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IRS Clarifies Previous Guidance on Form W-2 Informational Reporting Requirement

January 12, 2012

On January 3, 2012, the Internal Revenue Service ("IRS") released Notice 2012-9, which restates and clarifies its prior guidance on the requirement under the Affordable Care Act to report the cost of employer-sponsored health coverage on employees' annual Forms W-2 (using box 12, code DD). Notice 2012-9 supersedes the prior guidance issued under Notice 2011-28 and clarifies various aspects of the reporting requirement.

This alert provides a general overview of the reporting requirement, updated to reflect the latest guidance, and summarizes other changes and clarifications contained in Notice 2012-9. Our April 4, 2011 client alert, IRS Releases Guidance on Form W-2 Informational Reporting Requirement, describes other aspects of the reporting requirements in greater detail. Other than the changes and clarifications noted below, the summary contained in our April 4, 2011 client alert continues to be relevant.

Background

The purpose of the reporting requirement is to provide useful and comparable consumer information to employees on the cost of their health coverage. It does not cause otherwise excludable employer-provided health coverage to become taxable. For these purposes, the amount reported includes both the employer's and the employee's contributions towards coverage, regardless of whether the employee paid for the coverage on a pre-tax or after-tax basis.

When is the requirement effective, and to whom does it apply?

The reporting requirement is effective starting with the 2012 Forms W-2 (the Forms W-2 for calendar year 2012 that employers are generally required to furnish to employees in January 2013). Employers who are voluntarily complying with the reporting requirement for calendar year 2011 Forms W-2 that they are issuing this month may rely on this guidance.

The requirement applies to most employers, including federal, state and local government entities, churches and other religious organizations, and employers that are not subject to continuation coverage requirements under COBRA, to the extent such employers provide applicable employer-sponsored coverage under a group health plan (although employers who only sponsor self-funded group health plan coverage that is not subject to COBRA are not required to report the cost of the coverage on Form W-2). Notice 2012-9 clarifies that until further notice, the exemption for federally recognized Indian tribal governments is expanded to include employers that are tribally chartered corporations wholly owned by federally recognized Indian tribal governments.

Also, to the extent an employer chooses to honor the request of an employee who terminated employment during the year to receive his/her Form W-2 before the end of that calendar year, the employer is not required to include the reportable cost of coverage with respect to that employee.

Small Employer Exemption. The exemption for small employers contained in prior IRS guidance continues to apply under Notice 2012-9. Small employers (those that are required to file fewer than 250 Forms W-2 for the calendar year prior to the reporting year) are not subject to the reporting requirement for 2012 Forms W-2, nor subsequent years, until further guidance is issued. The Notice clarifies that if an employer filed fewer than 250 Forms W-2 only because the employer used an agent to file the forms, the exemption does not apply.

Employers who are in a professional employer organization ("PEO") relationship or who use employee leasing organizations should consult with legal counsel to determine how the reporting requirement applies to them.

Multiemployer Plans. Consistent with prior guidance, an employer that contributes to a multiemployer plan is not required to report the cost of coverage under that multiemployer plan. If the only applicable employer-sponsored coverage provided to an employee is provided under a multiemployer plan, the employer is not required to report any amount with respect to that employee.

Which lines of coverage are reported?

The reporting requirement applies to employer-sponsored group health plans (whether fully insured or self-funded), which generally include major medical plans and limited benefit plans (e.g., so-called "mini-med" plans). A determination of whether a particular arrangement constitutes a group health plan may require a review of the relevant facts and circumstances.

Which lines of coverage are not reported?

