Understanding the Rapidly Shifting Landscape of Healthcare Obligations

Thursday, September 14, 2017 General Session; 4:15 – 5:30 p.m.

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Rx for City Employers: Understanding the Rapidly Shifting Landscape of Health Care Obligations.

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*The author would like to express his appreciation to KMTG Summer Associates Callie Lindemann and Albert Mendoza for their invaluable contributions to this paper.

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INTRODUCTION:

Current U.S. healthcare costs are staggering! Based on the most recently available data (2015), the Centers for Medicare and Medicaid Services (CMS) estimate that the U.S. national health expenditure totals over $3 trillion.[1] A 2016 study by the UCLA Center for Health Policy Research, estimated total health care expenditures in California at $367 billion.[2] This same study revealed that public funds account for 71 percent of this expenditure in California compared to a national average of 45 percent.[3] To further underscore the magnitude of these numbers for California public employers, the UCLA study calculated public employer healthcare premium contributions at $13.1 billion.[4]

In addition to the high costs of providing healthcare coverage to existing employees demonstrated by the numbers cited above, public employers also often face the daunting task of providing retiree healthcare benefits, also known as Other Post-Employment Benefits (OPEB). Historically, cities have paid for these benefits on a "pay-as-you-go" basis, leaving cities with large unfunded liabilities. In September 2016, the League of California Cities (LOCC) issued its "Retiree Health Care Costs: A Cost Containment How-To Guide" to address the rapidly escalating costs of OPEBs.[5] The LOCC publication notes that "[b]ecause of rapidly rising medical costs, increases in longevity post-retirement, and the growing number of retirees receiving benefits, retiree health costs increased significantly over the last decade."[6] The LOCC publication cites a 2007 survey of 1,200 agencies in California that revealed unfunded liability for retiree health benefits of at least $118 billion. For the 231 cities responding to this same survey, the total unfunded liability equaled $8.8 billion. A more recent survey conducted by the LOCC in 2016 showed an unfunded liability of $10.8 billion for 312 responding cities.[7]

While the significance and magnitude of the issues created by employee healthcare costs and costs of OPEBs is undeniable, solutions have proven elusive. There are a number of reasons for this, some of which, e.g., accounting and actuarial considerations, are beyond the scope of this paper. This paper will address two factors, however, that certainly contribute to the difficulty in addressing the high costs of employee and retiree healthcare costs: (1) the fluid, highly-politicized, and largely unsuccessful nature of both federal and state legislative efforts to regulate the healthcare markets, and (2) constitutional and legal impediments to unilateral reduction of retiree benefits.

[1] Keehan SP, Cuckler GA, Sisko AM, Madison AJ, Smith SD, Lizonitz JM, Poisal JA, Wolfe CJ. 2012. *National Health Expenditure Projections: Modest Annual Growth Until Coverage Expands and Economic Growth Accelerates*. Health Aff 31(7). doi: 10.1377.
[2] Sorensen A, Nonzee N, Kominski G, *Public Funds Account for Over 70 Percent of Health Care Spending in California*, UCLA Center for Health Policy Research, Health Policy Brief (8/2016).
[3] *Ibid.*
[4] *Ibid.*
[5] League of California Cities City Managers Department – OPEB Task Force, *Retiree Health Care: A Cost Containment How-To Guide*, (September 2016).
[6] *Ibid.*
[7] *Ibid.*

SECTION 1: THE AFFORDABLE CARE ACT (ACA)

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act and also the Health Care and Education Reconciliation Act of 2010 on March 30, 2010.[8] Together, these acts are commonly referred to as the Affordable Care Act (ACA).[9] The ACA was designed to be implemented during the course of ten years and be fully implemented by 2020.[10]

The ACA requires Applicable Large Employers (defined as any entity employing 50 or more full-time equivalent employees, including governmental employers) to provide specified levels of health-care benefits to certain employees or face financial penalties.[11] The ACA, and the federal regulations for its implementation, provide options for how these benefits may be provided, and California has added its own requirements. Public-sector employers must stay abreast of all new requirements, evaluating whether they need to adjust their health-care programs and operations in order to comply.

The following sections address each of the major phases of the ACA and discusses the changes that the ACA brought, or will bring, during these phases.[12]

PHASE 1: THE "PATIENT'S BILL OF RIGHTS" 2010 PROVISIONS

To avoid insurance companies from undermining health care access, certain provisions of the ACA took effect six months after it was enacted. These provisions are known as the "Patient's Bill of Rights" and took effect either on or after September 23, 2010.[13] Significantly, these provisions apply to all plans, including grandfathered plans.[14] Under these provisions, the ACA sought to provide more protections, extend coverage and services, and reduce unnecessary spending among its more significant aspects.

First, any new individual or group health plans that provides dependent coverage is required to provide coverage to adult dependents until they are twenty-six (26) years old.[15] These plans were first prohibited from imposing a pre-existing condition exclusion on children under nineteen (19) and, as of January 2014, these plans were prohibited from discrimination against adults with pre-existing conditions.[16] Also, these plans could no longer rescind benefits or invalidating policies on the basis of a genuine mistake on the enrollee's insurance application.[17]

[8] Pub. L. No. 111-148, 124 Stat. 119 (2010); Pub. L. No. 111-152, 124 Stat. 1029 (2010).
[9] Rachel Hansen, Rebecca Newman, *Health Care: Access After Health Care Reform*, Georgetown Journal of Gender and the Law 192, 194 (2015).
[10] *Id.*
[11] See 26 U.S.C.A. § 4980H
[12] *Infra* Part *i-iii.*
[13] Rachel Hansen, Rebecca Newman, *Health Care: Access After Health Care Reform*, Georgetown Journal of Gender and the Law 192, 194 (2015).
[14] *Id.*
[15] 42 U.S.C.A. § 300gg-14.
[16] 42 U.S.C.A. § 300gg-3 (excluding grandfathered individual coverage).
[17] 42 U.S.C.A. § 300gg-12.

