Supreme Court Upholds Individual Mandate, Modifies Medicaid Expansion; ACA Implementation Continues

Implementation of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) will continue in the wake of the U.S. Supreme Court’s 5-to-4 vote to uphold the sweeping reform of the U.S. health care system (National Federation of Independent Business v Sebelius, No. 11-393, June 28, 2012).

Chief Justice John Roberts was joined by Justices Ginsburg, Breyer, Sotomayor, and Kagan in writing the majority opinion regarding the individual mandate. The key part of the decision was that the individual mandate to purchase health insurance was ruled constitutional. The Court disagreed, however, with the Obama Administration’s main arguments that the individual mandate was a valid exercise of Congress’ power under the Commerce Clause and the Necessary & Proper Clause of the U.S. Constitution. Instead, the Court concluded that the mandate fell within Congress’ power to tax.

The Court found that the ACA’s Medicaid expansion violated the Spending Clause of the U.S. Constitution because it threatened states with the loss of existing Medicaid funding.

Background

Insurance mandate. Under the ACA, starting in 2014 most Americans are required to carry health insurance, either through their employer; a public program such as Medicare, Medicaid or TRICARE; or by purchasing health insurance as an individual in the private health insurance market. Individuals purchasing insurance will have a choice of health plans to purchase, which will vary in coverage and price, with all plans having a minimum essential benefits package.

Any individual required under the law to purchase health insurance who refuses to do so will be subject to a penalty, or tax, for any month during a year in which he or she does not have coverage. The penalty or tax will be based on the individual’s income but will not be more than the cost of a basic health insurance plan in the person’s geographical area.

There are, however, four categories of individuals to whom this mandate is not considered applicable: prisoners, undocumented aliens, health care sharing ministry members, and those with religious conscience objections who are certified by an American Health Benefit Exchange as exempt from the penalty.

Individuals to whom the individual mandate is otherwise applicable may be exempt for other reasons, including that they cannot afford insurance coverage or that their household income is below the tax return filing threshold.

The monthly penalty is equal to 1/12 of the greater of: (1) the flat dollar amount ($695 when fully phased in for 2016) for each individual not properly insured by the taxpayer, up to a maximum of 300 percent of the ap-
plicable dollar amount, or (2) the applicable percentage of income (2.5 percent when fully phased in for 2016).

**Medicaid expansion.** The ACA also requires states to expand their Medicaid programs by 2014 to cover all individuals under the age of 65 with incomes below 133 percent of the federal poverty line. States also will have to provide to all Medicaid beneficiaries a new essential health benefits package that will match the benefits that a basic health plan in the private health insurance market will offer.

The federal government will pay 100 percent of the cost of the newly eligible under Medicaid through 2016. After that, the federal government’s share of the payment to cover the newly eligible will drop to 90 percent. States that do not expand Medicaid coverage to the newly eligible face loss of all federal funding for Medicaid.

Twenty-six states, several individuals, and the National Federation of Independent Business brought suit in federal district court, challenging the constitutionality of the individual mandate and the Medicaid expansion. The Court of Appeals for the Eleventh Circuit upheld the Medicaid expansion as a valid exercise of Congress’ spending power but concluded that Congress lacked authority to enact the individual mandate.

### The Supreme Court’s Decision

**Ruling on individual mandate**

The main argument that the Obama Administration used in defending the mandate was that it was a permissible exercise of Congress power under the Commerce Clause of the U.S. Constitution (Article I, Section 8, Clause 3). Roberts wrote for the majority that the Clause “authorizes Congress to regulate interstate commerce, not to order individuals to engage in it.”

Roberts reasoned that the power to regulate commerce is dependent on the existence of commercial activity that can be regulated. According to Roberts, the individual mandate does not regulate commercial activity; instead, it compels individuals to become active in commerce by purchasing a product, on the ground that the failure to do so affects interstate commerce. Congress does not have the power to force individuals who have chosen not to engage in commerce to buy a product they do not desire. To grant such a power to legislators would be dangerously opening a door to a “new and potentially vast domain to congressional authority,” putting a potentially unlimited number of individual decisions under Congress’ authority to make those decisions for people.

