Reasonable Rules For Reporting the Cost of Health Coverage on Form W-2 and Other News

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Recent guidance from the Internal Revenue Service, Department of Labor and Department of Health and Human Services (the "Departments") exhibits flexibility and appears to take into account the administrative burdens of compliance with the Patient Protection and Affordable Care Act (PPACA).

The PPACA requires that employers report the cost of health coverage on employees' Form W 2s. The IRS made reporting optional for 2011. Now, IRS Notice 2011-28 (available here) provides rules for reporting the cost of health coverage on 2012 Form W-2s, distributed in January 2013. The IRS stressed that the reporting is only informational and has no impact on the taxation of group health coverage.

Some employers will not have to report the cost of coverage at all

- Until further notice, employers that issue fewer than 250 Form W-2s in one year do not need to report the cost of health coverage on employees' Form W-2s for the following year. This means that an employer that issues fewer than 250 Form W-2s for 2011 is not required to report the cost of health coverage on the Form W-2s it issues for 2012.
- If your employees' health coverage is provided under a Taft-Hartley multiemployer plan, you do not need to do any reporting for that coverage. This is an important exception because allocating the cost of health coverage among contributing employers would have been a significant administrative burden on multiemployer plans and contributing employers.

Employers do not have to report the cost of coverage for non-employees

- You do not need to report the cost of coverage for individuals to whom you would not otherwise provide a Form W-2. This means you do not have to report the cost of coverage for individuals who retired or terminated employment in a prior year or a former spouse on COBRA.
- For employees who terminate employment during the year:
  - You may adopt a rule (applied consistently to all employees who terminate during the year) that either includes or excludes the cost of post-employment coverage. Thus, you do not have to report the value of COBRA coverage.
  - If the employee requests his or her Form W-2 before the end of the year, you are not required to report the cost of health coverage on the employee's Form W-2.

The reported cost of coverage does not include certain types of health coverage

The cost of coverage reported on Form W-2 does not include:

- Dental and vision coverage, provided the dental and vision coverage is separately insured or, if self-insured, subject to separate employee elections and contributions.
- Health savings account (HSA) contributions.
- Employees' health flexible spending account (FSA) contributions.
- The value of coverage under a health reimbursement arrangement (HRA).

The reported cost of health coverage is based on COBRA premiums

- The aggregate cost of coverage is reported in box 12 of Form W-2 with Code DD. The aggregate cost of coverage is the COBRA cost minus the 2% administration fee. You do not need to distinguish between the share of the cost paid by the employee and the employer. The reportable cost of coverage includes the value of coverage provided to domestic partners and domestic partners' children.
- If an employee enrolls, drops or changes health coverage mid-month, you may use any reasonable method for calculating the cost of coverage for the month. For example, if an employee changes from single to family coverage mid-month, you could use for the month (a) the cost of single coverage; (b) the cost of family coverage; or (c) a proration of the cost of single and family coverage. You have to use the same method for all employees enrolled in the plan during the year.
- If you calculate COBRA premiums on a 12-month period other than the calendar year, the reportable cost will change during the calendar year.

Future guidance on Form W-2 reporting

The IRS recognizes the system changes needed to implement Form W-2 changes and stated that future guidance will apply no sooner than the first calendar year starting at least six months after the guidance is issued.

Other News

Partial postponement of claims and appeals rules for non-grandfathered plans

Insurers and third-party administrators have found compliance with the governments' rules for claims, appeals and external review especially challenging. In recognition of the burdens, the Departments announced a postponement of enforcement of some (but not all) aspects of the rules to plan years starting on and after January 1, 2012. More significantly, the Departments said that they "intend to issue an amendment to the 2010 interim final regulations in the near future

that takes into account comments and other feedback received from stakeholders." Technical Release 2011-01 is available here.

Sixth set of PPACA FAQs

The FAQs Part VI (available here) provides six additional Q&As on grandfathered status. Two highlights:

- One FAQ appears to be part of an evolving standard to allow value-based insurance design. The Departments indicated that a grandfathered health plan would not lose grandfathered plan status if it were to impose a new copay on a preventive care service done in a outpatient hospital setting provided the service continues to be available without change at ambulatory surgical centers and a waiver of the copay is provided to individuals for whom it would be medically inappropriate to use the ambulatory setting.
- An anti-abuse rule in the grandfathered plan regulations provides that a benefit package loses grandfathered status if: (a) employees are involuntarily transferred into that option from another benefit package that was in some respects richer; and (b) there was no "bona fide employment-based reason" for the transfer. A new FAQ broadly interprets "bona fide employment-based reason" to embrace a variety of circumstances such as "low or declining participation...in the benefit package makes it impractical for the plan sponsor to continue to offer the benefit package." More generally, a bona fide employment-based reason includes the elimination of a benefit package for any reason as long as "multiple benefit packages covering a significant portion of other employees remain available to the employees being transferred."
