Arthur J. Gallagher & Co.
BUSINESS WITHOUT BARRIERS™

Updated January 2018

What Employers Need to Know About W-2 Reporting

The Patient Protection and Affordable Care Act ("PPACA") amended the Internal Revenue Code to require that employers report the aggregate cost of "applicable employer-sponsored coverage" on employee Forms W-2 in Box 12 using a DD code. This reporting is for informational purposes only, intended to provide useful and comparable consumer information to employees on the cost of their health coverage. The amount reported as applicable employer-sponsored coverage is not taxable and will not affect the amount includible in income. Despite being required for informational purposes, employers that do not comply with this reporting requirement may trigger a penalty.

CAUTION: Several items are "transitional relief," which will continue to apply until the IRS publishes additional future guidance. (Click here to view the IRS FAQs on Form W-2 reporting and transitional relief.) However, any changes will be effective prospectively and will not apply earlier than January 1st of the calendar year beginning at least six months after the guidance is issued.

Employers Subject to W-2 Reporting

Almost all employers filing 250 Forms W-2 or more during the previous calendar year will be required to report the aggregate cost of employer-sponsored coverage – including private employers; federal, state and local governments; and churches and other religious organizations. The requirement generally applies to both to insured and self-insured health coverage.

Employers Exempt from W-2 Reporting

Generally, the W-2 reporting requirement does not apply to:

- Coverage provided by federally recognized Indian tribal governments;
- Coverage provided by tribally chartered corporations that are wholly owned by a federally recognized Indian tribal government (until further guidance is issued);
- Third-party sick payers who issue Forms W-2; and
- Government plans that are maintained primarily for military and their families (e.g., TRICARE).

Under transition relief (and until future guidance is issued), the W-2 reporting requirement also does not apply to the following employers.

- Employers sponsoring self-insured health plans that are not subject to federal COBRA (e.g., self-insured church plans). For example, a church plan not subject to federal COBRA, but required to provide continuation coverage under a state coverage continuation law, would not be required to report. *Employers who provide insured health plans are required to report health care coverage costs even if they are not subject to federal COBRA requirements.*

- Employers contributing to a multiemployer plan (e.g., based on employer contributions of or dollars and cents per hour). *However, if the employer provides other coverage (i.e., not through the multiemployer plan), then the cost of that coverage must be reported.*

- Employers who issue fewer than 250 Form W-2s for a calendar year (note that the number of Forms W-2 is not determined by controlled group rules under IRS Code Section 414).

Employees Required to be Reported

The W-2 reporting does not create a requirement to provide Forms W-2 to any individuals who would not otherwise receive a Form W-2. For example, an employer would not be required to provide Forms W-2 to retirees just to report the aggregate cost of their retiree health coverage. Expatriate health plans are also exempt from W-2 reporting.

Special Situations

Special situations arise when an employee has multiple, related employers during a single calendar year. First, where an employee has multiple employers during a calendar year, each of those employers must report the cost of coverage it provides unless the two employers are related and have a common "paymaster." For example, an employee works for two related employers at the same time, and one of the two employers issues paychecks covering services for both employers. Under the initial IRS Form W-2 reporting guidance, a common paymaster among a group of related employers, within the meaning of IRS Code Section 3121(s), would be required to aggregate reportable cost of coverage provided to an employee by all of the employers for whom the organization served as the common paymaster.

If employers are among a group of related employers within the meaning of Section 3121(s), but do not compensate an employee that is concurrently employed by a group of related employers through a common paymaster, then the related employers may either:

(1) Report the entire aggregate cost on one of the Forms W-2 provided to the employee, or
(2) May allocate the aggregate reportable cost among the employers concurrently employing the individual using any reasonable allocation method.

In other words, if the group does not use a common paymaster and thus must provide multiple Forms W-2 to an individual, the aggregate can either be reported on one Form W-2 on behalf of the whole group of related employers, or each employer in the group may report an allocated amount on the Form W-2 that the employer provides to the individual.

Second, if an employee transfers to an employer that qualifies as a successor employer, the predecessor and successor employers will each report separately the cost of coverage on their respective Forms W-2. However, the successor employer may report the aggregate cost of coverage for both in accordance with IRS guidelines. If the successor reports the aggregate coverage for both, the predecessor employer must not report the cost of coverage.

Employee Terminating in Mid-Year

Employers furnishing a Form W-2 to employees who terminate before the end of the calendar year and request a Form W-2 before the end of that calendar year if the employer normally provides a Form W-2 in

January. Generally, an employer is required to provide a Form W-2 to a terminated employee within 30 days after receipt of a written request. The exemption for mid-year Form W-2s is only for a situation in which a Form W-2 is provided upon an employee's request.

Employer-Sponsored Coverage Included in the Aggregate Cost Reported

Most employer-provided health coverage must be included when reporting the cost of health coverage in Box 12 using Code DD. Types of coverage that are includable:

- Medical;
- Prescription drug;
- Dental (if not a HIPAA-excepted benefit);
- Vision (if not a HIPAA-excepted benefit);
- Hearing;
- Wellness program that qualifies as a health benefit[1] if the employer charges a COBRA premium for continuation of coverage;
- Health flexible spending accounts ("FSAs") where the employer's contributions exceed the employee's salary reduction election (see "How to Calculate the Cost of Coverage" below);
- Employee Assistance Plan that provides counseling and/or treatment if the employer charges a COBRA premium for continuation of coverage;
- On-site medical clinics if the employer charges a COBRA premium for continuation of coverage;
- Specified disease or hospital indemnity insurance (unless the employee pays the full cost after-tax)
- Executive medical coverage, including executive physical and screenings as well as any supplemental coverage;
- Medicare supplement coverage[2]; and
- Domestic partner coverage and coverage for a non-tax dependent even if the cost is included in employee's gross income.

