

## IRS Issues Guidance on Mandatory Form W-2 Informational Reporting of Employer-Sponsored Health Coverage

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On March 29, 2011, the IRS issued Notice 2011-28 (“Notice”), which provides interim guidance to employers regarding the new Form W-2 reporting requirement for employer-sponsored group health coverage. This requirement was added to the Internal Revenue Code (“Code”) by last year’s health reform legislation, the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-149 (“PPACA”). The IRS has requested comments, which are due by June 27, 2011, on this interim guidance.

### ***Background Regarding PPACA and New Form W-2 Reporting Requirement***

Section 6501(a) of the Code generally provides that employers must provide written statements to each employee – on or before January 31 of the succeeding year – showing the remuneration paid to that employee during the calendar year. Form W-2 is used to provide this information to employees.

PPACA, which was enacted on March 23, 2010, added a new reporting requirement to the Code that requires employers to report the cost of employer-provided health care coverage on the Form W-2. Code Section 6051(a)(14) generally provides that the “aggregate cost” of all “applicable employer-sponsored coverage” must be included on the Form W-2. Significantly, as discussed below, this generally includes coverage under any subject group health plan, regardless of whether such coverage is excludable from the employee’s gross income under Section 106 of the Code and whether it is paid for directly by the employer in the form of a premium subsidy, or by the employee on either a pre-tax (through a cafeteria plan) or after-tax basis.

Although the new Form W-2 reporting requirement was scheduled to become effective for this 2011 tax year, the IRS issued Notice 2010-69 on October 12, 2010. Notice 2010-69 provided employers with a one-year reprieve from the new rule by making the new requirement optional for purposes of 2011. Significantly, yesterday’s Notice, although it does not grant any overall further reprieve, does provide an exception for qualifying small employers unless and until further guidance is issued.

### ***Highlights of the Interim Guidance***

- ***The Reporting Requirement is for Informational Purposes Only and Does NOT Result in Additional Wages or Tax Liability for Form W-2 Recipients.*** The Notice makes clear that the new reporting requirement to employees “is for their information only . . . and does not cause [such coverage] to become taxable.” As set forth in the Notice, the stated purpose of the reporting is, “to provide useful and comparable consumer information to employees on the cost of their health care coverage.”

***Comment:*** Employers are likely to receive many questions from employees regarding the implications of the additional amounts being reported on their 2012 Form W-2s. Employers

may consider providing specific notice to employees of the new reporting requirements either in advance of, or in conjunction with, the issuance of 2012 Form W-2s.

- ***The Reporting Requirement Applies No Sooner Than With Respect to 2012 Form W-2s.*** The Notice provides that “[t]his interim guidance generally is applicable beginning with 2012 Forms W-2 (that is, the forms required for the calendar year 2012 that employers generally are required to furnish to employees in January 2013...).” The Notice also makes clear that there is no reporting requirement with respect to Forms W-2 issued for the 2010 and 2011 calendar years.

***Comment:*** As discussed below, employers are not required to comply with the new reporting requirement with respect to individuals who terminate employment mid-year and request a Form W-2 at time of their termination. Thus, employers who find themselves the recipient of such a request, including in 2011, can rest assured that they are not required to comply with the new reporting requirement in these instances.

- ***When Reporting Use “Code DD” in Box 12.*** The Notice provides that for purposes of listing the aggregate cost in Box 12 of the Form W-2, employers should use “code DD”.
- ***Special Rules Provided for Reporting with Respect to Form W-2s Requested and Issued Mid-Year.*** The Notice provides that an employer may apply any reasonable method of reporting the cost of coverage for an employee who terminates employment during the calendar year, so long as the method is used consistently for all employees who terminate employment during the plan year with respect to the same plan. Additionally, and perhaps even more importantly, the Notice provides that “regardless of the method of reporting used by the employer for other terminated employees, an employer is not required to report any amount . . . for an employee who . . . has requested before the end of the calendar year during which the employee terminated employment to receive a Form W-2” (emphasis added).

***Comment:*** Some employers as a matter of policy provide Forms W-2 to employees at the time of their termination, regardless of whether the employee requests a Form W-2. It appears that such employers will not be required to report the aggregate cost with respect to such terminated employees unless a Form W-2 is specifically requested. This appears to be the case for terminations that occur now or later in 2011.

- ***Qualifying Small Employers and Tribal Governments Enjoy Limited Exceptions from the Reporting Requirement.*** The Notice provides generally that all employers that provide applicable employer-sponsored coverage are subject to the new reporting requirement. This includes, among others: federal, state, and local government entities, churches and other religious organizations, and employers that are not subject to the COBRA continuation coverage requirements under Section 4980B (but see discussion below regarding special exception for self-funded plans that are not subject to federal COBRA).

