Proskauer

newsletter

ERISA Litigation

A report to clients and friends of the firm

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in this issue

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Editor's Overview

This month Richard Zall, Chair of Proskauer's Health Care Department, explores developments likely to occur with respect to the Affordable Care Act as a result of the new administration. In our Rulings, Filings and Settlements of Interest section, we provide an update on the litigation challenges to the DOL's conflict of interest rule and related exemptions, review the health benefit program available to small employers under the 21st Century Cures Act, and also review Oregon's adoption of a CEO pay ratio tax on employers.

Repealing and Replacing the ACA: Five Developments Likely to Occur in the Years Ahead

By Richard Zall and Krista White

On the back of the 2016 United States presidential election results, the health care industry ponders how a Republican president and Congress will transform the business environment. The health care industry has a number of important questions which need to be examined. We take this opportunity to look at key issues, including the meaning of "repeal and replace," the future of Medicare and Medicaid, the rigor of antitrust enforcement, and the viability of insurance exchanges.

While industry observers have speculated about the future, the only thing one can say with authority is that the health care landscape in 2017 and beyond remains highly uncertain.

Following the President-Elect's campaign refrain to "Repeal Obamacare," the President-Elect and Republican Congressional leaders would indeed find it difficult to repeal the legislation wholesale without creating substantial disruption – both to the approximately 20 million people who gained insurance as a result of the ACA between 2010 and 2016,[1] as well as to the hospitals and insurance companies which have large stakes in the

[1] "20 million people have gained health insurance coverage because of the Affordable Care Act, new estimates show," U.S. Dep't of Health & Human Services, http://www.hhs.gov/about/news/2016/03/03/20-million-people-have-gained-health-insurance-coverage-because-affordable-care-act-new-estimates (March 3, 2016).

expanded health care coverage the ACA created. Adding to the uncertainty, the Democrats retain a sufficient number of seats in the Senate to filibuster a wholesale Obamacare repeal bill.

Notwithstanding the difficulty of predicting with certainty what will transpire, we believe there are five developments that are likely to occur in the years ahead:

Reductions in Federal Subsidies, Changes to Medicaid Funding and Contraction of Insurance Coverage

Federal subsidies to individuals purchasing health insurance on the ACA health exchanges are likely to be reduced significantly by the next administration and Congress. Such a reduction would cause a dramatic shift in the health care landscape: the Department of Health and Human Services (HHS) estimates that 85% of all health exchange customers receive some sort of subsidy on the marketplace.[2]

Both House Speaker Paul Ryan and nominee for HHS Secretary Tom Price have proposed to replace the subsidies with tax credit schemes based on age.[3] In place of subsidies, for those individuals not covered by their employer, Medicare, or Medicaid, Speaker Ryan's plan proposes a fixed tax credit based on age as a proxy for need.[4] Under this scheme, older Americans would receive more support. Speaker Ryan's plan envisions the credit being large enough to "purchase the typical pre-Obamacare health insurance plan," reflecting the Speaker's general desire to decrease costs of plans by eliminating mandated benefits, such as essential health benefits (EHBs). Representative Price's plan proposes specific figures for the tax credits for each age group, ranging from $900 per year for individuals under age 18 to $3,000 per year for those over age 50.[5]

Some believe the elimination of subsidies in favor of tax credits, however, could result in many consumers falling through the cracks and insurance companies receiving less revenue: The companies will no longer receive the billions of dollars in subsidies the government provided on behalf of qualified individuals. Moreover, many of those individuals do not earn enough income to benefit from a tax credit and therefore would not be able to afford an insurance plan.

Elimination of subsidies and the likely reduction in Medicaid funding will also affect the bottom line for hospitals. The ACA – through the subsidies and expanded Medicaid programs – ensured that a greater number of previously uninsured patients could obtain insurance and pay their hospital bills. In fact, the HHS estimates that the ACA reduced uncompensated care costs by $7.4 billion in 2014.[6] In anticipation of this expanded coverage, the ACA provided for lower Disproportionate Share Hospital (DSH) payments

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[2] "More Than 70 Percent of Consumers Can Find Marketplace Plans for Less than $75 Per Month," U.S. Dep't of Health & Human Services, http://www.hhs.gov/about/news/2016/10/24/more-70-percent-consumers-can-find-marketplace-plans-less-75-month.html (October 24, 2016).

