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INSIGHT

Pension Plans Legislative and Agency Update

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CARES Act

On March 27, 2020, President Trump signed the *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act) into law. Among the many items intended to provide relief to individuals and businesses are the following key provisions that directly affect retirement plans.

Qualified Plan Withdrawals

The CARES Act provides for eligible distributions similar to the qualified disaster relief payments provided in the past for various disasters (e.g., Hurricanes Harvey, Irma, and Maria, and the California wildfires). Specifically, the CARES Act provides for temporary withdrawals of up to $100,000 for an individual from a 401(a) plan, 403(a) plan, 403(b) plan, governmental 457(b) plan or IRA.

For defined benefit plans, the individual must be otherwise eligible for a distribution from the plan to qualify for this distribution. These distributions can be taxed over three years, and may be repaid within three years. Further, the 10% early withdrawal tax under Internal Revenue Code Section 72(t) is not applicable, and the distribution is not treated as eligible for rollover for tax withholding and rollover notice rules (i.e., no mandatory 20% withholding or 402(f) notice).

Individuals eligible for these distributions are those: 1) who are diagnosed with SARS-CoV-2 or COVID-19 by a test approved by the CDC; 2) whose spouse or dependent is so diagnosed; or 3) who experience adverse financial consequences as a result of being quarantined, being furloughed or laid off or having work hours reduced to such virus, being unable to work due to a lack of child care due to the virus, closing or reducing hours of a business owned or operated by the individual due to the virus, or such other factors determined by Treasury. An employee certification will be accepted for withdrawal purposes, and these distributions may be made any time during 2020.

This provision: 1) is optional for the plan sponsor; 2) may be included in defined benefit or defined contribution plans; and 3) will require a plan amendment no earlier than the end of the 2024 plan year for governmental plans.

Loan Relief

The CARES Act also provides relief with respect to loans, which is applicable to 401(a) plans, 403(a) plans, 403(b) plans and governmental 457(b) plans. Under its provisions, loan limits under Code Section 72(p) for new loans are increased. The maximum statutory limits are increased to the lesser of $100,000 or 100% of the

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present value of the member's accrued benefit (from $50,000 and one-half of the present value of the member's accrued benefit). These limits apply to loans made through September 23, 2020 (180 days after enactment).

Additionally, payments due on existing loans from March 27, 2020 through December 31, 2020 may be delayed up to one year. During the one-year suspension period, interest will continue to accrue and future payments should be adjusted to reflect the interest accrued during the delay.[1]

This loan relief is available to the same individuals who are eligible for the qualified plan withdrawals previously noted. The provision: 1) is optional for the plan sponsor; 2) may be included in defined benefit or defined contribution plans; and 3) will require a plan amendment no earlier than the end of the 2024 plan year for governmental plans.

Waiver of 2020 Required Minimum Distributions (RMDs)

Generally tracking the waiver provided for 2009 to provide relief after the economic downturn of 2008, the CARES Act provides for the waiver of required minimum distributions (RMDs) during 2020. This waiver applies to defined contribution plans, but not defined benefit plans.

For members, the relief extends to all 2020 RMD payments for: 1) individuals who are already receiving RMDs (e.g., those who attained age 70½ before 2019); 2) individuals who have a required beginning date in 2020 since they turned age 70½ in 2019 (with respect to both the 2020 RMD payment and the 2019 RMD payment, so long as it was not previously made by December 31, 2019); and 3) individuals who retire in 2020 and have an April 1, 2021 required beginning date.

Any RMD payments made during 2020 are treated as not eligible for rollover for certain purposes (such as withholding), but some amounts may be eligible to be rolled over. Further, for post-death distributions, the 2020 calendar year is disregarded when determining the five-year post-death payout period.

Internal Revenue Service (IRS) Relief for Upcoming Deadlines

Separately, the IRS also provided some relief for certain plan sponsors with upcoming deadlines. Through a posting on the Employee Plans section of their website, extensions were granted for the initial 403(b) plan remedial amendment period and certain remedial amendment cycle deadlines for pre-approved defined benefit plans.