Excluded Coverages

There are some types of health care coverage that are not includable when reporting using Code DD. Reporting is not required for:

- Specified disease or hospital indemnity insurance if the employee pays 100% of the cost on an after-tax basis;
- Health savings accounts (reportable using Code W);[3]

[1] Whether a wellness plan satisfies the definition of a health plan depends on the facts and circumstances. A wellness plan that provides a reward for completing a Health Risk Assessment would **not** qualify as a health plan. A wellness plan that provides flu shots or includes diagnostic tests or biometric screening would qualify as a health plan.
[2] Limited to employers with fewer than 20 employees because of the Medicare Secondary Payer rules.
[3] Employer contributions (and any employee contributions made under a cafeteria plan) to an HSA should be included in Box 12, using Code W, but should not be included in the amount reported for the cost of employer-sponsored coverage in Box 12 using Code DD.

- Archer Medical Savings Accounts (reportable using Code R);[4]
- Self-insured coverage not subject to federal COBRA continuation;
- Salary reduction contributions to a health FSAs;
- Accident or disability only coverage;
- Workers' compensation;
- Liability insurance;
- Supplemental liability insurance;
- Credit-only insurance;
- Automobile medical payment insurance;
- Long term care insurance;
- Health insurance costs for self-employed individuals;
- Health insurance costs for a 2% or greater shareholder-employee of an S-corporation (do not have to be reported on Form W-2 if the individual is required to include the premium payments in his or her gross income); and
- Excess reimbursements for highly compensated individuals required to be included in those individuals' gross income as a result Section 105(h) of the Internal Revenue Code.

Under transition relief (and until future guidance is issued), the W-2 reporting requirement also does not apply to:

- Dental and/or vision that qualify as HIPAA excepted benefits (insured or self-insured);[5] and
- Health reimbursement arrangements.

How to Calculate the Cost of Coverage

The reportable cost is the aggregate cost for includible coverage – employer contributions, employee pre-tax contributions and employee after-tax contributions (as applicable). It must include the cost for coverage where the cost of coverage is taxable to the employee, such as the cost of coverage for an older child or domestic partner who is not the employee's tax dependent. For example, if the cost of single coverage is $5,000 and the cost of coverage for an employee plus a domestic partner is $10,000, and the domestic partner is not the employee's tax dependent, the total cost of $10,000 would be included in Box 12. Only $5,000 of the $10,000 cost of coverage should be included in Box 1 as taxable income.

Cost is defined as the COBRA cost minus the 2% administrative charge permitted by COBRA. For an insured plan, the cost is equal to the total premium charged by the insurance company. For a self-insured plan, it is the COBRA cost calculated using one of two methods: (1) the past cost method; or (2) the actuarial method. (Note: The IRS has not provided regulations on calculating COBRA costs under self-insured health plans, but future guidance would be appreciated.)

[4] Employer contributions to an Archer MSA should be included in Box 12 using Code R, but should not be included in the amount reported for the cost of employer-sponsored coverage using Code DD.

[5] Generally, dental or vision benefits are HIPAA excepted benefits if they are either: (1) offered under a separate policy, certificate, or contract of insurance; or (2) participants must have the right not to elect the dental or vision benefits, or if the TPA administering the dental or vision plan is not the TPA that administers the medical plan.

Special Rule Where Employer Subsidizes COBRA Cost

An employer may use a modified COBRA premium method if the employer subsidizes or uses the prior year's cost when charging COBRA premiums. IRS Notice 2012-9 includes three helpful examples.

> **Example #1**: An employer did not calculate the actuarial cost for coverage for 2012. Instead, the employer used a good faith reasonable estimate of $300 per month for single coverage. The employer subsidized the COBRA cost by charging COBRA participants only $150 per month for continuation coverage. The employer must use the $300 per month good faith estimate to report the aggregate cost for coverage for 2012.
>
> **Example #2**: An employer determined that the COBRA cost for single coverage in calendar year 2011 was $350 per month and charged the full COBRA premium of $357 ($350 x 102%). The employer knows that the cost for COBRA coverage for 2012 is not less than the 2011 amount and decides to charge the 2011 COBRA rate of $357 per month in 2012 rather than calculate the 2012 COBRA rate. The employer must use $350 ($357 minus the $7 administrative charge) to calculate the amount reportable for calendar year 2012.
>
> **Example #3**: An employer makes a good faith estimate of the COBRA premium for single coverage of $500 per month for calendar year 2012. The employer decides to charge $350 per month to ensure that it is compliance with COBRA requirements despite not calculating the actual COBRA premium for 2012. The employer must use $500 per month to calculate the amount reportable for 2012.

