GRAY REED

Q&A on the U.S. Supreme Court's Decision on Healthcare Reform

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On June 28, 2012, the U.S. Supreme Court issued its long-awaited ruling on the constitutionality of President Obama's health care reform legislation (see Supreme Court Issues Landmark Decision on Healthcare Reform). The decision resulted in numerous questions due to the complexity of the legislation and the rationale behind the Supreme Court's decision. Provided below are answers to some of the many questions relating to this issue in hope of providing some guidance to you and your business.

What does the Supreme Court ruling change as it relates to the health care reform legislation passed in 2010?

The health care reform legislation remains generally the same except the decision addressed two separate matters contained in the legislation. The first issue was whether what was termed a "penalty" in the legislation is a "penalty" or a "tax". The requirement that individuals have insurance, commonly referred to as the "individual mandate", goes into effect in 2014. For the purposes of determining the constitutionality of the legislation, the Supreme Court held the charge for noncompliance was a "tax" and therefore within the power of Congress to pass under its taxing powers. The second issue pertained to Medicaid eligibility expansion and what steps the federal government could take against those states that do not implement the expansion. The federal government currently provides funds to each state to use in providing Medicaid to those who meet the requirements for participation, which is currently those whose income is below the federal poverty line. The legislation allows for increased funding to each state that expands Medicaid eligibility to include those who fall within 133% of the federal poverty line. The purpose of expanding eligibility requirements is to offer the uninsured who currently cannot afford to purchase health insurance and do not qualify for Medicaid the ability to participate in the program. The Supreme Court mandated that if a state chooses not to expand its eligibility, the federal government may only withhold those additional monies the state would be entitled to under the legislation. The monies a state already receives may not be impacted by its decision not to expand eligibility.

So whether it is a "penalty" or a "tax", what does the ruling mean to those individuals who do not have insurance beginning in 2014?

The Supreme Court decision does not change the amount that will be owed by uninsured individuals. Whether it is called one term or the other, those who do not have insurance will be subject to an annual financial charge that once it is fully phased in will be the greater of $695 per person (up to a maximum of $2,085 per family), or 2.5% of household income, each year. The Internal Revenue Service has been charged with the duty to administer the

collecting of the liability. Interestingly, the IRS does not have the same collection authority and tools at its disposal to collect these charges as it does for failure to pay income tax. It cannot pursue criminal penalties, file liens against property or issues levies to collect the tax. As of right now, the IRS has not stated how it will pursue those who do not pay but the only likely remedy is to employ offsets against federal tax refunds.

Is there any indication of whether states will expand Medicaid eligibility?

There are three categories of states that have considered Medicaid eligibility expansion following the lead of each state's Governor. There are those states that have already set in process the expansion, others that delayed any action on it until the Supreme Court acted and others that have indicated they have not decided to implement the expansion or will not do so. The states that have indicated they will proceed with Medicaid expansion are California, Connecticut, Delaware, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Vermont, Washington and the District of Columbia. Texas Governor Rick Perry has announced that he has no intention on implementing the expansion. Louisiana's Governor Bobby Jindal has stated he does not intend on implementing it, Arkansas Governor Mike Beebe is leaning towards implementing it and Oklahoma Governor Mary Fallin and New Mexico Governor Susana Martinez are still examining the subject and have yet to decide. Other states whose governors have indicated they will not proceed with Medicaid expansion are Florida, Iowa, Kansas, Nebraska, South Carolina and Wisconsin. If a state does not proceed with the Medicaid expansion, those citizens of the state who would have qualified for Medicaid under the expansion would be eligible for federal subsidies through income-based tax credits to allow them to afford participating in their state's health insurance exchange. In light of the numerous Governors' opposition to the Medicaid expansion, U.S. Department of Health and Human Services Secretary Kathleen Sebelius announced that low income citizens in states that opt-out of the expansion will not be subject to the individual mandate's penalty as a result of the unintended consequence resulting from such state action, The specifics regarding what would constitute a "low income citizen" were not provided by the Secretary.

What is a health insurance exchange?

A health insurance exchange is an organized effort at the state level that in 2014 will provide a marketplace for various insurance options which may be offered to individuals and some employers. The exchange may be through a governmental agency or a nonprofit corporation. A state may have multiple exchanges as long as one serves each geographic location within the state. If a state chooses not to implement an exchange, the federal government may establish the exchange for that state, which DHHS Secretary Kathleen Sebelius has stated will occur. From all indications, most of the states that are opposed to enacting the Medicaid expansion will not form a health insurance exchange.

As mentioned, employers with less than 100 employees (some states may limit to 50 employees through 2016) will be able to shop for insurance through the exchanges. The exchanges have the option of including employers with more than 100 employees beginning in 2017. The use of the exchanges will allow employers to choose the level of coverage they will provide and to offer their employees choices among qualified health plans within that level of coverage. This will let employers offer plans from multiple insurers but receive a single bill and write a single check. Employers purchasing coverage through an exchange may be eligible for a tax credit of up to 50 percent of their premium payments if they have 25 or fewer employees, pay employees an average annual wage of less than $50,000, offer all full-time employees coverage and pay at least 50 percent of the premium.

What does this mean for my taxes?

Increased Tax for Some Employees and Investors. Beginning in 2013, individual taxpayers with incomes in excess of $200,000 ($250,000 for couples filing married filing jointly) will pay an additional 0.9 percent Medicare tax on the excess. In addition, they'll pay a new, 3.8 percent Medicare tax on unearned income, such as interest, dividends, rents, royalties, and certain tax gains.

