



Subject: **Additional IRS Guidance on W-2 Reporting Requirement**

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While 2012 is yet in its infancy, the IRS has released additional guidance relating to the Form W-2 health coverage reporting requirement imposed by the Affordable Care Act. In 2011, the IRS issued interim guidance explaining the W-2 requirement (see the CBIZ Health Reform Bulletin, [IRS Issues Interim Guidance on W-2 Reporting](#)). On January 3, 2012, the IRS issued [Notice 2012-09](#) which modifies the prior 2011 guidance ([IRS Notice 2011-28](#)). Below are some of the pertinent modifications and clarifications made to the W-2 requirement.

Employers Exempt from the W-2 Reporting Requirement

Generally, certain types of employers are relieved, at least temporarily, from the reporting requirement. These include among others, Indian tribes and employers required to issue fewer than 250 Form W-2s. The 2012 guidance clarifies that:

- Federally-recognized Indian tribal governments, including employers that are tribally chartered corporations wholly-owned by a Federally-recognized Indian tribal government, are not subject to the W-2 reporting requirement.
- The small employer exception for employers who file fewer than 250 W-2s, which is based on the exemption from the electronic requirement to file W-2s, will continue to apply, until future guidance is issued.

Coverage Subject to the W-2 Reporting Requirement

- With regard to **flexible medical spending accounts** (“FSA”), the 2012 guidance clarifies that FSAs funded strictly with salary reduction contributions are not subject to the reporting requirement. If the FSA is funded with dollars, such as non-elective dollars or flex dollars (other than salary reduction dollars), then the amount to be reported on the W-2 excludes the salary reduction contributions.
- **Dental and vision plan coverage.** The guidance clarifies that limited scope dental and vision plans that are excepted from the HIPAA portability law are likewise excepted from the W-2 reporting requirement. To meet the “limited scope exemption” under HIPAA, the plan must specifically, and only provide benefits for, in the case of dental plans, issues relating to the function and structure of the mouth, and for vision coverage, issues relating to the function and structure of the eye. Further, to qualify for these exemptions, the plan must be a separate and independent policy; or, if it is not a separate and independent policy, for example, in the case of a self-funded situation, the dental or vision plan must not be integral with the health plan. What this means is that the participants must have the right to elect or decline the dental or vision coverage, and if elected, there must be a separate cost for the dental or vision coverage.

- **EAP, Wellness Programs and On-site Clinics.** With regard to coverage provided under an employee assistance program (EAP), a wellness program, or on-site medical clinic, if such coverage does not qualify as a “health plan”, for example, a referral only-EAP, then there is no W-2 reporting requirement. If such EAP, wellness program, or on-site medical clinic coverage does qualify as a health plan and premiums are charged to individuals on COBRA or comparable continuation coverage, then these amounts must be reflected on the W-2.
- **Hospital Indemnity or Fixed Dollar Coverage.** The amount of any hospital indemnity or fixed dollar plan coverage when funded in whole or in part by the employer, including salary reduction dollars, must be reported on the W-2. However, if such coverage is fully paid with after-tax employee dollars, then these amounts do not have to be reported.

Calculating the Amount of Coverage

The guidance makes several clarifications about how to calculate the amount to be reported.

- If the employer uses a composite rate for active employees, but a strict COBRA rate for COBRA participants, the amount to be reported on the W-2 can be the composite rate, or the COBRA rate, as long as it is consistently used.
- Amounts to be reported are determined based on the actual coverage the employee has throughout the year. If the employee has single coverage for half the year, and family coverage for half the year, this must be reflected. Similarly, if an individual joins a plan mid-month, the pro-rated cost of coverage for that month should be reported. Several examples in the IRS Notice illustrate these circumstances (Q&As 28, 29 and 30).
- If the COBRA rate minus the 2% administrative fee is used for the W-2 reporting, and if the COBRA 12-month determination period differs from the calendar year, the amount to be reported on the W-2 would have to reflect that which it charged during the relevant calendar year. In other words, the rate may not be the same throughout the calendar year.
- If an employer learns of a change in coverage after the end of the calendar year, such as the occurrence of divorce, the employer is not obligated to modify the W-2 to reflect the change. In other words, the employer can report, on the W-2, the information that it has as of December 31st.

In **determining the aggregate reportable cost**, the W-2 reporting is not required to reflect:

- Amounts includible in an individual's income as a result of any self-funded plan discrimination test failures; nor
- Health premium payment amounts includible in a Subchapter S over-2% shareholder's income.

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