Special Report:
Immediate Health Reform Implementation Steps
*A Blueprint for Employer Plans*
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I. Introduction

Health reform imposes new roles and duties on employers, including new taxes, paperwork, notification requirements and benefit design features.

Because all the law’s elements affecting employers and insurers were upheld in the U.S. Supreme Court ruling June 28 (excepting the reversal of the law’s Medicaid provisions against non-complying states), employers must ensure that they meet the law’s deadlines, or they can face fines and penalties.

Some plans are trying to achieve full compliance. Others are considering whether to hold off changes in order to achieve grandfather status (allowing them to avoid some reform mandates). Still others may drop coverage altogether and pay a per-employee tax penalty for not offering coverage.

Many plans have been implementing reform rules for the last year and a half, including: health coverage for adult children, no rescissions of coverage except in cases of fraud or misrepresentation and phasing out annual and lifetime dollar limits on essential benefits.

Now plans must address a host of other requirements, including: (1) developing and distributing summaries of benefits and coverage; (2) changing reimbursement for tax-advantaged health accounts and arrangements; (3) reporting the cost of group health insurance coverage to the IRS and participants; (4) paying more to fund Medicare; and (5) reporting to the IRS everything it needs to prove your plan is at least minimum value and covers essential benefits.

This report explains the next steps an employer must take in implementing the reform rules.
II. Immediate Reform Implementation
Is Revenue-reporting and Tax-related

By Todd Leeuwenburgh

With the Supreme Court’s June 28 ruling affirming health reform, its legal requirements on employer health plans in complete effect. Plans therefore continue to face important requirements this calendar year. Fortunately, they’re the same ones employers have known about for some time. But if an employer has been holding off from comprehensive implementation, a reminder of the most important reform requirements with looming adoption dates should help.

Many duties are related to new taxation and oversight by the IRS (for example, estimating the value of coverage and reporting it to the IRS, and demonstrating that health plans have sufficient value and cover “essential health benefits”).

One requirement employers cannot fail to meet is developing a new four-page summary of benefits and coverage and distributing it to participants when they enroll for the first time or re-enroll. This starts for plan years on or after Sept. 23, 2012. Basis: 77 Fed. Reg. 8668 (Feb. 14, 2012).

The second important requirement employers will not get away without addressing is reporting amounts spent on health coverage on W-2 forms. Employers must begin reporting the value of health coverage as an information item (but not a taxable income item) on employees’ W-2 forms at the end of the year. The IRS delayed mandatory compliance to the 2012 tax year. (See the next article, by attorneys Todd Solomon and Brian J. Tiemann for more details about the SBC and W-2 reporting.)

Determining Whether Coverage Is Minimum-Value

Notice 2012-31 issued by the IRS on April 26, 2012, calls for comment from the public in determining what kind of strategy it will recognize when plans present evidence that their coverage meets or exceeds coverage norms set by the government. It says it prefers to choose from among these three:

1) an actuarial value calculator (AV calculator) to be provided by the agencies;

2) design-based questionnaires and checklists that would certify that a plan passes muster without actuarial calculations; or

3) certification from an actuary when a plan’s features escape measurement by either of the first two methods.

On Feb. 24, 2012, HHS issued an actuarial value bulletin describing the assumptions and methodology that HHS anticipates will govern the calculation of actuarial value.

Here is a link to the IRS page with the latest guidance on IRS’ revenue reporting and tax-assessment provisions.
Written Notice of an Exchange

All employers covered by the health reform law have to give employees written notice of an health insurance exchange, for all new hires starting March 1, 2013, and for all existing employees on or by that date. Exchange notices must provide written information:

- that an exchange exists, including a description of the services provided by the exchange and contact information to request assistance;
- that if the employer plan’s share of the total allowed costs of plan benefits is less than 60 percent of the costs, then the employee may be eligible for a premium tax credit and a cost-sharing reduction if the employee gets coverage through the exchange; and
- that if the employee purchases coverage through the exchange, he or she may lose the employer contribution to employer-sponsored coverage and there might be tax implications for the employee in that case.

Limits on Health FSAs

The IRS halved the limit on pre-tax dollars — from $5,000 to $2,500 per year — that employees may set aside from their salaries to pay for qualified medical expenses through health flexible spending arrangements. The $2,500 limit takes effect plan years beginning in 2013.

