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CLIENT ALERT

Trump Administration Sets the Stage for Sweeping Health Care Changes

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In a one-two punch, last week, the Trump administration (Administration) dealt a crushing blow to the Affordable Care Act (ACA) in the form of an executive order and a decision by the Administration to stop funding cost-sharing reduction (CSR) payments on the public health care exchanges (Marketplace Exchanges). Together, these two actions, along with other extensive measures targeted at weakening the ACA, make good on a central Trump campaign promise to repeal and replace the ACA. These measures are born out of the Administration's frustration at Congress's failure to pass health care reform legislation this year. While the Administration cannot unilaterally change ACA provisions that are written into law, it can take administrative and regulatory action to dismantle the structural underpinnings of the law.

These broad and sweeping proposals have the potential to meaningfully change the health care landscape under the ACA. All stakeholders in the business of providing health care will be impacted in some manner by these recent developments. In this briefing, we summarize these developments and offer some insights as to how the health insurance markets and employer-provided coverage may be impacted.

Trump Executive Order

The Presidential Executive Order issued on October 12, 2017, entitled "Promoting Healthcare Choice and Competition Across the United States" (Order), directs regulatory agencies with authority over regulating health plans to make changes to regulatory and sub-regulatory guidance in three areas: (i) association health plans (AHPs); (ii) short-term limited duration insurance (STLDI); and (iii) health reimbursement arrangements (HRAs). The stated policy goals of the reforms are aimed at (1) expanding availability of and access to alternative and less expensive forms of insurance; (2) re-injecting competition into the health care markets by lowering barriers to entry, limiting excessive consolidation and preventing abuse of market power; and (3) improving access to and quality of information that people need to make informed health care decisions.

Association Health Plans

The Order directs the Secretary of the Department of Labor (DOL), within 60 days of the date of the Order, to consider proposing regulations or revising guidance to expand access to health coverage by allowing more

employers to form AHPs. This could be done through expanding the commonality of interest requirements under current DOL advisory opinions interpreting the definition of "employer" in Section 3(5) of the Employee Retirement Income Security Act of 1974 (ERISA), or promoting the formation of AHPs on the basis of common geography or industry.

The term "association coverage" or "association health plan" is not a distinct category of health insurance under the ACA, ERISA, or the Public Health Security Act (PHSA), nor does the ACA specify whether such plans are to be treated as individual policies, small, or large group health plans for purposes of the insurance market reforms under the ACA. In a guidance issued in 2011 by the Centers for Medicare and Medicaid Services (CMS), which has jurisdiction over enforcement of certain provisions of the ACA as applied to health insurance issuers, CMS referred to "association coverage" as health insurance coverage that is offered to a collection of individuals and/or employers through entities that may be called associations, trusts, multiple employer welfare arrangements, purchasing alliances, or purchasing cooperatives. CMS also took the position in this guidance that only in rare instances would an association of employers be treated as the employer, itself, and considered a single group health plan.

ERISA's definition of "employer" and, by extension, the criteria to constitute a "bona fide" association under ERISA is critical to determining how the insurance market requirements apply to association coverage. ERISA defines an "employer" to mean any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; ***and includes a group or association of employers acting for an employer in such capacity***. Most association health plans today are treated as small or individual groups for purposes of insurance underwriting and may also be subject to special reserve, registration, and licensing requirements under federal and state law applicable to multiple employer welfare arrangements (MEWAs). If an AHP is treated as a large group health plan sponsored by a single employer, it is exempt from these onerous MEWA rules and is also exempt from many of the insurance reform requirements applicable to individuals and small groups under the ACA, such as the prohibition on setting premiums based on health status, community rating, age-banded rating, and the requirement to cover ten essential health benefits.

For a group or association of employers to qualify as a single employer under ERISA, the group of employers must be: (1) a "bona fide" association of employers tied by a common economic or representation interest, unrelated to the provision of benefits (commonality of interest test); and (2) the employer members of the organization that sponsor the plan must exercise control, either directly or indirectly, both in form and in substance over the plan (control test).

