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Supreme Impact: The Decision and What it means for Employers, the Exchange and Health Reform Moving Forward

The Supreme Court decision handed down on June 28 (click here for a summary of the key decision points) provided both clarity and confusion in a legal parsing that filled nearly 200 pages; a little less than a quarter of the size of the pages that comprise the Affordable Care Act (ACA). The decision was not immune to the controversy and debate that has shrouded the health coverage reform law since long before it was even enacted. The Supreme Court, however, was not asked to weigh in on the merits of the law as a solution to this country's health access and affordability problems, but rather weigh in on whether the solution before it did indeed pass constitutional muster. Five of the nine justices concluded it did, not because Congress possessed the authority to force individuals to engage in commerce (purchase health insurance), but rather because Congress has the constitutional authority to tax and spend in order to "provide for . . . the general Welfare of the United States."

The decision to uphold the ACA was the modern day equivalent of a *Marbury vs. Madison*; exciting stuff for students of constitutional law and U.S. history, but cold comfort for those left to figure out how this all really falls into place in the end. Now that the ACA has dodged a sizable legal bullet, it now finds itself on politically shaky ground; ground zero for the battle over the White House in 2014.

In the meantime, employers, insurers, providers, consumers, states, and other stakeholders must prepare for the multitude of changes the ACA will bring to the health coverage system in 2014 regardless of who wins the November election.

Here is a look at some of the key issues that employers and other stakeholders should be aware of as the march towards 2014 continues:

The Health Insurance Exchange

One of the most discussed provisions of the ACA, particularly at the state level, is the health insurance exchange; a one-stop shop in which individuals and small businesses can purchase health insurance products and plans that best fit their needs. While the ACA never technically mandated states to establish their own health insurance exchanges, it did envision the states as the primary architects of such exchanges, incentivizing state exchange establishment through federal funding assistance and the threat of federal takeover in states that failed to establish their own.

The implementation of the exchange is perhaps the best evidence of just how complex and politically-charged the ACA is with the majority of states, including Illinois, falling short of meeting exchange establishment deadlines and facing a federally-facilitated or state-federal partnership exchange in 2014. Prior to the Supreme Court decision, Illinois was one of only 12 states (including DC) to take proactive steps towards establishing its own exchange; however, like many states, implementation efforts stalled in the face of the pending court decision.

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Now that the Supreme Court has given its constitutional blessing, Illinois will likely re-engage in efforts to create the Illinois Health Benefits Exchange, but not before the state enters into a federal partnership exchange for 2014. In order for the state to receive approval by the U.S. Department of Health and Human Services (HHS) to move forward with its own exchange, Illinois would have had to pass implementing legislation this past spring that defined how the exchange would be governed, how it would operate, and at the very least, acknowledged that the state's exchange had to be self-sustaining financially by 2015. In light of the pending Supreme Court decision and an upcoming election, the political perils of advancing exchange legislation – even in President Obama's home state –were too great, despite productive stakeholder negotiations to overcome differences on key exchange decision points. Illinois will therefore have to submit its exchange blueprint plan by the November 16, 2012 federal deadline requesting federal support for the implementation and operation of its exchange at least through the first year of operation.

Illinois, however, is not the only state taking this path towards introducing the exchange. Even states that were quick to lay the foundation for a state-level exchange have experienced delays in translating the legislative vision for their exchange into reality, as evidenced by the very few states that have actually received the federal grant for operation of their exchange through the first year. In fact, only two states - Rhode Island and Washington - of the 12 states that have made inroads towards a state-level exchange have actually qualified and received such funding. Since the Supreme Court ruling, several states have even publicly shunned any notion of establishing a state level exchange in the near or long-term future, meaning the federal exchange model will likely ending up serving a larger share of states that the federal government ever envisioned. Consequently Congress has appropriated insufficient federal funding to support such an extensive roll out.

