

New Electronic Form 5500 Filing Deadline for Calendar Year Plans Approaching Soon!

Before January 1, 2010, Form 5500 filings could be submitted to the Department of Labor (DOL) on paper **OR** electronically using a system called EFAST (Electronic Filing Acceptance System). The old EFAST system allowed for filers to continue submitting their Form 5500s in a hand print version generated on approved software, which could be filed by mail or transmitted online.

Effective for filings in 2010 to report on plan years beginning on or after January 1, 2009, the Form 5500s MUST be filed electronically.

The new all-electronic system should result in fewer errors or rejected filings, faster processing, greater security, more timely enforcement, and lower Form 5500 costs. Benefits Design Group, Inc. has chosen the IFILE system (one of two methods for preparing and transmitting filings to the DOL under EFAST2). This is a web application available on the DOL's website.

QUESTION: Our company has a cafeteria plan that permits participants to pay for certain benefits using pre-tax dollars. I'm confused about the Form 5500 filing requirements. Do we have to file a Form 5500 for our cafeteria plan?

ANSWER: In 2002, the IRS suspended this filing requirement for all the fringe benefits listed in Code 6039D for all future filing and past filing years. Notwithstanding this Code 6039D suspension, a plan sponsor offering ERISA benefits (i.e. General-Purpose or Limited-Purpose Medical Reimbursement) under a cafeteria plan must still file a Form 5500 for those

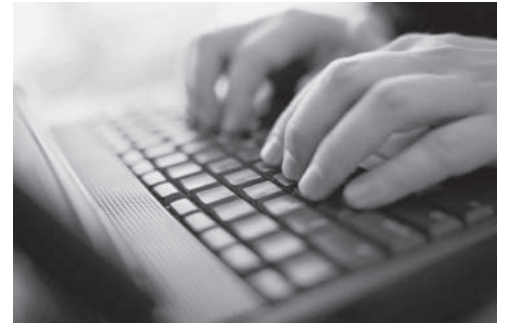
ERISA benefits, unless a Form 5500 exemption applies (e.g. for certain unfunded small plans with fewer than 100 participants at the beginning of the plan year).

It has been clarified that Schedule C is not required for unfunded plans that use a Section 125 cafeteria plan for participant contributions, and such contributions are held in the general assets of the employer. Unfunded HRAs that make reimbursements from the general assets of the employer will not need to file Schedule C as well.

For those full service clients subject to Form 5500 filing under their **cafeteria plan** with us, we have sent notification and instructions on how to log on and receive a PIN, user name and password. If more than one individual is to have signing authority, then each signer needs their own signing credentials on the DOL website. Also, if the individual signer leaves or a new individual is to have signing authority, the new signer needs their own signing credentials. For our Service Option 1 and HRA clients, the preparation of this form is part of our service agreement and will be done at no additional charge.

It is important to file these forms in a timely manner as under ERISA 502, the DOL may assess a civil penalty against a plan administrator of up to \$1,100 per day starting from the date of the administrator's failure or refusal to file the Form 5500.

As before, filing a Form 5558 (*Application for Extension of Time to File Certain Employee Plan Returns*), before the filing deadline, will



By Kim Ness, CFCI

automatically grant up to an additional 2½ months to file your Form 5500.

Editor's Note: Health Reimbursement Arrangements (HRA) that are unfunded and have fewer than 100 participants at the beginning of the plan year will be exempt as well. Just because you may qualify for an exemption on your cafeteria and/or HRA filing(s), does not automatically mean that you are exempt for all Form 5500 filings. You will need to review your other group sponsored benefits and any pension plans separately to determine what filing requirements may apply to those plans. ■

IN THIS ISSUE

New Electronic 5500 Deadline	1
COBRA ARRA Subsidy End	2
If You Like Your Health Plan.	3-4
Patient Protection & Affordable Care Act	5-6
Staff Updates.	7
New W-2 Reporting.	8

COBRA ARRA Subsidy Eligibility Ended May 31, 2010

By: Sonja Kerr



As you may already know the COBRA ARRA Subsidy provided Assistance Eligible Individuals (AEI) with a 65% reduction in premiums. The COBRA ARRA subsidy, which expired on May 31, 2010, had been extended three times since its enactment in February of 2009. Senate Democratic leaders on June 24, 2010 **did not** approve the proposed amendment to the tax bill H.R. 4213 that would have extended the ARRA premium subsidy through November 30, 2010. The bill received a 57-41 vote, Senate Democrat backers of the tax measure fell short of the 60 votes they need to invoke cloture and stop the debate on the tax bill. Senate Republicans and some fiscally conservative Democrats oppose the measure because it would add to the federal deficit.

