## Affordable Care Act: Current and Anticipated Growing Pains

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Location</th>
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<tbody>
<tr>
<td>Ellen Doyle</td>
<td>Feinstein Doyle Payne &amp; Kravec, LLC</td>
<td>Pittsburgh, PA</td>
</tr>
<tr>
<td>Howard Shapiro</td>
<td>Proskauer Rose LLP</td>
<td>New Orleans, LA</td>
</tr>
<tr>
<td>Mary Ellen Signorille</td>
<td>AARP Foundation Litigation</td>
<td>Washington, DC</td>
</tr>
<tr>
<td>Erin Sweeney</td>
<td>Dickstein Shapiro, LLP</td>
<td>Washington, DC</td>
</tr>
</tbody>
</table>
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  – AARP Foundation
  – Dickstein Shapiro, LLP
  – Feinstein Doyle Payne & Kravec, LLC
  – Proskauer Rose LLP

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  - Judith Broach, Broach & Stulberg, New York, NY
  - Margo Hasselman, Lewis Feinberg Lee Renaker & Jackson, PC, Oakland, CA,
  - Brian Neulander, formerly of Proskauer Rose, LLP, New Orleans, LA

• The contents were updated subsequently by:
  - Tulio Chirinos, Proskauer Rose, LLP, New Orleans, LA
  - M. Todd Mobley, Proskauer Rose, LLP, New Orleans, LA
  - Robert Rachal, Proskauer Rose, New Orleans, LA
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  - Howard Shapiro, Proskauer Rose, LLP, New Orleans, LA
  - Mary Ellen Signorille, AARP Foundation Litigation, Washington, DC
Today’s Topics

  – The constitutionality of PPACA

• Contraception Mandate Litigation

• Premium Tax Credit Cases
Today’s Topics (cont’d)

• Workforce realignments
  – The return of ERISA § 510, 29 U.S.C. § 1140?

• ACA Whistleblower protection

• Retiree only plans

• Benefit Claims Procedures

• Miscellaneous issues
Grandfathered Status

• A “grandfathered plan” is a group health plan that was in existence on the date of enactment of the ACA on March 23, 2010.

• To maintain grandfathered status, a plan must include in any plan material provided to the participant describing the benefits under the plan, a statement that the plan believes it is a grandfathered health plan and provide contact information for questions and complaints.

• Also special recordkeeping requirements to prove grandfathered status
Challenges to the ACA

• General Constitutional Challenge
• Contraceptive Mandate v. Freedom of Religion
• Tax Subsidies
Constitutional Challenges
General Constitutional Challenges
The Supreme Court: Big Picture

- The Supreme Court largely upheld ACA, except the Medicaid expansion provisions
- All coverage mandates remain
- Plan sponsors and administrators continue implementation or grandfathering efforts
Individual Mandate – Rulings

- Constitutional within the Taxing and Spending powers
- Unconstitutional under the Commerce Clause
- Both holdings were 5-4, with Roberts as the swing vote

- Medicaid Expansion Requirements:
  - States must cover all individuals under age 65 with income below 133% of the poverty line
  - “Essential benefits” must be provided to all Medicaid recipients

- Failure to comply = loss of all federal funds
Medicaid Expansion – Constitutional Provision at Issue

• The Spending Clause: Congress has the power to “pay the Debts and provide for the . . . general Welfare of the United States”

• This power allows the federal government to grant funds upon condition.
Medicaid Expansion – Unconstitutional

- Withholding of all Medicaid funds is Unconstitutional
- Coercion: “when pressure turns into compulsion, the legislation runs contrary to our system of federalism”
- Financial inducement at issue is “much more than relatively mild encouragement — it is a gun to the head”
- Remedy: states can opt out of expansion, without loss of existing Medicaid funds
Hotze v. Sebelius,
on appeal, No. 14-20039 (5th Cir.)

• Challenge to the ACA based on the Origination Clause
  – If the penalties qualify as a tax, the ACA violates the Origination Clause because it did not begin as a tax-raising bill in the House.

• District court held that the ACA is not subject to the Origination Clause because it is a law “plainly designed to expand health insurance” and not raise taxes.
Challenges to Provision of Contraceptive Coverage
Contraception Coverage Cases

• ACA added Section 2713 to Public Health Services Act
  – Without cost-sharing, group health plans and insurers must cover preventative services for women.
  – Provision does not apply to grandfathered plans


• Two primary groups challenging contraceptive coverage
  – Non-profit religiously affiliated organizations
  – For-profit secular employers
The Issue

• Does the RFRA and the Free Exercise Clause apply to for-profit, secular closely held corporations operating in accord with their families’ religious principles forbidding certain forms of contraception?

