

Part III – Administrative, Procedural, and Miscellaneous

Interim Guidance on Informational Reporting to Employees of the Cost of Their Group Health Insurance Coverage

Notice 2011-28

I. PURPOSE

This notice provides interim guidance on informational reporting to employees of the cost of their employer-sponsored group health plan coverage. This informational reporting is required under § 6051(a)(14) of the Code, enacted as part of the Affordable Care Act to provide useful and comparable consumer information to employees on the cost of their health care coverage. As more fully described below --

- This reporting to employees is for their information only, to inform them of the cost of their health care coverage, and does not cause excludable employer-provided health care coverage to become taxable. Nothing in § 6051(a)(14), this notice, or the additional guidance that is contemplated under § 6051(a)(14), causes or will cause otherwise excludable employer-provided health care coverage to become taxable.
- This notice provides interim guidance that generally applies beginning with 2012 Forms W-2 (that is, the forms required for the calendar year 2012 that employers generally are required to furnish to employees in January 2013 and then file with the Social Security Administration (SSA)). Employers are not required to report the cost of health coverage on any forms required to be furnished to employees prior to January 2013. See Notice 2010-69. However, any employers that choose to report earlier (on the 2011 Forms W-2 generally furnished to employees in January 2012) may look to this notice for guidance regarding that voluntary earlier reporting.
- This notice also provides additional transition relief for certain employers and with respect to certain types of employer-sponsored coverage. This transition relief will continue at least through the 2012 Forms W-2 which are required to be furnished to employees in January 2013. In other words, those employers to which the additional transition relief applies (which includes smaller employers that are required to file fewer than 250 2011 Forms W-2) will not be required to report the cost of health coverage on any forms required to be furnished to employees prior to January 2014. This transition relief will continue until the issuance of further guidance.

- Comments are invited on this interim guidance.

Section 6051(a)(14) was added to the Code by § 9002 of the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act), Public Law 111-148, enacted March 23, 2010, and provides that the reporting be made on Form W-2, Wage and Tax Statement. Notice 2010-69, 2010-44 I.R.B. 567, provides that this reporting will not be mandatory for 2011 Forms W-2 (that is, the forms required for the calendar year 2011 that employers are generally required to give employees in January 2012 and then file with the Social Security Administration).

As explained above, this notice provides interim guidance that generally is applicable beginning with 2012 Forms W-2. In addition, employers may rely on the guidance provided in this notice if they voluntarily choose to report the cost of coverage on 2011 Forms W-2, even though this reporting is not required for 2011. This interim guidance is applicable until further guidance is issued. To the extent that future guidance applies the reporting requirement to additional employers or categories of employers or additional types of coverage that guidance will apply prospectively only and will not apply to any calendar year beginning within six months of the date the guidance is issued. Also as explained above, this notice provides transition relief for certain employers and with respect to certain types of employer-sponsored coverage. See section IV of this notice. This transition relief will be extended at least through the 2012 Forms W-2 and the availability of this transition relief through the 2012 Forms W-2 will not be affected by the issuance of any further guidance. Thus, reporting by these employers and with respect to these types of coverage will not be required for calendar year 2012 (that is, on the Forms W-2 that employers generally are required to furnish to employees in January 2013 and then file with the SSA). For example, as provided in Q&A-3 of this notice, employers that are required to file fewer than 250 2011 Forms W-2 will not be subject to the reporting requirement for 2012 Forms W-2.

The interim guidance is set forth in section III of this notice. Q&A-1 and Q&A-2 discuss the general requirements. Q&A-3 identifies the employers subject to the reporting requirements. Q&A-4 through Q&A-10 provide the methods for reporting the cost of the coverage on the Form W-2. Q&A-11 through Q&A-15 define certain terms related to the cost of coverage required to be reported on the Form W-2. Q&A-16 through Q&A-23 set forth the types of coverage the cost of which is required to be included in the amount reported on the Form W-2. Q&A-24 through Q&A-27 discuss several calculation methods that may be used to determine the cost of the coverage. Q&A-28 through Q&A-31 address a number of other issues employers may encounter in determining the cost of the coverage. Section IV of this notice contains transition relief for certain employers and with respect to certain types of employer-sponsored coverage. Section V of this notice contains a request for comments on all aspects of this guidance, including any areas to be addressed in further guidance or future regulations that will provide the final rules under § 6051(a)(14).

II. BACKGROUND

Section 6051(a) provides generally that an employer must provide a written statement to each employee showing the remuneration paid by such person to such employee during the calendar year, on or before January 31 of the succeeding year (or, if the employee terminates employment during the year, within 30 days after the date of receipt of a written request from such employee submitted before January 2). Form W-2, Wage and Tax Statement, is the form used to provide an employee this information.

Section 6051(a)(14) provides generally that the aggregate cost of applicable employer-sponsored coverage must be included in the information reported on Form W-2, effective for taxable years beginning on or after January 1, 2011. Section 6051(a)(14), provides that, for this purpose, the aggregate cost is to be determined under rules similar to the rules of § 4980B(f)(4), referring to the definition of the “applicable premium” for purposes of COBRA continuation coverage.

