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Supreme Court Upholds the Affordable Care Act's Individual Mandate: What It Means for Employers and Plan Sponsors

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The Supreme Court of the United States (the "Court") ruled today, in a 5-to-4 landmark decision,[1] that the individual mandate under the Patient Protection and Affordable Care Act ("the Act") is constitutional, although it also held that certain Medicaid expansion provisions are unconstitutional. The Act's coverage mandates remain in effect and the implementation and administration of its various mandates will need to continue. Although the Act was upheld today, we expect that the legal challenges to healthcare reform are far from over.

Background and Procedural History

A variety of plaintiffs, including 26 states, challenged the constitutionality of the Act. The challengers argued that Congress exceeded its authority when it established the individual mandate, and that the Medicaid expansion provisions exceeded Congress' Spending Clause powers. With respect to the individual mandate, the plaintiffs argued that the Constitution does not grant Congress the power to require private citizens to buy a private product from a private enterprise. The Obama administration responded that Congress had the authority to establish this mandate under the power to regulate commerce (the "Commerce Clause") and the power to "lay and collect taxes" (the "Tax and Spend Clause"), each of which is set forth in Article I of the U.S. Constitution. As to Medicaid expansion, the challengers asserted that the Act unconstitutionally coerced states to expand Medicaid by threatening to withhold all federal Medicaid grants for non-compliance. The administration countered that the Medicaid expansion provisions were mere modifications of the existing program that offered financial inducements to comply with the new law. The lower courts generally divided along four lines: (i) the individual mandate and the entire Act was constitutional; (ii) the individual mandate was unconstitutional but severable from the rest of the Act; (iii) both the individual mandate and the entire law was unconstitutional; and (iv) the issue was not ripe for review because of the Anti-Injunction Act, which prohibits taxpayers from preemptively seeking to stop the government from assessing any tax before it is imposed.

The Supreme Court's Ruling

As noted, in a much anticipated decision, the Court upheld the Act as a constitutionally valid exercise of congressional power. There were four separate opinions on the various issues, with Chief Justice Roberts writing for the Court.

The Court upheld the individual mandate as constitutional, on the basis that it is within Congress' authority under the Tax and Spend Clause. In so ruling, the Court explained: "The Federal Government does not have the power to order people to buy health insurance. . . . [but it] does have the power to impose a tax on those without health insurance." Interestingly, the Chief Justice agreed with four other Justices, ruling that the individual mandate exceeded Congress' authority under the Commerce Clause, noting that the Commerce Clause does not authorize Congress to order individuals to engage in commercial activity. However, the Chief Justice determined that the Court should resort to "every reasonable construction . . . in order to save a statute from unconstitutionality." The Tax and Spend Clause, which grants Congress broad powers to assess and collect taxes, provided a basis for a reasonable construction that would permit the Court to find the Act constitutional.

Separately, the Court held that the Act's Medicaid eligibility expansion provisions were unconstitutional because the government cannot coerce states to expand Medicaid by threatening to withhold existing federal Medicaid funds. In other words, even non-participating states must still receive existing Medicaid funding. Further, the unconstitutional part of the Medicaid provisions could be severed and remedied, leaving the remainder of the statute fully operable.

What the Ruling Means For Employers and Plan Sponsors

Generally, the ruling means that it is back to business as usual for employers and plan sponsors, who must continue to implement the Act's various coverage mandates.

Although the Act was deemed largely constitutional, issues concerning the implementation and administration of the Act's various coverage mandates may be litigated in years to come. For example, dozens of Catholic dioceses and schools filed lawsuits in a number of states charging the Act's contraception coverage requirement violates their rights under the First Amendment to the U.S. Constitution. Separately, employers and plan sponsors could face litigation over whether the Act's coverage mandates were implemented and administered correctly. These issues will likely be among the next round of challenges to, or under, the Act.

