THE FOLLOWING HIGHLIGHTS THE PATIENT PROTECTION AND AFFORDABLE CARE ACT W-2 REPORTING AND PATIENT CENTERED OUTCOME FEES.

REPORTING HEALTH COVERAGE COSTS ON W-2s

The Patient Protection and Affordable Care Act (PPACA) requires employers to report the cost of employer-sponsored health coverage on employee 2012 W-2 forms. Generally, all employers that provide employer-sponsored coverage are required to adhere to the W-2 reporting requirement, although the Internal Revenue Service (IRS) has provided limited exemptions. Employer-sponsored coverage is defined as coverage under any group health plan that is excludable from the employee's gross income, or that would be excludable under the Internal Revenue Code (IRC) if it were employer-provided coverage.

WHO IS SUBJECT TO THE REQUIREMENT?

All employers providing applicable employer-sponsored coverage must report the cost on their employees' W-2 forms, larger employers immediately and smaller ones at a yet to be determined date. This includes federal, state and local government entities, churches and other religious organizations. It also includes employers who are not subject to the COBRA continuation coverage requirements. Those employers who filed less than 250 W-2 forms in 2011 do not have to report the value of employer-provided health benefits for 2012. Further guidance is expected to clarify when the W-2 reporting requirement will take effect for these smaller employers. Also, the reporting requirements do not apply to coverage under a self-insured plan that is not subject to COBRA or to plans primarily maintained for military members and their families.

WHAT COVERAGE SHOULD BE REPORTED?

The total value of employer-sponsored medical coverage must be reported on W-2 forms. This includes any portion paid with employee contributions plus the employer's amount. Additionally, while employee contributions to health flexible spending arrangements (FSAs) through salary reductions are not subject to the requirement, employer contributions to employee FSAs must be reported. Employers are not required to report contributions to the following:

- Long-term care insurance;
- Health savings accounts (HSAs);
- Health reimbursement arrangements (HRAs);
- Medical savings accounts (MSAs);
- Insurance coverage where benefits for medical care are secondary or incidental (i.e. accident or disability income insurance); or
- Stand-alone vision and dental plans that are not subject to HIPAA rules.

DO YOU HAVE TO REPORT COVERAGE FOR TERMINATED EMPLOYEES?

When reporting coverage, an employer should treat all terminated employees consistently. The employer may elect only to report those health costs for the portion of the year during which a former employee was active and covered by the plan, or an employer may choose to report post-employment coverage, such as COBRA. If a former employee requests their W-2 before the end of the 2012 year, the employer is not required to report the cost of health coverage on the form. Similarly, no reporting is required if an employer would not otherwise be required to issue a W-2.

HOW SHOULD YOU CALCULATE THE COST OF COVERAGE?

The law requires that the total cost of health coverage provided to the employee is reported, whether the cost is paid by the employer or the employee. To calculate the value of benefits the employer may use the COBRA applicable premium method, the premium charged method or the modified COBRA premium method, as explained by the COBRA regulations. Of note, the additional 2-percent premium allowable under COBRA is not included in reportable cost. If an employee is covered by an insured plan, then the employer may use the "premium charged" method and report the premium charged by the insurer for that employee's coverage for the period. Finally, the reportable cost for a year must take into account any changes in coverage for the employee during the year.

For additional guidance on the W-2 reporting requirement please see " HYPERLINK "http://www.irs.gov/pub/irs-drop/n-12-09.pdf" Internal Revenue Service Notice 2012-9, Interim Guidance on Informational Reporting to Employees of the Cost of Their Group Health Insurance Coverage".

Practically, many employers are finding that a listing of aggregate employee contributions for medical coverage is an excellent starting point. This is especially true when (1) employee contribution rates have changed during the year, (2) the employee has changed his election mid-year, or (3) the employee is covered for only part of the year. This approach only works in cases where employee contributions are a uniform percent of the total during the period of coverage. For example, if employee contributions for employee only coverage represent 25% of the total throughout the year, even though contributions may have changed or the employee was covered for only part of the year, the reported amount would be four times (100%/25%) the aggregate contributions.