Special Rule for Cafeteria Plans with Credits Allocated to a Health FSA

Form W-2 reporting requirement does not apply to coverage under a health FSA if contributions are made **only** through employee salary reduction elections. For example, if an employee elects a $1,500 salary reduction to make contributions to a health FSA, and the total amount of the FSA election is $1,500, the $1,500 is not included in the amount reported as the aggregate reportable health cost. Some employers maintain health FSAs that are not funded solely by salary reductions – usually in the form of an employer "seed" or matching contribution. If the employer provides a seed or matching contribution, the amount of the employer's contribution is includable.

Calculating the includible amount for a health FSA under a cafeteria plan that uses a credit methodology involves an additional step. In general, where both employee salary reduction amounts and flex credits are contributed to a health FSA, the amount that is includable is the total election minus the amount of the salary reduction. Regulations include three sample calculations.

> **Example #1**: The cafeteria plan only allows contributions through employee salary reductions, and the employer does not offer any flex credits. An employee elects a $2,000 salary reduction for several qualified benefits, including an election of $1,500 for a health care FSA. For reporting purposes, none of the contribution to the health FSA is included in the "aggregate reportable cost."
>
> **Example #2:** An employer provides $1,000 in flex credits under a cafeteria plan. An employee elects qualified benefits that cost $3,000 (including a $1,500 health care FSA election) and makes

a salary reduction of $2,000. The amount that must be included on this employee's W-2 form is $0 because his total salary reduction amount ($2,000) is greater than the FSA election ($1,500). *(While not specified in the IRS example, the employee's election of $3,000 of qualified benefits could be a combination such as $1,200 medical + $200 dental + $100 vision + $1,500 health FSA = $3,000 qualified benefits.)*

Example #3: The employee makes a $700 salary reduction election for a health FSA. The employer provides a $700 matching amount, which gives the employee a total health FSA election of $1,400. The amount that must be included on this employee's W-2 form is $700 ($1,400 total FSA election minus $700 salary reduction amount.)

Special Rule for EAPs, Wellness Programs, and On-Site Clinics

The cost of coverage provided under an Employee Assistance Program ("EAP"), wellness program, or on-site medical clinic that qualifies as a group health plan does not have to be included in the aggregate reportable cost only if the employer does not charge a premium to any COBRA qualified beneficiary that qualifies for the EAP, wellness program, or on-site clinic during the COBRA continuation period. If the employer charges a COBRA premium for such coverage, then it must be included in the aggregate reportable cost on the Form W-2.

For example, many employers allow former employees to continue benefits under their EAP, wellness program or on-site clinic for the duration of the applicable COBRA period without charging for access because the cost of such coverage is difficult to value. Thus, employers are permitted to exclude the cost from the aggregate reportable cost for any employees of an EAP, wellness program or on-site medical clinic if those benefits are provided to qualifying beneficiaries receiving COBRA without cost. But if an employer charges a COBRA premium, the employer must include the premium in the aggregate reportable cost on the Form W-2.

Additionally, the guidance provides relief to any employer that is not subject to any federal continuation coverage requirements (i.e., ERISA, Public Health Service Act, or the Federal Employees Health Benefits Program). Specifically, an employer that is not subject to any federal continuation coverage requirement (e.g., a self-insured church plan) does not have to report the cost of coverage provided under an EAP, wellness program, or on-site medical clinic, even if the coverage qualifies as a group health plan even if the plan is subject to a state coverage continuation requirement

Special Rule for Incidental Group Health Plan Benefits

Group health plan coverage provided as an add-on or value-added program (e.g., an EAP provided "free" by a long-term disability carrier) does not have to be reported if the portion of the program providing the health benefits is only incidental in comparison to the portion of the program providing the other benefits. If the value-added program is not "incidental," the cost must be allocated and the health coverage portion of the cost included.

Special Rule for Hospital or Other Fixed Indemnity Insurance or Specified Illness Insurance

If the employer: (1) makes any contribution towards the cost of the fixed indemnity or specified illness insurance, or (2) allows employees to purchase the coverage on a pre-tax basis under a Section 125

cafeteria plan, then the cost must be included in the aggregate reportable cost. The cost of hospital indemnity or other fixed indemnity insurance or specified illness coverage does not have to be reported on Form W-2 if the employer merely provides the opportunity for employees to purchase the coverage and the employee pays the full amount of the premium with after-tax dollars.

Special Rules for S-Corporations & Excess Reimbursements for Highly Compensated Individuals

Payments or reimbursements of health insurance premiums for a 2% or greater shareholder-employee of an S-corporation do not have to be reported on Form W-2 if the individual is required to include the premium payments in his or her gross income. Under current guidance, discriminatory excess reimbursements under Section 105(h) that are includable in income must be excluded from the aggregate reportable cost.

Special Rule for Composite Rates

A special rule is applicable to employers that charge a "composite rate." An employer is considered to be charging a "composite rate" if: (1) all employees are charged the same premium for coverage under the plan, regardless of scope of the coverage (e.g., single or family coverage); or (2) there are different levels of coverage (e.g., employee-only and employee plus family) and employees are charged the same premium for each level (e.g., all employees pay $200 for single coverage and $500 for family coverage).

For employers that charge a composite rate for active employees, but do not use a composite rate to determine applicable COBRA premiums for qualifying beneficiaries, the employer may use either the composite rate or the applicable COBRA premium to determine the aggregate cost of coverage reported on the Form W-2, but it must use the same method consistently for all active employees and for all qualifying beneficiaries.

