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New Guidance Related to Form W-2 Reporting Requirements

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The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) places various new reporting and disclosure requirements on employers, group health plans, and plan administrators. One such ACA requirement relates to reporting the cost of employer-sponsored health coverage on the Form W-2, Wage and Tax Statement. Employers have been uncertain regarding many aspects of the statute, such as whether all employers must comply, what types of plans must be considered, and how much flexibility employers have in calculating the cost of health coverage.

Recently, the Internal Revenue Service (IRS) issued Notice 2011-28 (the Notice), which provides needed guidance on the new Form W-2 reporting requirements. This guidance generally is applicable to calendar year 2012 Forms W-2 (which will be issued in January 2013), although employers may voluntarily report coverage for calendar year 2011 using the guidance. This LawFlash describes the relevant provisions of the ACA and the Notice, and also discusses the impact of the new rules on employers.

General Requirements

The ACA added section 6051(a)(14) to the Internal Revenue Code (Code), and generally requires annual reporting to employees of the "aggregate cost" of "applicable employer-sponsored coverage." As with other forms of remuneration that must be reported to employees under Code section 6051(a), employers meet this new requirement by using the Form W-2. The Form W-2 for each calendar year is due on or before January 31 of the succeeding year (or, within 30 days after a terminated employee requests a Form W-2). The ACA originally required the reporting of applicable employer-sponsored coverage starting in 2011, but this effective date was extended under Notice 2010-69 to calendar year 2012. The Notice maintains the calendar year 2012 effective date.

Applicable Employer-Sponsored Coverage

The ACA amended the Code to add section 4980I, and Code section 4980I(d) defines "applicable employer-sponsored coverage" to mean coverage under any group health plan made available to an employee by an employer, which is excludable from the employee's gross income under Code section 106 (or would be excludable if it were employer-provided coverage under Code section 106). A group health plan generally means a plan of (or a plan contributed to by) an employer or employee organization to provide healthcare to employees and former employees or their families. The Notice adds that for purposes of identifying whether an arrangement is a group health plan, a good-faith application of a reasonable interpretation of the statute and applicable guidance should be used.

The statute also provides that applicable employer-sponsored coverage includes coverage under a group health plan established and maintained primarily for civilian employees by the government of the United States, by the government of any state or any political subdivision thereof, or by any agency or instrumentality of any such government.

Exceptions. The statute provides, and the Notice confirms, that applicable employer-sponsored coverage does *not* include the following:

- Coverage only for accident or disability income insurance; coverage issued as a supplement to liability insurance; liability insurance; workers' compensation insurance; automobile medical payment insurance; and credit-only insurance (generally known as "excepted benefits," although certain differences apply; for example, coverage for on-site medical clinics *is included* in applicable employer-sponsored coverage).
- Coverage for long-term care.
- Coverage under a separate policy, certificate, or insurance contract that provides benefits substantially for the treatment of the mouth (including any organ or structure within the mouth) or for the treatment of the eye.
- Independent, noncoordinated coverage for a specified disease or illness, or hospital indemnity or other fixed indemnity insurance, where the payment for such coverage is not excludable from gross income and for which a deduction under Code section 162(l) is not permitted.

Aggregate Cost

Code section 6051(a)(14) provides that "aggregate cost" is determined according to rules similar to those under Code section 4980B(f)(4), which sets forth the general rules for determining the applicable premium for COBRA continuation coverage. While this Code section is not particularly clear or detailed, the pertinent Treasury regulations provide that employers must operate in good-faith compliance with a reasonable interpretation of Code section 4980B.

The Notice adds necessary details to the statutory definition of aggregate cost. It provides that the aggregate cost is the total cost of coverage under all applicable employer-sponsored coverage. This includes amounts paid by the employer and the employee, regardless of whether through pretax or post-tax contributions. The aggregate cost also includes the cost of coverage that is taxable to the employee (such as coverage for a domestic partner or for a dependent who is older than 27 by the end of the taxable year).

Exclusions. In determining aggregate cost, the statute provides that amounts contributed to an Archer Medical Savings Account or a Health Savings Account for an employee or an employee's spouse, and salary reduction contributions to a flexible spending arrangement under a cafeteria plan, are not included. The Notice adds to these exclusions, providing that aggregate cost also does not include the cost of coverage for government plans maintained primarily for members of the military and their families. The Notice further provides that, *until the issuance of future guidance (see paragraph below)*, aggregate cost does not include the cost of coverage under the following:

- Multiemployer plans.
- Health reimbursement arrangements.
- Stand-alone dental and vision plans.
- Self-insured group health plans that are not subject to any federal continuation coverage requirements (e.g., church plans).

