Employee Benefits & Executive Compensation ADVISORY

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The Supreme Court Decision on the Affordable Care Act – The Immediate Implications for Group Health Plans

During the week of March 26, 2012, the Supreme Court heard an unprecedented three days of oral argument on the question of the constitutionality of the Affordable Care Act (ACA). With the Court's decision expected by the end of June, the possible implications for group health plans should be considered. Of the possible outcomes of the case, the one that would create the most immediate issues for employers would be if the entire law is struck down. The precise near-term consequences will depend on a number of factors, including the details of the Court's decision, plan terms and agency actions that may be taken in response to the decision. The implications will involve a number of plan-related aspects, including plan design and administration and tax issues.

This advisory discusses the issues that employer group health plans will be facing depending on the Supreme Court's decision, with a particular focus on what employers will need to consider if the entire law is struck down.

Possible Supreme Court Decisions

There are four general scenarios for the Court's decision (although the actual decision may have further nuances).

- **All of the ACA is upheld:** The Supreme Court holds that the individual mandate is constitutional and upholds the ACA in its entirety. This decision would essentially be "business as usual," and implementation efforts should continue. In this regard, there are a number of short-term ACA requirements that employer/plan administrators will need to turn to in earnest (e.g., the requirement to issue a summary of benefits and coverage or "SBC" document in connection with open enrollment).
- **Only the individual mandate is struck down:** The Supreme Court holds that the individual mandate is unconstitutional, but finds that the mandate is severable from the other provisions of the ACA and upholds the rest of the ACA. This decision may ultimately have impact on the broader health care market and on exchanges. For employers, however, this decision should, at least in the near term, also result in "business as usual," and ACA implementation efforts should continue. It is possible that such a decision may affect the guidance issued by the regulatory agencies on particular issues, such as the guaranteed issue requirement and modified community rating provisions that apply to health insurers. However, in the near term, there should be no immediate impact on the ACA provisions affecting group health plans that have already taken effect or will take effect in the future.
- **The ACA is partially upheld:** The Supreme Court holds that the individual mandate is unconstitutional, and finds that only certain provisions are so intertwined with the mandate that they must be struck down with the mandate. For example, the government argued before the Supreme Court that all of the ACA,

except the guaranteed issue and community rating provisions, is severable from the individual mandate. If the Court takes this approach, then the provisions relating to group health plans will likely remain intact and implementation should continue. But employers should recognize that the Supreme Court could conclude that other provisions of the ACA—e.g., all of Title I (which includes the health insurance reforms and provisions relating to exchanges), Titles I and II (which includes changes to Medicaid), or all but a few provisions around the periphery of the ACA (e.g., the Biosimilars Act, Indian Health Care Improvement Act reauthorization)—are inseverable from the individual mandate. The precise contours of the implications for employers would depend on which provisions are struck down with the mandate.

- **All of the ACA is struck down:** The Supreme Court holds that the individual mandate is unconstitutional, finds that the remainder of the ACA is not severable from the mandate and strikes down the entire law. This is the outcome that will have the most impact on group health plans. The general implications of such a decision, as well the immediate effect on selected key provisions of the ACA, are discussed below.

General Implications if All of the ACA Is Struck Down

If the Supreme Court rules that the individual mandate is unconstitutional and that the remaining provisions of the ACA are inextricably intertwined with the mandate so as not to be severable from the mandate, the entire ACA will be struck down. Such a decision would have serious implications both prospectively and with respect to ACA compliance activities already under way. Prospectively, the federal agencies could not base regulatory requirements on the ACA; both the agencies and employers/group health plans would need to consider whether there is independent statutory authority—apart from the ACA—for the group health requirements imposed under the ACA.

More difficult questions would arise with respect to actions that occurred between March 23, 2010, the date on which the ACA was signed into law, and the date on which the Supreme Court ruling takes effect. The decision would come more than two years after passage of the ACA. Because the mandate itself is not yet effective, there is no issue of unwinding actions that have already been taken with respect to the mandate itself. However, striking down all of the ACA raises serious questions with respect to actions that have already been taken to comply with ACA requirements that are already in effect.