How the Cost of Coverage is Reported

All costs must be reported on a calendar year basis, regardless of the employer's plan or policy year. The calendar year amount will be equal to the sum of the actual monthly amounts. Proration of the cost of coverage for a coverage period that is less than one month is permitted as long as the method used is reasonable and the same method is used for all employees.

An employer is not required to report $0 using Code DD if the employee does not have health coverage. If married employees are employed with the same employer, and one employee has family coverage (and the spouse waives coverage), the cost of family coverage is only to be included on the Form W-2 of the employee who elected family coverage.

If there is a change in the cost during the calendar year, such as a change in insurance premium rates, that change must be reflected. For example, if premium rates increase from $100 to $105 on July 1, then $100 cost must be used for January - June and the $105 for July - December. Similarly, if an employee's cost changes during the year as the result of a status change (e.g., coverage changes from single to family), the cost on the W-2 must reflect the change. IRS guidance provides three examples.

> **Example #1**: Employer with an October 1 - September 30 plan year has a monthly rate for self-only coverage of $500 for the period October 1, 2014 - September 30, 2015 and a rate of $520 for

the period October 1, 2015 - September 30, 2016. The cost for self-only coverage for calendar year 2015 must be reported as $6,060 ($500 x 9 months + $520 for 3 months).

Example #2: The cost for coverage under an employer's plan is $500 per month for self-only coverage and $1,000 per month for employee plus spouse coverage. An employee has self-only coverage for January - June and employee plus spouse coverage for July - December. The employer must report a cost of $9,000 for the calendar year ($500 x 6 months + $1,000 x 6 months.)

Example #3: The monthly cost for self-only coverage is $500. A newly-hired employee begins coverage on March 14, 2015 and maintains self-only coverage from March 14 through the end of the calendar year. The employer may use a prorated amount of $250 ($500 x ½) for March 2015 and calculate the total cost for this employee as $4,750 ($250 + $500 x 9 months) – as long as the employer uses the same calculation method for all employees.

Impact of Status Changes after the End of the Reporting Year

Employers may rely on information available as of December 31st of the reporting year, without regard to any election or notification made by an employee after December 31st that retroactively affects coverage. Thus, if an employee provides notification of a status change in January 2018, which affects the cost of coverage in 2017, the changes in the cost of coverage need not be reflected in the aggregate reportable cost for 2017. For example, if an employee has employee plus spouse coverage at the beginning of 2017, but then provides notice in January 2018 that her child was born in December 2017 and she wants coverage increased to employee plus family coverage effective on the child's birthday, the employer need only report her aggregate reportable cost based upon employee plus spouse coverage for the entire year because that was the state of the information it had on December 31, 2017. Form W-2c does need not be furnished if a Form W-2 has already been provided for a calendar year, before the election or notification.

Special Rule for Midyear Terminations

A special rule may be used for reporting the cost of coverage for employees who terminate employment during the calendar year. The employer may include or exclude the cost of COBRA coverage as long as all former employees are treated the same. IRS guidance provides an example of two acceptable methods. Under both methods, the cost of the employee's coverage is $350 per month; the employee is active for January 1 - April 25; active coverage continues until the end of April; and the employee pays $350 per month (the 2% permissible administrative charge is not included in the example) for COBRA coverage for May through October (i.e., six months).

Method #1: The employer includes only the cost of active coverage or $1,400 for four months of non-COBRA coverage during the calendar year ($350 per month x 4 months).

Method #2: The employer includes the cost of both active and COBRA coverage (excluding the 2% administrative fee) or $3,500 for four months of active non-COBRA coverage plus 6 months of COBRA coverage ($350 per month x 10 months.)

Either method may be used as long as the employer uses the same method for all employees.

Special Rule for Retirees

A special rule may be used for reporting the cost of coverage for employees who retire mid-year and move from active to retiree health plan. During the year of retirement only, the employer may use the same approach as noted for employees who terminate mid-year and begin COBRA continuation coverage. The employer may include or exclude the cost of retiree coverage so long as all retirees are treated the same. Note that for any year that the employer provides a Form W-2 to a retiree after the year of retirement, the employer must include the cost of retiree health coverage in the "aggregate reportable cost" for that retiree. For example, if the retiree is due a Form W-2 for part-time work or for the purpose of reporting group term life insurance, then the aggregate cost of the retiree coverage must be reported on the retiree's Form W-2. However, the employer is not required to report the cost of retiree coverage if the retiree receives a Form 1099 or Form 1099R instead of a Form W-2.

Payroll Deductions that Span Two Taxable Years

Many employers make payroll deductions – as permitted by the cafeteria plan regulations – for coverage periods that relates to the end of one taxable year and the beginning of another taxable year. An employer may handle reporting of such coverage in one of three ways (provided that it does so consistently). If a coverage period includes December 31st but continues into the following year, the employer may:

(1) Treat the coverage as provided under the calendar year that includes December 31st;

(2) Treat the coverage as provided during the following calendar year; or

(3) Allocate the cost of coverage between each of the two years, using any reasonable allocation method (e.g., which generally should relate to the number of days of coverage).

Third Party Sick Pay Provider

Third party sick pay providers who furnish Forms W-2 to employees are not required to report the aggregate reportable cost of employer sponsored group health plan coverage. However, a Form W-2 furnished by an employer must include the aggregate reportable cost even if that Form W-2 includes sick pay or if a third party provider is furnishing a separate Form W-2 reporting the sick pay.

