

## Ask us about...

### **The Leading Edge**®

...a trend-setting employee benefits program from Mid American Group, including:

### **Administrative Services**

- COBRA Administration
- Flex Administration
- 5500 Form Preparation
- Cafeteria Plan Administration
- HIPAA Administration
- FMLA Administration
- Total Compensation Statements
- Dependent Eligibility Reports
- Integrated Payroll HRIS Systems
- Performance & Financial Guarantees

### **Employee Benefits**

- EAP
- Vision
- Wellness Services
- Internet Services

## Inside This Issue:

New W-2 Reporting Requirement	1
Congressional Inaction Results in Reduction in Monthly Commuter Benefit	2
Health Benefit Costs Continue to Rise	3
DOL Announces Ramped-up Compliance Enforcement Efforts	3
Medical Loss Ratio Rebates Expected in August 2012 - Could Constitute Plan Assets	3
HHS Announces States Will Define "Essential Health Benefits"	4

The Leading Edge® is published quarterly by Mid American Group, Inc.

760 Pasquinelli Drive, Suite 358, Westmont, IL 60559  
Editor: Ben Conley®, Employee Benefits Attorney  
Seyfarth Shaw LLP (312) 460-5228  
bconley@seyfarth.com  
Permission to quote with credit to source.

The information contained in this publication is intended for the general information of our clients. It should not be construed as legal advice or legal opinion regarding any specific or factual situation.

## New W-2 Reporting Requirement

The Affordable Care Act requires employers to report the cost of employer-sponsored health care coverage on employee Forms W-2 starting in 2012 (on the Form W-2 issued in January of 2013), although some employers may choose to implement the reporting earlier. This reporting is informational only and does not cause the coverage to be taxable.

### **Reporting Requirement Applies to All Employers**

All employers who provide health coverage must report the cost of that coverage, including federal, state and local governmental entities, churches and other religious organizations. There is a delayed effective date, however, for small employers that filed fewer than 250 Forms W-2 in the prior year. This relief continues until the IRS issues further guidance.

### **Employers Must Report Most "Group Health Plan" Coverage**

Employers must report the aggregate cost of employer-sponsored coverage (employer plus employee premiums). This generally includes any employer-provided coverage under a group health plan that is excludable from the employee's gross income, although there are several exceptions. The cost should be reported in Box 12 of the Form W-2 using Code DD. Employer-sponsored coverage would include, for example, major medical coverage, mini-med plans, Medicare supplemental coverage, on-site clinics and certain employer-provided flex credits contributed to a health care flexible spending account. Several of the exceptions are listed below.

### **Coverage That Does Not Need to be Reported on the Form W-2:**

- Archer MSA or Health Savings Account coverage;
- Salary reduction contributions to flexible spending accounts (but note, certain employer flex credits may need to be reported, as discussed below);
- Health Reimbursement Arrangement coverage;
- Long-term care coverage;
- Vision/dental coverage if either: (a) the coverage is fully-insured under a separate policy than the medical coverage (or the coverage is fully-insured and medical is self-funded) or (b) employees make a separate election **and** pay a separate premium for the coverage;
- Life insurance including voluntary life insurance;
- Accident or disability income insurance, although a disability policy that provides medical coverage rather than merely income replacement would be reported (i.e. a major medical policy for disabled former employees);
- Supplemental liability insurance;
- Workers' compensation insurance;
- Automobile medical payment insurance;

- Independent, non-coordinated coverage for a specified disease or illness (i.e. cancer insurance);
- Multiemployer plan coverage;
- Employee assistance plan, unless the coverage is considered a “group health plan”. The coverage will be a group health plan if any medical advice or treatment is provided to employees. Most of these plans provide some form of medical advice or treatment; or
- Self-insured coverage that is not subject to federal continuation coverage requirements (such as COBRA, the Public Health Service Act or the Federal Employees Health Benefits Program).

### **Generally, Employers Should Report the COBRA Cost of Coverage**

For insured coverage, employers should report the premium cost. For self-funded plans, premium cost is generally calculated in the same way as COBRA rates are calculated (minus the 2% administrative cost), using a good faith interpretation of the COBRA requirements. Employers should report both employer and employee contributions, regardless of whether those contributions are made on a pre or post-tax basis (i.e. post-tax premium payments for a domestic partner who does not meet the definition of dependent for federal tax purposes). The amount reported must account for any employee changes in coverage during the year (i.e. mid-year enrollment or change in status).

