July 18, 2011

Submitted electronically via e-mail to Notice.Comments@irscounsel.treas.gov.

Internal Revenue Service
CC:PA:LPD:RU (Notice 2011-28)
Room 5203
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Ben Franklin Station
Washington, DC 20224
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Re: Notice 2011-28: Interim Guidance on Informational Reporting to Employees of the Cost of Their Group Health Insurance Coverage

Sir or Madam:

We write to provide comments on behalf of the American Benefits Council ("Council") in response to Internal Revenue Service ("IRS") Notice 2011-28, Interim Guidance on Informational Reporting to Employees of the Cost of Their Group Health Insurance Coverage ("Notice"), issued on March 29, 2011. The Council represents primarily large employers and other organizations that collectively either sponsor or administer health and retirement benefits covering over 100 million Americans.

We appreciate the helpful guidance the Notice provides with respect to the new Form W-2 informational reporting requirements relating to the cost of group health insurance coverage under section 6051(a)(14) of the Internal Revenue Code of 1986, as amended ("Code"). We believe the comments discussed below will assist the IRS in formulating future guidance regarding the new obligations for employers.

EFFECTIVE DATE AND FUTURE GUIDANCE

We commend the IRS for making the new Form W-2 informational reporting requirements voluntary for 2011 Forms W-2 (*i.e.*, to only require the new informational reporting commencing with the 2012 Forms W-2). The decision to delay mandatory reporting will greatly assist employers in complying with the new reporting requirements by providing much-needed time to fully operationalize the new reporting requirements (including modification of payroll systems and tax reporting procedures and systems).

Our members also appreciate the important and helpful implementation guidance contained in the Notice. Although the Notice goes a very long way toward helping employers to understand their reporting obligations under new Code section 6051(a)(14), there remain a range of questions and concerns that will require additional clarification. These include, for example, whether and how to determine aggregate cost with respect to various types of coverage, such as wellness programs, on-site medical clinics, employer-provided diagnostic and preventive care services, and employee assistance programs ("EAPs").

We respectfully request that any additional guidance be issued in proposed form and allow for meaningful comment by all interested parties, and that any final rulemaking be subject to a prospective effective date that allows interested parties sufficient time to implement any changes.

TYPES OF COVERAGE SUBJECT TO REPORTING

Notice 2011-28 provides helpful guidance as to the types of health coverage that are subject to (or otherwise excepted from) the new reporting requirements. There are many types of coverage, however, that do not appear to clearly fit within the categories of benefits that are expressly excepted from the reporting requirements. As discussed below, these types of coverage also present significant challenges with respect to determining "aggregate cost" for purposes of the new Form W-2 reporting requirements. As a result, the Council requests the following additional guidance:

Coverages that Include Both Medical and Non-Medical Components. Many types of coverage offer a combination of two or more benefits, some of which may be specifically excepted from the Form W-2 reporting requirement and others of which may not be excepted. Very often the medical component is not the primary benefit afforded under the coverage. For example, this is the case with certain long-term disability policies that may be offered in conjunction with a wellness feature. The intention behind this combination product is that the ancillary wellness feature can help the policyholder stay healthy and minimize the likelihood of a resulting disability and subsequent payout under the primary disability coverage. As discussed in greater detail below, this is

often the case with respect to employee assistance programs ("EAPs") and wellness programs, among others.

Coverages providing for both medical and non-medical benefits raise a host of issues with respect to new Code section 6051(a)(14), including whether such coverages are subject to the new reporting requirement in the first instance. For a host of reasons, including the following, the Council requests additional clarifying guidance that coverages that provide both medical and non-medical benefits be excepted from the reporting requirement to the extent that the medical benefits are not primary to the non-medical benefits afforded under the coverage. First, depending on how the coverage is priced and/or underwritten, it may be very difficult if not impossible for an employer to determine the aggregate cost of the medical component of the product. Second, requiring employers to report the aggregate cost of such coverages is likely to inaccurately reflect the amount of health care an employee is receiving, because significant amounts of non-medical benefits would be included in determining "aggregate cost." Third, given that the new rules apply not only to larger employers, but also to smaller employers, it is important that the new reporting rules be cost efficient and easy to follow. For these reasons, we request additional clarifying guidance that coverages providing both medical and non-medical benefits be excepted from the reporting requirement to the extent that the medical benefits are not primary to the non-medical benefits afforded per the coverage.