The second argument that the Administration made to support the insurance mandate was that the mandate was necessary under the Necessary & Proper Clause (Article I, Section 8, Clause 18 of the Constitution) since it was an “integral part of a comprehensive scheme of economic regulation” of insurance reforms. The Court noted that the Necessary & Proper Clause does not license the exercise of any “great substantive and independent power” beyond those specifically granted in the Constitution. By contrast, the mandate provides Congress with the “extraordinary ability to create the necessary predicate to the exercise of an enumerated power.”

In addition, the individual mandate does not qualify under the Necessary & Proper Clause as an essential component of the government’s insurance reforms. Despite the fact that the government finds the mandate necessary to its reforms, it is not a proper vehicle.

The Court did, however, uphold the individual mandate under the Taxing Clause (Article I, Section 8, Clause 1 of the U.S. Constitution). Although the law itself refers to the payment that an individual would make in lieu of purchasing health insurance as a “penalty,” the Court concluded that regardless of its label, the payment was a tax because: (1) the “penalty” would be paid by individuals when they file their annual income tax returns; (2) the “penalty” does not apply to persons who do not pay federal income taxes; (3) the amount of the “penalty” is calculated by taking into account factors including number of dependents, joint filing status and amount of taxable income; and (4) the requirement is included in the Internal Revenue Code and is enforced by the IRS.

Roberts wrote —

Congress’s use of the Taxing Clause to encourage buying something is, by contrast, not new. Tax incentives already promote, for example, purchasing homes and professional educations.... Sustaining the mandate as a tax depends only on whether Congress has properly
exercised its taxing power to encourage purchasing health insurance, not whether it can. Upholding the individual mandate under the Taxing Clause thus does not recognize any new federal power. It determines that Congress has used an existing one.

He concluded his discussion of the individual mandate by stating “the Affordable Care Act’s requirement that certain individuals pay a financial penalty for not obtaining health insurance may reasonably be characterized as a tax. Because the Constitution permits such a tax, it is not our role to forbid it, or to pass upon its wisdom or fairness.”

Ruling on Medicaid

During the oral arguments in March, the states argued that the expansion of Medicaid and the threatened loss of all federal Medicaid funding for states that did not comply exceeded Congress’ authority under the Spending Clause, which grants Congress the power to pay the debts and provide for the general welfare of the states. The majority concluded that Congress cannot threaten to terminate all Medicaid funding as a means of pressuring states to accept an expansion of Medicaid eligibility. Specifically, the termination of all Medicaid funding was not “relatively mild encouragement” to expand a state Medicaid program to meet the needs of an entire population; rather, it was a “gun to the head.” States must be free to decline participation in the new program without losing their current level of funding. In effect, while Congress can offer new funds under the ACA to expand availability, they cannot withdraw any existing funding. Although Congress assumed that all states would participate in the expanded program, the Supreme Court found that even if they did not, the expanded coverage program can continue on a state-by-state basis. Failure of all the states to participate does not invalidate the entire portion of the ACA.

The dissent

Justice Kennedy, in the dissent (in which he was joined by Justices Scalia, Thomas and Alito), had harsh words for the conclusion that the mandate was valid if considered as a tax as opposed to a penalty. “[T]o say that the Individual Mandate merely imposes a tax is not to interpret the statute but to rewrite it,” according to the dissent. The dissent also noted that considering the mandate as a tax was an argument that even the Obama Administration spent little time supporting during the oral arguments in March. “Rewriting” the mandate as a tax in order to sustain its constitutionality, according to the dissent, “is a question of first impression that deserves more thoughtful consideration than the lick-and-a-promise accorded by the Government and its supporters.”

The majority concluded that Congress cannot threaten to terminate all Medicaid funding to pressure states to expand Medicaid.

Regarding Medicaid, the dissenting justices noted that “because the Medicaid Expansion is unconstitutional, … the most natural remedy would be to invalidate the Medicaid Expansion.” Instead, the majority’s conclusion that the Medicaid expansion is acceptable if states that reject the expansion of their Medicaid programs can still retain their existing Medicaid funding “takes the ACA and this Nation in a new direction and charts a course for federalism that the Court, not the Congress, has chosen; but under the Constitution, that power and authority do not rest with this Court.”

Implementation Continues

In remarks made after the Court’s decision, President Obama said, “The highest court in the land has now spoken. We will continue to implement this law.” In May 2012, our Briefing “Health Care Reform Journey Continues as Supreme Court Ponders Law’s Fate” focused on what had been implemented since March 2010, especially concerning employers, health care providers, the health insurance market, and the Medicare and Medicaid programs.