• The RFRA states: “the Government shall not substantially burden a person’s exercise of religion.”
  - For purposes of the RFRA, are for-profit corporations persons exercising religion?
The Decision

• Held 5-4:

• Profit-making businesses that are owned only by a family or other closely allied individuals or by a family trust have a legal right under RFRA not to be forced to include 4 specific form of birth control in their workers’ plans, if they have sincere religious beliefs.

• First time Court has decided that RFRA covers corporations not just persons.

- Contraceptive mandate clearly imposes a substantial burden on the owner’s beliefs and the company’s exercise of religion.

- Government did not show applying ACA’s contraceptive mandate was least burdensome way to avoid interfering with religious convictions
  - The plan and TPA, the insurer or the government could provide the contraceptives at issue
  - Could use the accommodation provided for religious-oriented not-for-profit corporations (which is also under challenge) where they certify their objections

• IRS defines closely held corporations:
  – 50% of the value of outstanding stock is owned by 5 or fewer individuals at any time during the last half of the tax year; and
  – Is not a personal service corporation
• Covers 90% or more of all businesses
• Employs 52% of American workforce

- Will corporations be able to deny other medical services such as blood transfusions, vaccinations, medical marijuana, medical care that uses embryonic stem cells?
- Will businesses be permitted to refuse to do business with gay people; or those in same sex marriages?

- Does the religious exemption go far enough?
- Is the use of a “middle man” to provide the contraceptive coverage an adequate accommodation to meet the religious objections?
- Is the required filing of government form stating religious objections an act of participation in the provision of the objected to contraceptive services?
Challenges To Premium Tax Credit
Premium Tax Credit Cases — Overview

• May 2012, IRS issues final rule implementing ACA’s premium tax credit provision
  – IRS decides that ACA authorizes Service to grant tax credits to individuals who purchase insurance on either state or federal exchanges
• But, Plaintiffs allege ACA authorizes tax credits only for those who purchase insurance on state exchanges
• May the IRS final rule authorize tax credits for individuals purchasing insurance on the federal exchange?

- First court to decide issue
- Plaintiffs reside in states with federally-facilitated exchanges.
- Plaintiffs argue that Congress intended to limit the availability of premium tax credits to state-run exchanges.
- According to Plaintiffs, the premium tax credits should not be available to individuals enrolling for coverage in states with federally-facilitated exchanges.

- Court found plaintiffs’ interpretation too narrow
- Held ACA makes clear that “where a state does not actually establish an Exchange, the federal government can create an ‘Exchange established by the State . . . .’ on behalf of that State.”
- Court relied on numerous cross-referenced provisions to conclude that ACA required (or, at least, assumed) that premium tax credits would be available for individuals purchasing insurance on federal exchanges
- Decision appealed to the D.C. Circuit Court of Appeals
Halbig v. Burwell,

• Decision reversed by the Circuit Court, 2-1.
• Concluded that ACA “unambiguously” restricts the premium tax credit subsidy to those purchasing insurance on Exchanges “established by the State.”
• “Nothing about the imperative to read [the exchange provision] in harmony with the rest of the ACA requires interpreting ‘established by the state’ to mean anything other than what it plainly says.”
• The court found that such a construction does not render other sections of the ACA unworkable.

• The court observed that evidence of congressional intent was not clear, and not enough to overcome the plain meaning of the statutory text.

• The court acknowledged “significant consequences” for those receiving tax credits through federal exchanges. “But, as high as those stakes are, the principle of legislative supremacy that guides us is higher still.”

• The government indicated it will seek an *en banc* review from the full D.C. Circuit Court of Appeals

• District court granted motion to dismiss relying on the same reasoning as the lower court in Halbig:
  – “Viewed in a vacuum, it seems comprehensible that the omission of any mention of federally-facilitated Exchanges . . . could imply that Congress intended to preclude individuals in federally-facilitated Exchanges from receiving tax subsidies. However, when statutory context is taken into account, Plaintiffs’ position is revealed as implausible.”

• Court also concluded that if statute was ambiguous, the IRS rule was reasonable and due deference was appropriate under Chevron

- Hours after the decision in Halbig v. Burwell, the Fourth Circuit Court of Appeals issued a contrary ruling, unanimously affirming the district court’s decision in King.
- The court found that Chevron deference applied.
- The statute was susceptible to multiple interpretations and Congressional intent was unclear.
- But, IRS’s construction of the rule, in light of the goals of the ACA, was permissible.
Timing

  - Response due Sept. 3

  - Petition for rehearing due to be filed no later than Sept. 6

- **Pruitt v. Sebelius**, No. CIV-11-30-RAW (E.D. Ok.)

