Employer Shared Responsibility Requirements

Counting hours and employees

Question:
Are we required to track actual hours worked for employees who are hired into full-time, salaried, exempt positions?
Answer:
No. If a full-time employee is paid on a non-hourly basis (such as a salaried employee), an employer may choose to track actual hours worked or use a days-worked or a weeks-worked equivalency method to estimate hours of service.
The days-worked method credits an employee with eight hours worked for each day an employee is required to be credited with one or more hours of service. The weeks-worked equivalency method credits an employee with 40 hours for each week an employee works at least one hour.
Employers cannot use an equivalency method if the result substantially understates an employee's hours of service so much that the employee loses full-time status.
Resources:
Shared Responsibility for Employers Regarding Health Coverage; Final Rule, 26 CFR Parts 1, 54, and 301, February 12, 2014

Question:
What is the “monthly method” for determining full-time employee status, and how is it used for new and ongoing employees?
Answer:
Under the monthly measurement method, an employer determines if an employee is a full-time employee on a month-by-month basis by looking at whether the employee has at least 130 hours of service for each month.
An hour of service is each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer during a period of time that no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence. An exclusion from the definition of hour of service is provided for volunteer employees, students performing work-study, members of religious orders, and compensation that is from a foreign source of income.
The monthly method can be used for both new and ongoing employees. However, in the context of new employees, employers will not be subject to a pay or play penalty for not offering coverage to an employee during a period of three full calendar months, beginning with the first full calendar month in which the employee is otherwise eligible for coverage. Health coverage must be offered no later than the first day of the first calendar month immediately following the three-month period and the coverage must provide minimum value. This rule applies only once per period of employment of an employee.
Resources:
Identifying Full-time Employees, IRS, 2/11/15
Shared Responsibility for Employers Regarding Health Coverage - Internal Revenue Bulletin 2014-9, IRS, 2/24/14

Question:
How do controlled group rules apply for purposes of counting the number of full-time employees?
Answer:
Code §4980H provides the guidelines for counting the number of full-time employees (or full-time equivalent employees; FTE’s) in order to determine whether or not an employer is an *applicable large employer* (ALE). The controlled group rule means that single employers under Code §414 (b), (c), (m) or (o) are treated as one single employer so that all of the employees of a controlled group of entities are combined to determine ALE status.
Example 1 on p. 8583 of the final rule addresses the applicable large employer/controlled group provisions.
Resources:
Shared Responsibility for Employers Regarding Health Coverage; Final Rule, 26 CFR Parts 1, 54, and 301, February 12, 2014

Question:
What are the 30 hours per week or 130 hours per month requirements that are used for determining full-time employee status under the Affordable Care Act?
Answer:
Beginning January 1, 2015, the Affordable Care Act requires applicable large employers to offer health coverage to full-time employees and certain dependents, or face possible penalties.
An "applicable large employer" is an employer who employed an average of at least 50 full-time and full-time equivalent employees on business days during the preceding calendar year.
A "full-time employee" for this purpose is a common law employee who is credited with an average of at least 30 hours of service per week. Employers can choose to treat hourly-paid employees who work at least 130 hours of service in a calendar month as full-time without determining the average weekly hours. An employer choosing to use the 130-hour equivalency option must apply it on a reasonable and consistent basis.
For this purpose, "hours of service" includes each hour for which an employee is paid or entitled to payment for performing duties for the employer, and each hour for which an employee is paid or entitled to payment even if no work is done (e.g., vacation, holiday, sick, jury duty, military duty, leave of absence, disability).
Full-time *equivalent* employees are determined separately from the full-time employees.
Employers may use safe harbors to determine whether employees who work variable hours are considered full-time employees. This Q&A does not go into the safe harbor measurements.
Resource:
Shared Responsibility for Employers Regarding Health Coverage; Final Rule
Federal Register, February 12, 2014 (See especially pages 8552 - 8553)

Question:
Is it true that when using the look-back method to count employee hours, the sum of the measurement and administrative periods must be less than 13 months?
Answer:
It's true that under the Affordable Care Act's employer shared responsibility provisions, there is a limit on combined length of initial measurement period and administrative period. Using the look-back method, if an employer is not sure whether a new employee is reasonably expected to work full-time, the employer may use a measurement period not to exceed 12 months and an administrative period not to exceed 90 days. However, the combined length can total, at most, 13 months and a fraction of a month. If the employee's start date is the first day of a calendar month, the effective date of coverage cannot extend beyond 13 months from the start date. If the employee's start date is not the first day of a calendar month, the effective date of coverage cannot extend beyond 13 months plus the fraction of a month until the first day of the next month.
Resources:
Shared Responsibility for Employers Regarding Health Coverage Final Regulations Federal Register, February 12, 2014 (p.8589 middle column (B)