Box 12 versus Box 1 on Form W-2

The aggregate cost of health coverage is reportable, but unless it is also taxable, the amount reported in Box 12 should not be included in Box 1. For example, coverage provided to domestic partners is often taxable. Thus, an employer would include the aggregate cost of coverage including the cost of all domestic partner coverage in Box 12, but only the value of the taxable domestic partner coverage would be included as taxable income in Box 1 of the Form W-2.

Voluntary Reporting of Coverage

An employer may voluntarily report on Form W-2 the cost of coverage that is not required to be included in the aggregate reportable cost under applicable interim relief, including coverage under a Health Reimbursement Arrangement ("HRA"), a multiemployer plan, a HIPAA-excepted dental or vision plan,

an EAP, a wellness program, or on-site medical clinic, provided such coverage constitutes applicable employer-sponsored coverage and is calculated using a permissible method under the IRS Guidance.

W-2 Deadlines

The deadline to provide copies of Form W-2 to employees is January 31. Employers are required to file Forms W-2 with the IRS by January 31. If the deadline falls on a Saturday, Sunday, or legal holiday, the deadline is the next business day.

Penalties for Failure to Comply

Generally, an employer could be subject to an indexed penalty up to a calendar year maximum for failing to comply with Form W-2 reporting. For returns filed in 2018 for coverage provided in 2017, the maximum penalty is $260 per return with an overall maximum of $3,218,500. There are some limited exceptions such as where the failure was due to reasonable cause and not to willful neglect and a *de minimis* rule for corrections. There is also the potential for an increased penalty if the failure to file a correct Form W-2 is due to intentional disregard of the filing requirements.

Action Steps

Larger employers that have already been including the cost of health coverage in Box 12 on Form W-2 will want to review their plans and information collected to ensure that they will be able to include accurate information when providing Forms W-2. These employers may also want to begin preparing for the reporting that may be required for the "Cadillac plan" tax beginning in 2020. Smaller employers that will be required to report health coverage costs in Box 12 should also review and collect the necessary information in order to be ready to include health cost information when required. Please see our "Checklist for W-2 Reporting" geared towards assisting employers with identifying what information they may need for W-2 reporting.

Gallagher Benefit Services, through its compliance experts and consultants, will continue to monitor developments on healthcare reform legislation and regulation and will provide you with relevant updated information as it becomes available. In the interim, please contact your Gallagher Benefit Services Representative with any questions that you may have.

Arthur J. Gallagher & Co.
BUSINESS WITHOUT BARRIERS™

Healthcare Reform
Form W-2 Reporting

Questions & Answers for Employers

Updated January 2018

Disclaimer

We share this information with our clients and friends for general informational purposes only. It does not necessarily address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues and application of these rules to your plans should be addressed by your legal counsel.

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Under the Patient Protection and Affordable Care Act, employers are required to include the cost of providing health coverage to employees and family members. Following are a number of frequently asked questions about this reporting requirement.

1. Which employers are subject to Form W-2 reporting?

Almost all employers filing 250 Forms W-2 or more during the previous calendar year are required to report the aggregate cost of employer-sponsored coverage – including private employers; federal, state and local governments; and churches and other religious organizations. The requirement generally applies to both grandfathered and non-grandfathered plans, as well as to insured and self-funded health care coverage.

Employers that are exempt from the reporting requirement are:

- Employers filing fewer than 250 Forms W-2 for the previous calendar year (for example, employers filing fewer than 250 Forms W-2 for taxable year 2017 will not be required to report the cost of coverage on the 2018 Forms W-2);
- Employers sponsoring self-funded plans that are not subject to federal COBRA continuation coverage such as self-funded church plans;
- Government plans that are maintained primarily for military and their families (e.g., TRICARE);
- Third-party sick payers who issue Form W-2; and
- Federally recognized Indian tribal governments and tribally chartered corporations that are wholly owned by a federally recognized Indian tribal government.

2. What coverages are included in the amount that the employer must report on Form W-2?

The aggregate cost of health coverage is the total cost of coverage provided to the employee under all employer-sponsored coverage including:

- Medical coverage;
- Dental and vision that are <u>not</u> HIPAA excepted stand-alone plans (i.e., coverage offered under a separate policy, certificate, or contract of insurance or participants must have the right not to elect the dental or vision benefits, or (3) if the TPA administering the dental or vision plan is not the TPA that administers the medical plan;
- Prescription drug coverage;
- Executive physical benefits;
- On-site clinics*;
- EAPs that provide medical care*;
- Wellness programs that provide medical care*;
- Medicare supplemental policies;
- Health FSA – employer contributions only (e.g., “seed” or match); and
- Hospital or other fixed indemnity insurance or specified illness insurance if the employer makes any contribution towards the cost of the fixed indemnity or specified illness insurance or allows employees to purchase the coverage on a pre-tax basis under a Section 125 plan.

**See below for more details and exceptions*

3. Our EAP and wellness programs are considered group health plans but the cost is so little we don’t charge a premium to COBRA qualified beneficiaries to access them. Do we still have to include their cost in the aggregate reportable cost?

No. The cost of coverage provided under an EAP, wellness program, or on-site medical clinic that qualifies as a group health plan subject to COBRA does not have to be included in the aggregate reportable cost if you do not charge COBRA qualified beneficiaries to access those benefits. However, if you charge a COBRA premium for such coverage, then it must be included in the aggregate reportable cost on Form W-2.