Section 6051(a)(14) does not apply to reporting the amount contributed to any Archer MSA (as defined in § 220(d)) or to any health savings account (as defined in § 223(d)) of an employee or an employee’s spouse. See § 6051(a)(11) and (a)(12). Section 6051(a)(14) also does not apply to the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of §§ 106(c)(2) and 125).

Section 6051(a)(14) provides that the aggregate cost of applicable employer-sponsored coverage (the amount required to be reported on Form W-2) has the same meaning as in § 4980I(d)(1). Section 4980I(d)(1)(A) provides that the term “applicable employer-sponsored coverage” means, with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee’s gross income under § 106, or would be so excludable if it were employer-provided coverage (within the meaning of § 106). Section 4980I(f)(4) provides that, for purposes of § 4980I(d)(1) the term “group health plan” has the same meaning as under § 5000(b)(1).

Under section 4980I(d)(1)(B), the term “applicable employer-sponsored coverage” does not include (i) any coverage (whether through insurance or otherwise) described in § 9832(c)(1) (other than coverage for on-site medical clinics described in subparagraph (G) thereof) or for long-term care, or (ii) any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye, or (iii) any coverage described in § 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under § 162(l) is not allowable.

The types of coverage described in § 9832(c)(1) (providing that certain “excepted benefits” are not subject to the requirements of chapter 100 of the Code) that are not subject to this reporting requirement are as follows:

- Coverage only for accident, or disability income insurance, or any combination thereof;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers’ compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

The types of coverage described in § 9832(c)(3) include the following, provided that such coverage is offered as independent, noncoordinated benefits:

- (A) coverage only for a specified disease or illness; and
- (B) hospital indemnity or other fixed indemnity insurance.

Section 49801(d)(1)(C) provides that coverage shall be treated as applicable employer-sponsored coverage without regard to whether the employer or employee pays for the coverage.

Section 49801(d)(1)(E) provides that applicable employer-sponsored coverage shall include coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

Section 4980B(f)(4)(A) provides that the term “applicable premium” means, with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee). Section 4980B(f)(4)(B) provides a special rule for self-insured plans, generally requiring that such plans calculate the applicable premium through one of two methods – the actuarial method or the past cost method. Section 4980B(f)(4)(C) provides that the determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

Section 54.4980B-1, Q&A-2 of the Miscellaneous Excise Tax Regulations, provides that, for purposes of § 4980B, for topics relating to the COBRA continuation coverage requirements of § 4980B that are not addressed in §§54.4980B-1 through 54.4980B-10 (such as methods for calculating the applicable premium), plans and employers must operate in good faith compliance with a reasonable interpretation of the statutory requirements in § 4980B.

III. INTERIM GUIDANCE

This interim guidance generally is applicable beginning with 2012 Forms W-2 (that is, the forms required for the calendar year 2012 that employers generally are required to furnish to employees in January 2013 and then file with the SSA). In addition, employers may rely on the guidance provided in this notice if they voluntarily choose to report the cost of coverage on 2011 Forms W-2, even though such reporting is not required for 2011. This interim guidance is applicable until further guidance is issued. To the extent that future guidance applies the reporting requirement to additional employers or categories of employers, additional types of coverage, or otherwise applies the reporting requirement more expansively, that guidance will apply prospectively only and will not apply to any calendar year beginning within six months of the date the guidance is issued. See also Section IV of this notice for certain transition relief that will be extended at least through the 2012 Forms W-2.

Except as otherwise specified, the interim guidance in this section applies solely for purposes of § 6051(a)(14) and no inference should be drawn concerning any other provision of the Code.

In General (Q&A-1 and Q&A-2)

Q-1: What does § 6051(a)(14) require?

A-1: Section 6051(a)(14) generally requires the aggregate cost of applicable employer-sponsored coverage to be reported on Form W-2.

Q-2: Does the new requirement under § 6051(a)(14) to report the aggregate cost of employer-sponsored coverage on Form W-2, or compliance with this requirement, have any impact on whether such coverage is taxable?

A-2: No. The new requirement is informational only. The provisions of § 6051(a)(14) do not affect whether any particular coverage is excludable from gross income under § 106 or any other Code provision, and the reporting of any amount on Form W-2 in compliance with the requirements of § 6051(a)(14) will not affect the amount includable in income or the amount reported in any other box on Form W-2. The purpose of the reporting is to provide useful and comparable consumer information to employees on the cost of their health care coverage.

Employers Subject to the Reporting Requirement (Q&A-3)

Q-3: What employers are subject to the reporting requirement under § 6051(a)(14)?

