

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

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On January 3, 2012, the Internal Revenue Service (“IRS”) issued Notice 2012-9 (“Notice”), which amends and restates the interim guidance initially provided to employers in Notice 2011-28 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 the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-149 (“Affordable Care Act”).

The IRS states in Notice 2012-9 that it will continue to consider comments submitted regarding Notice 2011-28 as it works toward issuing additional guidance (including regulations). Notice 2012-9 modifies some of the Q&As provided in Notice 2011-28 and also provides additional guidance through new Q&As.

### **Background Regarding the Affordable Care Act and the New Form W-2 Reporting Requirement**

Section 6051(a) of the Code generally requires that an employer provide a written statement to each employee on or before January 31<sup>st</sup> 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.

The Affordable Care Act 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” provided to an employee must be included on the employee’s Form W-2. The “aggregate cost” is determined under rules similar to those set forth in Code section 4980B(f)(4), *i.e.*, the rules regarding the calculation of COBRA premiums. As discussed below, the term “applicable employer-sponsored plan” is defined very broadly to generally include coverage under any subject group health plan, regardless of whether such coverage is excludable from the employee’s gross income under Code section 106 or 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 the 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. Employers that voluntarily choose to report the cost of coverage on 2011 Forms W-2 may rely on the interim guidance provided in Notice 2012-9. Significantly, as discussed below, the Notice provides 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 reiterates that the new reporting requirement to employees “is for their information only . . . and does not cause excludable employer-provided health care 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 Forms W-2. Employers may consider providing specific notice and/or explanation to employees of the new reporting requirement either in advance of, or in conjunction with, the issuance of 2012 Forms W-2.

- ***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 Reporting Rules Apply with Respect to Forms W-2 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 receiving coverage under the same plan who terminate employment during the plan year and continue or otherwise receive coverage after the termination of employment. Additionally, and perhaps 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 to receive a Form W-2 before the end of the calendar year during which the employee terminated employment” (emphasis added).

***Comment:*** An employer who finds itself the recipient of such a request can rest assured that it is not required to comply with the new reporting requirement in such an instance. Some employers as a matter of policy provide a Form W-2 to an employee at the time of termination, regardless of whether the employee requests a Form W-2. It is unclear whether such employers are required to report the aggregate cost with respect to such a terminated employee.

- ***The Reporting Requirement Applies Broadly to Most Employers.*** The Notice reiterates the statement in Notice 2011-28 that generally 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 Code section 4980B (but see discussion below regarding a special exception for self-funded plans that are not subject to federal COBRA).

**Comment:** To the extent future guidance applies the reporting requirement to additional employers or coverage types, the Notice states that such application will be prospective and will not become effective for any calendar year beginning within six months following publication of such guidance. Hence, it appears that guidance issued after July 1<sup>st</sup> of any year will not apply in either the year of issuance or the following year.

- ***Qualifying Small Employers Enjoy Limited Exceptions from the Reporting Requirement.*** 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 (“Small-Employer Exception”). The Notice states that whether an employer files fewer than 250 Forms W-2 for a calendar year is determined without regard to the employer’s use of an agent to fulfill its Form W-2 filing responsibilities.

**Comment:** The Notice states that the Small-Employer Exception is based on the exception from electronic return filing for small employers set forth in Code section 6011(e). The Notice does not specify whether application of the Small-Employer Exception is determined based on the employer’s controlled group. It is our understanding that the IRS intends for the Small-Employer Exception to apply on an entity-level basis rather than on a controlled-group basis.

- ***Indian Tribal Governments and Certain Related Corporations Also Enjoy Limited Exceptions from the Reporting Requirement.*** The Notice excludes employers that are federally-recognized Indian tribal governments. In addition, until further guidance is issued, employers that are tribally chartered corporations wholly-owned by federally-recognized Indian tribal governments also 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 (with certain limited exceptions described below).
- ***“Applicable Employer-Sponsored Coverage” Includes Certain Dependent Coverage and Domestic Partner Coverage.*** The term “applicable employer-sponsored coverage” includes not only coverage that is employer-provided coverage that is excludable from an employee’s income by reason of Code section 106, but also coverage that, if it had been provided to an employee, would have been employer-provided coverage excludable from an employee’s income by reason of Code section 106. Thus, it seems to be the case that employer-provided coverage of non-spouse, non-dependent beneficiaries constitutes “applicable employer-sponsored coverage” and thus would be subject to the new Form W-2 reporting requirement.

**Comment:** The Notice provides that “applicable employer-sponsored coverage” can encompass coverage that applies to individuals other than employees (and their Code section 152 dependents). Although it does not specifically address the issue of domestic partners or same-sex spouses, it appears that coverage of such domestic partners or same-sex spouses would be “applicable employer-sponsored coverage” and thus will need to be valued and reported on the related employee’s Form W-2. This is because, if the domestic partner or same-sex spouse were an employee, his or her coverage would be excludable by reason of Code section 106. As discussed above, coverage can be “applicable employer-sponsored coverage” regardless of whether it is paid for on a pre-tax or after-tax basis. Thus, the fact that an employer may impute as wages to an employee the cost of domestic partner or same-sex spouse coverage would not change the analysis with respect to application of the new reporting requirement.