With regard to these exceptions, as well as certain other noted exceptions, the Notice indicates that future guidance may be issued that would revise or eliminate one or more exceptions. However, such guidance would be prospective only and would not apply earlier than January 1 of the calendar year beginning at least six months after the date the guidance is issued.

The Notice sets forth special rules for determining whether to include in aggregate cost the amount of a health flexible-spending arrangement under a Code section 125 cafeteria plan, and provides examples that describe when such amounts must be reported.

Employers Subject to Reporting Requirement

The Notice provides that the new reporting requirement generally applies to all employers that provide applicable employer-sponsored coverage (as defined above) during a calendar year, including federal, state, and local government entities and churches and other religious organizations. The following employers are *excluded* from the new reporting requirement:

- Until future guidance is issued, employers who are required to file fewer than 250 Forms W-2 in the preceding calendar year (this corresponds with the W-2 electronic filing rules).
- Federally recognized Indian tribal governments.

As described elsewhere, the first exception above may be modified or eliminated under future guidance.

Methods of Calculating Cost of Coverage

The Notice describes the methods by which the employer can calculate the cost of coverage that must be reported on the Form W-2. As noted above, an employer may use the COBRA applicable premium method, calculating the premium that would be charged to COBRA beneficiaries in a manner that satisfies the requirements of Code section 4980B(f)(4) (less the 2% administrative charge). The Notice provides two additional methods to calculate the cost of coverage:

- <u>Premium charged method</u> – this method is for insured plans only and uses the premium charged by the insurer for each appropriate period.
- <u>Modified COBRA premium method</u> – this method can be used only when one of the following occurs:

- The employer subsidizes the cost of COBRA (in which case the Form W-2 reportable cost is based upon a reasonable good-faith estimate of the COBRA applicable premium); or
- The actual premium charged by the employer for each period in the current year is equal to the COBRA applicable premium for each period in the prior year (in which case the Form W-2 reportable cost is based on the COBRA applicable premium in the prior year).

The Notice also describes how to calculate the reportable cost for a period when the employer charges employees a composite rate (i.e., if there is a single coverage class or if employees are charged the same premium for each type of coverage under the plan).

If the cost of coverage for a period changes during the year, the reportable cost must reflect the change in cost. Further, with respect to an employee who commences, changes, or terminates coverage during the year, the reportable cost must consider the change in coverage. For example, if coverage begins midmonth where costs are determined on a monthly basis, the employer can use any reasonable method to determine the cost (such as using the cost at the beginning or end of the period, or by prorating the reportable costs) as long as the method is used consistently for all employees with coverage under the plan.

Method of Reporting on the Form W-2

The Notice provides various special rules related to the method of reporting on the Form W-2. For example, the aggregate cost of healthcare coverage is reported in box 12 of the Form W-2, using Code DD. Further, the reportable cost is based on the calendar year, regardless of the plan year. The total of the aggregate reportable costs attributable to employees is not required to be reported on Form W-3, Transmittal of Wage and Tax Statements.

Employers can use any reasonable method to report the cost of coverage for an employee who terminated employment during the calendar year, as long as the method is used consistently for all employees. For example, an employer may choose to report the cost of COBRA coverage for a terminated employee, or may choose not to report the cost of such COBRA coverage, as long as the method is used consistently for all employees terminating coverage during the calendar year.

Employers do not need to report the aggregate cost in box 12 of the Form W-2 for the following:

- An individual who would not otherwise receive a Form W-2, such as a retiree or a COBRA-qualified beneficiary.
- An employee who requests, prior to the end of the calendar year in which he or she terminates employment, to receive a Form W-2.

With respect to an individual who is an employee of multiple employers, each employer must report the cost on a Form W-2, although a common paymaster of related employers must report the aggregate cost for all employers for whom it is the common paymaster.

Informational Purposes Only

Interestingly, the Notice provides that the Form W-2 reporting requirement is for informational purposes only (allowing employees to compare the cost of their healthcare coverage), and does not affect the exclusion from taxation for employer plans under Code section 106. Nonetheless, the reporting likely will be used in the future for the special tax on "Cadillac" plans. In fact, the discussion in the Notice regarding the requirement's purposes tends to highlight the business community's concerns that the federal government, or, perhaps more likely, states in desperate need of new tax revenues, eventually may begin to tax the cost of health coverage as reported on the Form W-2.

Next Steps

In light of the new guidance, employers should commence discussions internally and with their payroll providers to identify programming changes needed to capture the cost of coverage beginning January 1, 2012 (i.e., the COBRA premiums less the 2% administrative charge). Further, employers must identify their plans that would constitute "applicable employer-sponsored coverage" as well as any applicable exemptions from the reporting requirements. Employers also must determine how to calculate the cost of coverage for employees who commence or terminate coverage during the year, such as whether to prorate the cost of coverage when midmonth changes occur.

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