This can only be done when an error is an intentional misrepresentation of a material fact or fraud.[18]

The ACA also grants policyholders the right to appeal coverage determinations, claims, and denials of services or treatment.[19] During an appeals process, the policyholder must continue to receive coverage until a decision is made.[20] Decisions by the insurer must be made within seventy-two hours when the denial is for urgent care, within thirty days for none urgent denials, and within sixty days for denials of services already rendered.[21] Any denial must include an explanation of the basis for its denial and how a policyholder can obtain an independent review of that decision.[22]

Second, the ACA extended services to policyholders by requiring most plans to cover the cost of preventive services without cost sharing.[23] These services include vaccinations, breast cancer screening, mammography, regular child visits, and certain counseling.[24]

Third, the ACA sought to make the health care industry more efficient by capping the amount of administrative spending and promoting spending towards services and to improve the quality of care provided.[25] For example, large group insurers are required to spend at least 85%, and small group insurers are required to spend at least 80%, of premium dollars on direct medical care and efforts to improve the quality of care.[26] If these insurers spend less than the amount they are required to spend, they must rebate policyholders the difference.[27]

Fourth, the ACA prohibited insurance companies from establishing lifetime limits on essential benefits under any plan.[28] However, these plans are still allowed to include annual lifetime limits on non-essential services.[29] In addition, most insurers are required to disclose a wide range of information to the public and to applicants before enrollment or re-enrollment, including periodic financial disclosures, data on enrollment and disenrollment, the number of claims denied, rating practices, etc.[30] Also, insurers may not establish rules for eligibility of a plan that discriminate in favor of higher wage employees and must annually report information to both the HHS Secretary and the enrollees of their plan.[31]

[18] *Id.*
[19] 42 U.S.C.A. § 300gg-19.
[20] *Id.*
[21] *Id.*; 29 C.F.R. § 2560.503-1.
[22] 42 U.S.C.A. § 300gg-19.
[23] 42 U.S.C.A. § 300gg-13.
[24] *Id.*
[25] 42 U.S.C.A. § 300gg-18.
[26] *Id.*
[27] *Id.*
[28] 42 U.S.C.A. § 300gg-11.
[29] *Id.* (excluding grandfathered plans).
[30] 42 U.S.C.A. § 300gg-15; 42 U.S.C.A. § 300gg-17; 42 U.S.C.A. § 18031.
[31] 42 U.S.C.A. § 300gg-16; 42 U.S.C.A. § 300gg-17; 42 U.S.C.A. § 300gg-18; 26 U.S.C.A. § 105.

PHASE 2: MARKET REFORM 2014 PROVISIONS

After the Patient's Bill of Rights took effect, significant change did not occur until the second phase of the ACA in 2014. During this phase the ACA opened the marketplaces, or exchanges, required the majority of Americans to have health insurance, penalized non-compliant employers or Americans, and provided subsidies and tax credits for low-income families.

The ACA created marketplaces, or exchanges, where either a state or the federal government provides an online platform.[32] Here, residents of each state can see what plans are available, compare plans, and choose the plan that best suits their needs.[33] These exchanges must maintain a call center, a website for customer service, and a single form for applying.[34] Every plan in these marketplaces, called a "qualified health plan,"[35] is required to provide essential health benefits, including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, preventive and wellness services, chronic disease management, and pediatric services.[36] The exchanges created under the ACA are either governmental or nonprofit agencies and are subject to regular review to ensure the plans being offered through those exchanges meet minimum coverage standards.[37] Although these plans must meet the federal minimum, a state can require higher benefits in addition to the essential health benefits as long as the state pays the extra cost.[38]

An exchange can offer four types of plans, which are defined by how the plan pays for the specified percentage of costs.[39] The Bronze level covers 60% of the full actuarial value of the benefits provided under the plan, the Silver level covers 70%, the Gold level covers 80%, and the Platinum level covers 90%.[40] All plans have an out-of-pocket limit equal to the Health Savings Account (HSA).[41] For plans beginning in 2017, the maximum amount that a consumer with individual health insurance coverage will pay out-of-pocket is $7,150, while a family will pay no more than $14,300.[42] Additionally, a lower-benefit "catastrophic plan" is available for individuals under age 30 and others who are exempt from the insurance mandate.[43]

On January 1, 2014, the ACA implemented an individual mandate where almost all Americans were required to be covered by health insurance or would have to pay a tax penalty.[44]

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[32] 42 U.S.C.A. § 18031; 42 U.S.C.A. § 18041.
[33] 42 U.S.C.A. § 18031; 42 U.S.C.A. § 18041.
[34] 42 U.S.C.A. § 18031 (d)(4); 42 U.S.C.A. § 18041.
[35] 42 U.S.C.A. § 18021 (defining a qualified health plan as a plan providing essential health benefits and offering at least one silver plan and one gold plan).
[36] 42 U.S.C.A. § 18022 (b).
[37] 42 U.S.C.A. § 18031.
[38] *Id.*
[39] 42 U.S.C.A. § 18022 (d).
[40] *Id.*
[41] 42 U.S.C.A. § 18022 (c)(1)(A).
[42] *Out-of-Pocket Maximum Limit*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/ (last visited June 13, 2017).
[43] 42 U.S.C.A. § 18022 (e).
[44] 26 U.S.C.A. § 5000A (b)(1).