A-3: Except as provided in this Q&A-3, all employers that provide applicable employer-sponsored coverage (see Q&A-12) during a calendar year are subject to the reporting requirement under § 6051(a)(14). This includes federal, state and local government entities, churches and other religious organizations, and employers that are not subject to the COBRA continuation coverage requirements under § 4980B, to the extent such employers provide applicable employer-sponsored coverage under a group health plan, but does not include Federally recognized Indian tribal governments. (Notice 2010-69 provides that reporting by these employers is not mandatory until the 2012 Forms W-2 (that is, the forms required for the calendar year 2012 that employers generally are required to furnish to employees in January 2013 and then file with the Social Security Administration (SSA))).

However, in the case of the 2012 Forms W-2 and until the issuance of further guidance, an employer is not subject to the reporting requirement for any calendar year if the employer was required to file fewer than 250 Forms W-2 for the preceding calendar year. (This rule is based upon the rule in § 6011(e) that exempts employers from filing returns electronically if they file fewer than 250 returns.) Therefore, if an employer files fewer than 250 2011 Forms W-2 (meaning the Forms W-2 for the 2011 calendar year that employers generally furnish to employees in January 2012 and then file with SSA), the employer would not be subject to the reporting requirement for Forms W-2 for the 2012 calendar year (meaning the Forms W-2 for the 2012 calendar year that employers generally furnish to employees in January, 2013 and then file with SSA). See also Q&A-21 for an exception to the reporting requirement for coverage under a self-insured plan that is not subject to any federal continuation coverage requirements, and see also Q&A-22 for an exception from the reporting requirement for plans maintained primarily for members of the military, or primarily for members of the military and their families.

Method of Reporting on the Form W-2 (Q&A-4 through Q&A-10)

Q-4: Is the reporting of the aggregate cost of applicable employer-sponsored coverage required for Forms W-2 issued for the 2010 or 2011 calendar years?

A-4: No. Section 6051(a)(14) does not apply to Forms W-2 for calendar years prior to 2011 and, accordingly, reporting of the aggregate cost of applicable employer-sponsored coverage is not required for Forms W-2 issued for the 2010 calendar year. Moreover, Notice 2010-69 provides that reporting will not be mandatory for the 2011 calendar year and, accordingly, an employer will not be treated as failing to meet the requirements of § 6051 for 2011, and will not be subject to any penalties for failure to meet such requirements, merely because it does not report the aggregate cost of applicable employer-sponsored coverage on Forms W-2 for 2011.

Q-5: How is the aggregate reportable cost reported on Form W-2?

A-5: The aggregate reportable cost is reported on Form W-2 in box 12, using code DD.

Q-6: What rules apply in the case of coverage provided by the employer for a period during a calendar year after an employee has terminated employment?

A-6: An employer may apply any reasonable method of reporting the cost of coverage provided under a group health plan for an employee who terminated employment during the calendar year, provided that the method is used consistently for all employees receiving coverage under that plan who terminate employment during the plan year. However, regardless of the method of reporting used by the employer for other terminated employees, an employer is not required to report any amount in box 12, Code DD for an employee who, pursuant to §31.6051-1(d)(1)(i), has requested before the end of the calendar year during which the employee terminated employment to receive a Form W-2.

Example 1. Employee is an employee of Employer on January 1, and continues in employment through April 25. During that entire period and through April 30, Employee had individual coverage for himself under a group health plan with a cost of coverage of \$350 per month. Employee elects continuation coverage for the six months following termination of employment, covering the period May 1 through October 31, for which the Employee pays \$350 per month. Employer reports \$1,400 as the reportable cost under the plan for the calendar year, covering the four months during which Employee performed services and had coverage as an active employee. Employer applies this method consistently for all employees terminating during the calendar year who have coverage under that group health plan. Employer has applied a reasonable method of reporting Employee's reportable cost under the plan.

Example 2. Same facts as Example 1, except that Employer reports \$3,500 as the reportable cost under the plan for the calendar year, covering both the monthly periods during which Employee performed services and had coverage as an active employee, and the monthly periods during which Employee retained continuation coverage under the plan. Employer applies this method consistently for all employees terminating during the calendar year who retained coverage under that group health plan. Employer has applied a reasonable method of reporting Employee's reportable cost under the plan.

Q-7: In the case of an individual who is an employee of multiple employers within a calendar year, must each employer provide a Form W-2 reporting the aggregate reportable cost?

A-7: Each employer providing employer-sponsored coverage must report the aggregate reportable cost of coverage it provides. However, if the employers are related employers within the meaning of § 3121(s) and one such employer is a common

paymaster within the meaning of § 3121(s) for wages paid to the employee, the common paymaster must include the aggregate reportable cost of the coverage provided to that employee by all the employers for whom it serves as the common paymaster on the Form W-2 issued by the common paymaster. In such case, the related employers that are not the common paymaster must not report the cost of coverage they provide. For employers participating in a multiemployer healthcare plan, see Q&A-17.

Q-8: In the case of an individual who transfers to a new employer that qualifies as a successor employer under § 3121(a)(1), must both the predecessor and successor employers report the aggregate reportable cost of coverage each provided?

