

## New W-2 Health Insurance Reporting Requirements

**NOTE: As of this writing, the IRS has not issued any guidance on this reporting requirement. We will update you as soon as such guidance becomes available.**

by Peter Stein  
 Vice President of Congressional Affairs  
 National Association of Health Underwriters  
 pstein@nahu.org

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.<sup>1</sup> 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,<sup>2</sup> 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.<sup>3</sup>

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").<sup>4</sup>

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* care<sup>5</sup>
- Medicare supplemental policies
- Employee assistance programs<sup>6</sup>

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 major medical plan, 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).<sup>7</sup> 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.<sup>8</sup> 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.<sup>9</sup> ■

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 49801.

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*.

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.