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## THE U.S. SUPREME COURT UPHOLDS THE HEALTH CARE REFORM LAW: WHAT'S NEXT FOR EMPLOYER-SPONSORED GROUP HEALTH PLANS?

*Stephen J. Mogila & Daniel L. Saperstein\**

### I. INTRODUCTION

In March of 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (commonly referred to as the health care reform law and hereinafter as the “Affordable Care Act” or “PPACA”).<sup>1</sup> Despite its stated dual intent to increase health insurance access and reduce health care costs for Americans, PPACA has evoked intense protests, threats of repeal, and prolonged litigation. Indeed, the United States Courts of Appeals for the Third, Fourth, Fifth, Sixth, Eighth, Ninth, Eleventh, and D.C. Circuits, as well as several federal district courts, considered the constitutionality of PPACA.<sup>2</sup> As the

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered titles of the U.S.C.), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of the U.S.C.).

2. The Third, Fourth, Fifth, Eighth, and Ninth Circuits declined to reach the merits of the constitutional challenges on jurisdictional grounds. *See Kinder v. Geithner*, No. 11-1973, slip op. at 2 (8th Cir. Oct. 4, 2012); *Physician Hosps. of Am. v. Sebelius*, No. 11-40631, slip op. at 3, 15 (5th Cir. Aug. 16, 2012); *Liberty Univ., Inc. v. Geithner*, 671 F.3d 391, 397 (4th Cir. 2011); *Virginia ex rel. Cuccinelli v. Sebelius*, 656 F.3d 253, 272-73 (4th Cir. 2011); *Baldwin v. Sebelius*, 654 F.3d 877, 878-80 (9th Cir. 2011); *N.J. Physicians, Inc. v. President of U.S.*, 653 F.3d 234, 236 (3d Cir. 2011); *Purpura v. Sebelius*, 446 F. App’x 496, 497-98 (3d Cir. 2011). The Eleventh Circuit ruled that the individual mandate was unconstitutional. *See Florida v. U.S. Dep’t of Health & Human Servs.*, 648 F.3d 1235, 1320 (11th Cir. 2011). The D.C. and Sixth Circuits upheld the constitutionality of the individual mandate. *See Seven-Sky v. Holder*, 661 F.3d 1, 4-5 (D.C. Cir.

circuits split, the U.S. Supreme Court weighed in this past summer with a controversial 5-4 decision,<sup>3</sup> upholding the constitutionality of PPACA's "individual mandate,"<sup>4</sup> which is scheduled to take effect on January 1, 2014.

The individual mandate effectively requires most Americans to maintain minimal essential health coverage or else become subject to a "[s]hared responsibility payment" to the federal government.<sup>5</sup> Although PPACA characterizes this payment as a penalty (as opposed to a tax), such penalty must be paid to the Internal Revenue Service ("IRS" or the "Service") as part of an individual's annual federal gross income tax return and assessed and collected in the same manner as a tax penalty under the Internal Revenue Code.<sup>6</sup>

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2011); Thomas More Law Ctr. v. Obama, 651 F.3d 529, 533-34 (6th Cir. 2011).

3. Before the Court for review, on a consolidated basis, was *National Federation of Independent Business v. Sebelius* (No. 11-393), *Department of Health and Human Services v. Florida* (No. 11-398), and *Florida v. Department of Health and Human Services* (No. 11-400). Nat'l Fed'n of Indep. Bus. v. Sebelius, No. 11-393 (U.S. June 28, 2012).

4. I.R.C. § 5000A(a) (Supp. IV 2011); *Sebelius*, slip op. at 1-2. An issue beyond the scope of this Idea, the Court also considered the constitutionality of PPACA's requirements that would have the effect of expanding the Medicaid program. Generally speaking, the Medicaid program offers federal funding to the states to assist pregnant women, children, needy families, the blind, the elderly, and the disabled in obtaining medical care. See 42 U.S.C. § 1396a(a)(10) (2006). PPACA's Medicaid provisions, slated to take effect in 2014, expanded the scope of this program by increasing the pool of individuals who would be eligible for assistance. To comply with PPACA, states were to provide Medicaid coverage to adults (and their dependent children) with incomes up to 133 percent of the federal poverty level. See 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (Supp. IV 2011), *invalidated* by Nat'l Fed'n of Indep. Bus. v. Sebelius, No. 11-393 (U.S. June 28, 2012). In contrast, under the existing Medicaid program, the income threshold is much lower, and many states only cover qualifying adults if they have dependent children.

Although PPACA provides additional federal funding to cover the cost of this expanded coverage, states were to bear some portion of the related cost as well. Under PPACA, states that failed or refused to expand their definition of Medicaid eligibility were penalized by losing all existing and any new additional Medicaid funds. This penalty left states with a "Morton's Fork": either (1) comply (i.e., pay the required costs of the non-subsidized portion of the Medicaid expansion requirements regardless of whether the state can afford them); or (2) risk losing all federal Medicaid funding which, in most cases, represents a significant portion of a state's overall budget. See 42 U.S.C. § 1396c (2006).

Upon review, the Court found that the Medicaid expansion provisions were unconstitutional. The Court noted that "[a] State could hardly anticipate that Congress's reservation of the right to 'alter' or 'amend' the Medicaid program included the power to transform it so dramatically." *Sebelius*, slip op. at 54. As such, non-complying states will be eligible to receive existing Medicaid funding. The Court also held that the unconstitutional part of the Medicaid provisions could be severed from the rest of PPACA, which remained intact and operative. *Id.* at 56-58.

