



# ACA and Reporting



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# Affordable Care Act (ACA) Reporting Requirements

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- ▶ **On February 8, 2015 the Internal Revenue Service (IRS) released final forms for information reporting under IRC §6055 (Plan) and §6056 (Employer).**
- ▶ **The forms and instructions for employers (1094-C and 1095-C) are available and may be downloaded from:**
- ▶ **<http://apps.irs.gov/app/picklist/list/formsPublications.html>**



# ACA Reporting for Employers

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- ▶ **§6056 requires large employers (50 or more employees) to report information concerning whether they offered affordable and minimum value coverage to full-time employees.**
- ▶ **This is accomplished with forms 1094 and 1095-C**
- ▶ **Employers will complete all of the 1094 and Parts I and II of the 1095-C**
- ▶ **PEIA will handle the Part III coverage information**
- ▶ **Do not mark the self insured coverage box in Part III**



# Employer Reporting

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- ▶ **The Affordable Care Act's employer reporting**
  - ▶ requires “large” employers (defined as those with at least 50 full-time employee equivalents) to report certain information concerning whether they offered affordable and minimum value coverage to full-time employees.
  - ▶ One of the purposes of the employer reporting requirements is to assist the IRS in administering the employer shared responsibility penalty.
  - ▶ The employer reporting requirements will also assist the IRS in determining whether individuals with access to employment-based coverage are eligible for the premium assistance tax credit.



# Reporting to Employees

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- ▶ Employers must also provide information on whether they offered affordable and minimum value coverage to each full-time employee identified on the report.
- ▶ Due by January 31 of the year after the calendar year to which the report relates.
- ▶ The first statement must be provided by February 1, 2016 (1/31/2016 is a Sunday).
- ▶ Employers may use third parties to facilitate filing reports and delivering employee statements, but the employer remains the responsible entity.



# Data Elements to be Reported

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- ▶ The Employer must report on 1095 C:
  - ▶ Employer's name, address and EIN
  - ▶ Name and telephone number of the employer's contact person
  - ▶ Certification of whether the employer offered its full-time employees the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, by calendar month
  - ▶ The months during the calendar year for which plan coverage was available
  - ▶ Each full-time employee's share of the lowest cost monthly premium (self-only) for coverage providing minimum value offered to that full-time employee under an eligible employer-sponsored plan, by calendar month



# Employer-Provided Health Insurance Offer and Coverage

► Information about Form 1095-C and its separate instructions is at [www.irs.gov/ff1095c](http://www.irs.gov/ff1095c).

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**2014**

<b>Part I Employee</b>						<b>Applicable Large Employer Member (Employer)</b>						
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		

<b>Part II Employee Offer and Coverage</b>													
	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 4980H 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"/>

## Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, the issuer of the insurance or the sponsor of the plan providing the coverage will furnish you information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, the provider of that coverage will furnish you information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



*Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.*

### Part I. Employee

Lines 1–6. Part I, lines 1–6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.



*If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN.*

### Part I. Applicable Large Employer Member (Employer)

Lines 7–13. Part I, lines 7–13, reports information about your employer.

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

## Part II. Employer Offer and Coverage, Lines 14–16

**Line 14.** The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. This information relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

**1A.** Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than \$1,108.65 (9.5% of the 48 contiguous states single federal poverty line) and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

**1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

**1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

**1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

**1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

**Line 15.** This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

**Line 16.** This line provides the IRS information to administer the employer shared responsibility provisions. None of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

### Part III. Covered Individuals, Lines 17–22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.



# Data Elements to be Reported

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- ▶ The Employer must report on 1094 C:
- ▶ Form 1094-C is a transmittal form that large employers must file with the IRS along with copies of the Forms 1095-C. However, it is much more than a cover sheet for filing these forms. Among other things, it requires the following:
  - ▶ A month-by-month indication of whether the employer offered coverage to 95 percent of its full-time employees,
  - ▶ A month-by-month count of the number of full-time employees, and
  - ▶ A month-by-month count of the total number of employees.



# 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/1094c](http://www.irs.gov/1094c).

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**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 . . . . . ►

**Part II ALE Member Information**

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

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.

► \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_  
 Signature

**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	

# Other Reporting Details...

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- ▶ Employers must report certain other information using what the IRS calls “indicator codes” for that reporting
- ▶ Complete details about the list of reportable items available with forms and instructions:
- ▶ <http://www.irs.gov/pub/irs-pdf/i109495c.pdf>



# ACA Reporting for Health Plans

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- ▶ **§6055 requires health plans to report information regarding an individual's health coverage during the preceding taxable year, in order to determine whether that individual had health coverage.**
- ▶ **PEIA will handle §6055 reporting for all enrolled policyholders**
- ▶ **This is done using form 1094-B and 1095-B**



# Plan Reporting

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- ▶ **The Affordable Care Act's plan reporting**
  - ▶ requires all providers of “minimum essential coverage” to report detailed information to the IRS regarding the individual's coverage during the preceding taxable year.
  - ▶ to determine whether an individual has satisfied the individual mandate to have minimum essential coverage or pay a penalty.
  - ▶ reporting must be filed with the IRS by February 28 on paper or by March 31 electronically, of the year after the calendar year in which the plan provided minimum essential coverage beginning with the 2015 plan year.



# Plan Reporting to Insureds

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- ▶ Each employee and retiree listed in the plan's report to the IRS must receive a written statement with:
  - ▶ the "policy number"
  - ▶ the name, address, a contact number for the plan sponsor,
  - ▶ the information the plan reported to the IRS, by January 31 of the year succeeding the calendar year to which the return relates.
- ▶ The first statement is due no later than February 1, 2016 (because 1/31/2016 is a Sunday).
- ▶ The statement must be provided on paper unless an employee consents to electronic delivery.
- ▶ For self-insured plans, the responsibility lies with the plan sponsor.





# Required Data

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- ▶ **PEIA must report the following on a 1095-B**
  - ▶ Name, address, and employer identification number (EIN) of the reporting entity (e.g., insurer or self-insured group health plan)
  - ▶ Name, address, and TIN (or date of birth if a TIN is not available) of the responsible individual (unless they are not enrolled). Responsible individuals include employees and retirees
  - ▶ Name and TIN (or date of birth if a TIN is not available) of each individual (member, spouse, dependent child) covered under the policy or program
  - ▶ For each covered individual, the months for which the individual was enrolled in coverage and entitled to receive benefits for at least one day
  - ▶ Any other information specified in final forms, instructions or published guidance

