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INSURANCE BRIEF

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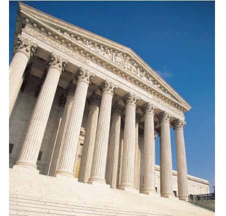
Supreme Court Decision



The Supreme Court of the United States (SCOTUS) heard oral arguments related to the constitutionality of the Patient Protection and Affordable Care Act (PPACA) on March 26—28th. On the first day the court heard arguments on whether or not the case should be heard, due to the Anti-injunction Act, before 2014 when the individual mandate will begin . SCOTUS ruled that the individual mandate's "shared responsibility payment" was a penalty, and not a tax, and therefore the Anti-Injunction Act is inapplicable.

The next session took up the question of whether Congress holds the constitutional power to require Americans to carry health insurance or pay a penalty, the "Individual Mandate." Here SCOTUS upheld the individual mandate based on Congress' taxing authority ruling that the payment was indeed a tax. Since the mandate was upheld the Justices did not address the issue of the severability clause. Because PPACA was upheld under the taxing authority, there was no need to address the Commerce Clause issue at all, and the general rule is that courts are not supposed to reach constitutional questions that they need not decide. Therefore, it is notable that the Chief Justice wrote extensively on this issue in his opinion, siding with the conservative Justices is stating that the law would not stand under the Commerce Clause.

SCOTUS struck down the law's provision tying a state's option to expand its Medicaid program with its right to continue to receive funding for its existing Medicaid program. The federal government may only withhold the extra Medicaid funds that would have covered the program's extension.

Impact: Other than the Medicaid provision, the decision has no impact on the rest of PPACA or the rules implementing PPACA. PPACA allows states to opt out of expanding their Medicaid programs. Those states that opt out will have an Exchange set up by the federal government. Through the Exchange individuals earning between 133% - 400% of the federal poverty level (FPL) are eligible for subsidized coverage. PPACA expected individuals with incomes under 133% FPL to receive coverage through the state Medicaid programs. States set their own income eligibility requirements. On average, state income requirements are only 33% FPL for an individual and 67% for a family. Therefore, the Court's ruling creates a potential gap in coverage for low income individuals.

The Politics: The Court exercised judicial restraint in its decision, sending a message to Congress that any changes to PPACA must be made by Congress. Politically, there are currently not enough votes in the Senate to pass a repeal of PPACA on July 11th, and

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Supreme Court Decision *cont'd*

in any event it would be vetoed by President Obama. The outcome of the November election could result in a change in control of Congress and/or the White House. Senate Minority Leader Mitch Connell says if opponents of the bill gain the majority in the Senate they will use the budget reconciliation process to repeal the bill. This process only requires a simple majority of 51 votes to succeed.

Under the Exchange provision, states have until January 1, 2013, to demonstrate to the Department of Health and Human Services (HHS) that the exchanges will be operational next year. If they do not meet this deadline, then HHS will step in and establish and operate the exchanges for the states. Republican Governor Scott Walker of Wisconsin has said that he will continue to delay implementing any part of PPACA while waiting for the election results. Only ten states and the District of Columbia have passed laws governing establishment of their insurance exchanges. (California is one of those states). Some are wondering whether this means that implementation will have to be delayed.

What's Next: The Court's decision certainly provided clarity in the near term. Employers must continue to prepare for the next provisions.

- Summary of Benefits and Coverage (SBC): Plan years on or after September 23, 2012.
- W-2 Reporting of health plan coverage: Employers with 250+ W-2 employees in 2011, include on 2012 W-2's.
- Comparative effectiveness research (CER) fees: plan/policy years ending after October 1, 2012.

The long-awaited guidance on the fully-insured discrimination provision is likely to be published this year, possibly going into effect in time to impact January 1, 2013 renewals.

The auto-enrollment provision is also pending guidance and is not expected to be implemented until January 1, 2014 at the earliest.

SML will continue to keep our clients up to date on any changes!

2013 HSA Limits

The IRS issued Revenue Procedure 2012-26 announcing the 2013 cost-of-living adjustments for HSA contribution limits and for high deductible health plan (HDHP) deductibles and out-of-pocket maximums.

The overall limits are the following:

- Maximum HSA Contribution: $3250 for individual, $6450 for families
- Minimum HDHP Deductible: $1250 self-only coverage, $2500 family coverage
- Out of Pocket Maximum: $6250 self-only coverage, $12500 family coverage

Comparative Effectiveness Research (CER) Fees

We initially reported on the comparative effectiveness research (CER) fees in our October 2011 issue of *Insurance Brief*. At that time what we knew was that the CER fee will be imposed on both health insurers and plan sponsors. If you have all fully-insured health plans then your insurer will be paying the fee. If you have a self-insured health plan then you are responsible for paying the fee. Exempt from the fee are "excepted benefits" as defined under HIPAA. These include stand-alone dental and vision as well as limited-purpose Sec. 125 FSA's, long-term care and expatriate plans.

Effective Date: The fee applies for each policy or plan year ending after October 1, 2012, but does not apply for policy or plan years ending before October 1, 2019. For example, a self-insured plan with a calendar plan year will pay the fee for plan years 2012 through 2018.

