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Employee Benefits | Life Insurance | Retirement Planning

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INSURANCE BRIEF

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California Tax Conformity

At long last the California legislature has cleared the way for Governor Brown to sign into law AB 36! On Thursday, March 24th the Senate approved the bill by a vote of 35-0. Governor Brown is expected to sign the bill next week. This bill updates the CA tax code to conform with the federal tax code regarding treatment of health benefits received by dependents up to age 26.

As reported in our *SML Update* of February 7th, this bill will be effective retroactively to March 30, 2010.

For employers who were impacted by the lack of tax conformity, you can expect to receive instruction from the California Employment Development Department (EDD) on how to file amended DE-6 and DE-7. Guidance is also expected from the Franchise Tax Board (FTB) on how to correct employee wage reporting.

What's Next: Employers can cease adjusting affected employee's wages immediately. As soon as the EDD and/or FTB release instructions we will send an update.

W-2 Reporting Guidance and Additional Relief

The IRS issued Notice 2011-28 on March 29th, providing guidance on the W-2 reporting provision as well as relief for certain small employers. It reminds us that this reporting to employees is for their information only, to inform them of the cost of their health care coverage, and does not cause excludable employer provided health care coverage to become taxable.

Key Points: Small employers are defined as those that are required to file fewer than 250 2011 Forms W-2. Their transition relief will continue at least through the 2012 Forms W-2 which are required to be furnished to employees in January 2013

The interim guidance issued applies beginning with 2012 W-2's. However, any employers that choose to report earlier (on the 2011 W-2's furnished to employees by January 31, 2012) may look to Notice 2011-28 for guidance.

Background: The Patient Protections and Affordable Health Care Act (PPACA) will require employers to disclose the aggregate cost of the applicable employer-sponsored coverage for the calendar year (Tax Year) on Form W-2. The law was to take effect beginning with the 2011 tax year for employees participating in health plan coverage. Then on October 12, 2010, the IRS announced in Notice 2010-69 that reporting would be optional for the 2011 tax year for all employers. It would take effect with the 2012 tax year, reportable on January 31, 2013. This date still applies for non-small employers.

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W-2 Reporting Guidance and Relief *cont'd*

Guidance: Here are just some highlights from the guidance section which is presented as Q&A in the Notice. To see all of the Q&A you can download a copy of the notice at Notice 2011-28.

What employers are subject to the reporting requirement? All sizes of employers that provide applicable employer-sponsored coverage. This includes federal, state and local government entities, churches and other religious organizations. Federally recognized Indian tribal governments are not included.

Q-5: How is the aggregate reportable cost reported on Form W-2?
A-5: The aggregate reportable cost is reported on Form W-2 in box 12, using code DD.

Aggregate Cost of Applicable Employer-Sponsored Coverage (Q&A-11 through Q&A-15)
Q-12: What is applicable employer-sponsored coverage?
A-12: Applicable employer-sponsored coverage means, with respect to any employee, coverage under any group health plan (see Q&A-13) made available to the employee by an employer that is excludable from the employee's gross income under § 106, or would be so excludable if it were employer-provided coverage
Excluded from employer sponsored coverage are:

- Section 125 salary reduction contributions made to Health Care Spending Accounts (FSAs);
- Long term care, accident or disability income insurance (LTD/STD);
- Aflac-type target benefits (e.g. cancer, specific disease, hospital indemnity, etc.); or
- Employer contributions to Health Savings Accounts or Archer Medical Savings Accounts.

Q-13: What is a group health plan?
A-13: A group health plan is a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

Q-14: Does the aggregate reportable cost include both the portion of the cost paid by the employer and the portion of the cost paid by the employee?
A-14: Yes. 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 through pre-tax or after-tax contributions.

Q-15: Does the aggregate reportable cost include any portion of the cost of coverage under an employer-sponsored group health plan that is includible in the employee's gross income, for example, the cost of coverage for a person other than an employee, the employee's spouse, the employee's dependent, or the employee's child who will not have attained age 27 by the end of the taxable year?
A-15: Yes. The aggregate reportable cost includes the cost of coverage under the employer-sponsored group health plan of the employee and any person covered by the plan because of a relationship to the employee, including any portion of the cost that is includible in an employee's gross income. Thus, the aggregate reportable cost is not reduced by the amount of the cost of coverage included in the employee's gross income.

Cost of Coverage Required to be Included in the Aggregate Reportable Cost (Q&A-16 through Q&A-23)
Q-18: Is the cost of coverage under a Health Reimbursement Arrangement (HRA) required to be included in the aggregate reportable cost reported on Form W-2?
A-18: No. An employer is not required to include the cost of coverage under an HRA in determining the aggregate reportable cost.

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W-2 Reporting Guidance and Relief *cont'd*

Q-20: Is the cost of coverage under a dental plan or a vision plan included in the aggregate reportable cost, if that plan is not integrated into a group health plan providing other types of health coverage subject to the reporting requirements of § 6051(a)(14)?
A-20: No. An employer is not required to include the cost of coverage under a dental plan or a vision plan if such plan is not integrated into a group health plan providing additional health care coverage subject to the reporting requirements of § 6051(a)(14). An employer must include the cost of coverage under a dental plan or a vision plan if such plan is integrated into a group health plan providing such additional health care coverage.

