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What Employers Need to Know about Form W-2 Healthcare Coverage Reporting

The Patient Protection and Affordable Care Act (ACA) amended the Internal Revenue Code (IRC) 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 (Form W-2, Box 1). 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 Form 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.

Note: On July 1, 2019, President Trump signed the Taxpayer First Act (the Act) into law. The Act lowered the threshold for electronic filing of information returns beginning in 2021 from 250 to 100 Forms W-2 and 1099 and thus the reporting requirement. The Act further decreased the threshold to 10 Forms for calendar years after 2021. However, the IRS issued a statement that the electronic filing threshold will remain at 250 until regulations are issued. As of April 15, 2022, the IRS had not issued such regulations.

A waiver from the electronic filing requirement will apply to areas without internet access.

Employers Exempt from Form W-2 Reporting

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

- Coverage provided by federally recognized Indian tribal governments;

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- 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. *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 IRC Section 414).

Employees Required to be Reported

The Form 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 IRC Section 3121(s), would be required to aggregate

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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 amount 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

Generally, an employer is required to provide a Form W-2 to a terminated employee within 30 days after receipt of a written request. An exemption from including the health benefits cost for mid-year Forms W-2 is available in 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 includible:

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- 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 (EAP) 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 includible 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 (HSAs) (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 prohibitions on employers with 20 or more employees in 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.

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- Archer Medical Savings Accounts (reportable using Code R);[4]
- Self-insured coverage not subject to federal COBRA continuation (e.g., self-insured church plans);
- 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 (LTC) 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 gross income); and
- Excess reimbursements for highly compensated individuals required to be included in those individuals' gross income as a result IRC Section 105(h).

Under transition relief (and until future guidance is issued), the Form 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 (HRAs).

Qualified Small Employer HRAs (QSEHRAs) are subject to reporting on the Form W-2, box 12, code FF; however, the amount is not required to be included in box 12, using code DD. Although the IRS released final Individual Coverage HRA (ICHRA) regulations in January 2021, the Biden Administration issued a memorandum on January 20, 2021 freezing certain regulations pending review by the new administration. As a result, employers will need to wait until further action is taken by the Biden Administration to rely on the 2021-issued final ICHRA regulations.

[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 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.

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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 guidance would be appreciated.)

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. Three helpful examples based upon IRS Notice 2012-9 include the following:

> **Example #1**: An employer did not calculate the actuarial cost for coverage for 2021. 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 2021.
>
> **Example #2**: An employer determined that the COBRA cost for single coverage in calendar year 2020 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 2021 is not less than the 2020 amount and decides to charge the 2020 COBRA rate of $357 per month in 2021 rather than calculate the 2021 COBRA rate. The employer must use $350 ($357 minus the $7 administrative charge) to calculate the amount reportable for calendar year 2021.
>
> **Example #3**: An employer makes a good faith estimate of the COBRA premium for single coverage of $500 per month for calendar year 2021. The employer

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> decides to charge $350 per month to ensure that it is compliance with COBRA requirements despite not calculating the actual COBRA premium for 2021. The employer must use $500 per month to calculate the amount reportable for 2021.

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

The 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, then 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 employee 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 includible.

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 includible is the total election minus the amount of the salary reduction. Examples based upon the regulations include the following:

> **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 FSA election) and makes a salary reduction of $2,000. The amount that must be included on this employee’s Form W-2 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 Form W-2 is $700 ($1,400 total FSA election minus $700 salary reduction amount).

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

The cost of coverage provided under an 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 qualified beneficiaries receiving COBRA without cost. But, if an employer charges a COBRA premium for those benefits, 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

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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 does not have to be reported on Form W-2 if the individual is required to include the premium payments in gross income. Under current guidance, discriminatory excess reimbursements under Section 105(h) that are includible 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 qualified 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.

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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, 2020 - September 30, 2021 and a rate of $520 for the period October 1, 2021 - September 30, 2022. The cost for self-only coverage for calendar year 2021 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, 2021 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 2021 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 2022, which affects the cost of coverage in 2021, the changes in the cost of coverage need not be reflected in the aggregate reportable cost for 2021. For example, if an employee has employee plus spouse coverage at the beginning of 2021, but then provides notice in January 2022 that her child was born in December 2021 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, 2021. 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.

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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 midyear 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 relate to the end of one taxable year and the

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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 an 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.

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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 2022 for coverage provided in 2021, the maximum penalty is $290 per return with an overall maximum of $3,532,500. 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. 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 Form W-2 reporting.

The intent of this analysis is to provide general information regarding the provisions of current federal laws and regulation. It does not necessarily fully address all your organization's specific issues. It should not be construed as, nor is it intended to provide, legal advice. Your organization's general counsel or an attorney who specializes in this practice area should address questions regarding specific issues.

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