5. I.R.C. § 5000A(b)(1).

6. See *id.* § 5000A(b)-(c), (g)(1).

In *National Federation of Independent Business v. Sebelius*,<sup>7</sup> the petitioners asked the Court to strike down the individual mandate by arguing that the U.S. Constitution does not vest Congress with the power to require individuals to engage in commercial activities or purchase unwanted goods or services from the market.<sup>8</sup> The respondents, on behalf of the federal government and its agencies, argued that Congress had the power to impose the mandate under its authority to: (1) regulate commerce pursuant to the Commerce Clause; and/or (2) lay and collect taxes under the Taxing and Spending Clause<sup>9</sup>—both of which are set forth in Article I of the Constitution.<sup>10</sup>

Because the individual mandate is not effective until 2014, the Court first had to determine whether the case was ripe for review under the Federal Anti-Injunction Act, which prohibits taxpayers from preemptively seeking to prevent the government from assessing a tax.<sup>11</sup> The Court found that the Anti-Injunction Act was inapplicable because PPACA's penalty on individuals who fail to obtain insurance coverage was not a "tax" for purposes of the Anti-Injunction Act.<sup>12</sup> Despite this finding, the Court determined that the individual mandate was nevertheless constitutional as a "tax" under the Taxing and Spending Clause.<sup>13</sup> In reaching this conclusion, the Court avoided addressing other contentious issues, like whether invalidating the individual mandate would, in turn, render all of PPACA unconstitutional (i.e., the so-called severability issue) or if the other PPACA mandates not specified in the suit were permissible.

As a result of the Court's ruling, at this time, all other provisions and mandates of PPACA remain in full force and effect, with the exception of the Medicaid expansion provisions (as noted above). Accordingly, employers and plan sponsors of group health plans must continue to implement the reforms set forth in PPACA. That said,

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7. No. 11-393 (June 28, 2012).

8. *Id.* at 8, 20-21.

9. *Id.* at 15.

10. U.S. CONST. art. I, § 8, cl. 1 ("The Congress shall have the Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States . . .").

11. *Sebelius*, slip op. at 11. The Anti-Injunction Act specifically provides that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed." I.R.C. § 7421(a).

12. *Sebelius*, slip op. at 15.

13. *Id.* at 44. In explaining this apparent paradox, Chief Justice John Roberts explained that "while that [penalty] label is fatal to the application of the Anti-Injunction Act, it does not determine whether the payment may be viewed as an exercise of Congress's taxing power [under the Constitution]." *Id.* at 33 (citation omitted).

PPACA was and remains subject to threats of repeal<sup>14</sup> and litigation still looms with regard to the implementation and administration of its other provisions.<sup>15</sup>

This Idea provides an overview of the Court's ruling and discusses the implications for employers and plan sponsors of group health plans for complying with PPACA and managing health care costs. Part II summarizes the Court's rationale in upholding the individual mandate. Part III addresses the material compliance requirements under PPACA scheduled to take effect this year and beyond for employers and plan sponsors of group health plans. Finally, recognizing that these upcoming compliance mandates will impose new cost burdens on employer-sponsored group health plans, Part IV discusses some practical cost-saving strategies to offset a plan's overall health and compliance costs.

## II. OVERVIEW OF THE COURT'S RULING ON THE INDIVIDUAL MANDATE

Chief Justice John Roberts wrote the opinion for the Court, in which Justices Ruth Bader Ginsburg, Sonia Sotomayor, Stephen Breyer, and Elena Kagan concurred, and Justices Antonin Scalia, Anthony

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14. Although the Supreme Court upheld the Act, failed Republican presidential candidate, Governor Mitt Romney, had repeatedly stated that if elected, he would have acted immediately to repeal PPACA. *See, e.g.*, Mitt Romney, Remarks in Washington, D.C. (June 28, 2012), available at <http://abcnews.go.com/blogs/politics/2012/06/romney-calls-for-obamacare-repeal-as-bad-law/>. Additionally, the Republican controlled House of Representatives has voted to repeal PPACA a number of times. *See, e.g.*, Repealing the Job-Killing Health Care Law Act, H.R. 2, 112th Cong. (1st Sess. 2011); H.R. 429, 112th Cong. (1st Sess. 2011); H.R. 215, 112th Cong. (1st Sess. 2011). Most recently, on July 11, 2012, the U.S. House of Representatives passed the Repeal of Obamacare Act in an effort to abolish the entire health care law. Repeal of Obamacare Act, H.R. 6079, 112th Cong. (2d Sess. 2012); Rachel Slajda, *House Passes 2nd Bill to Repeal Health Care Law*, LAW360 (July 11, 2012, 8:52 PM), <http://www.law360.com/employment/articles/358852>.

15. Although the Court held that the individual mandate required under PPACA was constitutional, challenges to other provisions of the law have already commenced and are likely to continue over the coming years. For example, on July 27, 2012, a Colorado federal district court judge granted a preliminary injunction in favor of a "for-profit, secular employer," enjoining the Department of Health and Human Services from enforcing against that employer's group health plan its regulations requiring non-grandfathered group health plans to provide birth control coverage. *Newland v. Sebelius*, No. 1:12-cv-1123-JLK, 2012 U.S. Dist. LEXIS 104835, at \*7-8, \*27-28 (D. Colo. July 27, 2012). In addition, more than forty Catholic employers (including churches, hospitals, and schools) recently sued the Obama Administration, claiming the same birth control provision in PPACA violates their constitutionally protected First Amendment right to freedom of religion. *See, e.g.*, Complaint and Demand for Jury Trial at 1-2, *Univ. of Notre Dame v. Sebelius*, No. 3:12-cv-253 (N.D. Ind. May 21, 2012). We expect that future cases may be brought by states like Texas that decline to implement the state exchanges as required by PPACA, by employers in such states, and other suits related to other aspects of PPACA—none of which were addressed in *Sebelius*. *See, e.g.*, Letter from Rick Perry, Governor, State of Tex., to Hon. Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. (July 9, 2012), available at <http://governor.state.tx.us/files/press-office/O-SebeliusKathleen201207090024.pdf>.

Kennedy, Clarence Thomas, and Samuel Alito dissented.<sup>16</sup> As discussed above, before turning to the merits of the constitutional question, the Court decided that it could hear the case under the Anti-Injunction Act, finding that the individual mandate was not a “tax” for purposes of statutory construction.<sup>17</sup>

Perhaps as a nod to the fact that a majority of Americans have been divided on the direction of health care reform, Chief Justice Roberts first stated that the Court “d[id] not consider whether the Act embodies sound policies. That judgment is entrusted to the Nation’s elected leaders.”<sup>18</sup> Indeed, the Court expressed “a general reticence to invalidate the acts of the Nation’s elected leaders.”<sup>19</sup> With this guiding principle in mind, the Court carefully parsed through the Commerce and Taxing and Spending Clauses to address the constitutionality of the individual mandate.