To the extent that the IRS does not wholly except from the new reporting requirements coverages providing both medical and non-medical benefits as requested, it is imperative that employers have flexibility with respect to such coverages in determining the reportable aggregate cost. Specifically, the Council requests guidance providing employers with the option of reporting either the cost of the coverage in whole (*i.e.*, the medical and non-medical benefits) or the cost of the coverage attributable to medical benefits only, so long as done in a reasonable and consistent manner (such option, a "Valuation Option").

On-Site Health Centers. Q&A-12 of the Notice states that the reported cost of coverage on a Form W-2 must include the cost of any coverage for on-site medical clinics. Currently, the only guidance for calculating the cost of such coverage is found in Code section 4980B(f)(4) and the regulations thereunder regarding the COBRA applicable premium. Treasury Regulation section 54.4980B-1, Q&A-2, establishes that the COBRA applicable premium calculation meets the requirements of Code section 4980B(f)(4) if the employer makes a calculation in good faith compliance with a reasonable interpretation of the statutory requirements under Code section 4980B(f)(4). For self-insured coverage, the statute merely indicates that the applicable premium must be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries, "which is determined on an actuarial basis," and which "takes into account such factors as the Secretary may prescribe in regulations." Since such factors have not yet been prescribed by the Secretary, the following are just a few

potential questions that employers may have regarding the calculation of the cost of on-site medical clinics:

- Are all costs of the medical clinic required to be included, *e.g.*, costs that, on their own, would not be considered related to the provision of medical care (such as providing first aid to current employees, as described in Treasury regulation section 54.4980B-2, Q&A-1(d))?

- If an employer has multiple locations, only some of which have on-site medical clinics, should the per-employee costs be calculated based on all employees who are eligible to use the clinics, even if they are unlikely to use them (due to not having such a clinic in their work location)?

- If an employee works at a location that does not have an on-site medical clinic but works for an employer that has on-site medical clinics at other locations (and which are available to that employee if the employee visits those locations), should that employee's W-2 contain the cost of coverage for the on-site medical clinics?

Given the uncertainty that exists on calculating the cost of coverage for on-site clinics, we urge the IRS to provide guidance excepting on-site clinics from the reporting requirements. If the IRS does not believe it is appropriate to grant a complete exception with respect to on-site clinics, we urge the IRS to permit employers to utilize the Valuation Option set forth above, and also to clarify that on-site health centers are excepted from the reporting requirement to the extent they provide only occupational health services for work-related incidents and provide an essential service and benefit to employees in the form of improved workplace safety.

Employee Assistance Plans ("EAPs"). EAPs have become a common offering in the American workplace. EAPs play an important role in helping to ensure that employees remain healthy and safe in the worksite and in their daily lives. EAPs typically include a host of benefits and services that would not by themselves constitute "medical care" within the meaning of Code section 213(d). Nonetheless, some types of EAPs may include at least some benefits that arguably rise to the level of Code section 213(d) "medical care." Generally, these benefits, however, are secondary to the primary non-medical benefits offered under the EAP. Because of the limited nature of the medical care provided by EAPs and because of the inherent difficulties for employers in determining any reportable component of the EAP coverage for purposes of new Code section 6051(a)(14), we respectfully request that EAPs be excepted from the reporting requirement in their entireties.

To the extent the IRS declines to except on-site clinics from mandatory reporting, we urge the IRS to permit employers to use the Valuation Option for purposes of reporting the "aggregate cost" of their EAPs. In this regard, we request that employers be

permitted to use the per capita cost of EAP coverage as the "aggregate cost" for reporting purposes. Such a rule would help minimize the costs and burdens on employers of complying with the new reporting rule to the extent the IRS finds it necessary to subject EAPs to mandatory reporting.

Wellness Programs and Preventive Care/Diagnostic Services. Wellness programs and other non-traditional types of coverage typically offer services for the treatment, prevention or diagnosis of a disease, *e.g.*, flu shots and cholesterol testing. A strict reading of the Notice would appear to require that the "aggregate cost" of such preventive care be reported on the Form W-2.

