ACA Reporting Compliance Frequently Asked Questions

Basics of Reporting by Health Coverage Providers (Section 6055)

What are the information reporting requirements for providers of health coverage?

The Affordable Care Act added section 6055 to the Internal Revenue Code, which provides that every provider of minimum essential coverage will report coverage information by filing an information return with the IRS and furnishing a statement to individuals. The information is used by the IRS to administer and individuals to show compliance with the individual shared responsibility provision in section 5000A.

When do the information reporting requirements go into effect?

The information reporting requirements are first effective for coverage provided in 2015. Thus, health coverage providers will file information returns with the IRS in 2016, and will furnish statements to individuals in 2016, to report coverage information in calendar year 2015.

Is relief available from penalties for incomplete or incorrect returns filed or statements furnished to covered individuals in 2016 for coverage provided in calendar year 2015?

Yes. In implementing new information reporting requirements, short-term relief from reporting penalties frequently is provided. This relief generally allows additional time to develop appropriate procedures for collection of data and compliance with the new reporting requirements. Accordingly, the IRS will not impose penalties under sections 6721 and 6722 for 2015 returns and statements filed and furnished in 2016 on reporting entities that can show that they have made good faith efforts to comply with the information reporting requirements. Specifically, relief is provided from penalties under sections 6721 and 6722 for returns and statements filed and furnished in 2016 to report coverage in 2015 for incorrect or incomplete information reported on the return or statement. For example, a group health plan insurer that makes a reasonable effort to obtain the EIN of the employer sponsoring the coverage will not be subject to penalties under sections 6721 or 6722 if the insurer fails to enter an EIN on line 11 of Form 1095-B for 2015 or enters an EIN that is found to be incorrect. No relief is provided in the case of reporting entities that cannot show a good faith effort to comply with the information reporting requirements or that fail to timely file an information return or furnish a statement. However, consistent with the existing information reporting rules, reporting entities that fail to timely meet the requirements still may be eligible for penalty relief if the IRS determines that the standards for reasonable cause under section 6724 are satisfied.

Who is Required to Report

Who must report under section 6055?

Any person that provides *minimum essential coverage* to an individual must report to the IRS and furnish statements to individuals, including the following:

- Health insurance issuers, or carriers, for insured coverage
- Plan sponsors of self-insured group health plan coverage, and
- The executive department or agency of a governmental unit that provides coverage under a government-sponsored program.

What is minimum essential coverage?

Minimum essential coverage includes the following:

- Eligible employer-sponsored coverage, including self-insured plans, COBRA coverage and retiree coverage
- Coverage purchased in the individual market, including a qualified health plan offered by the Health Insurance Marketplace
- Medicare Part A coverage and Medicare Advantage plans
- Most Medicaid coverage
- Children's Health Insurance Program (CHIP) coverage
- Certain types of veterans health coverage administered by the Veterans Administration
- Most types of TRICARE coverage under chapter 55 of title 10 of the United States Code
- Coverage provided to Peace Corps volunteers
- Coverage under the Nonappropriated Fund Health Benefit Program
- Refugee Medical Assistance supported by the Administration for Children and Families
- Self-funded health coverage offered to students by universities for plan or policy years that begin on or before Dec. 31, 2014 (for later plan or policy years, sponsors of these programs may apply to HHS to be recognized as minimum essential coverage)
- State high risk pools for plan or policy years that begin on or before Dec. 31, 2014 (for later plan or policy years, sponsors of these program may apply to HHS to be recognized as minimum essential coverage)

Other coverage recognized by the Secretary of HHS as minimum essential coverage

What is eligible employer-sponsored coverage?

Eligible employer-sponsored coverage is:

16. A self-insured group health plan under which coverage is offered by or on behalf of an employer to an employee, or
17. Group health insurance coverage offered by or on behalf of an employer to an employee that is –

- a governmental plan,
- a plan or coverage offered in the small or large group market within a state, or
- a grandfathered health plan offered in a group market.

Is an employer required to report under section 6055 if it sponsors a health plan that provides coverage by purchasing insurance from a health insurance issuer?

No. An employer that sponsors an insured health plan will not report as a provider of health coverage under section 6055. The health insurance issuer or carrier is responsible for reporting that health coverage. However, if the employer is subject to the employer shared responsibility provisions in section 4980H, it is responsible for reporting information under section 6056 about the coverage it offers to its full-time employees.

For self-insured group health plan coverage, who is the plan sponsor that must to report under section 6055? (SEE GRAPH - myacapartner.com)

- For a self-insured group health plan maintained by a single employer, the plan sponsor is the employer. For a plan maintained by more than one employer that is not a multiemployer plan (as defined in ERISA) the plan sponsor is each participating employer. For purposes of identifying the employer, the section 414 employer aggregation rules do not apply.
- For a plan that is a multiemployer plan (as defined in ERISA), the plan sponsor is the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.
- For a plan maintained solely by an employee organization, the plan sponsor is the employee organization.
- For any plan for which a plan sponsor is not identified above, the plan sponsor is the person designated by plan terms or, if no person is designated, each entity that maintains the plan.

How do the reporting requirements under section 6055 apply to reporting entities that are part of a controlled group?

Plan sponsors in a controlled group that is not an applicable large employer under section 4980H, and providers (such as issuers) that are not reporting as employers, may report under section 6055 as separate entities, or may have one entity report for the controlled group.

Must a health coverage provider report under section 6055 if some or all of its covered individuals may be exempt from the individual shared responsibility provision?

Yes. A health coverage provider may not have the information necessary to determine whether an individual is exempt from the shared responsibility provision. To ensure complete and accurate reporting, providers must report under section 6055 for all their covered individuals.

Should a health insurance issuer report under section 6055 for coverage in a qualified health plan in the individual market enrolled in through a Marketplace?

No. An issuer should not report on coverage under a qualified health plan in the individual market enrolled in through a Marketplace. The Marketplaces will separately report information on enrollments in a qualified health plan to the IRS and individuals under section 36B(f)(3). Issuers must report, however, on qualified health plans in the small group market enrolled in through the Small Business Health Options Program (SHOP).

Must a health coverage provider report under section 6055 for arrangements that provide benefits in addition or as a supplement to an arrangement that is minimum essential coverage?

If the additional or supplemental benefits are not minimum essential coverage (for example, if they are excepted benefits like coverage at an on-site medical clinic), no reporting is required for the additional or supplemental benefits. In addition, no reporting is required under section 6055 for additional or supplemental benefits that are minimum essential coverage if the primary and supplemental coverages have the same plan sponsor or the coverage supplements government-sponsored coverage such as Medicare.

Must a government employer report under section 6055 if it maintains a self-insured health plan?

Yes. However, unless prohibited by other law, a government employer that maintains a self-insured group health plan may designate a related governmental unit, or an agency or instrumentality of a governmental unit, as the person to file the returns and furnish the statements for some or all individuals covered under that plan.

What Information Must Providers Report

What information must a health coverage provider report to the IRS?

The information that a provider must report to the IRS includes the following:

- The name, address, and employer identification number (EIN) of the provider;
- The responsible individual's name, address, and TIN, or date of birth if a TIN is not available. If the responsible individual is not enrolled in the coverage, providers may, but are not required to, report the TIN of the responsible individual
- The name and TIN, or date of birth if a TIN is not available, of each individual covered under the policy or program and the months for which the individual was enrolled in coverage and entitled to receive benefits; and
- For coverage provided by a health insurance issuer through a group health plan, the name, address, and EIN of the employer sponsoring the plan and whether the coverage is a qualified health plan enrolled in through the SHOP and the SHOP's identifier.

Will a health coverage provider collect TINs from individuals, including dependents, covered under its plan or policy?

Yes. Reporting of TINs for all covered individuals is necessary for the IRS to verify an individual's coverage without the need to contact the individual.

If health coverage providers are unable to obtain a TIN after making a reasonable effort to do so, the covered individual's date of birth may be reported in lieu of a TIN.

If a health coverage provider does not furnish a TIN, will it be subject to penalties?

