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Health Care Reform Stands & Employers Must Now Take Action

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After months of anticipation and speculation, the U.S. Supreme Court has upheld the massive health care reform law, the Patient Protection and Affordable Care Act (ACA). Surprising many who predicted the demise of the law's *individual mandate* and, perhaps, the rest of the ACA with it, the Court concluded that Congress had the constitutional authority under its taxing power to require most Americans to obtain health insurance in 2014 or pay a penalty. By a 5-4 margin – Chief Justice Roberts cast the deciding vote – the Court voted in favor of upholding the individual mandate as a tax—despite its label as a penalty—although the Chief Justice, along with Justices Scalia, Kennedy, Thomas, and Alito, rejected the Obama administration's primary argument that the individual mandate fell within Congress's power to regulate interstate commerce. The Court also concluded that the government cannot penalize states for not expanding their Medicaid programs by taking away existing Medicaid funding.

While the law's individual mandate has survived constitutional scrutiny, many questions and challenges for employers and other stakeholders remain. Activity will now shift from the Court to Congress, the regulatory agencies, the states, and stakeholders as they react to the ruling. And, with the November presidential and congressional elections nearing, the political debate over the future of health care reform is far from over.

Meanwhile, employers face a renewed urgency to understand and implement the statute and its voluminous regulations. Employers must make critical decisions about their health care coverage as key provisions of the ACA become effective. The following is a discussion of the background of the ACA, the litigation, the Court's decision, and what it means for employers.

Background of Statute

The Affordable Care Act (ACA) made sweeping changes in several areas that affect employer health plans. Because employer coverage delivers health care for two-thirds of the non-Medicare-eligible population, nearly 170 million individuals are covered by plans affected by these changes. Some of the changes impose requirements and prohibitions on plan design, while others affect administrative processing of employer plans.

When combined with the mandate for employers to offer coverage (*pay or play* rules) and the requirement that all individuals obtained insurance coverage (the *individual mandate*), the

changes enacted by the ACA restructure the framework of health care coverage for the vast majority of Americans. While Littler has reported on the revamped structure in detail [previously](#), it is summarized below to provide context for the Court's decision.

Employer Plan Changes

The ACA attempted to both broaden and standardize the coverage provided by employers. The list of changes affecting employer plans is as follows (with parenthetical reference to (1) effective dates—generally shown here as the first year that calendar year plans were or are required to comply—and (2) the changes that only affect non-grandfathered plans):

- Plans must provide dependent coverage for children up to age 26 (effective in 2011; until 2014, grandfathered plans need not provide coverage to dependents who are eligible for other employer-provided coverage).
- Plans must provide for preventive care without cost-sharing (effective in 2011; non-grandfathered plans only).
- Plans must provide an enhanced internal appeals process and an external independent review stage (effective in 2011; non-grandfathered plans only).
- Plans must not rescind coverage retroactively, except in situations involving fraud (effective in 2011).
- Plans must not impose pre-existing condition exclusions for participants under the age of 19 (effective in 2011) and for all participants (effective in 2014).
- Insured plans must not discriminate in favor of highly compensated participants, under rules similar to the nondiscrimination rules already applicable to self-insured plans (effective in 2011, but enforcement delayed until regulations are issued; non-grandfathered plans only).
- Plans must not place lifetime limits on essential health benefits (effective in 2011) and may only place annual dollar limits that are at or above specified levels (with no annual limit permitted from and after 2014).
- Plans must provide an eight-page Summary of Benefits and Coverage upon application, enrollment, and re-enrollment in the plan. Also, a notice of material modifications describing plan changes must be provided 60 days before modifications are effective (both effective in 2013).
- Flexible spending account contributions by an employee must be limited to \$2,500 per year (effective in 2013).
- Plans must not have waiting periods for entry into a plan in excess of 90 days (effective in 2014).
- Employers with more than 200 employees must automatically enroll full-time employees (delayed until regulations are issued—will not be effective by the original 2014 effective date).
- The level of penalties/incentives for wellness plans may be as much as 30% of the cost of coverage—an increase from the current 20%; may rise up to 50% by regulation (effective in 2014).