Question:
Does an employer need to count employees on maternity leave when determining how many full-time employees it has?
Answer:
Yes. In counting full-time employees for the Employer Shared Responsibility requirement, an employer must count employee hours of service for the prior year. Paid leaves of absences, including paid maternity leave, are counted toward an employee's hours of service. Unpaid maternity leave is counted only if the employee also qualifies for federal Family and Medical Leave Act (FMLA) leave.
Resources:
What Counts As An Hour of Service? Arthur J. Gallagher & Co., January 2016 (See page 2)
Affordable Care Act (ACA): Understanding Hours of Service, Infinity HR, 4/9/15 (See starting on page 3)
Shared Responsibility for Employers Providing Health Coverage; Final Regulations, 79 Federal Register 8543, February 12, 2014
Hours of Service, 29 CFR 2530.200b-2
Employer Shared Responsibility Provisions, IRS

Question:
How do you count an employee's hours to determine if they are a full-time employee, if they are paid per diem and work on a case by case basis?
Answer:
For purposes of the employer shared responsibility rules, employees can be counted as full-time or part-time depending on the hours of service worked over the prior calendar year. For employees not paid on an hourly basis, employers can calculate the number of hours of service in one of the following ways:
 Counting actual hours of service (as if paid on an hourly basis) from records of hours worked and for which payment is due for vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence;
 Using a days-worked equivalency method whereby the employee is credited with eight hours of service for each day for which the employee would be required to be credited with at least one hour of service under these service crediting rules; or
 Using a weeks-worked equivalency of 40 hours of service per week for each week for which the employee would be required to be credited with at least one hour of service under these rules.

Using the days-worked or weeks-worked method must reflect hours actually worked and hours for which payment is made or due. Employers cannot use an equivalency method if the result substantially understates an employee's hours of service.
Employers may change the method of calculating non-hourly employees' hours of service for each calendar year. An employer is not required to use the same method for all non-hourly employees, and may apply different methods for different categories of non-hourly employees, provided the categories are reasonable and consistently applied.
Resources:
Shared Responsibility for Employers Regarding Health Coverage; Final Rule, 26 CFR Parts 1, 54, and 301, February 12, 2014

Question:
If an employer has only part-time employees but has over 50 full-time equivalents (FTEs) is the employer subject to the employer mandate?
Answer:
The number of FTEs is only relevant to determining whether an employer is an applicable large employer (ALE). Yes, the employer in this question is an ALE. However, ACA's employer shared responsibility provisions apply to full-time employees only and in this scenario there are no full-time employees.
ACA does not require an ALE to offer coverage to part-time employees, even if part-time employees make up the majority or total of the employer's workforce. A part-time employee's receipt of the premium tax credit for purchasing coverage through the public Marketplace will not trigger an employer shared responsibility payment.
A full-time equivalent is a combination of employees, each of whom individually is not a full-time employee, but who, in combination, are equivalent to a full-time employee. To determine your number of FTEs for a month, follow these steps:
1. Combine the number of hours of service of all non-full-time employees for the month but do not include more than 120 hours of service per employee, and
2. Divide the total by 120.

Use the Employer Shared Responsibility Provision Estimator to determine the number of your full-time employees, including FTEs, whether you might be an ALE, and your potential liability if you are an ALE.
Resources:
Determining if an Employer is an Applicable Large Employer, IRS, page last reviewed or updated 6/2/16.

Question:
What is the effect of probationary employment on the 90 day waiting period? When does coverage need to be offered?
Answer:
The Affordable Care Act prohibits group health plans and health insurers from imposing a waiting period that exceeds 90 days on individuals who are otherwise eligible for coverage for plan years beginning on or after January 1, 2015.
However, the final regulations make clear that orientation/probationary periods are permissible as long as they are not designed to avoid the 90-day maximum waiting period limitation.
An orientation period longer than one month is not permitted. If an orientation period lasts longer than one month, counting the 90-day waiting period limit starts after one month of the orientation period has passed. Any additional time will count toward the 90-day waiting period limit.
The orientation period begins on an employee's start date in a position that is otherwise eligible for coverage and runs for one calendar month, subtracting one calendar day. Weekends and holidays are counted.
Example. An employee starts in an otherwise eligible position on May 3. The last permitted day of the orientation period is June 2, and the 90-day waiting period starts on June 3.
Resources:
Ninety-Day Waiting Period Limitation, Final Rule, Federal Register (June 25, 2014).