[3] "A Better Way: Health Care," Office of the Speaker of the House, http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf, p. 14 (June 22, 2016); Empowering Patients First Act of 2015, H.R. 2300, 114th Cong. § 36B (2015).

[4] "A Better Way: Health Care," Office of the Speaker of the House, http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf, p. 14 (June 22, 2016).

[5] Empowering Patients First Act of 2015, H.R. 2300, 114th Cong. § 36B(b)(1) (2015).

[6] "Insurance Expansion, Hospital Uncompensated Care, and the Affordable Care Act," U.S. Dep't of Health & Human Services, https://aspe.hhs.gov/sites/default/files/pdf/139226/ib_UncompensatedCare.pdf (March 23, 2015).

to hospitals. The elimination of subsidized insurance coverage will likely increase the number of uninsured patients at hospitals, and, without an increase in DSH payments, more charity care provided by the hospitals.

Increased State Autonomy in Managing Medicaid Program Design

Speaker Ryan's plan emphasized that states should retain more regulatory control over Medicaid administration.[7] Both the President-Elect and Speaker Ryan support block grants of Medicaid funding to states and greater flexibility for states to determine (and possibly narrow) Medicaid eligibility. It remains unclear whether block grants would reduce overall federal spending on state Medicaid programs.

Under current law, states are permitted to request Section 1115 waivers to modify their provision of Medicaid, which several states opted to do in exchange for expanding their Medicaid programs. Conservative policy favors modifying Medicaid to include prerequisites to coverage, such as cost-sharing measures and work requirements. For example, Governor Mike Pence obtained a Section 1115 waiver to require Medicaid recipients in Indiana to pay premiums if their earnings fall above the federal poverty level. Other states may look to apply for Section 1115 waivers in the near future under what is likely to be a more flexible administration. President-Elect Trump's recent appointment of health care consultant Seema Verma to head the Centers for Medicare & Medicaid Services foreshadows a continued trend toward greater utilization of such waivers: Verma co-designed Indiana's Section 1115 waiver with Governor Pence.

Increased Emphasis on Marketplace Solutions and Consumer Choice

Republicans and the President-Elect have also favored a more consumer-based health care system, where the consumer can make decisions based on his or her needs. Both strongly oppose the individual mandate and support greater expansion of existing health care financing options, such as health savings accounts (HSAs) and health flexible spending accounts (FSAs).

With consumer choice comes the consumer's ability to choose not to buy insurance. The repeal of the individual and employer mandates – another likely action under the next administration – may, absent other action, render insurance companies the victims of adverse selection, where healthy consumers choose not to purchase health insurance, leading to an increase in the proportion of unhealthy consumers covered. Further, Speaker Ryan's plan would prohibit insurance companies from dropping patients simply because they are sick when they renew their plan.[8] President-Elect Trump has stated he also would ban insurance companies from dropping current policyholders just because they are sick; but as for new enrollees, the President-Elect and Speaker Ryan would put those individuals into high-risk pools. These pools could, in theory, provide an insurance option for high-risk individuals, but would require higher premiums and higher federal subsidies: Speaker Ryan's plan promises $25 billion in federal subsidies for such pools.[9]

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[7] "A Better Way: Health Care," Office of the Speaker of the House, http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf, p. 12 (June 22, 2016).

[8] "A Better Way: Health Care," Office of the Speaker of the House, http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf, p. 20 (June 22, 2016).