### A. Commerce Clause

A majority of the Court (Justices Roberts, Scalia, Kennedy, Thomas, and Alito) found that Congress had, in fact, exceeded its power under the Commerce Clause by enacting the individual mandate.<sup>20</sup> The Commerce Clause enables the U.S. Congress “[t]o regulate commerce . . . among the several States . . . .”<sup>21</sup> Although the Court noted that this “power over activities that substantially affect interstate commerce can be expansive,”<sup>22</sup> it also stressed that the decisions

16. *Sebelius*, slip op. at 1; *id.*, slip op. at 1 (Ginsberg, J., concurring); *id.*, slip op. at 1 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting).

17. According to the Court, “[t]he Anti-Injunction Act and [PPACA] are creatures of Congress’s own creation. How they relate to each other is up to Congress, and the best evidence of Congress’s intent is the statutory text. We have thus applied the Anti-Injunction Act to statutorily described ‘taxes’ even where that label was inaccurate.” *Sebelius*, slip op. at 13 (majority opinion) (citing *Bailey v. George*, 259 U.S. 16 (1922)).

18. *Id.* at 2.

19. *Id.* at 6.

20. *Id.* at 27. The Court also rejected the notion that Congress has the power under the Necessary and Proper Clause to enact the legislative mandate because it is an “integral part of a comprehensive scheme of economic regulation . . . .” *Id.* at 27 (internal quotation marks omitted). The Court found that “[j]ust as the individual mandate cannot be sustained as a law regulating the substantial effects of the failure to purchase health insurance, neither can it be upheld as a ‘necessary and proper’ component of the insurance reforms.” *Id.* at 30; *see also* U.S. CONST. art. I, § 8, cl. 18.

21. U.S. CONST. art. I, § 8, cl. 3. The Court has defined this Clause to mean that Congress may regulate “the channels of interstate commerce[,] . . . persons or things in interstate commerce, . . . [and] those activities that substantially affect interstate commerce.” *United States v. Morrison*, 529 U.S. 598, 608-09 (2000) (citations omitted) (internal quotation marks omitted).

22. *Sebelius*, slip op. at 4-5. For examples of this “expansive” power upholding the constitutionality of a regulation of a farmer’s decision to grow wheat for himself and his livestock and a loan shark’s extortionate collections from a neighborhood butcher shop, *see Wickard v. Filburn*, 317 U.S. 111, 128-29 (1942), and *Perez v. United States*, 402 U.S. 146, 147-48, 154

regarding this clause's interpretation "uniformly describe the power as reaching 'activity'" alone.<sup>23</sup>

The Court found that "[t]he individual mandate . . . does not regulate existing commercial activity[, but] . . . instead compels individuals to become active in commerce by purchasing a product, on the ground that their failure to do so affects interstate commerce."<sup>24</sup> The Court continued:

Construing the Commerce Clause to permit Congress to regulate individuals precisely because they are doing nothing would open a new and potentially vast domain to congressional authority. Every day individuals do not do an infinite number of things. In some cases they decide not to do something; in others they simply fail to do it. Allowing Congress to justify federal regulation by pointing to the effect of inaction on commerce would bring countless decisions an individual could potentially make within the scope of federal regulation, and—under the Government's theory—empower Congress to make those decisions for him.<sup>25</sup>

The Court, therefore, concluded that such an interpretation would allow Congress to "compel" commerce, not "regulate" it—a distinction which swayed the majority of the Justices.<sup>26</sup>

### B. Taxing and Spending Clause

Although the Court found the individual mandate unconstitutional under the Commerce Clause, the Court upheld the mandate as a permissible "tax" under the Taxing and Spending Clause.<sup>27</sup> The Court noted in its reasoning that, if an individual chooses not to purchase health insurance, "the only consequence" is making an additional payment to the IRS when paying his or her taxes.<sup>28</sup> The Court did not

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(1971), respectively.

23. *Sebelius*, slip op. at 19.

24. *Id.* at 20 (emphasis omitted).

25. *Id.* at 20-21 (emphasis omitted).

26. *See id.* at 20. The Chief Justice used this logic to attack the Government's argument that, because "sickness . . . [is] . . . unavoidable, the uninsured as a class are active in the market for the health care . . . ." *Id.* at 24 (internal quotation marks omitted). Indeed, the Court stated, "[e]veryone will likely participate in the markets for food, clothing, transportation, shelter, or energy; that does not authorize Congress to *direct* them to purchase particular products in those or other markets today." *Id.* at 26 (emphasis added).

27. *Id.* at 44. For the sake of brevity, this Idea will not discuss the Court's reasoning regarding why the individual mandate complied with "other [tax] requirements in the Constitution." *See id.* at 40.

28. *Id.* at 32. The Court elaborated why the individual mandate "looks like a tax." First, the "[s]hared responsibility payment" is disbursed to the Treasury when individuals pay their taxes. *Id.* at 33 (internal quotation marks omitted). Second, it does not cover individuals who do not pay

find it dispositive that PPACA classified the individual mandate as a “penalty” instead of a “tax”—noting that the statutory classification “does not . . . control whether an exaction is within Congress’s constitutional power to tax.”<sup>29</sup>

Indeed, the Court found that the circumstances weighed in favor of deeming the individual mandate a tax. First, for the majority of Americans, the penalty assessed for not purchasing health insurance will be significantly less (“and, by statute, . . . can[not] . . . be more”) than the price of insurance.<sup>30</sup> Second, the individual mandate does not have a “scienter requirement.”<sup>31</sup> Third, the payment is collected solely by the IRS like any other tax, “except that the Service is not allowed to use those means most suggestive of a punitive sanction, such as criminal prosecution.”<sup>32</sup> Accordingly, the Court concluded that:

[w]hile the individual mandate clearly aims to induce the purchase of health insurance, it need not be read that to declare failing to do so is unlawful. Neither the Act nor any other law attaches negative legal consequences to not buying health insurance, beyond requiring a payment to the IRS.<sup>33</sup>

### C. Severability

Given that PPACA did not contain a severability clause, had the Court invalidated the individual mandate, it also would have faced the dilemma of whether to discard the remainder of the health care reform law. This issue, however, was rendered moot by the Court’s decision to uphold the individual mandate.