Since the subsidy has now expired anyone losing their job on or after June 1, 2010 will have to pay the full COBRA premium amount. According to a new report by Families USA, the average monthly unemployment income is \$1,313 compared with the average charge of \$1,107 for COBRA coverage. Many families will have to choose between feeding their family and

choosing health care and will join the estimated 58.4 million people in the United States that are living without health care insurance.¹

According to a recent Congressional Budget Office (CBO) report, the largest problem for Americans who lacked insurance for part of the year correlated with the lack of employment, as 60.6 percent of unemployed adults (ages 18 to 64) experienced a lack of health coverage during that time as compared to only 21.8 percent of employed adults.

When COBRA was passed in 2009, the Congressional Budget Office (CBO) estimated that \$25 billion in subsidies would be provided to COBRA beneficiaries between 2009 and 2012, with \$14 billion in subsidies provided in 2009.² ARRA was also expected to assist seven million people with COBRA subsidies during 2009. More recently, CBO reports smaller than anticipated revenue losses due to COBRA subsidies. Furthermore, there is conflicting evidence as to the effect of the subsidies on the take-up of COBRA coverage.

US Treasury Department COBRA Survey Data

A recent Treasury Department survey,³ of the ARRA Federal subsidies of health insurance premiums for the unemployed were widely used by the middle class during the recession. Many laid-off workers and their families maintained their health coverage as a result of the subsidy. The Treasury Department estimates that for a typical family nationwide, the ARRA subsidy reduced the cost of COBRA from about \$13,500 to \$4,725.

The Treasury analysis is one of the earliest reports on the profile of unemployed individuals who obtained continuing health insurance coverage through the ARRA COBRA subsidy. The study surveyed more than 6,000 New Jersey workers receiving Unemployment Insurance in the fall and winter of 2009. The report found that between one-quarter and one-third of eligible unemployed workers enrolled in subsidized COBRA. In addition, roughly 15% of Unemployment Insurance beneficiaries received health insurance coverage through COBRA.

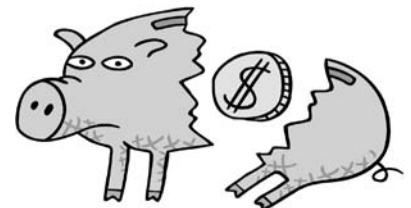
The report concludes that the subsidy appears to have been especially important for maintaining health coverage for middle-class families during the recession, and likely reduced the number of Americans who otherwise would have gone uninsured during the recession. A separate publication from the Treasury Department estimates that up to 2 million households were provided premium assistance in 2009, and over 300,000 claims were filed by employer tax reporting units through early 2010. The Treasury Department suggests that the availability of the program may have significantly slowed the growth of the uninsured population, which had been significantly increasing through Feb. 2009.

¹ www.healthnews.com/family-health/cobra-health-care-subsidies-end-4285.html.

² See [www.cbo.gov/ftpdocs/100xx/doc10008/03-02Marco of ARRA.pdf](http://www.cbo.gov/ftpdocs/100xx/doc10008/03-02Marco%20of%20ARRA.pdf) (last reviewed in April 2010).

³ US Treasury Department Office of Economic Policy, "COBRA Insurance Coverage Since the Recovery Act: Results from new Survey Data," <http://www.ustreas.gov/press/releases/reports/treasury%20cobra%20subsidy%20survey%20report%20final.pdf>

Editor's Note: *At print time, unemployment benefits and the COBRA subsidy remain expired as of May 31, 2010. Congress will return to session the week of July 12th after the holiday recess. We will continue to monitor legislative activity for any changes.*



“If You Like Your Health Plan you Can Keep It?” But for How Long?

