

Part III – Administrative, Procedural, and Miscellaneous

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

Notice 2012-9

I. PURPOSE

This notice restates and amends the interim guidance on informational reporting to employees of the cost of their employer-sponsored group health plan coverage initially provided in Notice 2011-28, 2011-16 I.R.B. 656. This informational reporting is required under § 6051(a)(14) of the Internal Revenue Code (Code), enacted as part of the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act), Public Law, 111-148, to provide useful and comparable consumer information to employees on the cost of their health care coverage. Notice 2011-28 solicited comments on various aspects of the reporting requirement. In response to comments, this notice supersedes Notice 2011-28 and makes the following changes to the guidance provided in Notice 2011-28:

- Modifies Q&A-3 to provide that until further guidance is issued, the reporting requirement will not apply to tribally chartered corporations wholly owned by Federally recognized Indian tribal governments.
- Modifies Q&A-3 to clarify the application of the interim relief from the reporting requirement for employers filing fewer than 250 Forms W-2 for the preceding calendar year.
- Modifies Q&A-7 to clarify the application of the reporting requirement to certain related employers not using a common paymaster.
- Adds a new example to Q&A-19 that demonstrates that the reporting requirement does not apply to coverage under a health flexible spending arrangement (FSA) if contributions occur only through employee salary reduction elections.
- Modifies Q&A-20 to clarify that the standard for determining whether coverage under a dental plan or vision plan is subject to the reporting requirement is based upon the same standard for determining whether the coverage is subject to the rules set forth in the regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- Modifies and corrects Q&A-23 to clarify that the reporting requirement does not apply to the cost of coverage includible in income under § 105(h), or payments or reimbursements of health insurance premiums for a 2% shareholder-employee of an S corporation who is required to include the premium payments in gross income.
- Modifies Q&A-28 to clarify the application of the reporting requirement if a composite rate is used with respect to the premium charged active participants, but not the premium charged under COBRA to a qualifying beneficiary.

The notice also provides the following additional guidance through new Q&A's:

- Provides that employers are not required to include the cost of coverage under an employee assistance program (EAP), wellness program, or on-site medical clinic in the reportable amount if the employer does not charge a premium with respect to that type of coverage provided under COBRA to a qualifying beneficiary (Q&A-32).
- Clarifies that employers may include the cost of coverage under programs not required to be included under applicable interim relief, such as the cost of coverage under a Health Reimbursement Arrangement (HRA) (Q&A-33).
- Clarifies how to calculate the reportable amount for coverage only a portion of which constitutes coverage under a group health plan (Q&A-34).
- Clarifies how to calculate the reportable amount if an employer is provided notice after December 31 of a calendar year of events that occurred on or before December 31 of a calendar year that affect the prior year's coverage, such as an employee providing an employer notice of a divorce or other change in family status that occurred during a prior calendar year (Q&A-35).
- Clarifies how to calculate the reportable amount where coverage extends over the payroll period including December 31 (Q&A-36).
- Clarifies the application of the exception for certain hospital indemnity or other fixed indemnity insurance offered by an employer on an after-tax basis (Q&A-37 and Q&A-38).
- Provides that the reportable amount is not required to be included on a Form W-2 provided by a third-party sick pay provider (Q&A-39).

This reporting to employees is for their information only. The reporting is intended 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.

Section 6051(a)(14) was added to the Code by § 9002 of the Affordable Care Act, and provides that the reporting be made on Form W-2, Wage and Tax Statement. Notice 2010-69, 2010-44 I.R.B. 576, 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 by the end of January 2012 and then file with the Social Security Administration (SSA)).

This notice provides interim guidance that generally is applicable beginning with 2012 Forms W-2 (that is, the forms required for the calendar year 2012 that employers are generally required to give employees by the end of 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 this reporting is not required for 2011. This interim guidance is applicable until further guidance is issued. Treasury and the IRS will continue to consider comments submitted in response to Notice 2011-28 as they work to develop regulations under § 6051(a)(14). 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.

As explained above, this notice provides transition relief for certain employers and with respect to certain types of employer-sponsored coverage. This transition relief will be available at least for 2012 Forms W-2 and the availability of this transition relief for 2012 Forms W-2 will not be affected by the issuance of any further guidance. Thus, reporting by employers and with respect to the types of coverage covered by the exceptions provided in this notice will not be required for 2012 Forms W-2. 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 describe 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. Q&A-32 through Q&A-38 contain additions to the guidance initially set forth in Notice 2011-28. 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 states that Notice 2011-28 is superseded.