A-8: Yes, unless the successor employer follows the optional procedure in Rev. Proc. 2004-53, 2004-2 C.B. 320, and issues one Form W-2 reflecting wages paid to the employee during the calendar year by both the predecessor employer and the successor employer. Consistent with the rules applicable to reporting of wages, the successor employer following the optional procedure must include the aggregate reportable cost of coverage provided by both employers on the Form W-2 that it issues, and the predecessor employer must not report the cost of coverage it provides.

Q-9: Must an employer issue a Form W-2 including the aggregate reportable cost to an individual to whom the employer is not otherwise required to issue a Form W-2, such as a retiree or other former employee receiving no compensation required to be reported on a Form W-2?

A-9: No. An employer is not required to issue a Form W-2 including the aggregate reportable cost to an individual to whom the employer is not otherwise required to issue a Form W-2.

Q-10: Is the total of the aggregate reportable costs attributable to an employer's employees required to be reported on Form W-3, Transmittal of Wage and Tax Statements?

A-10: No. The total of the aggregate reportable costs attributable to an employer's employees is not required to be reported on Form W-3, Transmittal of Wage and Tax Statements.

Aggregate Cost of Applicable Employer-Sponsored Coverage (Q&A-11 through Q&A-15)

Q-11: What is the aggregate cost of applicable employer-sponsored coverage and how is the aggregate cost of applicable employer-sponsored coverage referred to in this notice?

A-11: The aggregate cost of applicable employer-sponsored coverage is the total cost of coverage under all applicable employer-sponsored coverage (as defined in Q&A-12

of this Notice) provided to the employee. In this notice, the cost of coverage under a group health plan is referred to as the reportable cost and the aggregate cost of applicable employer-sponsored coverage is referred to as the aggregate reportable cost.

Q-12: What is applicable employer-sponsored coverage?

A-12: Applicable employer-sponsored coverage means, with respect to any employee, coverage under any group health plan (see Q&A-13) made available to the employee by an employer that is excludable from the employee's gross income under § 106, or would be so excludable if it were employer-provided coverage (within the meaning of such § 106), except that applicable employer-sponsored coverage does not include:

- (1) any coverage for long-term care,
- (2) any coverage (whether through insurance or otherwise) described in § 9832(c)(1) (other than subparagraph (G) thereof (coverage for on-site medical clinics)),
- (3) any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye, and
- (4) any coverage described in § 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under § 162(l) is not allowable.

See Q&A-16 through Q&A-23 for guidance on applicable employer-sponsored coverage that is not required to be included in the aggregate reportable cost.

Q-13: What is a group health plan?

A-13: A group health plan is a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. For purposes of identifying whether a specific arrangement is a group health plan, taxpayers may rely upon a good faith application of a reasonable interpretation of the statutory provisions and applicable guidance, including §54.4980B-2, Q&A-1.

Q-14: Does the aggregate reportable cost include both the portion of the cost paid by the employer and the portion of the cost paid by the employee?

A-14: Yes. The aggregate reportable cost generally includes both the portion of the cost paid by the employer and the portion of the cost paid by the employee, regardless of whether the employee paid for that cost through pre-tax or after-tax contributions. However, see Q&A-19 regarding contributions to a health FSA.

Q-15: Does the aggregate reportable cost include any portion of the cost of coverage under an employer-sponsored group health plan that is includible in the employee's gross income, for example, the cost of coverage for a person other than an employee, the employee's spouse, the employee's dependent, or the employee's child who will not have attained age 27 by the end of the taxable year?

A-15: Yes. The aggregate reportable cost includes the cost of coverage under the employer-sponsored group health plan of the employee and any person covered by the plan because of a relationship to the employee, including any portion of the cost that is includible in an employee's gross income. Thus, the aggregate reportable cost is not reduced by the amount of the cost of coverage included in the employee's gross income.

Example. An employee has family health coverage under an employer-sponsored group health plan for himself, his spouse and dependents, and an adult child age 28, with a cost of coverage of \$15,000. The fair market value of the health coverage for the adult child age 28 is included in the income and wages of the employee. The aggregate reportable cost with respect to the family health coverage is \$15,000.

Cost of Coverage Required to be Included in the Aggregate Reportable Cost (Q&A-16 through Q&A-23)

Q-16: Is the cost of coverage under all applicable employer-sponsored coverage required to be included in the aggregate reportable cost?

A-16: Except as provided in this Q&A and in Q&A-17 through Q&A-23, the cost of coverage under all applicable employer-sponsored coverage must be included in the aggregate reportable cost. However, the following amounts are not included in the aggregate reportable cost and are not permitted to be reported under § 6051(a)(14):

- (1) the amount contributed to any Archer MSA (as defined in § 220(d)),
- (2) the amount contributed to any Health Savings Account (as defined in § 223(d)), and
- (3) the amount of any salary reduction election to a flexible spending arrangement (within the meaning of §§ 106(c)(2) and 125).