By: *Cindy Davis, Esq.*

The Patient Protection and Affordable Care Act (“Affordable Care Act”) exempts “grandfathered plans” from certain requirements of the Affordable Care Act as long as plans retain their grandfathered-in status. On June 17, 2010 the Department of Health and Human Services (“HHS”) and Department of Labor (“DOL”) jointly issued Regulations that are effective June 14, 2010 (“Grandfathered Plan Regulations”). The DOL and HHS also released a set of nineteen Questions and Answers contemporaneous with the Grandfathered Plan regulations. The DOL and HHS used the Grandfathered Plan Regulations to clarify their interpretation of several key issues concerning grandfathered plans generally, and collectively bargained grandfathered plans in particular. The Grandfathered Plan Regulations clearly reflect the view recently articulated by representatives of the DOL and HHS that a primary objective of the Affordable Care Act is to have as many people subject to the Affordable Care Act as soon as possible. These same representatives went on to state that if the interpretation of the agencies was incorrect the legislators could pass additional legislation to clarify issues. This following summarizes the Grandfathered Plan Regulations and the Questions and Answers.

I. General Grandfathered Plan Rules

The Affordable Care Act provides that certain group health plans and group health insurance in effect as of March 23, 2010 are subject only to certain provisions of the Affordable Care Act. These plans are commonly referred to as grandfathered plans. The Grandfathered Plans Regulations clarify the following three points pertaining to the Affordable Care Act implications for collectively bargained grandfathered plans:

1. A grandfathered collectively bargained plan (insured or self-insured) DOES NOT have a delayed effective date for compliance with the Affordable Care Act provisions that are applicable to grandfathered plans that are not collectively bargained.
2. Coverage under an insured group health plan maintained pursuant to one or more collective bargaining agreements ratified before March 23, 2010 is grandfathered at least until the date on which the last agreement relating to the coverage that was in effect on March 23, 2010 terminates.
3. A collectively bargained self-insured group health plan in existence before March 23, 2010 must comply with the same rules to maintain grandfathered status that are applicable to non-collectively bargained plans.

II. Provisions Of The Affordable Care Act Applicable To Grandfathered Plans By The Start Of The Plan Year That Begins On Or After September 23, 2010.

Grandfathered plans are subject to the following provisions of the Affordable Care Act beginning with plan years that begin on or after September 23, 2010:

- Grandfathered plans may not impose lifetime or unreasonable annual limits on the dollar value of “essential health benefits.” The Secretary of HHS will define what constitutes “essential health benefits” at a later date.
- Grandfathered plans may not rescind coverage for a covered participant unless the participant has committed fraud or made an intentional misrepresentation of material fact prohibited by the terms of a plan.
- Grandfathered plans must make coverage available to an adult child of a participant until the child turns age 26 if the adult child is not eligible for coverage under another employer sponsored group health plan. The grandfathered plan cannot impose an additional charge for such coverage.
- Grandfathered plans may not impose pre-existing conditions requirements for children under the age of 19.
- Grandfathered plans are still eligible for the early retiree reinsurance program which will reimburse the plan for a portion of the cost of providing coverage to early retirees, their spouses, and dependents.

III. Provisions Of The Affordable Care Act That Are Not Applicable To Grandfathered Plans Until Plan Years Starting On Or After January 1, 2014.

Grandfathered plans may refuse to cover pre-existing conditions (except for children under the age of 19) until their plan year beginning on or after January 1, 2014. Grandfathered plans are also not required to cover adult children who are eligible to enroll in any other employer-provided plan until plan years starting on or after January 1, 2014. Grandfathered plans may also delay coverage for clinical trials until plan years starting on or after that date.

Continued next page

IV. Provisions Of The Affordable Care Act The Plan Must Comply With If It Loses Its Grandfathered Status.

If a plan loses its grandfathered status, it may no longer delay implementation of the changes discussed in item III above until plan years starting on or after January 1, 2014. Plans that lose their grandfathered status also will be required to:

- Cover preventative health services with no cost-sharing by the participant;
- Cover emergency services, without prior authorization, and at the same cost to participants as in-network care;
- Cover, without prior authorization, participant's obstetric, gynecological, or pediatric care;
- Create new internal and external appeals process with review by an ombudsman;
- Allow participants to designate any available primary care provider who will accept them as a patient;
- Insured group health plans must satisfy Code Section 105 which disallows discrimination in favor of highly compensated employees;
- Begin submitting annual reports to HHS for plan years starting on or after January 1, 2011 regarding measures taken to improve health outcomes and lessen hospital admissions; and
- Ensure that, by plan years starting on or after January 1, 2014, participants' cost-sharing does not exceed \$5,000 for individuals and \$10,000 for families.