[9] "A Better Way: Health Care," Office of the Speaker of the House, http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf, p. 21 (June 22, 2016); Karen

It is also possible that the new administration will eliminate the federal operation of state exchanges, while still encouraging states to operate their own exchanges. After all, the exchanges are the type of market-based mechanism that the Republican President-Elect and Congress typically support. At the same time, if subsidies are cut, insurance companies may decide to withdraw from the public exchanges, threatening the viability of the individual insurance marketplace platform. Several major insurers have already withdrawn from or scaled back their participation in the exchanges, leaving individual insurance-seekers with as little as one option on the exchange.

Potential Changes in the Shape of the Medicare Program

Speaker Ryan and the Republican Party hope to change the current structure of Medicare to a system based on "premium support." This plan allows private plans to compete with traditional fee-for-service (FFS) Medicare, building on the popularity of already privatized Medicare Advantage plans. Seniors would receive a voucher-like payment toward the plan of their choice – a voucher that may not cover the senior's desired level of care. President-Elect Trump also favors "moderniz[ing] Medicare," although he has not elaborated on a specific plan to do so.[10] In general, plans to change the structure of Medicare remain politically controversial and may not survive in their full proposed form.

Another target of Republican criticism has been the Center for Medicare and Medicaid Innovation (CMMI), which oversees alternative payment and service delivery models that aim to reduce government program expenditures. While some supporters believe CMMI provides a platform for innovation and cost-effective market research, some Republicans claim that the Center oversteps its legislatively authorized role. The new administration could diminish the role of CMMI and decrease its federal funding.

New Rules for the Pharma and Medical Device Sector

Deregulation of pharmaceutical products and medical devices is a likely possibility in 2017 and beyond. President-Elect Trump has stated that his administration will "[r]eform the Food and Drug Administration, to put greater focus on the need of patients for new and innovative medical products."[11] Industry players may face shorter approval periods, which could allow for greater competition and innovation, but may also leave consumers exposed to dangerous products. Nevertheless, investors and lenders may begin to see companies more willing to take risks if the FDA loosens its standards and hastens its process. The 21st Century Cures Act, which passed in the House with overwhelming bipartisan support and is likely to do the same in the Senate, pushes for a modernization of the drug and medical device approval process.[12] The bill appropriates more than $6 billion in federal funds toward high-risk, high-reward biomedical research.

The past year has also seen bipartisan support for lowering prescription drug costs and limiting drug price gouging. A bipartisan bill introduced in September 2016 proposes

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Pollitz, "High-Risk Pools For Uninsurable Individuals," Kaiser Family Foundation, http://kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/ (August 1, 2016).

[10] Healthcare, President Elect Donald Trump, https://www.greatagain.gov/policy/healthcare.html.

[11] Healthcare, President Elect Donald Trump, https://www.greatagain.gov/policy/healthcare.html.

[12] 21st Century Cures Act, H.R. 6, 114th Cong. (2015).

having drug companies report to HHS any price increases of 10% or more over a 12-month period.[13]

Lastly, the medical device industry may benefit from repeal of the medical device tax imposed by the ACA. H.R. 3762, a wide-sweeping health care reform bill that passed through the House and Senate but was vetoed by President Obama earlier this year, proposed an elimination of the tax, a move also supported by President-Elect Trump.[14]

Rulings, Filings, and Settlements of Interest

DOL Prevails in Kansas Litigation Challenging Conflict of Interest Rule and Related Exemptions

By Russell Hirschhorn and Benjamin Saper

> On November 28, 2016, Judge Crabtree in the U.S. District Court for the District of Kansas ruled in favor of the U.S. Department of Labor and denied the motion for a preliminary injunction filed by the Market Synergy Group, Inc., challenging implementation of the Department's conflict of interest rule and related exemptions. *Mkt. Synergy Grp., Inc. v. United States Dep't of Labor*, No. 16-CV-4083-DDC-KGS, 2016 WL 6948061 (D. Kan. Nov. 28, 2016). The court held that Market Synergy was not likely to prove that:

