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Employee Benefits & Executive Compensation ADVISORY

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IRS Issues Guidance on Form W-2 Reporting for Health Coverage Costs

The Patient Protection and Affordable Care Act (PPACA) requires for the first time that the value of employer-sponsored health coverage must be reported on employees' Forms W-2, even though the health coverage is excludable from gross income and wages for employment tax purposes. The definition of employer-sponsored coverage for purposes of the W-2 reporting requirement is generally the same as that used under PPACA's "Cadillac plan" tax, which is not effective until 2018. PPACA provides that the W-2 reporting requirement is effective for taxable years beginning on or after January 1, 2011. Last fall, in order to provide time for employers to make payroll systems changes to comply with the requirement, the IRS issued Notice 2010-69 providing that W-2 reporting for 2011 was voluntary.

The IRS recently issued Notice 2011-28, which provides guidance for complying with the new reporting requirement, as well as a formal delay in implementation—employers are not required to include the cost of employer-sponsored coverage on any Form W-2 required to be issued before January 2013. Thus, the reporting requirement will first apply with respect to coverage provided in 2012. Additional transition relief is provided, including an exception for certain small employers. Notice 2011-28 contains helpful guidance, but many issues still are not resolved.

The reporting requirement has a number of implications for employers:

- The penalties for failure to comply with the new requirement are the same as those applicable to W-2 reporting generally, which range between $30 and $100 per W-2, depending on the length of time the employer fails to comply, with capped penalties for small businesses.
- Employers need to begin to modify their systems now so that they are ready with required information for the January 2013 Forms W-2. In particular, employers (and payroll agents) must implement a system to determine what coverage is subject to the reporting requirement for each employee, determine the cost of the coverage, and report the aggregate value of such coverage.
- Further system changes may well be required when the IRS issues guidance with respect to the Cadillac plan tax for 2018 and issues left open by Notice 2011-28 are resolved.
- Employees understand that Form W-2 includes information regarding taxable compensation—employers should consider whether further employee communications are needed in order to prevent confusion.

This advisory provides further discussion of the guidance provided in Notice 2011-28.

What is the reporting requirement?

The reporting requirement is informational only and, according to the IRS, is designed to enable employees to determine the value of the coverage received through their employer. The new reporting requirement does not cause excludable employer-provided coverage to become taxable.

When is the requirement effective?

The requirement applies with respect to Forms W-2 required for 2012. Employers are not required to report the cost of health coverage on any Forms W-2 required to be furnished before January 1, 2013.

Where must the cost of employer-provided group health plan coverage be reported?

Starting with the Form W-2 that must be provided for 2012 in January 2013, employers must report the "aggregate cost" of "applicable employer sponsored coverage" on Form W-2, box 12, using code "DD." There is no corresponding requirement to report health care costs on the corresponding Form W-3 (Transmittal of Wage and Tax Statements).

What employees are covered by the reporting requirement?

Employers *do not* have to report coverage for anyone to whom they would not otherwise have to provide a Form W-2. Thus, for example, no additional reporting is required for coverage provided to retired former employees unless a Form W-2 is otherwise required (such as for the last year of employment).

See further discussion below on reporting when an employee terminates employment during the year.

Which employers will have to report the cost of employer-provided group health plan coverage?

In general, all employers, including governmental employers and tax-exempt entities, are subject to the reporting requirement. However, the reporting requirement is deferred at least for one additional year for small employers (meaning employers who issued fewer than 250 Forms W-2 for the prior year). Future guidance may apply the reporting requirement to small employers for Forms W-2 required to be issued on or after January 1, 2014. Until future guidance is issued, however, small employers are exempt from the reporting requirement. Federally recognized Indian tribal governments are also not subject to the reporting requirement.

What is a "group health plan" for W-2 reporting purposes?

The reporting requirement applies with respect to coverage under employer-sponsored group health plans. For this purpose, a group health plan is a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. For purposes of determining whether a specific arrangement is a group health plan, employers may rely on a good faith interpretation of the statute and any applicable guidance, including guidance under COBRA.

What coverage must be reported?

The IRS requires that employers report the aggregate cost of "applicable employer-provided coverage," which generally means all coverage under a group health plan made available to the employee by the employer, regardless of whether it is excludable from income. The Notice provides certain exclusions and transition rules.

The following types of coverage do not have to be reported:

- contributions to an Archer MSA or a Health Savings Account (HSA);
- salary reduction contributions to a health FSA (see further discussion below on calculating cost where employer flex credits are provided);
- specified disease (e.g., cancer) and fixed indemnity (e.g., hospitalization per diem coverage) coverage—***but only if such coverage is funded on an after-tax basis***; thus, specified disease and fixed indemnity benefits paid for by the employer or through employee pre-tax salary reduction (i.e., through a cafeteria plan) must be reported;
- stand-alone dental or vision coverage (see further discussion below relating to self funded coverage);*
- coverage under an HRA (i.e., if the only employer provided coverage is an HRA, no reporting is required);*
- coverage under a multiemployer plan;*
- long-term care coverage;
- coverage for accident and/or disability income insurance;
- coverage issued as a supplement to liability coverage;
- liability insurance;
- worker's compensation or similar insurance;
- automobile medical payment insurance;
- credit-only insurance;
- coverage under a plan of a self-insured employer that is not subject to any federal continuation coverage requirement (e.g., church plans);* and
- coverage provided by a federal, state or local government to members of the military and their family.

