SMALL BUSINESS LEGISLATIVE COUNCIL

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STATUS QUO

The United States Supreme Court has upheld the constitutional status of the Patient Protection and Affordable Care Act (PPACA) (except for a Medicaid portion). The Court actually concluded that the one aspect of the law was unconstitutional under two clauses of the Constitution but was constitutional under a third and the Court operates under precedents that there is presumption that a law should be considered constitutional if it can be found constitutional under any clause. The Court refers this as its "duty to save a statute." I think it is safe to say, this is was a bit more complicated than most of us can absorb, but the bottom line is it remains the "law of the land."

The Court ruled on the constitutionality of the individual mandate in PPACA. Beginning in 2014, PPACA will impose a "penalty" on any individual, not otherwise exempted or obtaining coverage from an employer, if the individual does not have health insurance with certain minimum benefits.

The Court concluded that Congress could not impose such a penalty under the clause in the Constitution that permits it to regulate commerce. The Court said, "The individual mandate, however, does not regulate existing commercial activity. It instead compels individuals to become active in commerce by purchasing a product, on the ground that their failure to do so affects interstate commerce. Construing the Commerce Clause to permit Congress to regulate individuals precisely because they are doing nothing would open a new and potentially vast domain to congressional authority. Every day individuals do not do an infinite number of things…The Commerce Clause is not a general license to regulate an individual from cradle to grave, simply because he will predictably engage in particular transactions. Any police power to regulate individuals as such, as opposed to their activities, remains vested in the States."

(While it does not change the outcome of this case, the Court's observations on the unconstitutionality of the individual mandate under the Commerce clause does have ramifications in the never-ending debate over the ability of Congress to extend its regulatory reach. This will have a chilling impact.)

The Court also determine that Congress did not have the authority to impose an individual mandate under the" necessary and proper clause" that allows Congress to do what it needs to do with respect to enumerated powers.

The Court however determined that Congress construed a tax and it was a constitutional tax. The logic went as follows:

"The '[s]hared responsibility payment,' as the statute entitles it, is paid into the Treasury by 'taxpayer[s]' when they file their tax returns. It does not apply to individuals who do not pay federal income taxes because their household income is less than the filing threshold in the Internal Revenue Code. For taxpayers who do owe the payment, its amount is determined by such familiar factors as taxable income, number of dependents, and joint filing status. The requirement to pay is found in the Internal Revenue Code and enforced by the IRS, which—as we previously explained—must assess and collect it 'in the same manner as taxes.' This process yields the essential feature of any tax: it produces at least some revenue for the Government."

The Court concluded that when it comes to taxes, Congress had broader latitude in imposing taxes than it does on regulating commerce and the individual mandate can be viewed as the tax for not having insurance rather

than a requirement to purchase insurance and thus is constitutional.

Said the Court, "But taxes that seek to influence conduct are nothing new. Some of our earliest federal taxes sought to deter the purchase of imported manufactured goods in order to foster the growth of domestic industry…Today, federal and state taxes can compose more than half the retail price of cigarettes, not just to raise more money, but to encourage people to quit smoking. And we have upheld such obviously regulatory measures as taxes on selling marijuana and sawed-off shotguns. Indeed, '[e]very tax is in some measure regulatory. To some extent it interposes an economic impediment to the activity taxed as compared with others not taxed.' That [PPACA] seeks to shape decisions about whether to buy health insurance does not mean that it cannot be a valid exercise of the taxing power."

(There is one convoluted discussion about the fact the penalty was not a tax for the purposes of the Anti-Injunction Act, which would have made the decision premature because it says a tax cannot be challenged until you paid, because that was a narrow statutory use of the word "tax," but for constitutional purposes, the analysis of what is a tax is broader.)

It is important to remember the Court was never considering whether the employer mandate was constitutional. The only way the employer mandate would have been overturned is if the Court had determined the individual mandate was completely unconstitutional under any theory. Then the Court would have had to decide whether the entire law had to be overturned because a key component, the individual mandate, was unconstitutional and you could not extract it from the law without the entire structure collapsing. The Court never had to address the issue of severability.

What's next?

Well, compliance is still a year and a half away. The individual mandate and the employer mandate under PPACA do not take effect until 2014. The States will have to get going on constructing the health care exchanges necessary to provide coverage to individuals (and through which small businesses will be able to obtain coverage if they wish.)