The penalty began at $95 in 2014, increased to $325 in 2015, and was indexed at $695 for 2016.[45] For any year after 2016, the penalty is $695 multiplied by the cost of living adjustment.[46] If the person is under the age of 18, the penalty is half of the penalty an adult would paid on the year of the violation.[47] People exempted from this individual mandate include some religious subscribers, people not covered for less than 3 months, unlawful immigrants, incarcerated inmates, members of an Indian tribe, and those receiving a hardship waiver or taxpayers for whom the lowest cost plan exceeds 8% of the individual's income.[48]

Additionally, on January 1, 2015, large employers were also required to offer health insurance coverage to their employees.[49] A large employer is an employer with more than fifty employees.[50] Failing to provide such insurance coverage will result in a fee of $2,000 for each full-time employee that receives federal premium tax credits to purchase health insurance, excluding the first thirty employees from the assessment.[51] If a large employer does offer such coverage, they will pay the lesser of $3,000 for each employee receiving a federal premium credit or $2,000 for each full-time employee.[52] Employers that do not offer such coverage must provide free vouchers to lower-income employees to purchase a plan through the marketplace.[53] The amount of the voucher will be equal to what the employee would have paid to get coverage under the employer's health plan.[54] Employers with fifty or fewer employees will be exempt from these requirements.[55] For small businesses with fewer than fifty employees and individuals who must purchase insurance on their own, each state will have an American Health Benefit Exchange and Small Business Health Options Program (SHOP) where people not covered through their employers can shop for health insurance at competitive rates.[56] Additionally, a Consumer Operated and Oriented Plan (CO-OP) program will create non-profit health plans wherein all profits from the CO-OP plans will be put toward lowering premiums, improving benefits, or improving the quality of health care delivered to members.[57]

After 2014, the ACA provides small businesses that elect to provide its employees with health care coverage with a tax credit.[58] A small business is classified as a business with no more than 25 employees.[59] However, the full credit will only be available to eligible businesses with ten or fewer employees, where the business's annual wages average less than $25,000 per full time employee, while eligible businesses with up to twenty-five employees and average annual

[45] 26 U.S.C.A. § 5000A (3)(c)(3).
[46] *Id.*
[47] 26 U.S.C.A. § 5000A (c)(3)(C).
[48] 26 U.S.C.A. § 5000A (e)(1)-(4).
[49] 26 U.S.C.A. § 4980H.
[50] *Id.*
[51] *Id.*
[52] *Id.*
[53] *Id.*
[54] *Id.*
[55] *Id.*
[56] 42 U.S.C.A. § 18031.
[57] 42 U.S.C.A. § 18042.
[58] 26 U.S.C.A. § 45R.
[59] *Id.*

wages of up to $50,000 will be eligible for a smaller tax credit.[60] The first phase of the provision provided up to four million eligible small businesses with tax credits that are worth up to 35% of the employer's contribution to the employees' health insurance provided that the employer contributes at least 50% of the premium cost.[61] Small non-profit organizations may also receive up to a 25% credit.[62] As of 2014, eligible employers who purchase coverage through the exchange are eligible to receive a tax credit for two years of up to 50% of their contribution.[63] Further, tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 35% of their contribution.[64]

Finally, the ACA provides cost-sharing subsidies (which reduce out of pocket expenses) and premium tax credits (which reduces monthly payments) to families and individuals with incomes of up to 400% the federal poverty level to make purchasing these plans affordable to them.[65] For example, in 2016 people making between 100 – 150% of poverty enrolled in a silver plan on healthcare.gov received cost-sharing assistance worth $1,440; those with incomes between 150 – 200% of poverty received $1,068 on average; and those with incomes between 200 – 250% of poverty received $144 on average.[66]

The premium tax credit is calculated on a sliding scale starting with a credit for 2% of income for those at 100% of the federal poverty level (FPL), and phasing out to a credit for 9.5% of income for those at 400% of poverty.[67] The tax credits are also refundable.[68] Therefore, if the amount of the credit is more than the amount of an individual or family's tax liability, they will receive the difference as a refund.[69] In the event that an individual or family owes no tax, they are eligible to receive the full amount of the credit as a refund.[70] It can also be paid to an individual's insurance company in advance to help cover the cost of premiums.[71] Individuals eligible for premium tax credits may also qualify for cost-sharing subsidies.[72] The subsidy pays for percentages of the full value of the plan on a sliding scale from 94% for those with an income at 150% of the FPL, and phasing out to a subsidy for 70% for those with an income at 400% of the FPL.[73] Out-of-pocket limits have also been reduced for enrollees with incomes up to 400% of

[60] *Id.*
[61] *Id.*
[62] *Id.*
[63] *Id.*
[64] *Id.*
[65] 26 U.S.C.A. § 36B.
[66] *Premiums and Tax Credits Under the Affordable Care Act vs. the American Health Care Act: Interactive Maps*, http://www.kff.org/interactive/tax-credits-under-the-affordable-care-act-vs-replacement-proposal-interactive-map/ (last visited June 15, 2017).
[67] 26 U.S.C.A. § 36B.
[68] *Id.*
[69] *Id.*
[70] *Id.*
[71] *Id.*
[72] 42 U.S.C.A. § 18071.
[73] 26 U.S.C.A. § 36B.

the FPL.[74] Further, those with incomes under 133% of the FPL will, if residing in a state opting into the Medicaid expansion, be able to enroll in a newly expanded Medicaid program.[75]

PHASE 3: FINAL IMPLEMENTATION 2020 PROVISIONS

The most significant change in the coming years is the "Cadillac tax."[76] The Cadillac tax becomes effective on Jan 1, 2018. The goal of the Cadillac tax is to reduce the overall health care cost of the ACA coverage provisions. The Cadillac tax imposes a 40 percent excise tax on the cost of coverage for health plans that exceed a certain annual limit.[77] This excise tax will apply to the overall aggregate cost, the premium for the insured, the COBRA rate for the self-insured that has no premiums, and contributions to flexible spending accounts, health savings accounts, and health reimbursement accounts.[78] If a plan is insured, the insurer will be responsible for the tax, if the plan is self-insured, the employer bears the tax.[79] Essentially, both fully insured and self-funded employer health plans will be assessed a nonrefundable 40 percent excise tax on the dollar amount of any employee premiums that exceed annual limits of $10,200 for individual coverage and $27,500 for family coverage.[80] For plans with a qualified retiree or whose majority of employees are employed in a high-risk job, the annual limit increases by $1,650 for an individual plan and by $3,450 for a family plan, totaling $11,850 and $30,950 respectively.[81] Additionally, these limits increase as the inflation rate increases.[82]

The deadline for the full implementation of the ACA is in the year 2020 with the goals of simplifying administration, reducing costs, and standardizing billing across electronic exchanges.[83] The ACA states that states may exclude insurance companies with unjustified premium rates from participation in the exchange beginning in 2014.[84] The Department of Health and Human Services is charged with operating and maintaining an internet portal and to assist states in developing their own for Exchanges to assist individuals and employers to be ACA compliant.[85]

SECTION 2: COVERED CALIFORNIA.