A health coverage provider will not be subject to a penalty it demonstrates that it properly solicits the TIN but does not receive it. Under these rules, the reporting entity must make an initial solicitation at the time the relationship with the payee is established. (However, the reporting entity is not required to make this initial solicitation if it already has the payee's TIN and uses that TIN for all relationships with the payee.) If the reporting entity does not receive the TIN, the first annual solicitation is generally required by December 31 of the year in which the relationship with the payee begins (January 31 of the following year if the relationship begins in December). Generally, if the TIN is still not provided, a second solicitation is required by December 31 of the following year. If a TIN is still not provided, the reporting entity need not continue to solicit a TIN.

What information must a health coverage provider furnish to individuals?

In addition to the information it reported to the IRS for each covered individual listed on the information return, a health coverage provider must include a phone number for the provider's designated contact person (if any) that the recipient of the statement can contact with questions about information on the statement.

How and When to Report the Required Information

When must a health coverage provider file the information return with the IRS?

A health coverage provider must file the information return and transmittal form with the IRS on or before February 28 (March 31 if filed electronically) of the year following the calendar year in which it provided minimum essential coverage to an individual. Regulations under section 6081 address extensions of time to file information returns.

What type of return must a health coverage provider file with the IRS?

Generally, a health coverage provider must file Form 1094-B and Form 1095-B (or other form that IRS designates, or a substitute form). However, if the provider is also an applicable large employer member as defined in the employer shared responsibility provisions under section 4980H and provides coverage to its employees through a self-insured group health plan, the provider must file Form 1094-C and Form 1095-C (or other form that IRS designates, or a substitute form), instead of Forms 1094-B and 1095-B, to report information with respect to its employees.

Must a health coverage provider file the return with the IRS electronically?

A health coverage provider that is required to file 250 or more Forms 1095-B or 250 or more Forms 1095-C during the calendar year must file the returns electronically. The 250 return threshold applies separately to each type of return required to be filed. Only Forms 1095-B or 1095-C are counted in applying the 250 return threshold for section 6055 reporting. However, if the 250 return threshold applies, Forms 1094-B and 1094-C also must be filed electronically. A provider that is required to file fewer than 250 Forms 1095-B or Forms 1095-C may file on paper or electronically.

To whom must a health coverage provider furnish the statement?

A health coverage provider must furnish the statement to a responsible individual. The responsible individual generally is the person who enrolls one or more individuals, which may include him or herself, in minimum essential coverage. The responsible individual may be the primary insured, employee, former employee, uniformed services sponsor, parent, or other related person named on the coverage application.

Must a health coverage provider furnish the statement to anyone who is not the responsible individual?

No. A provider is not required to provide a statement to any individual who is not the responsible individual.

When must a health coverage provider furnish the statement to the responsible individual?

A health coverage provider must furnish the statement to the responsible individual on or before January 31 of the year following the calendar year in which minimum essential coverage is provided. If the provider applies to the IRS in writing and shows good cause, the IRS may grant an extension of time up to 30 days for the provider to furnish the statement.

How must a health coverage provider furnish the statement to the responsible individual?

A health coverage provider generally must mail the statement to the responsible individual's last known permanent address or, if no permanent address is known, to the individual's temporary address. A provider's first class mailing to the last known permanent address, or if no permanent address is known, the temporary address, discharges the provider's requirement to furnish the statement.

A health coverage provider also may furnish the statement electronically to the responsible individual if the responsible individual affirmatively consents to it.

Does an employer that must file returns under section 6055 as a provider of self-insured health coverage to its employees and under section 6056 as an applicable large employer file combined information returns and statements?

Yes. An applicable large employer member, as defined in the employer shared responsibility provisions under section 4980H, that provides self-insured coverage is subject to the reporting requirements of both section 6055 and section 6056. To streamline and prevent duplication under each reporting requirement, applicable large employer members with self-insured coverage will combine section 6055 and section 6056 reporting. An applicable large employer member with self-insured coverage will report on Form 1095-C, completing separate sections to report the information required under sections 6055 and 6056. An applicable large employer member that provides insured coverage will complete only the section of Form 1095-C that reports the information required under section 6056. Entities reporting as health insurance issuers, sponsors of self-insured group health plans that are not applicable large employers, sponsors of multi-employer plans, and providers of government-sponsored coverage, will report under section 6055 on Form 1094-B and Form 1095-B.

May a health coverage provider hire a third party to fulfill the provider's reporting responsibilities?

Yes. Reporting arrangements between health care providers and other parties are not prohibited. However, entering into a reporting arrangement does not transfer the potential liability of the provider for failure to report information and furnish statements under section 6055. In addition, if a person who prepares returns or statements under section 6055 is a tax return preparer, that person will be subject to the requirements generally applicable to tax return preparers.

For information returns filed and furnished in 2017 for coverage provided in 2016 and later years, what penalties may apply if a health coverage provider fails to comply with the section 6055 information reporting requirements?

The penalty under section 6721 may apply to a provider that fails to file timely information returns, fails to include all the required information, or includes incorrect information on the return. The penalty under section 6722 may apply to a provider that fails to furnish timely the statement, fails to include all the required information, or includes incorrect information on the statement. The waiver of penalty and special rules under section 6724 and the applicable regulations, including abatement of information return penalties for reasonable cause, may apply to certain failures.

Basic Information

- Applicable large employers (ALE) must report to the IRS information about the health care coverage, if any, they offered to full-time employees. The IRS will use this information to administer the employer shared responsibility provisions and the premium tax credit.
- ALEs also must furnish to employees a statement that includes the same information provided to the IRS. Employees may use this information to determine whether, for each month of the calendar year, they may claim the premium tax credit on their individual income tax returns.
- Some ALEs may be eligible to use an alternative reporting method designed to simplify and reduce the cost of reporting.
- ALEs that file 250 or more information returns during the calendar year must file the returns electronically. For more information, see these Questions and Answers and the How to File Electronically section below. For information on the communication procedures, transmission formats, business rules and validation procedures for returns transmitted electronically through the ACA Information Reports (AIR) system, review draft Publication 5165, Guide for Electronically Filing Affordable Care Act (ACA) Information Returns.

Coordination With the Employer Shared Responsibility and Premium Tax Credit Provisions

This information reporting is integral to the administration of the employer shared responsibility provisions because it provides information to the IRS about the health coverage, if any, an employer offers to its full-time employees. Information reporting also is integral to the administration of the premium tax credit. The IRS and any employee who does not enroll in an employer plan (but instead enrolls in coverage at the Health Insurance Marketplace) need information on the employer's offer of coverage, including the cost of coverage, to determine whether that individual is eligible for the premium tax credit.

Affected Employers

This information reporting provision requires an ALE to report information about health insurance coverage offered to its full-time employees (and their dependents). ALEs are required to report to the IRS, as well as to their full-time employees, regardless of whether the ALE actually offers health insurance coverage. Even if an ALE with at least 50 but fewer than 100 full-time employees (including full-time equivalents) is eligible for the transition relief for 2015 from the employer shared responsibility provision, the ALE is still required to complete the information reporting for 2015.

Understanding the Reporting Requirements of the Affordable Care Act (ACA)

What forms must an ALE member file with the IRS to report the required information under sections 6055 and 6056?

The section 6056 regulations provide, under the general method of reporting, that an ALE member must file a separate Form 1095-C (or a substitute form) for each of its full-time employees, and a transmittal Form 1094-C (or a substitute form) for all of the returns filed for a given calendar year. **These forms must be filed regardless of whether the ALE member offers coverage, or the employee enrolls in any coverage offered**.

The section 6056 return (and, if the employer maintains a self-insured plan, the section 6055 return) may be filed using a substitute form, but the substitute form must include all of the information required on Form 1094-C and Form 1095-C and satisfy all form and content requirements as specified by the IRS.

For which employees must an ALE member file Form 1095-C?

Generally, an ALE member must file Form 1095-C (or a substitute form) for each employee who was a full-time employee of the ALE member for any month of the calendar year.

In addition, an ALE member that sponsors a self-insured plan must file Form 1095-C for each employee who enrolls in the self-insured health coverage or enrolls a family member in the coverage, regardless of whether the employee is a full-time employee for any month of the calendar year.

What information must an ALE member furnish to its full-time employees?

