ACA COMPLIANCE BULLETIN

FEDERAL COURTS WILL HEAR 2 NEW ACA CASES

HIGHLIGHTS

- A federal court will decide whether employers may reduce their employees' work hours in order to avoid providing health benefits.
- The court will address whether this strategy violates ERISA's prohibition on interfering with health benefits.
- A different federal court will address whether the ACA's health insurance providers fee may apply to state-run health coverage.

IMPORTANT DATES

February 9, 2016

A federal District Court denied a motion to dismiss in *Marin v. Dave & Buster's*, allowing the case to continue to trial.

February 24, 2016

Six states filed suit against the federal government to recover amounts paid by the states as a result of the ACA's health insurance providers fee.

Provided By:
Ronstadt Insurance, Inc.

OVERVIEW

Two lawsuits challenging certain provisions of the Affordable Care Act (ACA) will be heard in federal court.

- *Marin v. Dave & Buster's* is a class action lawsuit alleging that the restaurant chain reduced their employees' work hours in order to avoid providing health benefits, as required under the ACA.
- *Texas v. Burwell* is a lawsuit filed by six states claiming that it is unconstitutional to require states to pay the ACA's health insurance providers fee for state-sponsored health insurance coverage (such as Medicaid or the Children's Health Insurance Program).

ACTION STEPS

At this time, no rulings have been issued on the merits of either of these lawsuits. Ronstadt Insurance, Inc. will continue to monitor these cases as they move forward. Employers that have adopted or are considering similar strategies for their employees' work hours as a result of the ACA should carefully consider the potential legal consequences of those efforts.

Marin v. Dave & Buster's

The U.S. District Court for the Southern District of New York will hear the first case on whether employers may reduce their employees' work hours in order to avoid providing health benefits required under the ACA. *Marin v. Dave & Busters* is a class action lawsuit claiming that the restaurant chain violated federal law by intentionally interfering with their employees' eligibility for health benefits. On Feb. 9, 2016, the court rejected Dave & Busters' motion to dismiss the case.

While some workforce changes may not pose legal issues, employers should carefully consider any overt employment actions they may wish to take as a direct result of the ACA and its health coverage requirements.

Background

The ACA requires applicable large employers (ALEs) to offer affordable, minimum value health insurance coverage to their full-time employees, or pay a penalty. For this purpose, a "full-time employee" is defined as an employee that works, on average, at least 30 hours of service per week. In addition, Section 510 of the Employee Retirement Income Security Act (ERISA) prohibits employers and plan sponsors from interfering with an employee's rights to health benefits under the plan.

According to the group of about 10,000 employees who filed suit, beginning in June 2013, Dave & Buster's implemented "a nationwide effort to 'right size' the number of full-time and part-time employees[…]so as to avoid the costs associated with providing insurance that complied with the requirements of the ACA." As a result, a large number of Dave & Buster's employees saw their hours significantly reduced, seemingly for the purpose of keeping them below the ACA's "full-time employee" threshold.

Dave & Busters moved to have the case dismissed, arguing that their specific intention was only to avoid anticipated future costs, not to interfere with their employee's health benefits. However, the federal District Court disagreed, allowing the case to continue to trial. According to the court, the group of employees presented enough evidence to make a claim that Dave & Buster's "intentionally interfered with [the employees'] right to health-care coverage, motivated by [their] concern about future costs that would become associated with the plan's health-care coverage."

Impact on Employers

This case is the first of its kind, and will set a precedent for other employers who are considering or have implemented similar strategies for their employees' work hours as a result of the ACA.

While some workforce changes may not pose legal issues, employers should carefully consider any overt employment actions they may wish to take as a direct result of the ACA and its health coverage requirements.

This Compliance Bulletin is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

© 2016 Zywave, Inc. All rights reserved. BK 2/16

Texas v. Burwell

On Feb. 24, 2016, six states—Texas, Kansas, Louisiana, Indiana, Wisconsin and Nebraska—filed suit against the federal government over the implementation of the ACA's health insurance providers fee. These states claim that it is unconstitutional to require states to pay the ACA's health insurance providers fee for state-sponsored health insurance coverage, such as Medicaid or the Children's Health Insurance Program (CHIP).

Background

The health insurance providers fee is an annual, non-deductible excise tax imposed on the health insurance sector, allocated across the industry according to market share. Implemented in 2014, the first fees were due Sept. 30, 2014.

According to the states, these fees were to be imposed upon health insurance providers, and nothing in the ACA or implementing regulations indicated that the health insurance providers fee would apply to states as a result of state-run health programs, such as Medicaid and CHIP. Instead, a notice issued in March 2015 by the Actuarial Standards Board regarding standards of actuarial practice indicated that, functionally, the states are also liable for the fee.

In this case, the U.S. District Court for the Northern District of Texas will determine whether it is unconstitutional to require states to pay the health insurance providers fee. In particular, the states are arguing that:

- Requiring states to pay the health insurance providers' fee amounts to "an unconstitutionally coercive exercise of Congressional authority," because the federal government could legally deny federal Medicaid and CHIP funds if the states refuse to pay the fee.
- Because paying the health insurance providers fee is now effectively a condition of accepting federal Medicaid and CHIP funds, states were not provided with "clear notice on the conditions of accepting federal funding" as required under the Constitution's Spending Clause.
- The Actuarial Standards Board is a private entity that has no legislative or regulatory authority under the Constitution to extend the application of the health insurance providers fee to states.

To date, the six states involved in this case have collectively paid over $181 million as a result of the health insurance providers fee. If the court agrees with the states, the federal government could be required to repay those fees to the states, in addition to any amounts that the states may pay during the course of the lawsuit.

This Compliance Bulletin is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

© 2016 Zywave, Inc. All rights reserved. BK 2/16