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federal income taxes. *Id.* Third, for those individuals who qualify, the amount is decided by conventional factors such as “taxable income, number of dependents, and joint filing status.” *Id.* Fourth, the requirement to pay is located in the Internal Revenue Code and enforced by the IRS. *Id.* Accordingly, the Court stressed that “[t]his process yields the essential feature of any tax: it produces at least some revenue for the Government.” *Id.*

29. *Id.* at 33; *see also* *United States v. Sotelo*, 436 U.S. 268, 275 (1978) (“That the funds due are referred to as a ‘penalty’ . . . does not alter their essential character as taxes . . . .”); *Nelson v. Sears, Roebuck & Co.*, 312 U.S. 359, 363 (1941) (“In passing on the constitutionality of a tax law, we are concerned only with its practical operation, not its definition or the precise form of descriptive words which may be applied to it.” (internal quotation marks omitted)); *S. Pac. Co. v. Gallagher*, 306 U.S. 167, 177 (1939)); *Child Labor Tax Case*, 259 U.S. 20, 38 (1922) (holding that exaction designated a tax by Congress was not a tax).

30. *Sebelius*, slip op. at 35. Indeed, “the fact the exaction here is paid like a tax, to the agency that collects taxes—rather than, for example, exacted by Department of Labor inspectors after ferreting out willful malfeasance—suggests that this exaction may be viewed as a tax.” *Id.* at 36 n.9.

31. *Id.* at 36.

32. *Id.* (emphasis omitted); *see also* I.R.C. § 5000A(g) (Supp. IV 2011).

33. *Sebelius*, slip op. at 37.



### III. CONSEQUENCES OF THE COURT'S RULING FOR EMPLOYERS AND PLAN SPONSORS OF GROUP HEALTH PLANS

As a result of the Court's ruling, the *status quo* under PPACA effectively remains. From a compliance perspective, therefore, employers and plan sponsors who sponsor group health plans must continue to implement PPACA's various mandates, which may differ depending on an employer's "grandfathered" status.<sup>34</sup>

In the near term, the various PPACA mandates that must be addressed during 2012 include:

- The Form W-2 reporting requirement that requires all employers who issued more than 250 W-2s in the prior year to report the aggregate cost of health coverage received by each employee under the employer's health plan.<sup>35</sup> Whether 250 W-2s were issued in the prior tax year is determined on a "tax identification number" basis;
- The Summary of Benefits and Coverage ("SBC") requirements (for open enrollment periods starting on or after September 23, 2012);<sup>36</sup> and
- The Comparative Effectiveness Research Fee, which will be an additional tax on each member in all employer group health plans for the purpose of funding a trust to pay for comparative treatment methodologies. The fee is \$1 per member in the first year and will increase in following years.<sup>37</sup>

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34. Any existing group health plan that had at least one person enrolled as of March 23, 2010 (i.e., PPACA's effective date) and continues to enroll someone after such date constitutes a "grandfathered" health plan, so long as the plan does not implement certain design changes that would exceed the limits applicable to grandfathered plans. See 42 U.S.C. § 18011(a), (e) (Supp. IV 2011). Although PPACA imposes a multitude of coverage mandates, reporting requirements, and administrative requirements for group health plans, grandfathered plans may entirely avoid having to comply with certain health reform rules (such as those rules related to nondiscrimination testing, claims procedure, and preventive care) otherwise applicable to new plans established after March 23, 2010.

35. See I.R.C. §§ 6011(e)(2), 6051(a)(14) (2006 & Supp. IV 2011).

36. 42 U.S.C. § 300gg-15 (Supp. IV 2011). The SBC is a new disclosure requirement designed to standardize written descriptions of health insurance policies and coverage so that participants and consumers can better understand their health coverage in comparison to other health insurance options in the market. The SBC must follow a consistent four double-sided page format with twelve-point font written in a "culturally and linguistically" appropriate manner with language understandable to the average plan participant and beneficiary. *Id.* § 300gg-15(b)(1)–(2). The SBC also must address a total of eleven specific required content elements (e.g., descriptions of coverage, cost-sharing provisions, limitations or reductions on coverage, renewability and continuation of coverage provisions, a coverage facts label that includes examples of coverage and related cost-sharing, a disclosure statement regarding whether the plan provides minimum essential coverage, etc.) and be provided free of charge. See *id.* § 300gg-15(b)(3), (d).

37. See I.R.C. § 4375(a) (Supp. IV 2011); see also Fees on Health Insurance Policies and

For 2013, the various health care reforms and mandates include:

- A \$2500 maximum annual limit (indexed to the Consumer Price of Inflation) on employee contributions to health flexible spending accounts ("FSAs") (for plan years beginning on or after January 1, 2013);<sup>38</sup>
- Requirement for employers to notify employees of the availability of health insurance exchanges (March 1, 2013);<sup>39</sup> and
- 0.9% Medicare payroll tax increase on high income individuals (for the 2013 tax year).<sup>40</sup>

Additional PPACA requirements become effective in 2014, including:

- The "pay-or-play" mandate;<sup>41</sup>
- Requirement that group health plans provide coverage for adult dependent children up to age twenty-six, regardless of whether the child is eligible to enroll in other employer provided coverage;<sup>42</sup>

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Self-Insured Plans for the Patient-Centered Outcomes Research Trust Fund, 77 Fed. Reg. 22,691, 22,692 (Apr. 17, 2012) (to be codified at 26 C.F.R. pts. 40, 46).

38. I.R.C. § 125(i).

39. 29 U.S.C. § 218b (Supp. IV 2011).

