

HUMAN CAPITAL PRACTICE

Willis

ALERT: HEALTH CARE REFORM BILL

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W-2 COST OF COVERAGE REQUIREMENT - THAT WAS EASY!

Report the value of coverage on Form W-2. Sounds easy enough. However, compliance isn't all that simple.

CODE REQUIREMENTS AND REGULATORY GUIDANCE

EFFECTIVE DATES

The Patient Protection and Affordable Care Act of 2010 (PPACA), § 9002 requires employers, for the first time, to include on Form W-2 Wage and Tax Statements, the "cost of employer-sponsored health coverage." There is no corresponding requirement to report health care costs on the Form W-3 (Transmittal of Wage and Tax Statements).

Reporting is *required* for larger employers starting with the 2012 W-2, due out in January 2013. A larger employer is one who files W-2 information electronically with the IRS – a rule that generally applies to employers who issue 250 or more W-2s (partnerships with more than 100 partners must also file returns electronically). The W-2 reporting requirements will ultimately apply to almost every employer who provides employer-sponsored health coverage, including state and local government entities, churches and other religious organizations, and employers that are not subject to COBRA coverage requirements, but excluding federally recognized Indian tribal governments. Smaller employers, employers that are not subject to COBRA (e.g., self-insured church plans) and plans maintained primarily for members of the military and their families are not *required* to report the cost of coverage until further guidance is provided. Although employers will not be required to report these costs on the 2011 W-2, they may *voluntarily* report cost information in box 12 on the 2011 W-2 using code DD.

Failure to comply triggers the same penalties that apply to W-2 reporting in general – an amount ranging from \$30 to \$100 per W-2, depending on the length of time the employer fails to comply (maximum penalty provisions apply to small businesses).

LET YOUR PAYROLL SYSTEMS/PROCESSES BE YOUR COMPLIANCE GUIDE

The delay in enforcing the new reporting requirements gives employers, software providers and third-party service providers adequate time to plan and implement these new reporting requirements. W-2 reporting of health coverage is for informational purposes only – employer and employee pre-tax contributions continue to be excluded from gross income and wages for employment tax purposes.

As with all other elements reported on the W-2, plan sponsors will be heavily dependent on payroll administrators who in turn will be heavily dependent on software providers to accurately code the systems and elements of coverage that are used to accumulate and generate W-2 data. Envisioned is an accumulation process, perhaps similar to that used to accumulate contributions for a savings plan under Internal Revenue Code (IRC) § 401(k) – contributions which are also reported on the W-2. Because the accumulation and reporting processes will generally be driven by payroll systems, compliance and accuracy will largely be a function of the information reported by the employer.

This summary is a compliance starting point. However, the guidance includes many questions and answers that should be read carefully by individuals who are responsible for Form W-2 preparation and those individuals the preparer must rely upon to report and coordinate cost information. Additional information on the reporting requirements can be found in **IRS Notice 2011-28**.

“APPLICABLE EMPLOYER-SPONSORED COVERAGE” DEFINED

Applicable Employer-Sponsored Coverage (ESC) includes employer and employee organization health coverage (insured and self-insured) provided to employees, former employees, the employer and others associated or formerly associated with the employer in a business relationship, and their families. ESC generally includes all coverage from all plans regardless of whether it is excludable from income, but some types of health coverage are exempted from the reporting requirement. *In Notice 2011-28, the IRS interpreted these exemptions, and they provided some additional exemptions and promised further guidance which will be applied prospectively with at least six months notice. Accordingly, employers should be aware of the possibility that the previously exempted items will be subject to the reporting requirement in future years.*

Under IRS Notice 2011-28, the following items are not included in ESC:


- 1.** Contributions to an Archer Medical Savings Account
- 2.** Contributions to a Health Savings Account (HSA)
- 3.** Employee pre-tax contributions to a health Flexible Spending Account (FSA) (however, where the health FSA coverage exceeds the employee’s pre-tax contributions, such as where there are employer contributions to a FSA, that difference must be included in ESC)
- 4.** Coverage only for a specified disease or illness (e.g., cancer) and hospital indemnity or other fixed indemnity coverage offered on an independent, non-coordinated basis, provided that the payment for the coverage is not excludable from gross income and a deduction under § 162(l) is not allowable
- 5.** Dental or vision coverage that is not integrated into a group health plan that provides reportable coverage

- 6.** Long-term care coverage
- 7.** Coverage only for accidents, or disability income coverage or a combination of both
- 8.** Liability coverage or coverage issued to supplement liability coverage
- 9.** Workers’ compensation or similar insurance
- 10.** Coverage under a multi-employer plan
- 11.** Automobile medical payment insurance
- 12.** Credit-only insurance
- 13.** Coverage provided under a plan maintained by a government entity (federal, state or local) primarily for members of the military and their families (coverage provided under government plans maintained primarily for civilian employees must be reported)
- 14.** Coverage under a Health Reimbursement Arrangement (HRA)
- 15.** Coverage under plans of self-insured employers not subject to COBRA (e.g., self-insured church plans)

The exclusion for HIPAA excepted benefits (accident or disability income, liability, workers’ compensation or similar insurance, auto med pay, credit-only, and other similar coverage where medical care benefits are secondary or incidental) does not extend to the cost of care provided by on-site medical clinics. Such costs, and costs for Employee Assistance Programs that provide medical care, must be included in the reportable cost.