In the near term, employers and plan sponsors must continue implementing the Act's various reforms and coverage mandates. The Act's various reforms and mandates in effect or coming into effect in 2013 include:

- Form W-2 reporting requirement (for the 2012 tax year);

- 2,500 limit on employee contributions to health flexible spending accounts (FSAs) (for plan years beginning in 2013);

- Summary of Benefits and Coverage requirements (for open enrollment periods starting on or after September 23, 2012);

- Requirement for employers to notify employees of the availability of health insurance exchanges (March 2013);

- Expansion of FICA to include an additional 3.8% tax on the unearned income of high income individuals (for the 2013 tax year); and

- 0.9% Medicare payroll tax increase on high income individuals (for the 2013 tax year).

Additional coverage mandates and market reforms become effective in 2014, including:

- The "pay-or-play" mandate;

- Employer certification to the U.S. Department of Health and Human Services regarding whether its group health plan provides "minimum essential coverage";

- Increase in permitted wellness incentives from 20% to 30%;

- For large employers (200+ employees), automatic enrollment of new employees in a group health plan (effective date unknown);

- 90 day limit on waiting periods;

- Coverage under non-grandfathered plans for certain approved clinical trials;

- Initial phase of the Medicare Part D "donut hole" fix, which will completely eliminate the Medicare Part D coverage gap by 2020;

- Guaranteed availability and renewability of insured group health plans;

- Prohibition on preexisting condition exclusions; and

- Complete prohibition on annual dollar limits.

In addition, states will be required to have their health insurance exchanges up and running by 2014. The rules governing many of these mandates and the exchanges have not yet been drafted by the regulators. Thus, employers and plan sponsors should move carefully through the implementation phase of these mandates and continue to work closely with qualified advisors to attempt to make informed decisions that comply with applicable law.

What the Supreme Court's Ruling on Medicaid Eligibility Means

In 2014, the Act called for an expansion of Medicaid eligibility from incomes below 100% of the federal poverty level to incomes below 133% of the federal poverty level (in effect 138% of the federal poverty level due to an additional 5% income disregard provided under the Act). Under the Court's ruling, states may decide to forego the Act's Medicaid expansion provisions. If states do not expand Medicaid coverage, individuals who would have been eligible for Medicaid will now likely find coverage available under the Act's health insurance exchanges. In addition, these individuals could be eligible for federal subsidies for exchange-based coverage.

The impact of this on employers may be an increased exposure to shared responsibility payments under the Act's "pay-or-play" mandate for the following reasons. Under the "pay-or-play" mandate, employers are responsible for a shared responsibility payment if the employer either fails to offer group health plan coverage or offers coverage that fails to meet certain quality and affordability standards. In addition, the payment is imposed only if an employee receives a federal subsidy for, and enrolls in, coverage through a public health insurance exchange.

Therefore, in states that do not expand their Medicaid eligibility, the affected employees will potentially be eligible for a federal premium subsidy for exchange coverage. For example, an individual whose income puts him or her at 120% of the federal poverty level will not be eligible for Medicaid if his or her state declines to participate in the Act's Medicaid expansion. Such an individual may put his or her employer at risk for a shared responsibility payment under the "pay-or-play" mandate if the employer's plan fails certain quality and affordability standards (generally, if premiums for single coverage exceed 9.5% of the employee's household income or if the plan fails to provide at least a 60% "actuarial value") and the individual enrolls in coverage through a public health insurance exchange.

Proskauer is committed to working with its clients to monitor developments and to provide them with the latest, up-to-date information on new developments under the Act. Please contact your Proskauer lawyer or any member of our Health Care Reform Task Force should you have any questions regarding this or any other aspect of health care reform.

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[1] Consolidated before the Court were three cases challenging the Act: *Nat'l Fed. of Indep. Bus.* v. *Sebelius*, No. 11-393, *Dep't of Health & Human Servs. v. Florida*, No. 11-398, and *Florida v. Dep't of Health & Human Servs.*, No. 11-400.

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