On September 30, 2010, former Governor Arnold Schwarzenegger signed into law two complementary bills, AB 1602 and SB 900, to establish the California Health Benefit Exchange.

[74] *Id.*
[75] *Id.*
[76] 26 U.S.C.A. § 4980I.
[77] *Id.*
[78] *Id.*
[79] *Id.*
[80] *Id.* (excluding stand-alone dental and vision plans).
[81] 26 U.S.C.A. § 4980I (f)(2) (defining a qualified retiree as someone that receives coverage because he or she is retired, is 55 years old, or is not entitled to benefits or enrollment under the Medicare program).
[82] 26 U.S.C.A. § 4980I.
[83] Rachel Hanen, Rebecca Newman, Health Care: Access After Health Care Reform, 16 Geo. J. Gender L. 191, 203 (2015).
[84] 42 U.S.C.A. § 300gg-94 (b)(1)(B).
[85] 42 U.S.C.A. § 18031 (c)(5).

California was the first state in the nation to pass legislation creating a health insurance Marketplace. In October 2012, the Marketplace was renamed as Covered California.[86]

Covered California is a quasi-governmental organization, specifically an "independent public entity not affiliated with an agency or department."[87] It is governed by a five-member board, including the Secretary of California Health and Human Services, two members appointed by the Governor, one member appointed by the Senate Committee on Rules, and one member appointed by the Speaker of the Assembly.[88] The legislation specifies that each appointed member of the Board should possess expertise in key subject areas such as, individual or small employer health care coverage, health benefits plan administration, or health care finance.[89] Each member of the board has the responsibility and duty to meet the requirements under Covered California, the ACA, and all applicable state and federal laws and regulations.[90] Additionally, the Board is responsible for implementing procedures and standards to comply with section 1311 of the ACA and establishing an appeals process.[91] Covered California applied for a waiver to allow persons not able to obtain coverage by reason of immigration status under the ACA requirements.[92] However, in January 2017, following the election of President Trump, and at the request of the California Legislature, Covered California withdrew its application for such a waiver.[93]

Health plans and qualified health plans under Covered California are defined the same as ACA health plans.[94] Recently, Covered California unveiled sweeping reforms to its contracts with insurers, seeking to improve the quality of care, curtail costs, and increase transparency for consumers.[95] Now, health plans are required to dock hospitals at least 6 percent of their payments if they fail to meet certain quality standards, or alternatively, provide bonuses of an equal amount if they exceed the standards. Covered California requires health plans to identify hospitals and doctors that are performing poorly on a variety of quality metrics or charging excessively for their services.[96] The plans must drop providers from their networks as early as 2019 if they do not modify their practices to meet the standards.[97]

Additionally, Covered California requires that the health plans:

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[86] Cal. Gov't Code § 100500.
[87] Cal. Gov't Code § 100500 (a).
[88] Cal. Gov't Code § 100500 (b).
[89] Cal. Gov't Code § 100500 (c).
[90] Cal. Gov't Code § 100500.
[91] Cal. Gov't Code § 100502; Cal. Gov't Code § 100504.5; Cal. Gov't Code § 100506.
[92] *See* Cal. Gov't Code § 100522.
[93] See http://khn.org/news/california-withdraws-bid-to-allow-undocumented-immigrants-to-buy-unsubsidized-obamacare-plans/ (last visited Aug. 15, 2017
[94] Cal. Gov't Code § 100501.
[95] § 8.02 The Modern Health Care System, 2014 WL 9967454; http://californiahealthline.org/news/covered-california-imposes-new-quality-cost-conditions-on-plans/; http://news.coveredca.com/2016/04/covered-californias-board-adopts.html, (last visited Jul. 26, 2017)
[96] *Covered California's Board Adopts Prescriptions for A Better Health Care System*, NEWS.COVEREDCA.COM, http://news.coveredca.com/2016/04/covered-californias-board-adopts.html, (last visited Jul. 26, 2017).
[97] *Id.*

- Assign a primary care doctor to enrollees within 30 days of coverage.
- Share data with other plans and doctors to better track and treat patients with chronic conditions such as diabetes.
- Monitor and reduce health disparities among all their patients, starting with four major conditions: diabetes, hypertension, asthma and depression.
- Better manage the price of high-end pharmaceuticals and aid consumers in reducing the cost of expensive drug treatments.
- Help consumers better understand their diseases and treatment choices and their share of the costs for those treatments.[98]

SECTION 3: LEGAL CHALLENGES TO THE ACA

In *National Federation of Independent Business v. Sebelius*, the Supreme Court considered the constitutionality of the individual mandate and Medicaid expansion of the ACA.[99] The Court considered whether the individual mandate was constitutional as congressional regulation through the Commerce Clause, through congressional regulation through the Necessary and Proper Clause, or as an exercise of the power to tax. The Court held the individual mandate was only constitutional if interpreted as a tax.