Q-17: Is the cost of coverage under a multiemployer plan (as defined in § 54.4980B-2, Q&A-3) required to be included in the aggregate reportable cost reported on Form W-2?

A-17: No. An employer that contributes to a multiemployer plan is not required to include the cost of coverage provided to an employee under that multiemployer plan in determining the aggregate reportable cost. If the only applicable employer-sponsored coverage provided to an employee is provided under a multiemployer plan, the

employer is not required to report any amount under § 6051(a)(14) on the Form W-2 for that employee.

Q-18: Is the cost of coverage under a Health Reimbursement Arrangement (HRA) required to be included in the aggregate reportable cost reported on Form W-2?

A-18: No. An employer is not required to include the cost of coverage under an HRA in determining the aggregate reportable cost. If the only applicable employer-sponsored coverage provided to an employee is an HRA, the employer is not required to report any amount under § 6051(a)(14) on the Form W-2 for that employee.

Q-19: If an employer offers a health flexible spending arrangement (health FSA) through a § 125 cafeteria plan, is the amount of the health FSA required to be included in the aggregate reportable cost reported on Form W-2?

A-19: The amount of a health FSA for a cafeteria plan year equals the amount of salary reduction (as defined in Proposed Treas. Reg. §1.125-1(r)) elected by the employee for the plan year, plus the amount of any optional employer flex credits (as defined under Proposed Treas. Reg. §1.125-5(b), expressed as a fixed amount, or as a formula such as matching salary reduction), that the employee elects to apply to the health FSA. In determining the aggregate reportable cost, the amount of the health FSA is reduced (but not below zero) by the employee's salary reduction election (see Q&A-16).

If the amount of salary reduction (for all qualified benefits) elected by an employee equals or exceeds the amount of the health FSA for the plan year, the employer does not include the amount of the health FSA for that employee in the aggregate reportable cost. However, if the amount of the health FSA for the plan year exceeds the salary reduction elected by the employee for the plan year, then the amount of that employee's health FSA minus the employee's salary reduction election for the health FSA must be included in the aggregate reportable cost and reported under § 6051(a)(14).

For purposes of this Q&A-19, a health FSA means an FSA (as defined in Proposed Treas. Reg. §1.125-5(a)) that is a medical reimbursement arrangement.

Example 1: Employer maintains a § 125 cafeteria plan that offers permitted taxable benefits (including cash) and qualified nontaxable benefits (including a health FSA). The plan offers an employer flex credit of \$1,000. Employee makes a \$2,000 salary reduction election for several qualified benefits under the plan, including a health FSA for \$1,500. The cost of the qualified benefits for Employee under the plan for the year is \$3,000. The amount of Employee's salary reduction election (\$2,000) for the plan year equals or exceeds the amount of the health FSA (\$1,500) for the plan year. Thus, for purposes of reporting on Form W-2, none of the health FSA amount is taken into account for purposes of determining the aggregate reportable cost.

Example 2: Employer maintains a § 125 cafeteria plan that offers permitted taxable benefits (including cash) and qualified nontaxable benefits (including a health FSA). The plan offers a flex credit in the form of a match of each employee's salary reduction contribution. Employee makes a \$700 salary reduction election for a health FSA. Employer provides an additional \$700 to the health FSA to match Employee's salary reduction election. The amount of the health FSA for Employee for the plan year is \$1,400. The amount of Employee's health FSA (\$1,400) for the plan year exceeds the salary reduction election (\$700) for the plan year. The employer must include \$700 (\$1,400 health FSA amount minus \$700 salary reduction) in determining the aggregate reportable cost.

Q-20: Is the cost of coverage under a dental plan or a vision plan included in the aggregate reportable cost, if that plan is not integrated into a group health plan providing other types of health coverage subject to the reporting requirements of § 6051(a)(14)?

A-20: No. An employer is not required to include the cost of coverage under a dental plan or a vision plan if such plan is not integrated into a group health plan providing additional health care coverage subject to the reporting requirements of § 6051(a)(14). An employer must include the cost of coverage under a dental plan or a vision plan if such plan is integrated into a group health plan providing such additional health care coverage.

Q-21: Is the cost of coverage provided under a self-insured group health plan that is not subject to any federal continuation coverage requirements (for example, a church plan within the meaning of § 4980B(d)(3) that is a self-insured group health plan) required to be included in the aggregate reportable cost reported on Form W-2?

A-21: No. An employer is not required to include in the aggregate reportable cost the cost of coverage provided under a self-insured group health plan that is not subject to any federal continuation coverage requirements. If the only group health plan coverage provided to an employee by the employer is provided under a self-insured group health plan that is not subject to any federal continuation coverage requirements, the employer is not required to report any amount under § 6051(a)(14) on the Form W-2 for that employee. Employers who provide coverage under a self-insured group health plan that is subject to Federal continuation coverage requirements must report the cost of coverage on Form W-2. For this purpose, federal continuation coverage requirements include the COBRA requirements under the Code, the Employee Retirement Income Security Act of 1974 or the Public Health Service Act and the temporary continuation coverage requirement under the Federal Employees Health Benefits Program.