The Notice does, however, exclude employers that are federally-recognized Indian tribal governments. Additionally, the guidance provides transition relief for certain qualifying

small employers. Specifically, it provides that unless and until the IRS issues further guidance, employers filing fewer than 250 Forms W-2 for the preceding calendar year are not subject to the reporting requirement.

- ***The Reporting Requirement Applies to “Applicable Employer-Sponsored Coverage.”*** The Notice provides that the “aggregate cost” with respect to all “applicable employer-sponsored coverage” must be reported on the employee’s Form W-2. The term “applicable employer-sponsored coverage” is broad and encompasses group health plan coverage that is, or would be, excludable from an employee’s income by reason of Code section 106.

The broad definition of “applicable employer-sponsored coverage” means that very many types of employer-sponsored coverage, whether provided through insurance or otherwise, are subject to reporting. These include:

- Major medical
- “Mini-med” plans
- On-site medical clinics
- Medicare supplemental
- Medicare Advantage
- Employer flex credits contributed to a Code section 125 health flexible spending arrangement (“Health FSA”)

***Comment:*** With respect to Health FSAs, the Notice provides that employer flex credits, as defined in Proposed Treasury Regulation §1.125-5(b), are subject to reporting. This is true whether they are expressed as a fixed amount or as a matching contribution; however, employers should be cautious as to any flex credits contributed to a Health FSA because the Notice treats such amounts differently than other flex credits. Significantly, amounts contributed by an employee via salary reduction are not subject to reporting. Thus, employers who sponsor Health FSA arrangements that allow for both salary reduction and employer flex credits will need to be careful to distinguish between excepted salary reduction amounts and non-excepted flex credits.

The Notice provides that the following are NOT subject to reporting:

- Stand-alone dental or vision coverage
- Long-term care coverage or insurance
- Amounts salary reduced by employees into a Health FSA (see note above regarding employer flex credits)
- Contributions to a Health Savings Account (“HSA”) or Archer MSA
- Health reimbursement arrangement (“HRA”)
- Hospital or fixed indemnity insurance but only if it qualifies as “HIPAA-excepted” insurance and is paid for on an after-tax basis by the employee

- Specified disease or illness insurance but only if it qualifies as “HIPAA-excepted” insurance and is paid for on an after-tax basis by the employee
- Any coverage (whether through insurance or otherwise) described in Code section 9832(c)(1) (other than on-site medical clinics). This includes the following coverages so long as they qualify as “HIPAA-excepted”:
  - Accident
  - Accidental Death and Dismemberment
  - Disability
  - Liability
  - Workers’ compensation and similar
  - Automobile medical payment
  - Credit-only
- Any self-insured coverage that is not subject to federal COBRA.

**Comment:** Because of a statutory reference to excepted dental or vision coverage being pursuant to a “separate policy, certificate, or contract of insurance” many had wondered whether the statutory exception would only apply to *insured* stand-alone dental or vision. Per yesterday’s guidance, the exception appears to apply to insured and/or self-insured stand-alone dental and vision coverage. Note: The guidance makes clear that the exception ONLY applies to stand-alone coverage, i.e., coverage that is not integrated into a group health plan providing for additional coverage.

The Notice appears to go beyond the statute in excepting certain medical savings accounts from the reporting requirements. As noted above, the Notice excepts from reporting all amounts contributed to an HSA or Archer MSA. Based on the express statutory language of PPACA and new Code section 6051(a)(14), many had expected the guidance to require reporting of all employer contributions to HSAs and Archer MSAs (whether made directly by the employer or via an employee’s salary reduction through a cafeteria plan). The Notice, however, excepts all contributions to these accounts, whether made by an employer or by an employee on an after-tax basis. Similarly, many expected HRAs to be subject to reporting. The guidance, however, provides a broad exception for HRAs.

As noted above, the Notice provides a reporting exception for self-insured coverage that is not subject to federal COBRA. Given that plans sponsored by church entities are very often self-insured and generally not subject to federal COBRA, many church employers may find themselves with little to no reporting obligation. Additionally, federal COBRA generally only applies to governmental plans if the entity sponsoring the plan receives funding by reason of the Public Health Service Act (“PHSA”). A great many states receive funding through the PHSA. Thus, federal COBRA likely applies to governmental plans (as would the new Form W-2 reporting requirement). There may be limited instances where this is not the case, however.