Federal Exchange

The question of how all of this will work is a question that can be attached to virtually every provision of the ACA that is left on the implementation calendar for 2013 and beyond, but as states face imminent implementation of a state-federal partnership exchange (like Illinois) or a federally-facilitated exchange, few know exactly what these models will ultimately look like or how they will function. In the case of state-federal partnership and federally-facilitated exchange, however, another question looms that could perhaps attract further legal challenges and delays.

While the individual mandate has cleared the constitutional hurdle, which many believe is critical to any hope of keeping costs from exploding even higher and exchanges from faltering right out of the gate, questions still remain as to how the federal government will be able to reconcile what many have characterized as a glaring oversight in the law. The "glitch," highlighted in a Wall Street Journal opinion piece last November by Jonathan Adler, a professor of law and director of the Center for Business Law and Regulation at Case Western University and Michael Canon, director of health policy studies at the Cato Institute, is the law's silence in Section 1321 – the section regarding establishment of a federal exchange – on the use of premium tax credits.

Unlike Section 1311 – the section regarding establishment of state-level exchanges – Section 1321 says nothing about the ability of an individual's eligibility to qualify and apply a premium tax credits to purchase coverage on the exchange (individuals with incomes up to 400% of the federal poverty level qualify for these subsidies).

IRS regulations finalized in May attempted to "fix" the oversight, declaring that eligible individuals could indeed apply the credits towards purchase of a qualified health plan, whether it was offered on a state, regional, subsidiary, or federal exchange. Critics, however, including U.S. Senator Orrin Hatch- a ranking member of the Senate Finance Committee - continue to maintain that the IRS overstepped its constitutional bounds and cannot fix in regulation what is not authorized in the law, which opens the doors to litigation in states, like Illinois, that find itself with anything other than a state exchange.

The "glitch" has particular gravity for the employer community, as it is an employee's eligibility for and acceptance of a premium tax credit that triggers the employer "pay or play" penalty. If lawsuits attempt to block the use of premium tax credit in state-federal partnership and federally-facilitated exchanges because the law technically gave no authority for their use in such exchanges, then employers could be spared the penalties until the litigation either runs its course or the political tides turn one way or another.

Either way, it is a conundrum that relatively few have zeroed in on, but could have deep implications for employers, their employees, and other stakeholders in the state.

Essential Health Benefits

The exchange is also not the only thing states have been asked to decide upon under a constricted timeline. In December 2011, HHS announced it was handing the decision to define the Essential Health Benefits (EHB) package over to the states; a decision that many believed was a direct abdication of responsibility on an issue that was sure to generate a political firestorm among patient and disease advocate groups ahead of a major election. According to the ACA, all individual and small group plans sold both inside and outside of the exchange, including state Medicaid plans, will be required to offer an EHB by 2014 - a comprehensive package of items and services, including ambulatory and preventive care, mental/behavioral health, prescription, oral, and vision coverage, just to name a few.

Under the guidance issued by HHS, states must select a plan within their state to serve as the benchmark plan for that state's EHB; a selection that must be identified by the third quarter of this year. While many states, like Illinois, have laid the groundwork towards selecting their benchmark plan by way of surveys, assessment, and analysis of benchmark plan options, few states have formally established their benchmark plan to serve as the EHB. Illinois, like other states, will most likely have to grapple with the ongoing struggle to balance costs with coverage in the selection of its EHB and in order to avoid even greater sticker shock in 2014, may have to pull back on state health coverage mandates that elevate premium costs and are difficult to characterize as "essential."

In short, while much of the work towards implementing the ACA is not exactly foremost on the minds of employers and consumers, it has tremendous bearing on employer and consumer coverage decisions post-2014.

Employer Obligations

What is at the forefront, or should be, for employers is what preparations need to be made in advance of 2014 when individuals will be required to obtain health insurance either through the private market, public programs (Medicaid or Medicare), an employer-sponsored plan, or through the exchange. Additionally, employers with 50 or more employees will face new coverage obligations.