PATIENT - CENTERED OUTCOMES RESEARCH INSTITUTE FEE

For plan years beginning after September 30, 2012, the PPACA requires insurers, health maintenance organizations, et. al., ("issuers") and plan sponsors for individual and group policies to pay a Patient-Centered Outcomes Research Institute Fee (PCORI) for each covered life in their plan. The purpose of the fee, formerly called the comparative effectiveness research fee, is to fund research that will evaluate and compare the health outcomes from and effectiveness of medical treatments. The fee is scheduled to sunset, and will not apply to policy or plan years after September 30, 2019.

WHICH PLANS ARE SUBJECT TO THE FEE?

The fee applies to specified health insurance policies, including medical policies, retiree-only policies, and more generally, to any accident or health insurance policy issued to individuals in the United States. To avoid double-counting, if a participant is enrolled in more than one plan that is subject to the fee, it only needs to be paid once. The following plan-types are exempt:

- Expatriate coverage;
- Stop-loss and indemnity reinsurance insurance (under specific circumstances);
- Stand-alone vision and dental plans that are not subject to HIPAA rules.

WHO IS REQUIRED TO PAY THE FEE? AND WHEN IS IT DUE?

Issuers and plan sponsors are required to pay the fee for plan years ending after September 30, 2012. Liability for the fee must be reported on Tax Form 720, a federal excise tax return. Your Form 720 must be filed by July 31 of the calendar year immediately following the last day of the plan year. For instance, if your plan year ends December 31, 2012, then a Form 720 reporting the liability must be filed by July 31, 2013. Self-funded plans must pay the fee directly to the Internal Revenue Service (IRS).

HOW DO YOU CALCULATE THE APPLICABLE FEE?

The applicable fee is equal to the average number of covered lives for the plan year times the respective fee for that year. In the first year the fee is set at $1 per covered life, each subsequent year the fee increases according to the schedule below. Fees are only announced for plan years ending before October 1, 2014. The Secretary of Treasury will adjust the fee for subsequent years based on projected per capita increases in national health expenditures.

The fees are:

- **$1** per covered life for plan years ending after **September 30, 2012** but before **October 1, 2013**.
- **$2** per covered life for plan years ending after **September 30, 2013** but before **October 1, 2014**.

HOW DO YOU CALCULATE THE AVERAGE NUMBER OF COVERED LIVES? Methods for calculating the average number of covered lives vary depending on plan type.

Fully Insured Plans

Per IRS regulations, issuers may choose from four methods for determining the average number of covered lives. Issuers must consistently use their selected method for the entirety of the year in question and for all policies that are subject to the fee.

Actual Count: Calculate the total number of covered lives for each day of the plan year and divide by the number of days in the year.
Snapshot Method: Count the number of employees on a particular day during a quarter (i.e. the first day of the quarter) and divide by the total number of dates the count was made (i.e. divide by 4 if the count is made quarterly). The date used for each quarter must be the same (i.e. first day, last day).
National Association of Insurance Commissioners (NAIC) Member Method: Average the number of covered lives as reported to NAIC on the Supplemental Health Care Exhibit (SHCE) each month over the relevant 12-month period.
State Form Method: For those issuers not required to file the NAIC SHCE, they may average the number of covered lives reported on a state specific form for each month over a 12-month period.

Self-Funded Plans

Per IRS regulations, plans may choose from three methods for determining the average number of covered lives. Like fully insured plans, self-funded plans must consistently use their selected method for the entirety of the year in question and for all policies that are subject to the fee.

Actual Count: Calculate the total number of covered lives for each day of the plan year and divide by the number of days in the year.
Snapshot Method: Count the number of employees on a particular day during a quarter (i.e. the first day of the quarter) and divide by the total number of dates the count was made (i.e. divide by 4 if the count is made quarterly). The date used for each quarter must be the same (i.e. first day, last day). In order to account for plan participants that have partner/ dependent coverage, the number of participants with any coverage other than self-only coverage must be multiplied by 2.35 and then summed with the number of participants with self-only coverage, before averages are calculated.
Form 5500 Method: Sum and then average the number of total participants covered at the beginning and end of the plan year, as reported on the Form 5500.

If a plan sponsor has more than one self-funded plan then it may treat both as a single self-funded plan to avoid double-counting members. If a plan sponsor has both an FSA or HRA and a self-funded plan, they may treat both plans as a single plan. Additionally, if a plan sponsor maintains only a FSA or HRA then they may treat each participant's account as covering a single life.
For more information on the PCORI please see the proposed rule.