Initial Remedial Amendment Period for 403(b) Plans

The end of the initial remedial amendment period was extended from March 31, 2020 to June 30, 2020. Therefore, 403(b) plan sponsors now have until June 30, 2020 to update their plan documents (pre-approved or individually designed) to be in compliance with the Code and applicable regulations. Additionally, the IRS announced that changes will be made to Revenue Procedure 2019-39, which provides for a series of recurring remedial amendment periods for correcting form defects in 403(b) plans, to conform the requirements to the June 30, 2020 deadline.

Deadlines Relating to Pre-Approved Defined Benefit Plans

The IRS also extended deadlines with respect to the second remedial amendment cycle for pre-approved defined benefit plans, changing the following deadlines from April 30, 2020 to July 31, 2020:

- The deadline to adopt a pre-approved defined benefit plan and to submit a determination letter application (if eligible); and
- The end of the second six-year remedial amendment cycle for pre-approved defined benefit plans.

To conform with these changes, the beginning of the third six-year remedial amendment cycle has been pushed back to August 1, 2020, but the end of such cycle remains January 31, 2025 and the on-cycle submission period to submit opinion letter applications remains unchanged (i.e., August 1, 2020 through July 31, 2021).

[1]Note that Notice 2020-23 also provides a limited extension until July 15, 2020 for loan payments otherwise due between April 1, 2020 and July 15, 2020.

SECURE Act Impact on Governmental Plans

The *Setting Every Community Up for Retirement Enhancement Act of 2019* (SECURE Act) was enacted at the end of 2019 and substantially impacts retirement plans. The key provisions that may impact governmental plans include:

In-service Distributions (Age 59½ and Birth/Adoption)

The SECURE Act allows plan members to take an in-service distribution from their pension or governmental 457(b) plan at age 59½, which is a change from the old rules that required members to have attained a minimum age of 62 (for pension plans) and 70½ (for 457(b) plans). This change is optional and may be implemented for plan years beginning after December 31, 2019.

In addition, the SECURE Act allows individuals to take a penalty-free distribution of up to $5,000 from their defined contribution plans for expenses related to the birth or legal adoption of a child. The distribution is permissible for up to one year following the birth or adoption, and is subject to a recontribution right (for which we expect guidance from the IRS). This provision is optional and may be implemented for distributions after December 31, 2019.

RMD Changes (Age 72 and Lifetime Rules)

One of the main changes under the SECURE Act is the increase in the age tied to a member's required beginning date, from age 70½ to 72. This change is applicable to all types of retirement plans. This change is effective for employees who turn age 70½ after December 31, 2019, while the old rule continues for employees that had already reached age 70½ prior to January 1, 2020. For members working past age 70½, there is no change to the required actuarial adjustment for defined benefits plans.

The SECURE Act also limits the beneficiaries under a defined contribution plan who are eligible to receive payments over their life expectancy to those beneficiaries that qualify as an "eligible designated beneficiary." An eligible designated beneficiary is a: 1) surviving spouse; 2) disabled or chronically ill individual (and certain trusts for the same); 3) beneficiary no more than ten years younger than the member; or 4) a minor child of the member (generally until the child reaches the age of majority). Payments to other designated beneficiaries must generally be made by the end of the tenth calendar year following the year of the member's death. These rules apply to governmental plans for member deaths after December 31, 2021. Notably, for non-designated beneficiaries, the rules did not change (i.e., the five-year rule still applies).

403(b) Plan Termination

If an employer terminates a 403(b) plan, the SECURE Act permits a member's account balance to be distributed in-kind. Until paid out, the individual custodial account will be maintained on a tax deferred basis as a 403(b) custodial account, subject to compliance with the 403(b) plan rules in effect at the time that the individual custodial account is distributed.