V. Actions That Will Cause A Plan To Lose Its Grandfathered Status.

The Grandfathered Plan Regulations provided much needed guidance on the extent to which a plan may be changed without losing its grandfathered status. Unfortunately, the answer is very little. Under The Grandfather Plan Regulations a plan will lose its grandfathered status if even relatively minor plan benefit changes are made. A plan may increase its benefits and retain its grandfathered status, but any subsequent reduction in the benefit would likely result in the plan losing its grandfathered status. We now know that any of the following changes will result in a loss of grandfathered status:

- Elimination of all or most benefits regarding the diagnosis or treatment of a certain condition;
- Any increase in a percentage cost-sharing requirement, such as an individual's coinsurance;
- Any increase greater than the yearly medical inflation rate plus 15% of a fixed-amount cost-sharing requirement, such as a deductible or out-of-pocket limit;
- Any increase in co-payments greater than the larger of \$5 plus the medical inflation rate, or the medical inflation rate plus 15%;
- Any decrease of 5% or greater in employer or employee organization contribution rates; and
- Certain changes in annual limits, including the new addition of an annual limit, imposition of an annual limit that is less than the lifetime limit, or decrease in the annual limit.

Changes in plan coverage caused by mergers of plans or transferring of employees from one plan to another may also end a plan's eligibility for grandfathered status. A merger may end a plan's grandfathered status if its principal purpose is to cover new individuals under a grandfathered plan. If the transfer has no bona fide employment-based reason or was primarily for the purpose of changing the terms or cost of coverage, then the plan will also lose its grandfathered status.

V. Plan Changes Made After March 23, 2010.

If a plan made changes in coverage, contributions, or cost-sharing effective after March 23, 2010, pursuant to a legally binding contract entered into on or before March 23, 2010 or pursuant to amendments adopted on or before March 23, 2010, the changes are treated as part of the plan's terms as of March 23, 2010. If after March 23, 2010 a grandfathered plan made changes to the terms of the plan and the changes were adopted before June 14, 2010, the changes will not result in the plan losing its grandfathered status if the changes are revoked or modified effective as of the first day of the first plan year that begins on or after September 23, 2010 and the altered terms of the plan would not cause the plan to lose its grandfathered status under other requirements in the regulations.

VI. Additional Notice Requirements Applicable To Grandfathered Plans.

To maintain its grandfathered status, a plan must provide a statement in all of its plan materials provided to participants that states that the plan believes it is a grandfathered plan. The Grandfathered Plan Regulations include model language that a plan can use for this notice. The plan is also required to maintain records that detail the plan's coverage as of March 23, 2010 and any other documents necessary to verify, explain, or clarify its status. At the request of HHS, the plan must make these documents available for inspection. ■

Patient Protection And Affordable Care Act:

Preexisting Condition Exclusions, Lifetime And Annual Limit, Rescission And Patient Protection Regulations

By Cindy Davis, Esq.

The Department of Treasury, Department of Labor (“DOL”) and Department of Health and Human Services (“HHS”) have jointly issued additional final interim regulations implementing the rules for group health plans and individual and group health insurance under the Patient Protection and Affordable Care Act (“Affordable Care Act”). These interim final rules will be effective sixty days after publication in the Federal Register. Most changes addressed by the regulations apply to plan years that begin on or after September 23, 2010. This following provides an overview of the new regulations.

Prohibition on Preexisting Condition Exclusions

The Affordable Care Act generally prohibits any preexisting condition exclusion from being imposed by group health plans or group health insurance. The regulations do not prevent a plan or insurer from excluding all benefits for a condition; however, if a group health plan does provide benefits for a condition, then the rules pertaining to preexisting condition exclusions apply. Keep in mind that other Federal laws, and state laws in the case of insured group health plans, may require a group health plan to provide coverage for specific conditions. The preexisting condition provisions becomes effective for enrollees who are under age 19 for all plan years beginning on or after September 23, 2010, and for all other enrollees for plan years that begin on or after January 1, 2014.

