

Authors: Elizabeth T. Dold and Anubhav Gogna

Health and Welfare Team:

Jon W. Breyfogle

jbreyfogle@groom.com
(202) 861-6641

Jenifer A. Cromwell

jcromwell@groom.com
(202) 861-6329

Elizabeth T. Dold

edold@groom.com
(202) 861-5406

Thomas F. Fitzgerald

tfitzgerald@groom.com
(202) 861-6617

Anubhav Gogna

agogna@groom.com
(202) 861-2602

Cheryl Risley Hughes

chughes@groom.com
(202) 861-0167

Christine L. Keller

ckeller@groom.com
(202) 861-9371

Tamara S. Killion

tkillion@groom.com
(202) 861-6328

Mark C. Nielsen

mnielsen@groom.com
(202) 861-5429

William F. Sweetnam, Jr.

bsweetnam@groom.com
(202) 861-5427

Christy A. Tinnes

ctinnes@groom.com
(202) 861-6603

Brigen L. Winters

bwinters@groom.com
(202) 861-6618

Transition Guidance Issued on Form W-2 Reporting For Health Care Costs

The IRS recently issued Notice 2011-28 [<http://www.irs.gov/pub/irs-drop/n-11-28.pdf>] that provides important transition guidance and relief on reporting the cost of employer provided health care coverage on Form W-2. However, beginning with the 2012 Form W-2 (which are furnished to participants in January 2013), most employers will be required to report the cost of health care coverage to employees.¹

The Notice (which is set forth in Q&A format) is summarized below. This guidance shall apply until further guidance is issued, and any additional guidance shall be prospective in nature (with at least 6 month lead time for system changes). This is an important first step in providing guidance in this area, and the IRS has left the door open for additional relief following comments on this Notice.

Employers should take steps to work with their health care and payroll providers to understand the scope of this challenge and the needed system changes/processes to be able to accurately capture this data beginning next year. Although the Notice provides some much needed guidance, it is unclear if the necessary system changes can be made within the short nine month implementation period. Notably, unlike Notice 2010-69, this Notice does not provide any reporting penalty relief for failure to comply, and with the potential reporting penalty of \$200 per return, up to \$3M per year, it is important to give close attention to this provision.

1. What Employers are Impacted?

Except as noted above, all employers (including governmental and tax-exempt entities) are required to report the cost of employer-sponsored health care beginning next year with the 2012 Form W-2.

- **Small Employers:** Until future guidance is issued, employers who file fewer than 250 Forms W-2 for the prior year have optional reporting for the current year. For example, employers who file fewer than 250 Form W-2s for 2011 have optional reporting for 2012 Form W-2.
- **Indian Tribes:** Federally recognized Indian tribal governments are excluded from the Form W-2 reporting requirement.

¹ Section 6051(a)(14) to Code was added by section 9002 of the Patient Protection and Affordable Care Act ("PPACA") and requires that employers report the cost of employer provided health care coverage on the Form W-2. Pursuant to Notice 2010-69, this requirement was made optional for all employers for 2011 Forms W-2 (which are required to be furnished to employees in January 2012). [<http://www.groom.com/resources-544.html>]

2. Where is the Amount Reported?

This amount is reported on Form W-2, box 12, using Code "DD." No amount is required to be reported on Form W-3 (Transmittal).

3. What Types of Coverage are Reported?

Generally, the total cost of coverage under all "applicable employer-sponsored coverage"² is reported on Form W-2, except contributions to an Archer MSA, Health Savings Account (HSA), and salary reduction contributions to a health flexible spending account (health FSA). This includes the entire cost of the coverage under a group health plan,³ regardless of (1) the funding provisions of the plan (insured or self-insured), (2) the portion paid by the employee (with either pre-tax or after-tax contributions), (3) any imputed income to the employee as a result of the coverage (e.g., domestic partner coverage) or as a result of a discriminatory plan, and (4) the scope of the coverage (e.g., employee, spouse, dependent).

Although the Notice does not provide a listing of the types of coverage that must be reported, it does provide important exclusions that are available until additional guidance is provided. Specifically, it excludes:

- the cost of coverage under a Health Reimbursement Arrangement (HRA),
- the cost of coverage under a dental or vision plan, if such plan is not integrated into a group health plan (if integrated, this amount must be included),
- the cost of coverage provided under a self-insured group health plan that is not subject to any federal continuation requirements (e.g., COBRA, ERISA, Public Health Service Act, Federal Employees Health Benefits Program), such as a church plan, and
- the cost of coverage provided by the federal government, State government or any agency of such government, under a plan that is maintained primarily for members of the military and their families.