Part-Time Eligibility

The SECURE Act requires that employers include long-term part-time workers in 401(k) plans. For grandfathered governmental 401(k) plans, part-time employees who work a minimum of 500 hours each period for three consecutive 12-month periods must then be eligible to participate in the plan. This provision applies to plan years beginning after December 31, 2020 and service periods prior to 2021 are not required to be taken into account.

Lifetime Income Investment Portability

The SECURE Act allows members to transfer lifetime income investments or annuity contracts from their employer defined contribution plan to another eligible employer plan or IRA, where such investments are no longer authorized to be held as investment options under the transferor plan. This provision becomes effective for plan years beginning after December 31, 2019.

Disaster Relief

Under the SECURE Act, governmental plans may offer disaster relief to members in a federally declared disaster area, for disasters occurring on and after January 1, 2018 through February 18, 2020 (60 days following the SECURE Act's enactment). Eligible members may generally: 1) take withdrawals or loans of as much as $100,000 from their retirement accounts without penalty and with withdrawals treated as tax-free rollovers if repaid within three years; 2) pay back loans that were outstanding over an extra year; 3) recontribute certain withdrawals taken for homes in the disaster area; and 4) be subject to an automatic extension for certain retirement plan deadlines applicable to those affected by disasters.

Penalty Increases

The SECURE Act has increased the following IRS penalties for returns with due dates after December 31, 2019:

- **Annual Withholding Notice:** Penalties increased to $100 for each failure to provide the required notice (but not to exceed $50,000 per year).

- **Tax Returns (e.g., Form 945):** Penalties for late returns increased to the lesser of $435 (adjusted for inflation) or 100% of the tax to be reported.

Remedial Amendment Period for Governmental Plans

The SECURE Act provides for an extended remedial amendment period for amendments to implement its changes, with amendments to governmental plans generally not required until at least the end of the 2024 plan year. To take advantage of this extended amendment period, the plan must be operated in compliance with the requirements and the amendment must apply retroactively. Note that a separate amendment period applies to the disaster relief changes, with amendments required no later than the last day of the first plan year beginning on or after January 1, 2022 for governmental plans.

Actuarial Assumptions Cases Update

As discussed in the April 2019 issue of *GRS Insight*, defined benefit plan sponsors are facing litigation risk regarding their plan's actuarial assumptions, with eleven cases having been filed by plan participants and beneficiaries to date.[2] The plaintiffs argue that the plan fiduciaries are using outdated actuarial factors, even though generally required by plan terms, when converting a single life annuity to another optional form of benefits (i.e., calculations are based on shorter life expectancies than supported by more recent actuarial factors, which results in a smaller amount of benefits payable in the optional forms of benefits). In other words, the single life annuity is not actuarially equivalent to the optional form, as is required.

In some cases, plaintiffs have also made claims in connection with the plan's early retirement reduction factors, claiming such factors are unreasonable. While these cases generally contain allegations that plan fiduciaries breached their duty in that their reliance on decades-old actuarial tables is unreasonable under ERISA, the claims also rely on Internal Revenue Code requirements for the calculation of benefits, so the cases may have implications for governmental plans.

At this point, motions to dismiss have been filed in all eleven cases except one, *Brown et al. v. United Parcel Service of America, Inc.*, which was just filed on January 21, 2020. Most of the courts that have ruled on the defendants' motions to dismiss have denied the motions, holding that the plaintiffs have met their pleading standards for the cases to continue. However, in *DuBuske v. PepsiCo, Inc.*, the court granted the defendant's motion to dismiss, finding that the plaintiffs retired before normal retirement age and did not allege that they were deprived of their normal retirement benefits at normal retirement age. While the court gave the plaintiffs an opportunity to amend their complaint, it seems the case settled shortly thereafter.

Any decisions in these cases so far have been made at the pleadings stage. A motion for summary judgment was filed in the *Herndon* case, but the court there has yet to rule. Therefore, a decision has yet to be made on the merits where a court has weighed all of the relevant facts and any implications of a decision requiring an amendment to a plan's actuarial assumptions.