Lifetime and Annual Limits

The Affordable Care Act allows “restricted annual limits” with respect to essential health benefits for plan years beginning before January 1, 2014. This restriction does not apply to grandfathered individual market policies. The regulations pertaining to the prohibition on lifetime limits apply to all group health plans and policies for plan years beginning on or after September 23, 2010. A group health plan or insurer may impose annual or lifetime limits on specific covered benefits that are not essential health benefits. Essential health benefits are defined under the Affordable Care Act as including at least the items and services within the following general categories: “...ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative services and devices; laboratory services; preventative and wellness services and chronic disease management; and pediatric services, including oral and vision services.”

The DOL, HHS and Treasury have yet to issue regulations further defining and clarifying what constitutes essential health benefits. Consequently, the option to impose lifetime and annual benefits on benefits that are not essential health benefits currently has minimal, if any, value. For plan years beginning before January 1, 2010 the regulations establish a three-year phased approach for restricted annual limits that a plan can impose with respect to essential health benefits. The dollar value of annual limits on essential health benefits may not be less than the following:

- \$750,000 for plan or policy years beginning on or after September 23, 2010 but before September 23, 2011;
- \$1.25 million for plan or policy years beginning on or after September 23, 2011 but before September 23, 2012; and
- \$2 million for plan or policy years beginning on or after September 23, 2012 but before January 1, 2014.

These annual minimums for plan years beginning before January 1, 2014 are applied on an individual-by-individual basis. A plan or policy cannot apply a family annual benefit limit in a manner that denies a covered individual the applicable minimum annual benefit for the year. In determining whether an individual has received benefits that meet or exceed the applicable annual limit for essential health benefits, the plan may only take into account the value of essential health benefits provided.

The regulations require that plans implement new notice and enrollment procedures related to the lifetime limit restrictions. The plan must give written notice the lifetime limit no longer applies to each individual who reached a lifetime limit under the plan prior to the effective date of the regulations but who is still otherwise eligible for coverage under the plan. If any such individual is no longer enrolled in the plan, the plan must provide that individual an opportunity to re-enroll in the plan (at least 30 day enrollment period). The notice, if prominent, can be included with other plan enrollment materials that the plan distributes. The individual must be treated as a special enrollee, and must be offered all of the benefit options available to similarly situated individuals who did not lose coverage due to reaching a lifetime maximum. The plan must provide the notice and enrollment opportunity not later than the first day of the plan year that begins on or after September 23, 2010. Likewise, coverage for an individual who enrolls in the plan by virtue of the regulations must take effect no later than the first day of the first plan year that begins on or after September 23, 2010.

Application to FSAs, HRAs, MSAs and HRAs

The annual limit restriction applies differently to account-based health plans. Flexible spending accounts (FSA), health savings accounts (HSA), and medical savings accounts (MSA) are exempt from the restriction on annual limits. The application of the annual limit restriction to a health reimbursement account (HRA) depends on the design of the HRA. An HRA with limited benefits, that standing alone would not satisfy the annual benefit restriction, will not violate the annual limit restriction if the HRA is integrated with other coverage as part of a group health plan and the other coverage that satisfies the annual limit restriction. A retiree-only HRA is also not subject to the annual limit restriction because plans that benefits two or fewer current employees are generally exempt from the Affordable Care Act amendments to ERISA and the Code.

Prohibition on Rescission

The Affordable Care Act and the regulations significantly restrict the ability of a plan or insurer to rescind coverage for plan years that begin on or after September 23, 2010. All plans or insurers cannot rescind coverage for an individual unless the individual or a person seeking coverage on behalf of the individual (i.e. employer) was involved in fraud or made an intentional misrepresentation of material fact that is prohibited by the terms of the plan. The regulations also state that any Federal or State laws that may apply to the rescission or cancellation of coverage that are more protective of individuals do not conflict and are not preempted by this restriction. The regulations clarify the prohibition on rescission in several respects. First, the rules regarding rescission apply whether the rescission applies to a single individual, an individual within a family or an entire group of individuals. Rescission standards would apply if an insurer attempted to rescind coverage of entire employment-based group due to the actions of an individual in the group. Second, rescission rules apply equally to representations made by the individual or by a person seeking coverage on behalf of a group. Third, rescission rules confirm that a plan or insurer is permitted to rescind coverage if an omission constitutes fraud.

