, all ERISA-covered plans that provide benefits conditioned upon a finding of disability must comply with the special rules for disability claims, including pension and 401(k) plans. However, if the disability benefits from the retirement plan are conditioned on a finding of disability by a party other than the retirement plan for that party's own purposes, then the special rules do not apply. For instance, if a pension plan relies on a disability determination made by the SSA or the employer's long-term disability plan, then the retirement plan need not observe the special rules for disability claims.

Funded or insured STD plans and nearly all long-term disability (LTD) plans will generally be subject to the new disability claims procedures. An insurance carrier is liable for following ERISA's claims procedures, but an employer will want some sort of contractual protection that the insurer will follow applicable law, including ERISA.

C. The final DOL regulations require:

1. Independence and Impartiality in Decision-making.

a. Plans must determine claims and appeals "in a manner designed to ensure independence and impartiality of the persons involved in making the benefit determination":

b. The regulations prohibit plans from "making decisions regarding hiring, compensation, termination, promotion, or other matters with respect to any individual (such as a

claims adjudicator or medical or vocational expert)" based on the likelihood that the individual will support the denial of benefits (note: the final regulations add vocational experts).

2. Improved Disclosure.

a. To help ensure reasoned explanations of a denial, the regulations require all notices of adverse benefit determination (claim or appeal level), to discuss and explain the basis for disagreeing with or not following:

i. The views presented by the health care professionals who treated the claimant and the vocational professionals who evaluated the claimant;

ii. The views of medical and vocational experts whose advice was obtained on behalf of the plan without regard to whether the advice was relied upon in making the benefit determination;

iii. The claimant's disability determination by the Social Security Administration ("SSA"), if presented by the claimant.

b. The regulations require disability benefit plans to include the following in adverse benefit determinations at the initial claim and appeal levels:

i. An explanation of the scientific or clinical judgment for any adverse benefit determination that is based on a medical necessity or experimental treatment or similar exclusion or

limit, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

ii. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan that were relied upon in making the adverse benefit determination, or a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and

iii. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits (note: the regulations currently in effect do not require this statement in initial claim denial notices).

3. Rights to Review and Respond to New Information or New Rationale Before Final Decision.

a. New Information. If a disability benefit plan, insurer or other person making the benefit determination considers, relies upon or generates new or additional evidence in connection with the review of a denied claim, the plan must provide the claimant, free of charge, with such new evidence as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

b. New or Different Rationale. If a disability benefit plan intends to issue an adverse benefit determination at the appeal level that is based on a new or additional rationale, the plan must provide the claimant, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination is required to give the claimant a reasonable opportunity to respond prior to that date.

4. Disclosure of Any Contractual Limitations Period in Denial Notices.

Existing claims regulations require denial notices to include a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review. To ensure that this statement is complete and not misleading, the regulations now require such denial notices to include a description of any applicable contractual limitations period and its expiration period, if any (for example, 1-year limitations period measured from the date of the adverse benefit determination on appeal that expires on January 4, 2018).

5. Deemed Exhaustion of Claims and Appeals Processes.

The final regulations allow a claimant to file a civil suit under ERISA Section 502(a) immediately without exhausting the plan's administrative procedures if the plan fails to comply with the claims review regulations, unless the violation is (i) de minimis; (ii) non-prejudicial; (iii) attributable to good cause or matters beyond the plan's control; (iv) in the context of an ongoing good faith exchange of information; and (v) not

reflective of a pattern or practice of non-compliance. The regulations further require a plan to provide a written explanation of the violation within 10 days upon a claimant's request, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the plan to be deemed exhausted.

6. Retroactive Rescissions of Coverage Are Appealable. The regulations require a rescission of coverage that has a retroactive effect to be treated as an adverse benefit determination that triggers the claimant's right to file an appeal, except if the cancellation or discontinuance of coverage stems from a failure to timely pay required premiums or contributions towards the cost of coverage.

7. "Culturally and Linguistically Appropriate" Notices. Adopting the standards applicable to non-grandfathered health plans under the Affordable Care Act, the regulations require plans to provide notices in a "culturally and linguistically appropriate manner." This means that if a claimant's address is in a county where 10% or more of the population is literate only in the same non-English language as determined by guidance published by the United States Census Bureau (currently these are Chinese, Tagalog, Navajo and Spanish), any denial notice to the claimant must prominently disclose how to access the plan's language services in that non-English language. The plan must also provide a customer assistance process (such as a telephone hotline) with oral language services in the applicable non-English language (such as assistance with filing claims and appeals) and provide written notices translated in that non-English language upon request.