Because the Supreme Court’s decision focused just on the individual mandate and the expansion of Medicaid, neither of which go into effect until 2014, it’s a worthwhile exercise to focus, again, on the parts of the ACA that have already been implemented in the last two years.

Market reforms

Adult child coverage. According to the Department of Health and Human Services (HHS), 3.1 million young
adults have gained health insurance because of the ACA. As a result of the ACA, the proportion of insured adults ages 19 through 25 has increased to nearly 75 percent.

Under this provision, which took effect September 23, 2010, group health plans or issuers that make available dependent coverage of children must make such coverage available for children until they reach 26 years of age. Group health plans may not use student status, marital status, residency, or financial support from a parent to deny or restrict dependent coverage to children. The tax exclusion for employer-provided health benefits has been extended to include an adult child who, as of the end of the taxable year, has not attained age 27.

**Comment:** Because the ACA did not amend Code Sec. 223, which governs Health Savings Accounts (HSAs), it appears that HSAs cannot reimburse medical expenses for adult children on a tax-free basis unless the child otherwise qualifies as a tax dependent of the account holder (in other words, the law before health reform). Any HSA reimbursements for medical expenses of adult children would be treated as nonqualified reimbursements subject to income inclusion and penalties.

**Annual and lifetime limits.** Another provision in effect since September 23, 2010, is the prohibition on lifetime or annual limits on the dollar value of benefits for any participant or beneficiary. However, the annual limit prohibition on the dollar amount of benefits that are “essential health benefits” is being phased in for plan years beginning prior to January 1, 2014. Interim final rules establish the following minimum limits:

- $1.25 million, for a plan year beginning on or after September 23, 2011, but before September 23, 2012; and
- $2 million, for plan years beginning on or after September 23, 2012, but before January 1, 2014.

**Comment:** A list of the “essential health benefits” is found at Sec. 1302 of the ACA. Although the agencies have not issued regulations on this provision yet, HHS has released a bulletin describing the approach it plans to take in future rulemaking about essential health benefits. Subsequently, it released 22 frequently asked questions (FAQs) that arose from the bulletin (Frequently Asked Questions on Essential Health Benefits Bulletin).

**Rescissions.** The ACA also limits the extent to which a group health plan or health insurance issuer can rescind — or retroactively cancel or discontinue — coverage. Rescission may occur only when an individual seeking coverage (or a person or group plan seeking coverage on behalf of that individual):

- commits fraud;
- makes an intentional misrepresentation of material fact (as prohibited by the terms of the plan or coverage); or
- fails to timely pay required premiums.

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The ACA’s preventive care provision has provided 54 million Americans with at least one new free preventive service since 2011.
the Health Resources and Services Administration (HRSA); and
- with respect to women, any additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA.

New HRSA guidelines require that new health plans must include the following preventive services for women without cost-sharing for insurance policies with plan years beginning on or after August 1, 2012:
1. well-woman visits;
2. screening for gestational diabetes;
3. human papillomavirus (HPV) DNA testing for women 30 years and older;
4. sexually-transmitted infection counseling;
5. human immunodeficiency virus (HIV) screening and counseling;
6. FDA-approved contraception methods and contraceptive counseling;
7. breastfeeding support, supplies, and counseling; and
8. domestic violence screening and counseling.

Group health plans sponsored by certain religious employers are exempt from the requirement to provide contraceptive services. However, the definition of “religious employer” is narrow and excludes some nonprofit employers, such as religious hospitals and universities. For these nonprofit employers who, based on religious beliefs, do not currently provide contraceptive coverage in their insurance plan, the HHS has provided time to comply with the contraceptive services provision. These employers have until the first plan year that begins on or after August 1, 2013, but must provide certification that they qualify for the delayed implementation.

**Medical loss ratio.** HHS has predicted that by the beginning of August 2012, 8 million Americans will receive $1.1 billion in rebates from health insurance companies, due to the ACA’s minimum loss ratio provision. These rebates will be an average of $151 for each family covered by a health insurance policy.