“Pay or Play”—The Employer Mandate

Beginning in 2014, the *pay or play* rules will apply to employers with 50 or more “full-time equivalent” employees.

To understand the impact of the employer mandate, it is necessary to first review one aspect of the ACA that is not directly applicable to employers—the insurance *exchanges* that will be operational in 2014. These exchanges will permit individuals and small businesses to choose from various levels of coverage (known as “bronze,” “silver,” “gold,” and “platinum”). Individuals who are at or below 400% of the federal poverty level will be entitled to premium tax credits toward the cost of coverage in the exchanges.

Despite the availability of individual coverage through state or regional exchanges, the ACA is built on the premise that the majority of Americans will continue to receive their care through employer-sponsored coverage. Thus, the ACA introduced the pay or play concept aimed at employers and modeled after health care reform in Massachusetts. Under the mandate, an employer will either elect to *play*, by providing “minimum essential” health benefit coverage to their full-time employees, or to *pay* a penalty. Employers who fail to offer the required coverage will pay a penalty equal to \$2,000 for each full-time employee in excess of 30 employees. Those who offer coverage, but who fail to provide

at least 60% of the actuarial value or who have any full-time employees for whom the coverage costs more than 9.5% of their compensation, will pay the lesser of the first penalty or \$3,000 for each full-time employee receiving a premium tax credit to purchase coverage through the exchange.

Individual Mandate

While this requirement does not directly affect employers, the *individual mandate* was the main issue in the case before the Supreme Court. Under the mandate, with certain exceptions, all individuals will be required to maintain “minimum essential coverage” in 2014. Individuals who fail to satisfy this requirement will be subject to a penalty that varies depending on their income level—the penalty will be phased in between 2014 and 2016.

Cadillac Health Plan Tax

Targeting high-value employer-sponsored health plans, the ACA will impose a 40% excise tax on the annual value of employer-provided health coverage that exceeds \$10,200 for single coverage or \$27,500 for family coverage beginning in 2018. The value of coverage includes both employer and employee contributions.

The Litigation

Almost as soon as the ACA was enacted, lawsuits were filed challenging its constitutionality. While a group of states challenged certain aspects of the ACA that required the states to expand access to Medicaid, the primary focus of the arguments and the lower court decisions was the question of whether Congress has the power to compel an individual to purchase insurance or pay a penalty—the so-called *individual mandate*. Four U.S. Circuit Courts of Appeal considered this question. The U.S. Court of Appeals for the D.C. Circuit and the Sixth Circuit determined that the individual mandate was valid, while the Eleventh Circuit came to the opposite conclusion, finding that Congress exceeded its authority in enacting the mandate. The Fourth Circuit dismissed two lawsuits challenging the ACA's constitutionality on technical grounds. In one case the court found that the action was barred by the Anti-Injunction Act, while in the other it dismissed the lawsuit on the grounds that the Commonwealth of Virginia lacked standing to sue in the first place, as the provision had not yet taken effect.

Over the span of three days from March 26-28, 2012, the U.S. Supreme Court held oral arguments to determine the fate of the health care reform law. Specifically, the Court considered the challenges brought by the Attorneys General of 26 states and by the National Federation of Independent Business¹ on the following four issues:

1. Is the individual mandate constitutional?
2. If the individual mandate provision is deemed unconstitutional, which parts—if any—of the law can survive without it?
3. Does the Anti-Injunction Act (AIA) bar challenges to the individual mandate?
4. Is the law's expansion of the Medicaid program constitutional?

The questioning revealed deep divisions within the Court about the constitutionality of the law's individual mandate and whether the rest of the ACA would stand if the mandate was struck down.