The $2,500 limit will increase with inflation. Employers may upwardly adjust the limit in line with the consumer price index (in $50 increments) for tax years beginning after Dec. 31, 2013.

The IRS on May 30 issued Notice 2012-40, which extends the deadline by which plan documents must be amended for the new limits until Dec. 31, 2014, and describes other ways that health reform will affect FSAs.

Distributing Insurer Rebates under Medical Loss Ratio Rules

Employers that sponsor health plans might get rebates from their group health insurers thanks to reform’s medical loss ratio rules, but if they do, they are required to pass the proper amount of the rebate on to employees.

Under the MLR rule (mandated by the reform law), health insurers must spend a minimum percentage (80 percent for individual and small-group policies and 85 percent for large-group accounts) of the dollars they collect through premiums on actual medical services (and less on administrative costs). The final rule was published in the Dec. 7 Federal Register. Plans receiving these rebates will need to determine the proper allocation for the rebates based on detailed guidance in U.S. Department of Labor Technical Release No. 2011-04.

If an insurer fails to meet the ratios, it must issue rebates directly to the plan sponsor. The plan sponsor in turn must divide the rebate up and use the portion of the rebate attributable to the amount of premium paid by subscribers “for the benefit of subscribers.” Choices include premium reductions in the subsequent year and direct cash refunds. Here’s a link to an HHS fact sheet on the MLR rules.
Coverage Mandates for Plans and Insurers Stay

The reform mandates for insurers still stand. These include:

- the phase-out of pre-existing condition exclusions and annual and lifetime dollar limits on coverage;
- the requirement for plans that cover dependents to cover them until age 26;
- the ban on rescinding coverage except for fraud or intentional misrepresentation; and
- new enhanced claims and appeals review procedures.

Play-or-pay Questions Will be Asked

The biggest analysis employers will be asking is about whether to “play or pay.” Employer penalties for not providing coverage may turn out to be less costly than actually providing coverage (particularly if health costs continue to rise as they have in the last 15 years). If that is the case, employers may choose to pay the penalties and stop providing insurance to workers.

Once employers finish assessing the value of their plans as per IRS rules, they then can move on to considering whether to:

- drop plans or options;
- keep plans the way they are even if it exposes them to new taxes; or
- make only those changes necessary to comply with the law’s new provisions.

III. Health Reform Law Moves Employer Focus To New Processes, Reporting and Taxes

By Todd A. Solomon and Brian J. Tiemann

The survival of the health reform law means that employers must move forward amending key tax, reporting and paperwork elements of health plans. According to attorneys Todd Solomon and Brian Tiemann with McDermott Will & Emery in Washington, D.C., employers must come up to speed on new claims and appeal processes, rules on reporting plan changes to participants, and new taxes and fees on health plans.

Next Steps for Employers

Many plan sponsors have already taken action to amend their benefit plans to implement changes required by the health reform law in 2010 and 2011. Now that the law has been upheld by the Supreme Court, plan sponsors must implement these reform requirements for 2012:

- **Claims and Appeals.** Group health plans must establish internal and external review procedures consistent with standards described in federal rules. Beginning on or after Sept. 23, 2010, group health plans must have an internal appeals process that complies with the reform law. The definition of an “adverse benefit determination” expanded in June 24, 2011 U.S. DOL rules on claims procedures to include rescissions of coverage and eligibility determinations. For plans with two levels of appeal, the second-level appeal results in a “final internal adverse benefit determination” that triggers the right to external review. Claimants can appeal certain types of claims to an independent review organization. An IRO performs independent external reviews of adverse benefit determinations and final internal adverse benefit determinations under state or federal external review procedures. Group health plans were required to contract with at least two IROs by Jan. 1, 2012 and with at least three IROs by July 1, 2012, however many insurers and/or third-party administrators are offering this service to their customers. This rule does not apply to grandfathered plans.

- **Employer W-2 Reporting.** Employers are required to report the value of group health plan benefits on the employee’s annual Form W-2 beginning with the 2012 taxable year (the W-2 due in January 2013). The value of the coverage is calculated similar to the COBRA premium. Certain exceptions apply. No reporting is required for excepted benefits (such as standalone dental and vision), or most health FSAs, health reimbursement arrangements and health savings accounts and on-site clinics, employee assistance programs or wellness programs where the employer does not charge a COBRA-like rate for access.

