American Benefits Council

Priority Employer Concerns in Response to the U.S. Supreme Court's Decision on the Patient Protection and Affordable Care Act

The U.S. Supreme Court's decision on the constitutional challenges to the Patient Protection and Affordable Care Act (PPACA) could have far-reaching implications for employers as the sponsors of health coverage for most Americans. In particular, the Court's decision could affect several important provisions that employers have already implemented in response to detailed regulations and guidance issued by three federal agencies over more than two years since the law was enacted. In addition, the Court's decision could raise immediate questions for both employers and employees about how health plans are affected prospectively, starting with the date the decision is released.

There are several possible directions the Court's decision could take with respect to the central question on the constitutionality of the individual mandate provision.

Option One: Court Upholds the Individual Mandate as Constitutional

Under this option, if the majority of the Court decides the individual mandate is constitutional, the entire remainder of the law would also remain in place (although the Court must still make a separate decision on the constitutionality of the PPACA provisions requiring states to either expand the populations of individuals eligible for coverage under Medicaid or forfeit all federal funding for their Medicaid programs.)

For employers, this means that the *status quo* also remains in place. Absent any further action by Congress, all provisions of the law that have already been implemented remain in full effect and employers will again turn their full attention to those aspects of the law that have not yet become effective.

Under this scenario, priority employer concerns will be to know how the regulatory agencies will interpret several central elements of the law, especially those which will be effective in January 2014 where guidance has not yet been issued. These include:

- The "employer responsibility" provisions that subject employers with 50 or more employees to penalties if a full-time employee obtains subsidized coverage in a health insurance exchange either because their employer did

not offer health coverage to the employee or because coverage was offered but it was not affordable or did not meet a test for "minimum value" established by the law.

- Standards for determining whether an employee has "on average" worked more than 30 hours a week and is therefore considered a full-time employee for purposes of the employer responsibility provisions. This guidance is particularly important for employers with seasonal workers or those with highly variable schedules.

- Rules for determining whether a plan meets the law's test for "minimum value" and the extent to which employer contributions to account-based health plans such as health savings accounts (HSAs) or health reimbursement arrangements (HRAs) will be considered in calculating the value of a health plan offered to employees.

- Requirements to notify employees about the availability of health coverage from health insurance exchanges and the consequences of electing coverage under a health plan in an exchange rather than coverage offered by their employer.

- New incentives to encourage individuals to engage in employer wellness programs.

- Requirements to automatically enroll an employee into a "default" health plan offered by an employer (with an opportunity to choose a different option) if an employee fails to choose a health plan during an annual enrollment period.

Option Two: Only the Individual Mandate Is Found Unconstitutional and Is "Severed" from the Rest of the Law

If the Court determines that the individual mandate is unconstitutional, the justices could decide that the mandate is the only provision that must be invalidated and can be "severed" from the statute, leaving the entire rest of the law in place.

Although the U.S. Solicitor General argued on behalf of the Obama Administration that such a result would lead to significant disruption in the individual insurance market, the effect of such a decision on most employers -- who are group purchasers -- is likely to be more indirect, including:

- Unless an alternative mechanism is adopted promptly, the lack of the individual mandate provision is likely to lead to instability in the

individual insurance market, making it more difficult for important reforms in that market to succeed, including making coverage available on a "guarantee issue" basis and subject to rating limits.

- Many early retirees or part-time workers who are not covered under an employer-based health plan could find fewer, more costly coverage options in the individual market.

- Congress would need to consider how or whether to "cure" the constitutionally defective provision of the law, leading to uncertainty for employers about whether other provisions of the law might be reconsidered at the same time.

- States could also consider enacting an individual mandate or similar provision since the Supreme Court's decision would only prevent the federal government from applying the individual mandate provision included in PPACA. However, a state-by-state approach would, of course, lead to uneven results.

Option Three: Individual Mandate Is Found Unconstitutional and Certain Insurance Reforms Are Also Invalidated and "Severed" from the Law

A third option is that the Court could decide – as the Obama Administration and the health insurance industry have argued – that <u>if</u> the individual mandate is ruled unconstitutional, then certain individual market insurance reform provisions must also be invalidated; in particular the provisions requiring the "guaranteed issue" of coverage and rating restrictions. Under this approach, only the individual mandate and provisions immediately related to and dependent upon the mandate would be struck down, while the remainder of the law would continue in force.

Similar to Option Two, the effect of this decision by the Court could have several important indirect implications for employers, including:

- The individual insurance market would no longer be subject to key reforms included in PPACA, returning it to a difficult and uncertain source of coverage for those, such as early retirees or part-time workers, without access to health insurance either through an employer or under a government program such as Medicare or Medicaid.

