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IRS FORM W-2 INFORMATION REPORTING REQUIREMENTS FOR GROUP HEALTH PLANS

Beginning in 2012, health care reform requires employers to report the aggregate cost of their employer-sponsored health coverage on employees' Form W-2s. While the first W-2s to be affected will be those issued by employers in 2013 (for the 2012 calendar year), capturing the information necessary to meet the reporting requirements must begin January 1, 2012. This manual provides guidance to the steps that need to be taken now in order to be ready to do so. We hope that this will be a practical tool to help you start evaluating your reporting requirements, but is not intended to be an exhaustive treatment of all of the new reporting rules.

Briefly, the new rules require employers to calculate the total "reportable cost" of the health benefits provided to their employees. The reportable cost includes both the employer and employee share of the costs, and includes both non-taxable and taxable benefits. The report is informational only – employees are not subject to tax on the amounts reported. The cost is to be reported on IRS Form W-2 in Box 12 using Code DD.

This manual has been updated as of January 3, 2012 to incorporate the following revised guidance the Internal Revenue Service issued in Notice 2012-9:

- The cost of coverage for employee assistance programs, on-site medical clinics and wellness programs must be reported only where an employer charges COBRA premiums for such coverage.
- Clarification that stand-alone coverage for a specified disease or illness and stand-alone hospital indemnity or other fixed indemnity benefits:
    - Is required to be reported if the employee can pay for such coverage on a pretax basis or the employer makes contributions towards the cost of coverage.
    - Is NOT required to be reported if the employee's payment for those benefits is includable in the employee's gross income (i.e., not offered under a cafeteria plan) and the employer is merely providing the opportunity for employees to purchase the benefit on an independent non-coordinated basis.
- An additional example regarding whether contributions to a health care flexible spending account must be reported.
- Employers that are tribally charted corporations wholly-owned by a Federally recognized Indian tribal government are not subject to the reporting requirements (at least until further guidance is issued).

More detailed information, and issues to consider, are outlined below.

1. Which employers are subject to these new reporting rules?	***Comments, Considerations and Action Items***
General Rule: Most employers who provide employee health benefits must comply with the rules. There are some very limited exceptions.	
Exceptions:	
• There is a temporary exemption for employers who are required to file fewer than 250 Forms W-2 in the prior calendar year. This exemption will apply until further guidance is issued (and at least through 2012). It is outside the scope of this manual to provide detailed instructions on this exception. Please contact us if you have questions about whether this might apply to you.	*This is an employer-based determination; the number of covered employees will not be dispositive. If you have subsidiaries and other entities that do their own payroll reporting, some of them may not be subject to the requirements.* ***Action Item: Start now to identify any entities that are likely to be exempt. If you have related employers who use a common paymaster, you must make sure that the proper entity reports and that there is no duplicative reporting.***
• Until further guidance is issued (and at least through 2012), if the only health benefits provided by an employer are (1) self-insured and not subject to the COBRA continuation coverage or similar federal continuation requirements, (2) provided under a multi-employer plan, or (3) a health reimbursement arrangement, the employer is not subject to the reporting requirements. (See Question 3, "Which plans must be included in the reporting requirements?")	
• Federally-recognized Indian tribal governments are not subject to the reporting requirements. Until further guidance is issued, employers that are tribally chartered corporations wholly-owned by a Federally recognized Indian tribal government are also not subject to the reporting requirements.	
2. Which employees are subject to the reporting rules?	
You are only required to report coverage costs for employees for whom you are otherwise required to file a Form W-2 for the calendar year. This will generally include all current employees and those who terminated employment during the year. You are not required to report coverage costs for retirees, employees who terminated in a prior calendar year, independent contractors or COBRA beneficiaries (assuming the person is not receiving any compensation during the year that you would otherwise be required to report on a Form W-2). (Special rules apply to employees who transfer to a "successor employer"	*Remember that you may not know until the end of the year whether or not reporting is required for a particular employee, so you may have to track all covered employees in order to be able to calculate reportable costs at year's end.* ***Action Item: Start now to work with your payroll department or vendor to determine what steps need to be taken to***

