

The Patient Protection and Affordable Care Act: The Supreme Court Decision

July 19, 2012

On June 28, 2012, the Supreme Court of the United States resolved more than two years of litigation over one of the most hotly contested acts of Congress, definitively upholding virtually all of President Obama's signature domestic policy achievement, the Patient Protection and Affordable Care Act (PPACA). The Supreme Court concluded that the "individual mandate" requiring all Americans to have health insurance or pay a penalty was within Congress' taxing authorities, if not within its power under the Commerce Clause of the Constitution. However, the Supreme Court also invalidated a provision empowering the Secretary of the U.S. Department of Health and Human Services (HHS) to withhold all federal Medicaid funds from states that choose not to expand Medicaid as prescribed under the law. You may access the full opinion at www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf.

This long-awaited decision has profound implications for the U.S. health care industry—providers, payors, products companies—and employers. This *White Paper* assesses the decision and provides guidance for the U.S. health care industry in the immediate aftermath. For additional insights, please also view our webcast, "Health Care in the High Court: The Supreme Court Decision," which was held June 29, 2012. On the webcast, a panel of constitutional and health industry legal and political analysts discuss some of the more important implications of this landmark decision. View the full archived webcast at www.mwe.com/Health-Care-in-the-High-Court-The-Supreme-Court-Decision-06-29-2012/.

Implications of the Decision

Under current law, to qualify for Medicaid, a person generally must meet certain financial criteria and belong to one of the groups that are "categorically" eligible for the program, *e.g.*, pregnant women, children, parents and persons with disabilities. Historically, non-elderly adults without dependent children, no matter how poor, have been categorically excluded from Medicaid by federal law unless they are disabled or pregnant.

Medicaid is a federal-state partnership program, where states have certain latitude to define eligible groups and design programs; the federal government pays a portion of the costs to the state of providing that coverage. The PPACA sought to induce states to expand Medicaid eligibility by eliminating the category requirement and making eligible all citizens with annual incomes up to 133 percent of the federal poverty level (FPL; about \$15,000 for an individual and \$26,000 for a family in 2012). The law included two provisions to induce states to make this change. The first was a carrot: the federal government would pay substantially all of the costs of the expansion in the early years, 100 percent of the costs in 2014, followed by a gradual decline in cost payments to 90 percent by 2020. The second was the stick: states choosing not to expand Medicaid in this manner could be at risk of losing *all* of their federal Medicaid funding, a threat that would be untenable for most any state.

The Supreme Court concluded that the "stick" provision was unduly coercive, amounting to no real choice at all, and therefore is unconstitutional. Per the Supreme Court's decision, the federal government cannot "penalize States that choose not to participate in that new program by taking away their existing Medicaid funding."

This decision, not surprisingly, creates a number of new questions about how states will proceed with the Medicaid expansion. Some state executives may, for political or policy reasons, choose against expanding Medicaid. Several governors—including, most notably, Governor Rick Perry of Texas, where several million people were expected to gain coverage from the Medicaid expansion alone—have already declared that they will not participate in the Medicaid expansion. However, for the health care industry, an analysis of the situation is not as simple as determining whether the state will opt in or out. It remains unclear whether states may have the option of opting in partially; for example, expanding Medicaid eligibility up to 100 percent of the FPL, and leaving the federal government to subsidize health insurance purchases for those between 100 and 133 percent, or opting in up to 133 percent of the FPL only for certain groups of individuals. The U.S. government has not yet indicated whether it will provide enhanced federal financial participation under these and other scenarios, or if it will do so only if the state opts in entirely as envisioned under the PPACA.

For those states that opt out of the expansion, there could be a coverage gap for some individuals with incomes below 100 percent of the FPL, as these individuals are not eligible for health insurance purchase subsidies and also may not already qualify for Medicaid in the state. (In a letter to state governors on July 10, 2012, HHS Secretary Sebelius did announce her department's intent to exempt individuals who cannot afford coverage from the individual responsibility or mandate requirement.)

The decision also leaves many unanswered questions regarding which PPACA Medicaid provisions are considered part of the "expansion," and, if a state "opts out" of the expansion, whether it is also exempt from these other provisions. HHS presently is taking a narrow view of the PPACA provisions affected by the decision, but certain states (*e.g.*, Maine) are taking a broader view

and arguing that they may opt out of related PPACA Medicaid provisions, such as the maintenance of effort requirement, without jeopardizing existing Medicaid funding.

Whether and how states proceed could have significant implications for providers, payors, employers and others operating in the health industry in those states.

