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January, 2012

Black, Gould & Associates, Inc.

Legislative Update



W-2 REPORTING

Beginning with calendar year 2012, employers who issue 250 or more Forms W-2 are required to report to employees the cost of their employer-sponsored group health plan coverage. This reporting is for informational purposes only.

Employers will need to:

- Identify the applicable employer-sponsored coverage provided to employees;
- Calculate the aggregate cost of coverage for each employee; and
- Report this cost in box 12 of Form W-2 using code DD.

Even though the new requirement is for informational purposes and does not trigger tax liability, it appears that typical information reporting penalties will apply for noncompliance.

What Employers Must Comply?

Generally, all employers that provide employer-sponsored coverage must comply. This includes federal, state and local government entities, churches and other religious organizations. However, the requirement does not apply to Indian tribal governments. In addition, under a special transitional rule, if an employer files fewer than 250 Forms W-2 for the 2011 calendar year, the employer would not have to report the cost of health coverage on any Form W-2 issued for the 2012 calendar year.

Coverage That Must Be Reported

Employers are required to report the aggregate cost of coverage under any group health plan made available to the employee by an employer.

The types of coverage that must be reported include:

- Medical plan coverage
- Medicare supplemental coverage
- On-site medical clinics
- Retiree medical coverage, but only for those otherwise receiving a Form W-2 for the calendar year

The employer may decide whether or not to report the cost of COBRA coverage received by an employee who terminated employment during the year. However, the employer must do this uniformly for all such terminated employees.

Coverage Not Reported

The following are not reported:

- Stand-alone dental or vision coverage
- Salary reduction contributions to a FSA, although certain employer contributions, may be subject to reporting
- Health reimbursement arrangement contributions
- Employee Assistance Programs
- Wellness Programs or On-Site Medical Clinics (if the employer does not charge a premium for that type of coverage)
- Self-insured group health plan coverage that is not subject to any federal continuation coverage requirements such as COBRA, the Public Health Service Act or the Federal Employees Health Benefits Program
- Archer MSA contributions
- Health Savings Account contributions
- Coverage under a Multiple Employer Plan
- Long-term care coverage
- Accident-only or disability income insurance
- Workers' compensation insurance
- Automobile medical payment insurance
- Specified disease or illness coverage (such as cancer coverage) and hospital indemnity or other fixed income coverage
- The cost of coverage includable in income under IRC 105(h), or payments of health insurance premiums for a 2% shareholder-employee of an S corporation who is required to include the premium payments in gross income

Calculating the Cost of Coverage

The aggregate reportable cost generally includes:

- Both the portion of the cost paid by the employer and the portion of the cost paid by the employee, regardless of whether the employee paid for that cost on a pre-tax or after-tax basis; and
- The cost of coverage for the employee and any dependent covered by the plan, including any portion of the cost that is includable in an employee's gross income, such as coverage for a domestic partner who is not a tax dependent.

For insured plans, the cost of the coverage will equal the premium charged by the insurer for that employee and his dependents.

For self-funded plans, the cost of the coverage will generally equal the COBRA premium for coverage for that period.

To reach the complete IRS notice, click [here](#).

MEDICAL LOSS RATIO REBATES

Under PPACA's medical loss ratio (MLR) rules, health insurers must issue rebates if the insurer failed to meet the MLR percentages identified in PPACA. This means, unless at least 85% of each premium dollar or 80% in the small group* and individual markets is spent on medical care, the carrier must issue rebates. The final guidelines, which were recently issued, require insurers to issue the rebate checks to the policyholder (generally the employer). The insurance carriers have subsequently made the employer responsible for distributing the funds appropriately.

Modifications in the final guidelines include:

- Employees in group health plans can receive rebates in a manner that is not taxable.
- A proposal that consumers receive a notice showing not only the amount of any rebate, but also the insurer's MLR even if there is no rebate. It is anticipated that these will be published in the spring of 2012
- In 2011, limited medical plans received a special circumstances adjustment to their MLR in the form of a multiplier of 2.0 for 2011. The final rule phases it down from 1.75 in 2012 to 1.5 in 2013 and to 1.25 in 2014. Mini-med plans will not be allowed after 2014 due to the prohibition on annual limits for essential benefits.
- The final rule levels the playing field between nonprofit and for-profit insurers in states with premium taxes.

These rebate funds do not automatically go back to just the employer. Depending on the plan's cost-sharing formula, the funds may be allocated between both employer and employees (including terminated employees who were formerly plan participants.)

The first rebate payments are due on August 1, 2012.

** - Small employer (small group) is defined as up to 100 employees, except that as provided under ACA, until 2016 a state may substitute 50 employees for 100 employees consistent with current law in most states.*

PPACA PROVISIONS FOR 2012

Expatriate Plans: We are currently awaiting guidance regarding whether the plan design components of PPACA will apply to expatriate plans as well.

Uniform Benefit Summaries: This PPACA provision is effective for plan years beginning on or after 3/23/2012, the intent is to provide standardized benefit summaries including examples to eligible employees. We are still awaiting an interim final rule.

W-2 Reporting: Employers who issue 250 or more W-2's must begin including on the W-2's for calendar year 2012, the aggregate cost of medical group insurance coverage.

Women's Preventative Services: This expands the preventative services covered with no cost sharing for non-grandfathered plans, effective for plan year beginning on or after August 1, 2012.

Comparative Effectiveness Research Tax: Applies to the first plan year ending after 9/30/2012, there is a new fee on private insurance equal to \$2 annually for each covered individual.

Medicare Accountable Care Organizations: Effective 1/1/2012, incentives are provided for physicians to form ACO's in an effort to improve patient care.

MEDICAL LOSS RATIO AND HIGH DEDUCTIBLE HEALTH PLANS

Recently, final MLR regulations were issued and since that time a variety of studies showing the impact have been performed. Of much concern is the impact that MLR will have on the High Deductible Health Plans (HDHPs) and Health Savings Accounts (HSAs). The issues involved include:

- Because the insured person is required to pay more of the cost of care, the claim portion of the premium is lower for HDHPs. This means that to reach the 80 or 85% MLR requirement, the expenses must be lower than on a typical fully-insured health plan.
- As a result of high deductibles there are statistically fewer claims during a given year, but those claims are higher for HDHPs. This scenario generates greater variance in one year to the next, making the forecasting of expenses versus premium a greater challenge. The result is an increase in the likelihood that the plan will fall below the 80 or 85% MLR for a specific year.

The current "final" MLR regulations make it necessary to increase HDHP plan deductibles annually or the annual premium costs for HDHPs will surpass those of a traditional plan. Of course, with the PPACA regulation limiting rate increases, this may make HDHPs difficult to find.

This information is not intended to be, nor should it be construed as legal or tax advice. We are not authorized nor do we purport to provide tax or legal advice and this should not be viewed as a substitute thereof. It is intended merely as an educational tool.

As always, feel free to contact us with any questions at marketing@blackgould.com.

Sincerely,

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