The following lines of coverage are not included when reporting the cost of coverage:

- Employee assistance program (EAP), wellness program, or on-site medical clinic coverage if the employer does not charge a premium to COBRA-qualified beneficiaries with respect to that type of coverage; however, an employer may include these lines of coverage if desired, provided such coverage is applicable employer-sponsored coverage;[1]
- Dental or vision coverage, to the extent it qualifies as a HIPAA-excepted benefit;[2]
- Long-term care and accident-only or disability coverage;
- Specified disease or illness and hospital indemnity or other fixed indemnity insurance, to the extent that the cost of coverage is paid by the employee on an after-tax basis and the coverage is offered as an independent, noncoordinated benefit;
- Contributions made to an Archer medical savings account (MSA) or a health savings account (HSA) because they are reported separately in box 12 using code R for MSAs and code W for HSAs;
- Employee contributions to a health flexible spending account (FSA). Notice 2012-9 clarifies that the value of an employer-funded FSA is reported only if the amount of the FSA for the plan year exceeds the salary reduction elected by the employee for the plan year (in other words, the requirement does not apply to FSA coverage if contributions occur only through employee salary reduction elections); and
- Coverage under a health reimbursement arrangement (HRA); however, an employer may include it if desired.

The guidance clarifies that to the extent an employer offers a benefit that includes otherwise reportable coverage as an incidental part of the benefit, the employer is not required to include either the reportable or nonreportable portion of the benefit. Similarly, an employer may, but is not required to, include the nonreportable portion of otherwise reportable coverage if the nonreportable portion is an incidental part of the benefit, notwithstanding the prohibition on reporting coverage that is not applicable employer-sponsored coverage.

Additional Guidance in Notice 2012-9

In addition to the changes discussed above, the Notice clarifies several other topics from the previous guidance, including:

- Clarifying the application of the reporting requirement to certain related employers not using a common paymaster;
- Clarifying that the reporting requirement does not apply to excess reimbursements under a self-funded plan that fails certain discrimination requirements, or premium payments made on behalf of a 2% shareholder-employee of an S corporation who is required to include such payments in gross income; and
- Modifying the application of the reporting requirement if a composite rate (e.g., single coverage class or single-only coverage and family coverage, or self-plus-one coverage and family coverage, etc.) is used with respect to the premium charged to active participants, but not the premium charged under COBRA to a qualifying beneficiary. The guidance clarifies that if an employer is using a composite rate for active employees, but is not using a composite rate for determining applicable COBRA premiums for qualifying beneficiaries, 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.

In addition to the changes discussed above, the Notice also provides the following new guidance, which includes:

- Clarifying that any reasonable, consistently applied method may be used to calculate the reportable amount for coverage only a portion of which constitutes coverage under a group health plan;
- Clarifying that the reportable amount may be based on the information available to the employer as of December 31, and a corrected Form W-2 need not be provided if

an election change occurs that has a retroactive event (e.g., notice of a divorce in the prior year);

- Clarifying that any reasonable, consistently applied allocation method is acceptable to calculate the reportable amount where coverage extends over the payroll period including December 31; and
- Clarifying that the reportable amount is not required to be included on a Form W-2 provided by a third-party sick pay provider (the guidance clarifies that the employer must include the reportable cost of coverage on Form W-2 regardless of whether that Form W-2 includes sick pay, or whether a third-party sick pay provider is furnishing a separate Form W-2 reporting the sick pay).

Action Items

- Employers should continue to work with payroll administrators to determine their level of preparedness to administer this new reporting requirement.
- Employers should determine which of their benefit arrangements must be reported so as to accurately capture the correct benefit values for the 2012 Forms W-2.

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Please feel free to contact your Proskauer attorney or any member of our Health Care Reform Task Force should you have questions regarding any aspect of health care reform.

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[1] A determination of whether such coverage is subject to COBRA is a complicated question for which employers should seek legal counsel.

[2] Generally, to be an excepted benefit for purposes of HIPAA, the dental or vision coverage must (1) be offered under a separate policy, certificate, or contract of insurance or (2) provide participants with the right not to elect the dental or vision coverage and if they do elect the dental or vision coverage, they must pay an additional premium or contribution for that coverage.

Related Professionals

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