Health Insurance Premium Tax Credit. Refundable tax credits are available to eligible taxpayers to help cover the cost of health insurance premiums for individuals and families who purchase health insurance through a health benefit exchange. Credits are available for people with incomes above Medicaid eligibility and below 400 percent of the poverty level ($92,200 for a family of four in 2012) who are not eligible for or offered minimum essential coverage. The credits apply to both premiums and cost-sharing.

Cap on Flexible Spending Accounts. Beginning in 2013, Flexible Spending Account Contributions will be capped at $2,500 and future caps will be tied to increases in the Consumer Price Index.

HSA Withdrawal Penalty. The tax penalty for an unqualified withdrawal from an HSA account has been increased effective January 1, 2011, from the current level of 10% to 20%.

What does the Supreme Court decision mean for my business?

Whether you are an employer or an employee, the health care reform legislation will be of substantial impact in the workplace. The employer is now faced with addressing different requirements based upon the number of employees, types of insurance and benefits offered and implementation periods. The legislation created additional disclosures regarding insurance and other employee benefits that must be provided to the employee. There are requirements that provide for employer obligations to make available such insurance and penalties for not providing coverage. These issues create a myriad of sliding scales for the employer to address which will in turn impact the employee.

Employers with Less than 50 Full-Time or Full-Time Equivalent Employees. Employers with less than 50 full-time employees (those who work 30+ hours per week) or full-time equivalent employees (determined by dividing the total number of hours worked in a month by part-time employees by 120) are not responsible for providing health care coverage for their employees and are not liable for a fine for failing to do so.

Employers with 50 or more Full-Time or Full-Time Equivalent Employees. Beginning in 2014, employers with 50 or more full-time or full-time equivalent employees will have the option of providing health insurance for all of their employees or paying a fine.

- *Fine for Employers who Offer Health Insurance* – Employers must pay a non-deductible penalty of $3,000 per year for each full-time employee who obtains health insurance through a health care exchange and receives the premium tax credit if the employer does not offer minimum essential coverage to its full-time employees and their dependents. An employer does not offer minimum essential coverage if the employer medical plan contributions equal less than 60% of allowed costs, or if an employee pays more than 9.5% of his or her household income for health coverage. This penalty is limited to an amount equal to $2,000 multiplied by the number of full-time employees of the employer (less the first 30 employees).

- *Fine for Employers who do not Offer Health Insurance* – Employers who don't offer health coverage will be required to pay a non-deductible penalty of $2,000 per employee. An employer's first 30 employees who would otherwise qualify will not be included in the assessment.

Employers with Over 200 Employees. In addition to the rules provided above for employers with 50 or more full-time or full-time equivalent employees, beginning sometime in 2014 after the IRS issues regulations, employers with over 200 employees that offer health coverage must automatically enroll new full-time employees in a coverage option and must also automatically continue existing elections for current full-time employees from year to year.

Reporting Requirements. Beginning in 2013 (for 2012 Forms W-2), employers that provide health insurance to their employees, whether the employer or the employee pays the premiums, must disclose the value of health benefits on each employee's W-2 . Employers filing fewer than 250 Forms W-2 for the previous calendar year are currently exempt from this new reporting requirement until the IRS issues regulations stating otherwise.

What does this mean for my health care provider?

There are only two things we know for sure as it relates to health care providers: there will be more individuals presenting themselves to physicians and hospitals, and there should be more funding to provide for the increased care burdens. Whether such increased funding for

the additional health care services will match the needs for the services provided is yet to be seen. Also, whether the current facilities and providers will be sufficient to address the new participants is also something being debated by those in the health care field and outside of it as well. Short term, there should not be a substantial recognizable change, but as the different implementation periods come into effect, the health care provider and health insurance industries will need to evolve to address the mandated changes.

Is there a chance there still may be changes to the health care reform legislation?

Yes, but the degree of realistic change depends upon certain avenues by which change may occur and pending events. These different avenues include legal challenges, regulatory change and political events creating change. From a legal perspective, there is current litigation questioning the legality of certain aspects of the health care legislation. These cases are not proceeding as quickly as the recent litigation decided by the Supreme Court. After the Supreme Court decision where the aforementioned "penalty" was labeled a "tax", some have questioned whether the health care legislation was properly passed since it did not originate in the House of Representatives where all taxing legislation must originate but rather in the Senate. This argument does not take into account that each house of Congress passed its own version and then there was a reconciliation between the two. Whether this is sufficient to overcome the requirements is unknown but would be doubtful to prevail. Change could occur as the federal government issues regulations as to how certain aspects of the health care legislation should be implemented. Finally, the November elections may lead to change since both federal and state politicians have noted that depending upon who is elected there may be instances where the health care legislation is reviewed.

As you prepare to address compliance with the health care legislation, it is important to determine what dates certain aspects of the legislation go into effect and whether you are impacted. As previously mentioned, there are different requirements for different size employers and their employees as well as health care providers, payers and others involved with health care benefits. There will certainly be business and legal events and governmental actions which could change the timing or efforts that must be complied with as it is implemented. The most important thing is to begin to put together a game plan now with your financial, business and legal advisors to ensure compliance as well as being able to address any changes that may occur.

If you have any questions, contact your attorney or Gray Reed attorneys are available at your request.

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