- 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 section 1.125-5(b), are subject to reporting. Amounts contributed by an employee via salary reduction are not subject to reporting. Notably, if the amount of an employee’s salary reduction (for all qualified benefits) equals or exceeds the amount of the Health FSA for the plan year, the employer does not include the amount of the Health FSA for that employee in the aggregate cost. If the amount of an employee’s Health FSA for the plan year exceeds his or her salary reduction, then the amount of that employee’s Health FSA minus his or her salary reduction election for the Health FSA must be included in the aggregate cost.

- The Notice provides that the following are NOT subject to reporting:
- Stand-alone dental or vision coverage (if the coverage satisfies the requirements for being an excepted benefit under HIPAA)

**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 guidance issued to date, 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.

- 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”)

**Comment:** The Notice appears to go beyond the statute in excepting certain medical savings accounts from the reporting requirement. As noted above, the Notice excepts from reporting all amounts contributed to an HSA or Archer MSA. Based on the express language of 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.

- 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

**Comment:** Notice 2012-9 clarifies that an employer is not required to include the cost of coverage provided under hospital indemnity or other fixed indemnity insurance, or the cost of coverage for specified disease or illness, if those benefits are offered as independent, non-coordinated benefits and the employee pays the full amount of the premium with after-tax dollars. The cost must be included if the employer makes a contribution to the cost of coverage that is excludable under Code section 106 or an employee purchases the coverage on a pre-tax basis through a Code section 125 plan.

- Any coverage (whether through insurance or otherwise) described in Code section 9832(c)(1) (other than on-site medical clinics described in subsection (G) thereof); 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:** 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 may be self-insured and generally are not subject to federal COBRA, some 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.

- Coverage provided to an employee through a multiemployer plan
- Excess reimbursements to highly compensated individuals under Code section 105(h)
- Payments or reimbursements of health insurance premiums for a 2% shareholder-employee of an S-corporation who is required to include the premium payments in gross income
- Coverage provided by governments primarily for members of the military and their families
- Amounts reported on a Form W-2 furnished by a third-party sick pay provider

**Comment:** The guidance clarifies that an employer may report the cost of coverage that is not required to be reported under guidance issued to date, including the cost of coverage under an HRA, a multiemployer plan, an employee assistance program (“EAP”), a wellness program, or an on-site medical clinic, provided the calculation of such costs satisfies the requirements of guidance issued to date and constitutes applicable employer-sponsored coverage.

- **Notice 2012-9 Clarifies Treatment of “Split” Programs.** Notice 2012-9 provides new guidance regarding how to calculate the reportable cost under a program providing both benefits that constitute applicable employer-sponsored coverage and benefits that do not constitute applicable employer-sponsored coverage. As an example of such coverage, the Notice references long-term disability programs that also offer some medical benefits.

The Notice provides that an employer may use any reasonable allocation method to determine the cost of the portion of the program providing applicable employer-sponsored coverage. Where the medical benefits provided are “incidental” to the non-medical benefits provided, neither portion is required to be reported on the Form W-2. Where the non-medical benefits provided are “incidental” to the medical benefits provided, the non-medical portion may, but is not required to, be reported on the Form W-2 (notwithstanding the otherwise-applicable prohibition on reporting coverage that is not applicable employer-sponsored coverage).

**Comment:** The new guidance seems to require that coverage be bifurcated into the portion that constitutes applicable employer-sponsored coverage and the portion that does not. Unless the portion that constitutes applicable employer-sponsored coverage is “incidental” to the portion that does not, an employer would be required to report the cost of the portion that constitutes applicable employer-sponsored coverage as part of the aggregate reportable cost.

This apparent bifurcation requirement is likely to raise many issues for issuers and plan sponsors, including with regard to what constitutes an “incidental” level of medical benefits, and how to properly value the qualifying medical versus non-medical benefits offered under the coverage. In addition, the IRS’s perceived view that coverage should be bifurcated could have implications beyond those directly related to the Form W-2 reporting requirement, specifically with respect to COBRA continuation coverage requirements. This is because the apparent bifurcation requirement would appear to require that coverage be divided into that portion that constitutes “applicable employer-sponsored coverage” and that portion that does not. Notably, the preamble of Notice 2012-9 states that the interim guidance in the Notice applies solely for Code section 6051(a)(14) and no inference should be drawn concerning any other provision of the Code. However, with the proposed bifurcation of coverage, the IRS may be setting the stage (whether intentionally or not) for the concept to work its way into other areas.