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 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 health 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 § 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 the following:

- 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 4980I(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 4980I(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 to 2012 Forms W-2 (that is, the forms required for the calendar year 2012 that employers generally are required to furnish to employees by the end of January 2013 and then file with the SSA) and Forms W-2 for later years. In addition, employers may rely on the guidance provided in this notice if they voluntarily 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 for 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 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 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 employers that are 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. (Notice 2010-69, 2010-44 I.R.B. 576, provides that reporting by these employers is not mandatory prior to the issuance of the 2012 Forms W-2 (the forms required for the calendar year 2012 that employers generally are required to furnish to employees by the end of January 2013 and then file with the Social Security Administration (SSA))). Employers that are Federally recognized Indian tribal governments are not subject to the reporting requirements of § 6051(a)(14). Until further guidance is issued, employers that are tribally chartered corporations wholly-owned by a Federally recognized Indian tribal government also are not subject to the reporting requirements.

Also, in the case of the 2012 Forms W-2 (and Forms W-2 for later years unless and until further guidance is issued), 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 is required to file fewer than 250 2011 Forms W-2, the employer would not be subject to the reporting requirement for 2012 Forms W-2. For this purpose, whether an employer is required to file fewer than 250 Forms W-2 for a calendar year is determined based on the Forms W-2 that employer would be required to file if it filed Forms W-2 to report all wages paid by that employer and without regard to the use of an agent under § 3504. For example, an employer that would have filed only 100 Forms W-2 for the previous year had it not used an agent under § 3504 will not be subject to the reporting requirement for the year, nor will an agent under § 3504 with respect to that employer's Forms W-2 for the year. In contrast, if the same employer would have filed 300 Forms W-2 for the previous year had it not used an agent under § 3504 of the Code, that employer would be subject to the reporting requirement for the year so that if an agent under § 3504 is used again the information will need to be provided to the agent and reported on the Form W-2.

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 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 to an employee for a period during a calendar year after that 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 and continue or otherwise receive coverage after the termination of employment. 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 using Code DD for an employee who, pursuant to §31.6051-1(d)(1)(i), has requested to receive a Form W-2 before the end of the calendar year during which the employee terminated employment.

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 that such employer provided?

A-7: Each employer providing employer-sponsored coverage must report the aggregate reportable cost of coverage it provides. However, if the employers concurrently employ an employee and 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 an employee that is concurrently employed, 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 use the common paymaster and that are not the common paymaster must not report the cost of coverage they provide. If the employers are related employers within the meaning of § 3121(s) but do not compensate an employee that is concurrently employed with a common paymaster, then with respect to that employee, the related employers may either report the entire aggregate reportable cost on one of the Forms W-2 provided to the employee, or allocate the aggregate reportable cost among the employers that concurrently employ the employee using any reasonable method of allocation.

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, each of the predecessor and successor employers must report the aggregate reportable cost of coverage that that employer provided, 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 reporting 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) 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. Until further guidance is issued, 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 spouse of the employee, a dependent of the employee, or a child of the employee (provided that child 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. For the treatment of coverage included in gross income under § 105(h), or payments or reimbursements of health insurance premiums for a 2% shareholder-employee of an S corporation who is required to include the premium payments in gross income, see Q&A-23.

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 reported under § 6051(a)(14)¹:

- (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 health Flexible Spending Arrangement (FSA)(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 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: Yes, the amount of the health FSA is required to be included in the aggregate reportable cost reported on Form W-2, but only if the amount of the health FSA for the plan year exceeds the salary reduction elected by the employee for the plan year. 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)) that the employee elects to apply to the health FSA. In

¹ Contributions to an Archer MSA are separately required to be reported on a Form W-2 under § 6051(a)(11), and contributions to a Health Savings Account are separately required to be reported on a Form W-2 under § 6051(a)(12).

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 permits contributions only through employee salary reduction elections, and does not offer any employer flex credits. Employee makes a \$2,000 salary reduction election for several qualified benefits under the plan, including a health FSA for \$1,500. For purposes of reporting on Form W-2, none of the health FSA amount is included 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 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 permitted to be included for purposes of determining the aggregate reportable cost.

Example 3: 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 satisfies the requirements for being excepted benefits for purposes of HIPAA under §54.9831-1(b)(3)?

