President Obama has been reelected, and although there were some changes in Congress, the political make-up of the House and Senate remains the same, with Democrats controlling the Senate and Republicans controlling the House of Representatives.

For employers and plan sponsors that have been adopting a "wait and see" approach before focusing on compliance with the Patient Protection and Affordable Care Act (PPACA), the time to wait is over. PPACA's insurance mandates, market reforms, and employer requirements generally will move ahead as scheduled, with most of PPACA becoming fully effective just a short year from now, in 2014. Since the law left the task of working out many of the details to the regulatory agencies (the Department of Labor, the IRS and the Department of Health and Human Services), employers can now expect that an enormous number of regulations on many of the unanswered questions and other types of guidance will be issued between now and the end of 2013. Proskauer's client alerts on PPACA and health care reform-related issues can be found here.

WHAT TO THINK ABOUT IN 2013

2013 is clearly a critical planning year for employers and plan sponsors. Cost containment and compliance have to be the main focus. With respect to compliance, deliberate focus must be on PPACA's many requirements that either are currently in effect or which will become effective soon, including:

- Covering additional preventive care services for women with no cost-sharing, including coverage for contraceptives (non-grandfathered plans only; effective for plan years beginning on or after August 1, 2012);
- Form W-2 reporting of the value of each employee's health coverage (employers that issue fewer than 250 W-2s in a prior year are exempt; effective for the 2012 tax year);
- Issuance of Summaries of Benefits and Coverage (SBCs) to all eligible enrollees (60-day advance notice required for changes made *other than in connection with the plan's renewal*; effective for open enrollment periods and plan years beginning on or after September 23, 2012);
- $2,500 limit on employee contributions to health flexible spending accounts (FSAs) (limit applies on an individual basis; effective for plan years beginning in 2013);
- Notifying employees of the availability of health insurance exchanges (guidance not yet released; intended to be effective March 2013); and
- 0.9% Medicare payroll tax increase on highincome individuals (withholding required for employees earning over $200,000; effective for the 2013 tax year).

NEW 3.8% MEDICARE TAX EFFECTIVE IN 2013

In addition to the 0.9% increase to the existing Medicare payroll tax discussed above, there is a new, nonpayroll Medicare tax effective starting in 2013. This new Medicare tax of 3.8% applies to the lesser of (A) net investment income (defined below) or (B) the excess of modified adjusted gross income (AGI) over $200,000 ($250,000 for joint filers). Note that these threshold amounts are not indexed to inflation in future years, which means that this tax may apply to more taxpayers in future years. Also, for most taxpayers, their modified AGI is simply their AGI.

Generally, "net investment income" is the excess of gross income from interest, dividends, annuities, royalties, rents, passive activity income and capital gains, over any deductions allowed by the IRS that are allocated to such income. As such, net investment income does not include, for example, tax-exempt interest or distributions from tax qualified plans.

Note that this new 3.8% tax applies to an individual's investment income in excess of the $200,000 / $250,000 threshold described above on an uncapped basis. Individuals who may be subject to this 3.8% Medicare tax should consult with their personal tax advisor to determine if it might be advantageous to recognize capital gains in 2012, thus avoiding the 3.8% tax. This also may be attractive in light of the possibility of the maximum federal income tax rate increasing to 39.65% in 2013 and thereafter.

MANDATES TAKING EFFECT IN 2014

Mandates and market reforms taking effect in 2014 include:

- 90-day limit on eligibility waiting periods;
- Complete prohibition on annual dollar limits for "essential health benefits";
- Complete prohibition on preexisting condition exclusions for all individuals;
- Increase in permitted outcome-based wellness incentives from 20% to 30%;
- Guaranteed availability and renewability of insured group health plans;
- Coverage under non-grandfathered plans for certain approved clinical trials;
- Initial phase of the Medicare Part D "donut hole" fix, which will eliminate the Medicare Part D coverage gap by 2020;

- Limiting out-of-pocket expenses to the level set for HSA-compatible high-deductible health plans (non-grandfathered plans only; out-of-pocket limits are $6,250 single / $12,500 family in 2013);

- Limitations on cost-sharing (deductibles for non-grandfathered plans cannot exceed $2,000 single / $4,000 family; additional clarification is needed on the scope of this requirement);

- Employer certification to the U.S. Department of Health and Human Services regarding whether its group health plan provides "minimum essential coverage" for purposes of the share responsibility payment under the employer "pay or play" mandate (reports are actually due in 2015 based on 2014 benefits); and

- Availability of premium tax credits to reduce the cost of coverage purchased through a public health insurance exchange for citizens and legal U.S. residents who are not eligible for Medicaid and whose household income does not exceed 400% of the federal poverty level.

POST-ELECTION ROUNDUP

Now that the election is over, the federal regulators who have been holding off on issuing regulations that may have been viewed as controversial during the election will begin the process in earnest. Plan sponsors should expect a flood of regulations (maybe as early as the next 6-8 weeks) to be released that have been long anticipated, including:

- Formal Regulatory guidance on the employer mandate, including additional clarification on the mandate's definition of "full-time employee," rules for determining compliance with the mandate's "minimum value" requirement, and the application of the 90-day limit on waiting periods to multiemployer plans (guidance to date on the employer mandate has been in the form of IRS notices);

- Additional rules governing the health insurance exchanges established by the federal government in states that fail to establish an exchange;

- Guidance on calculating fees payable under the Transitional Reinsurance Program (a temporary assessment applicable to the 2014 – 2016 plan years, which is imposed on insurance carriers and third-party administrators of self-insured plans on a per-member basis in order to stabilize premiums in the individual markets);

- Rules governing increased wellness incentives under PPACA (in 2014, PPACA increases the reward available under an outcome-based wellness program from 20% of the total cost of coverage to 30% of the total cost of coverage); and

- Rules prohibiting discrimination under fully-insured plans in favor of highly compensated employees with respect to eligibility or benefits (non-grandfathered plans only).

