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Health Care Reform Management Alert Series

Issue 31

New Year, New W-2 Reporting Guidance

This is the thirty-first issue in our series of alerts for employers on selected topics in health care reform. (Click here to access our general summary of health care reform and other issues in this series.) This series of Health Care Reform Management Alerts is designed to provide an in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

Under the Patient Protection and Affordable Care Act (PPACA), employers will be required to include the cost of employer sponsored health care coverage on the Forms W-2 they issue to employees. This reporting requirement was originally effective for the 2011 tax year. In October, 2010, however, the Internal Revenue Service (IRS) issued Notice 2010-69 which provided that reporting would be optional for 2011, but required for 2012 (i.e., W-2s issued in January 2013). In 2011, the IRS issued Notice 2011-28, which provided interim guidance on the W-2 informational reporting requirement and invited comments on the interim rules. (Click *here* to access our prior Management Alert on Notice 2011-28).

[✔] Applies to grandfathered plans

[✔] Applies to new health plans and plans that lose grandfathered status

This week, the IRS issued new interim guidance in Notice 2012-9, which supersedes Notice 2011-8 and replaces it with a modified and expanded explanation of the PPACA's W-2 reporting mandate. Certain provisions of the interim guidance also provide transitional relief intended to facilitate compliance. The IRS will continue to consider comments submitted in response to Notice 2011-8 as it works to develop regulations, but the new guidance and transitional relief may be relied upon until the IRS issues additional guidance. This Alert summarizes: 1) Notice 2012-9's modifications to the previous interim rules, and 2) Notice 2012-9's new guidance.

Modifications to Prior Guidance

Generally speaking, Notice 2012-9 retains most of the original interim guidance set forth in Notice 2011-28, albeit with some additional modifications and clarifications to the prior interim rules. Thus, employers that have already begun preparing for the W-2 reporting requirement should not expect to significantly alter their plans in light of the new guidance. The only significant reversal of the previous guidance is with respect to excess reimbursements to highly-compensated employees (explained in detail below).

The introduction to Notice 2012-9 summarizes the modifications and clarifications it makes to the FAQs set forth in Notice 2011-28. Of note, these changes include the following:

Exemption for Small Employers (Transitional Relief)

Notice 2011-28 explained that employers are exempt from the new reporting requirement if they filed fewer than 250 Forms W-2 during the preceding calendar year. Notice 2012-9 clarifies that this rule applies regardless of whether the employer

uses an agent pursuant to Internal Revenue Code § 3504. For example, if an employer would have filed 300 Forms in 2011 had it not used an agent, that employer would be subject to the reporting requirement for 2012.

Common Paymasters

Notice 2011-8 discussed how the W-2 reporting requirement applies to employees with multiple employers. Notice 2012-9 builds on this guidance by stating that if related employers employ the same employee, but do not use a common paymaster, the employers may either: 1) report the total aggregate cost on a single W-2, or 2) allocate the cost between the employers and report the divided cost on separate Forms W-2.

Health Flexible Spending Accounts

The new guidance clarifies that the reporting requirement does not apply to coverage under a health FSA if contributions occur only through employee salary reduction elections. Accordingly, if an employer provides a flex credit, the cost of the FSA should not be reported unless the flex credit causes the employee's health FSA to exceed his or her salary reduction election.

Stand-Alone Dental and Vision (Transitional Relief)

The new guidance clarifies that dental and vision plans that are "HIPAA-excepted benefits" are not subject to the reporting requirements. Generally, to be an excepted benefit, dental or vision benefits must either be offered under a separate policy, certificate or contract of insurance; or participants must have the right not to elect the benefits and if they do elect the benefits, they must pay an additional premium or contribution for that coverage.

Excess Reimbursements

Certain reimbursements of highly compensated individuals under a self-funded medical plan may be includible in gross income if a plan is considered discriminatory under the Internal Revenue Code. These reimbursements are considered to be "excess reimbursements". The original guidance provided that employers should include excess reimbursements in the aggregate reportable cost. The IRS has reversed its position and states in the new guidance that excess reimbursements that are includible in income are not reportable.