Billions of dollars have been spent, including the award of grants and the cost of implementation efforts of the government, plans, insurers, third-party administrators and others. Tax rules were changed. Health insurance policies and group health plans have been amended to comply with the ACA, and further implementation efforts for health reforms that will soon be effective are already well in process. What happens? Are previously issued regulations undone? Are tax provisions changed retroactively? Do entities that received funds under ACA programs have to repay those funds? The Supreme Court has addressed issues of this nature in several instances where it has struck down significant provisions of a law on constitutional grounds. The general rule is that if a law (or portion of a law) is unconstitutional, Congress did not have the authority to enact the law in the first instance, so that the law is retroactively invalid. However, the Court has also recognized that this principle cannot be applied universally, and that the effect of a subsequent ruling as to invalidity of a statutory provision has to be considered. Thus, the Court does not necessarily apply a principle of absolute retroactivity if a provision is held unconstitutional.

Even if the Supreme Court does not decide whether the decision should be applied retroactively, the nature of the decision and the principle of "reasonable reliance" would seem to lead to the conclusion that completed activities—contracts and grants that have been issued, payments that have been made, tax changes that have already taken effect—likely would not be undone retroactively. If the Court strikes the mandate as unconstitutional and finds that the balance of the ACA's provisions are not severable from the mandate, it would be saying that the other ACA provisions are not necessarily unconstitutional but are being stricken because they are inextricably intertwined with the unconstitutional mandate. Arguably, actions of federal agencies taken under such provisions of the ACA prior to it being struck down would be deemed valid because they were pursuant to valid statutory authority. Indeed, the Supreme Court has recognized in various instances in the past that the government can be held to the benefit of bargains struck with private entities in cases ranging from congressional rescinding of tax incentives to contracts related to terminated defense programs. Further, plan documents and insurance contracts that have been amended to comply with the ACA would have created rights for plan participants and beneficiaries (and corresponding obligations on the part of the plans and the insurance companies), and these documents may create an independent basis for enforcing plan provisions that have already incorporated the ACA's requirements.

In sum, actions undertaken pursuant to the ACA prior to a Supreme Court decision striking down the ACA are unlikely to be undone. Indeed, provisions (other than the portion found to be unconstitutional) that are struck down because they cannot be severed will most likely be stricken prospectively from the date of the decision.

The Implications on Specific Provisions if All of the ACA Is Struck Down

Determining what rules apply and what actions to take if the ACA is struck down involves a variety of issues. It is not as simple as just stopping compliance and reverting to prior law and plan provisions. Factors that are relevant include the precise language of the Supreme Court decision regarding the effective date of the decision, the actions the regulatory agencies take in response to the decision (e.g., an agency might determine that it has the authority under pre-ACA law to take a particular position), plan provisions, the terms of applicable collective bargaining agreements and employee relations issues. Further, in the case of fully insured plans or plans that are not subject to ERISA and therefore do not benefit from ERISA's preemption of State laws, State laws will also be relevant.

The following discussion highlights certain of the ACA provisions that have already gone into effect. This discussion is premised on the assumption that only the mandate would be declared invalid from enactment, and that other provisions will be struck down prospectively only. Different issues will arise if other provisions in addition to the mandate are held to be invalid on a retroactive basis. At the end of this article, we have included a high-level snapshot analysis of the potential impact of such a ruling on individual account plans (FSAs, HRAs and HSAs).

Early Retiree Reinsurance Program

For employers that have participated in the early retiree reinsurance program, a principle question is whether any reimbursements received would need to be repaid to the federal government. Based on the preceding discussion, it is unlikely that reimbursements already received would need to be repaid, particularly if the reimbursements have already been applied to retiree health expenses as provided for under the program. HHS has previously issued guidance indicating that all reimbursements should be applied before the end of 2014.