All employers that provide “applicable employer-sponsored coverage” during a calendar year are subject to the requirement. This includes federal, state and local government entities, churches and other religious organizations, and employers that are not subject to the COBRA continuation coverage requirements. On April 26, 2012, IRS issued Notices 2012-32 and 2012-33, which invited comments to help inform the development of guidance on annual information reporting related to health insurance coverage.
• **Summary of Benefits Coverage.** Health plans must distribute a Uniform Summary of Benefits Coverage to all plan participants. The SBC is required to describe each benefit coverage option, cost-sharing, exclusions and limitations, provider information, formulary information, etc. Changes to the SBC must be communicated to participants 60 days in advance of the effective date of the change. If a group health plan willfully fails to provide the SBC to participants, it may be subject to a fine of up to $1,000 for each failure and applicable excise tax reporting requirements. An SBC is not required to be provided for plans, policies or benefit packages that are excepted benefits, such as stand-alone dental or vision plans, and certain health FSAs or HSAs. However, an SBC does need to be provided for an HRA. SBCs must be provided to participants and beneficiaries beginning on the first day of the first open enrollment period that begins on or after Sept. 23, 2012 (the first day of the plan year beginning on or after Sept. 23, 2012, for those participants and beneficiaries who do not enroll in coverage through an open enrollment period, including individuals who are newly eligible for coverage or who are eligible for special enrollment under the tax Code). SBCs are to be distributed by insurers to health plan sponsors and by health plan sponsors to participants and beneficiaries. Only in the case of individual policies are they required to be distributed to dependents. HHS has released a “coverage example calculator” that group health plans and insurers can use as a safe harbor for the first year of applicability to complete the coverage examples in a streamlined fashion. This and other “informational links” now available for completing the SBC are compiled in a June 26 memorandum from HHS’ Center for Consumer Information and Insurance Oversight.

• **Material Modification.** If a group health plan makes any material modification to the terms of the plan or coverage, and the modification is not reflected in the most recently provided summary of benefits and coverage, the plan must provide notice of the modification no more than 60 days before the day the modification takes effect. An earlier version of the rule would have allowed notice to take place within 60 days before or after adoption of the modification or change.

• **Comparative Effectiveness Research Fee.** For plan years beginning after Sept. 30, 2012 through 2013, self-insured health plans and fully insured health plans (through the insurer) will be assessed a $1 per participant fee to fund research regarding patient centered outcomes for medical treatment. The fee increases to $2 per participant for subsequent years through plan years ending on or before Sept. 30, 2019. The IRS in the April 17, 2012 Federal Register issued proposed regulations on the fee.

• **Quality-of-care Reporting.** HHS will develop reporting requirements for all non-grandfathered health plans regarding quality of care. The purpose is to improve health outcomes through quality reporting, effective case management, chronic disease management and medication and care compliance, prevent hospital readmissions, improve patient safety and care and implement wellness programs.

Plan sponsors should begin to prepare for these changes soon, because careful planning will be required to ensure compliance with the reform requirements for 2012.
Todd A. Solomon is a partner in the Employee Benefits Practice Group of McDermott Will & Emery’s Chicago office. He is the author of the third, fourth, fifth, sixth and seventh editions of Thompson Publishing Group’s Domestic Partner Benefits: An Employer’s Guide, and was the co-author of the book’s first and second editions. He also is a contributing editor of Thompson’s Employer’s Handbook: Complying With IRS Employee Benefit Rules.

Brian J. Tiemann is a member of the Employee Benefits Practice Group in the Chicago office of McDermott Will & Emery.
IV. How to Move Forward in Complying With Reform

By Rich Glass, JD, Chief Compliance Officer, Infinisource, Inc.

Regardless of how you feel about the Supreme Court’s recent health reform decision, the ruling is in the rear view mirror. The reality is that many employers will need to shift from “park” or “neutral” into “drive.”

How should employers — particularly small and medium ones — navigate the traffic in complying with the health reform law? Here are four areas on which to focus:

- **Think Before You Talk.** Your employees are probably wondering how the High Court’s opinion affects them. What will you tell them? How much employee input will you seek in making future decisions related to health coverage? Employers need to develop and implement an employee communication strategy that goes beyond just the next open enrollment.