Health insurance issuers must submit data on the proportion of premium revenues spent on clinical services and quality improvement—referred to as the “medical loss ratio” (MLR) in the ACA—and issue rebates to enrollees if this percentage does not meet minimum standards. MLR requires insurance companies to spend at least 80 or 85 percent of premium dollars on medical care.

**Comment:** The Centers for Medicare and Medicaid Services (CMS) will not grant extensions of the June 1, 2012 deadline for issuers to submit their MLR annual report or the August 1, 2012 deadline for issuers to provide rebates for the 2011 MLR reporting year.

**Reporting and disclosure**

**Appeals process.** Although the ACA’s new standards for health care internal claims and appeals and external review took effect six months after the law’s enactment, the Employee Benefits Security Administration provided an enforcement grace period until plan years beginning on or after January 1, 2012. But now, plans—including some non-ERISA plans (such as plans for employees of state and local governments and church groups) – must comply with the standards.

**The definition of “religious employer” is narrow and excludes some nonprofit employers, such as religious hospitals and universities.**

Group health plans and health insurers must have an “effective” process for appeals of coverage determinations and claims, including an internal claims appeal process and employee notification. This appeals process must include, at a minimum, the following:
- an established internal claims appeal process;
- a notice to participants, in a “culturally and linguistically appropriate manner,” of available internal and external appeals processes, including the availability of assistance with the appeals processes, such as an applicable office of health insurance consumer assistance or ombudsman; and
- a provision allowing an enrollee to review his or her file, to present evidence and testimony as part of the appeals process, and to receive continued coverage during the appeals process.

**SBC.** Beginning on September 23, 2012, group health plans and health insurers must provide a Summary of Benefits and Coverage (SBC) that clearly and accurately describes the benefits and coverage under the applicable plan or coverage. The summaries must be in a uniform
format, using easily understood language, and must include uniform definitions of standard insurance and medical terms. The explanation also must describe any cost-sharing, exceptions, reductions, and limitations on coverage, and use examples to illustrate common benefits scenarios.

In February 2012, the agencies issued a final rule implementing the SBC requirements and also published templates, instructions and a **uniform glossary**, which group health plans and issuers must make available to participants and beneficiaries. The Center for Consumer Information and Insurance Oversight (CCIIO) has also provided health insurance plans and issuers with a coverage example calculator on its website. The calculator is for plans and issuers to use as a safe harbor for the first year of applicability to complete the coverage examples in a streamlined fashion. This tool is intended to provide plans and issuers with time to develop accurate methods to populate the coverage examples treatment tables in the SBC template. However, the CCIIO noted that because this approach will be less accurate, it is being allowed as a transitional tool for the first year of applicability. Plans and issuers will be required to provide comprehensive coverage examples that are based on the coverage information specific to the benefit.

**Comment:** During the first year of applicability, the agencies will not impose penalties on plans and issuers that are working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the final regulations, according to FAQs About Affordable Care Act Implementation Part VIII, Q2.

**Forms W-2.** To provide useful and comparable consumer information to employers on the cost of their health coverage, employers must report the aggregate cost of applicable employer-sponsored coverage on employees’ 2012 Forms W-2 (that is, the forms required for the calendar year 2012 that employers are generally required to give employees by the end of January 2013 and then file with the SSA). Note that the IRS made this informational reporting requirement optional for 2011 Forms W-2. In addition, reporting is not required for 2012 Forms W-2 for any employer required to file fewer than 250 2011 Forms W-2.

**Exemptions**

**Grandfathered plans.** While many plans have been scrambling to comply with ACA’s provisions, some plans have been trying to remain exempt from the law. Certain group health plans and health insurance coverage that were in effect as of ACA’s enactment and that make no prohibited changes in plan provisions are subject only to certain provisions of the ACA. These plans are called grandfathered health plans.

**Waivers.** To protect coverage for workers in limited benefit plans and mini-med plans until more affordable and more valuable coverage is available in 2014, the ACA provided HHS with the authority to issue temporary waivers from the annual limit requirements. Plans that received waivers must comply with all other provisions of the law and must alert consumers that the plan has restrictive coverage and includes low annual limits. Additionally, these waivers are temporary and after 2014, no waivers of the annual limit provision are allowed.

