Health Care Reform Update

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Free Choice Vouchers and CO-OP Programs Eliminated

In what appears to be a change in strategy from outright repeal or defunding to piece-by-piece dismantling, Congressional Republicans negotiated the elimination of both the Wyden Free Choice Voucher and Consumer Operated and Oriented Plan (CO-OP) programs as part of a Congressional deal for the final 2011 federal budget. Both programs were set to take effect in 2014. The Wyden Free Choice Vouchers would have required employers to re-direct employer health plan contributions to employees who met certain income and contribution thresholds so they could purchase coverage from health insurance exchanges. The CO-OP program provided funds to states to create co-ops to be offered through health insurance exchanges.

Uniform Explanation of Coverage not yet Released

Despite the requirement in the Patient Protection and Affordable Care Act (PPACA), the Department of Health and Human Services (HHS) has yet to release guidance on the uniform explanation of coverage that was due by March 23, 2011. The model of the uniform benefit summary created by a working group of the National Association of Insurance Commissioners (NAIC) was provided to HHS in recent meetings. It is expected that HHS will adopt a final version very similar to this.

HHS To Stop Accepting New Applications for Early Retiree Reinsurance Program

Due to overwhelming demand and its prediction that the Early Retiree Reinsurance Program (ERRP) will run out of funding in 2012, HHS announced on April 1, 2011, that it will no longer accept new applications for the program as of 5:00 pm on May 5, 2011. The ERRP was established by PPACA to offer reimbursement to employer-sponsored health plans that covered retirees who were not Medicare-eligible. Program funding was limited to $5 billion. While the agency will stop taking new applications for employers seeking to enter the program, it will continue to process program claims for existing program enrollees until the program funding is exhausted.

Additional Guidance Issued on W-2 Reporting of Cost of Health Coverage

On March 29, the Internal Revenue Service (IRS) issued Notice 2011-28 to provide specific guidance for reporting the value of health coverage on W-2 forms, as required by PPACA Section 9002. Importantly, Section 9002 does not cause excludable employer-provided health coverage to become taxable, and the IRS Notice emphasizes that the W-2 reporting requirement is intended only to provide employees with information about the value of their employer-sponsored health coverage. Also important, the Notice advises that such W-2 reporting will continue to be voluntary for tax year 2011 (i.e., for W-2 forms that would be delivered to employees in January 2012), and provides additional relief for smaller employers (those filing fewer than 250 W-2 forms) by making this requirement optional for them at least an additional year (i.e., tax year 2012). This optional treatment for smaller employers will continue until the IRS issues further guidance.

Notice 2011-28 supplies long-awaited guidance on the specifics of how W-2 reporting of the cost of coverage is to be accomplished. The guidance includes definitions of the "cost of coverage," how to calculate the cost of coverage (for example, the COBRA premium calculation method can be used), and the method of reporting (report in W-2 form Box 12 using code DD). The IRS also seeks public comments on the W-2 reporting rules, with comment due 90 days from the date of Notice 2011-28's publication.

In state tax developments, California has passed AB36 that brings California tax law into conformity with part of last year's federal health care act that allowed the value of employer-provided benefits for adult dependents to be excluded from employees' income, as long as the child has not turned 27 by the end of the tax year. California did not immediately conform to this part of the federal legislation. As a result, employers who started covering nondependent children under age 27 last year were supposed to include the value of such coverage in their employees' state but not federal wages. This would have resulted in a difference between the federal and state wages reported on the employees' W-2 forms for 2010.

Further FAQs Released for Market Reforms
The Departments of Health and Human Services, Labor and the Treasury have released another in a series of Frequently Asked Questions (FAQs) to provide additional guidance on implementing the market reforms of the Affordable Care Act.

FAQs Part VI
Part VI was released April 1, 2011 and contained six Q&A clarifications.

Q&A 1 clarified what constitutes a bona fide employment-based reason for transferring employees from plan to another without causing a loss of grandfathered status. The reasons include: 1) When a benefit package is being eliminated because the issuer is exiting the market; 2) When a benefit package is being eliminated because the issuer no longer offers the product to the employer (for example, because the employer no longer satisfies the issuer's minimum participation requirement); 3) When low or declining participation by plan participants in the benefit package makes it impractical for the plan sponsor to continue to offer the benefit package; 4) When a benefit package is eliminated from a multiemployer plan as agreed upon as part of the collective bargaining process; or 5) When a benefit package is eliminated for any reason and multiple benefit packages covering a significant portion of other employees remain available to the employees being transferred.

Q&A 2 stated that the movement of a brand name drug into a higher-cost sharing tier when a generic alternative becomes available will not cause the plan to relinquish grandfather status.

Q&A 4 and Q&A 5 addressed loss of grandfathering. A plan operating on a calendar plan year will cease to be a grandfathered plan when an amendment that causes loss of grandfather status becomes effective, regardless of when the plan amendment is adopted.

Florida Health Care Reform Suit to be heard in June
The 11th Circuit Court of Appeals in Atlanta will hear oral arguments on June 8, 2011 in a government appeal of a Florida federal judge's ruling that found the health care reform law unconstitutional. The administration is appealing a decision in January by U.S. District Judge Roger Vinson that favored arguments by 26 states which say the law's requirement that Americans buy health insurance starting in 2014 or pay a penalty is unconstitutional. Judge Vinson found that the individual mandate would not be separated from the rest of the reform law and therefore found the entire law unconstitutional.

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