

Employers Association of New Jersey

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Issue: The Constitutionality of Individual Mandate Required under the Affordable Care Act and the Impact on New Jersey's Small Employer Health Care Market

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By agreeing to hear multiple challenges to the Affordable Care Act (ACA), the U.S. Supreme Court set the stage for a decision - probably in late June and in the midst of the presidential campaign - that could be among its most important in decades.

The central issue - but not the only important one - is whether Congress exceeded its constitutional powers to regulate interstate commerce and to impose a penalty when it adopted the so-called "individual mandate" at the heart of the health care law.

That provision would require millions of people starting in 2014 to buy commercial health insurance policies or pay financial penalties for failing to do so.

The question of the individual mandate's constitutionality, as presented by in multiple suits, turns on the interpretation of congressional authority to regulate interstate commerce as granted to it under Article I of the U.S. Constitution, known as the Commerce Clause. In approaching this analysis, at least one circuit court of appeals has accepted the argument that the Commerce Clause only applies to the regulation of individuals engaged in a commercial activity, refuting the Department of Justice's (DOJ) assertion that the presence of an activity is not required for Congress to assert its Commerce Clause power.

Having determined that the presence of an activity is an integral part of the Commerce Clause, the question of the individual mandate's constitutionality is framed on whether or not the failure to purchase health insurance constitutes an activity. According to the plaintiffs, the failure to purchase insurance is "inactivity", and Congress therefore exceeded its Commerce Clause authority in embedding this requirement in the ACA, making the individual mandate unconstitutional.

The DOJ counters this claim by arguing that the unique nature of the health care market makes opting out of medical care impossible, and thus the uninsured are not inactive, but rather are inevitable participants whose eventual care potentially shifts the burden of their health care costs to third parties.

The DOJ also argues that by seeking to finance their future medical needs out-of-pocket rather than by purchasing health insurance, the uninsured have made a calculated, economic decision to engage in market timing. This economic decision, according to DOJ, when coupled with the fact that the uninsured are guaranteed access to medical care in hospital emergency rooms regardless of their ability to pay, again resulting in cost-shifting, renders the failure to purchase insurance an activity.

Some federal courts have found the unique factors of the health care market, such as inevitable participation and cost-shifting, to be unpersuasive, ruling that the uniqueness of the health care market is not constitutionally significant, and if Congress exceeds its enumerated powers, the resulting legislation is unconstitutional, regardless of the purported uniqueness of the context in which it is being asserted.

In addition to the assertion that Congress was within its Commerce Clause authority in passing the individual mandate, the DOJ also puts forth the argument that the individual mandate is a valid use of Congressional authority if it is analyzed under the Necessary and Proper Clause (U.S. Const., Art. I, Sec. 8, cl. 18), because this clause authorizes Congress to make laws that are necessary and proper to carry out its enumerated powers, such as regulating interstate commerce.

Citing several of the Act's consumer protections, such as the law's prohibitions on denying coverage or charging higher premiums based on pre-existing conditions, DOJ suggests that individuals may delay obtaining insurance if they are guaranteed issue at a later date, resulting in fewer healthy people in the insured pool, thereby raising premiums and costs for both insurers and individuals. Thus, the DOJ argues that absent a mechanism to incentivize healthy, younger individuals to purchase insurance, which would control costs, the health insurance market would eventually collapse, and therefore the individual mandate is essential in order for the ACA to operate as intended by Congress.

While it is beyond dispute that the individual mandate plays an integral role in the overall structure of the ACA, it does not mean that Congress can require Americans to purchase health care insurance. The Necessary and Proper Clause is not an independent source of federal power, but is rather a formal declaration vesting Congress with the authority to carry out its enumerated powers, not to pass laws that are outside of this granted scope. If the individual mandate is an improper extension of Congress' commerce power, the court may also reject the DOJ's argument that the individual mandate can be otherwise authorized by the Necessary and Proper Clause.

On the other hand, if the Court declares the individual mandate unconstitutional "that would be the worst of all worlds for insurers," says Paul Heldman, a health policy analyst with Potomac Research Group in Washington. "You've got to have some way to ensure that healthy people are going to sign up for coverage to offset the cost of sicker people."

For New Jersey, striking down the individual mandate would wreak havoc on health care premiums for individuals and employers who purchase insurance from an insurance company.

In the state, increasing health care costs have eaten into paychecks. Employers passed health insurance costs onto employees at a sharply higher rate in 2010, reflecting an acceleration of a

trend that has been on the rise for years. As firms struggle to cut costs, more of them are reducing benefits they offer workers or making workers pay more for them.

The state has about 250,000 small employers (defined as 500 or less employees) and 8 of 10 New Jersey residents work for a small employer. About three of four New Jersey residents are covered under an employer-sponsored health care plan, although only about half by a small employer.

The recession has taken a toll on employer-sponsored health care in the state. In the first quarter of 2010, the small employer group market had about 775,000 covered lives, down 16.5% from 2000, as small employers have dropped coverage. The result has been increasing premiums for employers that have stayed in the game.

The individual mandate is supposedly one of the most important ways to mitigate more dramatic increases. Without it, premiums will most likely skyrocket, forcing more employers to cut or cancel health care. The worst-case scenario for New Jersey is that the small-employer market goes into a death-spiral as the remaining provisions of the ACA increases costs. Apparently the court is cognizant of this possible outcome because it made clear that if it decides to strike down the individual mandate, it will also decide which of the Act's hundreds of other provisions should go down too, by deciding whether Congress would have wanted some or all of them to be effective even without the voided provision or provisions.