Individual Mandate

The second day of oral argument addressed the most critical question of whether the individual mandate is constitutional. The key question debated was whether this mandate is a valid exercise of Congress's power or whether it is an unconstitutional legislative overreach.

The focus of the Obama administration's argument in favor of the individual mandate's constitutionality was that the individual mandate falls within Congress's authority to regulate interstate commerce. The government also argued that the individual mandate falls within the “Necessary and Proper” clause, and was within Congress's broad taxing power, although it was not labeled a tax. In support of this argument, the administration noted that the penalty is contained within the Internal Revenue Code and is collected along with income taxes.

¹ The petitions granted review were: *National Federation of Independent Business v. Sebelius* (11-393); *Department of Health and Human Services v. Florida* (11-398); and *Florida v. Department of Health and Human Services* (11-400).

The Solicitor General, who argued the government's case, fielded pointed questions about the limits of Congress's power to regulate individual decision-making and faced harsh questioning from Chief Justice Roberts, Justices Scalia and Alito, as well as Justice Kennedy. Many of the justices' questions on the limits of congressional authority under the Commerce Clause concerned a quest for a "limiting principle" that would distinguish the buying of health insurance from other ordinary individual buying decisions, such as purchasing food or burial services. However, the more liberal members of the Court – Justices Ginsburg, Breyer, Sotomayor, and Kagan – voiced support for the government's position.

In contrast, the law's challengers argued that the Commerce Clause governs economic activity, not *inactivity*, to which the decision to not purchase insurance essentially amounts. Paul Clement, Solicitor General during the George W. Bush administration, representing 26 state Attorneys General in their challenge to the ACA, began his argument by stating that the individual mandate is an "unprecedented effort by Congress to compel individuals to enter commerce in order to better regulate commerce." Clement also countered the government's position that the penalty is a "tax," and argued that, even if it were deemed a tax, it would be a forbidden direct tax.

Severability

Perhaps an equally important issue for employers faced with implementing the ACA—whether other parts of the law, if any, could survive if the individual mandate were found to be unconstitutional—was also addressed in the last day of oral arguments. The question of *severability* took on added importance following the tenor of the prior day's debate on the individual mandate. However, the Court's ruling today rendered this issue moot.

Anti-Injunction Act

Whether the controversial individual mandate contained in the ACA could even be challenged at this time was the subject of debate during the first day of oral argument. Specifically, the question was whether the AIA—which provides that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person"—bars the individual mandate challenge because no individual penalty has yet been assessed. If the AIA were found to apply, a lawsuit challenging the individual mandate would not ripen until 2015 at the earliest when the Internal Revenue Service (IRS) assesses the first penalties for those who do not obtain health insurance.

As expected, the Court rejected the argument that the AIA barred consideration of the case, finding that the ACA was a tax for purposes of congressional authority, but a penalty for purposes of the AIA.

Medicaid Expansion

The ACA will require states to cover approximately 16 million more low-income people under Medicaid in 2014. The 26 states involved in the lawsuit argued that Congress overstepped its authority in requiring states to enroll more people in the program as a condition of receiving federal funds. Although the Medicaid program is voluntary, the states contended that since Medicaid funding is the largest source of funding provided to states, failing to participate is not a viable option, and therefore attaching conditions to such large funding is unduly coercive. The administration disputed that the Medicaid expansion was a coercive use of Congress's spending power.

During this argument, Justice Breyer brought up the point that the government has expanded the Medicaid program several times throughout its 45-year history. Despite this, some justices remained concerned about the possibility of a state losing all of its federal funding for Medicaid if it refused to go along with the ACA's Medicaid expansion. This concern eventually made its way into the Court's opinion.

The Holding

Congress's Taxing Power Authorized the Individual Mandate

Although the taxing power was given relatively little attention during the oral argument, it was the one argument that ultimately saved the individual mandate, and along with it, the ACA. Because the Court upheld the individual mandate, it did not need to reach the question of severability. Accordingly, the employer mandate and the various provisions of the ACA regulating the content of employer group health plans remain intact and will take effect as scheduled.

