

W-2 Reporting Requirements

Under the Patient Protection and Affordable Care Act ("PPACA"), employers will be required to calculate and report the aggregate cost of applicable employer-sponsored health insurance coverage on employees' Form W-2s for taxable years beginning Jan. 1, 2011. However, because the Internal Revenue Code allows employees to request their Form W-2s earlier than required if they terminate employment during the year, employers should be ready to implement this change in early 2011. This reporting requirement is for informational purposes only; the amount reported does not affect the employer or employee's tax liability.

The Internal Revenue Service has yet to issue regulations or guidance regarding this new requirement. As such, this information is subject to possible change or clarification.

The coverage costs that must be reported under the new requirement include medical plans – including vision or dental benefits to the extent they are integrated into the medical plan – and pharmacy plans.

The following employer-provided benefits are not required to be reported on Form W-2 under PPACA:

- Long-term care, accident or disability income benefits
- Liability insurance
- Workers compensation insurance
- Specific disease or illness policies (such as cancer policies) and hospital (or other) indemnity insurance policies where the full premium is paid by the employee on an after-tax basis
- Archer medical savings account ("MSA") or health savings account ("HSA") contributions of the employee or the employee's spouse
- Salary reduction contributions to a health flexible spending account ("FSA")
- Stand-alone fully insured vision or dental plans[1]

In determining the value of health insurance coverage, the employer must calculate the applicable premiums for the taxable year for such health coverage for the employee under the rules for COBRA continuation coverage under IRC Sec. 4980B(f)(4) and accompanying Treasury regulations. The value that the employer is required to report is the aggregate COBRA premium excluding the administrative fee (2 percent maximum), not just the portion of the premium that the employee or employer pays.

Employers should contact their tax or payroll professionals for answers to specific questions about implementing this IRS requirement.

NEW EMPLOYER FORM W-2 HEALTH INSURANCE REPORTING REQUIREMENTS

IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

July 2010

NOTE: As of this writing, the IRS not issued any guidance on this reporting requirement.

We will update you as

soon as such guidance becomes available.

The Patient Protection and Affordable Care Act (PPACA) adds a new reporting requirement aimed at improving health care transparency and cost awareness by requiring employers to report the value of employees' health benefits on Form W-2s.

For taxable years beginning after December 31, 2010, employers will be required to calculate and report the

aggregate cost of applicable employer-sponsored health insurance coverage on employees'

Form W-2s.¹ This new

reporting requirement applies for employees' tax years beginning after December 31, 2010.

However, because

employees are entitled to request their Form W-2 early if they terminate employment during the year,² payroll

systems need to be updated for this change by January 2011.

Therefore, while most W-2s for tax year 2011 will be issued in January 2012, W-2s reflecting the new health

insurance information must be available no later than February 1, 2011, in the event that a

terminating employee

requests one.³

It is important to note that the aggregate cost of an employee's health benefits will not be included in the

employee's taxable income. The W-2 reporting will be a way to track coverage values for the 40% excise tax

(starting in 2018) on "high-cost" employer-based medical coverage above certain thresholds (the so-called

"Cadillac plan tax").⁴

The coverage costs (whether under an insured or self-insured plan) that must be reported under the new

requirement include:

- Medical plans
- Prescription drug plans
- Dental and vision plans, unless they are "stand alone" plans (i.e., an employee may elect only dental or only vision and is not required to also enroll in medical coverage)
- Executive physicals
- On-site clinics if they provide more than *de minimis* care⁵
- Medicare supplemental policies
- Employee assistance programs⁶

¹ Sec. 9002 of PPACA amended Internal Revenue Code section 6051(a) by adding a new subsection (14) to provide for this reporting requirement.

² Treas. Reg. section 31.6051-1(d)(1).

³ Maureen M. Maly, Faegre & Benson, LLP, "Health Care Reform Includes Form W-2 Reporting Requirement," Society for Human Resource Management, May 7, 2010.

⁴ PPACA § 9001 and the Health Care and Education Reconciliation Act § 1401 adding new IRC section 4980I.

⁵ The term *de minimis* means (as provided by IRC Sec. 132(e)(1)) any property or service, the value of which is (after taking into account the frequency with which similar fringe benefits are provided by the employer to the employer's employees) so small as to make accounting for it unreasonable or administratively impracticable. In other instances where the IRS was interpreting whether a medical clinic provided *de minimis* benefits, an on-site nurse who provided emergency services was considered a *de minimis* benefit, while a clinic at a hospital that provided full-scale medical treatment was not considered *de minimis*.

If an employee enrolls in employer-sponsored health insurance coverage under multiple plans, the aggregate value of all such health coverage (except certain benefits, discussed in section below) must be disclosed. For example, if an employee enrolls in employer-sponsored health insurance coverage under a dental plan and a vision plan, the employer is required to report the total value of the combination of all of these health-related insurance policies. For this purpose, employers generally use the same value for all similarly situated employees receiving the same category of coverage (such as single or family health insurance coverage).⁷

Employers will not be required to provide a specific breakdown of the various types of coverage, but must only report an aggregate cost. For example, if an employee enrolls in medical, dental and prescription drug coverage, the employer only has to report the total value of all coverage, not a value for each individual benefit.

Benefits Exempt from Form W-2 Reporting Requirements

The following employer provided benefits are not required to be reported on Form W-2 under the new health care law:

- Long-term care, accident or disability income benefits
- Specific disease or illness policies (such as cancer policies), and hospital (or other) indemnity insurance policies where the full premium is paid by the employee on an after-tax basis
- Archer MSA or HSA contributions of the employee or the employee's spouse
- Salary reduction contributions to a Health FSA

Valuing Plans

The most challenging aspect of this new reporting requirement is determining the value of the employer sponsored health coverage for each employee. In determining the value of health insurance coverage, the employer will calculate the applicable premiums for the taxable year for such health coverage for the employee under the rules for COBRA continuation coverage under IRC Sec. 4980B(f)(4) (and accompanying Treasury regulations). The value that the employer is required to report is the aggregate premium calculated under the COBRA rules, not the portion of the premium that the employee has to pay. If the employer's plan provides for the

same COBRA continuation coverage premium for both individual coverage and family coverage, the employer plan would be required to calculate separate individual and family premiums and the employer would report the value of the coverage the employee received.⁶ For example, if one employee received family coverage, the employer would report the premium amount for family coverage for that employee. For another employee that receives individual coverage, the employer would report the premium amount for individual coverage. A particular challenge for employers might be that some of the plans covered by the new reporting requirement, such as on-site medical clinics, are not plans that they have previously valued for COBRA purposes. With the new requirements, employers will need to come up with reportable values for coverage provided under these programs, and we understand that the IRS is currently working on this guidance.⁹

⁶ Maly, Faegre & Benson, LLP, Society for Human Resource Management.

⁷ Joint Committee on Taxation, "Technical Explanation of the Revenue Provisions of the Reconciliation Act of 2010, as Amended,

in Combination with the Patient Protection and Affordable Care Act" (March 21, 2010); JCX-18-10, pg. 67.

⁸ *Ibid.*

⁹ Maly, Faegre & Benson, LLP, Society for Human Resource Management.