For example, insurance companies will no longer be able to deny coverage based on pre-existing conditions. Also, under the Act all insured and self-insured health care plans will be required to offer these mandatory preventive health care benefits without co-pays or annual or life time limits.

Treatments for the prevention of alcohol abuse, depression and obesity are among services that will have no cost-sharing. For adults, the list of covered services includes mammograms, colonoscopies and other cancer screenings, diabetes screenings, counseling for tobacco use and prenatal care.

For children, covered services include pediatric visits, vision and hearing screenings, immunizations and obesity screenings.

The U.S. Department of Health and Human Services estimates that no cost preventive care will increase the cost of premiums by at least 1.5% per year, although evidence suggests a healthier workforce and higher productivity will make up for the increase over time.

Additionally, insurance companies will no longer be able to rescind or fail to renew essential health coverage except in cases of fraud or intentional misrepresentation.

Under the ACA, employers with 50 or more full-time workers must offer affordable insurance or pay a penalty. There will be no penalty for employers with less than 50 employees. Since those individuals will still be required to have insurance, they will purchase their own, many with a subsidy. Accordingly, a major new survey from McKinsey predicts that lots of employers will

stop offering coverage once the Affordable Care Act goes into full swing in 2014. But the Congressional Budget Office predicts that fairly few employers will stop offering health-care coverage in response to the Act. Thus the individual mandate creates an incentive for small employers to drop coverage. If that happens, it will raise the costs for every employer that continues to sponsor coverage. But as discussed above, should the individual mandate be declared unconstitutional, the costs of employer sponsored health care and individual insurance will spike. In short, whatever happens in court, it is likely that employers will continue to be stretched to the limit, unable to push more of the costs onto employees.

The Massachusetts reform was a good test case, as it also carried the combination of new options for workers and an easy opt-out for employers. The result so far? Employer-based coverage is now slightly more prevalent in Massachusetts than it was before the law was passed. So as much as employers might be theoretically interested in getting out of the health-care business, that's not an easy conversation for them to have with their employees. But if prices escalate out of control, the conversation becomes much more straight forward.

As reported by EANJ during a series of focus groups in 2010, many employers will indeed consider bailing out of health care, perhaps as many as one in three. But the health care market, particularly for small business, in New Jersey is complex. Many small business owners provide coverage to their families through a small group plan and they and their families will not be buying insurance on their own dime when it can be expensed through the business.

But if employers begin dropping health care coverage for employees, the states are left with at least two options. New Jersey could stop it from happening by passing a strong employer mandate, or the state could embrace it as a long-overdue opportunity to move beyond the employer-based health-care market.

In September 2010, New Jersey received a grant from the U.S. Department of Health and Human Services to lay the foundation for the creation of an Insurance Exchange which is mandated by the Act. An Exchange is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that should permit easy comparison of available plan options based on price, benefits and services, and quality. In theory, by pooling people together, reducing transaction costs, and increasing transparency, Exchanges create more efficient and competitive markets for individuals and small employers.

Historically, the individual and small group health insurance markets have suffered from adverse selection and high administrative costs, resulting in low value for consumers. To address these problems, the Small Employer Health Benefits (SEHB) Program became operational in New Jersey in 1994. Like the insurance reforms enacted by the Affordable Care Act that will become effective in 2014, under the SEHB Program employers with 2-49 employees have the ability to renew their coverage from year to year regardless of the group's claims experience or any changes in the health status of the group's members.

Among other purposes, the SEHM Program was supposed to make health coverage more affordable to small employers by the pooling of risk and by using market leverage and economies of scale that large employers enjoy.

But according to federal statistics, only about half of New Jersey employers with fewer than 50 employees provide health care coverage. This represents about 135,550 employers that employ 737,500 people. At the same time, there are approximately 1,253,000 uninsured people in the state, many of whom are employed.

The cost of health care continues to eat into profits and paychecks. The SEHB Program has been successful in providing access and choice to small employers but it has not worked as well in making health care more affordable, in part because the Program lacks the bargaining power to negotiate premiums as large companies often do.

Under the Act, states will have a range of options for how the Exchange operates from an “active purchaser” model, in which the Exchange operates as large employers often do in using market leverage and the tools of managed competition to negotiate product offerings with insurers, to an “open marketplace” model, in which the Exchange operates as a clearinghouse that is open to all qualified insurers and relies on market forces to generate product offerings.

It is clear that without the bargaining power of a big pool of employers, many employers will be forced to consider the dreadful decision of discontinuing health care for some or all of their employees. In New Jersey, eligible employers can provide health care coverage to their employees by purchasing directly from the Physicians and Employers Welfare Arrangement (MEWA). Through the MEWA, small and mid-sized employers have the same choice of health care plans, plan design flexibility and the same cost savings as a big corporation with thousands of employees.

A MEWA is not an insurance company. A MEWA is an employee benefit plan governed by the Employee Retirement Income Security Act (ERISA). The state of New Jersey also requires MEWAs to meet reserve, contribution, reporting and other requirements to ensure that the MEWA fulfills all of its obligations to subscribers. An employer that is a member in good standing of the Employers Association of New Jersey (EANJ) and that meets the underwriting and other criteria required by the MEWA.