The Court held the mandate could not be sustained under federal Commerce Clause. The court reasoned the individual mandate could not be sustained per Congress' Commerce Clause authority because of the distinction between the power to regulate versus the power to create.[100] Congress can only regulate activity through the Commerce if "there is already something to be regulated."[101] The individual mandate does not regulate an already existing commercial activity but compels individuals to enter a market and purchase a product.[102] Justification of the individual mandate would encourage federal regulation of inaction instead of activities and furtherance of such logic would allow the federal government to justify forced purchases of products to solve "almost any problem."[103]

The Court held the individual mandate could also not be sustained through the Necessary and Proper Clause. The Court reasoned only laws that are "derivative of, and in service to, a granted power" can be sustained and avoid being an unlawful usurpation of power.[104] In the case of the ACA, the individual mandate was not derivative of the exercise of a granted power and thus the Necessary and Proper Clause analysis failed.

[98] *Id.*
[99] Nat'l Fed'n of Indep. Bus. v. Sebelius 132 S. Ct. 2566, 2577.
[100] *Id*. at 2586.
[101] *Id*. at 2586.
[102] *Id*. at 2587.
[103] *Id*. at 2588.
[104] *Id*. at 2591.

However, the individual mandate was sustainable as a tax. Though the Act describes the individual mandate as prescribing a "penalty" and not a tax makes no difference whether the individual mandate can be analyzed under the taxing power of Congress.[105] The Court is concerned with the practical function of the mandate and not the label. Additionally, the court reasons that the "penalty" is not a penalty but rather a tax because there are no negative legal consequences for not buying health insurance; someone who chooses to pay the penalty instead of receiving health insurance will comply with the law.[106]

In 2015 the Supreme Court considered the jurisdictional scope of the ACA in *King v. Burwell*.[107] The ACA provides tax credits shall be allowed for applicable employers if the taxpayer enrolls in an insurance plan "through an Exchange established by the State."[108] An IRS regulation implementing the statute interpreted such an exchange could be established by a state or by a federal exchange.[109] Petitioners argued the IRS regulation was an unlawful agency interpretation contrary to the plain meaning of the statute. The Court reasoned that petitioners were incorrect to read the regulation by itself; the regulation must be read in context in the overall statutory scheme.[110] Though the term "exchange" is indeed ambiguous, according to the Court, the broader statutory scheme of the ACA provides illumination.[111] The Court reasons if "State" in the IRS regulation did not apply to federal exchanges, fewer people would meet coverage requirements of the ACA; the Court estimates in 2014 alone "approximately 87 percent of people who bought insurance on a Federal Exchange did so with tax credits, and virtually all those people would become exempt."[112] Additionally, a Court interpretation favorable to the plaintiffs "could well push a State's individual insurance market into a death spiral."[113] The Court reasons it is implausible Congress intended the statute to be interpreted in such a way and refuses to apply a plain meaning interpretation.[114]

SECTION 4: WHAT IS EXPECTED IN THE FUTURE?

Since the adoption of the Affordable Care Act, the mantra of opponents of that legislation has been "repeal and replace." Recently, however, the political difficulty of such a course has been on full display.

[105] *Id*. at 2594.
[106] *Id*. at 2597.
[107] King v. Burwell 135 S. Ct. 2480, 2483 (2015).
[108] 26 U.S.C. Section 36B (a).
[109] 45 C.F.R. Section 155.20.
[110] King v. Burwell 135 S. Ct. 2480, 2489 (2015).
[111] *Id*.
[112] *Id*.
[113] *Id*.
[114] *Id*.

THE AMERICAN HEALTH CARE ACT OF 2017: HR 1628

H.R. 1628, the American Health Care Act of 2017 (AHCA) was passed by the House on May 4, 2017. Given the Senate's inability to come to an agreement either to pass the AHCA, or to pass an alternative, the AHCA is now moribund. It does, however, provide an interesting glimpse into the alternatives to the ACA that are being proposed in Congress. This section will describe briefly those parts of the ACA that would have been repealed by H.R. 1628, those parts of the ACA that would have been changed by H.R. 1628, and those parts of the ACA that would have been retained by H.R. 1628. [115]

A. *H.R. 1628 and Repealed ACA*

The individual mandate would be eliminated.[116] There would be no penalty if individuals chose to forego health insurance. However, to encourage individuals to keep health insurance coverage the bill provides for a continuous health insurance coverage incentive.[117] The incentive provides for a 30% penalty for people on the individual market for lapses in health insurance.[118] The AHCA would also appeal the employer mandate[119] immediately. The cost-sharing subsidy would be repealed by 2020.[120]

The bill provides that no federal funding to Planned Parenthood would be granted following the first year after the AHCA is enacted.[121] The bill also would prohibit any spending on prohibited entities, either directly or indirectly, by the states using funding from federal payments.[122] Prohibited entities under this provision include entities who provide for abortions other than abortions for pregnancies resulting from rape or incest or if the pregnancy places a woman's life at risk.[123]

B. *H.R. 1628: What Would Change*

The bill changes the subsidization of health care coverage rates. Tax credits would be distributed by age instead of by income using a flat tax structure.[124] Tax credits would be available to individuals making less than $75,000 a year and households earning less than

[115] Haeyoun Park and Margot Sanger-Katz, The Parts of Obamacare Republicans Will Keep, Change, or Discard (March 6, 2017) https://www.nytimes.com/interactive/2017/03/06/us/politics/republican-obamacare-replacement.html?_r=0.
[116] H.R. 1628 § 204.
[117] H.R. 1628 § 133.
[118] *Id*.
[119] H.R. 1628 § 205.
[120] H.R. 1628 § 131.
[121] H.R. § 103 (a)(2).
[122] H.R. § 103 (a).
[123] H.R. § 103.
[124] H.R. § 36B.