- **Indiana v. IRS**, No. 13-1612 (S.D. Ind.)
Potential Effects of Premium Tax Credit Cases

• If Courts of Appeal or Supreme Court review and disagree, employers operating in states with federal exchanges may be exempt from the pay-or-play penalties.

• Thus, these cases have potential to disrupt distribution of subsidies to individuals obtaining coverage from the federally-facilitated exchanges, as well as imposition of penalties under the Employer Mandate.
Future ACA Litigation Issues
ACA Mandates: Future ERISA Litigation?

- Avoidance of employer pay-or-play mandate may result in ERISA Section 510 and ACA whistleblower claims.
- Using state exchanges for retirees may have similar consequences.
- New benefit claims procedures may alter *Firestone* deference.
- Unintended loss of grandfathered status may result in plan-wide failure to provide “minimum essential coverage.”
- Increase in permitted wellness incentives to 30% may result in additional usage and litigation regarding these plans.
ERISA’s Remedial Provisions and ACA Coverage Mandates

• ACA amended Public Health Services Act and ERISA
  – ACA’s mandates apply to individual and group health plans, including self-insured employer-sponsored plans.
  – See newly created Section 715 of ERISA which incorporates ACA’s mandates by reference
  – Section 715 resides in Title I, Part 7 of ERISA: plan participants can enforce their rights to ACA benefits via ERISA’s remedial provisions
ACA’s Employer Mandate (Pay-or-Play)

• Employer Mandate:
  - Applies to employers with 50 or more full-time employees
    - Full-time employees average at least 30 hours/week (employers may use 130 hours/month as monthly equivalent.
  - Requires that employers provide affordable minimum-value health coverage
    - Affordable = premiums do not exceed 9.5% of household income
    - Minimum Value = pays at least 60% of cost of covered services
  - **NOTE**: Supreme Court vacated earlier order and remanded *Liberty Univ. v. Geithner*, 133 S. Ct. 679 (2012), to Fourth Circuit for further consideration of Employer Mandate issues
Pay-or-Play Penalties

• No Coverage
  – If at least one full-time employee purchases coverage through a public insurance exchange and obtains a premium tax credit, the employer is subject to a penalty of $2,000 multiplied by all full-time employees employed for the year (minus up to 30 employees).

• Unaffordable Coverage or Coverage Not Providing Minimum Value
  – Annual penalty is the lesser of $3,000 for each full-time employee who obtains a premium tax credit on an exchange, or $2,000 multiplied by all full-time employees employed for the year (minus up to 30 employees).
Workforce Realignment

• How are employers responding to Employer Mandate?
  – Possible avoidance by reorganizing workforce.
  – Employers may reduce employees’ hours below 30/week to avoid “full-time” employees under ACA.

• Penalty determined based on full-time employees, which includes full-time equivalent employees
  – Full-time equivalent employees = number of hours worked by less-than-full-time employees (but no more than 120 hours per such employee) divided by 120

• Some employers experimenting with reorganization
Workforce Realignment

• Potential Litigation
  - ERISA § 510
    - Discrimination, retaliation as to future benefits?
    - Motivated by “specific intent” to interfere with benefits or legitimate business reason?
  - Whistleblower action under ACA
    - Improper motive need only be “contributing factor.”
  - ADEA and Title VII
    - Does “adverse” employment action (i.e., cutback in hours) disparately impact protected class?
    - Legitimate business reason other than avoiding penalties?
Benefit Discrimination by Refusing Full-time Employment to a Part-time Employee?

  - Plaintiff became employed with Amerimed as a part-time pharmacist, and in that position was not entitled to participate in Amerimed's group health plan. Plaintiff allegedly sought a full-time position because he wanted to participate in Amerimed's group health plan and receive other benefits; however, Plaintiff was never hired as a full-time pharmacist and eventually voluntarily resigned from his position in or around January 2013.
  - In addition to alleging discrimination on the basis of age and disability, Plaintiff alleges that Amerimed refused to hire him for a full-time position because it was concerned that Plaintiff would add substantial medical expenses to its group health plan.
Denying Amerimed’s motion to dismiss, the court pointed to the Sixth Circuit’s ruling in *Fleming v. Ayers & Assoc.*, 948 F.2d 993 (6th Cir.1991), in which the Sixth Circuit affirmed liability under ERISA where the employer had discharged the plaintiff because of high medical expenses it expected would be incurred by her infant child, and for which the employer's health insurance plan could have been responsible. Like the instant case, the plaintiff in *Fleming* was originally hired to work in a part-time position without benefits, but there was a reasonable expectation she would ultimately obtain a full-time position and become eligible for benefits. However, she was discharged before she was ever employed in a full-time position.
ACA Whistleblower Protections