An ALE member must furnish to each full-time employee a completed Form 1095-C (or a substitute form). This form must be furnished regardless of whether the ALE member offers coverage, or the employee enrolls in any coverage offered. An ALE member is not required to furnish to its full-time employees a copy of Form 1094-C as filed with the IRS.

A substitute form must include the information on Form 1095-C and must comply with generally applicable requirements for substitute forms.

For which employees is an ALE member not required to file a Form 1095-C?

Form 1095-C is not required for the following employees (unless the employee or the employee's family member was enrolled in a self-insured plan sponsored by an ALE member):

- an employee who was not a full-time employee in any month of the year; or
- an employee who was in a limited non-assessment period for all 12 months of the year (for example, a new variable hour employee still in an initial measurement period). See the definition of Limited Non-Assessment Period in the instructions to Form 1095-C for more details.

Which ALE members should complete Part III of Form 1095-C?

An ALE member that sponsors a self-insured health plan should complete Part III of Form 1095-C for employees and family members who enroll in the self-insured coverage.

If an ALE member sponsors a health plan that includes self-insured options and insured options, the ALE member should complete Part III of Form 1095-C only for employees and family members who enroll a self-insured option.

An ALE member that offers coverage through an employer-sponsored insured health plan (and does not sponsor a self-insured health plan) should **NOT** complete Part III. Instead, information

about coverage will be furnished to employees on Form 1095-B, which is filed by the insurance provider.

Reporting Offers of Coverage and other Enrollment Information

What code do we use if a Company only offers an employee's spouse coverage when no coverage is offered from the spouse's employer?

2016 forms will have a separate code to address this issue. For 2015, should treat as if spouse was offered coverage.

Which self-only premium is used if a Company offers wellness program incentives?

The final regulations retain the rules in the proposed regulations that wellness incentives unrelated to tobacco use are treated as unearned and wellness incentives related to tobacco use are treated as earned in determining affordability.

Using AGP's insurance plan as an example – we offer three tiers of coverage.

- No incentive
- No tobacco use
- No tobacco use and passing 3 of 5 cardiometabolic measures

AGP can use the premium for the second option (no tobacco use) as the lowest self-only premium for 1095-C.

Form W-2 wages safe harbor - what happens if employee was not employed all year?

Form W-2 wages can be adjusted based on number of months worked.

Form W-2 wages safe harbor – what wage is used?

Wages reported in Box 1 of Form W-2.

Can employer use more than one affordability safe harbor?

These safe harbors are all optional. An employer may choose to use one or more of these safe harbors for all of its employees or for any reasonable category of employees, provided it does so on a uniform and consistent basis for all employees in a category. In response to a comment, the final regulations clarify that reasonable categories generally include specified job categories, nature

of compensation (for example, salaried or hourly), geographic location, and similar bona fide business criteria. However, an enumeration of employees by name would not be considered a reasonable category.

How should an ALE member report whether an offer of coverage was made to an employee for a calendar month?

The ALE member uses line 14, Offer of Coverage, in Part II of Form 1095-C to report whether an offer of coverage was made to an employee for each month of the year. An offer of coverage is considered to have been made for a month only if the coverage offered would provide coverage for every day of that month. The ALE member should enter the appropriate indicator code to indicate what type of coverage, if any, was offered to the employee for that month (for example, employee-only coverage, employee and dependents coverage, employee, spouse and dependents coverage, etc.

How should information about the offer of coverage for the month in which an employee is hired be reported on Form 1095-C?

For the first month of employment, the ALE member should report that the employee was not offered coverage for that first month by entering code 1H, No offer of coverage, on line 14 (unless the offer of coverage extended to every day of that month). For example, if a newly-hired employee starts employment on the 10th of a calendar month, with the offer of coverage (if accepted) providing coverage also starting on the 10th of a calendar month, the ALE member should indicate that the employee was not offered coverage for that first month.

Note, however, that the ALE member may be entitled to relief from section 4980H liability for that month. For instance, the first three months after an employee first becomes a full-time employee may be treated as a limited non-assessment period if all applicable conditions are satisfied, which would be reported as code 2D, Employee in a section 4980H(b) Limited Non-Assessment Period, on line 16.

On Part III of Form 1095-C, an ALE member should report an individual as having coverage under the plan for the calendar month if the individual was covered for any day of the calendar month. Accordingly, if the ALE member offers a self-insured health plan, and the employee enrolls in the plan and obtains coverage for any day during the first month of hire, the employee (and any other individuals such as spouses and dependents who obtained coverage through the employee's enrollment) should be reported as having coverage for that month under Part III of Form 1095-C.

How should information about the offer of coverage for the month in which an employee terminates employment be reported on Form 1095-C?

As discussed in question 7 above, an ALE member reports that an employee was offered coverage for a month under Part II of Form 1095-C only if the offer of coverage would provide coverage for all days of the calendar month. Accordingly, if an employee terminates employment [with an ALE member] on any day other than the last day of a month and the coverage or offer of coverage expires upon termination of employment, the ALE member should report that the employee was not offered coverage for that final month of employment by entering code 1H, No offer of coverage, on line 14.

If the coverage or offer of coverage would have continued if the employee had not terminated employment during the month, the ALE member will be eligible for relief under section 4980H for that employee's last month of employment. In that case, the ALE member should enter code 2B, on line 16 for that month. See the instructions for Forms 1094-C and 1095-C for more information on reporting for a terminated employee and the use of indicator codes.

Is an ALE member required to enter a code in line 16, Applicable Section 4980H Safe Harbor, of Form 1095-C?

No. An ALE member is not required to make an entry on line 16 of Form 1095-C. However, an ALE member can use line 16 to indicate whether the ALE member qualifies for an exception from the assessable payment under section 4980H(b) for a given month. An ALE member should enter the appropriate code on line 16 if any applies. For more information about using line 16, see the Instructions for Forms 1094-C and 1095-C. If no code is applicable for a given month, line 16 should be left blank.

How should an employer report enrollment information for self-insured coverage provided to an individual who was not an employee on any day of the calendar year, such as a non-employee COBRA beneficiary (for example, the former spouse of an employee), member of the board of directors, or retired employee?

An employer that sponsors a self-insured health plan may report enrollment information for individuals who were not employees on any day of the calendar year by entering code 1G, Offer of coverage to employee who was not a full-time employee for any month of the calendar year, on line 14 of Part II of Form 1095-C for all twelve months and completing Part III of Form 1095-C. (Note, however, that Form 1095-C requires the recipient's Social Security number (SSN) on line 2 in all instances, so Form 1095-C cannot be used for covered individuals who have not provided a SSN to the employer regardless of whether the employer has requested the information.) Such individuals might include a non-employee director, a terminated employee receiving COBRA coverage who terminated employment in a previous calendar year, a retired employee who terminated employment in a previous calendar year, or a family member (including a surviving spouse or dependent) of such an individual if the family member is receiving coverage independent of the individual, such as by electing individual COBRA continuation coverage. All family members of the

individual who are covered individuals due to that individual's enrollment (for instance, a spouse of a retiree who is enrolled in the plan because the retiree elected self plus spousal coverage) should be included on the same Form 1095-C as the individual who enrolls in the coverage. For the ability to use Form 1095-B as an alternative to Form 1095-C for an individual who was not an employee on any day of the calendar year, see the instructions for Forms 1094-C and 1095-C.

How does an ALE member complete its authoritative transmittal Form 1094-C and Form 1095-C if the ALE member is eligible to use the Qualifying Offer method?

If an ALE member has made a Qualifying Offer for all 12 months of the year to one or more full-time employees (and the employee did not enroll in self-insured coverage), the ALE member may use an alternate reporting method for those employees who received a Qualifying Offer for all 12 months of the year. A "Qualifying Offer" is an offer that satisfies all of the following criteria:

- an offer of minimum essential coverage that provides minimum value;
- the employee cost for employee-only coverage for each month does not exceed 9.5 percent of the mainland single federal poverty line divided by 12; and
- an offer of minimum essential coverage is also made to the employee's spouse and dependents (if any).

On the Form 1094-C, Line 22 Certifications of Eligibility, the ALE member should check box A, Qualifying Offer Method. On Form 1095-C, line 14, the ALE member should enter code 1A, Qualifying Offer, for each employee receiving a Qualifying Offer for all 12 months of the year. When an employee receives a Qualifying Offer, no entry is required in line 15, Employee share of Lowest Cost Monthly Premium for Self-Only Minimum Value Coverage.