- **Return to School.** At least one of your employees needs to become a student of the health reform law, even if you are a small employer. This person should be familiar with the primary moving parts and deadlines. Certainly, insurance professionals, third-party administrators and other experts can help. Employers need to know about, but not be experts on, the law.

- **Decide Whether You Need to Hit “Reset.”** In 2014, employers with the equivalent of 50 or more full-time employees will have to provide coverage of minimum value at an affordable cost. If they do not, they will pay a significant penalty. This is known as “pay-or-play” and may represent the biggest health care decision facing small to mid-sized employers in 2014. Employers need to analyze the costs and benefits of paying or playing.

- **Shop Around.** Some employers are going to have to hit the reset button on their benefits approach. Consider new alternatives. If you haven’t done so already, it may be time to take a test drive on some consumer-driven plans like health savings accounts and health reimbursement arrangements. They are proven to help control costs and are not subject to use-or-lose. In 2014, insurance exchanges will be available in most states. More than $12 million in federal grants to start exchanges have already gone out to states. Through the Small Business Health Options Program, employers with up to 100 employees can obtain coverage through the exchange. Employers need to examine all alternatives to find the best solution.

The above four priorities may include destinations that seem just beyond the horizon in 2014. Until then, here are some road signs with which to comply:

- **Just the Facts.** As noted elsewhere in this report, employers must finalize summaries of benefits and coverage for affected plans starting with enrollment periods starting on or after Sept. 23, 2012. For HRAs that are bundled with a medical plan, you must show the effects of HRA coverage on the SBC. Stand-alone HRAs must have their own SBC.

- **Know Your Limits.** For plan years starting in 2013, health FSAs have a $2,500 salary reduction contribution limit. Plan documents and summary plan descriptions must be revised.
• **True to Form.** Many employers must now report the cost of health coverage on Form W-2, starting with the 2012 tax year. Employers that filed fewer than 250 W-2s for the 2011 tax year are currently exempt until the IRS indicates otherwise. Remember that HRAs and HSAs are exempt from the requirement. Health FSAs, funded solely through salary reduction contributions, are also exempt, but the any excess contributions (for example, flex credits, employer matching or seed contributions) must be reported.

• **Money Back from Insurers.** Insurance companies were supposed to send the first medical loss ratio rebates or a standard notice that no rebates were forthcoming no later than Aug. 1, 2012. Employers will likely receive the checks, but the rules require employers to share those amounts with participants. Estimates say 13 million Americans may be entitled to some form of refund. The no-rebate notices must be prominently displayed on the front of the plan document. Alternatively, they may be provided as a stand-alone document, according to December 2011 final rules from HHS. Employers must furnish them with the first plan document provided to enrollees on or after July 1, 2012. For most plans, that will be the next open enrollment. Employers may provide it electronically.

• **Financial Rewards for Covering Health.** Small employer tax credits are still available when companies with fewer than 25 employees offer health coverage. Currently, the credit is worth up to 35 percent of the employer contribution, 25 percent for non-profit organizations. In 2014, those credits increase to 50 and 35 percent, respectively.

• **Higher Medicare Taxes.** Starting in 2013, employers must withhold an additional 0.9-percent FICA tax on wages above $200,000. Also, there is an additional 3.8-percent FICA tax on unearned income for high income taxpayers.

• **Playing Fair.** Don’t forget that we are still awaiting guidance on nondiscrimination testing for fully insured plans. The compliance deadline was suspended by Notice 2011-1.

• **2014 — A Benefit Odyssey.** This year promises to offer more change in health benefits than any single year in the history of our country. Here are a few of the changes that will take effect:
  o Automatic enrollment for employers with 200 or more full-time employees
  o Maximum 90-day waiting period for health plans
  o Wellness rewards can increase to 30 percent of the cost of health coverage (HHS can increase to 50 percent)
  o Affordable insurance exchanges and the SHOPs
  o Employer certification to HHS of whether the group health plan is “minimum essential coverage”
  o Plan coverage for certain approved clinical trials
  o Guaranteed availability/renewability of insured group and individual health plans
  o No premium discrimination based on gender


