

## Health Care Reform Update

The Departments of Health and Human Services (“HHS”), Labor (“DOL”), and Treasury (“IRS”) (“Departments”) recently issued guidance regarding the implementation of certain Patient Protection and Affordable Care Act of 2010 (“PPACA”) requirements, including the rapidly approaching deadline for employers planning to apply for early-retiree funding from HHS, additional details on implementing the grandfathered plan rules, and the procedures for reporting the cost of employer-provided health coverage to employees. The DOL has also provided updated information on the status of the automatic enrollment requirement for large employers.

### Deadline For Early-Retiree Health Insurance Funding

Pursuant to the PPACA, \$5 billion was appropriated to establish a temporary program for partial reimbursement of the cost of providing health coverage to early retirees (including the spouses, dependents, and surviving spouses of early retirees). The program, which was implemented on June 1, 2010, began accepting applications on June 29, 2010. On March 31, 2011, HHS announced that it will stop accepting applications as of May 5, 2011, based on the amount of remaining program funds and the rate at which the funding is being disbursed. A copy of the application and instructions can be found at <http://www.errp.gov>. All applications must be physically *received* by HHS (i.e., not postmarked) on or before **May 5, 2011**.

### Additional Guidance For Grandfathered Health Plans

On April 1, 2011, the Departments issued a sixth set of FAQs regarding the implementation of the PPACA (“FAQs”), as summarized below.

Generally, a plan may lose grandfather status by:	According to the FAQs, however, a plan will generally <u>not</u> lose its grandfather status by:
<ul style="list-style-type: none"> <li>Transferring employees from one grandfathered plan or benefit package to another grandfathered plan or benefit package.</li> </ul>	<ul style="list-style-type: none"> <li>Transferring employees from one grandfathered plan or benefit package to another based on a “bona fide employment-based reason.” Such reasons include, but are not limited to the following:                             <ul style="list-style-type: none"> <li>the employer’s health insurance issuer exits the market;</li> <li>the employer’s health insurance issuer no longer offers the product to the employer (e.g., due to the employer’s failure to satisfy the issuer’s minimum participation requirements);</li> <li>the continued offering of a benefit package becomes impractical due to low or declining participation; and</li> <li>other employer-provided benefit packages that cover a significant portion of other employees are also available to the transferred employees.</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>Increasing the amount of cost-sharing (e.g., copayments, co-insurance, etc.) for participants.</li> </ul>	<ul style="list-style-type: none"> <li>Moving a brand-name prescription drug to a higher cost-sharing tier due to a newly available generic alternative (which is added to the plan sponsor’s formulary for determining the appropriate tier classification); or</li> <li>Imposing copayments as permitted under the “value-based insurance design” described in the fifth set of FAQs issued by the Departments.</li> </ul>
<ul style="list-style-type: none"> <li>Decreasing employer contribution rates.</li> </ul>	<ul style="list-style-type: none"> <li>Continuing to use the same dollar amount in a formula for retiree benefits (for plans that cover both active employees and retirees) even as the cost of coverage continues to increase over time.                             <ul style="list-style-type: none"> <li>For example, an employer contributes \$300/year multiplied by the individual’s years of service with the employer towards the cost of each retiree’s health plan coverage, capped at \$10,000/year. Despite any increase in the cost in coverage that may occur, the employer is not treated as decreasing contribution rates so long as the formula remains the same. If, however, the \$300/year constant, or the \$10,000 cap is decreased by more than 5 percent (i.e., to less than \$285/year, or a \$9,500 cap, respectively), the plan will cease to be a grandfathered plan.</li> </ul> </li> </ul>

**Effective Date Guidance.** For sponsors of grandfathered plans that wish to amend their plans, in a manner that will collaterally cause the loss of the plan's grandfather status, the FAQs state that grandfather status will cease on the applicable amendment's effective date, regardless of the date the amendment is adopted. Accordingly, to prevent the loss of grandfather status during the middle of the plan year, applicable plan amendments should generally be made effective as of the first day of the plan year that begins on or after the adoption date of the amendment.

### **Form W-2 Cost Of Coverage Reporting**

On March 29, 2011, the IRS issued interim guidance (Notice 2011-28) regarding the PPACA requirement that employers report the "aggregate cost of applicable employer-sponsored coverage" to employees on IRS Form W-2. Included in the interim guidance is a set of Q&As that addresses, among other things: (1) which employers are subject to the reporting requirement; (2) methods of cost-reporting in specific circumstances (e.g., termination from employment, successor employers, retirees, etc.); (3) how to determine the aggregate cost of applicable employer-sponsored coverage; (4) the coverage required to be reported; and (5) calculating the dollar amount of reportable coverage costs. The IRS emphasizes the fact that cost of coverage reporting to employees is for informational purposes only, and will not cause otherwise excludable employer-provided health benefits to become taxable income.

Although voluntary for the 2010 and 2011 tax years (Notice 2010-69), most employers that provide health coverage to their employees are required to report cost information beginning with the 2012 tax year. (Note, employers that choose to report the cost of coverage for 2010 and/or 2011 may rely on Notice 2011-28.) Transitional relief may be available, however, for: (1) small employers (i.e., employers that file less than 250 Forms W-2 for the 2011 tax year); (2) terminated employees to whom Forms W-2 are provided before the end of the year; (3) multiemployer plans; (4) health reimbursement arrangements; (5) stand-alone dental and vision plans; and (6) self-insured plans not subject to COBRA continuation coverage or other federal law requirements (e.g., church plans).

### **Automatic Enrollment Requirement For Large Employers**

The PPACA requires large employers (those with more than 200 full-time employees) that are subject to the Fair Labor Standards Act to automatically enroll new full-time employees (or continue enrollment for current employees) in one of the employer's health benefit plans. Employers are not required to comply with the automatic enrollment provisions until regulations are issued and effective, which the DOL intends to complete by 2014. To assist in the development of proposed regulatory guidance, the DOL hosted a public forum (held April 8, 2011) for individual and organizational stakeholders to exchange information and ideas regarding the automatic enrollment requirements. Forum topics included the definition of "full-time employee," selecting the appropriate plan/benefit package (for employers that maintain multiple health plans or benefit packages) and type of coverage (e.g., single or family) in which employees would be automatically enrolled, and notice requirements for employees who wish to opt out of coverage. A transcript of the forum will be available on the DOL's website at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Correction To Action Memo Dated DECEMBER 2010:** Our December, 2010 Action Memo covered, among other things, the Departments' announcement that compliance with the PPACA's nondiscrimination provisions will not be required until the issuance of further guidance. The Action Memo (see the third paragraph under the heading "IRS Delays Compliance with Nondiscrimination Rules for Insured Group Health Plans"), incorrectly indicated that "grandfathered insured plans [would otherwise be] required to comply with the nondiscrimination requirements beginning with the 2014 plan year, or the first plan year grandfather status is lost, if earlier." The correct date a grandfathered insured plan is required to comply with the nondiscrimination requirements (once the Departments require compliance), however, is the date such plan loses its grandfather status.

If you have any questions about this memorandum, please contact Susie Dahline in our Syracuse office (315.218.8227, [sdahline@bsk.com](mailto:sdahline@bsk.com)) or any of the other members of our Employee Benefits and Executive Compensation Practice Group listed below.

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