Among the factors considered by the DOL in determining whether an association is a bona fide association under the ERISA standard are: how members are solicited; who is entitled to participate and who actually participates in the association; the process by which the association was formed, the purposes for which it was formed, and what, if any, were the preexisting relationships of its members; the powers, rights, and privileges of employer members that exist by reason of their status as employers; and who actually controls and directs the activities and operations of the benefit program. Further, to be a bona fide association, the employers that participate in the program must, either directly or indirectly, exercise control over the program, both in form and in substance. In addition, association membership is limited to employers tied by a common economic interest unrelated to providing benefits and control of the plan. Conversely, where several unrelated employers merely execute participation agreements (such as through a commercial promoter) or similar documents as a means to fund benefits, in the absence of any genuine organizational relationship between the employers, no employer group or association is recognized under current DOL rules.

In interpreting the definition of "employer" for purposes of ERISA, the DOL has expressed the view in various opinion letters that where several unrelated employers merely execute identically worded trust agreements or similar documents as a means to fund or provide benefits, in the absence of any genuine organizational relationship between the employers, no employer group or association exists for purposes of ERISA. Similarly, where membership in a group or association is open to anyone engaged in a particular trade or profession regardless of their status as employers (i.e., the group or association members include persons who are not employers) or where control of the group or association is not vested solely in employer members, the group or association is not a bona fide group or association of employers for purposes of ERISA.

It is possible that CMS, taking direction from the Order, could reverse or revise its sub-regulatory guidance applicable to associations, thereby making it easier for AHPs to be treated as large employers for ACA purposes. It is also possible that the DOL, acting on the Order, could make changes to the MEWA rules by loosening restrictions on the requirements to be a bona fide association, such that small employers in different geographic areas or associations of individuals in the same trade or profession or in the same line of business could be recognized as one "employer" and underwritten as a large group for insurance purposes, or even band together to self-insure the risk and avoid state mandated benefit requirements. These changes would permit groups of small employers, or perhaps even individuals, to band together for purposes of providing insurance to its members on a large group fully-insured or self-insured basis exempting the arrangement from many of the more restrictive ACA requirements. Given that many states have their own MEWA laws and regulations, the application of state laws to such arrangements would still have to be analyzed, and it is possible that states may take legal action in response to the loosening of restrictions at the federal level.

Short Term Limited Duration Health Plans

The Order also directs the Secretaries of the Departments of Treasury, Labor, and Health and Human Services (Departments), within 60 days of the date of the Order, to consider proposing regulations or revising guidance to expand the availability of STLDI for longer periods and on a renewable basis by the insured.

STLDI is a type of insurance coverage designed to fill temporary gaps in health insurance coverage—for example, to cover periods of unemployment or when transitioning between employer-sponsored group health plans. STLDI policies are exempt from consumer protections added under the ACA, including restrictions on lifetime and annual dollar limits and pre-existing condition exclusions, and requirements to cover essential health benefits. STLDI policies can be medically underwritten, allowing insurance carriers to charge healthier individuals lower premiums than sick individuals. For these reasons, STLDI plans are generally substantially cheaper than Obamacare policies available through the individual health insurance Marketplace Exchanges and may be an attractive alternative for healthier individuals.

To prevent individuals from using STLDI as permanent, primary coverage, the Departments jointly issued final regulations in October 2016, revising the definition of STLDI to limit coverage to less than three months in duration, including any period for which the policy may be renewed. This was a change from previous regulations, which allowed STLDI policies to extend for less than 12 months.

STLDI is not qualifying health coverage that satisfies the ACA's individual mandate. Therefore, an individual enrolled only in STLDI coverage could be subject to the individual shared responsibility tax penalty. Limiting the coverage period for a STLDI policy to less than three months was intended to correspond the individual shared responsibility penalty exemption for gaps in coverage of less than three months.

If the ACA's individual mandate is ultimately repealed or goes unenforced, STLDI could become an increasingly attractive, lower cost option for younger and healthier individuals who want some health insurance protections but do not need the more robust and comprehensive plans available through the individual market or from their employer. As with the AHPs, if expansion of STLDI causes younger, healthier individuals to exit the Marketplace Exchanges, this could result in insurance market destabilization and significantly increased premiums.

Health Reimbursement Arrangements

Finally, the Order directs the Secretaries of the Departments, within 120 days of the date of the Order, to consider proposing regulations or revising guidance to increase the usability of HRAs, to expand employers' ability to offer HRAs to their employees and to allow HRAs to be used in connection with non-group coverage.