### **Reporting Employer Flex Credits**

Employers may be required to include the value of employer-provided flex credits in certain instances, as described below. The reporting requirement could vary from employee to employee, depending on how employees elect to allocate the employer flex credits.

### **Report the Value of Benefits**

**When to Report:** Employers should report the value of benefits when the amount of the total FSA balance (i.e. employee FSA deferrals plus employer flex credits) exceeds the amount of the employee’s total election for qualified benefits (including, but not limited to, pre-tax premium contributions for medical, dental and vision, employee FSA deferrals, employee DCAP deferrals, supplemental life contributions, etc.).

**What to Report:** The amount reported should equal the total FSA balance minus any employee FSA deferrals (i.e. only report employer flex credits allocated to the FSA).

### **Do Not Report the Value of Benefits**

Employers should not report the value of benefits when the employee’s total election for qualified benefits (as described above) exceeds the employee’s total FSA balance (as described below).

### **Example - Reporting the Value of Benefits**

Company provides \$1,500 in flex credits annually. Employee makes an election for qualified benefits of \$2,000, \$800 of which are employee FSA deferrals. Employee’s total FSA balance is \$2,100 (which amounts to \$800 of employee FSA deferrals and \$1,300 of company flex credits).

Because the total FSA balance (\$2,100) exceeds the employee’s total election for qualified benefits (\$2,000), the Company must report the benefit on the Employee’s Form W-2. The amount reported would be \$1,300 (the total FSA balance of \$2,100 minus the employee FSA deferral of \$800).

### **Post-Termination Reporting**

Employers are only required to report the value of EAP, on site clinic, or wellness programs if the employer charges a COBRA premium for employees electing continuation coverage for the benefit.

Employers may choose whether to include post-termination coverage (i.e. COBRA or continued active coverage due to a severance agreement) on the Form W-2. Employers are only required to: (1) use a reasonable method of reporting and (2) treat all employees in a consistent manner.

Until further IRS guidance indicates otherwise, employers are not required to report the cost of coverage at all if a terminating employee requests a mid-year Form W-2. The cost would be reported, however, if an employee terminates mid-year and is issued a Form W-2 at year-end.

Finally, employers are only required to report the cost of coverage for employees who would otherwise be entitled to receive a Form W-2. This means employers do not have to provide retirees with a Form W-2 solely to convey the cost of coverage. The cost should be reported though for any retiree that would otherwise receive a Form W-2.

## **Congressional Inaction Results in Reduction in Monthly Commuter Benefit**

Starting in 2012, employees may only defer \$125 per month on a pre-tax basis for mass transit benefits. The 2009 economic stimulus bill increased the maximum monthly deferral to

\$230 per month. While many had hoped for an extension of the increased limit, Congress failed to pass an extension before the deadline.

## Health Benefit Costs Continue to Rise

A recent survey by the Council of Insurance Agents & Brokers indicated that health benefit costs continue to rise for small employers. The survey of employers with 50 or fewer employees showed almost half of employers reporting a rise between 11% to 20%. This is a decrease from the May 2011 survey, when almost 65% of employers reported an increase in that range.

## DOL Announces Ramped-up Compliance Enforcement Efforts

According to employerlawreport.com, the DOL has announced a new compliance audit initiative focused on plan administrators of ERISA benefit plans. Potential penalties could start at \$1,100 per day, ranging up to \$50,000 per plan, per year. Plan sponsors can reduce risk of liability through a compliance self-audit.

## Medical Loss Ratio Rebates Expected in August 2012 - Could Constitute Plan Assets

Employers sponsoring a fully-insured group health plan or benefit option could receive a rebate from the insurance policy issuer as soon as August of this year, under the Affordable Care Act's new medical loss ratio (MLR) rules. DOL guidance confirms that at least a portion of these rebates are likely "plan assets." As a result, DOL rules will govern plan sponsors' disposition of these assets, discussed below.