- ***Contributions to Multiemployer Plans Are Not Subject to Reporting.*** In addition to the types of coverage that are expressly excepted from the definition of “applicable employer-sponsored coverage,” the Notice provides that an employer is not required to report any contributions made on behalf of an employee to a multiemployer plan.
- ***Coverage Provided by Governments Primarily for Members of the Military and their Families is Not Subject to Reporting.*** The guidance also provides that the cost of coverage provided by a governmental entity (federal or otherwise) primarily for the benefit of military members and their families is not subject to reporting.
- ***Aggregate Cost Includes Both the Employee and Employer Share of Premium.*** As anticipated, the Notice provides that the manner in which coverage is paid for does not affect whether the coverage is subject to reporting. Specifically, it provides that the aggregate 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.”

***Comment:*** Based on the foregoing, to the extent coverage qualifies as “applicable employer-sponsored coverage,” it generally must be reported by an employer on an employee’s Form W-2 regardless of whether it is paid for (i) directly by the employer in the form of a premium subsidy, (ii) by an employee via salary reduction through a cafeteria plan, or (iii) by an employee on an after-tax basis, *i.e.*, by payroll deduction. Accordingly, coverage that may be imputed to employees as additional wages for purposes of federal tax law (such as with respect to certain adult children or nondependent domestic partners and same-sex spouses and their children), generally will be subject to reporting.

- ***When Calculating Aggregate Cost, the Employer May Use the “COBRA Applicable Premium Method” or Alternatives.*** Under the COBRA applicable premium method, the reportable cost for a period equals the COBRA applicable premium for that coverage for that period. The Notice goes on to state that “[i]f the employer applies this method, the employer must calculate the COBRA applicable premium in a method that satisfies the requirements under Code section 4980B(f)(4), *i.e.*, the general requirements regarding determining the cost of coverage for purposes of setting COBRA rates.

***Comment:*** Many had expected the Notice to be preceded by or include new rules for employers regarding how to determine the COBRA applicable premium, *i.e.*, COBRA rates. The Notice, however, does not include new rules for employers in determining a plan’s COBRA applicable premium, but instead requires employers to use reasonable, good faith efforts in applying the existing regulations.

One of the reasons many were expecting new rules on setting COBRA premiums is because there have been some long-standing questions regarding how to determine COBRA premiums in the context of self-insured arrangements; specifically, where the cost to the plan of providing the coverage might be materially less the fair market value of the coverage

being provided. Up until now, this has not been all that significant. Given the new reporting requirement (and beginning in 2018, the 40% high-cost excise tax), this issue takes on new importance since individuals with the same coverage could result in different reported aggregate cost depending on whether the coverage is insured or self-insured, or more generally, whether an employer who self insures determines its COBRA applicable premium based on its cost versus fair market value. Notably, unless a system is developed to take account of differences in risk characteristics across employer groups more generally, differences in rates with respect to similar coverage is to be expected.

- ***If the Applicable Employer-Sponsored Coverage Is Fully Insured, the Employer May Use the Alternative “Premium Charged Method.”*** If the coverage is fully insured, the Notice provides that the employer may determine aggregate cost based on the premium charged by the employer for the coverage.
- ***Where the Employer Subsidizes the COBRA Coverage or Charges for the Current Year the “COBRA applicable premium” from last year, Such Employer May Use the Alternative “Modified COBRA Premium Method.”*** The Notice states that if the employer subsidizes the cost of COBRA coverage, the employer may determine the reportable cost based upon a reasonable good faith estimate of the COBRA applicable premium for that period. This is the case only if, in turn, the reasonable good faith estimate is used to determine the subsidized COBRA premium. Likewise, if the actual premium charged by the employer to COBRA-qualified beneficiaries for each period in the current year is equal to the premiums for each period in a prior year, the employer may use the COBRA applicable premium for each period in the prior year as the basis for reportable costs in the current year.

***Comment:*** The above rule is fairly complex and not all that intuitive. Thankfully, the Notice includes a series of examples to assist employers in implementing the Modified COBRA Premium Method. See Q&A No. 27 of the Notice.

- ***The Notice Provides Some Helpful Guidance for Employers that Charge a Blended or Composite Rate.*** The Notice addresses situations where (i) there is a single coverage class under the plan (*i.e.*, 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 others), or (ii) there are different types of coverage under a single plan (for example, self-only and family coverage, or self-plus-one and family coverage), but employees are charged the same premium for each type of coverage. With respect to the foregoing, the Notice provides that the employer may use the same reportable cost for a period for (i) the single class of coverage under the plan, or (ii) 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. The Notice provides the following example:

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.

