Employment, Labor & Benefits Advisory

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FEBRUARY 3, 2012

IRS Issues Additional Guidance under the Affordable Care Act on Informational Reporting to Employees of the Cost of Group Health Insurance Coverage

BY **ALDEN J. BIANCHI**

The Patient Protection and Affordable Care Act of 2010 (the Act)[1] requires employers that sponsor group health coverage to report to employees the aggregate cost of such coverage annually on their Form W-2 (Wage and Tax Statement). The Act's W-2 reporting requirement applies generally to employer-provided coverage without regard to whether the premiums are paid by the employer, the employee, or both, and without regard to whether the cost of coverage is includable in the employee's taxable income. The W-2 reporting requirement appears in newly added Internal Revenue Code § 6051(a)(14), which was originally slated to take effect in 2011. But IRS Notice 2010-69 [2] provided that W-2 reporting would not be mandatory until issuance of the 2012 W-2s.

In Notice 2011-28,[3] the IRS furnished initial guidance under the Act's W-2 reporting requirement. Recently issued Notice 2012-9,[4] which restates and expands on Notice 2011-28, provides employers and plan sponsors with some important clarifications. As was the case with Notice 2011-28, Notice 2012-9 makes clear that the Act's W-2 reporting requirement is informational. As Notice 2012-9 explains it:

"Nothing in [Internal Revenue Code] § 6051(a)(14), this notice, or the additional guidance that is contemplated under § 6051(a)(14), causes or will cause otherwise excludable employer-provided health care coverage to become taxable."

This client advisory reviews the key provisions of Notice 2012-9 and explains what employers will need to do to be ready to comply.

Notice 2012-9

Issued in question-and-answer format, Notice 2012-9 is organized into topics that include the following:

Employers subject to the reporting requirement

Employers that provide "applicable employer-sponsored coverage" under a group health plan, including federal, state, and local government entities, churches, and other religious organizations, are generally subject to the Act's reporting requirements. To this general rule, there are some exceptions. Specifically, the following entities, plans, and arrangements are not subject to the W-2 reporting rules:

- Employers that filed fewer than 250 Forms W-2 for the preceding calendar year. According to Notice 2012-9, whether an employer is required to file fewer than 250 Forms W-2 for a

calendar year is determined based on the Forms W-2 that the employer would be required to file if it filed its own Forms W-2 without the help of an agent. Thus, if an employer would have filed 300 Forms W-2 for the previous year had it not used an agent, that employer would be subject to the reporting requirement for the year.

- Federally recognized Indian tribal governments and tribally chartered corporations.
- A self-insured plan that is not subject to COBRA or any other federal continuation coverage requirements.
- Plans maintained primarily for members of the military, or primarily for members of the military and their families.

Method of Reporting on the Form W-2

The "aggregate reportable cost" (see below) is reported on Form W-2 in box 12, using code DD. In the case of terminated employees, employers are free to apply any reasonable method of reporting the cost of coverage provided under a group health plan, provided that the method is used consistently. Two examples provided in the notice make clear that this would include consistently including or consistently excluding the cost of coverage provided to these participants. Special rules apply to individuals who are employed by more than one employer during a calendar year. Under a general rule, each employer must report the aggregate reportable cost of coverage it provides. But if the employment is concurrent and if the employers are related, and if one of the employers functions as a common paymaster, the common paymaster must include the aggregate reportable cost of the coverage provided to that employee by all the employers for whom it serves as such. Additional rules apply in the case of predecessor and successor employers. Under a general rule, predecessor and successor employers must separately report the aggregate reportable cost of coverage that each employer provided. But under an optional procedure, predecessor and successor employers are permitted to issue a single Form W-2 reflecting wages paid to the employee during the entire calendar year. Under this latter approach, the successor employer must include the aggregate reportable cost of coverage provided by both employers on the Form W-2 that it issues, and the predecessor employer must not report the cost of coverage it provides. Form W-2 reporting of aggregate reportable cost is not required in the case of a retiree or other former employee receiving no compensation required to be reported on a Form W-2, nor is it required to be reported on Form W-3 (Transmittal of Wage and Tax Statements).

Aggregate Cost of Applicable Employer-Sponsored Coverage

The aggregate cost of "applicable employer-sponsored coverage" is the total cost of coverage (employer and employee paid) under all applicable employer-sponsored coverage provided to the employee. The notice clarifies that "applicable employer-sponsored coverage" means, with respect to any employee, coverage under any group health plan made available to the employee, except that applicable employer-sponsored coverage does not include:

- Any coverage for long-term care;
- Coverage described in Code § 9832(c)(1) (other than on-site medical clinics). Included under this exception are the following: (1) coverage only for accident, or disability income insurance, or any combination thereof; (2) coverage issued as a supplement to liability insurance; (3) liability insurance, including general liability insurance and automobile liability insurance; (4) workers' compensation or similar insurance; (5) automobile medical payment insurance; (6) credit-only insurance; and (7) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
- Any coverage under a separate policy, certificate, or contract of insurance that provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye; and
- Any coverage described in Code § 9832(c)(3) i.e., coverage only for a specified disease or

illness, and hospital indemnity or other fixed indemnity insurance.