The regulations define rescission as a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance is not a rescission for purposes of the regulation if it is prospective or due to a failure to timely remit required premiums or contributions toward the cost of coverage. Under the regulations a plan or insurer must provide at least thirty (30) days advance written notice of rescission to each participant who would be affected by the rescission. The plan or insurer must provide the rescission notice regardless of whether the rescission is of group or individual coverage; and in the case of group coverage, whether the coverage is insured or self-insured or the rescission will affect an entire group or just an individual within the group.

Patient Protections

For non-grandfathered plans, with plan years beginning on or after September 23, 2010 the Affordable Care Act and regulations impose new requirements relating to the choice of health care professionals applicable to a plan or health insurance coverage with a network of providers and new requirements relating to emergency room benefits as well.

The new rules make clear that participants are free to designate any available participating primary care provider as their provider. The rules also allow parents to choose any available participating pediatrician to be their children's primary care provider. And the rules prohibit insurers and employer plans from requiring a referral for obstetrical or gynecological (OB-GYN) care. The health plan or insurer must provide written notice whenever the health plan or insurer provides a summary plan description or other description on plan benefits.

The new rules impose significant changes on coverage of emergency room (ER) services. The rules require that a plan or insurer provide coverage for ER services: (1) without a preauthorization requirement (even if out-of-network); (2) without regard to if the provider is a participating network provider; (3) without imposing any administrative requirement or limitation for out-of-network services that don't apply in network; and (4) without charging higher cost-sharing (copays or coinsurance) for ER services that are obtained from out-of-network providers. A participant may, however, be balance billed for charges that exceed amount the plan or insurer is required to pay under the rules for out-of-network ER services.

Editors Note: The DOL, Treasury and HHS have indicated that they intend to release further guidance soon to address additional issues raised by the Affordable Care Act, such as what constitutes essential health benefits. We will continue to provide updates pertaining to implementation of the Affordable Care Act.

Cindy Davis is a partner with the law firm of Anderson, Helgen, Davis & Nissen, LLC located in Minneapolis, Minnesota. She has been practicing law in the areas of employee benefits, ERISA, employment law and general business matters for approximately 20 years. Ms. Davis advises employers, plan trustees, third-party administrators and other employee benefit plan service providers in pension and welfare benefit plan compliance with ERISA, the Internal Revenue Code, HIPAA, and state and federal continuation of coverage laws. Ms. Davis is a frequent presenter on employee benefit plan compliance and employment law issues. ■

Staff Updates

Changes

Missy Thill recently joined the Benefits Design Group team as an Account Representative. Missy is originally from the La Crosse area, and graduated from the University of Wisconsin-La Crosse in 2008 with a degree in Marketing. Prior to Benefits Design Group, her work experience consisted of group sales coordinator, bookkeeper, marketing assistant, door-to-door sales in New Mexico and California, and an event coordinator.

Missy is taking over responsibilities previously assigned to **Heather Smith**. Due to fast paced growth of our COBRA Administration Services area, Heather is still with Benefits Design Group but her job duties will be focused on our COBRA Administration clientele. Questions pertaining to our COBRA services can be directed to Heather Smith and / or Sonja Kerr. Missy has been working on your payroll reports and claims processing for the past month and going forward, those accustomed to speaking with Heather on many Section 125 issues will be able to direct payroll reports, changes, and any questions that you may have regarding your Plan to Missy at mthill@bdgflex.com. We are happy to expand our staff to accommodate the needs of our clients!

Change In Email Address For Kim Ness

Many of you have reported problems when sending emails to our Operations Manager, Kim Ness. When our secure email system was put in to place, it was discovered that Kim was able to receive messages to both Nessk@bdgflex.com as well as Kness@bdgflex.com. Our new AppRiver system would only allow one license for Kim Ness and therefore, in order to be consistent with our company email address system, the Nessk@bdgflex.com account was closed. If you have tried to email her and have had delivery failures, please check your default email address as that may be the problem.