Q-22: Is the cost of coverage provided by the federal government, the government of any State or political subdivision thereof, or any agency or instrumentality of any such government, under a plan maintained primarily for members of the military or for

members of the military and their families, required to be included in the aggregate reportable cost reported on Form W-2?

A-22: No.

Q-23: In determining the aggregate reportable cost, how should an employer treat an excess reimbursement of a highly compensated individual that is included in gross income under § 105(h)?

A-23: The cost of applicable employer-sponsored coverage is not modified because of excess reimbursements of highly compensated individuals that are included in gross income under § 105(h); that is, an excess reimbursement that is included in income is neither added to the cost of coverage, nor subtracted from the cost of coverage, in determining the aggregate reportable cost.

Example: Employer provides self-insured health coverage with a cost of coverage of \$12,000 under which a highly compensated individual receives a \$4,000 excess reimbursement. As a result, under § 105(h), that individual must include the \$4,000 excess reimbursement in gross income. The excess reimbursement does not modify the determination of the aggregate reportable cost, so that Employer must include \$12,000 as the cost of coverage under the plan in determining the aggregate reportable cost for that individual.

Methods of Calculating the Cost of Coverage (Q&A-24 through Q&A-27)

Q-24: How may an employer calculate the reportable cost under a plan?

A-24: An employer may calculate the reportable cost under a plan using the COBRA applicable premium method (Q&A-25). Alternatively, (1) an employer that is determining the cost of coverage for an employee covered by the employer's insured plan may calculate the reportable cost using the premium charged method (Q&A-26); and (2) an employer that subsidizes the cost of coverage or that determines the cost of coverage for a year by applying the cost of coverage in a prior year may calculate the reportable cost using the modified COBRA premium method (Q&A-27). For employers that charge employees a composite rate (the same premium for different types of coverage under a plan, for example, a premium for self-only coverage versus family coverage), see Q&A-28.

The reportable cost for an employee receiving coverage under the plan is the sum of the reportable costs for each period (such as a month) during the year as determined under the method used by the employer. An employer is not required to use the same method for every plan, but must use the same method with respect to a plan for every employee receiving coverage under that plan.

Q-25: How does an employer calculate the reportable cost for a period under the COBRA applicable premium method?

A-25: Under the COBRA applicable premium method, the reportable cost for a period equals the COBRA applicable premium for that coverage for that period. If the employer applies this method, the employer must calculate the COBRA applicable premium in a manner that satisfies the requirements under § 4980B(f)(4). Under current guidance, the COBRA applicable premium calculation would meet these requirements if the employer made such calculation in good faith compliance with a reasonable interpretation of the statutory requirements under § 4980B (see §54.4980B-1, Q&A-2).

Q-26: How does an employer calculate the reportable cost for a period under the premium charged method?

A-26: The premium charged method may be used to determine the reportable cost only for an employee covered by an employer's insured group health plan. In such a case, if the employer applies this method, the employer must use the premium charged by the insurer for that employee's coverage (for example, for single-only coverage or for family coverage, as applicable to the employee) for each period as the reportable cost for that period.

Q-27: How does an employer calculate the reportable cost for a period under the modified COBRA premium method?

A-27: An employer may use the modified COBRA premium method with respect to a plan only where it subsidizes the cost of COBRA (so that the premium charged to COBRA qualified beneficiaries is less than the COBRA applicable premium) or where the actual premium charged by the employer to COBRA qualified beneficiaries for each period in the current year is equal to the COBRA applicable premium for each period in a prior year. If the employer subsidizes the cost of COBRA, the employer may determine the reportable cost for a period based upon a reasonable good faith estimate of the COBRA applicable premium for that period, if such reasonable good faith estimate is used as the basis for determining the subsidized COBRA premium. If the actual premium charged by the employer to COBRA qualified beneficiaries for each period in the current year is equal to the COBRA applicable premium for each period in a prior year, the employer may use the COBRA applicable premium for each period in the prior year as the reportable cost for each period in the current year.

Example 1: For the calendar year 2012, Employer A subsidizes 50% of a reasonable good faith estimate of the COBRA applicable premium. Employer A's reasonable good faith estimate of the COBRA applicable premium for self-only coverage for each month in 2012 is \$300. Accordingly, the actual COBRA premium Employer A charges individuals eligible for COBRA continuation coverage electing self-only coverage is \$150 per month. Solely for purposes of § 6051(a)(14) reporting, if Employer A uses the modified COBRA premium

method, it must treat \$300 per month (the reasonable good faith estimate of the COBRA applicable premium) as the monthly reportable cost for self-only coverage for the calendar year 2012.

