SUTHERLAND

LEGAL ALERT

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# The Latest Guidance on Health Reform: Reporting the Cost of Coverage to Employees and More FAQs on Grandfathered Plans

Recently, the Internal Revenue Service issued guidance under the Patient Protection and Affordable Care Act (PPACA) to implement the requirement that employers report the cost of employer-sponsored health coverage to employees on Form W-2. As is described in more detail below, reporting is generally required for 2012, though there is an exception for small employers. In addition, the tri-agency task force that issues guidance regarding health plans' compliance with PPACA released additional Frequently Asked Questions. These latest FAQs address issues related to the loss of grandfather status under PPACA, providing several helpful clarifications on changes that can be made to a health plan without causing it to cease to be grandfathered and clarifying when loss of grandfather status will be effective if it does occur. The FAQs are discussed in more detail below.

## IRS Notice 2011-28 on W-2 Reporting for the Cost of Health Coverage

IRS Notice 2011-28 (the Notice) provides interim guidance on reporting the cost of employer-sponsored health coverage on Form W-2, as is required under the Internal Revenue Code (Code), based on amendments made by PPACA. The Code would have required reporting for 2011; however, IRS Notice 2010-69 delayed the requirement. Notice 2011-28 now makes the reporting mandatory for most employers beginning in 2012 (with the Forms W-2 issued in January 2013).

The requirement applies to all employers that provide applicable employer-sponsored coverage (whether fully insured or self-insured), except certain Indian tribal governments and employers that provide self-insured coverage that is not subject to continuation coverage requirements (such as COBRA). This coverage includes both health coverage paid for by an employer that is excludable from the employees' income under Code section 106 and the employee-paid portion of coverage that would be excludable under Code section 106 if it were employer-provided coverage. The cost of HIPAA-excepted coverage under Code section 9832(c)(1) (such as accident-only, disability, and general liability insurance), long-term care coverage, stand-alone vision or dental coverage, coverage specifically for specified diseases or illnesses or hospital indemnity insurance is not reportable. However, the reportable coverage includes coverage provided at on-site medical clinics, and vision and dental coverage provided under a comprehensive employer-sponsored group health plan.

Among other things, the Notice provides that:

- The aggregate reportable cost of coverage may be calculated based on the COBRA premium cost (or a modified version of that cost), the premium charged to the employee (under an insured plan), or a composite of the premiums charged under multiple coverage classes.
- Aggregate reportable cost does not include amounts contributed to an Archer MSA, HSA, FSA (unless employer flex credits are provided), or an HRA.
- An employer may apply any reasonable method for reporting the cost of coverage for an employee who terminates employment mid-year, provided the method is used consistently for all terminating employees.
- Employers that file fewer than 250 2011 Forms W-2 are exempted from mandatory reporting until further guidance is issued, though a transition rule indicates these employers may be required to report for 2013.

- Coverage under a plan maintained primarily for members of the military and their families is not included in the reportable cost.

The interim guidance is applicable until the IRS issues further guidance. The Notice says that any future guidance will apply prospectively only and will not apply to any calendar year within six months of the date that the guidance is issued, to the extent that the guidance applies the reporting requirement more expansively than does the Notice.

## Part VI of the PPACA FAQs: Additional FAQs on Grandfathered Plans

On April 1, 2011, the tri-agency task force that issues guidance on the rules of PPACA that apply to group health plans issued Part VI in a series of FAQs on the implementation of PPACA. As is noted above, the new FAQs all relate to grandfathered plans under PPACA and elaborate upon the interim final regulations on grandfathered plan status that were issued July 17, 2010, as well as prior FAQs. In several significant respects, these FAQs expand the types of changes that will not cause a health plan to lose grandfather status.

As background, health plans that were in effect on March 23, 2010, the date PPACA was enacted, are grandfathered and, therefore, are not subject to several new requirements under PPACA, including a new external appeals process and mandatory first-dollar preventive care coverage. The regulations on grandfathered plans provide that a plan can lose grandfather status if employer contributions to the plan are reduced by more than a certain percentage; the plan's copayments, deductibles, or coinsurance are increased above a threshold amount; certain benefits are eliminated; maximum annual or lifetime benefit limits are lowered; or certain anti-abuse rules are violated.

**Scope of Anti-Abuse Rules**

The anti-abuse rules in the regulations are designed to prevent plans from circumventing the limits on changes that cause a plan to lose grandfather status. When employees are transferred from one grandfathered plan (the transferring plan) to another (the receiving plan), an anti-abuse rule says that the receiving plan will cease to be grandfathered if (1) under the general rules, the transferring plan would have lost grandfathered status if it had been amended to have the same terms as the receiving plan, and (2) there is no "bona fide employment-based reason" for transferring the employees to the receiving plan. While the regulations do not elaborate on the circumstances that constitute a bona fide employment-based reason for a transfer, the examples indicate that changing the terms or cost of coverage generally will not satisfy this standard.