While the Republicans are talking about repeal bills, there is no chance that it will happen in this Congress with a Democratic President and Democratic-controlled Senate.

The possibility of repeal depends on the election of Governor Romney and the Republicans holding control of the House and gaining control of the Senate. Even then, there is no guarantee that it will be repealed. The Republicans will face a filibuster in the Senate and at the moment the election experts suggest it would take quite an effort for the Republicans to secure sixty votes in the Senate. When you peel away the returning members and the "safe" seats, there are probably twelve Senate seats really in play. In other words, the baseline is probably 44-44 going into the election.

So for the moment, let's see what the election yields.

If the repeal prospects do not improve, then small employers with less than 50 employees have more choices. There is no mandate for such employers. Right now, it is hard for me to imagine that anyone not offering benefits will choose to do so, no matter with credits or enticements are offered. For those with less than 50 employees that are offering benefits now, competing for employees might drive a decision to continue to offer them, otherwise not sure there are other downsides to dropping coverage.

For larger employers, the equation changes because they are subject to a penalty for not offering coverage. But truth be told, the penalty seems awfully low compared to the cost of continuing to offer coverage.

But again, that company by company analysis can wait until after the November election.

The Supreme Court said Congress cannot take away some of the States' current Medicaid funding if they do not accept the expanded Medicaid funding with expanded coverage for low income individuals. It is not clear whether States' will voluntarily reject the offer of increased funding with the expanded coverage. Most States will probably accept it anyway. Those that do not are concerned about getting stuck with more of the bill down the road.

For those of us who have not looked at it in a while, here's a summary of the PPACA as passed and as it remains today as the "law of the land."

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

AMERICAN HEALTH BENEFIT EXCHANGES

While the establishment of the Exchanges is a complex topic, four points are essential to understanding the impact of reform on employers:

- States are required to establish American Health Benefit Exchanges by 2014.
- Individuals may obtain their coverage through these Exchanges.
- Most subsidies for individuals are tied to coverage through the Exchanges.
- These Exchanges will include Small Health Option Programs (SHOPs) through which small businesses may obtain coverage. Generally, small businesses with up to 100 employees will be able to acquire coverage through the Exchanges. After 2016, States may expand the pools to include larger employers.

INDIVIDUAL RESPONSIBILITIES

Individuals must obtain "minimum essential coverage" for health insurance for themselves and dependents. The requirement begins in 2014 with a $95 minimum penalty. The minimum penalties increase to $325 in 2015 and to $695 in 2016. If household "modified adjusted gross income" exceeds specified levels, the penalty is greater. The percents of household income are 1.0 percent in 2014 (so an individual making more than $9,500 would pay more than the minimum flat amount as a penalty in 2014), 2.0 percent in 2015, and 2.5 percent for 2016 and thereafter.

There is a cap on the minimum penalty per family of no more than 300 percent of the minimum penalty (e.g. $95 x 300 percent = $285 for 2014), regardless of the size of the family. Children under 18 are assessed at half the minimum penalty. If the cost of lowest available plan exceeds 8 percent of income there is no penalty for not having coverage, and there are hardship and religious exclusions.

EMPLOYER RESPONSIBILITIES

Effective January 1, 2014, there are large employer "shared" responsibilities. An employer is a large employer with respect to any calendar year if it employed an average of at least 50 full-time employees during the preceding calendar year.

The law assesses a penalty on employers with 50 or more full time equivalent (FTE) workers that fail to provide coverage to their employees and have at least one full time employee who receives a premium tax credit established by the law. An FTE is 30 or more hours a week. In calculating the average, an employer shall, in addition to the number of full-time employees for any month, include for such month a number of full-time employees determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120.

If the large employer is required to pay a penalty, the annual assessment is $2,000 times all full time employees. The large employer can subtract the first 30 full time employees from the payment calculation (e.g., a firm with 51 workers that does not offer coverage will pay an amount equal to 51 minus 30, or 21 times the applicable per employee payment amount).

The law allows businesses to go over the 50 employee limit for 120 days when using seasonal employees, without triggering the potential assessment liability.

If the large employer offers coverage but there is an employee who obtains coverage through an Exchange and receives a premium tax credit, the employer is assessed $3,000 for each such employee. (The overall exposure is capped) An employee will be eligible for a premium tax credit if the cost of the employer plan exceeds more than 9.5 percent of the employee's income or the actuarial value of the plan is less than 60 percent of the law's specified minimum essential coverage.