$150,000 a year.[125] The AHCA provides states can create a mandatory work requirement for nondisabled, nonelderly, non-pregnant adults under Medicaid.[126]

The bill would have a substantial effect on older Americans and retirees. The AHCA permits states to keep the Medicaid expansion under the ACA and does not change the amount of federal funding until 2020.[127] After 2020, federal funding for individuals who recently qualify for eligibility and individuals who left the Medicaid program would have reduced funding. The bill would allow insurance companies to charge older customers five times the rate younger customers are charged.[128] This would substantially reduce the cost of premiums for young adults while substantially raising the cost of premiums for elderly Americans.[129] The Congressional Budget Office estimates these changes would result in an estimated 52 million Americans being uninsured by 2026, in large part because of the changes to Medicaid.[130] The savings in Medicaid spending would contribute to a reduction of the federal deficit by $337 million by 2026.[131]

C. *H.R. 1629: What Would Remain*

The bill does retain several components of the Affordable Care Act. The bill retains the prohibition for refusing coverage to individuals with pre-existing conditions. The bill retains health insurance marketplaces and an annual open enrollment period. The bill continues to allow children to remain on their parent's insurance policy until age 26.

THE HEALTHY CALIFORNIA ACT: SB 562

The Healthy California Act ("SB 562"), introduced on February 17, 2017, would create the Healthy California Program ("Cal-Health"). Cal-Health would provide comprehensive universal single-payer health care coverage in California, including a health care cost control system. It would create a Healthy California Board consisting of nine members from specific fields. Additionally, it would create a Healthy California Trust where all federal and state funds would be placed relating to health care.

Cal-Health prohibited health care service plans and health insurers from offering health benefits or covering services if they were not a part of Cal-Health. However, it left the same rules and standards in place for plans and providers. California would have to obtain waivers from federal and state programs so that those funds would be deposited to the Cal-Health trust fund. Thereafter, Cal-Health would provide health coverage equal to or exceeding what those

[125] *Id*.
[126] H.R. § 117.
[127] H.R. § 112.
[128] American Health Care Act Cost Estimate, Congressional Budget Office (March 13, 2017) *available at* https://www.cbo.gov/publication/52486.
[129] *Id*.
[130] American Health Care Act Cost Estimate, Congressional Budget Office (March 13, 2017) *available at* https://www.cbo.gov/publication/52486.
[131] *Id*.

programs usually provided. If a waiver for some funds was not obtained, these funds would be pooled in the Cal-Health trust fund and Cal-Health would provide the services.

On June 23, 2017, California Assembly Speaker Anthony Rendon announced that SB 562 was going to be held in the Assembly committee, while leaving open the possibility of reconsidering the bill during the second year of the legislative session. Although Speaker Rendon supports the idea of universal health care, he stated that the bill "didn't make sense … [i]t just didn't seem like public policy as much as it seemed a statement of principle." Speaker Rendon's position largely steamed from SB 562 not including a funding plan for the legislation estimated to cost $400 billion, calling the bill a "woefully incomplete proposal."[132]

Protest erupted after Speaker Rendon shelved SB 562 and proponents of the bill expressed a desire to make universal health care a litmus test for California Democrats and threatened to run candidates against opponents of SB 562 during the 2018 primaries.[133] The bill's sponsor, the California Nurses Association, described Speaker Rendon's action as a "cowardly act" and a campaign led by the nurses' Healthy California coalition, pressured Speaker Rendon to take up SB 562 by holding an "Inaction Equals Death" rally in Speaker Rendon's district office. Also, the President of the California Nurses Association denounced Speaker Rendon's action, describing him as the "Insurance Industry's Man of the Year." Speaker Rendon and his family even received death threats.[134]

As a strong supporter of a single payer system, U.S. Senator Bernie Sanders expressed that he was "extremely disappointed" by the Speaker's actions and called on the Speaker to allow a floor vote.[135] Senator Sanders stated that "[i]f the great state of California has the courage to take on the greed of the insurance companies and the drug companies, the rest of the country will follow."[136]

SECTION 5: THE ECONOMIC IMPACT OF THE ACA, COVERED CALIFORNIA, AND THE PROPOSED ALTERNATIVES

Since the passage of the ACA in 2010, the annual premiums for employer-sponsored health insurance have increased by approximately twenty percent.[137] With the cost of healthcare

[132] *Why Universal Health Care Died in* California, SACBEE.COM, http://www.sacbee.com/news/politics-government/capitol-alert/article158363674.html, (last visited on Jul. 26, 2017); *Will Anthony Rendon Pay a Price for Blocking Universal Health Care Bill in California?* http://www.sacbee.com/news/politics-government/capitol-alert/article158543369.html, (last visited on Jul. 26, 2017).
[133] *Id.*
[134] *Death Threats Directed at Assembly Leader Over Universal Care Bill*, SACBEE.COM, http://www.sacbee.com/news/politics-government/capitol-alert/article158738529.html
[135] *Will Anthony Rendon Pay a Price for Blocking Universal Health Care Bill in California?* http://www.sacbee.com/news/politics-government/capitol-alert/article158543369.html, (last visited on Jul. 26, 2017); http://www.washingtontimes.com/news/2017/jun/24/sen-bernie-sanders-rips-california-democrats-pulli/
[136] http://www.washingtontimes.com/news/2017/jun/24/sen-bernie-sanders-rips-california-democrats-pulli/;https://twitter.com/berniesanders/status/878659234916904960.
[137] Kaiser Family Foundation 2016 Employer Health Benefits Survey: http://www.kff.org/health-costs/report/2016-employer-health-benefits-survey/

continuing to rise, examining the economic impact of these increases and the potential alternative systems may design the path forward for California.

