



Affordable Care Act (ACA) Employer Health Coverage Reporting Requirements

Malcolm C. Slee, Esq.
Groom Law Group
December 9, 2015



Overview

- Focus on new IRS reporting requirements effective for 2015 (first filing in 2016):
 - Minimum essential coverage reporting (Code Section 6055)
 - Employer mandate reporting (Code Section 6056)
- Recap of the employer mandate rules
- Review of the forms: 1094-B and 1095-B; 1094-C and 1095-C
- Discussion of issues specifically impacting employers that participate in multiemployer plans

Introduction to Reporting Requirements

- New tax reporting requirements are foundation of IRS enforcement of various tax provisions of the ACA
 - Individual mandate (IRC section 5000A)
 - Employer mandate (IRC section 4980H)
 - Premium tax credits (“PTCs”) (IRC section 36B)
- Reporting requirements largely focus on different ACA provisions
 - IRC section 6055 – Individual mandate
 - IRC section 6056 – Employer mandate, PTCs

Introduction to Reporting Requirements

- Returns must generally be provided to the IRS by March 31st of the following year (February 28 if not filed electronically)
- Statements must be provided to applicable taxpayers/employees by January 31st of the following year
- These rules apply regardless of calendar or non-calendar year plans

Employer Mandate Basics

*“Applicable Large Employers” must **offer** medical coverage (“minimum essential coverage”) that meets certain standards to full-time employees (FTEs) and their dependent children up to age 26.*

Employer Mandate Basics

Employers with on average 50 or more **full-time** and **full-time equivalent** employees during the **preceding** calendar year are considered an “applicable large employer” and are generally subject to the employer mandate.

For each month during the **preceding** calendar year:

1. Determine how many employees worked an average of 30 or more hours per week (or 130 hours per month). This is your **full-time employee count**.
2. Add together all hours worked in the month by employees you did not count in Step A; however, not more than 120 hours in any month for one individual.
3. Divide the results in Step B by 120 (rounding down). This is your **full-time equivalent count**.
4. Add the results from Step A and Step C. This is your **total full-time employees and full-time equivalents count**.
5. Add together the totals from Step D for all 12 months, and divide by 12.

If the result from Step E is less than 50, you are not an applicable large employer. If the result from Step E is 50 or greater, you are an applicable large employer and will be subject to the employer mandate rules for the following year.

Employer Mandate Basics

Employer size	Effective for plans beginning in 2015	2016 plan year and beyond
Less than 50 full-time employees and equivalents	Does not apply	Does not apply
50-99 full-time employees and equivalents	Does not apply if certain requirements met (but reporting applies!)	Employer must offer coverage to 95% of FTEs
100 or more full-time employees and equivalents	Employer must offer coverage to 70% of FTEs	Employer must offer coverage to 95% of FTEs

Employer Mandate Basics

Employer size	Effective for plans beginning in 2015	2016 plan year and beyond
Less than 50 full-time employees and equivalents	Does not apply	Does not apply
50-99 full-time employees and equivalents	Does not apply if certain requirements met (but reporting applies!)	Employer must offer coverage to 95% of FTEs
100 or more full-time employees and equivalents	Employer must offer coverage to 70% of FTEs	Employer must offer coverage to 95% of FTEs

Employer Mandate Basics

Do you offer *minimum essential coverage*?

→ NO

→ "A-Penalty" (4980H(a))

- \$2,080 per FTE (minus first 30*)
- Only applies if a FTE receives tax credit



YES

→ Does the plan provide *minimum value*?

→ NO

→ "B-Penalty" (4980H(b))

- Lesser of \$3,120 per FTE receiving tax credit or \$2,080 per FTE (minus first 30*)

YES

→ Is the coverage *affordable*?

→ NO

YES

→ NO PENALTY!

What is a Full-Time Employee?