1. The Department provided insufficient notice that it would remove fixed indexed annuities ("FIAs") from the scope of PTE 84-24 because the language of the proposed rulemaking provided the requisite notice and, even if it did not, it amounted to harmless error because commenters made the same comments Market Synergy makes in this action.
2. The Department arbitrarily treated FIAs differently from all other fixed annuities because the Department provided a reasoned explanation for its decision to move FIAs from the scope of PTE 84-24 to better protect retirement investors.
3. The Department failed to consider the detrimental effects of its actions on independent insurance agent distribution channels. To the contrary, the Court found that the Department demonstrated its recognition of the effects that the final rule would have on the industry, but concluded that the need to protect consumers from conflicted investment advice outweighed those concerns.
4. The Department exceeded its statutory authority by seeking to manipulate the financial product market instead of regulating fiduciary conduct because Congress had authorized the Department to grant exemptions, and it was therefore entitled to great deference.

The Court also noted that even if plaintiff had carried its burden to demonstrate its likely success on the merits, it had not satisfied any of the other requirements for a preliminary injunction: irreparable harm, balance of harms, and public interest.

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[13] H.R. 6043, Fair Accountability and Innovative Research Drug Pricing Act of 2016, 114th Congress, 2nd Session (2016).

[14] H.R. 3762, 114th Cong. (2015).

This victory comes on the heels of the Department's win in the District Court for the District of Columbia where the court also denied a challenge to the Department's conflict of interest rule and related exemptions. *See Nat'l Ass'n for Fixed Annuities v. Perez*, No. CV 16-1035 (RDM), 2016 WL 6573480 (D.D.C. Nov. 4, 2016) (see our blog post here). The rule and related exemptions also are facing challenges in the Northern District of Texas and District of Minnesota (see our blog post here).

D.C. Court of Appeals Denies Emergency Request to Halt Conflict of Interest Rule and Related Exemptions

By Russell Hirschhorn and Benjamin Saper

On December 15, 2016, the U.S. Court of Appeals for the District of Columbia Circuit denied the emergency request from the National Association for Fixed Annuities ("NAFA") for an injunction blocking the implementation of the Department of Labor's conflict of interest rule and related exemptions. *Nat'l Ass'n for Fixed Annuities v. U.S. Dep't of Labor*, D.C. Cir., No. 16-5345, per curiam order 12/15/16. In a one-paragraph order, the panel ruled that NAFA "has not satisfied the stringent requirements for an injunction pending appeal." NAFA's challenge to the rule had already been rejected twice by Judge Moss in the U.S. District Court for the District of Columbia (see our blog here).

The Department also won a favorable ruling in a similar lawsuit challenging the new rule and exemptions in Kansas (see blog available here). Other lawsuits challenging the rule are pending in Texas and Minnesota, and the specter of a repeal, delay or revision of the rule after the Trump Administration takes office looms large.

DOL Prevails Again and NAFA Moves on to the Circuit Court Challenging the Conflict of Interest Rule and Related Exemptions

By Russell Hirschhorn and Benjamin Saper

> On November 23, 2016, Judge Moss in the U.S. District Court for the District of Columbia again ruled in favor of the Department and denied the renewed motion for a preliminary injunction brought by the National Association for Fixed Annuities ("NAFA") challenging implementation of the Department's conflict of interest rule and related exemptions. *Nat'l Ass'n for Fixed Annuities v. Perez*, No. CV 16-1035 (RDM), 2016 WL 6902113 (D.D.C. Nov. 23, 2016). Here, the Court applied both standards that the appellate court might apply when evaluating a preliminary injunction motion, and concluded that NAFA could not satisfy either standard. First, the court observed that it already had rejected NAFA's claims on the merits in a final judgment (*see* our blog available here). Second, the court found that the potential for irreparable harm, balance of equities, and public interest did not weigh so heavily in NAFA's favor as to outweigh NAFA's inability to establish a likelihood of success on the merits. The court explained that the types of irreparable harm alleged – *e.g.*, the fixed indexed annuity industry will incur substantial compliance costs, business practices will change when the new rules take effect, and the fixed indexed annuities industry will sustain economic losses from receiving lower commissions – while not insignificant, were outweighed by the potential harm to retirement investors should the rules not be implemented. NAFA has filed an Emergency Motion for an Injunction Pending Appeal with the U.S. Court of Appeals for the District of Columbia urging the Court to stay the April 10, 2017 applicability date of the rule pending appeal of the district court's rulings in favor of the Department.