Example 2: Employer B determined that the COBRA applicable premium for each month in calendar year 2011 for individuals eligible for COBRA continuation coverage electing self-only coverage would be \$350 per month, and charged an actual COBRA premium for such coverage of \$357 per month (\$350 x 102%). Employer B knows that the cost of coverage for 2012 is not less than the COBRA applicable premium for 2011 and decides not to make a new determination of the COBRA applicable premium for the calendar year 2012 but rather to continue to charge an actual COBRA premium for self-only coverage of \$357 per month (\$350 x 102%). Solely for purposes of § 6051(a)(14) reporting, if Employer B uses the modified COBRA premium method, it must treat \$350 per month (\$357 charged - \$7 increase permissible under COBRA) as the monthly reportable cost for self-only coverage for the calendar year 2012.

Example 3: Employer C makes a good faith estimate of the COBRA applicable premium for the calendar year 2012 for individuals eligible for COBRA continuation coverage electing self-only coverage of \$500 per month. To ensure compliance with the COBRA requirements despite not calculating a precise COBRA applicable premium, Employer C charges an actual COBRA premium of \$350 per month for individuals eligible for COBRA coverage electing self-only coverage. Solely for purposes of § 6051(a)(14) reporting, if Employer C uses the modified COBRA premium method, it must treat \$500 per month as the monthly reportable cost for self-only coverage for the calendar year 2012.

Other Issues Relating to Calculating the Cost of Coverage (Q&A-28 through Q&A-31)

Q-28: How may an employer charging an employee a composite rate calculate the reportable cost for a period?

A-28: An employer is considered to charge employees a composite rate (1) if there is a single coverage class under the plan (that is, if an employee elects coverage, all individuals eligible for coverage under the plan because of their relationship to the employee are included in the elections and no greater amount is charged to the employee regardless of whether the coverage will include only the employee or the employee plus other such individuals), or (2) if there are different types of coverage under a plan (for example, self-only coverage and family coverage, or self-plus-one coverage and family coverage) employees are charged the same premium for each type of coverage. In such a case, the employer using a composite rate may calculate and use the same reportable cost for a period for (1) the single class of coverage under the plan, or (2) all the different types of coverage under the plan for which the same premium is charged to employees, provided this method is applied to all types of coverage provided under the plan.

For example, if a plan charges one premium for either self-only coverage, or self-and-spouse coverage (the first coverage group), and also charges one premium for family coverage regardless of the number of family members covered (the second coverage group), an employer may calculate and report the same reportable cost for all of the coverage provided in the first coverage group, and the same reportable cost for all of the coverage provided in the second coverage group. In such a case, the reportable costs under the plan must be determined under one of the methods described in Q&A-25 through Q&A-27 for which the employer is eligible.

Q-29: If the reportable cost for a period changes during the year, must the reportable cost under the plan for the year for an employee reflect the increase or decrease?

A-29: If the cost for a period changes during the year (for example, under the COBRA applicable premium method because the 12-month period for determining the COBRA applicable premium is not the calendar year), the reportable cost under the plan for an employee for the year must reflect the increase or decrease for the periods to which the increase or decrease applies. For examples of the application of this rule, see Q&A-30 below.

Q-30: How is the reportable cost under a plan calculated if an employee commences, changes or terminates coverage during the year?

A-30: If an employee changes coverage during the year, the reportable cost under the plan for the employee for the year must take into account the change in coverage by reflecting the different reportable costs for the coverage elected by the employee for the periods for which such coverage is elected. If the change in coverage occurs during a period (for example, in the middle of a month where costs are determined on a monthly basis), an employer may use any reasonable method to determine the reportable cost for such period, such as using the reportable cost at the beginning of the period or at the end of the period, or averaging or prorating the reportable costs, provided that the same method is used for all employees with coverage under that plan. Similarly, if an employee commences coverage or terminates coverage during a period, an employer may use any reasonable method to calculate the reportable cost for that period, provided that the same method is used for all employees with coverage under the plan.

The following examples illustrate the principles set forth in Q&A-29 and Q&A-30:

Example 1: Employer determines that the monthly reportable cost under a group health plan for self-only coverage for the calendar year 2012 is \$500. Employee is employed by employer for the entire calendar year 2012, and had self-only coverage under the group health plan for the entire year. For purposes of reporting for the 2012 calendar year, Employer must treat the 2012 reportable cost under the plan for Employee as \$6,000 ($\500×12).

Example 2: Employer determines that the monthly reportable cost under a group health plan for self-only coverage for the period October 1, 2011 through September 31, 2012 is \$500, and that the monthly reportable cost under a group health plan for self-only coverage for the period October 1, 2012 through September 31, 2013 is \$520. Employee is employed by employer for the entire calendar year 2012 and had self-only coverage under the group health plan for the entire year. For purposes of reporting for the 2012 calendar year, Employer must treat the 2012 reportable cost under the plan for Employee as \$6,060 $((\$500 \times 9) + (\$520 \times 3))$.