during the year. Please contact us if you have questions about this.)	***prepare for tracking this information during the year.***
3. Which plans must be included in the reporting requirements?	
General Rule: The coverage costs of most group health plans must be reported. However, some common types of plans are excluded from the reporting requirements, while others that you might not think of will be subject to reporting.	***Action Item: Identify all covered plans now.***
Definition of Group Health Plan: As a starting point, any plan that is sponsored or provided by the employer or employee organization and that provides coverage for health care is considered a group health plan. And, any plan that is subject to COBRA or similar coverage continuation rules will be considered to be a group health plan. However, some group health plans are exempted from the reporting requirements. Examples of covered and exempted plans are listed below.	
Examples of the types of coverage that ARE subject to reporting requirements:	
• Medical	
• Dental (except stand-alone plans – see below)	
• Vision (except stand-alone plans – see below)	
• Mental health	
• Prescription drug	
• Employee assistance programs ("EAP") that provide counseling and other treatment services. However, if an employer does not charge a COBRA premium for coverage for its EAP, then the cost of coverage does NOT need to be reported.	*Employees who are not otherwise benefit-eligible are frequently covered under an EAP.* ***Action Item: Work with your payroll department or vendor to make sure that these employees can be "captured" for reporting requirements.***
• Health flexible spending accounts (but special rules apply. See Question 5C below).	
• Individual health policies, if the coverage would not be available at the same cost if not obtained through the employment relationship. This will apply even if the employer does not pay any part of the cost of coverage. However, there is an exception for stand-alone policies that provide benefits for specified diseases, or that provide indemnity benefits (see below); such policies will not be subject to reporting.	
• Medical evacuation or other health transportation benefits	
• On-site medical clinics. Some exceptions may apply if the clinic primarily provides only first aid for treatment of illness or injury that occurs during working hours; if only current employees are eligible; and if employees are not charged for facility use. However, if an employer does not charges a COBRA premium for coverage for its on-site medical clinics, then the cost of coverage does NOT need to be reported. A detailed description of this limitation is outside the scope	

of this manual; please contact us if you have any questions about this.	
• Wellness programs. However, if an employer does not charges a COBRA premium for coverage for its wellness programs, then the cost of coverage does NOT need to be reported.	
• Stand-alone coverage for specified disease or illness if provided on a pretax basis or the employer makes contributions towards the cost of coverage.	
• Stand-alone hospital indemnity or other fixed indemnity benefits if provided on a pretax basis or the employer makes contributions towards the cost of coverage.	
Examples of coverage that is NOT subject to the reporting requirements:	
• Self-insured medical, dental, vision or other health care if the plan is not subject to COBRA or similar continuation coverage requirements under ERISA, the Public Health Services Act or the Federal Employees Health Benefits Program	
• Coverage provided primarily to members of the military and provided by a federal, state or local government or its agencies	
• Coverage under a multiemployer plan. This exception does not apply to multiple employer plans, or multiple employer welfare arrangements.	
• Stand-alone dental	
• Stand-alone vision	
• Stand-alone coverage for specified disease or illness if the employee's payment for those benefits is includable in the employee's gross income (i.e., not offered under a cafeteria plan) and the employer is merely providing the opportunity for employees to purchase the benefit on an independent non-coordinated basis.	
• Stand-alone hospital indemnity or other fixed indemnity benefits if the employee's payment for those benefits is includable in the employee's gross income (i.e., not offered under a cafeteria plan) and the employer is merely providing the opportunity for employees to purchase the benefit on an independent non-coordinated basis. .	
• Health reimbursement accounts	
• Archer MSAs	
• Health savings accounts under Code § 223(d)	
• Long term care	
• Accident-only coverage	
• Disability income	
• Liability insurance	
• Workers' compensation or similar coverage	
• Automobile medical payment insurance	
• Credit-only insurance	
4. What must be reported?	
For <u>each</u> covered plan that you identify, you must report the total cost of	*This standard requires that you*