Health Insurance Reforms

In determining what plan changes to make in response to a Supreme Court decision striking down the ACA, a number of factors should be considered by plan sponsors as they determine how to react and what, if any, ACA requirements they wish to continue. These factors include legal issues (which may involve laws other than the ACA, such as HIPAA nondiscrimination rules and, if applicable, State laws), employee relations issues (e.g., coverage of dependents to age 26 is generally a popular provision) and plan terms relating to the plan amendment process. Any plan changes should also be carefully communicated to employees in order to avoid adverse employee relations issues.

Following is a discussion of certain key health insurance reform provisions of the ACA that would be impacted by a Court ruling striking down the ACA.

Coverage of adult dependent children up to age 26: One of the more popular provisions among employees is the ACA requirement that, if a plan provides dependent coverage, such coverage has to be provided to children up to age 26. Pre-ACA, many plans covered adult dependents only in certain circumstances, such as if the person were disabled or a full-time student. The ACA also amended the tax laws to provide that coverage for an adult dependent child is tax-free, even if the individual is not a tax dependent of the employee. Plan sponsors will need to review whether to continue to provide coverage for adult dependent children as under the ACA, or to again impose certain restrictions on such coverage. If coverage is to be curtailed, will it be curtailed immediately, after a short transition period or in connection with the next plan year? If coverage for adult dependents who are not tax dependents of the employee continues beyond the effective date of the Supreme Court decision, then the value of that coverage will be taxable income to the employee, as under the pre-ACA rules. Absent transition relief from the IRS, this would cause imputed income issues for employers and employees.

Prohibition on lifetime and annual dollar limits on essential benefits: As a result of the ACA, plans that previously had lifetime or annual limits removed those limits (subject to the application of the waiver program or the ability to use restricted annual dollar limits until 2014). In some cases, annual dollar limits have been replaced with other provisions, such as treatment or visit limits and medical management techniques. If the ACA is struck down, annual and lifetime dollar limits are again permissible; however, attempts to impose such limits before the beginning of the next coverage period may create special questions, including HIPAA nondiscrimination issues. If a lifetime limit is added (or re-imposed), then a decision will need to be made as to how to treat individuals whose benefit payments already exceed the lifetime limit. This involves legal issues, as well as questions of practical implementation and plan interpretation. Should affected individuals be provided some form of transition coverage (presumably COBRA would not be available)? On the bright side, the prohibition on annual and lifetime limits has created uncertainty with respect to the future of stand-alone health reimbursement arrangements (HRAs) under the ACA. The elimination of the prohibition would remove this cloud.

Prohibition on rescissions: The ACA prohibits the retroactive termination of coverage, other than in cases of fraud or intentional misrepresentation of a material fact or failure to pay premiums. Prior to the ACA's effective date, plan sponsors used a variety of practices, including certifications by employees and audits, to ensure that persons that had been enrolled in the plan were in fact eligible—e.g., that someone receiving coverage as a dependent was in fact a tax dependent of the employee. Plans may wish to consider reinstating such prior practices.

Preventive care: The ACA requires that non-grandfathered group health plans provide certain preventive care services without cost-sharing. This provision was generally effective with respect to plan years beginning on or after September 23, 2010, with requirements relating to additional women's preventive care scheduled to go into effect generally for plan years beginning on or after August 1, 2012 (with special rules for the plans of certain religious employers). Pre-ACA, many plans had robust preventive care coverage, although relatively few had coverage that had no deductible or copayment and/or was as broad as that required under the ACA. Plan sponsors will wish to review what changes to make with respect to the preventive care requirements that have already been adopted under the ACA. Most plans have not yet taken steps to adopt the additional women's preventive care requirements, and many plan sponsors may decide not to further expand their current preventive care coverage if no longer required to do so. Religious employers in particular that have objections to certain of the women's preventive care requirements relating to contraceptive coverage may not be required to provide such coverage. However, such requirements may continue to apply to fully insured plans and plans otherwise subject to State law requirements where an analogous State law mandate applies if there is no applicable religious exemption.