4. We offer an EAP to our employees that our long-term disability insurer provides for no additional cost as an add-on to the LTD benefits. Do we still have to include it in the aggregate reportable cost?

No. Group health plan coverage provided as an add-on or value-added program does not have to be reported if the EAP portion of the program providing the health benefits is only incidental in comparison to the portion of the program providing the disability benefits.

5. We are a church plan and our medical plan is self-funded and our dental and vision are excepted benefits so we are not required to report them. Do we still have to report the cost of our EAP or wellness program?

No. Because your plan is not subject to COBRA or any other federal continuation coverage requirement you do not have to report the cost of coverage provided under an EAP, wellness program, or on-site medical clinic, even if they qualify as group health plans.

6. Is there coverage we don't have to include in the reporting?

Yes. Your reporting should not include:

- Long term care;
- Accident, or disability income benefits;
- Health reimbursement arrangements (delayed until further notice);
- Specific disease, indemnity, etc. coverage if not excludable from employee's gross income;
- Specified illness or disease policies such as cancer policies where the full premium is paid by the employee on an after-tax basis;
- 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;
- Employee salary reduction contributions to a Health FSA;
- Wellness programs that do not provide health benefits; and
- Referral-only EAP.

* Employer contributions (and any employee contributions made under a cafeteria plan) to an HSA or QSEHRA should be included in Box 12, using Code W, but should not be included in the amount reported for the cost of employer-sponsored coverage in Box 12 using Code DD.

7. What value should we use for the costs that must be reported?

If your plan is insured, you can use the premium charged by the insurer as the reportable amount. If your plan is self-funded, you may calculate the reportable cost using the COBRA applicable premium (minus the 2% admin fee).

8. Our insurer charges us a composite rate for all covered employees. Do we report the same amount for every employee?

Yes. Where the insurer is charging a single composite rate for all employees, you can use that composite rate to calculate the reportable cost.

9. We are an S corporation and our 2% or greater shareholder-employees are required to include the value of group health plan premium payments we make on their behalf in their income. Would we still have to also report this cost in Box 12 of their Form W-2?

No. Payments or reimbursements of health insurance premiums for a 2% or greater shareholder-employee of an S corporation do not have to be reported in Box 12 on the Form W-2 if the individual is required to include the premium payments in gross income.

10. What do we do when an employee terminates employment in the middle of the year?

You may apply any reasonable method of reporting the cost of coverage for an employee who terminated employment during the calendar year, provided that the method is used consistently for all employees receiving coverage who terminate employment during the year. For example, calculating the total cost per month and then multiplying it by the number of covered months is a reasonable method.

Under the transition rules that apply until future guidance, if the terminated employee requests a FormW-2 before the end of the calendar year, the employer is not required to report any amount of health benefits on that Form W-2.

11. What amount do we report if there is a cost or coverage change in the middle of the year?

The reportable cost must reflect the increase or decrease in cost for the periods to which the increase or decrease applies.

If an employee changes coverage during the year (e.g. terminates coverage, changes plan options, adds or drops dependents) the reportable cost must take into account the change in coverage by reflecting the different reportable costs for the coverage elected by the employee for the periods the employee had coverage.

If the change in coverage is 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.

12. What happens if the employee notifies us of a coverage change that may have an effect on the aggregate reportable cost for the previous year? For example, if one of our employees notifies us of a divorce in January that occurred in the preceding year and would reduce the cost of the employee's coverage for that year?

The aggregate reportable cost for a calendar year reported on Form W-2 may be based on the information available to you as of December 31 of the calendar year. Therefore, if an employee notifies you of a coverage change in the subsequent calendar year that has a retroactive effect on his or her coverage for the prior year, you are not required to include it in the calculation of the aggregate reportable cost for that prior year. In addition, you are 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 notification (for example, if a Form W-2 is provided to employees on January 15, and an employee notifies you of a retroactive change on January 20).

13. We contribute to a multiemployer plan for our union employees. Do we have to report that contribution or the value of the multiemployer plan coverage on the union employee's Form W-2?

No. Neither the amount you contribute nor the cost of the coverage provided to an employee under a multiemployer plan must be included when determining the aggregate reportable cost that must be reported on the Form W-2.

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January 2018

W-2 Reporting: Comparison of Amounts Reportable in Code DD, Box 12 and Box 1

Type of Coverage & Individual Covered	Box 12	Box 1
Medical, Drug, Hearing, EAP, On-Site Clinic, Executive Medical, Wellness[1]		
Employee, spouse, child, and tax dependent[2]	Yes	No
Non-tax dependent[3]	Yes	Yes
Self-funded medical NOT subject to COBRA (e.g., church plans)		
Employee, spouse, child, and tax dependent	No	No
Non-tax dependent	No	Yes
EAP, Wellness, On-Site Clinic NOT subject to COBRA[1]		
Employee, spouse, child, and tax dependent	No	No
Non-tax dependent	No	Yes
Dental and/or Vision that is NOT HIPAA Excepted Benefit		
Employee, spouse, child, and tax dependent	Yes	No
Non-tax dependent	Yes	Yes
Dental and/or Vision that is HIPAA Excepted Benefit		
Employee, spouse, child, and tax dependent	No	No
Non-tax dependent	No	Yes
Health FSA (employee, spouse, child, and tax dependent only)		
Salary reduction amount	No	No
Employer contribution other than salary reduction amount	Yes	No
Heath Reimbursement Arrangement		
Employee, spouse, child, and tax dependent	No	No
Non-tax dependent	No	Yes
Health Savings Account (HSA), Archer Medical Savings Account[4]**, and Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)**	No	No