Though the most recent FAQs stop short of defining the full scope of this anti-abuse rule, they provide a list of specific situations in which plan-to-plan transfers will be considered to be for a bona fide employment-based reason, even if a benefit package is eliminated through the transfer. Specifically, there will be a bona fide employment-based reason for transferring employees to a different grandfathered plan if the transfer eliminates a benefit package because:

- the insurer is exiting the market or no longer offers the benefit package to that employer;
- low or declining participation makes it impractical to continue offering the package;
- elimination of the package from a multiemployer plan is agreed upon in collective bargaining; or
- *for any reason,* as long as multiple benefit packages covering a significant portion of other employees remain available to the transferred employees after the package is eliminated.

Thus, in these circumstances, the receiving plan will not lose its grandfather status. The last circumstance appears to provide a significant amount of flexibility for an employer to eliminate a benefit option if two or more other options remain available to the transferred employees, provided that the remaining options previously covered a significant portion of the employer's employees. The FAQs make clear that this list of bona fide reasons for a transfer is not exhaustive.

**Changes to Drug Formularies**

The regulations on grandfathered plans also provide that certain increases in participant cost-sharing requirements would result in the loss of grandfather status. Originally, this rule seemed to include increases that result from the re-classification of a brand name drug following the addition of a generic alternative to the plan's formulary, since the re-classification would generally trigger an increase in the participant's cost-sharing for the brand name drug.

The FAQs clarify that a plan will not cease to be grandfathered merely because a generic alternative to a brand name drug is added to the plan's formulary, even if that change increases the cost-sharing for participants who continue taking the brand name drug, rather than the generic alternative.

**Changes to Value-Based Insurance Designs**

Section 2713 of the Public Health Services Act (PHSA), as enacted by PPACA, requires non-grandfathered health plans to provide first-dollar coverage for certain preventive health services. However, the statute also says that the Secretary of Health and Human Services may develop guidelines permitting plans to use certain value-based insurance designs (VBIDs) in connection with preventive care coverage. VBIDs use plan-based cost incentives to encourage participants to use higher-value/higher-quality services or facilities as a technique to control costs.

Part V of the PPACA FAQs included an example of a VBID under which a plan imposed a copayment for certain preventive services performed on an outpatient basis in a hospital, while the same services performed at a more cost-effective ambulatory surgery center were not subject to cost-sharing. The plan also waived the cost-sharing requirement for patients who were required to have the service at the hospital because it would be medically inappropriate for them to have it in an ambulatory setting. Under these circumstances, the agencies concluded that the VBID did not cause the plan to fail to comply with the first-dollar preventive care coverage requirements for non-grandfathered plans under PHSA section 2713.

Part VI of the FAQs clarify that grandfathered plans are not limited to using VBIDs that the plan had in place on March 23, 2010, even though a new design might increase participant costs. Using facts similar to the previous example in Part V of the FAQs, the latest FAQs say that a plan that, as of March 23, 2010, did not impose a copayment on certain preventive care services in either an outpatient or an ambulatory care setting may adopt a VBID that imposes a new copayment for services performed on an outpatient basis, subject to a waiver of the copayment if it is medically inappropriate for a particular patient to have the service on an outpatient basis. According to the FAQs, the addition of the new VBID in these circumstances would not cause the plan to lose its grandfather status despite the potential increase in participant costs.

**Mid-Year Amendments: Effective Date of Loss of Grandfather Status**

The FAQs also clarify a long-standing question regarding the time as of which a plan amendment will cause a plan to cease to be grandfathered. The FAQs state that a plan will cease to be grandfathered as of the effective date of any amendment to the plan that causes the plan to lose its grandfathered status, regardless of when the amendment is adopted. Therefore, if an employer adopts a mid-year amendment that will cause the plan to lose its grandfather status, but makes the amendment effective the first day of the next plan year, the plan will not cease to be grandfathered until the beginning of the next plan year, on the amendment's effective date. If the amendment becomes effective during the course of the plan year, however, the plan loses its grandfathered status at that time.

**Changes to Contribution Formulas**

The regulations on grandfather status provide that a plan ceases to be grandfathered if the employer decreases its contribution rate by more than 5% below its contribution rate on March 23, 2010. However, the 5% threshold is difficult to measure if the employer makes contributions based on a formula, such as a dollar amount times years of service, up to a maximum annual contribution amount, for example, $300 times years of service, up to $10,000 per year.

The FAQs say that, if employer contributions are based on a formula, the plan will not relinquish its grandfather status if the formula does not change. This rule applies even though increasing costs under the plan may result in higher costs to participants. In the case of this type of formula, however, if the dollar-amount multiplier is decreased by more than 5%, or if the employer's maximum contribution amount decreases by more than 5%, the plan will lose its grandfather status.

**Comments Requested**

In the FAQ regarding VBIDs, the agencies requested further information on VBIDs and wellness programs and said that future regulations would address issues relating to these designs and programs. The agencies also noted that they have received comments indicating plan sponsors would like greater flexibility to adopt both VBIDs and wellness programs without having their plans lose grandfather status and indicated that these comments would be considered as future guidance is developed.

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*If you have any questions about this Legal Alert, please feel free to contact any of the attorneys listed below or the Sutherland attorney with whom you regularly work.*


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