- ACA prohibits adverse action against employees who:
  - actually receive a premium tax credit or subsidy for a health plan
  - provide information to the employer or the federal or state government concerning a violation, act, or omission the employee reasonably believes to be a violation relating to Title I of ACA
  - testifies in a proceeding concerning such violation
  - assists or participates in such a proceeding or
  - object to, or refuse to perform, any activity or assigned task the employee reasonably believes to be such a violation
ACA Whistleblower Protections

• Standards of Proof (Burden Shifting)
  – **Claimant:** must show by preponderance of the evidence that protected activity was contributing factor to adverse action
  – **Defense:** employer avoids liability only if it proves by clear and convincing evidence that same action would have resulted in the absence of the employee’s protected conduct

• Procedure
  – **Administrative Process:** complaint filed with OSHA within 180 days of retaliatory action. OSHA can order preliminary relief. Either party can appeal
  – **Federal Court:** either 90 days after employee receives OSHA’s written findings or if no final decision within 210 days of administrative claim, suit may be filed in federal court (trial by jury)
ACA Whistleblower Protections

- Remedies include:
  - reinstatement
  - back pay
  - special damages (including emotional distress damages)
  - attorneys’ fees

- Whistleblower protections are in addition to any other rights under federal or state law or under a collective bargaining agreement.

- Whistleblower protections cannot be waived.
§510 Interference and Retaliation Claims

• *Perez v. Brain*, 2:14-cv-03911-JAK-AGR (Central District of California)
  - The U.S. Department of Labor (“DOL”) filed a lawsuit on behalf of a former employee of the Cement Masons Southern California Administrative Corp., who was allegedly fired for cooperating with an ongoing DOL investigation.
  - When the trustees learned the employee had been cooperating with the DOL, they conspired to terminate the employee by having a service provider take over the department she worked in, with guarantee that the provider would hire all of the current employees except the employee cooperating with DOL.
Perez v. Brain

- The lawsuit alleges the violations of ERISA’s fiduciary duties and violation of ERISA Section 510.

- In addition to seeking the employee’s reinstatement with the service provider in a comparable position, the DOL seeks lost wages, plus interest, covering the time from the individual’s termination to her reinstatement, plus other costs that the individual may have incurred as a result of her termination. It also seeks the removal of several fiduciaries, named trustees and service providers; including a ban on their serving in the future as fiduciaries or service providers to any ERISA-covered plan. Finally, the suit seeks to require mandatory training for all affected employees and trustees on participants’ and workers’ rights under ERISA.
Retiree-Only Plans

- ACA generally does not apply to “retiree-only plans.”
  - Cover fewer than 2 active employees

- What if employer spins off a retiree-only plan?
  - ERISA § 502(a)(1)(B): claims to recover benefits due
  - ERISA § 502(a)(3): enjoin any act or practice which violates ERISA or the terms of the plan or to obtain other “appropriate equitable relief.”
  - LMRA § 301(a): enforcement of CBA terms
  - Disclosure claims?
  - ERISA Section 510 on class basis?
Exchanges and Retiree Medical Exit Strategy

- Surveys report that ACA is a catalyst to employers exiting sponsorship of retiree medical plans.
- Will employers use the exchanges as a “soft landing” for retirees who will lose employer-sponsored coverage?
- Risks are similar to the retiree medical spin-off.
- *But see Reese v. CNH Am. LLC, 694 F.3d 681 (6th Cir. 2012)* (unilateral reasonable changes to retiree health allowed)
- Is moving retirees to exchanges a “reasonable” change?
### Claims for Mandated Benefits

**Mandates for grandfathered and non-grandfathered plans**

- **Plan years beginning on or after September 23, 2010:**
  - No lifetime limits on essential health benefits
  - Minimum annual limits on dollar value of essential health benefits
  - Coverage of children to age 26 (grandfathered plans may exclude children eligible for other coverage)
  - No rescission except in case of fraud
  - No preexisting condition exclusions for children under age 19

- **Plan years beginning on or after January 1, 2014:**
  - No annual limit on dollar value of essential benefits, without exception
  - Coverage of children to age 26, regardless of other coverage
  - No preexisting condition exclusions
  - Waiting periods limited to 90 days
  - Changes to wellness plan incentives
Claims for Mandated Benefits — Additional Mandates for Non-Grandfathered Plans