Back from the Dead – Cures Act Resurrects Premium Reimbursement Arrangements for Small Employers

By Damian A. Myers

Last week, President Obama signed the 21st Century Cures Act (the "Cures Act"), which contains numerous provisions touching on a wide range of public health matters. Among the provisions is the creation of a new health benefit program available to small employers – the qualified small employer health reimbursement arrangement ("QSEHRA"). The purpose of the QSEHRA is to allow small employers to reimburse their employees for premiums paid for insurance purchased on the individual market, a practice that was prohibited under the Affordable Care Act ("ACA").

Background

Before the ACA became law, many employers sponsored health reimbursement arrangements (HRAs) that paid or reimbursed employees for insurance premiums and other eligible health expenses. However, after the ACA was passed, the IRS and other relevant agencies determined that HRAs were "group health plans" subject to the ACA market reforms (see, Notice 2013-54, FAQ XXII, Notice 2015-17 and Notice 2015-87), such as first dollar coverage of preventive services and the prohibition of annual and lifetime limits. This guidance means that employers could not use HRAs to reimburse employees for premiums paid for individual market coverage because by their very design, stand-alone HRAs could not satisfy all of the ACA's market reforms. Except in very limited circumstances, the only way for an HRA to comply with the ACA market reforms is for the HRA to be integrated with an ACA-compliant group health plan (for more information on HRA integration, see our February 23, 2015 and December 21, 2015 blog posts).

The Cures Act and Qualified Small Employer Health Reimbursement Arrangements

The Cures Act allows small employers to set up HRAs in the form of QSEHRAs. In many ways, QSEHRAs are just like pre-ACA HRAs – employer payments through the QSEHRA are deductible and reimbursements from the QSEHRA are excludible from employees' income. However, there are some important differences. Below is summary of the key aspects of the new QSEHRAs.

- QSEHRAs may be adopted effective for plan years beginning on or after January 1, 2017.
- Only small employers may establish QSEHRAs. A "small employer" means the employer is not an applicable large employer or "ALE," as determined under ACA rules. Generally, an employer is an ALE if it averaged 50 or more full-time employees during each month in the prior calendar year. Importantly, ALE status is determined on a controlled group basis, so a small subsidiary with fewer than 50 full-time employees might be ineligible for QSEHRA if related companies cause the subsidiary to be an ALE.
- The QSEHRA must be offered on the same terms to all eligible employees. Eligible employees are defined as all employees, subject to the following exclusions: employees who have been employed fewer than 90 days, employees under age 25, part-time and seasonal employees, union employees unless the relevant collective bargaining agreement provides for eligibility, and non-resident aliens with no US-source income. If a QSEHRA is limited to premium reimbursement, the QSEHRA will

still be treated as being offered on the same terms despite variation in premiums based on age and family size.

- QSEHRA amounts are capped at $4,950 (single) or $10,000 (family), subject to adjustment for inflation. Employees eligible for only part of a year are subject to a pro-rated cap. Employees cannot contribute to QSEHRAs through salary reduction or otherwise.
- Eligible employees must provide employers with proof of coverage before receiving reimbursement. If an employee is not enrolled in minimum essential coverage, the employee could be subject to an individual mandate penalty and any QSEHRA reimbursement could be includible in taxable income.
- Employers must provide employees with written notice no later than 90 days before the start of the plan year (or the start of eligibility for a new employee) describing the amount of reimbursement available under the QSEHRA and explaining that the employee must disclose the presence of the QSEHRA when applying for or renewing coverage purchased from the Marketplace. If an employer fails to provide the notice, the employer could face a penalty of $50 per employee per failure with a maximum penalty of $2,500.
- The amount available under a QSEHRA will be coordinated with any available premium tax credit available on the Marketplace. For example, if an employee covered by a QSEHRA is eligible for a premium tax credit, the amount available through the QSEHRA will offset the amount of the premium tax credit. It is possible for a QSEHRA to disqualify an individual from any premium tax credit if the QSEHRA is considered affordable coverage. A QSEHRA will be considered affordable coverage if the excess of the Marketplace premium for the second lowest cost silver plan over the QSEHRA amount available does not exceed 9.5% (indexed for inflation) of household income.
- The QSEHRA is considered "applicable employer-sponsored coverage" for purposes of the excise tax on high-cost employer-sponsored health coverage (the so-called "Cadillac Tax"). The effective date of the Cadillac Tax, however, was previously delayed until 2020. More information on the Cadillac Tax can be found here and here.
- The amount available under the QSEHRA must be reported on Form W-2 as the cost of coverage under an employer-sponsored group health plan.