40. I.R.C. § 3101.

41. *Id.* § 4980H; *New Guidance on Counting Full-Time Employees*, PINNACLE FIN. GROUP, <http://www.pinnaclefinancialconsultants.com/index.cfm/page/New-Guidance-on-Counting-Full-Time-Employees/cdid/10761/pid/10399> (last visited Nov. 5, 2012). PPACA requires large employers (those with fifty or more full-time equivalent employees) to pay a penalty if one of their full-time employees obtains subsidized coverage through a state health insurance exchange beginning in 2014. *Id.* § 4980H(b)–(c). The amount of the penalty will vary depending on whether or not the employer offers health coverage to its employees. *See id.* § 4980H. For this purpose, a full-time employee is an employee who is employed on average at least thirty hours of service per week. *Id.* § 4980H(c)(4)(A). Accordingly, in 2014, larger employers who do not offer health coverage and have at least one full-time employee who receives a premium tax credit through the state exchange will be assessed a penalty of \$166.67 per month for each full-time employee. *Id.* § 4980H(b)–(c). An employer's first thirty employees are excluded from this assessment. *Id.* § 4980H(c)(2)(D). Furthermore, if an employer offers unaffordable health coverage and has at least one full-time employee receiving a premium tax credit through the state exchange, the employer will be assessed a penalty equal to the lesser of \$250.00 per month for each employee receiving a premium credit, or \$166.67 per month for each full-time employee. *Id.* § 4980H(b)–(c). An employee is only eligible to receive a tax credit if his or her premium for the employer-sponsored insurance is more than 9.5% of their household income, or if the plan's share of the total allowed costs of benefits provided under the plan is less than 60% of such costs. *Id.* § 36B(c)(2)(C). The Internal Revenue Service intends to propose a "safe harbor" that will permit employers to use an employee's Form W-2 wages in lieu of household income. I.R.S. Notice 2011-73, IR-2011-40 (Oct. 3, 2011).

42. 42 U.S.C. § 300gg-14 (Supp. IV 2011). Prior to 2014, grandfathered plans could exclude children who were eligible for other employer coverage.

- Employer certification to the U.S. Department of Health and Human Services regarding whether its group health plan provides “minimum essential coverage;”<sup>43</sup>
- Increase in permitted wellness incentives from 20% to 30%;<sup>44</sup>
- In or after 2014, large employers (two hundred or more employees) must automatically enroll their new full-time employees into the employer-sponsored health plan, unless an employee opts-out of such coverage;<sup>45</sup>
- Ninety-day limit on waiting periods;<sup>46</sup>
- Coverage under non-grandfathered plans for certain approved clinical trials;<sup>47</sup>
- Initial phase of the Medicare Part D “donut hole”<sup>48</sup> fix, which will completely eliminate the Medicare Part D coverage gap by 2020 and be replaced by a 25% cost-sharing across the board for both generic and brand drugs.<sup>49</sup> This change will be covered partly through subsidies agreed to by pharmaceutical companies and partly through gradual increases in Medicare funding;
- Guaranteed availability and renewability of insured group health plans;<sup>50</sup>
- Prohibition on preexisting condition exclusions for all participants (currently this requirement only applies to preexisting conditions for participants under the age of nineteen);<sup>51</sup>
- Complete prohibition on annual dollar limits for “essential health benefits”;<sup>52</sup> and

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43. I.R.C. § 6056.

44. See 42 U.S.C. § 300gg-4(j)(3).

45. 29 U.S.C. § 218a (Supp. IV 2011).

46. 42 U.S.C. § 300gg-7.

47. See *id.* § 300gg-8.

48. The Medicare “donut hole” under the prescription drug benefit added to Medicare in 2006 left a coverage gap for individuals between the initial coverage limit and the catastrophic coverage threshold, as set forth in the Medicare Prescription drug program. See Jonathan Blum, *What is the Donut Hole?*, MEDICARE BLOG (Aug. 9, 2010), <http://blog.medicare.gov/2010/08/09/what-is-the-donut-hole/>.

49. *Id.*

50. 42 U.S.C. §§ 300gg-1–2.

51. *Id.* § 300gg-3.

52. *Id.* § 300gg-11. Essential health benefits generally include “[a]mbulatory patient services[,] . . . [h]ospitalization[,] . . . [m]aternity and newborn care[,] . . . [m]ental health and substance [ab]use disorder services, . . . [p]rescription drugs[,] . . . [r]ehabilitative . . . services and devices[,] . . . [l]aboratory services[,] . . . [p]reventive and wellness services and chronic disease management [services, and] . . . [p]ediatric services, including oral and vision care.” *Id.* § 18022(b)(1).

- Tax on insured and self-insured plans to fund temporary reinsurance program assessed against group plans to stabilize increased costs in the individual markets.<sup>53</sup>

In addition, States will be required to have their health insurance exchanges up and running by 2014.<sup>54</sup>

Beyond 2014, there will be an excise tax on high-cost health plans. Specifically, effective January 1, 2018, a non-deductible 40% excise tax will be imposed on employer-sponsored health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage (\$11,850 and \$30,950 for retirees and certain high-risk professionals; a flat \$27,500 for any coverage provided through multi-employer plans).<sup>55</sup> These thresholds are indexed to inflation and may increase if health care costs escalate prior to 2018. For insured plans, the insurer is responsible for payment of the excise tax, whereas the plan administrator (typically the employer) of self-insured plans is directly responsible for such payment.<sup>56</sup> In either case, however, the plan administrator (not the insurer) is responsible for calculating the amount of the excess benefit subject to the excise tax imposed for each applicable period.<sup>57</sup>

#### IV. OVERVIEW OF CERTAIN COST-SAVING STRATEGIES TO REDUCE A GROUP HEALTH PLAN'S OVERALL COSTS

##### *A. Cost Challenges in Maintaining Employer-Sponsored Group Health Coverage*

Most employers and plan sponsors faced rising premium and plan costs and struggled to maintain the scope of their group health benefit packages prior to PPACA's enactment. Post-enactment, employers and other plan sponsors still face medical inflation and spiraling health costs<sup>58</sup>—a problem exacerbated by the most severe recession since the Great Depression and the struggling economic recovery thereafter.

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53. *Id.* § 18061.

54. *Id.* § 18031(b)(1).

55. I.R.C. § 4980I (Supp. IV 2011).

56. *Id.* § 4980I(c)(1)–(2).

57. *Id.* § 4980I(c)(4).

58. The Kaiser Family Foundation's 2011 Survey of Employer Health Benefits found that employer-provided health benefits have risen approximately 160 percent since 1999, with the average yearly cost of family coverage trending around \$15,000. *See* THE KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2011 ANNUAL SURVEY 31, exhibit 1.13 (2011), available at <http://ehbs.kff.org/pdf/2011/8225.pdf>. Indeed, medical inflation continues to rise.

Compounding this problem is the cost of the PPACA compliance mandates already implemented. Thus, it is apparent that health care costs will only continue to grow as the remainder of PPACA's compliance mandates goes into effect.