**Rich Glass** is Chief Compliance Officer for Infinisource, Inc. He is a licensed attorney and brings more than 19 years of legal expertise, specializing in benefits, human resources and related
regulatory compliance. He is a member of the Health Plan Advisory Panel at Thompson Publishing Group and Contributing Editor of Thompson’s Flex Plan Handbook. He is a frequent speaker and author on various benefits, employment law and compliance issues.
V. What Employers Need to Do Next to Comply

By Tonie Bitseff and Thomas McCord

Now that the U.S. Supreme Court has upheld the constitutionality of federal health reform, employers need to focus on the next steps they need to take to implement this far-reaching legislation. Many aspects of the legislation are only now becoming effective.

SBCs: Self-funded Plans Are Responsible

Employers are preparing to issue a new uniform four-page summary of benefits and coverage to all participants and beneficiaries with the 2013 open enrollment materials. In doing so:

1) Employers with insured plan options should contact their insurance carriers, which will provide the SBCs for insured options.

2) But for self-funded options, employers will be responsible for producing the SBCs. Sponsors of self-funded plans may also need assistance from their third-party administrators or other service providers.

Templates and instructions are available online from the U.S. Department of Labor (scroll to the section marked Templates, Instructions, and Related Material).

Health FSAs: Communication Is Key

Beginning in 2013, health flexible spending accounts benefits must be limited to $2,500 a year. Many employers have plan limitations in excess of this amount and will need to reduce the maximum annual contribution to comply with the new limit. Employers that have already imposed caps below $2,500 on health FSA contributions, perhaps in order to control liability associated with employees who leave employment in the middle of the plan year, will be able to retain these more restrictive limits. Communications to employees will need to highlight the differences between the unchanged dependent care FSA limits, which generally apply to both spouses on a calendar year basis, and the new health FSA limits, which apply on an employee-by-employee basis to the plan year. This change will probably not significantly impact FSA nondiscrimination testing because the contribution limits for dependent care FSA, which are subject to the more problematic nondiscrimination tests, remain unchanged.

Regarding the W-2 reporting requirement, note that the value of the employee’s health coverage will be reported on Box 12 of the W-2, with the Code DD. Also remember that individual account plans such as FSAs and HSAs are exempt, and reporting is not required for mid-year requests. IRS Notice 2011-28 provides guidance, and employers need to be working with their payroll departments on this implementation.

Guidance Awaited: Preventive Care, Individual Privacy

Existing rules, such as preventative care coverage and HIPAA privacy rules, are the subject of ongoing updates and guidance. New HIPAA privacy protocols were recently issued providing detailed guidance on individual privacy rights. Specific guidelines for women’s preventative care have also been issued and will go into effect for plan years beginning on or after Aug. 1, 2012.
Fees, Taxes, Auto-enrollment and Testing

Employers also will be required to make several changes in 2013 and 2014 and should be on the lookout for future guidance that addresses the following:

- The requirement that employers withhold a new increased Medicare payroll tax on individuals making $200,000 a year or couples making $250,000 (but employer payroll taxes are not increased).
- New nondiscrimination eligibility and benefits testing for insured plans.
- A requirement that employers with more than 200 employees automatically enroll employees into the employer’s health plan unless an employee affirmatively opts out.
- A new fee on plans for covered beneficiaries. As mentioned earlier, insurers and self-insured plans must pay $1 per covered beneficiary for plan years starting after Oct. 1, 2012, and $2 per covered beneficiary per year until 2018.

The Ultimate Decision: Play or Pay

But by far the most significant component of the law for employers is the so-called “play or pay” provision that becomes effective Jan. 1, 2014, for employers with at least 50 full-time equivalent employees. These employers will be required to pay a penalty if they do not offer certain specified minimum levels of health coverage or offer this coverage through a plan that either:

- does not cover 60 percent of the cost of benefits or
- requires an employee premium that exceeds 9.5 percent of the employee’s household income.

Many of the necessary calculations, including determining household income and “full-time equivalence” await additional clarification. The penalty will range from $2,000 to $3,000 per employee, but there are rules that allow employers to disregard the first 30 employees and allow the employer to pay the penalty only for employees receiving credits or subsidies through an exchange as long as the specified minimum level of health coverage is offered by the employer. Employers subject to the “play or pay” mandate will need to consider whether design changes to their health benefit plans will be necessary to avoid the penalty and to evaluate the relative costs of these changes versus paying the penalty.