Example 3: Employer determines that the monthly reportable cost under a group health plan for self-only coverage for the calendar year 2012 is \$500, and that the monthly reportable cost under the same group health plan for self-plus-spouse coverage for the calendar year 2012 is \$1,000. Employee is employed by Employer for the entire calendar year 2012. Employee had self-only coverage under the group health plan from January 1, 2012 through June 30, 2012, and then had self-plus-spouse coverage from July 1, 2012 through December 31, 2012. For purposes of reporting for the 2012 calendar year, Employer must treat the 2012 reportable cost under the plan for Employee as \$9,000 $((\$500 \times 6) + (\$1,000 \times 6))$.

Example 4: Employer determines that the monthly reportable cost under a group health plan for self-only coverage for the calendar year 2012 is \$500. Employee commences employment and self-only coverage under the group health plan on March 14, 2012, and continues employment and self-only coverage through the remainder of the calendar year. For purposes of reporting for the 2012 calendar year, Employer treats the cost of coverage under the plan for Employee for March 2012 as \$250 $(\$500 \times \frac{1}{2})$. Because Employer's method of calculating the reportable cost of under the plan for March 2012 by prorating the reportable cost for March 2012 to reflect Employee's date of commencement of coverage is reasonable, Employer must treat the 2012 reportable cost under the plan for Employee as \$4,750 $((\$500 \times \frac{1}{2}) + (\$500 \times 9))$.

Q-31: If an employer has used a 12-month determination period that is not the calendar year for purposes of applying the COBRA applicable premium under a plan, may the employer also use that 12-month determination period for purposes of calculating the reportable cost for the year under the plan?

A-31: No. The reportable cost under a plan must be determined on a calendar year basis. For rules on translating the COBRA applicable premium to a calendar year amount, see Q&A-29 and Q&A-30.

IV. TRANSITION RELIEF

Certain provisions of this interim guidance provide transition relief intended to facilitate compliance with the reporting requirement under § 6051(a)(14). See Q&A-3 (relief for

employers filing fewer than 250 Forms W-2); Q&A-6 (relief with respect to certain Forms W-2 furnished to terminated employees before the end of the year); Q&A-17 (relief with respect to multiemployer plans); Q&A-18 (relief for HRAs); Q&A-20 (relief with respect to certain dental and vision plans); and Q&A-21 (relief with respect to self-insured plans of employers not subject to COBRA continuation coverage or similar requirements). Future guidance may limit the availability of some or all of this transition relief; however, such guidance will be prospective only and will not be applicable earlier than January 1 of the calendar year beginning at least six months after its date of issuance. In no case will such guidance limit the availability of this transition relief for the 2012 Forms W-2 (meaning Forms W-2 for the calendar year 2012 that employers generally are required to furnish to employees in January 2013 and then file with the SSA). For example, in no event will reporting be required for 2012 Forms W-2 for any employer required to file fewer than 250 2011 Forms W-2.

V. REQUEST FOR COMMENTS

The Treasury Department and the IRS request comments on all aspects of this interim guidance and the reporting requirements under § 6051(a)(14), including areas that should be addressed in proposed and final regulations or other future guidance. Comments are requested on how future guidance could further reduce the burden of compliance with the reporting requirements while still providing useful and comparable consumer information to employees on the cost of their health care coverage. In addition, the Treasury Department and the IRS request comments on any challenges employers may face in implementing the reporting requirements for the 2012 Forms W-2, and how further guidance could address those challenges, including through the provision of additional transition relief. In particular, Treasury and IRS request comments on issues that would arise in applying the reporting requirements to employers contributing to multiemployer plans (see Q&A-17), such as the potential methods by which the coverage provided to an employee could be allocated among the contributing employers and the potential methods by which contributing employers could obtain the requisite information to report the reportable cost. Comments are also particularly requested as to issues that would arise in applying the reporting requirements to employers that filed fewer than 250 Forms W-2 for the previous calendar year (see Q&A-3), and to employers that sponsor a self-insured plan that is not subject to any federal continuation coverage requirements (see Q&A-21).

Comments must be submitted by July 18, 2011. All materials submitted will be available for public inspection and copying. Comments should be submitted to Internal Revenue Service, CC:PA:LPD:RU (Notice 2011-28), Room 5203, PO Box 7604, Ben Franklin Station, Washington, DC 20224. Submissions may also be hand-delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to the Courier's Desk, 1111 Constitution Avenue, NW, Washington, DC 20224, Attn: CC:PA:LPD:RU (Notice 2011-28), Room 5203. Submission may also be sent electronically via the internet to the following email address: Notice.comments@irs.counsel.treas.gov. Include the notice number (Notice 2011-28) in the subject line.

VI. DRAFTING INFORMATION

The principal author of this notice is Leslie Paul of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities), though other Treasury Department and IRS officials participated in its development. For further information on the submission of comments or the comments submitted, contact Regina Johnson at (202) 622-7180 (not a toll-free number). For further information on all other provisions of this notice, contact Leslie Paul at (202) 622-6080 (not a toll-free number).