Although ERISA does not apply to governmental defined benefit plans, interested parties should monitor the cases since there are other claims made which either apply or have analogous application to such plans.

Congress Passes Two Significant Relief Measures Addressing COVID-19 Pandemic

In March 2020, Congress passed two major pieces of legislation providing relief for employees and employers in the midst of the COVID-19 pandemic. Both bills contain a number of provisions affecting employer obligations related to health benefits and paid leave, as follows:

[2] *Masten v. Metropolitan Life Ins. Co.*, 1:18-cv-11229 (S.D.N.Y. Dec. 3, 2018); *Martinez Torres v. Am. Airlines, Inc.*, 4:18-cv-00983 (N.D. Tex. Dec. 11, 2018); *DuBuske v. PepsiCo, Inc.*, 7:18-cv-11618 (S.D.N.Y. Dec. 12, 2018); *Smith v. U.S. Bancorp*, 0:18-cv-03405 (C.D. Minn. Dec. 14, 2018); *Smith v. Rockwell Automation, Inc.*, 2:19-cv-00505 (E.D.Wis. Apr. 8, 2019); *Duffy v. Anheuser-Busch Companies, LLC,* 4:19-cv-1189 (E.D.Mo. May 6, 2019); *Herndon v. Huntington Ingalls Industries, Inc.,* 4:19-cv-00052 (E.D. Va. May 20, 2019); *Cruz v. Raytheon Company,* 1:19-cv-11425 (D. Mass. Jun. 27, 2019); *Belknap v. Partners Healthcare System, Inc.,* 1:19-cv-11437 (D. Mass. June 28, 2019); *Eliason v. AT&T, Inc.*, 3:19-cv-06232 (N.D.Cal. Oct. 1, 2019); and *Brown et al. v. United Parcel Service of America, Inc. et al.*, 1:20-cv-00460 (N.D.Ga. Jan. 31, 2020).

Families First Coronavirus Response Act

On March 18, 2020, President Trump signed into law the *Families First Coronavirus Response Act* (Families First Act), which contains a number of measures affecting employer-sponsored group health plans, including: 1) mandated COVID-19 testing without cost-sharing; 2) mandated paid leave for small employers; 3) expanded Family and Medical Leave Act (FMLA) leave; and 4) $1 billion in funding for state unemployment insurance expansion.

The key health and welfare provisions include:

- **Free COVID-19 Testing.** Under the Families First Act, group health plans and issuers (including grandfathered plans) must cover FDA-approved COVID-19 diagnostic testing without any cost-sharing (including deductibles, copayments, and coinsurance) or prior authorization or other medical management requirements. If a COVID-19 test is ordered or administered at a provider visit (in-person, telehealth, urgent care, emergency room), plans and issuers must cover items and services related to the: 1) COVID-19 testing product itself; and 2) evaluation of an individual's need for the testing product. The COVID-19 testing mandate became effective immediately and expires when the Secretary of Health and Human Services (HHS) concludes that the coronavirus public health emergency has ended.

- **Mandated Emergency Paid Leave.** The Families First Act requires small employers (i.e., those with fewer than 500 employees) to offer employees up to 80 hours of emergency paid sick leave to use in a variety of coronavirus-related circumstances, including when: 1) the employee is under a quarantine or isolation order; 2) the employee has been instructed by a health care provider to self-isolate; 3) the employee is experiencing COVID-19 symptoms and seeks a medical diagnosis; 4) the employee is caring for an individual who is subject to a quarantine or isolation order or who has been instructed to self-isolate; or 5) the employee is caring for a child whose school or place of care is closed due to COVID-19. Full-time employees receive the full 80 hours of paid leave, while part-time employees receive a prorated amount depending on the number of hours worked. These provisions remain effective until December 31, 2020.