coverage for each covered employee for the calendar year. • This includes the employer portion as well as the employee's share of the cost. • Cost is reported whether or not benefits are provided on a tax-free basis. The examples below illustrate these general rules. Remember that you need to add the costs of all of an employee's covered plans during the calendar year for final reporting purposes. (The method of calculating the cost that must be reported is described in more detail in Question 5.)	*determine the cost of coverage provided to (not just available to) each employee. For contributory plans, this will usually be plans in which the employee enrolls or elects coverage. For non-contributory benefits, coverage may be provided simply on the basis of eligibility.* ***Action Item: Establish methods for determining which employees are covered for each plan.***
Examples:	
A. The total cost of single medical coverage is $500 per month. Employee Fred is covered for the entire calendar year and pays $80 per month and the employer pays the remainder. The Form W-2 would reflect a cost of $6000 for this coverage for the year. ($500 x 12)	
B. The total cost of family medical coverage is $900 per month. Employee Jane has elected family coverage for herself, her child and her domestic partner. She pays $500 per month. Part of the premium is withheld from her paycheck on an after-tax basis to reflect the value of coverage for the domestic partner. The employer pays the remainder. Some part of this amount is treated as imputed income to Employee Jane to reflect the value of the employer's portion of the domestic partner coverage. Jane's Form W-2 would reflect a cost of $10,800 for the year ($900 x 12). Note that for these purposes only, you disregard the fact that part of the benefit is not a tax-free benefit. (The fact that Jane pays part of the premium on an after-tax basis, and the imputed income resulting from the employer's contribution, will be reflected in Jane's taxable income on the W-2, but will not be reported in Box 12.)	
5. How is the cost of coverage calculated for reporting purposes?	
The method used for calculating the "reportable cost" of coverage depends upon whether the plan is insured or self-insured. You are not required to use the same method for all covered plans, but you must use the same method for all employees in a single plan. A special rule applies for health care flexible spending account plans.	
A. Self-insured plans: COBRA applicable premium method.	
For each covered plan, you must determine the reportable cost of coverage in accordance with the rules for determining the applicable COBRA premium. (This does not include the 2% administrative fee that you may charge to COBRA participants.) If the applicable COBRA premium changes during the calendar year, the reportable cost should reflect this change.	*Covered plans subject to the reporting requirement are all generally subject to COBRA.* ***Action Item: Ensure that the applicable COBRA premium is being calculated for all***

	covered plans, even if the plan has not been administered as a COBRA plan in the past. ***Additional Action Item: If you determine that some of your group health plans have not been administered in compliance with COBRA, this may be a good time to address those issues as well.***
There are special rules for: • Calculating reportable cost for employers who do not charge the full COBRA applicable premium for COBRA beneficiaries. We have not included this method in this manual because (1) in our experience, this is an unusual practice, and (2) the alternative method for calculating reportable costs is only marginally less cumbersome. **However, the alternative method may come into play if you do not re-calculate your COBRA applicable premium each year.** • Plans that charge employees a composite rate, such as a blended rate for single and family coverage. Please contact us if you have questions about these methods.	
B. Insured plans: Premium charged method	
For fully-insured plans, the reportable cost is the premium charged by the insurer for the coverage applicable to the employee (e.g., family or single coverage) for each period during the year. If the cost charged by the insurer changes during the calendar year, the reportable cost should reflect this change.	
(Note that a fully-insured plan could also use the COBRA applicable premium method, but this would only rarely result in a different reportable cost than under the premium charged method. If you have questions about these circumstances, please contact us.)	
Example:	
An employer maintains group medical coverage with a renewal date of July 1. As of January 1, 2012, the premium charged by the insurance company (or, in the case of a self-insured plan, the COBRA applicable premium) for single coverage is $500 per month. At renewal, this charge increases to $550. For Employee Hugo, the reportable cost for this coverage for calendar year 2012 is $3300 ($500 x 6) + ($550 x 6).	
C. Health care flexible spending account plans	
The reportable cost of an employee's health care flexible spending account (HCFSA) does not include the employee's own salary reduction election. If these are the only contributions to the account, and there are no employer credits to the HCFSA or other benefit options under the cafeteria plan, there will be no costs to report for this plan. However, you may need to report costs if your plan provides any other	***Action Item: Evaluate your HCFSA and cafeteria plan design to determine whether your HCFSA will be a covered plan for reporting purposes.***