THE ACA'S IMPACT ON HEALTHCARE COST

In 2008, the average employer-sponsored family plan cost a total of $12,680, with employees paying $3,354.[138] By 2016, the cost of the average employer family plan was $18,142, with workers paying $5,277.[139] Also, the average family premiums rose 20% from 2011 to 2016. However, that rate of increase was lower than the previous five years (up 31% from 2006 to 2011) and the five years before that (up 63% from 2001 to 2006).[140]

Additionally, in 2008, 18% of covered workers had deductibles of at least $1,000, up from only 10% in 2006.[141] For workers with employer-sponsored plans at small firms, 35% had deductibles of $1,000 or more in 2008, up from 16% in 2006. In contrast, in 2016, 51% of all covered workers, and 65% of workers in small firms, face deductibles of at least $1,000.[142]

The total prescription drug spending in the U.S. was $457 billion in 2015, representing 16.7% of all health care service expenditures. In 2012, by contrast, total drug spending was measured at $367 billion, for 15.4% of all health care service dollars.[143]

COVERED CALIFORNIA'S IMPACT ON HEALTHCARE COST

For the first time since launching, Covered California announced double-digit rate increases, averaging 13.2 percent for 2017.[144] In each of the past two years, rate hikes for Covered California policies were about 4 percent, putting the state's three-year average at 7 percent.

THE SINGLE PAYOR SYSTEM ALTERNATIVE

California's recent attempt to implement a single payer system begs the question whether such a system is the right way for California to move forward economically. Several previous studies examining the economic impact of a single payer system determined the impact it would have on several states. The two following studies examined the impact a single payer system would have nationally, and the impact such a system would have on California.

The Funding HR 676: The Expanded and Improved Medicare for All Act: How We Can Afford a National Single-Payer Health Plan study examined the single-payer system created by HR 676, The Expanded and Improved Medicare for All Act, introduced by Rep. John Conyers Jr., D-Mich. The study found that the U.S. could save an estimated $592 billion annually by

[138] http://time.com/money/4503325/obama-health-care-costs-obamacare/.
[139] *Id.*
[140] *Id.*
[141] *Id.*
[142] *Id.*
[143] *Id.*
[144] http://news.coveredca.com/2016/07/covered-california-announces-rates-and.html.

slashing the administrative waste associated with the private insurance industry ($476 billion) and reducing pharmaceutical prices to European levels ($116 billion).[145]

Also, a recent study by the Lewin Group, The Health Care For All Californians Act: Cost and Economic Impacts Analysis, found that a single payer system would save California $343.6 billion in health care costs over 10 years, mainly by cutting administration and using bulk purchases of drugs and medical equipment.[146] This study examined a California bill that would have achieved universal coverage in California while reducing total health spending for California by about $8 billion in the first year alone.[147] The study found that these savings would come from replacing the current system of multiple public and private insurers with a single, reliable insurance plan, saving about $20 billion in administrative costs.[148] Additionally, California buying prescription drugs and durable medical equipment (e.g., wheelchairs) in bulk, would result in saving about $5.2 billion in spending.[149]

In terms of state and local governments, the study found that they would save about $900 million during the first year in spending for health benefits provided to state and local government workers and retirees.[150] Under the study, an aggregate savings to state and local governments from 2006 to 2015 was calculated to be about $43.8 billion.[151]

SECTION 6: RETIREE HEALTH CARE BENEFITS (OPEBS): ARE THEY STILL IMMUTABLE?

Aside from the escalating costs of providing healthcare coverage to existing employees, local public agencies also generally bear the cost of retiree health benefits or (OPEBs). Historically, efforts to reduce those costs through changes to retiree benefits have run head long into challenges brought under the Contracts Clause of both the U.S. and California Constitutions. Article 1 Section 10 of the U.S. Constitution provides "No state shall enter into any Treaty, Alliance, or Confederation…or Law impairing the Obligation of Contracts."[152] The California Constitution similarly provides "A… law impairing the obligation of contracts may not be passed." The California Supreme Court currently has before it two cases that could change the legal landscape in this area.

Public employers attempting to reduce or change pension benefits is not a new struggle in the state. The current California legal structure, often referred to as the "vested rights doctrine", originates from a series of cases from the 1940's and 1950's when the City of Long Beach struggled to fund police and firefighter retirement obligations when veterans returned from World War II.[153] In 1955, the California Supreme court ruled in the seminal case *Allen v. Long Beach* that modifications to public pensions do not violate the Contracts Clause if the

[145] http://www.pnhp.org/sites/default/files/Funding%20HR%20676_Friedman_7.31.13_proofed.pdf.
[146] *Id.*
[147] *Id.*
[148] *Id.*
[149] *Id.*
[150] *Id.*
[151] *Id.*
[152] U.S. Constitution Art 1. § 10.
[153] 1-9 California Public Sector Employment Law § 9.03 (2017).

modifications are (1) reasonable; (2) have a material relation to the pension system and its successful operation; and (3) that "changes in a pension plan which result in disadvantages to employees should be accompanied by comparable new advantages."[154] As a result, if pension benefits of a vested contractual nature are withdrawn by the Legislature, the modification must be reasonable and must also be replaced by a comparable benefit.

The vested rights legal analysis has been evolved since the decision in *Allen.* Today, in analyzing on a contracts clause case, the focus is on whether (1) a valid contract exists; (2) was a valid contract impaired, i.e. what was the nature and extent of any contractual obligation; (3) did the impairment of the contract substantially affect the rights in the contract, invalidate the contract, or significantly alter it; and (4) was the modification reasonably expected under the contract?[155] The California Supreme Court expanded the vested rights doctrine as recently as 2011 in *Retired Employees Assn. of Orange County, Inc. v. County of Orange*.[156] In that case. the court considered whether county public employees can form an implied contract that confers vested rights for health benefits for retirees. The court held there could be vested rights in a contract with implied terms if there is clear legislative intent to create a vested contractual right.[157]