- **Under ACA's employer shared responsibility rules, a full-time employee is defined as someone who is employed on average at least 30 hours of service per week**
- Compare IRS Code Section 105(h) (*nondiscrimination rules for self-funded health plans and which is likely to be incorporated for insured nondiscrimination rules*) which defines part-time employees as employees whose customary weekly employment is less than 35 hours
- Your health plan (or your group insurance contract) might have a different definition of full vs. part-time
- Other federal and state laws may have a different definition of full vs. part-time
- **TAKEAWAY: Think carefully about how you define part-time employees. An employee classified as part-time could be considered full-time for certain ACA requirements**

Know Your A, B, C Forms

1095-A: Used by Health Insurance Marketplaces to report individuals enrolled in qualified health plans in the individual market

1094-B and 1095-B: Used by providers to report individuals who were enrolled in minimum essential coverage

1094-C and 1095-C: Used by Applicable Large Employers to report offers of health coverage to full-time employees (and enrollment in coverage if the coverage was self-insured)

Know Your A, B, C Forms

"A" Forms

- Only filed by Marketplaces (Exchanges)
 - Marketplaces will use to report on coverage provided to individuals enrolled in qualified health plans through Marketplaces
- Will be filed with IRS and provided to individuals

Know Your A, B, C Forms

A Form

- Offered by Marketplaces (Exchanges)
- Marketplaces use to report on coverage provided to individuals enrolled in qualified health plans through Marketplace
- Will be filed with IRS and provided to individuals

Know Your A, B, C Forms

**“B”
Forms**

**“C”
Forms**

- Used to report actual enrollment

Know Your A, B, C Forms

**“B”
Forms**

**“C”
Forms**

- Will be used by health insurers to report insured coverage, multiemployer plans to report self-insured coverage, and small employers who self-fund to report coverage

Know Your A, B, C Forms

“B”
Forms

“C”
Forms

- Large employers may use to report coverage provided to non-employees

Know Your A, B, C Forms

**“B”
Forms**

**“C”
Forms**

- Large employer may use to report coverage provided to non-employees
- However, no requirement that large employers use “B” Forms



Health Coverage

Information about Form 1095-B and its separate instructions is at www.irs.gov/form1095b.

VOID
 CORRECTED

Part I Responsible Individual

1 Name of responsible individual		2 Social security number (SSN)	3 Date of birth (if SSN is not available)
4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
8 Enter letter identifying Origin of the Policy (see instructions for codes): <input type="checkbox"/>		9 Small Business Health Options Program (SHOP) Marketplace Identifier, if applicable	

Part II Employer Sponsored Coverage (see instructions)

10 Employer name			11 Employer identification number (EIN)
12 Street address (including room or suite no.)	13 City or town	14 State or province	15 Country and ZIP or foreign postal code

Part III Issuer or Other Coverage Provider (see instructions)

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
19 Street address (including room or suite no.)	20 City or town	21 State or province	22 Country and ZIP or foreign postal code

Part IV Covered Individuals (Enter the information for each covered individual(s).)

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Health Coverage

► Information about Form 1095-B and its separate instructions is at www.irs.gov/form1095b.

VOID
 CORRECTED

Part I Responsible Individual

1 Name of responsible individual		2 Social security number (SSN)	3 Date of birth (if SSN is not available)
4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
8 Enter letter identifying Origin of the Policy (see instructions for codes): ► <input type="checkbox"/>		9 Small Business Health Options Program (SHOP) Marketplace Identifier, if applicable	

Part II Employer Sponsored Coverage (see instructions)

10 Employer name			11 Employer identification number (EIN)
12 Street address (including room or suite no.)	13 City or town	14 State or province	15 Country and ZIP or foreign postal code

Part III Issuer or Other Coverage Provider (see instructions)

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
19 Street address (including room or suite no.)	20 City or town	21 State or province	22 Country and ZIP or foreign postal code

Part IV Covered Individuals (Enter the information for each covered individual(s).)