The aggregate reportable cost includes any portion of the cost that is includible in an employee's gross income. Thus, for example, the aggregate reportable cost includes coverage of an adult child age 28, even though the fair market value of such coverage is taxable to the employee.

Cost of Coverage Required to be Included

The cost of coverage under all applicable employer-sponsored coverage must be included in the aggregate reportable cost. To this general rule, the notice sets out the following exceptions that are not included in the aggregate reportable cost:

- The amount contributed to any Archer MSA;
- The amount contributed to any Health Savings Account;
- The amount of any salary reduction election to a health flexible spending arrangement (FSA);
- Coverage under a multiemployer plan;
- Coverage under a health reimbursement arrangement (HRA); and
- Coverage under a stand-alone vision or dental plan.

The notice establishes a set of special rules governing health FSAs that include employer contributions (e.g., "flex credits"). The amount of the health FSA that is required to be included in the aggregate reportable cost reported on Form W-2 is the amount of the health FSA for the plan year, if any, that exceeds the salary reduction elected by the employee for the plan year. The amount of a health FSA for a cafeteria plan year equals the amount of salary reduction elected by the employee for the plan year, plus the amount of any optional employer flex credits that the employee elects to apply to the health FSA. If the amount of salary reduction (for all qualified benefits) elected by an employee 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 reportable cost. But if the amount of the health FSA for the plan year exceeds the salary reduction elected by the employee for the plan year, then the amount of that employee's health FSA minus the employee's salary reduction election (but not below zero) must be included in the aggregate reportable cost.

Methods of Calculating the Cost of Coverage

Employers are generally required to calculate reportable cost using the COBRA cost. In the case of a fully-insured plan, the notice permits the use of premium cost as an alternative. And where an employer subsidizes the cost of COBRA coverage, additional rules apply to ensure that amounts are reported in a manner consistent with the Act.

Employee Assistance Plans, Wellness Programs, and On-Site Medical Clinics

The notice includes an important clarification relating to EAPs, wellness programs, and on-site medical clinics. EAPs, wellness programs, and on-site medical clinics are includible in the aggregate reportable cost *only* to the extent that the coverage is provided under a program that is a group health plan and *only* in instances where the employer charges a premium with respect to that type of coverage provided to a beneficiary qualifying for coverage in accordance with any applicable federal continuation coverage requirements. Thus, if an employer charges no COBRA premium for the EAP, wellness program or on-site medical clinic, it is not required to include the cost of such coverage.

Apportionment of costs

The notice separately addresses the apportionment of costs under a program providing benefits that constitute applicable employer-sponsored coverage and other benefits that do not constitute applicable employer-sponsored coverage (e.g., a long-term disability program that also provides certain health care benefits), saying that the "employer may use any reasonable allocation method to determine the

cost of the portion of the program providing applicable employer-sponsored coverage." Where the portion of the program providing a benefit that is applicable employer-sponsored coverage is only incidental, however, the employer is not required to include either portion of the cost in the aggregate reportable cost. Conversely, if the portion of the program providing a benefit that is not applicable employer-sponsored coverage is only incidental, the employer may, at its option, include the benefit that is not applicable employer-sponsored coverage in determining the reportable cost.

Late notice of events affecting the reportable amount

The notice establishes rules governing the calculating of the reportable amount if an employer is provided notice after December 31 of a calendar year of events that occurred on or before December 31. Employers may rely on information available as of the last day of the year, without having to reissue W-2s.

Implications for Employers

Notice 2012-9 answers a handful of questions not covered in prior guidance. For example, it is now clear that reporting is not required for EAPs, wellness programs, and on-site medical clinics where COBRA enrollees are not charged a premium for coverage. Also, employers are free to rely on information available as of December 31, without having to reissue and recalculate W-2s where new information comes to light thereafter (e.g., a divorce that took place in November). While the enhancements included in Notice 2012-9 are welcome, the reporting rules of Code § 6051(a)(14) are nevertheless burdensome. Employers subject to the W-2 reporting requirements for 2012 (required to be furnished to employees by the end of 2013) should begin immediately to understand the new rules, and prepare to timely implement the system changes and processes required to accurately capture required data.

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Endnotes

1 Pub. L. No. 111-148 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152 (2010)), the Medicare and Medicaid Extenders Act of 2010 (Pub. L. 111-309 (2011)), and the Department of Defense and Full-Year Continuing Appropriations Act of 2011 (Pub. L. 112-10 (2011)).

2 2010-44 I.R.B. 576 (Oct. 12, 2010).

3 2011-16 I.R.B. 656 (Mar. 29, 2011).

4 2012-4 I.R.B. (Jan. 3, 2012).

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1608-0112-NAT-ELB