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EMPLOYEE BENEFITS AND EXECUTIVE COMPENSATION

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# IRS Issues Clarifying Guidance on PPACA's W-2 Reporting Requirements

The Internal Revenue Service (IRS) recently issued Notice 2012-9, which restates and amends its previous guidance on complying with the Patient Protection and Affordable Care Act's (PPACA's) requirement that employers report to employees the cost of their employer-sponsored group health plan coverage. A summary of the IRS's earlier guidance is available on page 8 of our Employee Benefits Year-End LEGALcurrents.

This LEGALcurrents provides a brief overview of the reporting requirement and summarizes the changes to the guidance as announced by the IRS in Notice 2012-9.

## General Requirement

PPACA requires employers to report to employees the aggregate cost of their employer-sponsored group health plan coverage on the annual Form W-2, in box 12 using code DD. Reporting the aggregate cost of employer-sponsored group health plan coverage on an employee's Form W-2 does not make the cost of such coverage taxable to the employee. Rather, the stated purpose of the reporting requirement is "to provide useful and comparable information to employees on the cost of their health care coverage" (Notice 2012-9, Q&A2).

The reporting requirement is effective starting with the 2012 Forms W-2 (i.e., the forms required for the calendar year 2012 that employers are generally required to give employees by the end of January 2013). Employers who voluntarily choose to report the cost of coverage on 2011 Forms W-2 may do so.

## Employers Subject to the Reporting Requirement

Generally, any employer that provides coverage to its employees under a group health plan is subject to this reporting requirement. This includes employers that are federal, state, and local government entities and churches and other religious organizations. Only two categories of employers are exempt from the requirement – small employers and employers that are Federally recognized Indian tribal governments. Notice 2012-9 provides additional detail regarding both of these exemptions.

- Small Employer Exemption. Small employers are those employers that were required to file fewer than 250 Forms W-2 in the preceding calendar year. The 250 Form threshold is not measured across the employer's controlled group. For example, if a parent corporation separately filed 200 Forms W-2 for 2011 and has two subsidiary corporations that each separately filed 200 Forms W-2 for 2011, all three corporations could qualify for the small employer exemption for 2012. Notice 2012-9 clarifies that the determination of whether an employer is required to file fewer than 250 Forms W-2 in a calendar year is determined based on the Forms W-2 that the employer would have been required to file without regard to the employer's use of an agent under Internal Revenue Code section 3504.[1] At a minimum, this small employer exemption is applicable for 2012 Forms W-2; it will apply for later years unless further guidance is issued.

[1] A section 3504 agent generally pays wages to one or more employer's employees and is responsible for withholding, reporting and paying federal employment taxes from those wages.

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- Indian Tribal Governments. In its previous guidance, the IRS stated that employers that are Federally recognized Indian tribal governments are not subject to PPACA's reporting requirement. Notice 2012-9 expands the scope of this exemption, stating that until further guidance is issued, employers that are tribally chartered corporations wholly-owned by a Federally recognized Indian tribal government also are not subject to the reporting requirement.

Any employer who does not qualify for one of the above exemptions should begin considering now how it will comply with PPACA's reporting requirement. The first step in developing a plan for compliance is determining whether the employer offers "applicable employer-sponsored coverage", which is the type of coverage an employer is required to value when determining the aggregate cost of coverage for an employee.

## What is "Applicable Employer-Sponsored Coverage"?

"Applicable employer-sponsored coverage" is coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under Internal Revenue Code section 106, or would be so excludable if it were employer-provided coverage. A group health plan is a plan sponsored by, or contributed to by, an employer or employee organization (e.g., union) to provide health care (directly or otherwise) to employees or former employees and their family members. Certain types of coverage are, however, excluded from the definition of applicable employer-sponsored coverage, including:

- any coverage for long-term care;
- dental or vision coverage, if, as clarified by Notice 2012-9, such coverage qualifies as a HIPAA excepted benefit;[2]
- accident-only, disability, and accidental death and dismemberment coverage; workers' compensation and similar coverage;
- automobile medical payments; and
- coverage for a specified illness or disease, hospital indemnity insurance, or other fixed indemnity insurance, provided that such coverage or insurance is paid for on an after-tax basis by the employee and is independent from an employer's other group health plan coverage.