The Form 1095-C must be filed with the IRS; however, as an alternative to furnishing the employee with a copy of Form 1095-C filed with the IRS, the employer may furnish a statement containing certain information and stating that because the employee received a Qualifying Offer for all 12 months of the year, the employee is not eligible for the premium tax credit. This alternative may not be used by an employer that sponsors a self-insured plan with respect to any employee who has enrolled in the coverage under the plan because the employer is required to report that coverage on Form 1095-C. In that case the employer must furnish a copy of the Form 1095-C as filed with the IRS which will include enrollment in coverage information (Part III) as well as offer of coverage information (Part II).

How does an ALE member complete its Authoritative Transmittal, Form 1094-C and Form 1095-C if the ALE member is eligible to use the Qualifying Offer Method Transition Relief for 2015?

For the 2015 calendar year, an ALE member that certifies it made Qualifying Offers for one or more months of 2015 to at least 95% of its full-time employees may qualify for simplified reporting

procedures. An ALE member using this method for 2015 should check box B on line 22 of Form 1094-C and should enter code 1A, Qualifying Offer, on line 14 of Form 1095-C for any month for which an employee received a Qualifying Offer, or code 1I, Qualifying Offer Transition Relief 2015, for any month for which an employee did not receive a Qualifying Offer. No entry is required on line 15 of Form 1095-C.

The Form 1095-C must be filed with the IRS, however, an ALE member using this Qualifying Offer reporting method for 2015 may also provide employees with an alternative statement instead of providing them with a copy of Form 1095-C. This alternative furnishing method may not be used by an employer that sponsors a self-insured plan with respect to any employee who has enrolled in self-insured coverage under the plan because the employer is required to report that coverage on Form 1095-C. In that case the employer must furnish a copy of the Form 1095-C as filed with the IRS which will include enrollment in coverage information (Part III) as well as offer of coverage information (Part II).

How does an ALE member complete its authoritative transmittal, Form 1094-C and Form 1095-C if the ALE member is using the 98 percent offer method?

An ALE member that, for all months of the calendar year, has offered affordable health coverage providing minimum value to at least 98% of its employees for whom it is filing a Form 1095-C employee statement, and offered minimum essential coverage to those employees' dependents, may qualify for simplified reporting procedures. Note that for purposes of the 98% offer method, an offer to an employee's spouse is not required.

If an ALE member is using this method, it should check box D, 98% Offer Method, on line 22 of Form 1094-C. The ALE member is not required to determine whether all of the employees for whom it is filing were full-time employees and therefore, is not required to complete Form 1094-C, Part III (b), Full-Time Employee Count for ALE Member, on its authoritative transmittal. However, the ALE member is required to file Forms 1095-C on behalf of all employees taken into account in satisfying the 98% offer method. (For this purpose, the health coverage is affordable if the ALE member meets one of the section 4980H affordability safe harbors.)

For further details on the 98 percent offer method, see the section 6056 regulations and the instructions for Forms 1094-C and 1095-C.

Reporting for Governmental Units

How does a governmental unit that has been designated to report on behalf of another governmental unit that is an ALE member complete Form 1094-C and Form 1095-C?

A governmental unit (defined as the government of the United States, any State or political subdivision thereof, or any Indian tribal government (as defined in section 7701(a)(40)) or subdivision of an Indian tribal government (as defined in section 7871(d)), may report under section 6056 on its own behalf or may appropriately designate another person or persons to report on its behalf. A person may be appropriately designated to file the return and furnish the statements under section 6056 on behalf of the ALE member if the person is part of or related to the same governmental unit as the ALE member. A government entity that is designated to file for another governmental unit is referred to as a Designated Government Entity (DGE).

If a DGE is designated to file returns on behalf of more than one ALE member, the DGE must file a separate Form 1094-C for each ALE member for which the DGE is reporting. On lines 9-13 of Form 1094-C, Part I, the DGE would report its name, address and EIN and on lines 1-8 the name, address, and EIN of the ALE member for which it is reporting. Contact names and telephone numbers must be provided for both the ALE member and the DGE. Additionally, the regulations require that there be a single identified Form 1094-C Authoritative Transmittal reporting aggregate employer-level data for the ALE member (including full-time employees of the ALE member the reporting for which has been transferred to a DGE), and that there be only one Form 1095-C for each full-time employee of the ALE member with respect to employment with that ALE member. For additional details, see the instructions to Forms 1094-C and 1095-C.

What forms do a DGE and the designating governmental unit use to report the required information?

A governmental unit and a DGE should use Form 1094-B, Transmittal of Health Coverage Information Returns, and Form 1095-B, Health Coverage, or Form 1094-C and Form 1095-C, as follows:

(A) An ALE member with an insured employer-sponsored health plan (or options under the employer-sponsored health plan that are insured) that has delegated to a DGE the responsibilities for reporting the offer of coverage (section 6056) information.

In this case, the DGE must report the offer of coverage information using a Form 1094-C and a Form 1095-C for each employee for whom the governmental unit has delegated the reporting to the DGE. The Form 1094-C and Form 1095-C will identify the ALE member as the employer and the DGE as the entity filing on behalf of the governmental unit, so that the DGE must file a separate

Form 1094-C for each ALE member that has delegated the reporting responsibility to the DGE. The DGE is responsible for furnishing each employee a copy of the Form 1095-C filed for that employee. Because the employer-sponsored health plan is an insured group health plan (or the employee has elected an option under the employer-sponsored health plan that is an insured option), the insurance company will report the enrollment in coverage information on a Form 1094-B and Form 1095-B, and furnish a copy of the Form 1095-B to each employee for whom a Form 1095-B was filed.

(B) ALE member with a self-insured employer-sponsored health plan (or options under the group health plan that are self-insured) that has delegated to the DGE the responsibilities for reporting the offer of coverage (section 6056) information and the enrollment in coverage (section 6055) information.

In this case, the DGE must report the offer of coverage information and the enrollment information using a Form 1094-C and a Form 1095-C for each employee for whom the governmental unit has delegated the reporting to the DGE. The Form 1094-C and Form 1095-C will identify the governmental unit as the employer and the DGE as the entity filing on behalf of the governmental unit, so that the DGE must file a separate Form 1094-C for each governmental unit that has delegated its reporting responsibilities to the DGE.

(C) ALE member with a self-insured employer-sponsored health plan (or options under the group health plan that are self-insured) that has delegated to the DGE the responsibilities for reporting the enrollment in coverage (section 6055) information but NOT the offer of coverage (section 6056) information.

In this case, the DGE will report the enrollment information on Form 1094-B and a Form 1095-B. The Form 1094-B will identify the DGE as the filer and the Form 1095-B will identify the DGE as the Issuer or Other Provider in Part III. The DGE is responsible for furnishing the employee a copy of the Form 1095-B filed for that employee. Because the governmental unit did not delegate its responsibilities for reporting the offer of coverage information, the governmental unit must report the offer of coverage information on a Form 1094-C and a Form 1095-C for each full-time employee, and not complete Form 1095-C, Part III (since the enrollment information will be provided by the DGE on a Form 1095-B).

Reporting Offers of COBRA Coverage

How should an ALE member complete Part II of Form 1095-C for a full-time employee who terminates employment during a calendar year and receives an offer of COBRA continuation coverage?

In general, an offer of COBRA continuation coverage that is made to a former employee due to termination of employment is not reported as an offer of coverage on Part II of Form 1095-C, unless the former employee enrolls in the COBRA coverage.

An offer of COBRA continuation coverage that is made to a current employee due to a reduction in hours is reported differently than an offer of COBRA continuation coverage to a former employee.

Note, however, that an ALE member that sponsors a self-insured plan must report regarding the enrollment of any former employee or family member.

Example 1: Steve was a full-time employee of ABC Corporation and received an offer of coverage providing minimum value for an employee, spouse and dependents (family coverage) under the ABC Corporation health plan. ABC Corporation is an ALE and its health plan is a self-insured health plan. Steve enrolled in family coverage under the ABC Corporation health plan effective January 1, 2015 through the earlier of December 31, 2015 or Steve's termination of employment. On June 15, 2015, Steve terminated employment with ABC Corporation and received an offer of continuation coverage under COBRA but did not enroll in the coverage.