An HRA is an arrangement that reimburses an employee up to a maximum amount for medical care expenses incurred by the employee or his/her spouse, dependents, and eligible children. While there is significant flexibility in how an employer can structure an HRA, such arrangements do not permit employee contributions and generally provide for the rollover of unused amounts from year to year.

The ACA added certain market reforms that apply to group health plans—for example, a prohibition on annual and lifetime dollar limits on essential health benefits and coverage for young adult children. Failure to comply with market reform requirements can result in a $100 per day penalty for each affected individual.

The Departments previously concluded, in guidance issued under the ACA, that an HRA will not satisfy market reforms unless it is integrated with a group health plan that satisfies these market reform requirements. Specifically, in the Departments' view, an HRA will violate the prohibition on annual dollar limits on essential health benefits and the requirement that certain preventative services be provided without imposing cost-sharing requirements.

Importantly, the Departments also determined that an HRA that is used to purchase coverage on the individual market is not integrated with that individual market coverage for purposes of satisfying the market reform annual dollar limit prohibition. As a result, employers have been required to integrate HRAs with other coverage that, when combined with the HRA, meets market reform requirements. This has largely resulted in HRAs being made available only to employees who are covered by the employer's primary group health plan or to retirees because retiree-only plans are exempt from many ACA group market reforms.

In addition, qualifying small employers are permitted to sponsor HRAs provided certain statutory requirements are met. In 2016, Congress enabled the adoption of qualified small employer HRAs (QSEHRAs) that are not subject to ACA mandates and are exempt from the HRA rules. Under QSEHRAs, small employers can pay or reimburse employees for premiums for health insurance that qualify as minimum essential coverage under the ACA.

In light of the Order, the HRA guidance issued by the Departments seems fertile ground for reinterpretation and change. Aside from the group market reform requirements, which are codified in the ACA, the HRA guidance described above is largely based on regulation preambles, notices and FAQs issued by the Departments. Based on the Order's direction to the Departments that they expand employers' ability to offer HRAs to their employees and to allow HRAs to be used in connection with non-group coverage, it appears likely that the Departments will loosen integration requirements. This may allow employers to offer HRAs to a wider set of employees. It also may open the door for large employers to offer HRAs that reimburse premiums for individuals who purchase individual health coverage. This would permit an employer to essentially take a defined contribution approach to its health care offering by capping the employer contribution to the reimbursement amount under the HRA and having employees purchase their desired level of coverage through the individual insurance market. Importantly, large employers who decide to offer such arrangements will need to consider ACA employer mandate requirements under Section 4980H of the Internal Revenue Code of 1986.

Trump Announces End of Cost-Sharing Reduction Payments

On October 12, 2017, the White House Office of the Press Secretary announced that "[b]ased on guidance from the Department of Justice, the Department of Health and Human Services has concluded that there is no appropriation for cost-sharing reduction payments to insurance companies under Obamacare. In light of this analysis, the Government cannot lawfully make the cost-sharing reduction payments."

Previously, President Trump had threatened to stop the payment of CSR subsidies to insurance companies that help make individual silver insurance policies on the health insurance Marketplace Exchanges affordable by covering deductibles, co-payments, and co-insurance (out-of-pocket medical expense amounts) for qualifying low-income individuals. According to the CMS, in 2017, seven million people qualified for CSR payments. This is equal to approximately 58% of all Marketplace Exchange enrollees.

Insurers offering insurance on the state and federal Marketplace Exchanges have agreed to participate with the understanding that CSR payments will be available to qualified individuals. Many insurers relied on the promise of the CSR subsidies when they submitted their rate proposals for health plans sold on the Marketplace Exchanges in 2018. Once CSR payments are eliminated, some insurers may seek to terminate their exchange contracts with the state or federal exchanges early because of the loss of these payments. Alternatively, these carriers may stay in the Marketplace Exchange markets, but may request an increase in the insurance premiums originally submitted to the state Departments of Insurance, to make up for the lost government subsidy payments. Ironically, an increase in premiums will also increase costs to the government by increasing premium tax credits, potentially wiping out any

savings from elimination of the CSR subsidies. The nonpartisan Congressional Budget Office had predicted that ending CSR payments would increase the federal deficit by $194 billion over the next ten years.