type of credit, such as:	
• matching contributions	
• opt out credits	
• flex credits, or	
• similar credits that may increase an employee's account	
If the plan offers these credits for any of the benefit options under the plan, you must determine whether the amount allocated to the employee's HCFSA exceeds the employee's total salary reduction contribution to the plan. If so, the reportable cost will be the total amount of the employee's HCFSA credits for the calendar year MINUS the amount of the employee's total salary reduction election to the cafeteria plan for the calendar year. Note that this is based on the employee's total salary reduction election, not just the amount he allocates to his health flexible spending account plan.	
Examples:	
A. Employee elects to contribution $1,500 to a health care flexible spending account offered through employer's cafeteria plan. The employer does not offer any employer flex credits. The contribution to the flexible spending account is not reportable.	
B. Employer offers a 50% matching contribution to employees' health care flexible spending accounts. There are no other benefits offered under the employer's plan. Employee Liz elects to contribute $1000 for the calendar year. The employer's matching contribution is $500, resulting in a total account balance of $1500. The reportable cost for this year is $500 ($1500 - $1000).	
C. Employer offers flexible credits of $1000 under its cafeteria plan for the calendar year. Employees can allocate these credits to any qualified benefits offered under the cafeteria plan. Employee George elects benefits for which the "price tag" results in a total salary reduction of $2000. George allocates his $3000 credit ($1000 flex credits + $2000 salary reduction) as follows: $1500 to his health care flexible spending account and $1500 toward his share of health insurance premiums. In this case, there is no reportable cost because George's salary reduction agreement ($2000) is larger than his health care flexible spending account ($1500).	
6. How do we account for mid-year changes and termination of employment?	
General rule: You must calculate the reportable cost for each "period of coverage" within a calendar year. If an employee changes coverage or terminates employment in the middle of the year, the reportable cost must reflect these changes for each "period of coverage." For most plans, the "period of coverage" will be monthly, since premiums and contributions tend to be based upon a month of coverage. However, if your plan treats premium or coverage changes on the basis of a different period, you may use that period of coverage. You are not required to use the same period of coverage for all covered plans, but you must use the same period for all employees in a single plan.	*This requirement to report costs for each period of coverage means that you will need to be able to capture mid-year enrollment changes and any resulting cost changes.* ***Action Item: Establish a "period of coverage" for each covered plan based on current payroll practices and plan premium structures..***

If there is a change in coverage during the period of coverage, you may use any reasonable method to determine the reportable cost for that period, including using the cost at the beginning of the period, at the end of the period, or averaging or pro-rating costs, provided that the same method is used for all employees in that plan.	***Action Item: Start now to work on coordinating your enrollment/change processes with payroll. Among other things, determine whether and when payroll withholding changes are made relative to the effective date of coverage under a new option in order to determine how to treat reportable costs during a period of coverage.***
Example:	
Employee Roger gets married on April 4 and requests that his new spouse be added to his coverage. This results in an increase from a total monthly cost of $500 to a total monthly cost of $900. The plan treats this coverage as being effective as of April 4, the date of the marriage. The plan decides to calculate the reportable cost by using the cost of single coverage for January, February and March, and the cost of family coverage from April on. ($500 x 3) + ($900 x 9) = $9600.	
Special rule for coverage continuing after termination of employment: It is not necessary to continue to calculate and report the cost of coverage once an employee terminates employment, as long as all former employees in the plan are treated the same. So, for example, in the case of an employee who elects COBRA coverage following termination of employment, you may calculate the reportable cost for the period of active coverage only, or you may also report the cost of COBRA coverage for the remainder of that calendar year. (After the close of that calendar year, no additional reporting is necessary unless you otherwise must provide a W-2 to that former employee for the succeeding year.)	*If an employee terminates mid-year and requests his W-2 before the end of the year, you are not required to report any cost of coverage for that employee for that year.*