Banking on Repeal Now Would Be Imprudent

Some employers may be tempted to wait for the outcome of the November elections before reviving their preparations for implementing health care reform. But in light of the timing and scope of the steps that need to be taken, prudent employers will begin now to act to meet the upcoming compliance deadlines.

Tonie Bitseff and Thomas McCord are members of Nixon Peabody LLP’s Labor & Employment practice group. Both are experienced ERISA lawyers. Ms. Bitseff is a leading authority on HIPAA, COBRA and health plan compliance. Mr. McCord specializes in employee stock ownership plans, flexible benefit programs and executive compensation arrangements.
VI. Time to Focus on SBC, HIPAA Transaction Sets

By David Slaughter

The impending requirement to provide a concise summary of benefits and coverage looms large as employers and other plan sponsors refocus on immediate compliance in the wake of the U.S. Supreme Court’s 5-4 decision to uphold health reform.

Federal regulators recently provided a coverage calculator and other resources for completing the SBC’s coverage examples. The SBC must be distributed as early as this fall during open enrollment. The SBC’s complexity and lack of clarity have vexed plan sponsors, especially self-funded ones. For more information on the SBC, see the June 26 memorandum from HHS.

In addition to the SBC and the various coverage mandates, the Supreme Court’s reform decision also means that the law’s changes to HIPAA’s electronic transaction standards remain in effect. The law directed HHS to issue new uniform “operating rules” for each transaction, and will require plan sponsors or administrators to certify compliance with the standards and operating rules, or face potentially substantial penalties.

Other health reform provisions requiring prompt attention, according to Joanne Hustead of The Segal Company, include:

- ensuring that any reimbursements received under the early retiree reinsurance program are properly spent and accounted for;
- distributing any rebates received from insurers under the medical loss ratio rules; and
- continuing to assess the plan’s grandfathered status and act accordingly.

Non-grandfathered plans face other mandates such as preventive and emergency care, and elaborate new procedures for claim appeals and external review.

The health reform law was upheld in a 5-4 decision on June 28 by the U.S. Supreme Court, which concluded that the controversial individual mandate is a tax and therefore falls under congressional authority in the Taxing Clause of the U.S. Constitution. However, the mandate was found unconstitutional under congressional authority to regulate commerce.

The majority opinion by Chief Justice John Roberts explained that the individual mandate is not a legal command to buy insurance. Rather, it makes going without insurance just another thing that the federal government taxes, “like buying gasoline or earning income.” He added that it is not unusual for the government to assess taxes to influence conduct, for example, such as federal and state taxes that are assessed on cigarettes in order to get people to quit smoking.

Because the Court deemed the “penalty” in the individual mandate as a “tax” that Congress has the right to assess under its taxing authority, it refused to strike down the individual mandate. Regarding other constitutionality arguments, the Court found that:

1) The individual mandate was unconstitutional under the Commerce Clause, because the mandate does not regulate existing commercial activity. Instead it compels individuals to become active in commerce by buying a health policy, on the ground that their failure to do so affects interstate commerce. However, Supreme Court precedent has “never permitted Congress to anticipate” an activity in order to regulate individuals not currently engaged in commerce.

2) The individual mandate could not be sustained under the Necessary and Proper Clause because that clause involves an exercise of congressional power different to that granted under the reform law.

The Court’s Permissive Reading of its Role

In what was key in shaping the opinion philosophically, the Roberts opinion undertook a “permissive reading” of congressional powers, partly due to a “general reticence to invalidate the acts of the Nation’s elected leaders.”

Roberts said, “We do not consider whether the Act embodies sound policies. That judgment is entrusted to the Nation’s elected leaders. We ask only whether Congress has the power under the Constitution to enact the challenged provisions.”

Members of this Court are vested with the authority to interpret the law; we possess neither the expertise nor the prerogative to make policy judgments. Those decisions are entrusted to our Nation’s elected leaders, who can be thrown out of office if the people disagree with them. It is not our job to protect the people from the consequences of their political choices. …

Our respect for Congress’s policy judgments thus can never extend so far as to disavow restraints on federal power that the Constitution carefully constructed. … And there can be no question that it is the responsibility of this Court to enforce the limits on federal power by striking down acts of Congress that transgress those limits.