- The future of the health insurance exchanges would be uncertain unless states acted to put workable insurance reforms in place to substitute for those struck down by the Court. In addition, employers could be subject to significant penalty payments under the "employer responsibility"

provisions of PPACA. These include payments on behalf of workers with prior health conditions who might be unable to obtain coverage in an insurance exchange because of the absence of the "guarantee issue" requirement.

- As with Option 2, Congress might act to "cure" the Court's action either by enacting an acceptable alternative mechanism to the individual mandate at the federal level or States would still be free to enact an individual mandate or similar mechanisms on their own. However, it is unclear how or when such solutions could be approved and, if state-based, could lead to uneven results.

Option Four: Individual Mandate Is Found Unconstitutional and the Entire Law is Invalidated

This is the option advocated by the 26 states and other groups in their challenges to the law. Proponents of this approach argued that Congress should start over from a clean slate if the "heart" of the law -- the individual mandate -- is found unconstitutional. If the Court agrees with this argument, it would, in essence, be deciding that it should be up to Congress, not the judiciary, to determine which provisions of the health reform law are so closely related to the individual mandate that they might never have been enacted at all or could not operate in the absence of an individual health coverage mandate.

This fourth option would raise some of the most immediate and significant questions for employers, particularly with respect to provisions that have already been implemented since President Obama signed PPACA into law on March 23, 2010:

- While several health insurers and many employers have indicated that they would continue to offer coverage to children up to age 26 at least until the end of the current plan year, employers need immediate clarification from the Department of Treasury and the IRS that this coverage offered to a family member will not suddenly be considered taxable income to an employee or require employers to count the value of this coverage as "wages" for payroll tax purposes. If the Supreme Court strikes down the entire law, not only would it affect the requirement to allow children up to age 26 to be covered under their parents' plan, but it also would eliminate the PPACA provision which changed the tax code to exclude the value of this coverage from taxation. In order to clarify this situation and help keep this coverage in place, employers need immediate assurance that the IRS will not subject workers – or their employers -- to a tax simply because the employer was dutifully following the law until it was struck down.

- Another immediate requirement for many employers would be assurance that they are not required to repay any portion of the funds received under the Early Retiree Reinsurance Program (ERRP). This program was included in PPACA to provide transitional assistance to those who provided health coverage for pre-65 retirees, by reimbursing employers for a portion of the high health care cost claims these retirees incurred since the date of enactment. PPACA authorized $5 billion for this purpose, nearly all of which has now been disbursed to help stabilize health coverage for early retirees. As with the concern about possible tax consequence for coverage offered to children up to age 26, employers that received these funds relied in good faith on the provisions of PPACA which authorized them to be reimbursed for certain eligible expenses of these retirees. Along with any other entity that received funds under similar circumstances since the date of PPACA's enactment, employers will need immediate assurance that they would not have an obligation to repay these funds if the law is struck down.

- Employers will have numerous questions about whether any of the health reform requirements they have already implemented could remain in place based on authority independent of PPACA. For example, for insured health coverage which is subject to state regulation, there may be separate state insurance laws or regulations related to the same issues as addressed by PPACA, such as prohibitions on annual or lifetime dollar limits, first-dollar coverage of preventive health services, and significantly expanded claims and appeals procedures. For self-insured plans subject only to federal requirements, not state insurance laws, employers will also need to know whether the federal agencies believe that any of the requirements included in PPACA could continue in force under other existing federal statutes.

- PPACA included many other tax requirements and changes to the coverage or operations of employer-sponsored health plans, such as the changed treatment of subsidies for employer-provided retiree prescription drug coverage, annual tax form W2 reports to employees on the value of their health coverage, contribution limits on flexible spending arrangements (FSAs), and new summaries of benefits and coverage (SBCs). Employers are likely to have to make decisions quickly about how to proceed in all of these areas and may need to do so even before further guidance is issued by agencies interpreting the Court's decision. Employers will need clarity that there will be no adverse legal consequences or agency enforcement actions if they either complied with a PPACA provision prior to its invalidation, or they proceeded in good faith to "unwind" any requirements after the Court's decision.

- Finally, there was broad, bipartisan agreement during the 2009-2010 legislative consideration phase of health care reform, that many improvements were urgently needed to increase the quality of health care, reimburse health services based on value rather than volume, evaluate the "comparative effectiveness" of a wide range of health care services and products, and make information on health care providers and services more transparent and useful for both consumers and purchasers. Even if the health reform law is struck down in its entirety, employers have a strong and common interest with many in Congress who recognized the vital role of many of these improvements to our health care delivery system. Employers and policymakers will look to the Centers for Medicare and Medicaid Services (CMS), which has responsibility for implementing nearly all of these quality improvement provisions, to determine as rapidly as possible which of these initiatives can continue to move forward and under what authority.

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