**Certain group health plans that were in effect as of ACA’s enactment are subject only to certain provisions of the ACA.**

**Delays and repeals**

**Nondiscrimination rules.** In addition to some of the enforcement delays mentioned previously, the IRS has delayed the application of the nondiscrimination requirements in the ACA until regulations are issued. Insured group health plans and plans that are not grandfathered must comply with the Code Sec. 105(h) nondiscrimination requirements, including rules that the plan does not discriminate in favor of highly compensated individuals as to eligibility to participate. In addition, the benefits provided under the plan may not discriminate in favor of participants who are highly compensated individuals.

**CLASS program.** The ACA established the Community Living Assistance Services and Supports (CLASS) program, which was intended to be a national voluntary insurance program for purchasing community living assistance services and supports. In a letter to Congressional leaders on October 14, 2011, Kathleen Sebelius, the HHS Secretary, indicated that the CLASS program will not be implemented. According to Sebelius, actuarial analysis presented to Congress “does
not identify a benefit plan that I can certify as both actuarially sound for the next 75 years and consistent with the statutory requirements.”

**1099 reporting.** On April 14, 2011, President Obama signed into law a bill repealing the Form 1099 reporting requirement contained in the ACA. The Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (P.L. 112-9) repealed expanded information reporting on Form 1099 for certain business payments and rental property expense payments. The law also contains an offset provision to pay for the cost of repeal, estimated at approximately $25 billion over 10 years.

The ACA included among its revenue raisers an expansion of business information reporting. Section 9006 of the ACA required businesses, charities, and government entities to file a Form 1099 when they make annual purchases aggregating $600 or more to a single provider of goods, other than to a vendor that is a tax-exempt organization, for payments made after December 31, 2011, and reported in 2013 and thereafter. The ACA also repealed the long-standing reporting exception for payments made to corporations. P.L. 112-9 repeals the expanded information reporting requirements for business payments as if Section 9006 of the ACA had not been enacted.

**State Exchanges**

The ACA requires states to establish American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges to be administered by a governmental agency or non-profit organization. Under these Exchanges, individuals and small businesses with 100 or fewer employees can purchase qualified coverage, though, eventually, states may allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area.

By January 1, 2014, each state must establish an American Health Benefit Exchange for that state that would facilitate the purchase of qualified health plans. These Exchanges also must meet other rules.

According to CMS and HHS, over the last two years, more than $1 billion of Exchange-related grants have been provided to states. In 2010, 49 states and the District of Columbia received Exchange Planning grants totaling more than $54 million; in 2011, seven states received more than $249 million in Early Innovation grants; and to date, 34 states and the District of Columbia have received more than $856 million in Establishment grants.

**New Regulations**

The Obama administration has issued over 50 new final rules since the law was enacted, putting in place regulations that affect the health insurance market and the Medicare and Medicaid programs. Some of these regulations are summarized below.

**The Obama administration has issued over 50 new final rules related to ACA since it was enacted.**

**Health Insurance Market**

The following are summaries of final rules that introduced new regulations or revised existing regulations regarding the health insurance market.

- Implementing the recommendations in the model regulation of the National Association of Insurance Commissioners (NAIC) regarding medical loss ratios (MLRs) of health insurance providers (Final rule, 75 FR 74864, December 1, 2010; Final rule, 76 FR 76574, December 7, 2011; Interim final rule, 76 FR 76596, December 7, 2011).
- Requiring health insurance companies that meet or exceed MLR standards to issue a one-time notice of this fact to their enrollees, in the first paper or electronic document they provide to enrollees on or after July 1, 2012 (Final rule, 77 FR 28790, May 16, 2012).
- Implementing rules concerning the new Affordable Insurance Exchanges (“Exchanges”), which will provide competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors (Final rule, 77 FR 18310, March 27, 2012).
- Implementing standards for states related to reinsurance and risk adjustment, and for health insurance issuers related to reinsurance, risk corridors, and risk adjustment consistent (Final rule, 77 FR 17220, March 23, 2012).
Establishing requirements for student health insurance; defining “student health insurance coverage” as a type of individual health insurance coverage, and specifying that certain PHS Act requirements are inapplicable to this type of individual health insurance coverage (Final rule, 77 FR 16453, March 21, 2012).

Requiring that group health plans and health insurance issuers offering group or individual health insurance coverage provide benefits for, and prohibit the imposition of, cost-sharing requirements with respect to preventative health services (Interim final rule, 75 FR 41726, July 19, 2010; Interim Final rule, 76 FR 46621, August 2, 2011; Final rule, 77 FR 8725, February 15, 2012).

