

Form W-2 Reporting of Employer-Sponsored Group Health Plan Coverage

On March 29, 2011, the IRS issued guidance on the new health reform Form W-2 reporting requirement for employer-sponsored group health plan coverage. The guidance appears in Notice 2011-28 and in a related set of Frequently Asked Questions. According to the IRS, the purpose of the new requirement is to provide employees with information on the cost of their health plan coverage. For most employers, the reporting requirement will be effective beginning with the 2012 calendar year (W-2s issued in January 2013). However, small employers (those issuing fewer than 250 W-2s for the preceding calendar year) are not required to comply with the new reporting requirement until further notice. This memorandum summarizes the IRS guidance.

General requirements. Affected employers are required to report the aggregate cost of applicable employer-sponsored group health plan coverage in Box 12 of Form W-2, using code DD. The reported amount is not taxable – it is provided only for informational purposes. No reporting is required for individuals for whom a Form W-2 is not otherwise issued (such as retirees or independent contractors with no wages).

Affected employers. All employers that provide applicable employer-sponsored group health plan coverage are subject to the new Form W-2 reporting requirement. This includes for-profit, not-for-profit, governmental and church employers, but does not include Federally recognized Indian tribal governments. As noted, employers that file fewer than 250 Form W-2s for the 2011 calendar year are not subject to the Form W-2 reporting requirement for the 2012 calendar year.

Applicable coverage. Applicable employer-sponsored group health plan coverage generally includes any group health plan coverage excludable from income under Code section 106, with certain exceptions. The IRS-specified exceptions include:

- Coverage for long-term care
- Employee pre-tax contributions to a Health Flexible Spending Arrangement
- Contributions to a Health Savings Account or Archer Medical Savings Account
- Coverage for certain HIPAA-excepted benefits*
- Coverage under a Health Reimbursement Arrangement**
- Coverage under a multi-employer plan**
- Coverage under stand-alone dental and vision plans**
- Coverage under a self-insured church plan**

* For this purpose, HIPAA-excepted benefits include only those benefits described in Code section 9832(c)(1)(other than coverage for on-site medical clinics) and in Code section 9832(c)(3)(if paid for with after-tax employee contributions).

** Notice 2011-28 indicates that these exceptions are “transitional” and may be modified in the future.

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Aggregate cost. The aggregate cost of applicable coverage includes the portion of the cost paid by the employer and the portion of the cost paid by the employee (on either a pre-tax or after-tax basis). The cost of coverage is determined under one of three cost determination methods:

- **Method #1** – For self-insured plans, the cost of coverage is determined using the COBRA applicable premium. Notice 2011-28 does not provide any guidance regarding the calculation of the COBRA applicable premium for self-insured plans.
- **Method #2** – For fully-insured plans, the cost of coverage is determined using the premium charged by the insurance carrier.
- **Method #3** – In two special situations, the cost of coverage may be determined using a “modified” version of the COBRA applicable premium.
 - Situation #1 – If the employer subsidizes COBRA premiums and uses a reasonable good faith estimate of the COBRA applicable premium to determine the subsidized COBRA premium, the cost of coverage may be based on that reasonable good faith estimate.
 - Situation #2 – If the actual premium charged to COBRA qualified beneficiaries in the current year is equal to the COBRA applicable premium for the prior year, the cost of coverage may be based on the COBRA applicable premium for the prior year.

If a plan uses either a single coverage tier (i.e., when an employee elects coverage, all eligible family members are covered) or multiple coverage tiers (i.e., when an employee elects coverage, the employee must elect a specified level of coverage to enroll additional family members such as employee-only, employee-plus-one and employee-plus-two or more), the same cost of coverage may be determined for all employees in the applicable tier using one of the three cost determination methods.

Additional rules. Notice 2011-28 includes the following additional rules:

- **COBRA coverage.** If an employee loses coverage mid-year and thereafter elects COBRA coverage, employers may choose whether or not to report the cost of the COBRA coverage. The same reporting method must be applied uniformly to all plan participants.
- **Partial-year coverage.** Employers must determine aggregate cost taking into account both the actual period of coverage during the year (e.g., an employee’s coverage begins July 1st, or ends on September 30th) and any changes in coverage tier during the year (e.g., an employee moves from employee-only coverage to employee-plus-one coverage).

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- *Flex credit contributions to Health FSAs.* If an employer makes flex credit contributions available under a cafeteria plan, the employer must report the amount by which an employee's Health FSA election exceeds the amount of the employee's pre-tax contributions for all cafeteria plan benefits including the Health FSA.
- *Military coverage.* Governmental employers are not required to report the cost of coverage provided to military members and their families.
- *Mid-Year Forms W-2.* Employers are only required to report the cost of coverage on Forms W-2 issued after the end of a calendar year. If an employee terminates employment mid-year and requests a Form W-2 at that time (or if an employer routinely provides a Form W-2 in this circumstance), the employer is not required to report the cost of coverage on the mid-year Form W-2.

Future changes expected. The IRS makes clear that certain rules in Notice 2011-28 are transition relief intended to facilitate compliance and that future guidance may limit this "relief" on a prospective basis. The IRS specifically identifies the following rules as subject to change:

- Relief for employers filing fewer than 250 Forms W-2
- Relief for employers furnishing Forms W-2 to employees mid-year
- Relief for multi-employer plan coverage
- Relief for coverage under Health Reimbursement Arrangements
- Relief for stand-alone dental and vision plan coverage
- Relief for self-insured church plans

The IRS notes that if future guidance limits the availability of these rules, the future guidance will be prospective only and will not begin until January 1 of the calendar year beginning at least six months after the guidance is issued.

Resources. Copies of the IRS guidance are available at these links:

- Notice 2011-28 - <http://www.irs.gov/pub/irs-drop/n-11-28.pdf>
- FAQs - <http://www.irs.gov/newsroom/article/0,,id=237894,00.html>

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