A-20: No. An employer is not required to include the cost of coverage under a dental plan or a vision plan if the plan satisfies the requirements for being excepted benefits for purposes of HIPAA under §54.9831-1(b)(3). (Generally, to be excepted benefits for purposes of HIPAA under §54.9831-1(b)(3), the dental or vision benefits must either (1) be offered under a separate policy, certificate, or contract of insurance (that is, not offered under the same policy, certificate, or contract of insurance under which major medical or other health benefits are offered) or (2) participants must have the right not to elect the dental or vision benefits and if they do elect the dental or vision benefits they must pay an additional premium or contribution for that coverage.) An employer must include the cost of coverage under a dental plan or a vision plan if the plan does not satisfy the requirements for being excepted benefits for purposes of HIPAA under §54.9831-1(b)(3).

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 Government of the United States, 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. The cost of coverage provided by the Government of the United States, 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, is not required to be included in the aggregate reportable cost reported on Form W-2

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), or payments or reimbursements of health insurance premiums for a 2% shareholder-employee of an S corporation who is required to include the premium payments in gross income?

A-23: The cost of applicable employer-sponsored coverage does not include 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 subtracted from the cost of coverage in determining the aggregate reportable cost. Similarly, the cost of applicable employer-sponsored coverage does not include the cost of coverage taken into income as the result of an employee being a 2% shareholder-employee of an employer that is an S corporation. For more information regarding the treatment of the employer payment or reimbursement of health insurance premiums for a 2% shareholder-employee, see Notice 2008-1, 2008-1 C.B. 251.

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 is not included in the determination of the aggregate reportable cost, so that Employer must include \$8,000 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 self-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 ($\$350 \times 102\%$). 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 ($\$350 \times 102\%$). 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 if (1) 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) 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) and 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.

If an employer is using a composite rate for active employees, but is not using a composite rate for determining applicable COBRA premiums for qualifying beneficiaries, the employer may use either the composite rate or the applicable COBRA premium for determining the aggregate cost of coverage, provided that the same method is used consistently for all active employees and is used consistently for all qualifying beneficiaries receiving COBRA coverage.

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.

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 30, 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 30, 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.

Additional Issues

Q-32: Is the cost of coverage provided under an employee assistance program (EAP), wellness program, or on-site medical clinic required to be included in the aggregate reportable cost reported on Form W-2?

A-32: Coverage provided under an EAP, wellness program, or on-site medical clinic is only includible in the aggregate reportable cost to the extent that the coverage is provided under a program that is a group health plan for purposes of § 5000(b)(1). An employer is not required to include the cost of coverage provided under an EAP, wellness program, or on-site medical clinic that otherwise would be required to be included in the aggregate reportable cost reported on Form W-2 because it constitutes applicable employer-sponsored coverage, if that employer does not charge a premium with respect to that type of coverage provided to a beneficiary qualifying for coverage in accordance with any applicable federal continuation coverage requirements. If an employer charges a premium with respect to that type of coverage provided to a beneficiary qualifying for coverage in accordance with any applicable federal continuation coverage requirements, that employer is required to include the cost of that type of coverage provided. An employer that is not subject to any federal continuation coverage requirements is not required to include the cost of coverage provided under an EAP, wellness program, or on-site medical clinic. 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-33: Are there circumstances in which an employer may include in the aggregate reportable cost reported on Form W-2 the cost of coverage that is not required to be included in the aggregate reportable cost under applicable interim relief?

A-33: Yes. An employer may include in the aggregate reportable cost the cost of coverage that is not required to be included in the aggregate reportable cost under applicable interim relief, such as the cost of coverage under a Health Reimbursement Account (HRA), a multi-employer plan, an EAP, wellness program, or on-site medical clinic, provided that the calculation of the cost of coverage otherwise meets the requirements of Q&A-24 through Q&A-27, and provided that such coverage constitutes applicable employer-sponsored coverage.

Q-34: How may an employer calculate the reportable cost under a program providing benefits that constitute applicable employer-sponsored coverage and other benefits that do not constitute applicable employer-sponsored coverage, such as a long-term disability program that also provides certain health care benefits?

A-34: For a program under which an employee receives benefits that constitute applicable employer-sponsored coverage and other benefits that do not constitute applicable employer-sponsored coverage, an employer may use any reasonable

allocation method to determine the cost of the portion of the program providing applicable employer-sponsored coverage.

If the portion of the program providing a benefit that is applicable employer-sponsored coverage is only incidental in comparison to the portion of the program providing other benefits, the employer is not required to include either portion of the cost in the aggregate reportable cost. Similarly, if the portion of the program providing a benefit that is not applicable employer-sponsored coverage is only incidental to the portion of the program providing a benefit that is applicable employer-sponsored coverage, the employer may, at its option, include the benefit that is not applicable employer-sponsored coverage in determining the reportable cost, notwithstanding the prohibition in Q&A-33 on reporting coverage that is not applicable employer-sponsored coverage.