Mandating that employers report the cost of a stand-alone preventive care item or stand-alone wellness program, *i.e.*, where the preventive care item or wellness program is not part of a major medical plan, would impose substantial administrative cost and burden on employers. Similar to on-site medical clinics, discussed above, reporting the cost of wellness programs that provide health coverage involves challenges and unanswered questions. For example, with respect to large employers, these programs and/or services may vary across individual worksites and lines of business. Should the costs to run these programs be reported only on the Forms W-2 of individuals who use such programs or who are employed at work locations where they are offered? Moreover, in many cases, such services and programs are paid for directly by an employer out of general assets and may not be paid as a separate charge or premium to a third party issuer or provider, thereby making valuation of "aggregate cost" difficult to determine.

Given the administrative complexity and burden of determining the aggregate cost of wellness programs and other preventive services, the Council requests additional guidance clarifying that wellness programs and other employer-provided preventive and diagnostic care services and items are excepted from Code section 6051(a)(14) reporting. If such coverage is subject to reporting, we respectfully request that the IRS provide a transition period delaying inclusion of these costs on Forms W-2 until the Secretary provides additional guidance on how to calculate the costs of these programs for eligible individuals.

Dental and Vision Coverage. Additional guidance is requested regarding the scope of the exception for stand-alone dental and vision coverage, as set forth in Q&A-20. Per the terms of the Notice, "[a]n employer is not required to include the cost of coverage under a dental
plan or a vision plan if such plan is <u>not integrated into</u> a group health plan providing additional health care coverage subject to the reporting requirements of [Code section] 6051(a)(14)" (emphasis added).

Questions have arisen as to what is meant by the phrase "not integrated into," specifically regarding whether the language is intended to incorporate the regulatory

definition of "non-integrated" HIPAA-excepted dental and vision coverage as set forth in Treasury Regulation section 54.9831-1(c)(3)(ii) (which generally requires that the coverage be subject to some employee premium contribution and a separate coverage election) or whether the language is intended to convey a more plain language meaning that dental or vision coverage merely not be part and parcel to major medical coverage. The Council requests guidance clarifying that the language is intended to have the latter meaning, *i.e.*, a plain-language meaning that dental or vision coverage is excepted not only where it satisfies the requirements to be a HIPAA-excepted benefit, but also in other circumstances where it is equally clear that such coverage is not integrated into major medical coverage, *i.e.*, where the facts and circumstances indicate that the coverage is not simply a component of the larger major medical product.

Non-U.S. Health Plans. We also urge the IRS to issue clarifying guidance that the new reporting requirements do not apply to U.S. citizens working abroad and participating in non-U.S.-based health plans, given the difficulty of valuing such coverage.

REPORTING THE AGGREGATE COST OF COVERAGE AMONG RELATED EMPLOYERS WITH NO COMMON PAYMASTER

Q&A-7 of the Notice sets out a rule with respect to reporting for individuals who are employees of multiple employers within a calendar year. Specifically, the Notice provides that if the employers are related employers within the meaning of Code section 3121(s) and one such employer is a common paymaster for wages paid to the employee, then the common paymaster is the employer responsible for reporting the aggregate cost of health coverage on the Form W-2 (and other related employers do not report the cost of health coverage).

While this rule is indeed helpful, we do not believe it goes far enough in providing needed guidance. Specifically, we urge the IRS to issue guidance permitting flexibility where an employee works for multiple related employers throughout the tax year, but there is no common paymaster. In these situations, an employee is likely to receive multiple Forms W-2. Requiring the calendar-year cost to be split among multiple employers complicates matters for all parties involved, including employees, who would then have to add up the aggregate cost reported by each employer for purposes of tax reporting – and in many cases likely would not do so.

We request additional guidance permitting employers flexibility to decide how to report the aggregate cost of coverage, so long as the method is reasonable and consistently applied. For this purpose, a method should be deemed reasonable and consistently applied if the employers determine on their own whether to report the aggregate cost of coverage during a taxable year on only the Form W-2 issued by the most recent employer and not by any prior employers within the calendar year. We believe such a method would serve the goal of the new Form W-2 reporting

requirement, *i.e.*, to inform employees of the aggregate cost of coverage during a calendar year. Such additional guidance should also take into account those employees who have transitioned employment as a result of a merger or acquisition or who have transitioned employment within the same controlled group of entities.

CATEGORY OF INDIVIDUALS TO WHOM A FORM W-2 MUST BE PROVIDED

COBRA Qualified Beneficiaries. The Notice clarifies that, if an employer is not otherwise required to provide an individual with a Form W-2, the employer is not required to issue a Form W-2 solely for purposes of complying with new Code section 6051(a)(14). Notwithstanding this important clarification, some have suggested that the reporting requirement applies with respect to recipients of COBRA continuation coverage, even where a COBRA recipient is not otherwise due a Form W-2 by his or her former employer for the calendar year at issue (such as where the recipient has no taxable wages for the calendar year at issue). The Council requests confirmation that a Form W-2 need not be provided to a COBRA beneficiary solely for purposes of complying with new Code section 6051(a)(14).