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Health Coverage

VOID
 CORRECTED

Department of the Treasury
Internal Revenue Service

► Information about Form 1095-B and its separate instructions is at www.irs.gov/form1095b.

Part I Responsible Individual

1 Name of responsible individual		2 Social security number (SSN)	3 Date of birth (if SSN is not available)
4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
8 Enter letter identifying plan of the Policy (see instructions for codes): ► <input type="checkbox"/>		9 Small Business Health Options Program (SHOP) Marketplace Identifier, if applicable	

Part II Employer-Sponsored Coverage (see instructions)

10 Employer name			11 Employer identification number (EIN)
12 Street address (including room or suite no.)	13 City or town	14 State or province	15 Country and ZIP or foreign postal code

Part III Issuer or Other Coverage Provider (see instructions)

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
19 Street address (including room or suite no.)	20 City or town	21 State or province	22 Country and ZIP or foreign postal code

Part IV Covered Individuals (Enter the information for each covered individual(s).)

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Health Coverage

► Information about Form 1095-B and its separate instructions is at www.irs.gov/form1095b.

VOID
 CORRECTED

Part I Responsible Individual

1 Name of responsible individual		2 Social security number (SSN)	3 Date of birth (if SSN is not available)
4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
8 Enter letter identifying Origin of the Policy (see instructions for codes): ► <input type="checkbox"/>		9 Small Business Health Options Program (SHOP) Marketplace Identifier, if applicable	

Part II Employer Sponsored Coverage (see instructions)

10 Employer name			11 Employer identification number (EIN)
12 Street address (including room or suite no.)	13 City or town	14 State or province	15 Country and ZIP or foreign postal code

Part III Issuer or Coverage Provider (see instructions)

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
19 Street address (including room or suite no.)	20 City or town	21 State or province	22 Country and ZIP or foreign postal code

Part IV Covered Individuals (Enter the information for each covered individual(s).)

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Know Your A, B, C Forms

“B”
Forms

“C”
Forms

- **ONLY** used by large employers

Know Your A, B, C Forms

**“B”
Forms**

**“C”
Forms**

- **ONLY** used by large employers
- **Will demonstrate compliance with employer mandate (Part II)**

Know Your A, B, C Forms

**“B”
Forms**

**“C”
Forms**

- **ONLY** used by large employers
- Will demonstrate compliance with employer mandate (Part II)
- If coverage is self-insured, will report on coverage provided to individuals (Part III)

Know Your A, B, C Forms

**“B”
Forms**

**“C”
Forms**

- **ONLY used by large employers**
- **Will demonstrate compliance with employer mandate (Part II)**
- **If coverage is self-insured, will report on coverage provided to individuals (Part III)**
- **Large employer must complete a Form 1095-C for full-time employees for whom it makes a contribution to a multiemployer plan- but special codes apply in Part II, and Part III doesn't have to be completed**



Employer Provided Health Insurance Offer and Coverage

For more information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

VOID
 CORRECTED

Part I Employee

1 Name of employee		2 Social security number (SSN)	7 Name of employer				8 Employer identification number (EIN)				
3 Street address (including apartment no.)						9 Street address (including room or suite no.)				10 Contact telephone number	
4 City or town	5 State or province	6 Country and ZIP or foreign postal code		11 City or town		12 State or province		13 Country and ZIP or foreign postal code			

Part II Employee Offer and Coverage

Plan Start Month (Enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)													
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4960H Safe Harbor (enter code, if applicable)													

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employer-Provided Health Insurance Offer and Coverage

▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

VOID
 CORRECTED

Part I Employee

1 Name of employee	2 Social security number (SSN)
3 Street address (including apartment no.)	
4 City or town	5 State or province
6 Country and ZIP or foreign postal code	

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
9 Street address (including room or suite no.)	
11 City or town	12 State or province
13 Country and ZIP or foreign postal code	

Part II Employee Offer and Coverage

Plan Start Month (Enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)													
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4960H Safe Harbor (enter code, if applicable)													