The ACA has already instituted coverage changes for many employer-sponsored plans that will remain intact in light of the Court's ruling, including the elimination of lifetime limits on essential health benefits, restrictions on annual limits, first-dollar coverage for certain preventive services, dependent coverage for adult children through the age of 26, and prohibition on reimbursement for over-the-counter medications under health savings accounts, Archer MSAs, or health flexible spending accounts.

Some of the biggest changes with the most direct impact on employers and their health plan offerings, however, are only several months away, including:

- The required distribution of uniform summaries of benefits and coverage explanations prior to enrollment and re-enrollment (September 2012);
- Restricting contributions to flexible spending accounts for medical expenses to $2,500 a year (January 1, 2013);
- Increasing Medicare Part A tax rate on wages by 0.9% (January 1, 2013);
- Eliminating the employer tax-deduction for Medicare Part D retiree drug subsidy payments (January 1, 2013);
- Requiring public and private employers who filed more than 250 W-2s in the previous tax year to report cost of coverage for group health benefits, including some non-traditional plans, such as on-site medical clinics and mini-medical plans, on W-2s (January 1, 2013.) *(Employers with 250 or less will have to begin this reporting in 2014)*; and
- Increasing the threshold for itemized deduction for unreimbursed medical expenses from 7.5% to 10% of adjusted gross income (January 1, 2013).

In the meantime, employers of all sizes should be looking to the fall of 2013 and 2014 with a strong degree of planning and preparation. For the most part, large and jumbo-size employers will be mostly untouched by the marketplace changes that will occur at that time, but will face other changes including new plan non-discrimination requirements for highly-compensated employees and a new employee automatic enrollment requirements in the group's health plan coverage (employers with more than 200 employees.) Large employers will also likely be focused on cutting plan costs to avoid the massive tax hit high-cost plans or "Cadillac" plans could face in 2018.

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For mid-size and small employers, 2014 could bear a lot of change, not only for employer benefit offerings, but also for business operation costs, employee hiring decisions, and business models in general.

Under the ACA, employers with fewer than 50 employees are exempt from coverage requirements, leaving them free to either maintain their current health insurance plan, purchase a plan on the small group health insurance exchange, or let their employees make their own decisions about their coverage (i.e., purchase health insurance on the individual exchange market, the non-exchange market, or simply pay the penalty.) Employers with at least 50 employees, however, are not as fortunate because the ACA requires these employers, beginning in 2014, to provide coverage that is "affordable" for full-time employees or risk a financial penalty.

The "shared responsibility" provisions for these employers is, to say the least, a complex set of criteria and requirements that have yet to be fully fleshed out by the IRS. Employers with at least 50 employees are technically not mandated to provide coverage or even "affordable" coverage, but if they do not, they may find themselves facing a penalty if one or more of their full-time employees qualifies for, and takes advantage of, a federal premium tax credit to purchase a qualified health plan on the individual exchange market (part-time employees do count towards determining employer size, but not for the purposes of determining employer coverage obligations.)

The ACA defines "affordable" coverage as covering at least 60% of medical costs and not extracting an employee contribution towards the price of that coverage in excess of 9.5% of that employee's household income. The reference to "household income" as one of the measuring sticks for affordability has already caused a great deal of consternation because employers have no way of knowing, nor do they want to know, the status of an employee's household income.

The employer shared responsibility provisions also raise a complicated set of questions surrounding how employers are expected to define a full-time employee for the purposes of the coverage mandate. The law defines full-time employees or full-time equivalent employees as employees that work at least 30 hours a week for at least one week per month. The ACA's treatment of full-time equivalent employees is highly problematic, potentially forcing many employers to furnish coverage for employees for whom they typically do not offer coverage; employees that could very well qualify for a federal premium tax subsidy that ends up sticking employers with higher penalties for lack of "affordable coverage."