Please note the correct address is kness@bdgflex.com and we certainly apologize for any confusion during this transition.

In Demand

Sue Sieger, CFCI, has once again been selected by the Employer Council on Flexible Compensation (ECFC) to teach one of the courses used to prepare candidates for the certification exam. The CFC designation is awarded as a result of a rigorous examination covering employee benefit plan design and administration, the law, regulations and ethical standards. Sue will be conducting the session on Consumer Driven Health Care-HRAs and HSAs at the Flexible Benefit Plan Administrators Symposium in San Diego, CA in early August. Sue also serves on both the ECFC Planning and Education Committees which are responsible for organizing and running the conferences for the ECFC that occur throughout the year, as well as developing and maintaining the educational curriculum for the certification programs.

Sue Sieger, CFCI, has been requested by several Society for Human Resources Management (SHRM) chapters throughout Wisconsin as a speaker on health care reform, as they hold meetings to help employers try to sift through all of the upcoming changes. In addition, Sue was recently interviewed by the La Crosse Tribune and her comments on health care reform were published on July 4, 2010 in the River Valley Business Report. You can read the full article at: http://lacrossetribune.com/business/local/business-report/article_e9cd4664-8398-11df-a2ad-001cc4c03286.html ■

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New W-2 Reporting Requirements

Will my Health Benefits be Taxed?

By: Kim Ness, CFCI



Employers will face many changes under Health Care Reform and among them is the new W-2 Reporting Requirement. Health Care Reform will require employers to calculate and report the aggregate cost of employer-sponsored health insurance coverage on employees' Form W-2s for tax years beginning after December 31, 2010. However, because terminated employees are entitled to request their W-2 early if they terminate during the year, employers may need to have systems in place to

accommodate such requests early in 2011. The IRS will have Form W-2s for tax year 2011 available no later than February 1, 2011.

Plans for which coverage cost must be reported include:

- *Medical Plans
- *Executive Physicals
- *On-site Clinics (if providing more than de minimus care)
- *Dental and Vision (unless they are "stand alone" plans)
- *Prescription Drug plans
- *Medicare Supplemental policies
- *Employee Assistance Programs

The cost of coverage under the health flexible spending accounts, health savings accounts, and specified disease or hospital/fixed indemnity plans is excluded from the reporting requirement. Employers will still be responsible for reporting Dependent Care Expenses in Box 10 of the W-2 and Health Savings Account (HSA) contributions (both employee contributions made under a cafeteria plan and employer contributions) in Box 12 of the W-2.

How will Employers Value these Plans?

Additional guidance on how to calculate the value of these plans is expected to be released soon. Once this is available, we will pass that information along to our clients. However, we presume the determination of the value will be made with similar rules to that of COBRA premium calculation minus the 2 percent administrative charge allowed under COBRA. What may become challenging for employers is some plans covered by the new reporting requirements (i.e. onsite clinics) are not plans that have been valued for COBRA purposes. Employers will need to calculate reportable values for coverage under these plans.

In addition, an employer's overall W-2 reporting requirements may increase dramatically if employers are to report employees, former employees, and all those provided coverage through the employer sponsored programs as this may include retirees, terminated employees on COBRA and surviving spouses. Many of these individuals would not previously have received a Form W2 from the employer. It seems that the new reporting requirements require a monthly calculation of coverage, additional guidance is needed on how to report coverage if employees have less than a month's coverage (coverage starts and/or stops mid-month).

Although there is the potential for further guidance, we thought we would be proactive by sending you this analysis, as you may find it helpful as you begin preliminary work with your payroll department.

Editor's Note: *We have been told that a chain email has been circulating on the internet that indicates that because your health benefits will show up on your W-2 in 2011 you will have to pay taxes on your health benefits in 2011. This is NOT true. The aggregate value of health benefits will appear on the W-2 as information to the taxpayer. In the future the IRS will likely use the information to determine who does not have employer-sponsored health benefits when the "pay or play" mandates kick in 2014. Penalties may apply to a taxpayer who does not have insurance coverage as mandated in 2014.* ■

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