On April 12th the IRS issued proposed regulations that implement and provide guidance on the CER fees. These proposed regulations affect the issuers and plan sponsors that are directed to pay those fees.

Key Provisions

The Fee: For plans ending on or after October 1, 2012 (the first year), the fee is $1.00 multiplied by the number of lives (including spouses and dependents) covered under the plan during that year. For the second year, the fee will be $2.00 multiplied by the number of lives covered in the second year.

Calculating the Fee: For self-insured plans, plan sponsors may choose from three different methods. Once chosen, the plan sponsor must use only the one method for that reporting year. Here are the options:

Actual Count Method. Plan sponsors calculate the sum of lives covered for each day of the plan year and then divide that sum by the number of days in the year. This count includes employees plus dependents.
Snapshot Method. Plan sponsors calculate the sum of the lives covered on one or more dates in each quarter of the plan year and then divide that number by the number of dates used. Under this method, the plan sponsor can count the number of covered employees and multiply that number by 2.35 to obtain the spouse and dependents count.
The 5500 Method. By adding the total number of employee lives on the first day of the plan year to the total number of lives on the last day of the plan year as reported on the Form 5500 (without dividing by 2).

In the event the employer has a self-funded medical plan and a supplemental health reimbursement account (HRA) covering the same group, the fee will be payable on the self-funded medical plan. If the employer offers a self-funded medical plan to one class (e.g. management employees) and a self-funded HRA to non-management employees, then the fee would be based on the aggregate number of covered lives.

A return will generally cover policy years and plan years that end during the preceding calendar year. For example, a plan sponsor with a policy that has a policy year that ends on June 30, Policy A, may determine lives covered under Policy A for July 1, 2012 to June 30, 2013, using the actual count method, which will be reported on the Form 720, "Quarterly Federal Excise Tax Return," due by July 31, 2014.

Penalties: Since PPACA includes the fee payment under Section 4975 of the IRC, the fee is actually a tax. As such, failure to pay the fee when due may result in IRS late payment and other tax penalties.

What's Next: Plan sponsors who offer self-funded medical plans should review their workforce ebb and flow and then establish a methodology for calculating the number of lives covered for the plan year ending on or after October 1, 2012.

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1st Circuit Rules DOMA Unconstitutional

On June 5, 2012, the First Circuit found that the federal Defense of Marriage Act ("DOMA") is unconstitutional. (The three-judge panel, which issued a unanimous opinion, included two Republican appointees and one Democratic appointee.) The First Circuit has put a "hold" on enforcing the decision so that the parties may request Supreme Court review. DOMA's supporters have 90 days in which to seek Supreme Court review and they are widely expected to do so. Employers do not need to take any action at this time. However, this case should be watched carefully.

Background: Congress adopted DOMA in 1996. DOMA provides that for purposes of all federal legislation, "marriage" means the legal union of one man and one woman and the "spouse" means someone in such a marriage. DOMA does not invalidate same-gender marriages, but under DOMA, certain federal benefits can flow only to opposite-gender spouses. For example, the surviving spouse of an opposite-gender marriage can collect Social Security survivor benefits, but a surviving spouse of a same-gender marriage cannot. DOMA affects employee benefit plans because while DOMA is in place, employers are generally free to choose whether to offer benefits to same-gender spouses.

Ruling: The plaintiffs in this case argued that DOMA violated the Equal Protection Clause of the U.S. Constitution. The First Circuit agreed. The court considered each of the justifications offered by Congress for the law, but the court found that none were a sufficient basis for DOMA's "discrepant treatment" of a minority, particularly because marriage is a legal area usually regulated by the states. Anticipating that the parties will seek Supreme Court review, and believing that Supreme Court review of DOMA is "highly likely," the First Circuit will not enforce its ruling until further notice.

The court did not announce a federal constitutional right to same-gender marriage. Thus, the decision does not overturn state laws defining marriage as being between one man and one woman. The court was not asked to consider the provisions of DOMA that allow each state to define marriage for itself. Thus, one state need not recognize a same-gender marriage performed in another state.

What's Next: An employer's next steps will depend on how the Supreme Court handles a request for review.

- The Supreme Court may refuse to review the First Circuit decision. If this happens, the decision will become law in the First Circuit only (Maine, Massachusetts, New Hampshire, Rhode Island, and Puerto Rico). If a state in the First Circuit permits same-gender marriage (i.e., Massachusetts and New Hampshire), and if a company has employees in that state, and if the company's benefit plans include spousal benefits, the company will be required to offer its spousal benefits to spouses in same-gender marriages as well as those in opposite-gender marriages.

- The Supreme Court may hear the case and uphold the decision. If a company has employees in any state that permits same-gender marriage, and if the company's benefit plans include spousal benefits, the company will be required to offer its spousal benefits to spouses in same-gender marriages as well as those in opposite-gender marriages.

- The Supreme Court may hear the case and reverse the decision. The law now in effect will continue—a company generally will not be required to provide spousal benefits to spouses in same-gender marriages.