Retirees. We urge the IRS to issue clarification and/or additional guidance providing that a Form W-2 need not be provided to retirees who may receive employer-sponsored group health plan coverage during a given calendar year solely for purposes of complying with new Code section 6051(a)(14). We also request clarification that employers need not report the value of retiree health coverage on a Form W-2, even where a retiree receives a Form W-2 for reasons other than new Code section 6051(a)(14), *e.g.*, because the retiree receives some taxable compensation that is reportable on a Form W-2 (such as deferred compensation or severance pay). We believe this rule is appropriate given the limited class of retirees who otherwise receive Forms W-2 by reason of having post-employment taxable wages. Also, given that the IRS has already decided that most retirees do not need to receive information regarding the cost of their health coverage, there is no policy justification for requiring that only certain retirees receive such information, and significant time and expense would be required to comply with the new reporting requirement for this limited class.

A requirement that health care costs be reported on Forms W-2 for retirees receiving post-employment taxable wages could promote confusion among retirees and employers alike. For example, some retirees may receive Forms W-2 by virtue of receiving distributions from a nonqualified deferred compensation plan, and other retirees may receive a Form 1099 by virtue of receiving distributions from qualified plans. A requirement to report the cost of coverage for some retirees but not all retirees (or only for certain years for such retirees) could present confusion among retirees and result in burden on the employer.

METHODS OF CALCULATING THE AGGREGATE COST OF COVERAGE

The Notice provides important guidance with regard to permissible methods of calculating the cost of coverage for purposes of satisfying the new Form W-2 reporting requirements. The Council urges the IRS to issue additional guidance as discussed below.

Revisions of Calculated Costs. We believe that employers may, despite best efforts, encounter situations where calculations of the cost of health coverage turn out to be inaccurate and discover such inaccuracies after it is too late to correct the errors on timely furnished Forms W-2.

We urge the IRS to issue guidance clarifying when an amended Form W-2 is required to be filed where an employer, acting in good faith and using reasonable calculation methods, has misreported the aggregate cost of coverage. Specifically, we recommend that in such cases an amended Form W-2 need only be filed with the correct aggregate cost of coverage where the employer is otherwise required to file an amended Form W-2 as a result of an error on the Form W-2 affecting the tax liability of an individual (i.e., incorrect reporting of wages or withholding).

Forms W-2 generally are intended to provide tax information to employees. The new reporting requirements, on the other hand, are intended to provide the cost of health coverage only for *informational* purposes and do not impact taxation. It makes sense, therefore, that an employer would only need to take steps to issue an amended Form W-2 on the aggregate cost of health coverage where factors other than this miscalculation may require that the Form W-2 be amended (i.e., in instances where an amended W-2 is required to correct errors where an individual's tax liability is potentially affected). This approach makes sense for many reasons, including the costs associated with preparing and filing amended Forms W-2 and that the aggregate cost reported by employers does not affect an employee's state or federal income and payroll tax liability.

SMALL EMPLOYER TRANSITION RULE

We commend the IRS for providing an exception/transition rule for small employers such that, in the case of 2012 Forms W-2 and until the issuance of further guidance, an employer is not subject to the new reporting requirements for any calendar year if it was required to file fewer than 250 Forms W-2 for the preceding calendar year. We encourage the IRS to expand the relief to employers that were required to file fewer than 500 Forms W-2 for the preceding calendar year. The policy rationale for providing this important transition relief to employers that file less than 250 Forms W-2 in a given calendar year apply equally to employers that file fewer than 500 Forms W-2 – notably, the costs and administrative difficulties in complying with this rule in the near term.

Accordingly, the Council requests that the existing small employer transition rule be expanded to apply to employers that issue fewer than 500 Forms W-2.

Related to the above, we urge the IRS to clarify that the small employer transition rule may be applied to larger employers to the extent they operate separate facilities or lines of business that, but for being part of a larger controlled group, would otherwise qualify for the transition rule, *i.e.*, the facility or line of business files fewer than 500 Forms W-2 for the preceding calendar year. These small geographic locations and/or separate lines of business that have their own payroll systems encounter many of the same issues as small employers and would greatly benefit from the ability to take advantage of the small employer exception in much the same way that small employers themselves do. For these reasons, we request that the transition rule be made available to large employers in these limited instances.