Some of the coverage types specified above provide a mix of benefits – those that constitute applicable employer-sponsored coverage and those that do not constitute applicable employer-sponsored coverage (e.g., long-term disability insurance that includes a medical benefit rider). Notice 2012-9 clarifies how employers should treat these coverage types for cost reporting purposes. If the medical benefits included in the coverage are incidental to the non-medical benefits, the IRS has advised that the coverage does not have to be treated as applicable employer-sponsored coverage and no cost reporting is required. Alternatively, if the non-medical benefits included in the coverage are incidental to the medical benefits, the IRS had advised that the non-medical benefit portion of the coverage may, at the employer's option, be treated as applicable employer-sponsored coverage and included in the employer's reportable cost. Notice 2012-9 does not define "incidental"; additional guidance from the IRS would be helpful.

[2] Generally, to be an excepted benefit for HIPAA purposes, dental or vision coverage must either be (1) offered under a policy, certificate or contract of insurance separate from that under which major medical or other health benefits are offered, or (2) participants must have the right not to elect the dental or vision benefits and if they do not elect the dental or vision benefits they must pay an additional premium or contribution for that coverage.

## Determining the Aggregate Cost of Coverage

Once an employer has identified any applicable employer-sponsored coverage that it provides to an employee, the employer must calculate the cost of such coverage for reporting purposes. To determine the cost of coverage, employers may use what the IRS guidance refers to as the "COBRA applicable premium method" (the 2% administrative charge is not reported), the "premium charged method" (for insured plans), or the "modified COBRA premium method" (when employer subsidizes the cost of COBRA). The IRS has advised that regulators are reviewing the existing COBRA regulations, so it is possible that we will see changes to the way coverage costs are required to be calculated.

The cost of all applicable employer-sponsored coverages must be aggregated for Form W-2 reporting purposes. Note, though, that the IRS has advised that certain costs should be excluded when calculating aggregate cost. Notice 2012-9 confirms the costs that should be excluded and adds clarifying detail. According to Notice 2012-9, the following costs should be excluded from an employer's aggregate cost calculation:

- Amounts contributed to an Archer MSA or any Health Savings Account.
- Amount of any salary reduction election to a health Flexible Spending Arrangement. Notice 2012-9 makes clear that the amount of a health FSA should only be included in an aggregate cost calculation if the amount of the health FSA for the plan year exceeds the salary reduction elected by the employee for the plan year. This means, then, that if the employer's section 125 plan does not offer any employer flex credits, there is no reportable cost associated with an employee's health FSA. If the employer's section 125 plan offers employer flex credits, the reportable cost associated with the health FSA is equal to the amount of the health FSA reduced by the employee's salary reduction election.
- The cost of coverage provided under a self-insured group health plan that is not subject to Federal COBRA (e.g., a self-insured church plan).
- The cost of coverage under a Health Reimbursement Arrangement, although such cost may be included at the employer's election.
- The cost of coverage provided by the Federal government, any State government, or any political subdivision thereof under a plan maintained primarily for members or former members of the military and their families.
- The cost of coverage provided to an employee under a multiemployer plan to which the employer contributes, although such cost may be included at the employer's election.
- Excess reimbursements of highly-compensated individuals that are included in gross income under Internal Revenue Code section 105(h). This means that an excess reimbursement that is included in the highly-compensated employee's income should be subtracted from the cost of coverage when determining the employee's aggregate cost. This rule supersedes earlier IRS guidance, which stated the opposite. Similarly, an aggregate cost calculation should not include amounts taken into income by an employee who is a 2% shareholder of an employer that is an S corporation.
- The cost of coverage provided under an Employee Assistance Program (EAP), wellness program, or on-site medical clinic, unless the employer charges a COBRA premium for the coverage provided. If the employer charges a COBRA premium for the coverage, the cost of the coverage will be reportable. An employer that does not charge a COBRA premium for these types of coverage may nonetheless elect to include the cost of coverage in its aggregate cost calculation.