Instituting final regulations regarding the summary of benefits and coverage and the uniform glossary for group health plans and health insurance coverage in the group and individual markets under ACA (Final rule, 77 FR 8668, February 14, 2012).

Implementing the Consumer Operated and Oriented Plan (CO-OP) program, which provides loans to foster the creation of consumer-governed, private, nonprofit health insurance issuers to offer qualified health plans in the Affordable Insurance Exchanges (Final rule, 76 FR 77392, December 13, 2011).

Amending the definitions of “individual market” and “small group market” that apply for rate review purposes to include coverage sold to individuals and small groups through associations even if the state does not include such coverage in its definitions of individual and small group market (Final rule, 76 FR 54969, September 6, 2011).

Providing that religious organizations may be exempt from having to offer health insurance to their employees that provides coverage for contraceptive services without cost sharing (Interim Final rule, 76 FR 46621, August 2, 2011).

Providing standards and operating rules to govern electronic transactions with and among private health plans concerning patient eligibility and claim status (Interim final rule with comment period, 76 FR 40458, July 8, 2011).

Specifying internal claims and appeals and external review processes for group health plans and health insurance coverage in the group and individual markets (Final interim rule, 75 FR 43330, July 23, 2010; Amendment to interim final rules with request for comments, 76 FR 37208, June 24, 2011).

Requiring issuers of health insurance policies in the individual and small group markets to submit preliminary justifications for proposed rate increases exceeding 10 percent to CMS or the appropriate stage agency for review (Final rule, 76 FR 29964, May 23, 2011).

Establishing requirements for the issuers of health insurance policies to report information that will be made available to consumers on a website maintained by CMS, called the “web portal” (Final rule, 75 FR 24470, May 5, 2010).

Establishing the Early Retiree Reinsurance Program (ERRP), which provides reimbursement to participating employment-based plans for a portion of the cost of health benefits for early retirees and their spouses, surviving spouses and dependents (Interim final rule, 75 FR 24450, May 5, 2010).

**Medicaid**

The following are summaries of final rules that introduced new regulations or revised existing regulations regarding the Medicaid program.

- Extending the deadline for states’ repayment of the federal share of Medicaid overpayments a state has made to providers (Final rule, 77 FR 31499, May 29, 2012).
- Adopting the requirements for state plan amendments adopting the optional Community First Choice benefit added by ACA §2402 have been finalized (Final rule, 77 FR 26828, May 7, 2012).
- Codifying policy and procedural changes to the Medicaid and Children’s Health Insurance Program (CHIP) related to eligibility, enrollment, renewals, public availability of program information and coordination across insurance affordability programs (Final rule, 77 FR 17144, March 23, 2012).
- Implementing a regulatory framework for the submission and review of initial applications for Waivers for State Innovation under Medicaid (Final rule, 77 FR 11700, February 27, 2012).
- Implementing provisions that set forth transparency and public notice procedures for experimental, pilot, and demonstration projects approved under section 1115 of the Social Security Act relating to Medicaid and CHIP (Final rule, 77 FR 11678, February 27, 2012).
- Directing the Secretary of Health and Human Services to issue Medicaid regulations effective as of July 1, 2011 prohibiting Federal payments to States under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for health care-acquired conditions (Final rule, 76 FR 32816, June 6, 2011).
Providing methodologies and procedures for determining states’ fiscal years 2009 through 2015 allotments and payments under Medicaid and CHIP (Final rule, 76 FR 9233, February 17, 2011).

Medicare

The following are summaries of final rules that introduced new regulations or revised existing regulations regarding the Medicare program.