[1] EAP and wellness included only if they meet the definition of a health plan and employer charges a COBRA premium. Excludes EAP that is referral only or an incidental benefit under a LTD contract.
[2] Includes spouse, employee's natural, adopted, step or foster child until the end of the calendar year the child reaches age 26 and any other individual who is the employee's tax dependent.
[3] Value of coverage must be imputed as income to the employee.
[4] Employer contributions to an Archer MSA should be included in Box 12 using Code R, but should not be included in the amount reported for the cost of employer-sponsored coverage using Code DD. Employer contributions (and any employee contributions made under a cafeteria plan) to an HSA should be included in Box 12, using Code W, but should not be included in the amount reported for the cost of employer-sponsored coverage in Box 12 using Code DD. Contributions to a QSEHRA should be included in Box 12 using Code FF, but also should not be included as part of the cost of employer-sponsored coverage in Box 12, Code DD.

Type of Coverage & Individual Covered	Box 12	Box 1
Employee, spouse, child, and tax dependent Non-tax dependent	No	No
Specific Disease, Hospital Indemnity Employee pays 100% of premium after-tax Employer contribution or employee pre-tax premium payment	 No Yes	 No Yes
HIPAA Excepted Coverage (e.g., accident or disability only coverage, workers' compensation, liability, supplemental liability, auto medical payment insurance, credit only insurance)	No	Maybe[5]
Long Term Care	No	Maybe[5]
Excess reimbursement to highly compensated employee under a self-insured health plan	No	Yes
Employer contribution to multi-employer plan	No	Maybe[5]

Note: Medicare supplements (small employers only because of Medicare Secondary Payer law), reported and taxed the same as medical.

Gallagher Benefit Services, through its compliance experts and consultants, will continue to monitor developments on healthcare reform legislation and regulation and will provide you with relevant updated information as it becomes available. In the interim, please contact your Gallagher Benefit Services Representative with any questions that you may have.

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[5] Tax status based on the facts and circumstances – may be taxable in some cases, not taxable in others.

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Quick Reference Tool
What Is Included in W-2 Reporting

Coverage	Yes	No
Primary medical	✓	
Prescription drug	✓	
HIPAA excepted dental (not integrated with group health plan)		✓
HIPAA excepted vision(not integrated with group health plan)		✓
Long-term care		✓
Medicare supplemental*	✓	
Medicare Advantage*	✓	
Health Savings Accounts (“HSAs”)**		✓
Health Reimbursement Accounts (“HRAs”)		✓
Qualified Small Employer Health Reimbursement Arrangements (“QSEHRAs”)**		✓
Accident, disability and disability (“AD&D”)		✓
On-site medical clinics (but only if employer charges COBRA premium)	✓	
Self-insured plans not subject to COBRA (e.g., church plans)		✓
Employer contributions to multiemployer plans		✓
Employer contributions to health FSA (including flex credits employee elects to apply)	✓	
Employee contributions to HIPAA excepted benefit paid on after-tax basis (e.g., hospital or fixed indemnity plan or specified disease or illness insurance)		✓
Employer contributions or employee contributions paid on pre-tax basis for hospital or fixed indemnity plan, or specified disease or illness insurance	✓	
Employee salary reduction contributions to health FSA		✓
Workers’ compensation		✓
Liability insurance, Credit-only insurance, Automobile medical insurance		✓
Coverage provided by a governmental entity for members of military of military families		✓
Excess reimbursements of highly compensated individuals under IRC section 105(h)		✓
Wellness benefits that provides medical benefits and employer charges COBRA premium	✓	
Employee assistance plan that provides counseling and/or treatment and employer charges COBRA premium	✓	
Incidental employee assistance or similar benefit under an LTD Contract (or referral only plan)		✓
Executive medical coverage (includes executive physical and screenings and supplemental coverage)	✓	
Health insurance costs for self-employed individuals		✓
Health insurance cost for 2% shareholder in Subchapter S-corporation if includable in income		✓

* Small employers only because of Medicare Secondary Payer law.

** Employer contributions to an Archer MSA should be included in Box 12 using Code R, but should not be included in the amount reported for the cost of employer-sponsored coverage using Code DD. Employer contributions (and any employee contributions made under a cafeteria plan) to an HSA should be included in Box 12, using Code W, but should not be included in the amount reported for the cost of employer-sponsored coverage in Box 12 using Code DD. Contributions to a QSEHRA should be included in Box 12 using Code FF, but also should not be included as part of the cost of employer-sponsored coverage in Box 12, Code DD.