Q-35: Must the aggregate reportable cost reported on Form W-2 for a calendar year be adjusted for any elections or notifications in the subsequent year that may have an effect on the cost of coverage in the earlier year, such as notice of a divorce in the earlier year?

A-35: No. The aggregate reportable cost for a calendar year reported on Form W-2 may be based on the information available to the employer as of December 31 of the calendar year. Therefore, any election or notification that is made or provided in the subsequent calendar year that has a retroactive effect on coverage in the earlier year is not required to be included in the calculation of the aggregate reportable cost for the calendar year. In addition, an employer is not required to furnish a Form W-2c if a Form W-2 has already been provided for a calendar year, before this type of election or notification (for example, if a Form W-2 is provided on January 15, and the election or notification is provided on January 20).

Q-36: How may an employer address a coverage period, such as the final payroll period of a calendar year that includes December 31 but continues into the subsequent calendar year?

A-36: An employer may include the coverage period that includes December 31 but continues into the subsequent calendar year in one of the following manners: (1) treat the coverage as provided during the calendar year that includes December 31; (2) treat the coverage as provided during the calendar year immediately subsequent to the calendar year that includes December 31; or (3) allocate the cost of coverage for the coverage period between each of the two calendar years under any reasonable allocation method, which generally should relate to the number of days in the period of coverage that fall within each of the two calendar years. Whichever method the employer uses must be applied consistently to all employees.

Q-37: Is the cost of coverage provided under hospital indemnity or other fixed indemnity insurance by an employer on an excludible or pre-tax basis required to be included in the aggregate reportable cost reported on Form W-2?

A-37: Yes. An employer is required to include in the aggregate reportable cost reported on Form W-2 the cost of coverage provided under hospital indemnity or other fixed indemnity insurance, or the cost of coverage only for a specified disease or illness, if the employer makes any contribution to the cost of coverage that is excludable under § 106 or if the employee purchases the policy on a pre-tax basis under a § 125 cafeteria plan.

Q-38: Is the cost of coverage provided under hospital indemnity or other fixed indemnity insurance required to be included in the aggregate reportable cost reported on Form W-2 if the payment for those benefits is includable in the employee's gross income (or, in the case of a self-employed individual, the payment is one for which a deduction under § 162(l) is allowable) ?

A-38: No. An employer is not required to include in the aggregate reportable cost reported on Form W-2 the cost of coverage provided under hospital indemnity or other fixed indemnity insurance, or the cost of coverage only for a specified disease or illness, if those benefits are offered as independent, noncoordinated benefits and if the payment for those benefits is includable in the employee's gross income (or, in the case of a self-employed individual, the payment is one for which a deduction under § 162(l) is allowable). Therefore, to the extent the employer merely provides the opportunity for employees to purchase an independent, noncoordinated fixed indemnity policy and the employee pays the full amount of the premium with after-tax dollars, the cost of coverage provided under that policy is not required to be reported on Form W-2.

Q-39: Must the aggregate reportable cost be reported on a Form W-2 provided by a third-party sick pay provider?

A-39: No. Third-party sick pay providers are required to furnish Forms W-2 to employees to report the sick pay unless (1) the third party withholds and deposits the employee tax and notifies the employer within the required time period, or (2) the third party is acting only as the agent of the employer and has not otherwise agreed with the employer to act as the employer with respect to the sick pay. The aggregate reportable cost is not required to be reported on a Form W-2 furnished by a third-party sick pay provider. However, a Form W-2 furnished by the employer to an employee must include the aggregate reportable cost regardless of whether that Form W-2 includes sick pay, or whether a third-party sick pay provider is furnishing a separate Form W-2 reporting the sick pay. For more information about reporting of third-party payments of sick pay, see Publication 15-A, Employer's Supplemental Tax Guide (Circular E), Section 6 (Sick Pay Reporting).

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); Q&A-21 (relief with respect to self-insured plans of

employers not subject to COBRA continuation coverage or similar requirements); and Q&A-32 (relief for certain employers with respect to coverage under an employee assistance program, on-site medical clinic or wellness program). Future guidance may limit the availability of some or all of this transition relief; however, any such future guidance will be prospective only and will not be applicable earlier than January 1 of the calendar year beginning at least six months after the date of issuance of the guidance. In no case will any such future guidance limit the availability of this transition relief for the 2012 Forms W-2 (the 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. EFFECT ON OTHER DOCUMENTS

Notice 2011-28 is superseded by this notice.

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 provisions of this notice, contact Leslie Paul at (202) 622-6080 (not a toll-free number).