Reporting Composite/Blended Rates. Special rules apply for determining an employee's aggregate cost when the employer charges what the IRS refers to as a "composite rate" for coverage. This is not a typical employer practice. An employer is considered to charge a composite rate in the following two circumstances: (1) when a single class of coverage is provided under the plan (i.e., if an employee elects coverage, all eligible family members are included in the election and no greater amount is charged to the employee regardless of the number of covered individuals), or (2) when a single premium is charged for different types of coverage under a single plan (e.g., self-only coverage and family coverage, or self-plus-one and family coverage, but only one premium is charged regardless of coverage level). In the first instance, an employer may calculate and use the same reportable cost for a period for a single class of coverage under the plan. In the second case, an employer may calculate and use the same reportable cost for a period for the different types of coverage under the plan for which the same premium is charged to employees.

Employers that use a composite rate for active employees but not for determining the applicable COBRA premium for qualified beneficiaries may use either the composite rate or the applicable COBRA premium for determining the aggregate cost of coverage, as long as the same method is used consistently for active employees and COBRA qualified beneficiaries.

## Other Notable Issues Regarding Form W-2 Reporting

Reportable Costs for Former Employees. Notice 2012-9 states that an employer may apply any reasonable method of reporting the cost of coverage provided under a group health plan for an employee who terminated employment during the calendar year, provided that the method is used consistently for all employees receiving coverage under the plan who terminate employment during the plan year and continue or otherwise receive coverage after the termination of employment. The examples provided in Notice 2012-9 indicate that it would be permissible for an employer, when calculating a former employee's aggregate cost of coverage for a calendar year, to either include or exclude the value of any applicable employer-sponsored coverage provided after the employee's termination date (for example, COBRA coverage), as long as the employer treats all similarly-situated former employees the same way.

The option to exclude the cost of continuation coverage provided after an employee's termination date from aggregate cost reporting suggests that employers may elect to ignore the value of any coverage provided to a terminated employee after the date of termination. However, an IRS official recently commented that this guidance is only applicable for the calendar year in which the employee terminates. With respect to subsequent calendar years, if an employer is otherwise required to provide a former employee with a Form W-2, the employer must report the aggregate cost of coverage provided to the former employee for those subsequent years. For example, if an employer provides retiree life insurance to a former employee in an amount greater than $50,000 and accordingly has to issue the former employee a Form W-2 to reflect imputed income associated with the life insurance benefit, then the employer will also have to report on such Form W-2 the cost of any retiree medical coverage or COBRA coverage provided to the former employee in years subsequent to the year in which the employee's employment terminated. Similarly, if an employer pays a terminated employee an amount in the year after termination that is required to be reported on a Form W-2 (e.g., a cash bonus related to the year in which termination occurred), the employer will also have to report on such Form W-2 the cost of any retiree medical or COBRA coverage provided to the terminated employee in the year in which the amount is paid to the terminated employee.

Reporting by Related Employers. Notice 2012-9 addresses how PPACA's reporting requirement applies to related employers, depending on whether the employers use a common paymaster. If an individual is an employee of multiple employers within a calendar year who use a common paymaster, the common paymaster must include the aggregate reportable cost of the coverage provided to that employee by all employers on the Form W-2 issued by the common paymaster. If the related employers do not use a common paymaster, then the related employers may either report the aggregate cost of all coverage on a single Form W-2 provided to the employee, or allocate the aggregate cost among the related employers that employ the employee using any reasonable method of allocation.

Reporting by a Third-Party Sick Pay Provider. In some circumstances, a third-party sick pay provider is required to furnish a Form W-2 to an employee to report sick pay. In Notice 2012-9, the IRS advised that a third-party sick pay provider is not required to report the aggregate cost of applicable employer-sponsored coverage on a Form W-2. However, a Form W-2 furnished by an employer to an employee must include the aggregate reportable cost, regardless of whether that Form W-2 includes sick pay or whether a third-party sick pay provider is issuing a separate Form W-2 reporting sick pay.

## Key Action Items for Employers

- Employers should identify any benefit arrangements they offer that meet the definition of "applicable employer-sponsored coverage".
- Employers should identify any costs that should be excluded from their aggregate cost calculations.
- Employers should reach out to their payroll administrators to discuss implementing PPACA's Form W-2 reporting requirement.

If you have any questions regarding this LEGALcurrents, please contact any member of the HSE Employee Benefits & Executive Compensation Practice Area at 585-232-6500.

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