- Requiring health care providers and suppliers to include their National Provider Identifier (NPI) on all claims and must ensure that their NPI is in its Medicare enrollment (Final rule, 77 FR 25284, April 27, 2012).
- Implementing new regulations relating to the Medicare Advantage (MA) program (Part C) and prescription drug benefit program (Part D) to strengthen beneficiary protections; excluding plan participants that perform poorly; improving program efficiencies; and clarifying program requirements (Final rule with comment period, 77 FR 22072, April 12, 2012; Final rule, 76 FR 21432, April 15, 2011).
- Changing the Medicare prescription drug coverage low-income subsidy (Extra Help) program (Final rule, 75 FR 81843, December 29, 2010).
- Implementing the adoption of a standard for electronic funds transfers (EFT); defining EFT and explaining how the adopted standards support and facilitate health care EFT transmissions (Interim final rule with comment period, 77 FR 1556, January 10, 2012).
- Requiring qualified employers, insurance groups, and consumer groups to be able to utilize Medicare data to create report cards to measure the quality standards of physicians and hospitals (Final rule, 76 FR 76542, December 7, 2011).
- Implementing regulations relating to Medicare payments to providers of services and suppliers participating in Accountable Care Organizations (ACOs) under the Medicare Shared Savings Program. Under these provisions, providers of services and suppliers can continue to receive traditional Medicare fee-for-service (FFS) payments under Parts A and B, and be eligible for additional payments if they meet specified quality and savings requirements (Final rule, 76 FR 67802, November 2, 2011).
- Implementing ACA-related changes to the prospective payment systems for inpatient and outpatient hospital services, skilled nursing facilities, inpatient rehabilitation hospitals, inpatient psychiatric hospitals, the physician fee schedule, home health agencies, and hospices (numerous regulations).
- Revising and expanding current Medicare and Medicaid regulations regarding the imposition and collection of civil money penalties by CMS when nursing homes are not in compliance with federal participation requirements (Final rule, 76 FR 15106, March 18, 2011).

Fraud and Abuse

The following are summaries of final rules that introduced new regulations or revised existing regulations regarding fraud and abuse in federal health programs.

- Requiring that when a long term care (LTC) facility plans to close, the administrator of the skilled nursing facility (SNF) or the nursing facility (NF) will provide written notification of the impending closure to the HHS Secretary, the state’s LTC ombudsman, residents of the facility and their legal representatives and other responsible parties (Interim final rule with comment period, 76 FR 9503, February 18, 2011).
include their NPI on all applications to enroll in the Medicare and Medicaid programs and on all claims for payment submitted under the Medicare and Medicaid programs. This interim final rule with comment period also requires physicians and eligible professionals to order and refer covered items and services for Medicare beneficiaries to be enrolled in Medicare (Interim final rule with comment period, 75 FR 24437, May 5, 2010).

What’s Next?

Except for the curtailment of the Medicaid expansion, all provisions of the ACA remain in effect after the Court’s ruling. This includes all of the provisions summarized above affecting the health insurance market, employers, Medicare, and Medicaid. In addition, the regulatory agencies presumably will continue to get ready for implementation of provisions not effective until 2014: finalizing the requirements for the essential benefit package, and continuing to work on the nondiscrimination rules, among others.

For employers, the impact of the ruling somewhat depends on how active they have been in complying with the law over the last two years. According to Benjamin Lupin, Director of Compliance for Corporate Synergies Group, LLC, for those who have been implementing the law, “there shouldn’t be much to be concerned with based upon the Court’s ruling. If, however, an employer was waiting for the Court’s decision before taking the actions needed to comply with the law, the time is now to ‘get into gear’ and think about 2012 requirements and the approaching 2013 and 2014 requirements.”

“For 2012, this means that employers will need to make sure that they are issuing summaries of benefits and coverage (SBCs) after September of 2012 and continuing to gather information to report on 2012 W-2s,” he explained. “Employers will also need to make sure their ERISA plan documents are in order. In addition, contributions to FSA accounts will be limited to $2,500 in 2013, and employers will need to prepare for the upcoming release of the state exchanges for review in 2013 and implementation in 2014, and will need to decide whether or not they will ‘pay or play’ moving forward.”

“Since we now know that the law is constitutional, it becomes vital for all employers to ensure compliance with the law,” he advised. “There are sure to be audits by the government to make sure that the law is being followed (and to raise revenue) and no employer wants to end up on the front page because of a failure to comply with the law.”

Also still alive at this point is the requirement that states have up and running by 2014 a health benefit exchange that will allow those seeking health coverage to compare qualified plans and choose the one that works best for them. Fewer than 20 states to date have established an exchange; many were waiting for the ruling from the Supreme Court.

However, it’s not likely that states that have resisted enacting the legislation necessary to create an Exchange will rush to do so now. Instead, they may await the outcome of the next test for the Affordable Care Act – the presidential election on November 6, 2012.