- **Additional mandates for non-grandfathered plans only:**
  - Limits on deductibles and out-of-pocket maximums
  - Nondiscrimination for insured plans determined under IRC 105(h)
  - Internal and external appeal process rules
  - Coverage of in-network preventive services with no cost-sharing
  - Special rules on choosing primary care provider
  - No prior authorization for OB/GYN visits
  - Coverage of out-of-network emergency services using in-network cost-sharing, no prior authorization requirement
  - Coverage of treatment for those in clinical trials
Claims for Mandated Benefits — Risks for Maintaining Grandfathered Status

• Is Plan Really Grandfathered?
  – No substantial modifications, including:
    – Coverage for a particular condition
    – Costs (deductibles, copayments, out-of-pocket limits)
      – Percentages — no increases
      – Fixed costs — only certain increases
    – Employer contributions
    – Annual dollar limits on coverage

• Document and provide proof of grandfathered status in written plan documents and in ERISA reporting and disclosure requests.
ACA – Litigation As to Grandfathered Status
Grandfathered Status

• A plan may lose “grandfathered” status when:
  – It eliminates all or substantially all plan benefits to diagnose or treat a particular condition
  – It increases a percentage cost-sharing requirement
  – Co-payments increased (above certain amount)
  – Other costs (e.g., deductible or out-of-pocket limit), increased above a certain amount
  – Employer contributions decrease (beyond certain amount)
  – Plan is amended to create new annual benefit limits

• If a plan’s grandfathered status is challenged:
  – What are defenses to class-wide claim?
  – How will damages be measured?
ACA Benefit Claim Review Issues
New Internal Claim Review Regulations

• **Additional protections for claimants:**
  - Changes to rules under ERISA § 503, 29 C.F.R. § 2560.503-1 (does **not** apply to grandfathered plans)
  - Rescission of coverage is an “adverse benefit determination”
  - Deference to treating doc on whether claim is urgent
  - Claimant allowed to review file as part of internal review
  - Claimant allowed to submit evidence **and** testimony
  - Claimant gets opportunity to respond to new evidence or rationale
    - Sufficiently in advance of deadline to allow reasonable opportunity to respond before original deadline for final determination
External Appeals & IROs

Federal external appeals process (does not apply to grandfathered plans)

- Group health plans, e.g., self-funded ERISA plans, are required to provide external review processes by Independent Review Organizations (“IROs”).
- External review is final and binding.
- Will IROs be subject to ERISA’s fiduciary duties?
- How does this affect the standard of review?
External Appeals & IROs

• IRO litigation scenarios:
  – Participant vs. IRO
    – If IRO is a fiduciary, may face benefit claim and § 502(a)(3) for equitable relief in form of surcharge
    – If IRO is not a fiduciary, claims preempted?
  – Plan Participant vs. IRO and Plan Administrator
    – Combination ERISA § 502(a)(1)(B) and § 502(a)(3) claims, *i.e.*, benefit claim *plus* failure to monitor/supervise
  – IROs must review claims *de novo*, what standard of review applies to their decisions?
External Appeals & IROs

• Other IRO Litigation Scenarios
  - Plan Administrator vs. IRO
    - If IRO is a fiduciary, may face ERISA § 502(a)(2) claims for overpaying claims
    - If IRO is not a fiduciary, may face state court breach of contract or professional negligence claims
    - What standard of review in these cases if plan grants discretionary decision-making to IRO?

- Plaintiffs sued United Healthcare as claims administrator
  - Exercised discretion to deny coverage for benefits on behalf of several different self-funded welfare plans
  - Plaintiff (medical provider group and patients) apparently sought to aggregate litigation against major TPA.

- Alleged defendant breached fiduciary duties by not following new ACA claim review procedures.

- Court dismissed ACA claims because plaintiffs failed to name underlying plans or plan administrators
  - Only “group health plans” or entities “providing health insurance coverage in connection” therewith liable under ACA

- The district court noted some significant issues:

- In dismissing United as wrong party, court stated that since Mental Health Parity and Addiction Equity Act has been incorporated into ERISA, “its requirements automatically become “terms” of every ERISA plan” and is enforceable against the plan administrator under 502(a)(1)(B).

- Court also noted that ACA entitles participants to continuation of coverage while internal appeal is pending (the allegations were that mental health treatment had been stopped during appeals), and that these rights have also become terms of the plan enforceable under 502(a)(1)(B).

• Argument: ACA is not enforced as a plan term unless the plan is amended to include the specific right at issue
• This can provide defenses on harm and causation and defeat or limit class claims.
• Case illustrates how ACA and other acts can work together to significantly enhance benefit rights and costs
• May create obligations to continue to provide expensive mental health treatment (which included residential confinement) as long as the appeal is pending