He added that resolving the health reform controversy “requires us to examine both the limits of the Government’s power, and our own limited role in policing those boundaries. In doing so, he
noted the government has “expanded dramatically” over the past two centuries, but still must show that a constitutional grant of power authorizes each of its actions. Here is where the Commerce Clause and Congress’ ability to levy taxes come into play:

Put simply, Congress may tax and spend. This grant gives the Federal Government considerable influence even in areas where it cannot directly regulate. The Federal Government may enact a tax on an activity that it cannot authorize, forbid, or otherwise control.

**It’s Not a Mandate, It’s a Tax**

A majority concurred that Congress lacked authority under the Commerce Clause because it could allow the federal government to mandate purchases of an ever widening variety of goods and services and to outlaw non-participation in markets.

**Note:** Employers are seeing similarities between a mandate to purchase a product, and a tax on folks who refrain from purchasing that product. However, the law prohibits the IRS from using its criminal enforcement authorities to punish people who fail to pay tax penalties that result from failures to meet reform’s individual mandate.

However, the opinion agreed with another argument made by the Obama Administration — that the individual mandate was constitutional if one viewed it as raising taxes on people who do not have health insurance. As noted earlier, Congress does have the power to “lay and collect taxes.”

Roberts agreed that, even if Congress lacks the power to order people to buy insurance, it still had the power to raise taxes on people without coverage.

He explained that essentially, the mandate “commands individuals to purchase insurance.” If they don’t the “only consequence” is that they must make an additional payment to the IRS when they pay taxes. In the government’s view:

This means that the mandate can be regarded as establishing a condition — not owning health insurance — that triggers a tax — the required payment to the IRS. Under that theory, the mandate is not a legal command to buy insurance. Rather, it makes going without insurance just another thing the Government taxes, like buying gasoline or earning income. And if the mandate is in effect just a tax hike on certain taxpayers who do not have health insurance it may be within Congress’s constitutional power to tax.

In agreeing that the mandate reads like a tax, Roberts made the following points:

1) The shared responsibility payment is paid into the treasury by taxpayers when they file their tax returns.

2) It does not apply to certain low-income households.

3) The payment rate is determined by factors such as taxable income, number of dependents and joint filing status.

4) The payment requirement is found in the tax code and enforced by IRS, which must assess and collect it in the same manner as taxes.

5) It produces at least some revenue for the government.
He explained that the shared responsibility payment may be considered a tax, not a penalty, for constitutional purposes, for the following reasons:

1) For most Americans the amount due will be “far less” than the price of insurance, and by statute, it can never be more.

2) It may often be a reasonable financial decision to make the payment rather than purchase insurance — and accordingly, is not a “prohibitory financial punishment.”

3) The individual mandate contains no scienter requirement.

4) The payment is collected solely by the IRS through the normal means of taxation — except that the IRS is not allowed to use those means most suggestive of a punitive sanction, such as criminal prosecution.

Roberts noted this is not to say that the payment is not intended to affect individual conduct. Furthermore, it will raise “considerable revenue” and is “plainly designed to expand health insurance coverage.” However, he noted that using taxes to influence conduct is “nothing new.” For example, high federal and state taxes on cigarettes are assessed not just to raise money but to encourage people to quit smoking.

Whether or not the justices agreed with tax increases, it was definitely in Congress’ purview, Roberts said.

Our precedent demonstrates that Congress had the power to impose the [shared responsibility payment] under the taxing power, and that the [shared responsibility payment] need not be read to do more than impose a tax. This is sufficient to sustain it.

In closing, Roberts stated:

The Federal Government does not have the power to order people to buy health insurance. [The shared responsibility payment] would therefore be unconstitutional if read as a command. The Federal Government does have the power to impose a tax on those without health insurance. [The shared responsibility payment] is therefore constitutional, because it can reasonably be read as a tax.