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Checklist for Form W-2 Reporting

- ☐ Identify applicable employer-sponsored group health plan coverage that is subject to the Form W-2 reporting requirement.
- ☐ Determine COBRA applicable premium (or other permitted cost valuation) for applicable employer-sponsored group health plan coverage.
- ☐ Compile and review health coverage cost reporting information and materials provided by payroll vendor, if applicable.
- ☐ Identify what information on health coverage is currently being collected and transmitted to payroll.
- ☐ Determine what additional information (if any) must be collected.
- ☐ Determine what information on health coverage is being collected but should be excluded from the Box 12 calculation (e.g., HIPAA-excepted dental and/or vision, etc.).
- ☐ Determine what information on health coverage (if any) should be included in the Box 12 calculation and also be included in the Box 1 calculation (e.g., coverage for a domestic partner).
- ☐ Verify that cost information is based on actual coverage level elected by employee.
- ☐ **(Optional)** When reviewing what should be provided to payroll, employers may also want to consider the type of reporting that may be required for the “”Cadillac” plan tax beginning in 2020. While similar, there are differences such as the type of health coverage that must be included.
- ☐ Decide how to handle special circumstances (e.g., reporting for situations where coverage is part active and part COBRA because an employee terminated mid-year).
- ☐ Coordinate benefits with payroll to ensure that the appropriate information is tracked, transmitted to payroll and included correctly.
- ☐ Make any needed systems or recordkeeping changes and test the system(s) before the employer needs to begin producing Forms W-2.
- ☐ Coordinate with any disability vendor that provides Form W-2 services for a self-insured, short-term disability plan (some carriers and TPAs that provide “advice to pay” services on disability claims also provide W-2 information forms reflecting disability payments made on behalf of the employer). If the employer provides a Form W-2 for regular wages paid during part of the year when the employee was not disabled and the disability vendor provides a Form W-2 for the part of the year when disability benefits were paid, then the employer must include the full amount on its Form W-2.

- Develop communications that will explain the W-2 reporting requirement and reassure employees that this provision does not affect the tax status of their coverage. A GBS sample employee communication is available here.
- Determine if the employer can/wants to include the monthly cost (on an informational basis) on employee paystubs.
- Employers may want to use this as an opportunity to help employees understand the value of their health benefits. For any future compensation, total rewards, or benefits cost decisions, include PR impact of any change to value shown in Box 12 with respect to value shown in Box 1.
- For off-calendar-year plan years, remember that costs must be reported on a calendar-year basis, regardless of plan year. So, at enrollment, update all of the above to reflect any benefit and cost changes that occur at enrollment.
- Employer contributions (and any employee contributions made under a cafeteria plan) to an HSA should be included in Box 12, using Code W, but should not be included in the amount reported for the cost of employer-sponsored coverage in Box 12 using Code DD. Contributions to a QSEHRA should be included in Box 12 using Code FF, but also should not be included as part of the cost of employer-sponsored coverage in Box 12, Code DD.
- Stay tuned for further guidance, which will be applied on a prospective basis.

Gallagher Benefit Services, through its compliance experts and consultants, will continue to monitor developments on healthcare reform legislation and regulation and will provide you with relevant updated information as it becomes available. In the interim, please contact your Gallagher Benefit Services Representative with any questions that you may have.

Form W-2 Reporting Sample Employee Communication

Attached is a sample communication letter that employers may use to provide employees an explanation of the required reporting of the total cost of employer-sponsored health coverages on Form W-2. This communication explains why it is being reported, the requirements of the reporting, including the type of coverage that is reportable, the type not reportable and emphasizes that the amount is for information purposes only. It is not subject to tax or withholding.

In the text of the letter, there is text that appears in red font that requires customization, including lists of coverage types that require and do not require reporting. Employers should review and modify the lists to match the benefit plans that they actually sponsor, in order to indicate which benefits are used or not used in calculating the total cost of employer sponsored health coverages for the purpose of the Form W-2 disclosure.

W-2 REPORTING OF HEALTH CARE BENEFITS

The Patient Protection and Affordable Care Act requires us to report the total cost of your health benefits on your Form W-2. Do not be concerned: this required reporting is for information purposes only, and it does not represent a new tax.

What Needs To Be Reported

Contributions: The total cost of your health care benefits reported will include both your contribution to the cost of your health coverage as well as the Employer's contribution.

Types of coverage: The employer-sponsored coverages included in the calculation vary based on the coverage offered by each employer. Generally, the type of coverage included in the calculation will be: [**select applicable benefits –** medical; integrated dental and vision; hearing; employee assistance plans; on-site medical clinics; health flexible spending accounts (contributions by the employer only); specified disease or hospital indemnity insurance (unless the employee pays the full cost after tax); executive medical coverage; wellness benefits (if the program qualifies as a health plan); and Medicare supplement coverage (for certain employers)].

Certain employer –sponsored coverages are not included: [s**elect applicable benefits –** Health Savings Accounts; Archer Medical Savings Accounts; Health Reimbursement Arrangements; Hospital Indemnity Insurance (if the employee pays the full premium on an after-tax basis); and accident and disability policies].

Remember, this reporting of the cost of your health care benefits is for information purposes only.

Where It Will Be Reported

This total cost of health care benefits will be reported in Box 12 of your Form W-2, and it will be labeled "Code DD." On the Form W-2, Box 12 is used for reporting many different kinds of information. The different types of information are each labeled with a certain code, which the IRS assigns. Due to the healthcare reform law, the IRS has created Code DD as a label for the reporting of the total cost of your employer-sponsored health care benefits.

In January, when you receive your Form W-2, look at Box 12, and find Code DD. This will be the amount that we have determined is the total cost of your employer-sponsored health care benefits for the previous year. This amount will not be taxed because this amount is for information purposes only.

Questions

If you should have questions, please direct your inquiry to: [insert contact information for Human Resources].