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employer-Provided Health Insurance Offer and Coverage

▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

VOID
 CORRECTED

Part I Employee

1 Name of employee		2 Social security number (SSN)		7 Name of employer				8 Employer identification number (EIN)		
3 Street address (including apartment no.)				9 Street address (including room or suite no.)				10 Contact telephone number		
4 City or town		5 State or province		6 Country and ZIP or foreign postal code		11 City or town		12 State or province		13 Country and ZIP or foreign postal code

Part II Employee Offer and Coverage

Plan Start Month (Enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)													
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4960H Safe Harbor (enter code, if applicable)													



Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Know Your A, B, C Forms

"B"
Forms

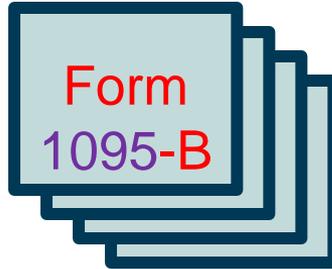
```
graph TD; A["B Forms"] --> B["Form 1095-B"]; A --> C["Form 1094-B"];
```

One copy goes to the IRS and another copy to the “responsible person”

Form
1095-B

Form
1094-B

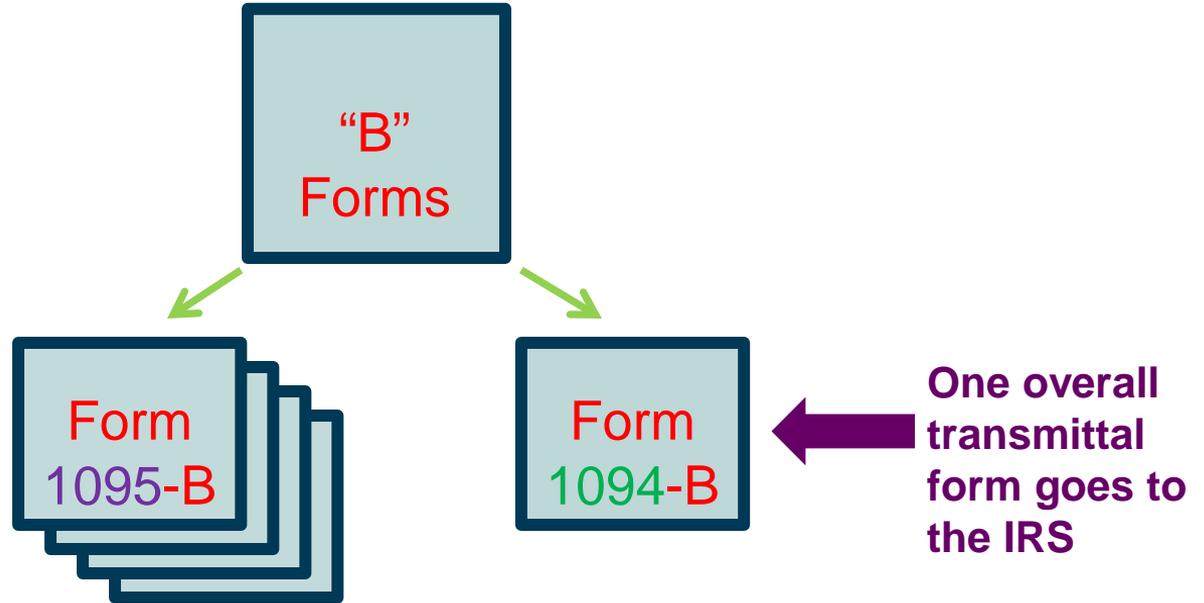
Know Your A, B, C Forms



One copy goes to
the IRS and
another copy to
the "responsible
person"



Know Your A, B, C Forms



Transmittal of Health Coverage Information Returns

► Information about Form 1094-B and its separate instructions is at www.irs.gov/form1094b.