The IRS has been at work on these very issues for the past year, issuing several notices seeking comments on how to make these provisions more flexible and realistic for the employer community, but with a little less than 18 months out from the effective date of these requirements, the agency has yet to capture all of this into formal proposed regulations. Many groups, like the Illinois Chamber and the US Chamber, have been pleading for maximum regulatory flexibility in the application of these provisions, including allowing employers a full year of "look back" to determine whether an employee's

hours worked on average meet the full-time equivalent criteria, tying the affordability test to an employee's W-2 wages as opposed to household income, and even granting a delay in the implementation of these provisions altogether to give employers more time to prepare for the confusing myriad of changes.

In the meantime, the decisions and determinations that affect employers with 50 or more employees extend well beyond simply making sense of the employer-shared responsibility provisions of the law. Employers will be forced to look at their coverage options and the demographics of their workforce in ways they perhaps never have, exploring tough decisions that range from dropping benefits altogether to holding on to current coverage at the cost of increased cost-sharing (which could put an otherwise affordable plan in danger of becoming unaffordable in the eyes of the IRS) or perhaps transitioning out of a fully-insured plan into a self-insured plan.

This list is by no means exhaustive, but representative of the kinds of questions employers should be asking themselves now. For instance, for those employers with a relatively large population of lower wage employees, many of which may qualify for a premium tax subsidy, the benefits and costs of continuing to provide employer-sponsored coverage may not outweigh the cost of the shared responsibility penalties. But for those employers in a more competitive industry with a need to attract a more highly skilled and highly paid workforce that is unlikely to qualify *en masse* for a premium tax credit, the costs of dropping coverage and simply paying the penalty, while probably less than the overall cost of continuing to provide an employer-sponsored plan, may not outweigh the benefits of maintaining coverage to remain attractive to employees that ultimately contribute to an employer's competitive edge.

Ultimately, employer response to the 2014 changes and responsibilities will likely be evolutionary, with many waiting to see how well the exchanges operate and how satisfied consumers are with the coverage they can purchase and the services they can access. If exchanges flounder and individuals are unhappy with their options, the advantages of employing a distracted workforce that is constantly distressed by their health coverage options and access to health services are likely few and far between.

Communications with employees are, therefore, more important than ever. The ACA obligates employers to inform employees about the exchange and their coverage options post-2014, including their potential to qualify for and receive a premium tax credit. Communications, however, should begin now to educate and prepare employees for the onslaught of changes that could very well impact how the employer decides to structure its benefit plan in the near future.

The Persistent Questions over Costs

The Supreme Court decision did much answer the concerns that the individual mandate was not a breach of constitutional authority, but has done very little to allay ongoing concerns that the health reform law, while going along way towards improving access, will do very little to reel in inflating

healthcare costs. In fact, actuaries for the U.S. Centers for Medicare and Medicaid Services (CMS) have predicted that costs will increase dramatically between 2013 and 2016 under the ACA over what the cost trend would have been without the ACA.

CMS actuaries, however, do predict that costs under the ACA will stabilize between 2016 and 2017 and perhaps even dip below the cost trends that are predicted without the ACA. By 2021, cost trends will be only very slightly lower than they would have been without the ACA, increasing on average 6.5% over the previous year, as opposed to 6.6%.

The reasons for this are numerous but for the sake of brevity; there are two worth discussing because of their direct impact on employers. The first of these cost inflators is the new tax on insurance companies that will take effect in 2014; a tax that will inevitably be passed along in the form of higher premiums to employers and their employees.

The second cost pressure is slightly more complex and highlights one of the many contradictions this law advances; that is, how we reconcile individual health behavior and risk with the realities of the marketplace and how we reward or penalize that behavior.

The individual mandate is undoubtedly central to the overall integrity of the law, but there are still many questions as to whether it will truly drive healthy individuals who might otherwise abstain from the purchase of health coverage to actually purchase health insurance; healthy individuals who are considered important to the overall health risk equation. The overarching concern is that exchanges could become a dumping ground for the unhealthy - the high risk population that ultimately drives up costs and strains the system.