- **The Notice Provides Guidance Regarding the Treatment of EAPs, Wellness Programs, and On-Site Medical Clinics.** The Notice provides new guidance regarding the treatment of employee assistance programs (“EAPs”), wellness programs, and on-site medical clinics. The Notice states that coverage under such a program is only included in the aggregate reportable cost to the extent that it constitutes “applicable employer-sponsored coverage.” Moreover, the Notice provides that if an employer does not charge a separate premium for continuation coverage (such as COBRA) provided under an EAP, wellness program or on-site medical clinic, then the coverage is not subject to the Form W-2 reporting requirement for either active or terminated employees. If, however, an employer does charge a separate premium for such continuation coverage, then the coverage is subject to the Form W-2

reporting requirement for both active and terminated employees.

**Comment:** The Notice does not address the treatment of EAPs, wellness programs, and on-site medical clinics where an employer does not provide such coverage as part of continuation coverage. This is interesting given that, in practice, certain employers may not offer continuation coverage for EAPs, wellness programs, and/or on-site medical clinics (based on varying legal theories).

Additionally, although the Notice seems to suggest that EAPs, wellness programs, and on-site medical clinics – or at least a portion of such – may qualify as “applicable employer-sponsored coverage,” the Notice provides no guidance for issuers and plan sponsors in terms of making such determinations. As noted above, the Notice provides that an employer need not report the value of coverage if the portion of coverage that constitutes “applicable employer-sponsored coverage” is “incidental” to the non-medical portion of the coverage. This rule may be helpful for employers seeking to not value and report the cost of EAPs and wellness programs, to the extent the medical component of such programs is only “incidental.” This rule would seem to be unhelpful with respect to on-site medical clinics where most if not all of the benefits provided in connection therewith likely qualify as medical care.

- **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 manner 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 hoped the notices to be preceded by or to include new rules for employers regarding how to determine the COBRA applicable premium, *i.e.*, COBRA rates. Neither Notice 2011-28 nor Notice 2012-9, however, includes any 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 than 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 costs 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, differing rates with respect to similar coverage are 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 for an employee based on the premium charged by the employer for that employee's coverage.
- ***Where the Employer Subsidizes the COBRA Coverage or Charges for the Current Year Equal the “COBRA Applicable Premium” from Last Year, the 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 for a period based upon a reasonable good faith estimate of the COBRA applicable premium for that period, if the employer uses such reasonable good faith estimate as the basis for determining 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.
- ***The Notice Provides Some Helpful Guidance for Employers that Charge a 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) (“Single Class Coverage”), 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 (“Blended Rate Coverage”). The Notice provides that, with respect to Single Class Coverage, the employer may use the same reportable cost for a period for all of the

coverage provided under the plan. The Notice further provides that, with respect to Blended Rate Coverage, the employer may use the same reportable cost for a period for all of the coverage subject to the same rate. If the employer chooses to use one of these methods, the method must be 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.

**Comment:** Notice 2012-9 clarifies that if an employer is using a composite rate with respect to the premium charged to active participants, but not the premium charged to COBRA continuation coverage beneficiaries, then the employer may use either the composite rate or the applicable COBRA premium for determining the aggregate cost of coverage, provided that the same method is used consistently for all active employees and is used consistently for all qualifying beneficiaries receiving COBRA coverage.

- **“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 during a calendar year.

**Comment:** The Notice makes clear that for purposes of the new reporting requirement an employer can either include or otherwise disregard continuation coverage provided to an individual post-termination. Where an employer seeks to include such continuation coverage, however, it is not entirely clear whether the employer can use the active employee rate for purposes of valuing such continuation coverage or whether the employer must account for any increased premium charged to an employee during the continuation coverage period.

- **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:** Notice 2012-9 clarifies that the aggregate reportable cost for a calendar year on Form W-2 may be based on information available to the employer as of December 31<sup>st</sup> of the calendar year. In addition, Notice 2012-9 clarifies how an employer may treat a coverage period, such as the final payroll period of a calendar year, that continues into a subsequent calendar year for purposes of allocating the cost of coverage.

**Comment:** 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 as Q&A-29 and Q&A-30 in the Notice.

- ***Application of Form W-2 Reporting Requirement to Employee of Multiple Employers.*** In the case of an individual who is an employee of multiple employers within a calendar year, each employer providing employer-sponsored coverage must report the aggregate reportable cost of the coverage it provides. However, if the employers are related employers within the meaning of Code section 3121(s) and one employer is a common paymaster within the meaning of Code section 3121(s), then the common paymaster must include the aggregate reportable cost of coverage of all employers for whom it serves as the common paymaster. Where there is not a common paymaster, then the related employers may either report the entire aggregate reportable cost on one of the Forms W-2 provided to the employee, or they may allocate the aggregate reportable cost among the employers that concurrently employ the employee using any reasonable method of allocation.

***For more information, please call us at (202) 624-2500.***

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