### **Background - Affordable Care Act Requires Medical Loss Ratio Reporting and Refunds**

The Affordable Care Act requires health insurers to monitor and report to HHS their MLR, which generally means the ratio of health care claims paid to premiums received (health care claims ÷ premiums). If the MLR drops below a certain percentage (85% for large group health plans, 80% for small group health plans), the insurer must issue the excess as a rebate to the insured individual or group health plan sponsor by August 1st of the following year.

### **Rebates Will Usually Constitute Plan Assets**

Employers sponsoring fully-insured group health plans will receive the rebate directly. In most instances though, a portion of these rebates will constitute plan assets. While circumstances may vary depending on the terms of the plan document, insurance policy and other factors, the following rules generally apply:

#### **Premiums Paid Entirely by Employer**

If the insurance premiums are 100% paid by the employer, with no participant premium contribution, the rebate probably will not constitute plan assets and can revert to the employer. Employers should still verify that this treatment is consistent with the terms of the insurance policy and plan document.

#### **Premiums Paid Entirely by Participants**

If the insurance premiums are 100% paid by the participant, with no employer contribution, the entire rebate will constitute plan assets. As a result, ERISA's general standards of fiduciary conduct will govern use of the assets, as discussed below.

#### **Premiums Paid Partially by the Employer, Partially by Participants**

Most employer-sponsored plans fall into this category. While the rules vary depending on the contribution structure, generally the percentage of the rebate that constitutes plan assets will correspond to the ratio of the premium paid by participants. If participants pay a fixed amount though (as opposed to a percentage), the amount of the rebate that constitutes plan assets will never exceed the fixed cost paid by the participants. The reverse is also true. If the employer only pays a fixed amount (as opposed to a percentage), the amount of the rebate that may revert to the employer can never exceed the fixed amount the employer pays.

#### **Fiduciary Rules Govern Use of Plan Assets**

If any portion of the rebate is determined to be plan assets, ERISA's general fiduciary obligations apply when allocating those assets. Generally, this means the rebates must be used to benefit both current and, in some instances, former participants. Most importantly, plan sponsors should apply the rebates within three months of receipt, otherwise ERISA's trust requirement applies (which can be costly).

# MID AMERICAN GROUP

THE LEADING EDGE™

A quarterly Newsletter to our valued friends and clients...

760 Pasquinelli Drive, Suite 358, Westmont, IL 60559

Phone: (630) 789-9508 • Fax: (630) 789-9516



PRESORTED  
FIRST-CLASS  
U.S. POSTAGE  
PAID  
DOWNERS GROVE, IL  
PERMIT #254

## Save The Date:

### Spring Seminar & Luncheon

Friday - May 18, 2012

The Westin Yorktown

70 Yorktown Center, Lombard, IL 60148

Please RSVP to Sabrina Pierard

(630) 366 7441 or [sabrinapierard@midamgroup.com](mailto:sabrinapierard@midamgroup.com)

## Topics:

### Medicare:

Medicare Advantage vs Fee For Service Medicare  
What Medicare Drug Coverage Offers  
How to Select the Best Plan

### 401(k)

401(k) Withdrawal & Rollover Options  
401(k) Fee Disclosures  
Prohibited Transactions

## HHS Announces States Will Define "Essential Health Benefits"

The Affordable Care Act requires all plans offered through the exchanges in 2014 to offer a package of "essential health benefits." The Act broadly outlined ten categories of benefits that the package should include, but it tasked HHS with further defining the package. Instead, HHS recently released guidance indicating it will allow the states to define the benefits that must be offered in the exchanges.

### ***Each state can choose between the following options:***

- One of the three largest small group plans in the state by enrollment
- One of the three largest state employee health plans by enrollment
- One of the three largest federal employee health plan options by enrollment
- The largest HMO plan offered in the state's commercial market by enrollment.

The outcome of the essential health benefits determination is significant for two reasons. First, if a state chooses a more comprehensive package of benefits, coverage provided through the exchanges will be more expensive for individuals and small businesses. Second, the Affordable Care Act also prohibits all group health plans from imposing annual dollar limits on "essential health benefits" (whether fully-insured, self-funded, inside the exchanges, or outside the exchanges). It remains to be seen how this rule will apply now that HHS will allow states to separately define the term. This could potentially create difficulties for employers offering plans in multiple states.