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SCOTUS and California v. Texas: What's Next?

BenefitsPRO **| December 10, 2020**

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On November 10, the Supreme Court heard oral arguments in *California v. Texas*, the latest challenge to the constitutionality of the Affordable Care Act ("ACA"). The positions of the parties to the case have changed throughout its path to the Supreme Court, but, as argued, there are three basic questions to be answered:

- Do the plaintiffs in this case have the right to bring the lawsuit at all, or do they lack "standing"?
- Is the individual mandate for each individual to purchase health insurance a valid use of Congress' power to tax if Congress removes the tax to be paid?
- If the answer to the first question is "no", can the remainder of the law survive (i.e., is the individual mandate "severable").

Because of the sweeping impact of the ACA, the case has the potential to upset the entire health insurance industry. Professionals should be prepared for substantial changes. However, it is probably (hopefully?) more likely that these changes will occur incrementally.

It is, of course, not possible to accurately predict the Court's decision. However, drawing clues from the questions asked during oral argument may help establish the most likely result. Each of the questions to be answered by the Court depends upon the answer to the previous one. If the plaintiffs are determined to not have standing in the first question, the remaining questions would go undecided, effectively upholding the law. This would maintain the status quo, although the increased certainty in the legal environment may have its own impact on the insurance markets. If the oral arguments provide a clue, it is entirely possible that the Court will dodge the substantive questions by denying standing. This possibility would result in the least disruption to the business of health insurance.

If the plaintiffs are determined to have standing, however, the Court still has several paths. Oral arguments suggested that, should the plaintiffs clear the standing hurdle, there are sufficient votes on the Court to strike the individual mandate. This would eliminate one of the primary cost-reducing aspects of the law. If ACA's market reforms (including, most notably, the prohibition on preexisting condition exclusions) are retained, the elimination of the individual mandate would potentially create a large adverse selection problem. This could cause individual insurance premiums to skyrocket. This possibility is a large portion of the severability argument presented to the Court.

However, as several of the Justices pointed out, this problem should have presented itself once the "shared responsibility payment" was eliminated in 2017. Since it has not, the argument that an enforceable individual mandate is necessary to fund the market reforms loses some of its viability. This line of discussion, as well as other comments by the Justices, seemed to indicate that the Court was willing to sever the individual mandate if it was found unconstitutional.

Assuming that the individual mandate is stricken, and found severable, there would be little direct effect on the health insurance market outside of the individual market. ACA regulation of group insurance would be unaffected. Of course, there would be indirect effects, both due to financial effects on insurers that operate in both markets, and on the potential increased demand in the group markets if individual markets become unviable. However, employer sponsors of health insurance (and their service providers) would be able to continue operating without substantial disruption.

By far, the most impactful way in which the case could be decided is that the individual mandate is both unconstitutional and inseverable. If this is the Court's decision, ACA's regulations on group insurance (including the "pay or play" mandate and the related rules regarding the types of coverage that can be offered) would be eliminated. The regulation of group coverage would return to its pre-ACA status.

On the whole, this decision would result in an increase in the flexibility of the group market to provide creative solutions. Under ACA, most large employers needed to tread carefully when designing their health insurance plans to avoid running afoul of the potentially massive penalties associated with ACA's pay or play mandate. Pricing, eligibility, and plan design were all stringently restricted by ACA's rules. Congress and the Executive branch have slowly eased some of those restrictions, but the potential for the imposition of the penalties made some creative plan designs risky.

If the possibility of these penalties is removed, these creative designs become much more viable. Brokers and consultants will be able to more specifically tailor a group benefits program to the particular population. However, it is important to note that pre-ACA regulations would remain in effect. Notably, group insurance would still be prohibited from imposing a preexisting condition exclusion. This requirement for group coverage pre-dates ACA by more than a decade and would be unaffected. Similarly, prohibitions on discrimination based on health status or "lasering out" specific individuals from group coverage would remain in effect.

It is difficult to anticipate the effect this would have on pricing in the group insurance market. In general, the availability of alternatives drives the cost of "traditional" coverage up (because companies with more attractive risk profiles are able to pare down their coverage for their own cost savings, leaving only higher-risk groups in the market for more comprehensive coverage). However, even for comprehensive coverage, the easing of restrictions should help to lower costs.

Given the multiple ways the Court could decide, it is difficult to give concrete advice on how to prepare. Additionally, the possibility that Congress or the Executive could act to change existing regulations or rules make the landscape very uncertain. Employer sponsors are likely to lean heavily on their service providers to be ready to navigate the new environment.

This article first appeared on Benefitspro.com.

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