In reaching the conclusion that the individual mandate was a tax, Chief Justice Roberts reasoned that:

Under the mandate, if an individual does not maintain health insurance, the only consequence is that he must make an additional payment to the IRS when he pays his taxes. See § 5000A(b). That, according to the Government, means the mandate can be regarded as establishing a condition—not owning health insurance—that triggers a tax—the required payment to the IRS. Under that theory, the mandate is not a legal command to buy insurance. Rather, it makes going without insurance just another thing the Government taxes, like buying gasoline or earning income. And if the mandate is in effect just a tax hike on certain taxpayers who do not have health insurance, it may be within Congress’s constitutional power to tax. The question is not whether that is the most natural interpretation of the mandate, but only whether it is a ‘fairly possible’ one.

Therefore, Roberts concluded that the ACA’s “requirement that certain individuals pay a financial penalty for not obtaining health insurance may reasonably be characterized as a tax. Because the Constitution permits such a tax, it is not our role to forbid it, or to pass upon its wisdom or fairness.”

The fact that the individual mandate was labeled a “penalty” instead of a “tax” was not dispositive to Roberts’ conclusion that the individual mandate was a valid exercise of congressional taxing power. He observed that “the exaction the Affordable Care Act imposes on those without health insurance looks like a tax in many respects.”

The Anti-Injunction Act Did Not Apply, Allowing the Court to Render its Decision

Interestingly, Chief Justice Roberts drew a distinction between the “penalty” label for purposes of the Anti-Injunction Act (AIA) versus its application to Congress’s taxing power authority; labeling the individual mandate a “penalty” evidenced congressional intent that it not be treated as a “tax” for purposes of the Anti-Injunction Act, which would have precluded the Court from hearing the case until the individual mandate went into effect in 2014 and the penalty had been applied. Roberts explained, however, that the label did not preclude the Court from analyzing the individual mandate under Congress’s taxing power, writing: “It is of course true that the Act describes the payment as a ‘penalty,’ not a ‘tax.’ But while that label is fatal to the application of the Anti-Injunction Act ... it does not determine whether the payment may be viewed as an exercise of Congress’s taxing power.”

Majority of the Court Would Have Struck Down the Mandate Under the Commerce Clause

The decision to uphold the individual mandate under the taxing power came as a surprise to many who expected that its constitutionality would turn on the Commerce Clause. However, the majority of the Court rejected the government’s argument that the individual mandate is a valid exercise of Congress’s power under the Commerce Clause and the Necessary and Proper Clause because the failure to purchase health insurance has a substantial and deleterious effect on interstate commerce by creating a significant cost-shifting problem. Echoing concerns raised during oral arguments, Chief Justice Roberts wrote that:

Given its expansive scope, it is no surprise that Congress has employed the commerce power in a wide variety of ways to address the pressing needs of the time. But Congress has never attempted to rely on that power to compel individuals not engaged in commerce to purchase an unwanted product. Legislative novelty is not necessarily fatal; there is a first time for everything. But sometimes “the most telling indication of [a] severe constitutional problem ... is the lack of historical precedent” for Congress’s action.

Roberts concluded that the individual mandate does not regulate existing commercial activity, but “instead compels individuals to become active in commerce by purchasing a product, on the ground that their failure to do so affects interstate commerce.” Such logic, Roberts feared, “would justify a mandatory purchase to solve almost any problem.” The distinction between activity and inactivity was a critical one to the Chief Justice—and one that ultimately doomed the government’s Commerce Clause argument.

Court Limited ACA's Medicaid Expansion Based on Its Proposed Penalty

The Court found that the ACA's Medicaid expansion provisions are unconstitutional to the extent that states risked existing Medicaid funding if they rejected the expansion, but noted that this finding did not otherwise invalidate the rest of the law. In essence, the Court determined that Congress cannot penalize states that choose not to participate in the expansion of Medicaid coverage imposed by the ACA by taking away their existing Medicaid funding.