While the law provides for certain mechanisms at both the state and federal level to help with “risk smoothing” to prevent health insurance companies from drowning under the bad risk, there are provisions in the ACA that will almost inevitably work against one another.

In 2014, when individuals will be required to purchase health insurance, health insurance companies will also be required to guarantee issuance; that is to say they are no longer allowed to discriminate on the basis of an individual’s “pre-existing condition.” This means that insurance companies are also prohibited from considering an individual’s health status in their underwriting practices. In fact, the only factors that can be considered in health insurance underwriting is geography, family composition, tobacco use and age- young healthy individuals can only pay three times less than older, higher-risk individuals.

This is not to suggest that the elimination of the pre-existing condition barrier is not a positive development within the law. It is an integral component to how we address access to health insurance, but it also raises legitimate questions about whether placing such extreme restrictions on health risk considerations in underwriting practices is sending a counterproductive message that personal

investment in one's own healthcare needs and behaviors is not as important as having access to insurance for insurance's sake.

In other words, the delicate balance that has always existed in our health coverage system where the healthier, lower risk individuals subsidize – albeit somewhat indirectly – the unhealthier, higher risk individuals just became much more direct and tilted in favor of the unhealthy risk with very few incentives in place to restore that delicate balance. It is somewhat akin to eliminating all risk factors, such as age, driver experience (traffic violations and accident rates), and other vehicle considerations, from car insurance underwriting practices, giving individuals less incentive to be careful, responsible drivers.

At the same time, insurers, who will be absorbing greater costs- both through the risk they must assume and the taxes they incur – will be asked to keep annual premium increases below 10%. If they fail to do that, they trigger a rate review mechanism that requires them to, at the very least, justify such increases. Analysts are already predicting that the onslaught of changes with regard to rating practices and other provisions could force premiums well north of 15% making it difficult to reconcile reality with what the law dictates.

Ultimately, it translates into extreme sticker shock for those that may have otherwise thought the ACA would achieve some level of "affordability" and particularly for those employers that have worked so hard to keep their population healthy and low-risk.

Conclusion

The bottom line is that the ACA makes it all the more important for the conversation around health reform to change. The discussion to date has been largely focused on ACA compliance and the politics and legal clouds that have and will continue to shroud the law; however, the Supreme Court decision made one thing clear: the ACA is not going away any time soon, so we must proceed with implementation. .

It is therefore incumbent upon employers and other stakeholders to re-center the discussion and begin to focus on how we address the cost drivers that the ACA cannot and will not address. The "shared responsibility" of the ACA should extend well beyond simply making a consumer or business decision at the risk of a financial penalty. Simply tying "responsibility" to finances is glazing over the bigger problem: the fact that our nation's prevalence of chronic, treatable conditions is increasing at an unsustainable rate.

Employers have made tremendous strides in finding ways to encourage their employees to make bigger investments in their own health and well-being. The need to continue this trend is becoming more imperative at a time it is also becoming much more difficult to do in light of ACA compliance issues and increasing insurance costs.

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The ACA did, however, advance health prevention measures that states like Illinois are taking advantage of and organizations like the Illinois Chamber of Commerce are working to support, such as worksite wellness and other community health and prevention initiatives.

The Illinois Chamber and its Healthcare Council remain committed to ongoing efforts to elevate the employer voice throughout implementation of the ACA and to ensure that the focus of the health reform law does not lose site of the realities of our nation's health status for it is as much about injecting sustainability into our future healthcare costs as it is about fostering a healthy, productive and vibrant workforce now and for generations to come.

If you are interested in joining or learning more about the Chamber's Healthcare Council, please contact Laura Minzer at lminzer@ilchamber.org.

If you are interested in learning more about the Supreme Court decision and what it means for employers and compliance issues moving forward, click here to register an upcoming webinar hosted by SmithAmundsen on July 19 at 2:30 pm.