Expert Q&A on the US Supreme Court's Health Care Reform Decision

Health and Welfare Plans

Beginning in 2014, the individual mandate under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (together known as the Affordable Care Act (ACA)) requires most individuals to purchase health coverage that provides minimum levels of coverage or make an annual payment. On June 28, 2012, the US Supreme Court (Court) ruled in the cases challenging the individual mandate requirement. Practical Law Company asked Christine Keller and Mark Nielsen of Groom Law Group, Chartered for their insights regarding the Court's decision.

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What did the Court rule regarding the individual mandate?

The Court ruled that the individual mandate is a tax on individuals who fail to obtain health insurance and that Congress is permitted to assess the tax under its constitutional taxing authority. Interestingly, a majority of the Court (Justices Scalia, Kennedy, Thomas, Alito and Chief Justice Roberts) concluded that the individual mandate exceeded Congress's authority to regulate interstate commerce, which was the Obama administration's primary argument for defending the validity of the law. However, because Chief Justice Roberts (along with Justices Ginsburg, Breyer, Sotomayor and Kagan) concluded that the individual mandate was, in essence, a tax that Congress could assess under the Constitution's separate taxing power, the majority of the Court ruled that the mandate was constitutional.

In this regard, the Court accepted the Obama administration's backup argument that even if the individual mandate exceeded Congress's authority to regulate interstate commerce, it was still constitutional under Congress's independent taxing power. The Court majority reasoned that the individual mandate is a tax based on the fact that it is codified in the Internal Revenue Code (IRC), paid to the Internal Revenue Service (IRS) and produces at least some revenue for the federal government. Thus, the Court majority viewed the mandate not as a command for Americans to obtain health insurance, but as a tax that would be assessed if they failed to do so.

Now that the individual mandate has been upheld, which health care reform requirements should employers focus on for 2012 and 2013?

Employers and other plan sponsors should prepare to address a number of compliance challenges in the immediate future, including:

- Developing and issuing the summary of benefits and coverage (SBC), which is generally required for open enrollments and plan years beginning on or after September 23, 2012.
- Tracking and reporting the value of health care coverage for W-2 purposes, for calendar year 2012.
- Handling medical loss ratio rebates received from insurers in accordance with guidance issued by the Department of Labor (for ERISA plans) and the Department of Health and Human Services (for non-federal governmental and church plans).
- Amending health flexible spending arrangements (health FSAs) to limit reimbursement to $2,500 for plan years beginning on or after January 1, 2013.
- Preparing notices to employees, which will be required beginning in 2013, as to the availability of health insurance

coverage through a health insurance exchange, and eligibility for premium tax credits through an exchange if the employer's health care coverage does not satisfy the ACA's minimum value test.

- Paying new taxes and fees, such as the Patient-Centered Outcomes Research Institute fee, which is $2 per covered life for the year ending on or after October 1, 2013 (until 2019), and $1 per covered life for years ending on or after October 1, 2012 and before October 1, 2013.

Should employers expect an additional wave of implementing guidance?

Yes, employers and other plan sponsors should prepare themselves for a flurry of regulations and guidance from the federal agencies addressing critical aspects of the ACA that generally take effect in 2014, including:

- The ACA's employer "shared responsibility" provision, which is applicable to employers with 50 or more full-time employees. The provision subjects these employers to penalties if a full-time employee obtains subsidized coverage through a health insurance exchange (either because the employer does not offer coverage at all, or because the coverage offered is "unaffordable" or does not satisfy the ACA's "minimum value" test).
- Standards for calculating the number of full-time employees (that is, determining whether an employee works an average of 30 hours or more per week, which is how the ACA defines a full-time employee).
- Rules for determining whether a plan satisfies the ACA's "minimum value" test (that is, whether a particular employer plan covers at least 60% of the costs of benefits that the employer has determined will be provided under its plan).
- Guidance related to the measurement of waiting periods for plan eligibility, which the ACA generally limits to no more than 90 days.
- Guidance on the definition of essential health benefits, which will determine:
  - which benefits that insured plans available on the exchange need to offer; and
  - for insured and self-insured plans, which benefits are subject to the prohibition on lifetime and annual limits (for plan years beginning before January 1, 2014, the prohibition on annual limits is phased in).
- Standards regarding the ACA's automatic enrollment provision, which requires employers with more than 200 full-time employees to automatically enroll employees into a default plan (subject to employee opt-out), if the employee does not affirmatively elect health plan coverage.
- Rules governing the design of wellness programs and the ACA's enhanced incentives for employees to participate in such programs.

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The federal agencies also plan to issue regulations that would accommodate the religious objections of certain non-profit religious organizations to covering contraceptive services without cost sharing, as required under the ACA's preventive services rules. The regulations would:

- Be effective by the end of a temporary enforcement safe harbor for certain religious organizations.
- Apply for plan years beginning on or after August 1, 2013.

Are there any requirements for which guidance is still needed but not expected in the near future? How should employers handle those requirements?

Guidance is needed on the nondiscrimination requirements that apply to insured, non-grandfathered plans. The statute (new Section 2716 of the Public Health Service Act) provides that the rules will be similar to those under Section 105(h) of the IRC. Section 105(h) rules are very much in need of update, and the IRS has received numerous comments regarding issues that should be clarified. The IRS has announced that it will not enforce nondiscrimination rules that apply to insured arrangements until such guidance is issued, and this could take some time.

In the meantime, employers should be aware that insured arrangements that benefit highly compensated employees (for example, the top-paid 25%) with respect to eligibility and benefits may eventually be prohibited, to the extent that plans are not grandfathered. Employers should be prepared to modify these arrangements when guidance is issued or, alternatively, preserve the grandfathered plan status of these arrangements.

Guidance is also needed on new IRC Section 4980I, the "Excise Tax on High Cost Employer-Sponsored Health Coverage," (also referred to as the "Cadillac Plan Tax") which is not effective until 2018. Because of the delayed effective date, it is unlikely that employers will receive clarification regarding the application of the tax anytime soon. Nevertheless, employers should begin considering, from a plan design perspective, whether the current plan design is likely to trigger the tax and, if so, whether the design can be changed in advance of 2018 to avoid it.