For the months January 2015 through May 2015, ABC Corporation should enter code 1E, Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse, on line 14 of Form 1095-C and should enter code 2C, Employee enrolled in coverage offered, on line 16 to report that Steve enrolled in coverage under the plan. For the months January 2015 through May 2015, ABC Corporation should report on line 15 the employee contribution for the lowest-cost self-only coverage providing minimum value offered under the ABC Corporation health plan to Steve as an active employee. For June 2015 (the month in which Steve terminated employment), ABC Corporation should enter code 1H, No offer of coverage, on line 14 and code 2B, Employee not a full-time employee, on line 16 (see question 8 above concerning reporting an offer of coverage in the month of termination of employment). For July 2015 through December 2015, ABC Corporation should enter code 1H, No offer of coverage, on line 14 and code 2A on line 16 (reporting that Steve was no longer an employee in those months).

Example 2: Same facts as Example 1, except that Steve enrolls in family COBRA coverage covering himself, his spouse and dependents under the plan effective June 15, 2015 through December 31, 2015.

For the months January 2015 through December 2015, ABC Corporation should enter code 1E, Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse, on line 14 of Form 1095-C and should enter code 2C, Employee enrolled in coverage offered, on line 16 to report that Steve enrolled in coverage under the plan. For the months January 2015 through May 2015, ABC Corporation should report the employee contribution for the lowest-cost self-only coverage providing minimum value offered under the ABC Corporation health plan to Steve as an active employee. For the months June 2015 through December 2015, ABC Corporation should report the COBRA premium for the lowest-cost self-only coverage providing minimum value offered to Steve. For the months January 2015 through December 2015, ABC Corporation should enter code 2C, Employee enrolled in coverage offered, on line 16 to report that Steve enrolled in coverage under the plan.

Example 3: Same facts as Example 1, except that Steve enrolls in self-only COBRA coverage under the plan effective June 15, 2015 through December 31, 2015.

For the months January through May 2015, ABC Corporation should enter code 1E, Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse, on line 14 of Form 1095-C, should report the employee contribution for the lowest-cost self-only coverage providing minimum value offered under the ABC Corporation health plan to Steve as an active employee on line 15, and should enter code 2C, Employee enrolled in coverage offered, on line 16. For the months June 2015 through December 2015, ABC Corporation should enter code 1B, Minimum essential coverage providing minimum value offered to employee only, on line 14, should report the COBRA premium for the lowest-cost self-only coverage providing minimum value offered to Steve on line 15, and should enter code 2C, Employee enrolled in coverage offered, on line 16.

How should an ALE member complete Part II of Form 1095-C for an ongoing employee who receives an offer of COBRA continuation coverage due to a reduction in hours?

An ALE member making an offer of COBRA continuation coverage to an ongoing employee who loses eligibility for non-COBRA coverage due to a reduction in hours (for instance, a change from full-time to part-time status resulting in loss of eligibility under the plan) should report the offer of COBRA coverage as an offer of coverage in Part II of Form 1095-C.

Example 1: James was a full-time employee of ABC Corporation and received an offer of coverage under the ABC Corporation health plan providing minimum value, including an offer of minimum essential coverage to his spouse and dependents. James enrolled in self-only coverage offered from January 1, 2015 through October 31, 2015. The required employee contribution for the lowest cost self-only coverage option under the plan was $150 per month. On November 1, 2015, James transferred to a part-time position and was no longer eligible for coverage under the terms of the ABC Corporation health plan. James received an offer of COBRA continuation coverage on account

of the transfer to the reduced-hours position, with a COBRA premium of $250 per month for self-only coverage (which was the lowest-cost option for COBRA coverage available). James elected to enroll in the COBRA continuation coverage for the months of November and December, 2015.

ABC Corporation should complete Part II of Form 1095-C for James as follows. For January through October, ABC Corporation should enter code 1E, Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse, on line 14, should report $150 as the employee contribution on line 15, and should enter code 2C, Employee enrolled in coverage offered, on line 16 to report that James enrolled in the coverage offered. For November and December, ABC Corporation should enter code 1E, Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse, on line 14, should report $250 on line 15 (the required employee contribution for the lowest-cost self-only COBRA coverage providing minimum value), and should enter code 2C, Employee enrolled in coverage offered, on line 16.

Example 2: The same facts as Example 1, except James elects not to enroll in the COBRA continuation coverage. ABC Corporation should complete line 14 and line 15 in the same manner as in Example 1. However, the applicable code, if any, for line 16 is determined as it would be for any other active employee, and so will depend on whether James is treated as a full-time employee for purposes of section 4980H, and if so, whether the offer of COBRA continuation coverage for James satisfies one of the section 4980H affordability safe harbors.

How should an employer that sponsors a self-insured plan report coverage of spouses and dependents of an employee who separately elect to receive COBRA coverage?

In some circumstances, a current or former employee's spouse and dependents may be offered COBRA continuation coverage and be entitled to make an independent election to enroll in COBRA continuation coverage, for example if the employee is deceased or elects not to enroll. An employer that sponsors a self-insured plan should report coverage of each non-employee spouse and dependent who separately elects COBRA continuation coverage on a separate Form 1095-B (or Form 1095-C; see question 10 above). By contrast, if a spouse (or former spouse) or dependent receives COBRA continuation coverage because the employee or former employee has elected COBRA continuation coverage that also provides coverage to the spouse and/or dependent (for example, family coverage), the coverage of the employee, spouse and dependents should be reported together on the same Form 1095-C or Form 1095-B that is provided to the employee or former employee.

Example 1: Keri was a full-time employee of ABC Corporation and effective for the plan year beginning January 1, 2015, elected to receive self-and-spouse coverage under the self-insured ABC Corporation health plan covering herself and her spouse, Gerald. On May 15, 2015, Keri and Gerald divorce and Gerald loses eligibility for coverage under the plan. ABC Corporation makes an offer

of COBRA continuation coverage to Gerald, who elects to enroll in the COBRA continuation coverage and remains enrolled from May 15, 2015 through December 31, 2015.

ABC Corporation should report Keri's enrollment on Part III of Form 1095-C by reporting that Keri was enrolled in minimum essential coverage in January 2015 through May 2015, and that Gerald had coverage (due to Keri's enrollment in coverage providing coverage to a spouse) for the months January through May 2015.

For the period June through December 2015, Gerald should receive a separate Form 1095-B or Form 1095-C reporting him as enrolled in minimum essential coverage under ABC Corporation's self-insured health plan.

Understanding the Employer Shared Responsibility (ESR) Provisions of the Affordable Care Act (added to the Internal Revenue Code as §4980H)

What are the ESR provisions?

Beginning in 2015, employers employing at least 50 full-time employees or a combination of full-time and part-time employees that is equivalent to 50 full-time employees are subject to the ESR provisions.

A *full-time employee* is an individual employed on average at least 30 hours of service per week. An employer that meets the 50 full-time employee (FT) employee and *full-time employee equivalent* (FTE) is known as an *applicable large employer* (ALE).

Under the ESR provisions, if these employers do not offer affordable health coverage that provides a minimum level of coverage to their full-time employees (and their dependents), the employer may be subject to an ESR payment if at least one of its FT employees receives a premium tax credit for purchasing individual coverage on the Affordable Insurance Exchanges, also called a Health Insurance Marketplace (Marketplace). All for employers offering self-funded health plans or with $\geq$ 100 FT/FTEs.

What is the effective date of the ESR provisions?

The ESR provisions are effective Jan. 1, 2015. Employers will use information about the number of employees they employ and their hours of service during 2014 to determine whether they employ enough employees to be an ALE for 2015.

Which employers are subject to the ESR provisions?

All employers that are ALEs are subject to the ESR provisions, including for-profit, not-for-profit, and government entity employers.

How many employees must an employer have to be subject to the ESR provisions?

To be subject to the ESR provisions for the current calendar year, an employer must have employed during the previous calendar year at least 50 FT or a combination of FT and part-time employees that equals at least 50, known as FTE.