1 Filer's name		2 Employer identification number (EIN)	
3 Name of person to contact		4 Contact telephone number	
5 Street address (including room or suite no.)		6 City or town	
7 State or province		8 Country and ZIP or foreign postal code	
9 Total number of Forms 1095-B submitted with this transmittal ►			



Under penalties of perjury, I declare that I have examined this return and accompanying documents, and, to the best of my knowledge and belief, they are true, correct and complete.

► _____
Signature

► _____
Title

► _____
Date

Know Your A, B, C Forms



One copy goes to
the IRS and another
copy to the full-time
employee



Know Your A, B, C Forms

“C”
Forms

```
graph TD; C["C Forms"] --> F1095["Form 1095-C"]; C --> F1094["Form 1094-C"];
```

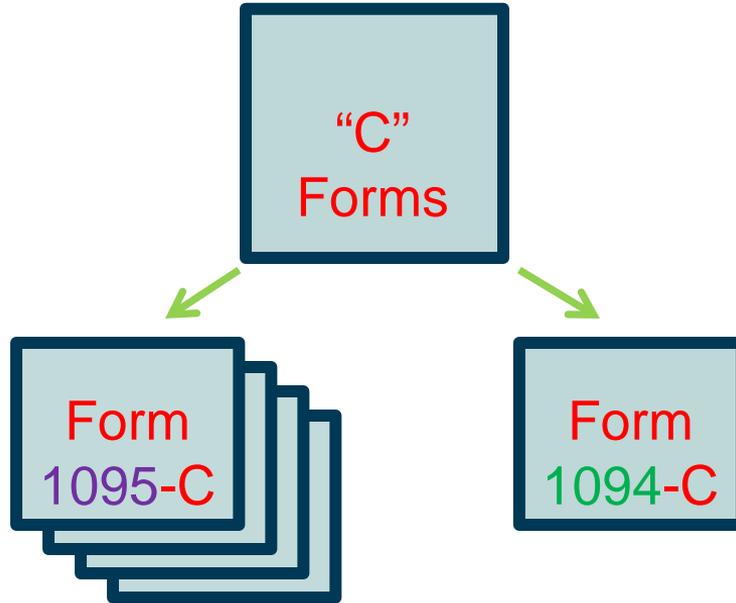
IF SELF-INSURED,
EMPLOYER-
SPONSORED
COVERAGE.... one
copy goes to the IRS
and another copy to
individual enrolled in
coverage, EVEN IF NOT
a full-time employee