Practical Considerations

The new QSEHRAs may be a great option for small employers that have struggled to provide affordable health coverage options for their employees. However, unlike the pre-ACA HRAs, QSEHRAs are subject to many new requirements. In addition to consulting with legal counsel, small employers should consider the following when implementing QSEHRAs.

- QSEHRAs are "excepted benefits" excluded from the definition of "group health plan" for many purposes of the Code, the Employee Retirement Income Security Act and the Public Health Safety Act ("PHSA"). This means that QSEHRAs are not considered minimum essential coverage under the ACA, is not subject to coverage continuation requirements under COBRA or the PHSA, and is not subject to HIPAA

portability requirements. The HIPAA privacy requirements, however, likely apply to QSEHRAs.

- Although the continuation coverage requirements under federal COBRA rules and the PHSA do not apply to QSEHRAs, many states have coverage continuation requirements separate from federal requirements. Thus, employers must consider whether state coverage continuation requirements still apply to the QSEHRA.
- A QSEHRA is likely disqualifying coverage for purposes of determining health savings account (HSA) eligibility. Thus, if an employee purchases an HSA-compliant high-deductible health plan on the Marketplace, the QSEHRA could disqualify the HSA component.
- In the context of corporate transactions, acquiring companies should conduct diligence to determine whether the target sponsors a QSEHRA. If the transaction will result in the target becoming an ALE upon closing (i.e., as a result of controlled-group attribution), there does not appear to be any transition relief that would allow continuation of the QSEHRA. Therefore, the QSEHRA should be terminated prior to closing the transaction. Failure to terminate the QSEHRA prior to closing would disqualify the QSEHRA, meaning that QSEHRA could be subject to an ACA excise tax of $100 per employee per day.

Portland, Oregon Adopts First-of-Its-Kind CEO Pay Ratio Tax on Employers

By Allan Bloom and Laura Fant

The Portland, Oregon City Council has passed an ordinance that will impose a tax surcharge on publicly traded companies whose chief executive officers are paid at least 100 times more than the median pay of other company employees. Portland is the first locality in the nation to enact such a requirement.

The law, which passed by a 3-1 vote (with one absence), creates a surtax to the city's Business License Tax for companies that will be subject to a new Securities and Exchange Commission rule taking effect in January 2017 requiring publicly traded companies to report the ratio of CEO pay to its median employee compensation. The current annual tax rate established by Portland's Business License Law is 2.2 percent of adjusted net income. For tax years beginning on or after January 1, 2017, a surcharge of 10 percent of base tax liability will be imposed if a covered company reports a pay ratio of at least 100:1 but less than 250:1 between CEO and median employee pay. The surcharge increases to 25 percent of base tax liability if the ratio is 250:1 or greater. The surcharge provision will apply to all publicly traded companies otherwise covered by the city's Business License Tax, regardless of whether the company is headquartered in Portland.

Our ERISA Litigation practice is a significant component of Proskauer's Employee Benefits & Executive Compensation Group. Led by Howard Shapiro and Myron Rumeld, the ERISA Litigation practice defends complex and class action employee benefits litigation.

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