Example - an employer employs 40 full-time employees (employees employed 30 or

more hours per week on average) and 20 employees employed 15 hours per week on

average has the equivalent of 50 full-time employees, and is an ALE.

What employees have to be included in the count?

Seasonal workers must be included when determining the number of full-time employees. However, if an employer's workforce exceeds 50 FT/FTE for 120 days in a calendar year, and the employees in excess of 50 who were employed during that period of no more than 120 days were seasonal workers, the employer is not considered an ALE.

Seasonal workers are workers who perform labor or services on a seasonal basis as defined by the Secretary of Labor, and retail workers employed exclusively during holiday seasons. For this purpose, employers may apply a reasonable, good faith interpretation of the term "seasonal worker."

Note: The term *seasonal employee* is relevant for determine an employee's status as a full-time employee.

When is the count taken?

Employers must determine each year, based on their current number of employees, whether they will be considered an ALE for the next year. The term seasonal employee is relevant for determining an employee's status as a full-time employee. If an employer has at least 50 FT/FTE for 2014, it will be considered an ALE for 2015. There is a transition rule intended to make 2015, the first calculation, easier.

Employers average their number of employees across the months in the year to see whether they will be an ALE for the next year. Averaging takes into account the fluctuations that many employers may experience in their work force across the year.

How does a new employer (not in existence throughout the preceding calendar year) determine whether it is subject to the ESR provisions?

An employer that was not in existence on any business day in the prior calendar year is considered an ALE in the current year if the employer is reasonably expected to employ an average of at least 50 FT/FTE on business days during the current calendar year and it actually employs an average of at least 50 FT/FTE on business days during the calendar year.

For the next year (the year after the first year the employer was in existence), the employer determines its status as an ALE using the rules that generally apply (that is, based on the number of full-time employees and full-time equivalents that the employer employed in the preceding year).

What if two or more companies have a common owner or are otherwise related?

Under the IRC controlled group rules, companies that have a common owner or are otherwise related generally are combined and treated as a single employer, and so would be combined for purposes of determining whether or not they collectively employ at least 50 FT/FTE. If the combined total meets the threshold, then each separate company is subject to the ESR provisions, even those companies that individually do not employ enough employees to meet the threshold.

These rules for combining related employers do not apply for purposes of determining whether a particular company owes an ESR payment or the amount of any payment. That is determined separately for each related company.

Do the ESR provisions apply to employers with full-time employees who are eligible for health coverage through another source, such as Medicare, Medicaid, Health Care Sharing Ministry, federally recognized Indian tribe, status as a full-time employee or a spouse's employer?

Yes. For purposes of determining whether an employer is an ALE, all employees are counted (see seasonal workers exceptions), regardless of whether the employees are eligible for health coverage from another source, such as Medicare, Medicaid, Health Care Sharing Ministry, federally recognized Indian tribe or a spouse's employer.

Employees who are eligible for Medicare or Medicaid are not eligible for a premium tax credit. If no full-time employee receives a premium tax credit (for example, because all of an employer's full-time employees are eligible for Medicare or Medicaid), the employer will not be subject to an ESR payment.

If an ALE does not offer coverage to its full-time employees (and their dependents) or offers coverage to fewer than 95% (70% in 2015) of its full-time employees (and their dependents) and a full-time employee receives a premium tax credit, the employer will be liable for an ESR payment, which will be calculated based on the employer's number of full-time employees. For this purpose, the number of full-time employees includes full-time employees who are eligible for coverage from another source.

Which employers are not subject to the ESR provisions?

For a calendar year, employers who employ fewer than 50 FT/FTE in the prior calendar year are not subject to the ESR provisions.

Are companies with employees working outside the United States subject to the ESR provisions?

For purposes of determining whether an employer is an ALE, an employer generally takes into account only work performed in the United States. For example, if a foreign employer has a large workforce worldwide, but fewer than 50 FT/FTE in the United States, the foreign employer generally would not be subject to the ESR provisions.

Are companies that employ U.S. citizens working abroad subject to the ESR provisions?

A company that employs U.S. citizens working abroad generally would be subject to the ESR provisions only if the company had at least 50 FT/FTE, determined by taking into account work performed in the United States. Thus, employees working only abroad, whether or not U.S. citizens, generally will not be taken into account for purposes of determining whether an employer is ALE or for purposes of determining whether the employer owes an ESR payment or the amount of any such payment.

Identification of FT/FTES

How does an employer identify its full-time employees for purposes of the ESR provisions?

Why does the number of FT/FTES matter? An employer's number of full-time employees matters both for purposes of whether the ESR provisions apply to an employer and whether an ESR payment is owed by an employer (and the amount of that payment). An employer identifies its full-time employees based on each employee's hours of service. For purposes of the ESR provisions, an employee is a full-time employee for a calendar month if he or she averages at least 30 hours of service per week.

To determine full-time employee status, 130 hours of service in a calendar month is treated as the monthly equivalent of at least 30 hours of service per week.

For purposes of determining hours of service, interns are treated like all other employees.

An employee, including an intern, who receives no payment from an employer, will not have any hours of service.

Measurement Periods

For purposes of the ESR provisions, what is an hour of service?

Generally, an hour of service means each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer, and each hour for which an employee is paid, or entitled to payment, for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

Under the final regulations, an hour of service does not include any hour of service performed as a bona fide volunteer, as part of a Federal Work-Study Program (or a substantially similar program of a State or political subdivision thereof) or to the extent the compensation for services performed constitutes income from sources without the United States.

A religious order is permitted, for purposes of determining if an employee is a full-time employee for the ESR provisions, to not count as an hour of service any work performed by an individual who is subject to a vow of poverty as a member of that order when the work is in the performance of tasks usually required (and to the extent usually required) of an active member of the order.

For purposes of the ESR provisions, what is an hour of service?

Generally, an hour of service means each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer, and each hour for which an employee is paid, or entitled to payment, for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

Under the final regulations, an hour of service does not include any hour of service performed as a bona fide volunteer, as part of a Federal Work-Study Program (or a substantially similar program of a State or political subdivision thereof) or to the extent the compensation for services performed constitutes income from sources without the United States.

A religious order is permitted, for purposes of determining if an employee is a full-time employee for the ESR provisions, to not count as an hour of service any work performed by an individual who is subject to a vow of poverty as a member of that order when the work is in the performance of tasks usually required (and to the extent usually required) of an active member of the order.

Are there special rules for hours of service that are particularly challenging to identify or track or for whom the final regulations' general rules for determining hours of service may present special difficulties?

Treasury and the IRS continue to consider additional rules for the determination of hours of service for certain categories of employees whose hours of service are particularly challenging to identify or track or for whom the general rules for determining hours of service may present special difficulties (including adjunct faculty, commissioned salespeople and airline employees) and certain categories of work hours associated with some positions of employment, including layover hours (for example for airline employees) and on-call hours. For this purpose, until further guidance is issued, employers are required to use a reasonable method of crediting hours of service that is consistent with section 4980H. The preamble to the final regulations includes examples of methods of crediting these hours that are reasonable and that are not reasonable, including a method that is considered reasonable for crediting hours of service for adjunct faculty members.

Under what circumstances will an employer owe an ESR payment?

An ALE will be liable for an ESR payment only if:

- The employer does not offer health coverage or offers coverage to fewer than 95% (70% for 2015) of its full-time employees and the dependents of those employees, and at least one of the full-time employees receives a premium tax credit to help pay for coverage on a Marketplace; OR
- The employer offers health coverage to all or at least 95% (70% for 2015) of its full-time employees, but at least one full-time employee receives a premium tax credit to help pay for coverage on a Marketplace, which may occur because the employer did not offer coverage to that employee or because the coverage the employer offered that employee was either unaffordable to the employee or did not provide minimum value.

How does an employer know whether the coverage it offers is affordable?

If an employee's share of the premium for employer-provided coverage would cost the employee more than 9.5% of that employee's annual household income, the coverage is not considered affordable for that employee. Because employers generally will not know their employees' household incomes, employers can take advantage of one or more of the three affordability safe harbors set forth in the final regulations that are based on information the employer will have

available, such as the employee's Form W-2 wages or the employee's rate of pay. If an employer meets the requirements of any of these safe harbors, the offer of coverage will be deemed affordable for purposes of the ESR provisions regardless of whether it was affordable to the employee for purposes of the premium tax credit.