The CSR subsidies are seen by many as crucial to stabilizing the individual insurance market and have attracted bipartisan support. Qualified health plan applications in the Marketplace Exchanges and final rates were due on August 16, 2017, and final contracts with insurers providing coverage through the Marketplace Exchanges had to be signed by September 27, 2017. Some insurers built the uncertainty of continuing CSR subsidies into their rates, but those that did not, and those in states where market withdrawal rates are more strict, could be hit the hardest.

This situation is very fluid depending on the state involved. Some states may seek to enjoin the administration from cutting of the CSRs through legal action, or it is possible that Congress will be spurred into action as a result of increasing pressure from insurance companies, health plans and health care providers who view the subsidies as essentially to keeping the markets working efficiently. Attorneys general from a coalition of 18 states and the District of Columbia have filed a lawsuit in the Northern District of California to attempt to prevent the Administration from ending the CSR payments. Many of those states have already successfully intervened in a pending appeal before the U.S. Court of Appeals for the D.C. Circuit brought by House of Representatives Republicans to block the CSR payments.

In combination with ceasing CSR subsidy payments to insurers, the Administration has also taken steps to destabilize the Marketplace Exchanges by terminating contracts to market the exchanges to the public, shortening the open enrollment period and defunding subsidies for navigators who assist individuals enrolling in Marketplace Exchange coverage. There will also be scheduled shut-downs of the federal website used in connection with Marketplace Exchange open enrollment, Health care.gov, on all but one Sunday morning during the open enrollment period for system maintenance.

What Do These Changes Mean for Employers and Other Stakeholders?

The Order is a direction to the Departments to engage in rulemaking, and it will take several months before any changes could take effect. Proposed regulations issued by the Departments pursuant to the Order would be subject to the rulemaking process under the Administrative Procedure Act, which requires publication in the Federal Register and a notice and comment period before being finalized. Final regulations would also have to be reviewed and approved by the Office of Management and Budget. The issuance of subregulatory guidance by the agencies would not be subject to a notice and comment period, but would not carry the same weight as regulations. It is unlikely that such regulations or subregulatory guidance would affect health plan offerings for 2018, and they likely will not have a retroactive effect.

While it may be too late in the year for these actions to affect health plan open enrollment for health plan offerings in 2018, health insurers and employers will be actively reviewing forthcoming guidance to assess their health care strategy options in the future. In particular, employers who have counted on the viability of Marketplace Exchange coverage to provide health coverage for certain employees or former employees, such as part-time employees or early retirees, may need to reconsider such a strategy. Employers will also want to carefully analyze any changes to the HRA rules to determine whether it would be possible to take a defined contribution approach to health care by providing reimbursement of individual insurance policy premiums without sponsoring a group health plan. Such a strategy will likely be impacted by the quality of the policies sold on the individual market with regard to network and provider choice, and also the price of such coverage on the individual market. In addition, as long as the employer and individual mandates remain part of the law, such strategies will have to be evaluated in light of potential individual and/or employer penalties for failure to offer coverage and/or offer coverage that meets minimum value and affordability requirements.

In the individual market, there will be winners and losers as insurers develop products made possible by these reforms. As healthier individuals move out of the public Marketplace Exchanges and the individual market into cheaper, less comprehensive STLDI plans or AHPs, older and sicker individuals with no other viable options will

remain in the public Marketplace Exchanges without a pool of healthier individuals to spread risk, causing a spike in pricing.

Employers and insurers will need to stay abreast of these quick-moving developments.

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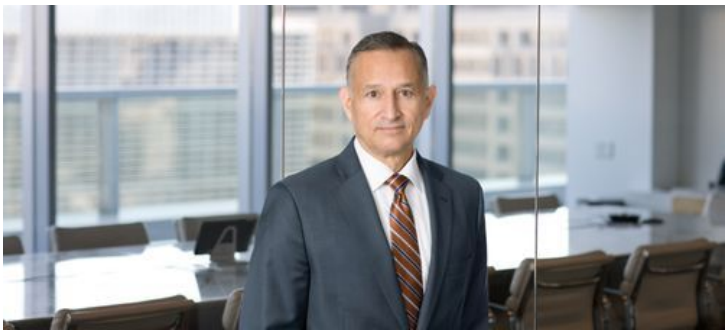

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