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Health Care Reform — Recent Legislative Developments and Guidance on Grandfather Rules and New W-2 Reporting Rules

The Obama administration continues to move forward on implementing the Patient Protection and Affordable Care Act of 2010, as amended (the “Health Care Reform Act”), as it has recently issued additional guidance on the grandfather rules for group health plans and the new Form W-2 rules for reporting the cost of employee group health coverage. Of note, the guidance reaffirms that the W-2 reporting of group health coverage costs will not be required until 2012, which means that any such reporting for 2011 will remain optional. The guidance also provides some important clarification on the grandfather rules. On a separate note, legislation repealing the employer “free choice” voucher requirements (which were to go into effect in 2014) has just been enacted.

This alert summarizes the more important aspects of the recent guidance and repeal of free choice vouchers.

Clarification of “Anti-Abuse” and Other Grandfather Rules

The regulations addressing the grandfathered plan rules contain several anti-abuse rules, one of which generally provides that the transfer of employees from one grandfathered benefit option to another will cause the recipient option to

lose grandfathered status if the transferor option would lose grandfathered status were it amended to replicate the recipient plan. This rule does not apply, though, if there is a “bona fide employment-based” reason for the transfer. Unfortunately, however, there has been considerable uncertainty as to the scope of this exception and whether it applies where the reason for the transfer is the elimination of the other coverage.

The government has just issued guidance that provides helpful clarification on this subject. See [Department of Labor FAQs About Affordable Care Act Implementation Part VI](#) (Q1). This guidance is especially welcomed as it reflects a practical, reasonable approach to applying the “bona fide employment-based” exemption. What the FAQs provide in this regard is that transfers in the following (or similar) circumstances will not cause the recipient program to lose grandfathered status:

- The insurer exits the market or ceases offering the product to the employer;
- Low/declining participation in the option makes it impractical to continue to offer the option;

- An option is eliminated for any reason, as long as multiple options (covering a significant portion of other employees) are available to the transferred employees; or
- Elimination of an option under a multiemployer plan in the course of collective bargaining.

Of note, the guidance emphasizes that this is *not* a complete list of the circumstances in which the bona fide employment-based exception could apply. Thus, there may be other situations which would qualify as well.

In addition, the guidance clarifies that where participant contributions are determined using a formula in effect on the date of enactment (March 23, 2010), contribution increases resulting from the application of the formula will not result in the loss of grandfathered status. Lastly, the guidance addresses when grandfathered status is lost due to a disqualifying change. Specifically, it provides that a plan option will become subject to the non-grandfathered plan rules on the date that the change becomes effective, even if it occurs mid-year. Consequently, because the loss of grandfathered status occurs immediately upon making a disqualifying change, employers should carefully consider the potential impact of any proposed change on grandfathered status before it becomes effective.

Application of W-2 Reporting of Group Health Costs

The IRS recently issued additional guidance on W-2 reporting requirements for group health plan costs in [Notice 2011-28](#). As indicated above,

the Notice provides that such costs do not have to be reported on a W-2 that is required to be provided prior to January 1, 2013. It also provides additional guidance on the following topics:

1. Who must comply?

While all employers (including churches and other religious organizations, as well as state and local governments) who provide group health benefits are generally subject to the reporting requirements, the Notice exempts any employer who filed less than 250 W-2 forms for the calendar year preceding the year involved.

2. Who gets the group health cost information?

This information must only be provided to those individuals who will otherwise receive a W-2 for the year. Thus, an employer is not required to issue a W-2 to report this cost for anyone for whom the employer is not otherwise required to issue a W-2 for the year (e.g., retirees).

3. What must be reported?

The total cost of coverage for an individual under any employer-sponsored group health coverage for the year must be reported in Box 12 (using code DD). In general, this will include any coverage that is nontaxable (or would be such if paid by the employer), including on-site medical clinic coverage. However, it generally does not include long term care, health care reimbursement arrangements, separate vision/dental insurance or uncoordinated hospital (or other fixed) indemnity coverage. In addition, reporting is not required for self-insured health plans that are exempt from the COBRA requirements (such

as a church plan) or for coverage provided under a multiemployer plan.

4. What cost must be reported on the W-2?

All coverage costs for both the covered individual and his/her covered dependents must be reported, including any portion that is paid by or taxable to the individual. However, it does not include any health savings or medical savings account contributions or employee contributions to a health care flexible spending account.

5. How is the cost to be calculated?

In general, the reportable cost is to be determined on a calendar year basis. In making this determination, the following methods may be used:

1. The actual COBRA rate for the year;
2. A modified COBRA rate, which can only be used where —
 - the employer subsidizes COBRA (in which case, the premium used to determine the subsidized COBRA rates generally can be used), or
 - the current COBRA premium is based on a rate for a prior year (in which case, that rate can be used); or
3. In the case of an insured option, the premium charged by the insurer for the coverage(s) involved.

In addition, any mid-year changes in coverage or premium cost must be taken into account. Lastly, an employer who charges all covered

employees a composite (*i.e.*, uniform) rate for coverage may, in certain circumstances, use that rate for the affected employee group.

Repeal of Free Choice Voucher Provisions
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The appropriations bill for the 2011 fiscal year, which was signed into law on April 15th, repeals the free choice voucher provisions contained in the

Health Care Reform Act. These provisions would have required employers to provide (beginning in 2014) vouchers to eligible employees which they could use to purchase coverage on the new exchanges or in the private market. In general, employees with group health plan coverage costs of between 8 and 9.8 percent of their family income would have been eligible for a voucher, with the voucher amount

equaling the employer-paid portion of its group health plan coverage. This is obviously a welcomed development since the voucher program would likely have been extremely costly and difficult to administer.

We welcome the opportunity to respond to any questions you may have regarding these or any other aspects of the Health Care Reform Act.

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