Employers with more than 200 employees must automatically enroll all employees in their plans.

A large employer's plan will have to meet the minimum essential coverage requirements to be a "qualified employer sponsored plan," however, the law does "grandfather" existing employer plans. The grandfathering applies to the benefit standards imposed by the law. However, those plans must comply with some new requirements within six months of enactment including: eliminating

pre-existing conditions exclusions for children (by 2014 for adults); using a definition of dependent child, if dependent coverage is offered, to allow coverage up to age 26; and prohibiting lifetime limits on coverage and rescissions of coverage. The plans must meet new restrictions on annual dollar coverage limits this year, and eliminate them by 2014. Grandfathered employer plans must be modified by 2014 to eliminate waiting periods beyond 90 days.

While a small employer is not required to offer health insurance plans, most group plans will have to meet the insurance reforms (e.g. no pre-existing conditions) imposed by law on grandfathered plans.

The government has issued regulations on grandfathered plans. One of the most common questions is what types of changes would result in a plan losing "grandfathered" status. According the government, the following are considered to change a health plan so significantly that they will cause a group health plan or health insurance coverage to relinquish grandfather status:

*Elimination of all or substantially all benefits to diagnose or treat a particular condition.

*Increase in a percentage cost-sharing requirement (e.g., raising an individual's coinsurance requirement from 20% to 25%).

*Increase in a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15 percentage points.

*Increase in a copayment by an amount that exceeds medical inflation plus 15 percentage points (or, if greater, $5 plus medical inflation).

*Decrease in an employer's contribution rate towards the cost of coverage by more than 5 percentage points.

*Imposition of annual limits on the dollar value of all benefits below specified amounts.

Conversely, the government has said that the following types of changes would not be considered significant: cost adjustments to keep pace with medical inflation, adding new benefits, making modest adjustments to existing benefits, voluntarily adopting new consumer protections under the law, or making changes to comply with State or other Federal laws. Premium changes are not taken into account when determining whether or not a plan is grandfathered.

Also the government has indicated that an employer can change the "carrier" (enter into a new policy, certificate, or contract of insurance) without ceasing to be a grandfathered health plan, provided no major changes have been made to the plan itself.

ESSENTIAL BENEFITS

The law requires non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges to include certain essential health benefits (EHBs) beginning in 2014. Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover the essential health benefits. The law provides that EHBs include items and services within the following 10 benefit categories: (1) ambulatory patient services, (2) emergency services (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.

Under the law, the Department of Health and Human Services (HHS) was given the task to determine the scope of the essential health benefits and the standard is "equal to the scope of benefits provided under a typical employer plan," but the law did not define "typical." The HHS has decided to let the States decide. States would have the flexibility to select an existing health plan to set the "benchmark" for the items and services included in the essential health benefits package. States may choose one of the following health insurance plans as a benchmark:

- One of the three largest small group plans in the state;
- One of the three largest state employee health plans;
- One of the three largest federal employee health plan options;
- The largest HMO plan offered in the state's commercial market.

If states choose not to select a benchmark, HHS intends to propose that the default benchmark will be the small group plan with the largest enrollment in the state.

SMALL BUSINESS TAX CREDIT

The law created a 35 percent tax credit for 2010-2013 of the lesser of (1) the amount of contributions the employer made on behalf of the employees during the taxable year for the qualifying health coverage and (2) the amount of contributions that the employer would have made during the taxable year if each employee had enrolled in coverage with a small business benchmark premium. There is a similar 50 percent credit beginning in 2014 for no more than two consecutive taxable years but the insurance must be obtained through an Exchange.

To be eligible for the credits, small employers have to contribute at least 50 percent of the cost of premiums towards a qualified health plan. Small businesses with 10 or fewer full-time employees and with average taxable wages of $25,000 or less could claim the full credit. It is phased out as average employee compensation increases from $25,000 to $50,000 and as the number of full-time employees increases from 10 to 25. Full-time employees would be calculated by dividing the total hours worked by all employees during the tax year by 2,080 (with a maximum of 2,080 hours for any one employee). Seasonal workers would be exempt from this calculation. Self-employed individuals, including partners and sole proprietors, two percent shareholders of an S Corporation, and five percent owners of the employer are not treated as employees for purposes of this credit. There is also a special rule to prevent sole proprietorships from receiving the credit for the owner and their family members.