Nondiscrimination requirements for fully insured plans: The ACA imposes nondiscrimination requirements on non-grandfathered fully insured plans that are similar to those imposed on self-funded plans under Code section 105(h). The statute provides that the new nondiscrimination requirements were to be effective for plan years beginning on or after September 23, 2010. However, the regulatory agencies determined that additional guidance was needed before such rules could be effective and issued a notice delaying the effective date until further guidance is issued. If the ACA is struck down, then fully insured plans will not be subject to these nondiscrimination requirements. One of the pre-ACA practices that was sometimes used to avoid application of the 105(h) nondiscrimination rules was to use fully insured products. This practice will continue to be permissible if all of the ACA is struck down.

Summary of benefits and coverage (SBC): The SBC requirements are considered by many employers to be one of the most administratively burdensome requirements imposed by the ACA. Under the final regulations, these requirements are generally scheduled to take effect for annual open enrollment periods that begin on or after September 23, 2012 (a different effective date applies for enrollments occurring outside open enrollment—e.g., for new hires). While plan sponsors have been preparing to comply, due to the legal uncertainty involving the ACA, many have waited to take steps that involve significant unrecoverable costs until the Supreme Court decision is issued. For group health plans subject to ERISA, information similar to that required in the SBC is already included in other materials, such as the summary plan description and enrollment booklets. If the ACA is struck down, it is expected that employers will not, on their own, adopt the SBC standards for their employee communication materials.

Internal claims and external appeals: The ACA imposes new claims and appeals requirements on non-grandfathered plans, including a required independent external review. The starting point for the internal claims process is the pre-ACA claims procedures under ERISA. The ACA regulations impose additional requirements for internal claims procedures, as well as adopt specific requirements for independent external review. Pre-ACA, many plans already had external review processes for some claims. If the ACA is struck down, sponsors may wish to review their claims and appeals process to determine what changes should be made with respect to processes adopted specifically in response to the ACA. Under ERISA, the Department of Labor (DOL) has the regulatory authority to prescribe rules for notices to plan participants of an adverse benefit determination and for a full and fair review of such a determination. If all of the ACA is struck down,

the DOL may revise current ERISA regulations to take into account some of the ACA requirements. If so, it is expected that any changes to the current ERISA claims procedures would follow the normal regulatory process, including a notice and comment period. Any such changes would only apply to plans subject to ERISA.

Tax Provisions

Prohibition on reimbursement of over-the-counter (OTC) medicines: This provision took effect on January 1, 2011. Going forward, reimbursement of OTC medicines on a tax-free basis from group health plans, health FSAs, HRAs and HSAs would again be permitted. Guidance may be needed as to the effective date of removal of the prohibition depending on the date that the Supreme Court sets as the effective date of its decision—e.g., it may not be clear whether removal of the prohibition would apply for reimbursements for claims payable after the date of the Supreme Court decision or for claims incurred after such a date. Because the IRS required plans to incorporate the prohibition, employers that wish to again allow such reimbursements would need to amend their plans. Employers should consult with their administrators to determine how quickly claims processing may be adjusted. In addition, due to the prohibition, the IRS provided additional requirements on the use of debit cards under health FSAs and HRAs in Notice 2011-5. Such rules should not be necessary if the prohibition no longer applies, but clarifying guidance may be needed from the IRS.

Coverage of adult dependent children: As noted above, if coverage for adult dependents who are not tax dependents of the employee continues beyond the effective date of the Supreme Court decision, then the value of that coverage will be taxable income to the employee, as under the pre-ACA rules. Absent transition relief from the IRS, this would cause imputed income issues for employers and employees.

$2,500 cap on salary reduction contributions to health FSAs: Although the cap is not scheduled to go into effect until January 1, 2013, a decision striking down all of ACA would still raise a number of questions with respect to this cap. The IRS and Treasury only recently announced in Notice 2012-40 that the cap does not apply to fiscal plan years beginning before January 1, 2013. However, before this guidance was issued, some employers seeking to comply may have already instituted the cap for salary reduction elections for the non-calendar year plan year that includes January 1, 2013. It is unclear whether the IRS would allow new elections to be made in such cases. In addition, in Notice 2012-40, the IRS and Treasury announced that, in light of the dollar cap, they are considering relaxing the use-it-or-lose-it rule. This would be welcome news. However, if the cap does not go into effect, it is unclear whether IRS and Treasury will be willing to pursue relaxation of the rule without a similar limitation on potential abuse.