- **“Aggregate Cost” Can Include Period of Continuation Coverage.** The Notice provides that in determining aggregate cost, an employer may choose to include any continuation coverage provided to an individual following his or her termination of employment for the calendar year at issue. The Notice makes clear, however, that the employer must apply the same methodology with respect to all plan participants for the calendar year at issue. Thus, for example, with respect to an individual who was enrolled in coverage for the full 2012 calendar year at a rate of \$400, but where eight months of the coverage was continuation coverage pursuant to applicable law, the employer can determine the aggregate cost to be \$400 (based on the aggregate cost of the active employee coverage)
- **What If An Employee Commences, Changes, or Terminates Coverage During the Calendar Year?** Employers are required to take into account any changes in cost of coverage by reason of employee action. The Notice provides that the reportable cost with respect to a given employee must reflect the different reportable costs for the coverage elected by the employee for the different periods of election. The Notice provides the following example:

Employer determines that the monthly reportable cost under a group health plan for self-only coverage for the calendar year 2012 is \$500, and that the monthly reportable cost under the same group health plan for self-plus-spouse coverage for the calendar year 2012 is \$1,000. Employee is employed by Employer for the entire calendar year 2012. Employee had self-only coverage under the group health plan from January 1, 2012 through June 30, 2012, and then had self-plus-spouse coverage from July 1, 2012 through December 31, 2012. For purposes of reporting for the 2012 calendar year, Employer must treat the 2012 reportable cost under the plan for Employee as \$9,000  $((\$500 \times 6) + (\$1,000 \times 6))$ .

The Notice provides that where a change occurs during a period (for example, during the middle of a month where costs are determined on a monthly basis), an “employer may use any reasonable method to determine the reportable cost for such period, such as using the reportable cost at the beginning of the period or at the end of the period, or averaging or prorating the reportable costs, provided that the same method is used for all employees with coverage under that plan.” As an example of this rule, the Notice provides:

Employer determines that the monthly reportable cost under a group health plan for self-only coverage for the calendar year 2012 is \$500. Employee commences employment and self-only coverage under the group health plan on March 14, 2012, and continues employment and self-only coverage through the remainder of the calendar year. For purposes of reporting for the 2012 calendar year, Employer treats the cost of coverage under the plan for Employee for March 2012 as \$250  $(\$500 \times 1/2)$ . Because Employer's method of calculating the reportable cost of under the plan for March 2012 by prorating the reportable cost for March 2012 to reflect Employee's date of commencement of coverage is reasonable, Employer must treat the 2012 reportable cost under the plan for Employee as \$4,750  $((\$500 \times 1/2) + (\$500 \times 9))$ .

- **What if the Cost of Coverage Changes During the Calendar Year?** Employers are required to take into account changes in the cost of coverage that occur during the course of a plan year. As discussed in the section above, where a change occurs during a period (for example, during the middle of a month where costs are determined on a monthly basis), the Notice provides that an employer may use any reasonable method to determine the reportable cost for such period. The Notice provides the following example regarding cost of coverage changes:

Employer determines that the monthly reportable cost under a group health plan for self-only coverage for the period October 1, 2011 through September 31, 2012 is \$500, and that the monthly reportable cost under a group health plan for self-only coverage for the period October 1, 2012 through September 31, 2013 is \$520. Employee is employed by employer for the entire calendar year 2012 and had self-only coverage under the group health plan for the entire year. For purposes of reporting for the 2012 calendar year, Employer must treat the 2012 reportable cost under the plan for Employee as \$6,060 ( $(\$500 \times 9) + (\$520 \times 3)$ ).

**Comment:** Q&A 31 of the Notice provides that if an employer uses a 12 month determination period that is not the calendar year for purposes of determining COBRA rates, it will need to measure reportable cost across the calendar year for purposes of the new reporting requirement. For employers in this situation, they should carefully review the above examples as well Q&As 29 and 30 in the Notice.

- **Request for Comments.** The Treasury Department and the IRS have requested comments on or before June 27, 2010 regarding all aspects of this interim guidance, including areas that should be addressed in proposed and final regulations or other future guidance. Specific comments are also requested regarding the following:
  - How future guidance could further reduce the burden of compliance with the reporting requirements while still providing useful and comparable consumer information to employees on the cost of their health care coverage.
  - Any challenges employers may face in implementing the reporting requirements for the 2012 Forms W-2, and how further guidance could address those challenges, including through the provision of additional transition relief.
  - Issues that may arise in applying the reporting requirements to (i) employers contributing to multiemployer plans, (ii) employers that filed fewer than 250 Forms W-2 for the previous calendar year, (iii) employers that sponsor a self-insured plan that is not subject to any federal COBRA (such as government and church employers).

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