- **Expanded FMLA Leave.** In addition to the emergency paid leave mandate, the Families First Act also amends the FMLA to require small employers (again, those with fewer than 500 employees) to allow certain employees to take up to 12 weeks of job-protected leave in certain coronavirus-related circumstances. Specifically, an employee may take FMLA leave in the event that the employee is unable to work (or telework) due to the need to care for a child whose school or place of care has been closed, or whose child care provider is unavailable due to the coronavirus emergency. The 12-week leave period generally must be paid at two-thirds the regular rate of pay, although the first ten days may be unpaid. Unlike the current FMLA, which applies to employees who have worked for at least 12 months, the coronavirus-related FMLA leave expansion applies to employees who have been employed for at least 30 calendar days. These provisions remain effective until December 31, 2020.

- **Paid Leave Tax Credits.** To help pay for the two new paid leave requirements, the Families First Act provides several refundable tax credits to employers subject to the paid leave requirements. Specifically, with respect to the emergency paid sick leave provisions, employers can claim a refundable tax credit to account for the sick leave wages that an employer must pay under the Act (limited to 10 days of sick leave wages per employee and capped at either $511 or $200 per day, depending on the reason for the leave). With respect to the FMLA leave expansion, employers can claim a refundable tax credit to account for wages paid for up to $200 per day per individual, capped at $10,000 per individual. The tax credit provisions remain effective until December 31, 2020.

- **Unemployment Insurance Expansion.** The Families First Act also provides $1 billion in federal funding to assist states in paying out unemployment insurance benefits resulting from COVID-19.

Coronavirus Aid, Relief, and Economic Security Act

On March 27, 2020, President Trump signed into law the *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act), a $2 trillion economic stimulus bill providing relief to individuals and small businesses. Some of the key health and welfare provisions include:

- **Paid Leave Caps.** In clarifying the paid leave provisions of the Families First Act, the CARES Act specifies that an employer's mandate to provide emergency paid leave

is capped at either $511 per employee per day, and $5,110 per employee in the aggregate (for leave to care for oneself) or $200 per employee per day, and $2,000 (for leave to care for another) per employee in the aggregate. The CARES Act also caps the expanded FMLA leave obligation at $200 per employee per day, and $10,000 per employee in the aggregate.

- **Advancement of Tax Credit for Paid Leave.** The CARES Act expands the refundable tax credits implemented by the Families First Act by allowing an advancement of the credit and by waiving certain tax penalties that might otherwise apply in connection with the advancement.

- **Expansion of Free COVID-19 Testing.** Building on the mandated COVID-19 testing requirements of the Families First Act, the CARES Act expands the kinds of diagnostic tests that employers must cover without cost-sharing to include tests for which the developer has requested or intends to request emergency use authorization from the U.S. Food & Drug Administration. The expansion also includes tests that are developed by a State and those that are deemed appropriate by the Secretary of HHS.

- **Pricing of Testing.** The CARES Act specifies the pricing that applies to mandated COVID-19 testing. Specifically, group health plans and issuers must pay health care providers the same rate that was previously negotiated before HHS made an emergency declaration related to COVID-19, if a negotiated rate was in place. If no negotiated rate was in place, then the plan or issuer must pay the provider's listed cash price for the COVID-19 test or may negotiate a lower price.

- **Coverage of COVID-19 Preventive Services and Vaccines.** The CARES Act requires group health plans and issuers to cover coronavirus-related preventive services without cost-sharing. Specifically, plans and issuers must cover items, services, and immunizations intended to prevent or mitigate COVID-19 and which are recommended by either the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices. Such preventive services must be covered within 15 business days of the date that the recommendation is made.

- **Telehealth and HSAs.** In order to promote the availability of all telehealth during the coronavirus pandemic, the CARES Act allows high deductible health plans to remain health savings account (HSA)-eligible even if they cover telehealth services before the plan's deductible is met.