However, more recently, appellate courts have begun taking a more limited view of the vested rights doctrine. For example, in *Protect Our Benefits v. City and County of San Francisco*, the First Appellate District considered whether a San Francisco initiative amendment conditioning payment of a supplemental cost of living allowance to retired city employees on the retirement fund being fully funded impairs the vested contractual right.[158] The court held that employees who retired before the implementation of the living allowance was enacted in 1996 did not have a vested contractual right to the living allowance. Employees who retired between 1996 and the implementation of Proposition C did have a fully vested contractual right and the requirement of Proposition C could not lawfully apply to their benefits.[159] In 1996, retired San Francisco employees were able to receive supplemental cost of living allowance as part of their pension benefits when the retirement fund's annual earnings exceed projected earnings.[160] In 2011, voters passed Proposition C, a reaction to the effects of the Great Recession, which only allowed payment of the supplemental living allowance if the fund was fully funded. The court reasoned that individuals only have vested rights for the benefits in effect at the time of their retirement but there is no contractual expectation for a benefit not in existence at the time of retirement.[161] This supports the rule that the Legislature, in accordance with their sovereign powers, may modify retiree benefits if the right has not fully vested; i.e. the right only becomes

[154]Allen v. Long Beach, 45 Cal. 2d 128.
[155] Marin Ass'n of Pub. Emps. v. Marin Cty. Employee's Ret. Ass'n, 2 Cal App. 5th 674, 703 (2016).
[156] Retired Emps. Ass'n of Orange Cty., Inc. v. Cty. of Orange, 52 Cal. 4th 1171, 1172 (2011).
[157] *Id*. at 176.
[158] Protect Our Benefits v. City and County of San Francisco, 235 Cal. App. 4th 619 (2015).
[159] *Id*. at 622.
[160] *Id*. at 622.
[161] *Id*. at 427-428.

vested upon retirement and the vested right is only the right which existed at the time of retirement.

The conflicting policies have presented two cases that have been granted review in the California Supreme Court which may determine the hierarchy between the Legislature's power and vested retiree benefits in *Marin Association of Public Employees v. Marin County Employees Retirement Association* and *Cal Fire Local 2881 v. California Public Employees Retirement System*.

In *Marin County*, the First Appellate District of California considered whether a new pension formula for Marin County employees constituted a substantial impairment of the employee's contracts.[162] California's Public Employees' Pension Reform Act of 2013 (PEPRA) enacted, among other things, an amendment to Government Code 1 section 31461, a provision of the County Employees Retirement Law, with the aim of curtailing pension spiking by excluding specified items from the calculation of retirement income.[163] In response, Marin County began excluding standby pay, administrative response pay, callback pay, cash payment for health insurance waivers, and other items from the calculation of final pensions.[164] The pension policy change was challenged under a contracts clause theory and plaintiffs alleged certain provisions of PEPRA impaired their vested pension rights.[165] The court held it did not.[166] The court reasoned that while pension rights may not be destroyed, the government has the right to modify and such right is "inalienable."[167] In regards to active employees, any modification of a vested pension right must be reasonable.[168]The modification of an employee's future pension benefits is only a limited vested right that is subject to legislative modification.[169] Before a pension is payable, the legislature may make reasonable modifications subject to changing public policy.[170] Employees only retain the right to a substantial pension subject to changeable benefits.[171]

In *Cal Fire*, the First Appellate District considered whether there was a contract clause violation based on a separate provision of PEPRA, namely, the revocation of so-called airtime service credits, which when purchased by a retiree with at least five years of state service, could become credits increasing the retirement allowance of the retiree. Under PEPRA, CalPERS members could no longer purchase airtime service credits after 2012. In response to a claim this provision of PEPRA violated employees' vested rights, the appellate court determined there was no viable Contracts Clause claim because retirees are only entitled to a reasonable pension, not a pension of fixed benefits. Because the issue was the right *to purchase* credit, not the denial of a

[162] Marin Ass'n of Pub. Emps. v. Marin Cty. Employee's Ret. Ass'n, 2 Cal App. 5th 674, 703 (2016) and Cal Fire Local 2881 v. California Public Employees' Retirement System, 7. Cal. App. 5th 115 (2016).
[163] *Id*.
[164] *Id*. at 687.
[165] *Id*. at 690.
[166] *Id*. at 694.
[167] *Id*. at 697.
[168] *Id*. at 698 citing Allen v. Board of Administration 34 Cal.3d 114, 120.
[169] *Id*. at 700.
[170] *Id*. at 701 citing Allen v. Board of Administration 34 Cal.3d 119, 120.
[171] *Id*. at 707.

retirement allowance rate because of purchased claims, there was no vested right and such a legislative modification was reasonable.

Both *Marin County* and *Cal Fire* have been accepted for review by the California Supreme Court. Both cases have the potential to impact dramatically Contracts Clause challenges to so-called vested rights. A decision by the California Supreme Court that the legislative changes wrought by PEPRA do not violate the Contracts Clause in either the U.S. or California Constitutions could become a vehicle for changes to retiree healthcare benefits – if not for current retirees then for existing employees who have yet to retire. If the Supreme Court upholds the rulings by the First Appellate District, such a decision could well constitute an erosion of the vested rights doctrines thereby enabling local governments and the Legislature to respond to the growing unfunded liability issue resulting from OPEBs.

SECTION 7: CONCLUDING THOUGHTS

Local public employers will continue to struggle with the high costs of healthcare for existing employees and retirees absent a solution either in the Legislature or in the courts. At this point, the legislative solution seems more remote. At the federal level, the effort to "repeal and replace" the ACA is stalled. Efforts by the California Legislature to enact a single payor system also have been set aside for the time being.

Developments in the court appear more hopeful, however. A decision by the California Supreme Court affirming the rulings in *Marin County* and *Cal Fire*, would give local public employers greater flexibility to reduce retiree benefits at least prospectively.

While both the political and legal landscape remain uncertain, one fact is beyond debate. Healthcare costs continue to increase at significant rates. If these costs continue to increase unchecked, the cost of healthcare will become an ever increasing and debilitating drain on public resources in the future.