New Guidance

Notice 2012-9 also adds several new FAQs under the broad heading of "Additional Issues." These new issues include the following:

EAP, Wellness & On-site Clinics (Transitional Relief)

Importantly, Notice 2012-9 provides definitive guidance on whether employers should report the cost of employee assistance programs (EAPs), onsite clinics, and other wellness initiatives that qualify as group health plans (as defined in Internal Revenue Code § 5000(b)(1)). The answer depends on how the employer administers COBRA continuation coverage for such benefits. If the employer does not charge a COBRA premium for continued coverage under the EAP, onsite clinic, or wellness programs, the employer is not required to report the value of such coverage on the employee's W2. However, if the employer does charge a COBRA premium, it must report the value of the coverage.

This guidance heightens the need for employers to carefully review their EAP and wellness programs to determine whether they qualify as "group health plans." Failure to properly administer such benefits as group health plans could have potentially far-reaching impact, including COBRA penalties, ERISA penalties, and now W-2 reporting penalties.

Allocating Cost When Coverage Includes Medical and Non-Medical Components

In many cases, an employer-sponsored benefit plan will include medical benefits that must be reported on the W-2 and non-medical benefits that are not required to be reported (e.g., long-term disability). Notice 2012-9 allows employers to use "any reasonable allocation method" to calculate the cost of the portion of coverage that is required to be reported. If the medical component of a benefit plan is "incidental" in comparison to the non-medical portion, the employer is not required to report either portion. Similarly if the non-medical portion is incidental to the medical portion, the employer may include both in determining the reportable cost.

Retroactive Changes to Coverage After Year-End

Notice 2012-9 clarifies that the information reported on the Form W-2 should be based on the information available on December 31 of the reporting year. Thus, if an employee makes a benefit election in the following calendar year that has a retroactive effect (such as the addition of a newborn child to the employee's coverage), the employer does not need to consider that benefit change when calculating the cost of coverage for the reporting year (i.e., the year ending on December 31).

Coverage that Straddles Two Reporting Years

Additionally, where a coverage period (e.g. final payroll period) extends beyond December 31 of a reporting year, employers may use a reasonable allocation method to divide the cost between the two years, or treat the coverage period as occurring either entirely before December 31 or entirely after December 31. The option selected by the employer should be applied consistently to all employees.

Independent Individual Policies

To the extent an employer merely provides the opportunity for employees to purchase a fixed indemnity policy or coverage for a specified disease or illness, and employees pay with after-tax dollars, the cost of coverage need not be reported. If the employer makes any contribution or employees pay with pre-tax dollars, however, the cost of coverage must be reported.

Third-Party Sick Pay

Generally, a third party provider that makes payments of sick pay to employees on the employer's behalf has no responsibility for reporting such payments on a W-2. However, under an exception to this rule, the parties may enter into an agreement that makes the third-party agent responsible for issuing W-2s. Notice 2012-9 explains that sick pay payments made by a third-party provider should not be reported on the W 2 prepared by the provider. Instead the employer should report the amounts on the employer-prepared W-2.

Employer Action Steps

In light of the revised guidance, employers should add the following new items to their W-2 action plan:

- Determine whether stand-alone dental and vision benefits meet the HIPAA definition of "excepted benefits."
- Evaluate whether EAP, wellness programs, and onsite clinics are "group health plans" for purposes of COBRA, and if so, how the reportable cost will be determined.
- Choose a consistent method for allocating the cost of coverage when a benefit program includes both medical and non-medical benefits, and for allocating the cost of coverage for reporting periods that straddle two reporting years.
- As always, coordinate with payroll staff and vendors to ensure proper reporting on the Form W-2.
- Communicate with employees regarding the new information they'll see reported on their W-2.

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