Form
1095-C

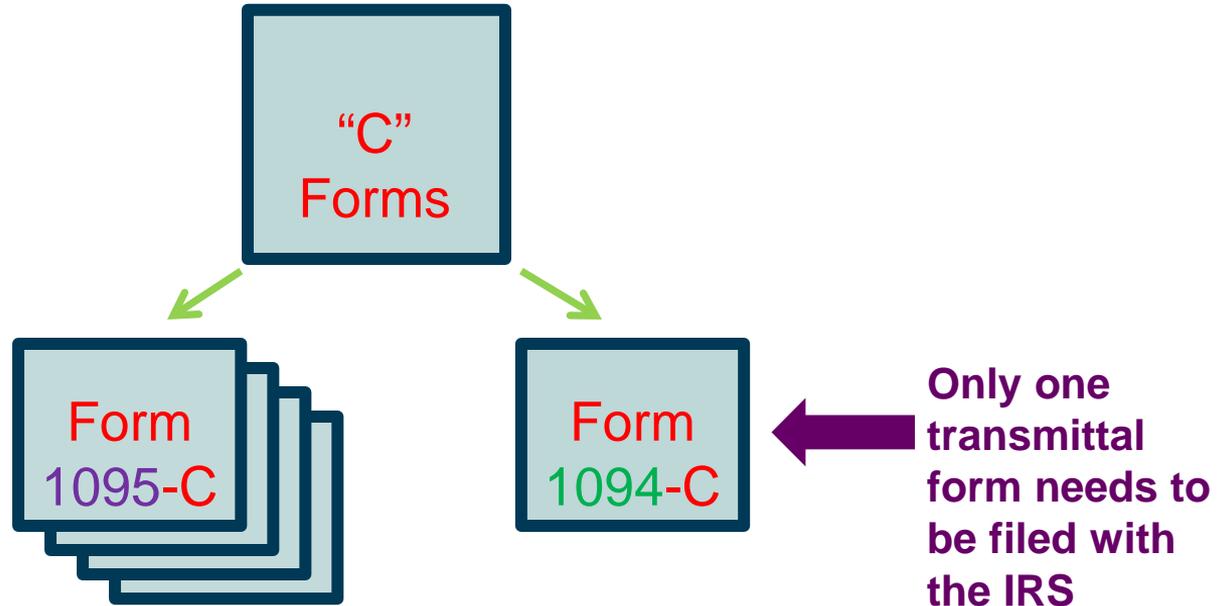
Form
1094-C

Know Your A, B, C Forms

Forms must be prepared for each full-time employee... and if self-insured, employer-sponsored coverage, non-full-time employees covered by the plan



Know Your A, B, C Forms



Form **1094-C**

Department of the Treasury
Internal Revenue Service

Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

Information about Form 1094-C and its instructions is available at www.irs.gov/form1094c

CORRECTED

120116
OMB No. 1545-2251

2015

Part I Applicable Large Employer Member (ALE Member)

1 Name of ALE Member (Employer)		2 Employer identification number (EIN)
3 Street address (including room or suite no.)		
4 City or town	5 State or province	6 Country and ZIP or foreign postal code
7 Name of person to contact		8 Contact telephone number
9 Name of Designated Government Entity (only if applicable)		10 Employer identification number (EIN)
11 Street address (including room or suite no.)		
12 City or town	13 State or province	14 Country and ZIP or foreign postal code
15 Name of person to contact		16 Contact telephone number

For Official Use Only

17 Reserved

18 Total number of Forms 1095-C submitted with this transmittal ▶

19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions

Part II ALE Member Information

20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member ▶

21 Is ALE Member a member of an Aggregated ALE Group? Yes No

If "No," do not complete Part IV.

22 Certifications of Eligibility (select all that apply):

- A. Qualifying Offer Method
- B. Qualifying Offer Method Transition Relief
- C. Section 4980H Transition Relief
- D. 98% Offer Method

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and to the best of my knowledge and belief, they are true, correct, and complete.

Signature _____ Title _____ Date _____

Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

► Information about Form 1094-C and its separate instructions is at www.irs.gov/form1094c

CORRECTED

Part I Applicable Large Employer Member (ALE Member)

1 Name of ALE Member (Employer)		2 Employer identification number (EIN)	
3 Street address (including room or suite no.)			
4 City or town	5 State or province	6 Country and ZIP or foreign postal code	
7 Name of person to contact		8 Contact telephone number	
9 Name of Designated Government Entity (only if applicable)		10 Employer identification number (EIN)	
11 Street address (including room or suite no.)			
12 City or town	13 State or province	14 Country and ZIP or foreign postal code	
15 Name of person to contact		16 Contact telephone number	

For Official Use Only



17 Reserved

18 Total number of Forms 1095-C submitted with this transmittal ►

19 Is this the authoritative transmittal for this information? If "Yes," check the box and continue. If "No," see instructions

Part II ALE Member Information

20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member ►

21 Is ALE Member a member of an Aggregated ALE Group? Yes No

If "No," do not complete Part IV.

22 Certifications of Eligibility (select all that apply):

- A. Qualifying Offer Method
 B. Qualifying Offer Method Transition Relief
 C. Section 4980H Transition Relief
 D. 98% Offer Method

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and to the best of my knowledge and belief, they are true, correct, and complete.