For a health FSA offered through a cafeteria plan, the Notice also clarifies the amount included in income (if any).

4. How is the cost of coverage calculated?

The Notice provides welcomed flexibility in determining the amount to be reported to each employee. Any one of the following methods may be used to determine cost for each period during the calendar year, provided that the same method is used for every employee receiving coverage under the plan.

- COBRA applicable premium – report using the COBRA rate for that period, applying a good faith standard. (This is particularly helpful for self-funded plans, for which the rules for calculating the COBRA premium are unclear.)

2 The Code (and the Notice) also excludes coverage described in Code section 9832(c)(1) (which includes coverage only for accident or disability income insurance, coverage supplemental to liability insurance, liability insurance, workers' compensation, automobile medical insurance, credit-only insurance) or for long-term care, Code section 9832(c)(3), and separate dental or vision coverage.

3 The Notice defines a "group health plan" as a plan of, or contributed to by, an employer or employee organization to provide health care to employees, former employees, the employer or its associates, or their families. A good faith standard applies for this purpose.

- Premium charged – report using the actual premium charged by the insurer for the employee's coverage for that period (insured plans only).
- Modified COBRA premium – if the employer subsidizes the cost of COBRA then a reasonable good faith estimate of the COBRA applicable premium is reported, and if the actual premium charged is equal to a prior year's COBRA rate, the reportable cost is determined using the COBRA premium for each period in the prior year (without the 2% fee).

Employers that charge the same rate for all employees under the plan, regardless of the scope of the coverage (employee only, family) can report the same amount for all employees for the period, using one of the methods described above. Also, if the plan has different types of coverage (employee-only, employee plus one, family, etc.), and the employees in each of the coverage groups pay the same premium, then each coverage group can have the same reported amount for the period, using one of the methods described above.

Notably, if the cost for a period changes during the year, the reported amount must reflect the increase or decrease for the periods to which the change applies.

5. What happens if there is a change in coverage during the year?

If an employee changes coverage during the year, then the amount reported must take into account the change in coverage for the period. If the change in coverage occurs during a period (e.g., in the middle of the month), the employer may use any reasonable method to determine the reportable cost for such period (e.g., using the reportable cost at the beginning of the month, or at the end of the month), or the employer can average or prorate the reportable costs, so long as the same method is used for all employees who have coverage under the plan. The same rule applies if the employee commences or terminates coverage during a period. The Notice includes examples (Q&A-30) to help explain this tracking requirement.

6. What if the policy year is not a calendar year?

If an employer used a 12-month determination period that is not a calendar year for purposes of applying the COBRA applicable premium under the plan, the employer cannot use that 12-month determination period for purposes of calculating the reportable cost for the year. The reportable cost under a plan must be determined on a calendar year basis.

7. Are there any special rules for certain employees?

Yes. The Notice provides the following relief for certain employees:

- Terminated Employment Mid-Year: If an employee terminates employment during the year, the employer may apply any reasonable method of reporting the cost of coverage, so long as this method is used consistently for all employees. Importantly, if a terminated employee requests a Form W-2 prior to the end of the calendar year in which the employee was terminated, the employer is not required to report the cost of health coverage for such year.

- Work for Multiple Employers: If an employee works for multiple employers during a calendar year, each employer that provides employer-sponsored coverage must report the cost of its coverage on its Form W-2. However, if a common paymaster (Code 3121(s)) is used, only the common paymaster reports the cost of the coverage. Also, if an individual transfers to a new employer, both employers report the cost of the respective coverage, unless the successor employer issues one Form W-2 reflecting wages paid to the employee by both the predecessor employer and successor employer.
- Former Employees: No amount is required to be reported for any individual who is not otherwise receiving a Form W-2. This includes retirees or other former employees who do not receive any compensation from the employer. Unfortunately, to the extent that any deferred compensation is reported on Form W-2 (e.g., nonqualified plan benefits), this may trigger the reporting.
- Multiemployer Plan: An employer that contributes to a multiemployer plan (as defined in § 54.4980B-2, Q&A-3) is not required to include any amount for participating in that plan.

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The IRS has requested comments on the interim guidance which will be due 90 days after the date the interim guidance is officially published in the Federal Register.

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