Methods of Calculating the Cost of Coverage (Q&A-24 through Q&A-27)
Q-24: How may an employer calculate the reportable cost under a plan?
A-24: An employer may calculate the reportable cost under a plan using the COBRA applicable premium method (Q&A-25). Alternatively, (1) an employer that is determining the cost of coverage for an employee covered by the employer's insured plan may calculate the reportable cost using the premium charged method (Q&A-26); and (2) an employer that subsidizes the cost of coverage or that determines the cost of coverage for a year by applying the cost of coverage in a prior year may calculate the reportable cost using the modified COBRA premium method (Q&A-27). For employers that charge employees a composite rate (the same premium for different types of coverage under a plan, for example, a premium for self-only coverage versus family coverage), see Q&A-28.

The reportable cost for an employee receiving coverage under the plan is the sum of the reportable costs for each period (such as a month) during the year as determined under the method used by the employer. An employer is not required to use the same method for every plan, but must use the same method with respect to a plan for every employee receiving coverage under that plan.

Q-28: How may an employer charging an employee a composite rate calculate the reportable cost for a period?
A-28: An employer is considered to charge employees a composite rate (1) if there is a single coverage class under the plan (that is, if an employee elects coverage, all individuals eligible for coverage under the plan because of their relationship to the employee are included in the elections and no greater amount is charged to the employee regardless of whether the coverage will include only the employee or the employee plus other such individuals), or (2) if there are different types of coverage under a plan (for example, self-only coverage and family coverage, or self-plus-one coverage and family coverage) employees are charged the same premium for each type of coverage. In such a case, the employer using a composite rate may calculate and use the same reportable cost for a period for (1) the single class of coverage under the plan, or (2) all the different types of coverage under the plan for which the same premium is charged to employees, provided this method is applied to all types of coverage provided under the plan.

For example, if a plan charges one premium for either self-only coverage, or self-and spouse coverage (the first coverage group), and also charges one premium for family coverage regardless of the number of family members covered (the second coverage group), an employer may calculate and report the same reportable cost for all of the coverage provided in the first coverage group, and the same reportable cost for all of the coverage provided in the second coverage group. In such a case, the reportable costs under the plan must be determined under one of the methods described in Q&A-25 through Q&A-27 for which the employer is eligible.

What's Next: This is interim guidance and comments have been requested by the Treasury Department and the IRS. Should future guidance be issued it will be prospective only and will not be applicable earlier than January 1 of the first year beginning at least six months after issuance. The relief provided to small employers, however, will not be limited in any case. So, many employers can sit back for now and see how this requirement continues to unfold.

Rescissions and Retroactive Terminations

The health care reform provision prohibiting rescissions was effective for plan years beginning on or after September 23, 2010. Responsibility for compliance falls on the plan sponsor and recently carriers have been issuing communication pieces reiterating that fact, so we thought it would be a good time to remind you of the rules.

Key Points: The Department of Labor's FAQ page states "A rescission is defined as it is commonly understood under the law—a cancellation or discontinuation of coverage that has a retroactive effect, except to the extent attributable to a failure to pay timely premiums towards coverage." Exceptions to the ban on rescission are fraudulent or intentional misrepresentations. For example, marital status or dependent eligibility misrepresentations.

- Plans cannot terminate coverage retroactively if the participant was covered through plan error and the participant paid premium. Where premiums have been paid by the participant coverage can only be terminated prospectively.
- When coverage is rescinded due to intentional misrepresentation of material fact or fraud, then a 30-day written notice is required, and the rescission may be appealed.

An example in the Departments' interim final regulations on rescissions clarifies that some plan errors (such as mistakenly covering a part-time employee and providing coverage upon which the employee relies for some time) may be cancelled prospectively once identified, but not retroactively rescinded unless there was some fraud or intentional misrepresentation by the employee.

Some employers' human resource departments may reconcile lists of eligible individuals with their plan or issuer via data feed only once per month. If a plan covers only active employees and an employee pays no premiums for coverage after termination of employment, the Departments do not consider the retroactive elimination of coverage back to the date of termination of employment to be a rescission.

What's Next: Employers are advised to monitor their eligibility closely and report terminations promptly. Contact your SML Account Team if you have any questions.

Premium Increase Disclosures—Small Group

The Department of Health and Human Services (HHS) proposed premium rate review regulations in December 2010 which would apply to non-grandfathered insurance plans in the individual and small group markets. Small group market would be defined as it is under the applicable State's rate filing laws. For example, in California the small group market is 2-50 employees.

Under the proposed rules, if an insurer tries to raise rates at or above a certain threshold amount that rate increase is subject to review by either State insurance officials or HHS if the State does not have an effective process for reviewing rates. The proposed threshold for the first year is 10%. After 2011, a state-specific threshold will be set for disclosure of rate increases, using data and trends that better reflect cost trends particular to that state.

Under the proposed rule, this review of rates could begin as early as July 2011. And, once rates begin being reviewed, HHS will work to post information on these proposed rates as quickly as possible.

Recently, proposed consumer disclosure notices have been released by the Centers for Medicare & Medicaid Services (CMS). (For a Zip file containing all of the notices click CMS-10379.) These notices will have to be completed by insurers when they propose a rate increase over 10%. This information would then be accessible on the HHS website. Posting this information would help consumers know what their insurance companies are proposing while the rate increase requests are being reviewed. Disclosing proposed increases, along with the insurer's justification, will allow consumers to better understand the reasons and rationale behind the proposed increases.