*The exclusions marked with an asterisk are provided on a transition basis and apply at least with respect to Forms W-2 required for 2012. Future guidance from the IRS may limit the availability of some of this transition relief. Any future guidance that is more restrictive will be prospective only.

The value of on-site medical clinics must be reported.

Note on dental and vision coverage: The Notice departs from the normal definition of stand-alone vision and dental coverage that is an "excepted benefit" under HIPAA. Under the Notice, vision and dental provided under a separate contract or policy of insurance is permanently exempt from reporting. Coverage that is not provided under a separate contract or policy but that is not integrated into a group health plan is exempt from reporting, but potentially only on a transition basis. Thus, future guidance may change the exception for non-integrated coverage. Hopefully, this disparity will be resolved, so that all vision and dental that is an excepted benefit will be exempt from reporting.

What cost must be reported and what are permissible calculation methods?

The entire cost of applicable employer coverage must be reported to the employee, without regard to whether (i) the employer or employee pays for the coverage; (ii) the coverage covers just the employee or the employee, his or her spouse and any dependents; or (iii) a portion of the coverage is taxable to the employee (e.g., coverage provided to a non-dependent adult child over age 26 or to a non-tax-dependent domestic partner).

The IRS provided four methods that employers may use to calculate the cost of coverage. Employers may use different methods for different plans, provided that they use the same method for every employee receiving coverage under the same plan.

- **COBRA Applicable Premium:** Report the cost of coverage by using the COBRA rate for that period. A good faith estimate of the COBRA premium may be used.
- **Premium Charged:** Report the cost of coverage by using the premium charged by the insurer for the employee's coverage for the applicable period.
- **Modified COBRA Premium:** For employers who subsidize the cost of COBRA, report the cost of coverage by using a reasonable good faith estimate of the COBRA applicable premium. If the actual premium charged is equal to the COBRA applicable premium for a prior year, report the cost of coverage by using the COBRA period for each period in the prior year.
- **Composite Rate:** Report the cost of coverage by using the same reportable cost for a period for (1) the single class of coverage under the plan; or (2) all the different types of coverage under the plan for which the same premium is charged to employees, provided that this method is applied to all types of coverage provided under the plan. An example of a plan with a composite rate would be a plan that charges a self-only rate, a self-and-spouse rate and a family rate, regardless of how many members are in the family.

If the cost of coverage for a period changes during the year, the reported amount must reflect the increase or decrease for the periods following the change.

Calculating aggregate cost of coverage may be difficult for certain types of coverage

Calculating the aggregate cost of coverage for insured health coverage will be fairly straightforward. On the other hand, self-funded plan coverage will require that COBRA rates be utilized, and for many types of coverage (e.g., HRA, employer clinic, EAP and wellness benefits) there is no clear guidance as to how coverage costs should be determined. Fortunately, for HRA benefits, the IRS has provided some transition relief whereby no amount is required to be reported pending further IRS guidance. Other types of self-funded coverage must be included—even though there may be no convention as to how to value such coverage.

For health FSAs, the amount of any salary reduction election is not reported on Form W-2. For most FSA arrangements that are funded by salary reduction, any salary reduction amounts would merely be excluded from the total amount reported. Where the FSA is funded by flex credits (expressed as a fixed amount, or as a formula such as matching salary reduction) if the amount in the health FSA exceeds the aggregate salary reduction amount (for all qualified benefits), then the excess of the health FSA amount minus the employee's salary reduction for the health FSA must be included in the total amount reported.

What reporting is required when an employee has a change in coverage or employment during the year?

If an employee enrolls in, terminates or changes coverage during the year, then the amount reported must take into account the change in coverage for the period. For changes during the middle of a period, the employer can use any reasonable method to determine reportable cost for such period, including averaging or prorating the reportable costs, as long as the employer uses the same method for all employees it covers under the plan.

If an employee terminates employment before the end of the year, the employer may use any reasonable method of reporting the cost of coverage, provided that the same method is used for all employees in the plan. If a terminated employee requests a W-2 prior to the end of the calendar year in which they terminated employment, the employer does not have to report the cost of coverage on that employee's W-2, and does not need to issue a separate W-2 solely for purposes of satisfying the health coverage reporting requirement.

If an employee has multiple employers during a calendar year, each employer must report the cost of coverage. However, if the employee has a "common paymaster" among the multiple employers, only the common paymaster must report the cost of the coverage. If an employee transfers from a predecessor to a successor employer, the successor employer can report the cost of coverage for both employers.

For what time period must coverage be reported on the W-2?

The employer must report the cost of coverage on a *calendar year* basis, regardless of the plan year used for the health plan.

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