Gwen Cofield is an Associate Publisher at Thompson Publishing Group. She oversees Thompson’s line of human resources products. She is also editor of publications such as Mandated Health Benefits — The COBRA Guide and The 403(b) and 457 Plan Requirements Handbook.
VIII. Highlights from the Supreme Court’s Dissent

By Gwen Cofield

Issues related to constitutionality of the health reform law were the focus of U.S. Supreme Court’s June 28 decision in National Federation of Independent Business Et Al. v. Sebelius. Here is a recap of the dissent authored by Justices Scalia, Kennedy, Thomas and Alito, which pointed to flaws in the majority’s finding that the enforcement should be considered a tax.

The government’s argument that the individual mandate was a valid use of its taxing authority met with success in the majority opinion. However, the dissent dismissed it as “feeble.”

In the dissent’s view, the government was introducing “a creature never hitherto seen” — a penalty that is also a tax for constitutional purposes. The dissent said in all of the High Court’s cases, the two are mutually exclusive, and the Court has established a “clear line” between a tax and a penalty: (1) a tax is an enforced contribution to provide for the support of government; and a penalty is an “exaction” imposed by law as punishment for an unlawful act.

As such, the individual mandate is either a penalty or a tax, and the issue is not whether Congress had the power to frame it as a tax, but whether it did so.

The dissent emphasized that the Court has “never held — never — that a penalty imposed for violation of the law was so trivial as to be in effect a tax. We have never held that any exaction imposed for violation of the law is an exercise of Congress’ taxing power — even when the statute calls it a tax, much less when (as here) the statute repeatedly calls it a penalty.”

The dissent then pointed out various places in the reform law and legislative “findings” where the individual mandate was referred to as a penalty. It also pointed out other problems with the government’s “self-serving,” argument, including:

1) Some are exempt from the “tax” who are not exempt from the mandate. Several classes of individuals are exempt from the penalty for not having minimum coverage under the mandate. The dissent noted that if the mandate were a tax, “these two classes of exemption would make no sense; there being no requirement, all the exemptions would attach to the penalty (renamed tax) alone.”

2) The government argued that the mandate is a tax because the IRS will assess and collect the penalty in the same manner as “assessable penalties under the Internal Revenue Code.” The dissent noted that this “flimsiest” of arguments could suggest the mandate was a tax if IRS penalty collection was unheard of or rare, but it’s not. Furthermore, the individual mandate rules are administered by the IRS, HHS and the VA, “a feature that would be quite extraordinary for taxes.”

3) Varying the amount of the penalty according to the ability to pay is an “utterly familiar practice” that does not bring the mandate under the category of a tax.

4) Congress rejected an earlier version of the law that imposed a tax instead of a requirement-with-penalty.

5) And in what the dissent called “the nail in the coffin,” it noted that the “mandate and penalty are located in Title I of the Act, its operative core, rather than where a tax would be found — in Title IX, containing the Act’s ‘Revenue Provisions.’”
IX. Interesting Quotes from the Supreme Court Ruling

By Rich Glass, Infinisource, Inc.

Even though National Federation of Independent Business v. Sebelius was only recently decided in late June, the case already stands as a historic landmark decision. Regardless of your view of the outcome, the case also stands as a well-written piece of legal analysis. In no uncertain order, here are five memorable excerpts:

• “The exaction the Affordable Care Act imposes on those without health insurance looks like a tax in many respects.” Majority opinion, written by Chief Justice John Roberts. This was the foundation on which the individual mandate was upheld by a 5-4 vote.

• “What the Government would have us believe in these cases is that the very same textual indications that show this is not a tax under the Anti-Injunction Act show that it is a tax under the Constitution. That carries verbal wizardry too far, deep into the forbidden land of the sophists.” Minority Opinion, written by the four dissenting Justices. This pointed out the inconsistency of labeling the individual as a tax under the Taxing Clause of the U.S. Constitution while concluding it was not a tax under the Anti-Injunction Act. The sophists, by the way, were ancient Greek philosophers who could use clever reasoning to support false arguments.

• “Members of this Court are vested with the authority to interpret the law; we possess neither the expertise nor the prerogative to make policy judgments. Those decisions are entrusted to our Nation’s elected leaders, who can be thrown out of office if the people disagree with them. It is not our job to protect the people from the consequences of their political choices.” Majority opinion, observing that the U.S. Supreme Court’s job was not to judge whether the Affordable Care Act was good policy. Instead, that is ultimately the responsibility of We the People, who elect the president and members of Congress.