Small employer health tax credit: The ACA provides a credit for small employers (for this purpose, an employer with fewer than 25 full-time equivalent employees), for certain health insurance expenses. This credit has been in effect since 2010. If the ACA is struck down, then the credit will no longer be available, but it is unlikely that any credits already received would need to be repaid. Guidance may be needed to determine whether the credit would not be available at all for the 2012 tax year, whether a partial credit would be available based on the part of the year up to the Supreme Court decision or whether it would be available for all of 2012.

Tax provisions relating to Medicare Part D subsidies: Medicare Part D subsidies received by employers are not taxable income. In addition, for years prior to 2013, the employer's deduction for retiree prescription drug expenses is not reduced by the amount of subsidy received. The ACA changed this rule for taxable years beginning on or after January 1, 2013, so that the otherwise available employer deduction is reduced by the

amount of subsidy received. Although this change in tax treatment is not yet effective, it will already have been taken into account for accounting purposes. Thus, accounting treatment will again need to be examined.

W-2 reporting: The ACA requires that the value of health coverage be reported on employees' Forms W-2. This is a reporting requirement only; it does not affect employees' tax liability. Under IRS guidance, this information is required to be provided on Forms W-2 for 2012—i.e., generally for Forms W-2 that are required to be provided in January of 2013. This requirement should no longer apply if all of the ACA is struck down.

Fee to fund the Patient Centered Outcomes Research Institute: The ACA imposes a fee to fund the Patient Centered Outcomes Research Institute (also referred to as the "CER" fee) on fully insured and self-funded plans. In the case of calendar year plan years, the fee is effective for the 2012 through 2018 plan years. Under proposed regulations, the fee for 2012 is payable July 31, 2013. This fee will no longer apply if all of the ACA is struck down.

Cadillac plan tax: Although the Cadillac plan tax is not effective until 2018, many employers have already been reviewing their plans to determine if the tax would apply. If all of the ACA is struck down, the tax will not go into effect. Note, however, that the exclusion for employer-provided health coverage is by far one of the largest tax expenditure items, estimated at over $700 billion over five years for the income tax effect alone (i.e., not taking into account the exclusion for Social Security tax purposes). Because of this fact, whether the exclusion should be modified or eliminated is an issue that continues to arise in congressional discussions regarding tax reform and deficit reduction. There may be more interest in making changes to the exclusion if the Cadillac plan tax is struck down as part of the ACA.

Additional Considerations for Fully Insured Plans and Other Plans Subject to State Law

ERISA does not preempt State laws that apply to insurance, so that health insurance issuers providing coverage under group health plans are required to comply with State-law mandates. Many States have adopted legislation to implement the provisions of the ACA. Thus, even if all of the ACA is struck down by the Supreme Court, State laws implementing the ACA may still be in place. Depending on the specifics of the State legislation, action of the State legislature may be required to undo the ACA implementing legislation. Plans that are not subject to ERISA, such as self-funded church plans and governmental plans, also need to consider State law. In the case of fully insured plans, policy and contract terms will need to be taken into account when an employer is considering plan design changes if the ACA is struck down.

Conclusion

A decision striking down all of the ACA will have significant implications and creates the potential for confusion in the near term as employers, insurers and government regulators seek to determine the full effect of the decision. If the ACA, or most of the ACA is upheld, then implementation efforts will continue. In either case, we can expect that legislative efforts regarding health care will continue; the precise nature of such efforts will depend in large part on the outcome of the November elections. Further, even if no part of the ACA is held unconstitutional, litigation regarding specific provisions or regulations implementing specific provisions, such as the requirement that religious organizations provide contraceptive coverage, is ongoing, and other challenges to specific provisions or regulations may also occur.

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