The three affordability safe harbors are (1) the Form W-2 wages safe harbor, (2) the rate of pay safe harbor, and (3) the federal poverty line safe harbor. These safe harbors are all optional. An employer may use one or more of the safe harbors only if the employer offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan that provides minimum value for the self-only coverage offered to the employee. An employer may choose to use one or more of the safe harbors for all of its employees or for any reasonable category of employees, provided it does so on a uniform and consistent basis for all employees in a category. If an employer offers multiple healthcare coverage options, the affordability test applies to the lowest-cost self-only option available to the employee that also meets the minimum value requirement.

The Form W-2 wages safe harbor generally is based on the amount of wages paid to the employee that are reported in Box 1 of that employee's Form W-2. The rate of pay safe harbor generally is based on the employee's rate of pay at the beginning of the coverage period, with adjustments permitted, for an hourly employee, if the rate of pay is decreased (but not if the rate of pay is increased). The federal poverty line safe harbor generally treats coverage as affordable if the employee contribution for the year does not exceed 9.5% of the federal poverty line for a single individual for the applicable calendar year.

How does an employer know whether the coverage it offers provides minimum value?

A plan provides minimum value if it covers at least 60 percent of the total allowed cost of benefits that are expected to be incurred under the plan. The Department of Health and Human Services (HHS) and the IRS have produced a minimum value calculator. By entering certain information about the plan, such as deductibles and co-pays, into the calculator employers can get a determination as to whether the plan provides minimum value.

If an employer offers health coverage that is affordable and that provides minimum value to its full-time employees and offers health coverage to the dependents of those employees, will it be subject to an ESR payment if some of its employees purchase health insurance through a Marketplace or if some of its employees enroll in Medicare or Medicaid?

No. An ALE will not be subject to an ESR payment solely because one, some, or all of its employees purchase health insurance coverage through a Marketplace or enroll in Medicare or Medicaid. An employer will not be liable for an ESR payment unless at least one full-time employee receives a premium tax credit. In general, an employee will not be eligible for a premium tax credit if the

employer has offered that employee health coverage that is affordable and that provides minimum value, even if that employee rejects the offer of coverage and instead enrolls in coverage through a Marketplace or enrolls in Medicare or Medicaid. If no full-time employee receives a premium tax credit, the employer will not be subject to an ESR payment.

If an employer offers health coverage that is affordable and that provides minimum value to its full-time employees and offers health coverage to the dependents of those employees, will it be subject to an ESR payment if an employee's spouse purchases health insurance through a Marketplace, or if a spouse enrolls in Medicare or Medicaid?

No. To avoid a potential ESR payment an ALE must offer health coverage that is affordable and provides minimum value to its full-time employees and must offer health coverage to the dependents of those employees.

For this purpose, a spouse is not a dependent. An ALE will not be subject to an ESR payment solely because it does not offer health coverage to an employee's spouse or if the spouse purchases health insurance coverage through a Marketplace or enrolls in Medicare or Medicaid.

An employer will not be liable for an ESR payment unless a full-time employee receives a premium tax credit. If no full-time employee receives a premium tax credit, the employer will not be subject to an ESR payment. Thus, even if an employee's spouse receives a premium tax credit, the employer will not be subject to an ESR payment.

If an ALE offers health coverage that is affordable and that provides minimum value to a full-time employee's spouse, the spouse will not be eligible for the premium tax credit.

If an employer offers health coverage that is affordable and that provides minimum value to its full-time employees and offers health coverage to the dependents of those employees, will it be subject to an ESR payment if some of its employees purchase health insurance coverage for their dependents through a Marketplace or if some of its employees enroll their dependents in Medicare or Medicaid?

No. An ALE will not be subject to an ESR payment solely because one, some or all of its employees purchase health insurance coverage for their dependents through a Marketplace or enroll their dependents in Medicare or Medicaid. An employer will not be liable for an ESR payment unless a full-time employee receives a premium tax credit. If no full-time employee receives a premium tax credit, the employer will not be subject to an ESR payment.

If an employer offers health coverage that is affordable and that provides minimum value to the dependents of its full-time employees, those dependents will not be eligible for a premium tax credit.

If an employer that does not offer coverage or that offers coverage to fewer than 95% (70% for 2015) of its full-time employees (and their dependents) owes an ESR payment, how is the amount of the payment calculated?

If an ALE does not offer coverage or offers coverage to fewer than 95% (70% FOR 2015) of its full-time employees (and their dependents), it owes an ESR payment equal to the number of full-time employees the employer employed for the year (minus up to 30) multiplied by $2,000, as long as at least one full-time employee receives the premium tax credit. For purposes of this calculation, a full-time employee does not include a full-time equivalent.

For an employer that offers coverage for some months but not others during the calendar year, the payment is computed separately for each month for which coverage was not offered. The amount of the payment for the month equals the number of full-time employees the employer employed for the month (minus up to 30; 80 for 2015) multiplied by 1/12 of $2,000. If the employer is related to other employers, then the 30-employee exclusion is allocated among all the related employers in proportion to each employer's number of full-time employees.

If an employer offers coverage to at least 95% (70% for 2015) of its full-time employees (and their dependents), but, nevertheless, owes the ESR payment, how is the amount of the payment calculated?

For an employer that offers coverage to at least 95% (70% for 2015) of its full-time employees (and their dependents), but has one or more full-time employees who receive a premium tax credit, the payment is computed separately for each month. The amount of the payment for the month equals the number of full-time employees who receive a premium tax credit for that month multiplied by 1/12 of $3,000. The amount of the payment for any calendar month is capped at the number of the employer's full-time employees for the month (minus up to 30; 80 for 2015) multiplied by 1/12 of $2,000. (The cap ensures that the payment for an employer that offers coverage can never exceed the payment that employer would owe if it did not offer coverage.

Will the amount of the ESR payment be increased over time?

Yes. The ESR provisions provide an inflation adjustment mechanism.

Measurement determines whether an employee has sufficient hours of service to be a full-time employee. One method is the monthly measurement method under which an employer determines each employee's status as a full-time employee by counting the employee's hours of service for each month. The other method is the look-back measurement method under which an employer may determine the status of an employee as a full-time employee during a future period (referred to as the stability period), based upon the hours of service of the employee in a prior period (referred to as the measurement period). The look-back measurement method for identifying full-

time employees is available only for purposes of determining and computing liability for an ESR payment, and not for purposes of determining if the employer is an ALE.

The term "*seasonal employee*" is relevant for determining an employee's status as a full-time employee under the look-back measurement method. The look-back measurement method includes special rules that apply to new employees who are seasonal employees. For this purpose, a seasonal employee means an employee who is hired into a position for which the customary annual employment is six months or less and for which the period of employment begins each calendar year in approximately the same part of the year, such as summer or winter. Note that the look-back measurement method is not available for purposes of determining whether the employer is an ALE.

Making an ESR Payment

How will an employer know that it owes an ESR payment?

The IRS will adopt procedures that ensure employers receive certification that one or more employees have received a premium tax credit. The IRS will contact employers to inform them of their potential liability and provide them an opportunity to respond before any liability is assessed or notice and demand for payment is made. The contact for a given calendar year will not occur until after the due date for employees to file individual tax returns for that year claiming premium tax credits and after the due date for ALEs to file the information returns identifying their full-time employees and describing the coverage that was offered (if any).

How will an employer make an ESR payment?

If it is determined that an employer is liable for an ESR payment after the employer has responded to the initial IRS contact, the IRS will send a notice and demand for payment. That notice will instruct the employer on how to make the payment. Employers will not be required to include the ESR payment on any tax return that they file.

Non-Calendar Year Plans

The health plan offered to the employees runs on a non-calendar year plan year that starts in 2014. How is the plan impacted?

