ACA Implications for Public Plans

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Agenda

- Impact of Specific ACA Reforms/Provisions on Public Plans
  - Cadillac tax
  - Section 1557 nondiscrimination rule
  - Interaction of ACA changes with collective bargaining and state/local requirements
Cadillac Tax - Overview

- Nondeductible 40% excise tax located in new IRC Section 4980I
- Effective beginning January 1, 2018— but **DELAYED** until 2020
- Purpose of Excise Tax:
  - Reduce the 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
- Very complicated and will be difficult to administer
Cadillac Tax - Annual Limitation

- 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

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<td>Self-only</td>
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<td>Other-than-self-only</td>
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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
Cadillac Tax—Who Calculates the Tax?

- The **sponsoring employer** is required to determine the total amount of any excise tax due with respect to a given employee.

- Once the employer has determined the amount of any tax owed, it must allocate the amount among all entities liable for paying their share of the tax.

- If the employer fails to correctly calculate the tax attributable to each responsible entity, and as a result an entity pays too little tax, the employer is on the hook for:
  - A penalty equal to 100% of the error amount
  - Underpayment interest
Cadillac Tax—Who Pays the Tax?

- Tax is allocated among the following entities on a pro rata basis (based on the extent of coverage):
  - Health insurance issuer with respect to insured coverage
  - Employer plan sponsor with respect to HSA/MSA contributions
    - Presumably excludes after-tax contributions by an employee
  - “In the case of any other applicable employer-sponsored coverage, the person that administers the plan benefits”
    - Will this be the TPA or the “plan administrator” (e.g., Board of Trustees or Board of Directors)?
Cadillac Tax—What to do in 2016-2017?

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 to be Restructured 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, employer 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
Section 1557 Nondiscrimination Rule

- ACA Section 1557 prohibits discrimination based on:
  - race,
  - color,
  - national origin,
  - sex,
  - age, or
  - disability

for “any health program or activity, any part of which is receiving Federal financial assistance ... or under any program or activity that is administered by an Executive agency or any entity established under [Title I of the ACA].”

- September 8, 2015: The Office of Civil Rights (“OCR”) within the Department of Health and Human Services (“HHS”) issued a proposed rule

- Comments were due by November 9, 2015
Potential Implications

- Could result in application of federal nondiscrimination statutes to health programs sponsored by state and local governments—in ways not foreseen

- Section 1557 incorporates procedural and substantive rights
  - Right to sue in federal court
  - Potential for broader class action litigation
  - Broader rights to recovery (e.g., consequential damages in some instances)
History

- Existing federal nondiscrimination statutes generally provide:
  - that an individual **shall not**, because of race, color, sex, age or disability
  - **be excluded from participation in, be denied the benefits of, or be subjected to discrimination**
  - under any **program or activity**
  - which is receiving **federal financial assistance**
The proposed rule, if adopted, would apply these non-discrimination rules to:

1. All health programs and activities, “any part of which receives Federal financial assistance administered by HHS;”

2. Health programs and activities administered by HHS, including the Federally-facilitated Marketplaces; and

3. Health programs and activities administered by entities established under Title I of the ACA, including the State-based Marketplaces.
“Health Program or Activity”

- Includes the provision or administration of health-related services or health-related insurance coverage.

- HHS proposes “all of the operations” of an entity principally engaged in providing or administering health services or health insurance coverage – such as a hospital, health clinic, community health center, group health plan, health insurance issuer – be covered by Section 1557.
1557 NPRM – Definitions

- "Health Program or Activity"
  - NPRM also suggests a TPA/ASO service provider could be subject to rule--

  Based on the longstanding civil rights principles discussed in connection with the definition of “health program or activity” in § 92.4 of this proposed rule, we propose to apply this part to all issuers that receive Federal financial assistance, whether those issuers’ products are offered through the Marketplace, outside the Marketplace, in the individual or group health insurance markets, or as an employee health benefit program through an employer-sponsored group health plan.

  Thus, for example, an issuer that participates in the Marketplace and thereby receives Federal financial assistance, and that also offers plans outside the Marketplace, will be covered by the proposed regulation for all of its health plans, as well as when it acts as a third party administrator for an employer-sponsored group health plan.73
Specific Proposed Nondiscrimination Rules

- Meaningful access for individuals with limited English proficiency
- Specific requirements for interpreter services
- Require effective communication for individuals with disabilities
- Accessibility standards for buildings and facilities
- Accessibility of electronic and IT
- Reasonable accommodation required
- Equal program access on the basis of sex
- Nondiscrimination in health-related insurance and coverage
- Employer liability for discrimination regarding employer health benefit plans
- Nondiscrimination on the basis of association
Specific Proposed Nondiscrimination Rules

Meaningful access for individuals with limited English proficiency (“LEP”)

- Must take reasonable steps to provide meaningful access to health programs and activities for all persons regardless of national origin
- Must ensure the LEP person is given adequate information, is able to understand the services and benefits available, and is able to receive those for which he or she is eligible
- Must ensure the LEP person can effectively communicate the relevant circumstances of his or her situation to the service provider
- The level, type and manner of language assistance services required should vary based on relevant facts, which may include the operations and capacity of the covered entity
- Services required must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency
Specific Proposed Nondiscrimination Rules

Specific requirements for interpreter services

- When a covered entity is required to provide oral interpretation as a reasonable step to provide meaningful access to an individual with limited English proficiency, the covered entity must offer that individual a qualified interpreter.

- “Qualified interpreter” = Individual who possesses certain characteristics and skills necessary to interpret competently and effectively under the circumstances and adheres to generally accepted interpreter ethics principles, including client confidentiality.