The credit is only available to offset actual tax liability and is claimed on the employer's tax return. The credit is not payable in advance to the taxpayer or refundable. Thus, the employer must pay the employees' premiums during the year and claim the credit at the end of the year on its income tax return.

INDIVIDUAL SUBSIDIES

If individuals obtain their coverage through an Exchange, they may be eligible for a premium tax credit. There is a sliding scale based of a percent of the Federal Poverty Level (FPL). The lower your income, the bigger the subsidy (or looking at it the other way, the less of your income you are required to pay for obtain coverage). Individuals and families with household income of up to 400 percent of FPL would not be required to spend more than a specified percent of their income on premiums. Individuals and families will receive a credit so that families at the 400 percent FPL will have to pay no more than 9.5 percent of their incomes. (The 2012 Poverty Guidelines for the 48 Contiguous States and the District of Columbia for one person in the family - $11,170 for two - $15,130, for three - $19,090, or for 4 - $23,050 and so forth). Therefore, a family of four with household income of $92,200 (400 percent of $23,050) would be eligible for a premium tax credit.

(The subsequent law that repealed the infamous Form 1099 requirement used a "recapture of excessive subsidy payments" as the offset for the repeal, but it did not change the basic subsidy formula.)

As noted in the employer mandate section, if an employer offers coverage but the employee's contribution would exceed 9.5 percent of income or if the plan pays for less than 60 percent of covered expenses, the employee is eligible for the premium credit.

TAX INCREASES

Hospital Insurance Trust Tax

The law increases the Medicare Hospital Insurance (HI) trust portion) of the payroll tax to 2.35 percent from 1.45 percent (i.e. a 0.9 increase) on wages or self-employment income over $200,000 for individual return and $250,000 for a joint return. There is no limit on the amount of wages or self-employment income that is subject to the tax (unlike the social security portion of the FICA tax, which has a wage cap). This is an increase in the employee's share only. The employer will continue to pay to its 1.45 percent rate share on the employee's wages. In the case of the self-employed, they will pay "only" the additional 0.9 percent. The increase takes effect in 2013.

Unearned Income Medicare Contribution Tax

Since the HI applies only to earned income, the law establishes a new "Unearned Income Medicare Contribution" (UIMC) tax. This is calculated separately from the HI tax and would apply to "net

investment income" which is interest, dividends, royalties, rents, gross income from a trade or business involving passive activities, and net gain from disposition of property (other than property held in a trade or business). The rate is 3.8 percent. The UIMC tax on net investment income would not apply if modified adjusted gross income is less than $250,000 in the case of a joint return, or $200,000 in the case of a single return. The UIMC tax takes effect in 2013.

Health Care Benefit Excise Tax

The law imposes an excise tax of 40 percent on health insurers and health plan administrators for coverage that exceeds certain thresholds ($10,200 single coverage and $27,500 for family coverage; 11,850 and $30,950 for retirees and employees in high-risk professions, indexed for inflation.) Health insurance coverage subject to the excise tax is broadly defined to include not only the employer and employee premium payments for health insurance (including self-insured plans). In addition, tax advantaged accounts such as flexible spending accounts (FSAs), health savings accounts (HSAs) and health reimbursement accounts (HRAs) are also specified as health insurance coverage and subject to the excise tax. It excludes stand-alone dental and vision plans from the tax and permits an employer to reduce the cost of the coverage when applying the tax if the employer's age and gender demographics are not representative of the age and gender demographics of a national risk pool.
The excise tax takes effect in 2018.

Miscellaneous Tax Items

*The threshold for claiming the itemized deduction for medical expenses is increased from 7.5 percent to 10 percent, beginning in 2013.

*Contributions to Flexible Spending Accounts (FSAs) are capped at $2,500 (indexed) annually, beginning in 2013.

*Employers would have been required to include the value of an employee's health coverage on the Form W-2 beginning with the forms for the 2011 tax year but the IRS subsequently postponed the requirement for a year and postponed it for two years for employers that issue fewer than 250 W-2s. Since then, the IRS has published guidance on how the larger employers and eventually small employers are to comply with this disclosure requirement. For larger employers, the information will be on the W-2s for 2012 wages (that is, the forms required for the calendar year 2012 that employers generally are required to furnish to employees in January 2013 and then file with the Social Security Administration (SSA)).