REPORTABLE COST OF ESC

Guidance anticipates a cumulative process in determining the amount to be reported. The reportable cost is the sum of the reportable costs for each coverage period during the year as determined under the method used by the employer. Generally speaking, until additional guidance is provided, employers can calculate the reportable value based on



methods to estimate cost similar to those used under COBRA (minus the 2% COBRA administrative fee, if charged).

The entire cost of the applicable employer coverage provided to an employee must be reported, without regard to who is covered, whether the coverage is taxable and regardless of who paid the cost – the employer or the employee. While an employer may use a different method for different plans (options), they must use the same method for every employee who receives coverage under a specific plan (option). Besides using the COBRA applicable premium method, the Notice provides two additional methods to calculate the cost of coverage:

- **PREMIUM CHARGED METHOD** - This method is for insured plans only and uses the premium charged by the insurer for each appropriate period.
- **MODIFIED COBRA PREMIUM METHOD** - This method can be used only when one of the following occurs:
 - The employer subsidizes the cost of COBRA (in which case the Form W-2 reportable cost is based upon a reasonable good-faith estimate of the COBRA applicable premium); or
 - The actual premium charged by the employer for each period in the current year is equal to the COBRA applicable premium for each period in the prior year (in which case the Form W-2 reportable cost is based on the COBRA applicable premium in the prior year).

The Notice also describes how to calculate the reportable cost for a period when the employer charges employees a composite rate (i.e., if there is a single coverage class or if employees are charged the same premium for each type of coverage under the plan).

If the cost of coverage for a period changes during the year, the reportable cost must reflect the change in cost. Further, with respect to an employee who commences, changes or terminates coverage during the year, the reportable cost must consider the change in coverage. For example, if coverage begins mid-month where costs are determined on a monthly basis, the employer can use any reasonable method to determine the cost (such as using the cost at the beginning or end of the period, or by prorating the reportable costs) as long as the method is used consistently for all employees with coverage under the plan.

Finally, reportable cost is a calendar year calculation, regardless of the plan year used for the health plan and regardless of the 12-month period for determining the COBRA applicable premium. Employer-sponsored coverage costs must be reported on a calendar year basis, so the W-2 reportable cost under the plan for an employee for the year must reflect the reportable cost, with any increases or decreases that occur during the calendar year.


SPECIAL SITUATIONS

There is guidance for special situations.

SEPARATION: An employer may apply any reasonable method of reporting the cost of coverage for an employee who terminates employment before the end of the calendar year. The employer has the flexibility to report only the cost of coverage received prior to termination or to include the cost of post-employment COBRA coverage so long as the same method is used for all who terminate. In 2012, if the W-2 is requested prior to the end of the calendar year, no amount need be reported in box 12. It is not clear what the requirements will be in 2013 and later years for those who separate and request a W-2 mid-year.

INDIVIDUALS WITH MULTIPLE RELATED EMPLOYERS: Special rules apply for individuals who perform services for multiple related employers within the meaning of IRC §3121(s), where one of the employers is a “common paymaster.” There, the common paymaster must include aggregate reportable costs for coverage provided by all employers it serves. The individual employers do not report the cost of coverage that they provided.

EMPLOYEE TRANSFERS TO SUCCESSOR EMPLOYER: If an employee transfers to a successor employer, both the predecessor



and the successor must report the aggregate reportable cost of coverage that each provided unless the successor employer chooses to issue one W-2 reflecting wages paid and the aggregate reportable cost of ESC provided to the employee during the calendar year by both the predecessor and successor employers.

RETIREES, COBRA PARTICIPANTS: An employer is not required to report aggregate costs of health coverage to an individual for whom the employer is not otherwise required to issue a W-2. No guidance was provided about reporting the cost of coverage where a W-2 is issued to a former employee to report deferred compensation payments; however, see the prior information about reporting the cost of coverage after separation.

CONCLUSION

Most employers will be able to rely on their payroll administrators to achieve compliance with the new W-2 reporting requirements. We anticipate, however, that payroll administrators will require employers to provide them with the health coverage costs to accumulate and include on the W-2. However, for comparison, most employees who participate in tax preferred benefits (a 401(k), cafeteria plan, etc.) are generally unable to explain the difference between their federal wages (box 1), FICA wages (box 5), state wages (box 16) and local wages (box 19). Employees may not even notice the new health cost number on their W-2 – or – at the other extreme, it may surprise them or confuse them because few employees understand the cost of health coverage. The new W-2 reporting requirements offer employers a choice between simple compliance and incorporating the new reporting requirement into a larger strategy designed to confirm the value of the health coverage offered.