- Cannot require individual with LEP to provide his or her own interpreter. (Limited exceptions are made for certain friends and relatives.)
Specific Proposed Nondiscrimination Rules

- Equal protection on the basis of sex
  - Equal access to health programs or activities without discrimination on the basis of sex
  - Requires covered entities to treat individuals consistent with their gender identity
    - The covered entity or health plan could not deny or limit health services that are ordinarily or exclusively available to individuals of one gender based on the fact that the individual’s sex assigned at birth –
Specific Proposed Nondiscrimination Rules

- Nondiscrimination in health-related insurance and other health-related coverage

  OCR proposes to apply this requirement to all issuers that receive Federal financial assistance, whether those issuers’ products are offered through the Marketplace, outside the Marketplace, in the individual or group health insurance markets, or as an employee health benefit program to its own employees through an employer-sponsored group health plan.
Specific Proposed Nondiscrimination Rules

- Proposed rule would not require plans to cover any particular benefit or service
  - However, a covered entity cannot have a coverage policy that operates in a “discriminatory” manner
  - Proposed rule further provides that it would not prevent a covered entity from determining whether a particular health care service is medically necessary or otherwise meets applicable coverage requirements in any individual case
Specific Proposed Nondiscrimination Rules

Transgender coverage:

- Covered entities (and insurers/TPAs) **may not:**
  - deny or limit coverage or impose additional cost sharing when
  - the denial or limitation is due to the fact that the individual’s sex assigned at birth (or gender identity, or gender otherwise recorded by the plan or issuer) is different from the one to which such services are ordinarily or exclusively available
Specific Proposed Nondiscrimination Rules

**Transgender coverage:**

- A categorical (or automatic) exclusion of coverage for all health services related to gender transition would be unlawful under the proposed rule.
Specific Proposed Nondiscrimination Rules

**Transgender coverage:**

- The rule would bar a covered entity from denying or limiting coverage, for health services related to gender transition where such a denial or limitation results in discrimination against a transgender individual.

  - In evaluating whether a plan provision is discriminatory, HHS will start by inquiring whether – and to what extent – the coverage is available when the service is not related to gender transition.
Specific Proposed Nondiscrimination Rules

Transgender coverage:

- Likely implicates certain existing policy exclusions and limitations
- Potential implications for TPA/ASO services depending on application of ACA section 1557 to these services
Enforcement Mechanisms

In reliance on the statutory language of ACA section 1557, the proposed rule provides that **the enforcement mechanisms** under Title VI, Title IX, the Age Act, or Section 504 apply for violations of section 1557.

- Potential remedies: termination/suspension of federal financial assistance, injunctive relief, consequential damages, attorney’s fees
- Class litigation permissible and access to federal courts
- Evidentiary standards of underlying statutes apply
- Appears no exhaustion requirement (except for age-based claims)
Section 1557 Complaints Filed with HHS

- Examples
  - Complaint filed against Coventry and others in Florida regarding the copayments and coinsurance for HIV/AIDS medications
  - National Women's Law Center complaints against employers re: denial of pregnancy coverage for dependent children
  - Lawsuit filed re: plan’s refusal to cover mastectomy when related to gender transition
Section 1557 Nondiscrimination Litigation

  - Private cause of action recognized
  - Transgender discrimination claim allowed
  - Required to prove intent to discriminate?
  - Private cause of action recognized
  - Challenges pricing of Hep C drugs as disproportionately burdening disabled and minorities
  - Court rejects: (1) no claim that people with Hep C are “disabled;” (2) pricing structure does not implicate discrimination based on disability; and (3) no evidence of intent to prove race-based discrimination
Remedial and Voluntary Action

If the covered entity is found to have discriminated on any of the bases prohibited by Section 1557, it may be **required** to take remedial action as required by the Director of HHS OCR to overcome the effects of that discrimination.
Effective Date and Impact

- Comments on Proposed Rule were due no later than **November 9, 2015**
- OCR proposes that the rule will be **effective 60 days after being finalized**
- The NPRM is of **critical importance** to issuers, health care providers, and group health plans.
- HHS has read the statutory requirements extremely broadly, potentially sweeping entire entities into the scope of 1557, when even one plan or program receives any federal funds from HHS
Impact of ACA Changes on Public Plans

- Plan Design Changes
  - To address Cadillac Tax, Section 1557 rules, and other market reforms
  - E.g., more narrow networks; drug formulary design; HSAs and HRAs

- Collective Bargaining Impact
  - Re-opening of collective bargaining agreements, or changes to CBAs

- Changes to Applicable Laws
  - E.g., transgendered benefits
Impact of ACA Changes on Public Plans

- Government’s Share of Plan Costs
  - Either as premiums or in cost-sharing (deductibles, copayments, coinsure) may decrease
  - Already seeing a drop in costs that public entities can/will pay

- Changes to Funding Vehicles
  - Move to self-insurance?
  - Move to larger risk pools?
  - Private Exchanges
Impact of ACA Changes on Public Plans

- Retiree Health Benefits
  - Premium changes
  - Differential benefit designs
  - Pre- and post-Medicare benefit design differentials
  - Health reimbursement accounts/Exchange coverage
Discussion
Key Takeaways

- **Caddy Tax:**
  - Work with your benefits consultant to evaluate whether—and how soon—tax may apply
  - Consider benefit changes that may be required to stay below annual limitation
  - Lobby your legislators!

- **Section 1557**
  - Carefully review final regulations
  - Consider blanket exclusions in self-funded or insured policies that may have to be changed (e.g., exclusion of coverage for transgender services)
  - Evaluate benefit designs for potential Section 1557 claims (e.g., tier levels of specialty drugs)
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