Suggested Action Steps

Despite the uncertainty around the Medicaid expansion, the Supreme Court's decision resolves many uncertainties surrounding the PPACA, and should serve as notice that most, if not all, of the coverage expansions, the delivery system reforms and cost reduction changes will be implemented. While health industry organizations in states that may balk at Medicaid expansions should revisit strategies dependent upon Medicaid expansion, the Supreme Court's decision upholds virtually every aspect of the PPACA; therefore, most pre-decision reform-response strategies remain appropriate and should continue to be pursued. Specific industry sectors should consider—and perhaps take—the following steps:

PROVIDERS

- Providers should consider joining or forming an accountable care organization (ACO) or other integrated care organizations capable of managing their patients' health care needs in a high-quality and cost-effective manner. For those providers who have been “sitting on the sidelines,” waiting to see what would happen with PPACA and other health care reforms associated with the shift from fee-for-service to value and/or budget-based payments, it is time to get off the sidelines and into the game. Providers who cannot meet value and/or budget-based metrics will pay an increasingly high price in terms of foregone revenue.
- The most successful integrated care organizations will continue to make substantial investments in information technology and other managed care infrastructure, are already at or will attain sufficient size to be able to bear financial risk and spread the costs of such investments, and, if contracting with Medicare as a Shared Savings Program or Pioneer ACO, will use the applicable regulatory waivers to federal fraud and abuse laws so as to properly align financial incentives among participating providers.
- Those providers without adequate resources to make the necessary investments should consider collaborating with a system with the resources to do so, although in some markets such an option may also be constrained by increasing antitrust scrutiny of provider consolidations.

PAYORS

- Payors must be prepared to address the community rating and guaranteed issue/renewability provisions that go into effect in 2014.
- Payors should accelerate the exploration of new initiatives to address the issue of affordability, since even with the individual mandate requirement, if coverage is unaffordable, people will make economic choices that may mean payment of a tax rather than purchase of coverage. Weak tax, unaffordable coverage and potential for adverse selection could lead to a downward spiral for insurers.
- Payors need to understand the status of Health Insurance Exchanges (HIE) in which they operate. For instance, insurers need to know what benefit packages will be required and what actuarial designs of the plans will be required. Uncertainty around systems, rate development and marketing, among other things, create challenges and require significant advance planning.
 - HIEs have significant approaching deadlines: November 16, 2012, is the deadline for submission of a blueprint by the state to HHS as to how the state is planning to proceed, and state exchange plans must be approved or conditionally approved by January 1, 2013. States are in various stages of development, but many are falling behind in this process and need to plan accordingly. There is a risk that states that aren't ready may lose control of the exchanges to HHS, although the partnership option may be an alternative until the state has greater capacity to run the exchange on its own.

- Payors need to consider how to manage continuity of coverage and care management for populations that churn in/out of Medicaid and HIEs. This issue is potentially more challenging with a population that may not be covered by an expanded Medicaid program. In states that do not expand Medicaid coverage, payors should strategize how to manage the likely perpetuation of cost shifting to the insured population in that particular state.

LIFE SCIENCES COMPANIES

- Products companies should review sales projections that took into consideration expansions in covered lives due to PPACA. They should also estimate how these projections may change if states choose not to participate in Medicaid expansion or if individuals choose to pay the penalty/tax rather than purchase insurance through the exchanges.
- Organizations need to review research and development programs where expansions in covered lives due to PPACA were key to projections about net revenue returns on investments. They should assess how these estimated returns may change if states choose not to participate in Medicaid expansion or if individuals choose to pay the penalty/tax rather than purchase insurance through the exchanges.
- Companies should identify those provisions of PPACA that are expected to impact the rates paid to providers from private payors for the items and services they sell. Organizations must consider how those rates may change if states choose not to participate in Medicaid expansion but other insurance reforms remain in place, thus “squeezing” payor revenues. Life sciences entities should also estimate likely downstream implications for vendor purchasing contracts from providers, depending upon how their payment rates change. Companies should also consider how they may show the value of their products under various payment models that shift from traditional fee-for-service payment models to bundled payment or shared savings models. Companies should also consider the impact of such drivers on comparative effectiveness data and real-world effectiveness data of their products (*i.e.*, data beyond those typically developed for regulatory approvals).
- Companies should identify those provisions of PPACA that impact revenues or costs of operations specific for their business lines, such as the Medicaid rebate expansions (increased percentage rebates and expansion to Managed Medicaid), 340B expansion, brand pharmaceutical fees, medical device tax, coverage gap (donut hole) rebates, implementation of biosimilars approval pathway, compliance with Sunshine Act reporting, and compliance with samples reporting.