In addition, the Council understands that the small employer exception is currently a transition rule. Nonetheless, we anticipate the need for a permanent exception for small employers given the costs and difficulties in complying with this reporting requirement. To the extent the IRS decides to make the transition rule permanent, the IRS would be free to reassess the appropriate threshold for purposes of any permanent exception – be it 500 or another number – at the appropriate time.

MID-YEAR TERMINATIONS OF EMPLOYMENT

We appreciate the provision in the Notice that provides that an employer is not required to adhere to the new Form W-2 reporting requirements with respect to an employee who, pursuant to Treasury Regulation section 31.6051-1(d)(1)(i), requests to receive a Form W-2 before the end of the calendar year during which the employee terminates employment.

The Council requests additional guidance clarifying that an employer need not comply with the mandatory reporting requirements with respect to Forms W-2 that the employer issues to terminated employees prior to the end of the calendar year at issue, regardless of whether a Form W-2 is requested by a terminated employee. The rationale for not requiring an employer to adhere to the new Form W-2 reporting requirements for a terminated employee who has requested a Form W-2 (as set forth in the Notice) would appear to apply equally to a situation in which an employer affirmatively provides Forms W-2 to terminated employees during the course of a calendar year. Accordingly, the Council requests that future guidance except from the reporting requirement Forms W-2 issued during the course of a calendar year to terminated employees regardless of whether such Forms are requested by terminated employees.

SPECIFIC AREAS WHERE THE IRS REQUESTS COMMENT

How Future Guidance Could Further Reduce the Compliance Burden but Still Provide Useful Information. Q&A-29 and Q&A-30 of the Notice generally provide that an employer must take into account changes in the cost of coverage throughout the year. For example, where an employee changes coverage during the year, the reportable cost under the plan for the employee for the year must take into account the different reportable costs for the coverage elected by the employee for the periods for which such coverage is elected. We believe the complexity of such mid-year calculations for Form W-2 reporting purposes will create substantial administrative cost and burden. We urge the IRS to adopt a rule of administrative convenience for this purpose that would permit an employer to determine an employee's cost of coverage based on a snapshot in time, *e.g.*, a first- or last-day-of-the-year rule, whereby the employer can report the cost of coverage based on an employee's coverage on the first or last day of the year, respectively.

If the IRS does require mid-year changes be taken into account in its final guidance, we request transition relief such that employers may calculate an employee's aggregate cost of coverage for 2012 based on his or her coverage as of December 31, 2012 without regard to any earlier mid-year changes in coverage. Such transition relief would be warranted as it will take time for employers to establish systems that will facilitate the new Form W-2 reporting requirements in 2012 in a manner that would enable them to efficiently calculate mid-year cost of coverage changes.

Issues that May Arise in Applying the Reporting Requirements to Employers Contributing to Multiemployer Plans. It may be difficult for employers that participate in a multiemployer plan to have knowledge about the benefits ultimately provided to a participant (either a current or former employee). For example, an employer is unlikely to know the applicable COBRA premium in order to determine cost with respect to any particular employee or even whether any particular employee is an active participant in the plan. As a result, employers contributing to multiemployer plans would face substantial challenges in reporting the applicable cost of coverage on an employee's Form W-2. We recommend that the exception in Q&A-17 that provides that an employer that contributes to a multiemployer plan is not required to include the cost of coverage provided to an employee under that multiemployer plan in determining the aggregate reportable cost on such employee's Form W-2 be made permanent.

Issues that May Arise in Applying the Reporting Requirements to Certain Employers. As noted above, we urge the IRS to clarify that large employers with multiple geographic locations or separate lines of business that operate on separate payroll systems are allowed to utilize the exception for small employers. These small geographic locations and/or separate lines of business that have their own payroll systems encounter many of the same issues as small employers and would greatly

benefit from the ability to take advantage of the small employer exception in much the same way that small employers themselves do.

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Thank you for the opportunity to provide comments regarding implementing guidance for the new Form W-2 informational reporting requirements relating to the cost of group health insurance coverage under Code section 6051(a)(14). If you have any questions or would like to discuss these comments further, please contact us at (202) 289- 6700.

Sincerely,

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