In addition, employers and group health plans will continue to shoulder additional compliance burdens under PPACA (and the many new regulatory requirements thereunder) over the coming years.<sup>59</sup> One example illustrates, on a *monthly* basis, employers subject to the "pay-or-play" mandates will be required to interface with the federal government, reporting on their demographics and providing other information, *whether or not they continue to provide group health insurance*.<sup>60</sup> This monthly interface will cost employers inestimable time and money. The bottom line is that there is not much that is *affordable* for employers and other plan sponsors in the Affordable Care Act.

Furthermore, benefits professionals know that a participant's lifestyle and benefit decisions are significant cost drivers for group health plans.<sup>61</sup> Yet, with limited exception, today's group health plans focus very little on "consumerism." While the use of high deductible health plans has grown over the last few years, it is still not the predominant approach to paying for health care in America. Other than limited cost-sharing provisions (e.g., co-pays, coinsurance, deductibles), participants today have very little accountability as to the cost of health services under the plan or the current regulatory landscape—and very little to nothing in PPACA addresses "consumerism." Unfortunately, it is not uncommon for a handful of chronic or high-cost illnesses (e.g., diabetes, heart disease, cancer) to account for the majority of a group health plan's costs.<sup>62</sup> Indeed, a participant's lifestyle choices or habits (e.g., obesity, smoking, drug abuse, alcoholism) may cause or contribute

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59. In terms of compliance costs, it also should be noted that PPACA provides expansive whistleblowing protections and generous remedies for employees who oppose any practice prohibited therein. For a more complete discussion, see Steven J. Mogila & Daniel L. Saperstein, *Whistleblower Protections: Understanding the New Private Rights of Action Available to Employees Under Health-Care Reform and Financial Reform Legislation*, 203 N.J. L.J. 954, 954 (2011).

60. See *supra* note 41 and accompanying text.

61. Indeed, although the current regulatory landscape (including PPACA) seeks to reduce the cost of health coverage (by imposing mandates upon employers, health-care providers, and medical and pharmaceutical manufacturers), it does not presently impose cost-saving measures or accountability standards on a plan's participants to make the plan (and the health care system) more affordable as a whole.

62. See *Affordable Care Act Rules on Expanding Access to Preventive Services for Women*, HEALTHCARE.GOV (July 31, 2012), <http://www.healthcare.gov/news/factsheets/2011/08/womens-prevention08012011a.html> (noting that "chronic diseases . . . are responsible for 7 of 10 deaths among Americans each year and account for 75% of the nation's health spending").

to the existence or severity of such chronic or high-cost illnesses, resulting in greater cost to the group health plan.

Finally, while a group health plan's grandfathered status provides some level of cost-savings (i.e., not having to comply with certain health care reform mandates), those savings ultimately may not outweigh the benefits derived from implementing a nonconforming plan design or cost-sharing changes, which will trigger the loss of a grandfathered plan's status.<sup>63</sup>

For the foregoing reasons, in a post-PPACA world, employers and other plan sponsors will face the prospect of having to implement cost-saving strategies to offset the continuously rising costs of health care. As a result, employers and other group health plan sponsors now should be taking proactive steps to control medical and compliance costs in the future.

### *B. Cost-Saving Measures*

An obvious way to control plan costs is to reduce benefits or increase cost-sharing for participants. This approach, however, may not be such a viable option. First, it could have the effect of reducing employee morale or the employer's competitive advantage in attracting and retaining an optimal workforce. Second, to the extent that a group health plan is grandfathered, these measures could potentially jeopardize its grandfathered status, thereby triggering additional compliance obligations under PPACA.<sup>64</sup> For these reasons, employers and plan

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63. According to the final interim rules issued by the Departments of Labor, Health and Human Services, and Treasury on June 17, 2010:

[The regulatory agencies'] mid-range estimate is that 66 percent of small employer plans and 45 percent of large employer plans will relinquish their grandfather status by the end of 2013. The low-end estimates are for 49 percent and 34 percent of small and large employer plans, respectively, to have relinquished grandfathered status, and the high-end estimates are 80 percent and 64 percent, respectively.

Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,538, 34,552 (June 17, 2010).

64. In accordance with the final interim rules issued by the Departments of Labor, Health and Human Services, and Treasury on June 17, 2010, as amended on November 15, 2010, a health plan may forfeit its grandfathered status upon the implementation of any of the following plan modifications:

1. Subject to . . . [the] special rule for insured collectively bargained plans, entering into a "new" policy, certificate or contract of insurance after March 23[, 2010]. However, "renewing" an insurance policy, certificate, or contract that was otherwise grandfathered will not in and of itself cause the loss of grandfathered health plan status.

2. Eliminating all or substantially all benefits to diagnose or treat a particular condition. The elimination of benefits for any necessary element to diagnose or treat a condition will also cause a plan to lose its grandfathered status.

sponsors may try to preserve the plan's current cost-sharing levels and forego extensive benefit cuts. Nevertheless, for those employers and plan sponsors that cannot afford to maintain their group health plan's current design, cost-sharing increases and benefit cuts may be unavoidable.

With this in mind, the following discusses some practical cost-saving strategies designed to avoid changes (such as benefit reductions or cost-sharing measures) that would trigger the loss of a plan's grandfathered status. These measures include: (1) implementing prescription drug cost-saving techniques; (2) encouraging participants to utilize low-cost, high-quality benefits and service providers; (3) assisting participants to effectively manage their chronic conditions, and encouraging participants and their families to be (and stay) healthy; and (4) promoting, and connecting participants with, quality primary and specialty care providers and facilities.

### 1. Implement a Generic Prescription Drug Strategy Program

One way to reduce a group health plan's prescription drug cost is to introduce a "generic strategy" program to encourage participants taking brand-name drugs that have generic alternatives to switch to the generic

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3. Increasing the plan's co-insurance percentages by any percentage.

4. Increasing the plan's fixed-amount cost-sharing requirement other than a copayment by more than the rate of medical inflation plus 15 percentage points.

5. Increasing the plan's fixed-amount co-payment (measured as of March 23, [2010]), if the total increase exceeds the greater of: (i) \$5 increased by medical inflation (\$5 times medical inflation, plus \$5), or (ii) the maximum percentage increase, which is the rate of medical inflation (the increase in the overall medical care component of the Consumer Price Index for All Urban Consumers ("CPI-U")) plus 15 percentage points.