EMPLOYERS (WITH MORE THAN 50 EMPLOYEES)

- 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 is due in January 2013).
- Employers with material modifications to their group health plans are required to coordinate with their health provider vendors to redraft the Summary of Benefits and Coverage (SBC), which in turn must be distributed to all plan participants 60 days in advance of the effective date of the modification.
- Employers with more than 200 full-time employees that offer at least one health plan benefit option must be ready to automatically enroll all new employees in a benefit option and continue the enrollment of current employees in a health benefit plan offered by the employer. The effective date on this is based on when federal regulations are issued.
- Unless grandfathered, an employer’s group health plans must now establish internal and external review procedures that comply with PPACA. Claimants can appeal certain types of claims to an independent review organization (IRO). An IRO is an entity that performs independent external reviews of adverse benefit determinations and final internal adverse benefit determinations under state or federal external review procedures. Group health plans are required to contract with at least three IROs by July 1, 2012; however, many insurers and/or third-party administrators are offering this service to their customers.
- For employer’s with plan years beginning after September 30, 2012, through 2013, self-insured health plans and fully insured health plans (through the insurer) will be assessed an annual fee of \$1 times the average number of covered lives covered under the plan to fund research regarding patient centered outcomes for medical treatment. The annual fee will increase to \$2 thereafter and will be indexed for inflation starting in 2014. Employers should budget for these fees.

- Employers should know whether insurers meet the medical loss ratio (MLR) standards. If not, the insurer must provide an annual rebate to the employer's group health plan. The existing fiduciary duty rules under ERISA apply to the treatment of insurer rebates. Employers should review DOL Technical Release 2011-4 for guidance.
- Employees will only be allowed \$2,500 annually for health FSA deferrals starting on January 1, 2013 (currently there is no such limit).
- Employers should plan for the fact that the current 7.5 percent of adjusted gross income (AGI) floor on income-tax deductions for health care expenses is raised to 10 percent of AGI effective January 1, 2013; however, the new floor is waived during 2013, 2014, 2015 and 2016 for individuals who turn age 65 before the close of those years.
- Employers should plan for the elimination of the deduction for the portion of health care expenses that are reimbursed to the employer through the Medicare Part D subsidy program (effective January 1, 2013).
- Employer group health plans must comply with "administrative simplification" rules for electronic exchange health information and electronic fund transfers, and file a certification with the federal government that the plans are in compliance. The employer must also ensure that service providers also comply with the transaction and certification requirements. The penalty for non-compliance is \$1.00 per covered life per day of non-compliance up to a maximum of \$20.00 per covered life per year, but a double penalty applies in the case of any employer misrepresentation. These penalties also apply to grandfathered plans. Systems must be effective starting January 1, 2013, and employers must certify compliance by December 31, 2013.
- Employers are required to collect 0.9 percent for the employee's share of the FICA Medicare tax for wages/earnings over \$200,000 (\$250,000 for married couples filing jointly); i.e., a combined 2.35 percent on wages over \$200,000 (\$250,000 for joint filers). The law does not increase the employer's share of FICA Medicare tax (effective for tax years beginning January 1, 2013).
- Employers must provide notice to employees of the upcoming existence of state insurance exchanges, which are to be established by all the states in 2014. Notice must be in the form specified in upcoming DOL guidance (effective March 1, 2013 or such later date as set forth in future DOL guidance).

The Future of the PPACA

Although the Supreme Court's decision probably resolves the question of the PPACA's constitutionality in total once and for all, it will not be the last judicial challenge to the law. Several other court challenges to discrete provisions of the PPACA—including litigation challenging the physician-hospital ownership restrictions and Independent Payment Advisory Board—are pending and could render aspects of the law invalid. Nonetheless, none of these or any future challenge is expected to threaten or undermine the entire law, as the present challenge did.

While the question of constitutionality is resolved, the future of the ACA is still at some risk. On July 11, 2012, the U.S. House of Representatives, presently controlled by Republican opponents of the PPACA, voted again to repeal the law in its entirety. Barring a Republican 60-vote majority in the next Senate, which is unlikely, and Republican control of the White House, Senate Democrats could block efforts to repeal the law in its entirety. Nonetheless, if Republicans control both houses of Congress and the executive branch, they could conceivably succeed in repealing portions—perhaps even vast portions—of the law.

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