In so ruling, however, the Court asserted that it was "confident" that Congress did not intend for the rest of the ACA to fall "in light of our constitutional holding." According to the Court, the decision "limits the financial pressure the Secretary may apply to induce States to accept the terms of the Medicaid expansion. As a practical matter, that means States may now choose to reject the expansion; that is the whole point. But that does not mean all or even any will."

What's Next?

Employers Should Anticipate an Avalanche of Regulatory Guidance

With the constitutionality of the ACA now settled, the regulatory agencies will continue to issue guidance on the various provisions as their effective dates arrive. There are a number of pending regulations that will be particularly important to employers, including the requirements under the pay or play employer mandate, the definition of a full-time employee under the law, rules detailing the employer obligation to offer automatic health coverage enrollment for employees, and the application of the nondiscrimination rules to insured plans. Additionally, it is important to recognize that a significant portion of the formal guidance has been issued on an "interim" basis and final changes may be forthcoming.

Challenges, from the Legislative and Judicial Branches, Will Continue

Depending on the outcome of the 2012 presidential and congressional elections, it is anticipated that Republican lawmakers will move aggressively to eliminate or modify some of the more controversial provisions of the ACA; in addition to an attempt for a full repeal, they are expected to attempt to repeal the individual mandate, to raise the cap on flexible spending account elections, and to roll back the Medicaid expansion. There may also be attempts to modify the employer mandate, on the theory that the employer mandate may dampen job creation, particularly for small businesses and retail businesses.

In addition, there is continued unhappiness with the minimal effect the ACA is expected to have on the continued escalation of medical costs, and additional efforts can be expected to expand cost containment for Medicare and Medicaid, and to expand wellness programs and outcomes-based medical research.

In the courts, we will be following the cases that have been filed by Catholic-affiliated institutions challenging the regulatory requirement that "essential health benefits" must include coverage of contraceptive services without cost-sharing – effective for plan years beginning on or after August 1, 2012 (*i.e.*, January 1, 2013 for a calendar year plan). At issue is the scope of the "religious employer" exemption to the contraceptive services coverage requirement. As currently written, the exemption would already apply to many non-profit, educational and health care institutions with religious affiliations. These institutions, which object to covering contraceptive services on the basis of their religious beliefs, have until the first plan year beginning on or after August 1, 2013 to provide such coverage.

Despite Regulatory & Political Uncertainty, Employers Need to Take Action Now

Based on today's Supreme Court decision, all of the mandates set forth in the ACA that impact employer-provided group health plans will officially take effect as scheduled unless Congress takes further action. Important new obligations are looming, including summary of benefits and coverage requirements and W-2 reporting of health care coverage. In addition to the many provisions already in effect or that will soon become effective, employers should be making critical decisions now about the more important provisions set to take effect in 2014. Perhaps the most important business and strategic decision will be whether a company maintains its health coverage for full-time employees or decides to accept the employer penalty. Employers also face related questions about how full-time status will be defined, and whether their coverage will be deemed "unaffordable" or not providing "minimum value," thereby triggering a penalty. Even though 2018 sounds far away, any strategic decision by employers must also take into account the Cadillac tax as they continue to consider ways to control health care costs.

The Supreme Court's historic decision marks the end of the waiting game on the constitutionality of the ACA. However, the final verdict on how the law will impact employers has yet to be rendered. What is certain is that critical questions and decisions for employers are ahead.

Littler's Health Care Reform Task Force, in conjunction with the [Employee Benefits Practice Group](#), will continue to issue up-to-date information on Littler's [Employee Benefits Counsel blog](#) regarding regulatory, legislative, and judicial developments related to the ACA as they arise. Littler will also host complimentary client Webinars on this critical development on [Friday, June 29, 2012](#), and [Wednesday, July 11, 2012](#).

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