The Big Test

Supreme Court of the U.S. decision: A road map for plan sponsors

The U.S. Supreme Court hearings on health care reform have garnered an extraordinary amount of press and opinions, some more accurate than others.

We have received a number of questions about the court's possible decision—which may be handed down this month—and, in particular, what specific provisions are at stake under various decision scenarios. Here are a few:

Which Affordable Care Act (ACA) provisions affecting group health plans are at issue?

The only ACA requirement that the Supreme Court is deciding that directly affects group health plans is the individual mandate. Generally, the ACA requires individuals to all have minimum essential coverage beginning in 2014 or face a penalty, payable on their personal tax return in 2015 (for the 2014 tax year).

What if the court deems the individual mandate a tax under the Anti-Injunction Act?

One of the first questions for the court to decide is whether it is able to hear the case at all. If the court finds the penalty is actually a tax, as the Fourth Circuit Court of Appeals did, it may also find that, under the Anti-Injunction Act, it cannot decide the case until the tax actually applies, in 2015. In that case, all of the current and future ACA provisions that apply to group health plans will continue to apply. The issue then may be brought up again in or after 2015.

What if the court decides the individual mandate is not a tax—and therefore may be considered—and that the individual mandate is constitutional?

If the court decides it can take up the question of the individual mandate, next it must decide if the mandate is within Congress' powers under the Commerce Clause and is, then, constitutional. If the court finds the individual mandate constitutional, all ACA provisions that apply to group health plans will continue to apply, unchanged.

What if the court finds the individual mandate unconstitutional?

If the court finds the individual mandate unconstitutional, next it must decide whether the individual mandate is severable from the other requirements of the law. Even if considering the individual mandate separately from the law as a whole may be illogical, it still may be legally possible for the rest of the law to remain, even if the individual mandate is dropped.

If the individual mandate is found unconstitutional and severable from the rest of the law, only the individual mandate will be void. The other requirements of the ACA, including the age 26 rule, annual and lifetime limit rules, preventive care requirements, new summary of benefits document, employer "pay or play" mandates, new exchange coverage and Cadillac tax all will still apply.

If the individual mandate is found unconstitutional and not severable from the rest of the law, or so intertwined with certain provisions that they cannot stand alone, these provisions, or even the entire law, may be struck down. The impact on group health plans may depend on whether the requirement is or is not already applicable.

If a requirement that is not yet applicable is struck down, it generally no longer will apply, so plans will not have to comply with it.

If a requirement that has already become applicable, such as the insurance market reforms, is struck down, even if the law no longer requires compliance, the new rules likely would already have become part of the plan through a plan amendment or contract term with an insurer or third-party administrator (TPA). To unwind these requirements quickly may be difficult—plans probably will need to review their insurance policies, TPA agreements, plan documents, summary plan descriptions (SPDs) and other communications and procedures to see what amendments may be required. TPA fees and insurance premiums may need to be renegotiated.

Plans also may need to communicate changes to participants. The Employee Retirement Income Securities Act (ERISA) requires a group health plan to provide a summary of material modification (SMM) when there is material reduction in covered health benefits, within 60 days of adoption. A "material reduction" is any modification that an average plan participant would consider—either independently or in conjunction with other changes—to be an important reduction in covered services or benefits. For example, if the plan decides to drop the age 26 rule because it no longer is required and revert to its original requirement of only covering dependents who are full-time students, the plan likely would need to send an SMM to plan participants within 60 days of adopting the new change. Plans will need to determine the best timing to adopt changes and the avenue by which to deliver these notices.

Plan sponsors should be on the lookout for the Supreme Court's decision, so, regardless of the outcome, they can be prepared to incorporate any plan changes or move forward with ACA compliance.

These Q&As first appeared on www.plansponsor.com in April. As health care law is evolving rapidly, there may have been further developments since the initial publication.

CONTRIBUTORS

Christy Tinnes is a principal in the Health & Welfare group of Groom Law Group in Washington, D.C. She is involved in all aspects of health and welfare plans, including ERISA, HIPAA portability, HIPAA privacy, COBRA and Medicare. She represents employers designing health plans, as well as insurers designing new products. Most recently, she has been extensively involved in the insurance market reform and employer mandate provisions of the health-care reform legislation.

Brigen Winters is a principal at Groom Law Group, Chartered, where he co-chairs the firm's Policy and Legislation group. He counsels plan sponsors, insurers and other financial institutions regarding health and welfare, executive compensation and tax-qualified arrangements and advises clients on legislative and regulatory matters, with a particular focus on the recently enacted health-reform legislation.

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