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W-2 Reporting of Health Coverage Costs: Updated Matrix Available

LEGISLATIVE BRIEF

January 11, 2012

In January 2012 the IRS made several changes and clarifications to its 2011 guidance on what costs employers must include in reportable aggregate health coverage cost on 2012 W-2s. An updated matrix of health coverage costs for W-2 reporting can be found below. This matrix is an UPDATED VERSION of the matrix that was sent out on December 12, 2011 (which reflected the IRS guidance at the time).

This recent IRS Notice 2012-9 also clarifies several ambiguous issues in the prior guidance and also provided additional guidance through new Q&As. Some of the items of most interest in Notice 2012-9 are:

1. What costs employers must report for dental and vision benefits, EAPs, wellness programs, and on-site medical clinics, voluntary hospital indemnity and other fixed indemnity policies.
2. In which tax year an employer should report the cost of coverage that includes December 31 and continues into the following year.
3. An employer's obligation to report the costs of health coverage even if a disability carrier or third-party sick pay provider furnishes a separate Form W-2 reporting sick or disability pay.
4. If future guidance is issued that requires employers to report additional amounts, such guidance will be prospective only.

Additional Detail on Selected Q&As in Notice 2012-9

Dental & vision coverage: Employers are not required to report the cost of dental and vision benefits that meet the HIPAA definition of "excepted" benefits. That means an employer is not required to report insured dental or vision benefits that are provided under a separate contract from the medical benefits; and is not required to report self-funded dental or vision benefits that participants can elect not to receive, and if the elect to receive them, they must pay an additional contribution. (Q&A 20)

EAPs, Wellness programs, on-site medical clinics: Employers are not required to report the cost of coverage for an EAP, wellness program or on-site medical clinic if the employer does not charge a premium for such coverage under COBRA to qualified beneficiaries. (Q&A 32)

Voluntary hospital indemnity and other fixed indemnity policies: Employers are not required to report the cost of such coverage if it is funded by the employee on an after-tax basis; however, employers must report the cost of such coverage if it is provided by the employer on an excludible or pre-tax basis. (Q&As 37 &38)

Employer may elect to report costs of coverage it is not required to include. An employer may elect to report the cost of coverage under a Health Reimbursement Account (HRA), an EAP, wellness program, on-site medical clinic or multi-employer plan, provided the coverage constitutes applicable employer-sponsored coverage and otherwise meets the requirements for methods of calculating costs. (Q&A 33)

Reporting year if coverage period spans two tax years: If the payroll period for which coverage is provided includes December 31 and continues into the following year, the employer can either report all costs on the W-2 for the first year (i.e., the year including December 31), report all costs on the W-2 for the subsequent year, or allocate costs on a reasonable basis between the two years. The same method must be used for all employees. (Q&A 36)

Form W-2 furnished by an employer must include reportable health coverage costs even if employee also receives a W-2 from a disability carrier. Even if an employee was off work all or part of the year due to sickness or disability and receives a W-2 from the third-party sick pay provider or disability insurer, that W-2 is not required to include the cost of employer-sponsored health coverage. If the employer issues a W-2, it must include reportable health coverage costs for the entire year, even for the periods for which the employee received sick or disability pay from a third party. (Q&A 39)

Future guidance will be prospective. If future guidance is issued that requires employers to report additional amounts, such guidance will be prospective only and will not apply until January 1 of the calendar year beginning at least six months after the date the guidance is issued. (Section IV)

Revised W-2 Reporting Matrix

TYPE OF COVERAGE OR COST	REPORT ON W-2	DO NOT REPORT ON W-2
Group medical coverage for employee, spouse & covered dependents. Covered dependents include any person covered by the plan because of a relationship to the employee, whether or not the individual is a dependent per the tax code, e.g., 25-year old adult child who is not a tax dependent, or a domestic partner who is not a tax dependent.	X	
Dental or vision coverage that <i>is</i> integrated into the group medical plan, i.e., insured medical and dental provided under the same contract; or self-funded dental or vision that is bundled or integrated with self-funded medical.	X	
Dental or vision coverage that meets the HIPAA definition of “excepted benefits,” i.e., insured dental and vision are provided under a separate contract from medical benefits; or self-funded dental or vision that participants can elect <u>not</u> to receive, and if they elect <u>to</u> receive it, they must pay an additional contribution for it.		X
Voluntary hospital indemnity policies or other fixed indemnity policies – where such coverage is <u>provided by the employer on an excludible or pre-tax basis</u> .	X	

TYPE OF COVERAGE OR COST		REPORT ON W-2	DO NOT REPORT ON W-2
Voluntary hospital indemnity policies or other fixed indemnity policies – where such coverage is <u>funded by the employee on an after-tax basis</u> .			X
Employee assistance program (EAP), wellness program or on-site medical clinic, if employer <u>does</u> charge a premium for such coverage under COBRA to qualified beneficiaries.		X	
Employee assistance program (EAP), wellness program or on-site medical clinic, if employer <u>does not</u> charge a premium for such coverage under COBRA to qualified beneficiaries. (Although employer is not required to include these costs in aggregate reportable coverage, it can elect to if it wishes.)			X
Voluntary coverage for specific disease or illness, such as cancer policies -- where such coverage is funded by the employee on an after-tax basis.			X
Health Flexible Spending Account (HFSA) pre-tax contributions by employee.			X
Archer Medical Savings Account (MSA) contributions.			X
Health Savings Account (H.S.A.) contributions.			X
Long-Term Care coverage.			X
Health Reimbursement Arrangement (HRA) contributions and coverage. (Employer may elect to report HRA costs, although not required to.)			X
Medical coverage provided to an individual employed by related employers:	If each employer issues a separate W-2	X	
	If one employer is the common paymaster for all wages paid to the individual:	Common paymaster X	Other employers X
Secondary or Incidental insurance benefits such as: coverage for accident or disability income insurance, medical benefits insurance issued as a supplement to liability insurance or under auto liability insurance, workers' compensation insurance, credit-only insurance, or other similar insurance (please see IRC section 9832(c)(1)).			X
Employer contributions to multiemployer plans for employee health coverage			X
Excess reimbursements of highly compensated individuals (HCIs) under IRC section 105(h), even though the excess reimbursements are included in income of the affected HCIs. (Report this amount on the W-2 as income, but not in Box 12.)			X
Coverage under a self-funded group health plan that is not subject to any federal continuation coverage requirements, e.g., a self-funded church plan.			X
Coverage under a plan maintained primarily for members of the military or for their families that is provided and maintained by any governmental entity (e.g., federal government, state or local)			X
Employer-sponsored health care provided to retirees or other former employees for whom the employer is not otherwise required to issue Form W-2s.			X
Coverage under a medical plan sponsored by an employer that is a Federally recognized Indian tribal government.			X

Does this W-2 requirement apply to you in 2012?

The 2012 reporting requirement applies to you if you are a "large employer" -- defined as one who issued at least 250 W-2s for 2011. If so, you are required to report the aggregate cost of applicable employer-sponsored group health coverage on Form W-2 starting with the 2012 tax year. Such employers should ensure that procedures are in place to capture the necessary information each payroll period. This reporting requirement applies to both grandfathered and non-grandfathered plans but does not apply to smaller employers until the 2013 tax year.

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If you have questions, contact Lisa-Klinger@Leavitt.com.

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