6. Decreasing the employer's contributions towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points (5 percent) below the contribution rate in effect for the coverage period as of March [2010].

7. Imposing an overall annual dollar limit on the value of all benefits if the plan did not provide for such limits as of March 23[, 2010]. If a plan imposed an overall lifetime dollar limit on plan benefits but not an overall annual limit as of March 23[, 2010], the plan cannot impose an overall annual dollar limit that is lower than the lifetime dollar limit that was in effect as of March 23[, 2010] without losing its grandfathered status. Finally, if a plan imposed an overall annual dollar limit on plan benefits as of March 23[, 2010], it can't decrease the annual dollar limit without losing its grandfathered status.

Stephen J. Mogila, *Health Care Reform Update: Compliance Issues for Retaining a Health Plan's Grandfathered Status*, 201 N.J. L.J. 845, 845-46 (2010); *see also* Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 70,114, 70,116 (Nov. 17, 2010).

version.<sup>65</sup> The following components can be integrated as part of a generic strategy program:

- Step Therapy/Prior Authorization Programs;<sup>66</sup>
- Incentive Coupons for Generic Purchases;
- Reduction of Co-pays for Generics to Increase Utilization; Introduction and Promotion of “Statin Therapy”<sup>67</sup> for High-Cost Chronic Diseases (such as Diabetes and Coronary Artery Disease); and
- Limit Wasteful Prescription Utilization.<sup>68</sup>

## 2. Implement an Employer Group Waiver Plan Plus Wrap Plan for Medicare Part D Prescription Benefits

For group health plans that offer retiree drug coverage, another way to reduce costs is to restructure these benefits to an Employer Group Waiver Plan (“EGWP”) with a wrap-around plan. This approach offers savings over a traditional Retiree Drug Subsidy (“RDS”) Medicare Part D Plan (given that the RDS will become taxable in 2013).<sup>69</sup> Under PPACA, the EGWP generally will permit the same prescription drug benefit structure as that of the RDS, but will enable the plan to receive increased governmental subsidies, as it will be eligible for a fifty percent

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65. In 2012, ten of the most frequently prescribed brand-name prescription drugs will have gone off patent. Katie Moisse, *10 Top-Selling Drugs Coming Off Patent*, ABC NEWS (July 25, 2011), <http://abcnews.go.com/Health/Drugs/prescription-drug-prices-plummet/story?id=14152014>; see also *Generic Prescription Drugs: Maintaining Health Care Standards While Controlling Costs*, JOHNSTONE’S J. (Johnstone’s Benefits, North Vancouver, B.C.), Mar. 2012, available at [http://www.cga-pdnet.org/Non\\_VerifiableProducts/ArticlePublication/jj/jj03mar\\_2012.pdf](http://www.cga-pdnet.org/Non_VerifiableProducts/ArticlePublication/jj/jj03mar_2012.pdf) (“With many commonly-prescribed medications due to come off patent over the next several years, there will be more generic choices than ever before.”). For example, in 2012, generics have already, or will, become available for Singulair, Seroquel, and Plavix, and will thereby generate a significant cost-savings opportunity for health plans. See Moisse, *supra*.

66. These programs generally require that a participant obtain prior approval to receive certain target formulary drugs under the plan. They can also include limits either on the quantity of a formulary drug or step therapy criteria which require the participant to use the generic drug as a first step before requesting authorization for the formulary brand drug.

67. For a discussion regarding the use of cholesterol-lowering statin drugs in “statin therapy,” see *FDA Drug Safety Communication: Important Safety Label Changes to Cholesterol-Lowering Statin Drugs*, U.S. FOOD & DRUG ADMIN., <http://www.fda.gov/Drugs/DrugSafety/ucm293101.htm> (last updated July 3, 2012).

68. For example, limit Proton Pump Inhibitor (“PPI”) brand drugs used to treat gastric reflux (heartburn) to a short-term treatment period (180 days), except in certain instances (e.g., erosive esophagitis and esophageal cancer)—particularly since there are a wide variety of PPI drugs available over-the-counter.

69. See *EGWP + Wrap Drug Plans Present Savings Opportunities for Employers*, PRICEWATERHOUSECOOPERS EQUITYPLANNER (Sept. 3, 2010), <http://www.equityplanner.pwc.com/HRS/EquityPlanner/EPv1.nsf/10a76c5ebfac5dc685257528007b434e/db6d377288d91df8852577970069211a?OpenDocument> (noting that by utilizing this arrangement, “employers can potentially reduce their pre-tax cash cost by 20% or more below current levels under the [RDS] program”).



brand discount in the coverage gap (otherwise known as the “donut hole”).<sup>70</sup>

The EGWP arrangement generally consists of two separate but integrated plans. The first plan (the EGWP) is offered exclusively to the employer’s retirees (with the benefits mirroring those provided under the defined standard Medicare Part D plan).<sup>71</sup> The second plan constitutes the non-Part D benefits wrapped around the EGWP’s plan of benefits.<sup>72</sup> Based on this structure, the employer typically does not have to make significant benefit plan design changes to experience meaningful cost-savings. This structure also allows for quicker access to federal reinsurance because the reimbursement aspect is already accounted for under the EGWP. Other potential advantages of the EGWP include not having to meet the actuarial equivalence test with respect to net benefits that would otherwise be required under a traditional Medicare Part D Plan.

For the foregoing reasons, plans offering retiree Medicare Part D prescription drug coverage should evaluate shifting these benefits to an EGWP plus wrap plan alternative as a result of the changes to the RDS rules under PPACA and the higher subsidies that will be offered by the Centers for Medicare and Medicaid Services (“CMS”).