The preamble to the final regulations provides three pieces of transition relief addressing non-calendar year plans — (1) pre-2015 eligibility transition relief, (2) significant percentage transition relief (all employees) and (3) significant percentage transition relief (full-time employees). The first piece of relief generally addresses employees that are already eligible to participate in the non-calendar year plan. Specifically the pre-2015 eligibility transition relief provides that for any

employees (whenever hired) who are eligible for coverage on the first day of the 2015 plan year under the eligibility terms of the plan as of Feb. 9, 2014, (whether or not they take the coverage) and who are offered affordable coverage that provides minimum value effective no later than the first day of the 2015 plan year, the employer will not be subject to a potential ESR payment until the first day of the 2015 plan year. The remaining two pieces of relief generally address employees that have not been eligible to participate in the non-calendar year plan. They provide that if the employer meets certain requirements generally related to the portion of the employer's employees already eligible for or participating in the non-calendar year plan, the relief may be extended to those employees that have not been eligible to participate. The preamble to the final regulations provides additional information on the rules for determining whether an employer is eligible for this relief. All of this transition relief applies for the period before the first day of the first non-calendar year plan year beginning in 2015 (the 2015 plan year) but only for employers that maintained non-calendar year plans as of Dec. 27, 2012, and only if the plan year was not modified after Dec. 27, 2012, to begin at a later calendar date. See question 36 on 2015 transition relief.

Is transition relief available to assist employers that are close to the 50 full-time employee threshold in determining if they are an ALE for 2015?

Yes. Rather than being required to use the full twelve months of 2014 to measure whether it has 50 FT/FTEs, an employer may measure during any consecutive six-month period (as chosen by the employer) during 2014. For example, an employer could use a period of at least six months through August 2014 to determine its ALE status and, if it is an ALE, the period from September through December 2014 to make any needed adjustments to its plan (or to establish a plan).

For 2015, will employees who receive offers of coverage effective as of the first day of the first pay period beginning on or after the first day of the year be treated as having been offered coverage for January 2015?

Yes. Generally, if an employer fails to offer coverage to a full-time employee for any day of a calendar month, that employee is treated as not offered coverage during the entire month. Solely for purposes of January 2015, if an employer offers coverage to a full-time employee no later than the first day of the first payroll period that begins in January 2015, the employee will be treated as having been offered coverage for January 2015.

Do employers have additional time to expand their 2015 health plans to add dependent coverage?

The transition relief in the preamble to the final regulation generally extends the transition relief that had been provided for plan years that begin in 2014 (2014 plan years) to plan years that begin in 2015 (2015 plan years). Under this transition relief, an employer that took steps during its 2014 plan

year toward offering dependent coverage will not be subject to an ESR payment solely on account of a failure to offer coverage to dependents for that plan year.

This extended transition relief applies to employers for the 2015 plan year for plans under which (1) dependent coverage is not offered, (2) dependent coverage that does not constitute minimum essential coverage is offered, or (3) dependent coverage is offered for some, but not all, dependents.

The transition relief is not available to the extent the employer had offered dependent coverage during either the plan year that begins in 2013 (2013 plan year), or the 2014 plan year and subsequently dropped that offer of coverage. The transition relief, as extended, applies only for dependents who were without an offer of coverage from the employer in both the 2013 and 2014 plan years and if the employer takes steps during the 2014 or 2015 plan year (or both) to extend coverage under the plan to dependents not offered coverage during the 2013 or 2014 plan year (or both).

Is additional transition relief available for employers with at least 50 but fewer than 100 FT/FTE?

Yes. For employers with fewer than 100 FT/FTE in 2014, that meet the conditions described below, no ESR payment under section 4980H(a) or (b) will apply for any calendar month during 2015. For employers with non-calendar-year health plans, this applies to any calendar month during the 2015 plan year, including months during the 2015 plan year that fall in 2016.

In order to be eligible for the relief, an employer must certify that it meets the following conditions:

(1) **Limited Workforce Size**. The employer must employ on average at least 50 FT/FTE but fewer than 100 FT/FTE on business days during 2014. (Employers with fewer than 50 FT/FTE on business days during the previous year are not subject to the ESR provisions.) The number of FT/FTE is determined in accordance with the otherwise applicable rules in the final regulations for determining status as an ALE.

(2) **Maintenance of Workforce and Aggregate Hours of Service.** During the period beginning on Feb. 9, 2014 and ending on Dec. 31, 2014, the employer may not reduce the size of its workforce or the overall hours of service of its employees in order to qualify for the transition relief. However, an employer that reduces workforce size or overall hours of service for bona fide business reasons is still eligible for the relief.

(3) **Maintenance of Previously Offered Health Coverage.** During the period beginning on Feb. 9, 2014 and ending on Dec. 31, 2015 (or, for employers with non-calendar-year plans, ending on the last day of the 2015 plan year) the employer does not eliminate or materially

reduce the health coverage, if any, it offered as of Feb. 9, 2014. An employer will not be treated as eliminating or materially reducing health coverage if (i) it continues to offer each employee who is eligible for coverage an employer contribution toward the cost of employee-only coverage that either (A) is at least 95 percent of the dollar amount of the contribution toward such coverage that the employer was offering on Feb. 9, 2014, or (B) is at least the same percentage of the cost of coverage that the employer was offering to contribute toward coverage on Feb. 9, 2014; (ii) in the event of a change in benefits under the employee-only coverage offered, that coverage provides minimum value after the change; and (iii) it does not alter the terms of its group health plans to narrow or reduce the class or classes of employees (or the employees' dependents) to whom coverage under those plans was offered on Feb. 9, 2014.

Is the transition relief for employers with at least 50 but fewer than 100 FT/FTE available to newly formed employers? If so, how does a new employer know whether it qualifies for the relief?

Yes, the relief is available to new employers (that is, employers that are not in existence on any business day in 2014).

For new employers that would be ALEs under the general rules in the final regulations, the special transition relief applies if the employer certifies that it (i) reasonably expects to employ and actually employs fewer than 100 FT/FTE on business days during 2015; and (ii) reasonably expects to meet and actually meets the standards relating to maintenance of workforce and aggregate hours of service and of previously offered health coverage, as measured from the date the employer is first in existence.

How does the transition relief for employers with fewer than 100 full-time employees coordinate with other transition relief available under the final regulations?

For periods on or after Jan. 1, 2016 (or, if applicable, for any period after the last day of the 2015 plan year) the transition relief for 2015 generally is not available. An employer may, however, use the shorter period in 2014 permitted for determining ALE status for 2015 in determining ALE status and full-time employee count for 2015 (but not for any subsequent year). See questions 30 through 33.

Related Provisions

When can an employee receive a premium tax credit?

The premium tax credit generally is available to help pay for coverage for employees who

- have household income between 100% and 400% of the federal poverty line and enroll in coverage through a Marketplace,
- are not eligible for coverage through a government-sponsored program like Medicaid or CHIP, and
- are not eligible for coverage offered by an employer or are eligible only for employer coverage that is unaffordable or that does not provide minimum value.

If an employer does not employ enough employees to be subject to the ESR provisions, does that affect the employees' eligibility for a premium tax credit?

No. The rules for how eligibility for employer-sponsored insurance affects eligibility for the premium tax credit are the same, regardless of whether the employer is subject to the ESR provisions.

If a business that is subject to the ESR provisions does not offer insurance, is it subject to an ESR payment?

Yes. An ALE must generally offer coverage to its full-time employees (and their dependents) even if the employee is eligible for coverage from another source, to avoid a potential ESR payment. An ALE may be subject to an ESR payment if the employer does not offer health coverage to its full-time employees (and their dependents) and at least one of its full-time employees receives a premium tax credit for purchasing individual coverage on the Marketplace. If an ALE does not offer coverage to its full-time employees (and their dependents) or offers coverage to fewer than 95% of its full-time employees (70% in 2015 as a transition) (and their dependents), and at least one full-time employee receives a premium tax credit, the employer will be liable for an ESR payment, which will be calculated based on the employer's number of full-time employees. For this purpose, all full-time employees are counted, including those who are eligible for coverage from another source. Years toward offering dependent coverage may not be subject to an ESR payment solely on account of a failure to offer coverage to dependents.)

An employer may owe an ESR payment only if one or more full-time employees receive a premium tax credit. Individuals (including employees) who are eligible for Medicare or Medicaid are generally not eligible for a premium tax credit. Thus, if all of an employer's full-time employees are eligible for Medicare or Medicaid, the employer will not be subject to an ESR payment. However, if even one full-time employee receives a premium tax credit, the employer may be subject to an ESR payment.