- **Over-the-Counter Drugs and Products and Account-Based Plans.** The CARES Act permits individuals to use their HSAs, flexible spending accounts, health reimbursement accounts, and Archer Medical Savings Accounts to purchase over-the-counter drugs and other specified products without a prescription. This provision reverses a long-standing provision in the Affordable Care Act that required individuals to obtain a prescription in order to purchase over-the-counter drugs using funds in an account-based health plan.

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Depending on the severity and duration of the COVID-19 pandemic, further legislative action affecting employer sponsors of group health plans remains a distinct likelihood. Any such action would likely include additional measures aimed at providing relief for employers and employees.

Recent Health-Related Tax Changes

On December 20, 2019, President Trump signed into the law the *Setting Every Community Up for Retirement Enhancement Act of 2019* (SECURE Act), which, among other things, makes major changes to three health-related fees and taxes put in place by the Affordable Care Act (ACA) – the Patient-Centered Outcomes Research Institute (PCORI) fee, the health insurer fee (HIF), and the Cadillac Tax. A summary of the changes includes:

PCORI Fee

The SECURE Act extended the PCORI fee for 10 years. The PCORI fee is a fee on issuers of group health insurance policies and plan sponsors of self-insured group health plans that helps fund the Patient-Centered Outcomes Research Institute (PCORI). It is an annual fee that issuers and plan sponsors must pay (currently $2.45) for each "covered life" under the plan.

The fee was originally scheduled to apply to each plan/policy year ending on or after October 1, 2012 and until September 30, 2019. The SECURE Act extended the PCORI fee through plan years ending until September 30, 2029. The last payment for calendar year plans will be July 31, 2029.

Insurers and plan sponsors must file IRS Form 720 and pay the 2019 fee by July 31, 2020. Although for insured plans, the issuers themselves (and not plan sponsors) owe the fee, plan sponsors of insured plans could expect their premiums to increase as issuers seek to recover the fee through increased premiums. The IRS has not yet published the fee amount, but is expected to do so soon.

Health Insurer Fee

The SECURE Act repeals the HIF, effective in 2021 (the last fee owed is in 2020, based on 2019 premiums). The HIF is an annual fee on issuers of insurance policies in the individual, group, and Medicare/Medicaid markets. The HIF was effective in 2014 and has since been suspended and restarted by Congress intermittently. Only health insurance issuers owe the HIF, so this change will not impact self-insured plans.

Cadillac Tax

The SECURE Act also repeals the ACA's so-called "Cadillac Tax" on high-cost employer-sponsored health plans. Stakeholder groups for many years have urged lawmakers to repeal the tax, which has been delayed several times by Congress, most recently until 2022.

The Cadillac Tax would have imposed a 40% excise tax on employer coverage that exceeds certain thresholds and would have applied to both employers' and employees' share of the cost of health coverage, as well as to contributions to certain medical spending accounts.

Health Litigation Update: *Texas v. United States*

In December 2019, the U.S. Court of Appeals for the Fifth Circuit issued its decision in *Texas v. United States*—the case challenging the constitutionality of the Affordable Care Act (ACA). Although the Fifth Circuit Court affirmed the lower court's holding that the ACA's individual mandate was unconstitutional, the court also remanded the case to the District Court for a severability analysis of what provisions of the ACA, if any, could be severed from the individual mandate or whether the entire statute was now unconstitutional. The U.S. Supreme Court subsequently agreed to take up the case, setting the stage for a showdown on the constitutionality of the ACA.

Recap

In early 2018, two private citizens and eighteen states filed a lawsuit challenging the constitutionality of the ACA's individual mandate and, in turn, the entire ACA. The plaintiffs argued that because the U.S. Supreme Court had previously upheld the constitutionality of the individual mandate solely under Congress' taxing authority, and because Congress in 2017 reduced the penalty for failing to obtain health coverage to zero, the individual mandate no longer functioned as a "tax" since individuals were no longer required to pay anything to the Internal Revenue Service (IRS) for failing to obtain health coverage. Thus, in the plaintiffs' view, the individual mandate was no longer constitutional because the sole means by which the Supreme Court had previously upheld its constitutionality (i.e., Congress' power to tax) no longer applied. Furthermore, the plaintiffs argued that because the individual mandate was inextricably intertwined with the rest of the ACA, it was "inseverable" from the ACA at large, meaning the entire ACA was unconstitutional.