### 3. Promote Quality Care Initiatives at the Participant Level

A participant’s lifestyle and decisions regarding whom they choose as a health provider can be a significant cost driver to a health plan (given that out-of-network providers typically charge more than in-network providers). It is quite common for one percent of a group health plan’s participants to account for a significant percentage (up to thirty percent or more in some cases) of the plan’s medical costs.<sup>73</sup> As such,

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70. *See id.* Although the application of the fifty percent discount to EGWPs alone was insufficient to generate any meaningful savings for EGWP plans, subsequent guidance issued by the Center for Medicare and Medicaid Services (“CMS”) clarified that this discount would be applied before any additional coverage provided under a non-Part D plan—providing a significant savings opportunity for certain benefit configurations under an integrated EGWP and wrap plan. *Id.*

71. *Id.*

72. *Id.* Both the EGWP and the wrap plans typically are self-insured. *Id.*

73. It has been noted that:

High-coverage group health plans mostly offered generous benefits and protection against catastrophically high medical bills . . . . But even these plans did not offer complete protection for the top 1% of spenders—people in poor health. The top spenders in group plans paid on average \$7,513 in out-of-pocket medical expenses on a yearly basis.

Lisa Gillespie, *More Than Half Individual Health Plans Fall Short of PPACA Standards*, EMP. BENEFIT NEWS (May 30, 2012), <http://ebn.benefitnews.com/news/commonwealthfund-ppaca-individual-health-insurance-2724982-1.html>.

cost-savings may follow by encouraging participants to become more informed and take responsibility for their health care choices. For obvious reasons, education and participant communication are critical to having an effective program.

This initiative encourages participants to create a relationship with a high-quality primary care doctor. Through this relationship, the primary care doctor can direct participants to use appropriate high-quality, low-cost providers and facilities. In addition, a plan can offer a case management program within a certain geographic area for participants who require an extraordinary amount of health care. Generally speaking, a case management program typically will target very high-cost, high-risk users and offer them in-person professional assistance (e.g., a nurse practitioner) to help navigate the health system and manage/improve their care with the aim of yielding significant savings (e.g., by reducing emergency room usage and the length of hospital stays). In terms of design, case management programs typically focus on high-cost participants whose medical costs average above a certain monetary threshold (e.g., \$150,000 per health episode).

With regard to lifestyle choices, wellness and preventive programs<sup>74</sup> may be offered to encourage participants to make healthy lifestyle decisions.<sup>75</sup> Common preventive programs cover communications, screenings, education, and behavior changes related to blood pressure, cholesterol, smoking, weight control, stress, depression and preventive health (e.g., flu shots). Similarly, expanding the plan's chronic care or disease management programs to cover the most prevalent high-cost chronic diseases (e.g., asthma or coronary artery disease) may offer longer term savings to the extent that a participant may change or stabilize his or her health status and, as a result, avoid higher cost benefits or services otherwise attributed to the condition becoming more severe as a result of an unhealthy lifestyle.

When designing these programs, it is important to have voluntary participation, as mandatory participation may create compliance issues.<sup>76</sup>

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74. See U.S. DEP'T OF LABOR, FAQs ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART V AND MENTAL HEALTH PARITY IMPLEMENTATION (Dec. 22, 2010), <http://www.dol.gov/ebsa/pdf/faq-aca5.pdf> (recognizing that there are two types of wellness programs: (1) "participatory wellness programs" that do not require an individual to meet a standard related to a health factor to obtain a reward from the plan; and (2) "health-contingent wellness programs" that require the satisfaction of a standard related to a health factor to obtain a reward from the plan (internal quotation marks omitted)).

75. Under PPACA, non-grandfathered plans must provide certain preventive care without cost-sharing. *Id.*

76. See U.S. DEP'T OF HEALTH & HUMAN SERVS. U.S. DEP'T OF LABOR & U.S. DEP'T OF TREASURY, FAQs ABOUT AFFORDABLE CARE ACT IMPLEMENTATION—PART II (Oct. 8, 2010),

It is also important to remember that, although these programs may cost more at the outset (in terms of implementation relative to the initial utilization), these programs can be targeted to cut costs over the long term (the cost of health care typically is less than the cost of treating/curing the disease). The up-front costs, however, may be controlled by leveraging the tools and resources that the plan's vendors (administrative service organization and benefit consultants) may have in place. For this reason, it will be important to coordinate with the plan's providers and professionals throughout the design and implementation process.

#### 4. Encourage Use of Low-Cost, High-Quality Providers

Another way to enhance cost-savings is to encourage participants to use low-cost, high-quality providers for high-cost medical services (e.g., kidney dialysis, colonoscopies, orthopedic, dermatology, physical therapy). There are a couple of ways to promote this objective. One way is to reduce the participant's cost-sharing (co-pays, coinsurance, and deductibles) for such conditions. This can be achieved by implementing a new and reduced co-pay tier for high-quality, in-network primary care providers or specialists for certain high-cost health care services. Another way is to implement a quality cost incentive or value-based design feature.<sup>77</sup> Under this feature, the plan will typically offer participants a reward in the form of a credit related to the participant's cost of coverage under the plan based on a portion of the savings generated by switching from an out-of-network (high-cost) provider to an in-network (low-cost) provider for the targeted high-cost diseases/services. The credit can then apply against the participant's cost-sharing amounts attributed to other eligible benefits/services under the plan. Accordingly, efforts should be made to work in concert with the plan's providers and professionals during the design and implementation process.

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<http://www.dol.gov/ebsa/pdf/faq-aca2.pdf> (recognizing that "[g]roup health plans may continue to provide incentives for wellness by providing premium discounts or additional benefits to reward healthy behaviors by participants or beneficiaries...[but] penalties (such as cost-sharing surcharges) may implicate [the grandfathering status of a plan and therefore] should be examined carefully"); *see also* 29 C.F.R. § 2590.702 (2011).

77. *See* U.S. DEP'T OF LABOR, *supra* note 74 (noting that the Departments will develop guidelines to permit group health plans and insurers to utilize value-based designs that provide incentives for enrollees to select higher-value and/or higher-quality services or venues of care).

## V. CONCLUSION

Now that the Court has found PPACA a valid exercise of Congressional power (and given the outcome of the presidential election), employers and plan sponsors will be subject to additional costs as compliance mandates continue to roll out. Therefore, employers and plan sponsors should brace themselves for the long haul and plan accordingly. Although the rules governing many of the upcoming PPACA mandates and exchanges remain unclear (insofar as they are subject to further regulatory guidance), the compliance cost associated with them is inevitable. As such, employers and plan sponsors should work closely with the group health plan's counsel and professionals to make informed decisions on how to comply with the new mandates and, as necessary, implement cost-saving measures.

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