_____ Signature
 _____ Title
 _____ Date

Part III ALE Member Information – Monthly

		(a) Minimum Essential Coverage Offer Indicator		(b) Full-Time Employee Count for ALE Member	(c) Total Employee Count for ALE Member	(d) Aggregated Group Indicator	(e) Section 4980H Transition Relief Indicator
		Yes	No				
23	All 12 Months	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
24	Jan	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
25	Feb	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
26	Mar	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
27	Apr	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
28	May	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
29	June	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
30	July	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
31	Aug	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
32	Sept	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
33	Oct	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
34	Nov	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
35	Dec	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	

Part IV Other ALE Members of Aggregated ALE Group

Enter the names and EINs of Other ALE Members of the Aggregated ALE Group (who were members at any time during the calendar year).

Name	EIN	Name	EIN
36		51	
37		52	
38		53	
39		54	
40		55	
41		56	
42		57	
43		58	
44		59	
45		60	
46		61	
47		62	
48		63	
49		64	
50		65	

Multiemployer Plan “Interim Relief”

- Under the employer mandate rules, an employer is treated as having offered coverage to a full-time employee for a month if:
 - The employer is required by a CBA or participation agreement to make a contribution to a multiemployer plan for that month for the full-time employee;
 - The multiemployer plan offers, to individuals who satisfy the plan’s eligibility conditions, coverage that provides minimum value and is affordable;
 - The multiemployer plan offers coverage to those individuals’ children up to age 26.
- This applies even if the plan doesn’t actually offer coverage to the employee for that month (e.g., the employee is in a waiting period)

Multiemployer Plan “Interim Relief” – Employer Reporting

- Form 1094-C
 - The employer is treated as having offered coverage to full-time employees for whom the relief applies for purposes of the 70/95% coverage test.
- Form 1095-C
 - The employer reports no offer (Code 1H) on line 14, leaves the cost of coverage on line 15 blank, and reports multiemployer plan interim relief (Code 2E) on line 16.
 - This approach can be used regardless of whether the plan actually offered the employee coverage for that month.
 - Leave Part III blank – either the insurer (for insured multiemployer plan coverage) or the plan (for self-insured multiemployer plan coverage) will complete this information in the Form 1095-B.

Employer-Provided Health Insurance Offer and Coverage

▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

VOID
 CORRECTED

Part I Employee

1 Name of employee		2 Social security number (SSN)	
3 Street address (including apartment no.)			
4 City or town	5 State or province	6 Country and ZIP or foreign postal code	

Applicable Large Employer Member (Employer)

7 Name of employer		8 Employer identification number (EIN)	
9 Street address (including room or suite no.)			
11 City or town	12 State or province	13 Country and ZIP or foreign postal code	

Part II Employee Offer and Coverage

Plan Start Month (Enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)													
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4960H Safe Harbor (enter code, if applicable)													

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Multiemployer Plan Employer Reporting- Practical Issues

- It was contemplated in regulations that the multiemployer plan administrator could prepare the Forms 1095-C for employees eligible for the multiemployer plan- but this approach has essentially been abandoned
 - Practical issues made this approach unlikely (e.g. the employer would maintain liability if forms were not filed or furnished correctly)
 - It appears the IRS recognizes this now
- It will be very challenging for many multiemployer plans to have sufficient information from employers to complete and issue Forms 1095-B by January 31
 - Possibility of extensions?
- Employers should not assume they qualify for the multiemployer plan “interim relief” with regard to their employees in multiemployer plans!
 - Need to confirm dependent coverage, minimum value- and most of all, affordability
 - May require outreach to plan for information- different plans are taking different approaches



Deadlines

- February 1, 2016 – Deadline to furnish forms to employees/covered individuals
- February 29, 2016 – Deadline to file forms with IRS by paper (only an option if filing less than 250 returns)
- March 31, 2016- Deadline to file forms with IRS electronically (electronic filing required if filing 250 or more returns)

Questions?

Malcolm Slee

202-861-6337

mslee@groom.com