In late 2018, the U.S. District Court for the Northern District of Texas agreed, finding the individual mandate both unconstitutional and inseverable, thus invalidating the entirety of the ACA.[3] The defendants subsequently appealed, and the effect of the district court's ruling was placed on hold.

Fifth Circuit Court Decision

In December 2019, the U.S. Court of Appeals for the Fifth Circuit affirmed in part and remanded in part.[4] As to the individual mandate, the Fifth Circuit Court held that it was unconstitutional because without any penalty for noncompliance, it could no longer be read as a tax, and there was no other basis upon which to find it constitutional. However, as to severability, the court remanded the issue back to the district court for further consideration before deciding the issue on the merits.

The key threshold issue considered by the court was whether the individual plaintiffs had standing to sue—that is, whether the ACA's individual mandate injured them to a

[3] *Texas v. United States*, 352 F. Supp. 3d 665 (N.D. Tex. 2018).
[4] *Texas v. United States*, 945 F.3d 355 (5th Cir. 2019).

degree sufficient to warrant a federal court's consideration of their claims. The Democratic Attorneys General intervenors argued that the individual plaintiffs had no standing to sue: after all, without any penalty for failing to purchase health coverage, the plaintiffs were perfectly free to purchase health coverage—or not—as they pleased. Any "harm" that the plaintiffs suffered resulting from the individual mandate was, therefore, entirely self-inflicted and plaintiffs generally do not have standing to bring lawsuits addressing self-inflicted harms. On the other hand, the individual plaintiffs argued that regardless of the fact that the penalty for failing to purchase health coverage was zero dollars, the law on the books still required them to purchase coverage. Since they felt compelled to follow the law, they believed the law required them to purchase health coverage, thereby injuring them by requiring them to purchase something that they did not wish to purchase.

In a lengthy opinion, the court found that the individual plaintiffs did have standing. Although the court acknowledged that the individual plaintiffs no longer faced any penalty for failing to purchase health coverage, the court reasoned that they (and many other individuals) would still feel compelled to obtain health coverage to comply with the individual mandate because they believed in abiding by the nation's laws. In that sense, the court concluded that the individual mandate injured them because it required them to spend additional funds that they did not want to spend.

The other key issue that the court considered was the constitutionality of the individual mandate itself. Among other things, the Democratic Attorneys General intervenors argued that even without a penalty for noncompliance, the individual mandate was still a tax because it had the potential to produce revenue. That is, it was still set out in the Internal Revenue Code and could be amended in the future to tax individuals for failing to purchase health coverage. However, the court disagreed. It held that because the individual mandate still commanded people to buy health coverage, and because the penalty for noncompliance no longer produced any revenue, it could no longer be read as a tax and, therefore, had no constitutional support.

As to whether the individual mandate was severable from the rest of the ACA, the court declined to rule, instead remanding the issue back to the district court for further consideration.

Next Steps

Despite the remand to the district court, both sides filed petitions for certiorari with the U.S. Supreme Court in early January 2020. Subsequently, the Supreme Court granted the petitions, which means it will take up the case in the not-too-distant future. At the time of writing, briefing is currently scheduled to be completed in August 2020—although that could get pushed back depending on the severity and duration of the coronavirus pandemic. However, if the case stays on schedule, oral argument will be held in October 2020, with a decision coming by June 2021, the end of the term.

The Supreme Court proceedings will no doubt be some of the most closely-watched in recent years. Interested parties should be sure to monitor the tenor of oral argument in October, particularly the Justices' questions on standing and severability.

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