When new guidance is released, the issuing agencies often extend a comment period, during which interested parties can comment on the guidance and recommend changes favorable to their position. We encourage employers and plan sponsors to take advantage of any comment periods and engage counsel for assistance with drafting comments.

Obviously with new guidance will come new compliance concerns. In addition, cost containment is going to be critical. Premiums, which increased significantly across the nation in 2011 when the initial mandates became effective, will rise, likely dramatically, in 2014 when PPACA is fully implemented. Fees (including those enforced through the Tax Code) will be levied against health plans to help pay for the new programs, particularly for coverage in the individual market. For example, beginning in 2013, health plans pay a fee to fund research to study outcomes of various medical approaches. In 2014, plans will be assessed a fee to help stabilize rate increases in the individual market. These fees (and others), of course, will be passed on to employers and employer-sponsored group health plans and these costs may be passed through in part to covered participants via increased costs and premiums.

In addition, 2014 sees the commencement of the shared responsibility payment, often referred to as the "pay-or-play" provisions. Employers will be required to play (by providing quality health care to their employees and dependents) or pay a "shared responsibility payment" to the federal government.

A shared responsibility payment generally applies when a full-time employee (using a 30-hour per week standard under PPACA) receives a federal premium subsidy and obtains coverage in a public health insurance exchange. The payment will be assessed against employers that either (A) fail to offer health coverage to all full-time employees and their dependents (an "opt-out" payment), or (B) provide coverage that fails to satisfy certain quality and affordability standards under PPACA (an "affordability" payment). To satisfy the standard for affordability, the plan's premiums for single coverage cannot exceed 9.5% of an employee’s household income (or W-2 wages as reported in Box 1, per the IRS' "affordability safe harbor"). The quality standard is satisfied if the plan has at least a 60% actuarial value, which is a measure of the plan's overall level of financial protection. A plan with a 60% actuarial value is designed to cover at least 60% of health care costs for the average participant, which assumes that the plan has both low and high utilizers of covered services. The 60% measure is not based on actual claims experience; rather, it is an actuarial estimate based on the design of the plan (e.g., its cost-sharing features, such as deductibles, copayments, coinsurance, and out-of-pocket limits). An employer's premium contribution is not considered for purposes of determining actuarial value, although it is considered for purposes of the affordability standard.

Some employers that have considered these provisions are already contemplating whether to reduce the number of full-time employees (30 hours or more under PPACA) in order to avoid the share responsibility payment with respect to those employees. But preplanning may be necessary to ensure compliance with the employer mandate, which is effective January 1, 2014 regardless of plan year. Under recent IRS guidance, employers with "variable hour" employees will use a "look back" period to determine who is full-time. Obviously, employers considering workforce realignment strategies should be discussing approaches now, with an eye toward implementation in 2013, so that they will have reduced numbers during the look back for 2014. Some employers who are contemplating whether to "pay" rather than "play" also are considering expanding the offering of nonmedical voluntary benefit options, such as dental, vision, accident, life and cancer policies. However, employers should be aware of the peril of making employment-related decisions without thoroughly examining the implications under employment law and ERISA.

STATE ACTION ON HEALTH INSURANCE EXCHACNGES

Because employees may choose to obtain coverage through an exchange even if they have access to employer-sponsored group health plan coverage (although they'll lose their employer's contribution toward its group health plan coverage) and because the health insurance exchanges are required to provide information to prospective enrollees about their eligibility for premium tax credits (and likely will request information from employers to determine such eligibility), employers also should have an understanding of whether the states in which they operate will have a state-run health insurance exchange. The health insurance exchanges are scheduled to begin operation in January 2014.

As of the date of this alert, a number of states (California, Colorado, Connecticut, District of Columbia, Hawaii, Kentucky, Maryland, Massachusetts, Nevada, New York, Oregon, Rhode Island, Utah, Vermont, Washington and West Virginia) have established state exchanges. Arkansas, Delaware and Illinois are planning for a partnership exchange with the federal government. Several states have affirmatively decided not to create a state exchange (including Alaska, Florida, Louisiana, Maine, New Hampshire, South Carolina and South Dakota), which means the federal government will run the exchange on the state's behalf. The remaining states are studying their options but could end up with a federally run exchange at least for 2014 since the deadline to submit the state's plan for implementing an exchange is December 14 (recently extended from November 16). It remains to be seen whether the federal government will be able to implement so many exchanges on behalf of states electing not to operate an exchange. It also remains to be seen whether a change of various state public officers (such as governor or insurance commissioner) or control of a state legislature, will change a state's position on the implementation of an exchange.

Employers that have not begun work on cost containment and other strategies should begin now by talking with their Proskauer lawyer. Proskauer is committed to monitoring developments and providing its clients with

the latest, up-to-date information on new developments under PPACA. Please contact your Proskauer lawyer for answers to your questions on health care reform.