Question:
How do the Affordable Care Act's 90-day waiting period, permissible orientation period, and employer shared-responsibility requirements interact?
Answer:
A "waiting period" is defined as the time that must pass before employee or dependent health care coverage becomes effective. Final regulations issued February 24, 2014 state that a group health plan waiting period cannot be more than 90 days. All days from an eligible employee's start date are counted, including weekends and holidays.
On June 25, 2014, final regulations were issued permitting employers to establish a one-month orientation period before beginning the 90-day waiting period. The "month" is determined by adding one calendar month and subtracting one calendar day and is measured from an eligible employee's start date. One month is the maximum allowed length of a "reasonable" and "bona fide" employment-based orientation period. The start of the 90-day count begins at the end of the month, even if the orientation period is longer. Plans may impose eligibility criteria, such as requiring a worker to fit within a particular job classification or to achieve job-related licensure requirements but may not impose conditions that are subterfuges for the passage of time.
If an orientation period is combined with a maximum 90-day waiting period, care should be taken to coordinate the timing with the employer shared responsibility requirements. Under the shared responsibility requirements, health care coverage must begin no later than the first day of the fourth month of employment. Since counting for the orientation and waiting periods can begin with an eligible employee's start date, it is possible for this combined period to extend beyond the first day of the fourth month of employment.
Resources:
Ninety-Day Waiting Period Limitation and Technical Amendments to Certain, Health Coverage Requirements Under the Affordable Care Act; Final Rule, 26 CFR Part 54, 29 CFR Part 2590, 45 CFR Parts 144, 146, and 147, February 24, 2014
Ninety-Day Waiting Period Limitation; Final Rules, 26 CFR Part 54, 29 CFR Part 2590, 45 CFR Part 147, 79, June 25, 2014

Question:
If an employer provides paid leave (such as vacation, funeral and jury duty) to its employees, should these hours be counted when determining full-time employee status?
Answer:
Yes.
For purposes of employer shared responsibility provisions, an employee is considered full-time if the employee averages 30 hours per week for a calendar month. Employers can choose to treat hourly-paid employees who work at least 130 hours of service in a calendar month as full-time without determining the average weekly hours, as long as they apply this 130 hour rule consistently.
Hours of service is defined as each hour for which an employee is paid or entitled to payment for the performance of duties for the employer. This includes hours for which no duties are performed, such as vacation, holiday, jury duty, etc. Regulations do not limit the number of paid non-work hours that are to be counted.
Resources:
Shared Responsibility for Employers Regarding Health Coverage; Final Rule, 26 CFR Parts 1, 54, and 301, February 12, 2014
Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act [Q 15-17], Internal Revenue Service, February 2014

Question:
How do employers measure hours for employees who are out on unpaid family and medical leave for purposes of the employer shared responsibility (pay-or-play) provisions?
Answer:
The Affordable Care Act provides rules for averaging hours during a measurement period if an employee is on *special unpaid leave*. Special leaves are defined as unpaid Family and Medical Leave Act (FMLA) leave, Uniformed Services Employment and Reemployment Rights Act (USERRA) leave, and jury duty.
Employers can treat the special unpaid leave period in one of the following ways:

- determine average hours of service after excluding the special leave period from the measurement period and use that average as the average for the entire measurement period, or

- credit hours of service for the special unpaid leave at a rate equal to the average weekly hours of service earned in the weeks during the measurement period that are not part of a period of special unpaid leave. Employers may use any reasonable method for calculating the average weekly rate.

The special unpaid leave rule applies to the look-back measurement method, not the monthly measurement method. There is no limit on the number of hours of service required to be excluded or credited for special unpaid leave.
Resources:
Shared Responsibility for Employers Regarding Health Coverage; Final Rule, 26 CFR Parts 1, 54, and 301, Federal Register, February 12, 2014

Question:
How do you count temporary workers (assigned by a temporary staffing agency) for purposes of the employer shared responsibility requirements?
Answer:
Generally, an employer is responsible for counting and offering coverage to its common law employees. It's not always clear whether temporary workers could be classified as common law employees of the staffing agency or the client or both. The common law relationship exists when you have the right to control how services are performed by someone who performs services for you. Such a worker is your common law employee and is counted for purposes of the employer shared responsibility requirements.
A special rule applies if the client is the common law employer of a worker and if the staffing agreement contains a provision for an offer of coverage. Specifically, if the staffing agency offers coverage under its health plan, the client is treated as offering that coverage as long as the client pays the staffing agency more for a worker who *accepts* the offer of coverage than the client would pay if the worker *declines* the offer. The increased fee can only apply to the workers who elect the staffing agency plan coverage.
Resources:
Employee (Common-Law Employee), IRS, last reviewed November 2, 2015.
Shared Responsibility for Employers Regarding Health Coverage Final Rule Federal Register, February 12, 2014 (see page 8598, *Offer of coverage on behalf of another entity*)

Question:
Do employers include expatriates (U.S. citizens) in their pay or play calculations?
Answer:
Proposed regulations issued January 2, 2013, indicate that hours of service generally do not include hours of service worked outside the United States (foreign source income consistent with Federal tax compensation rules). Employees working overseas will not have hours of service, and will not qualify as full-time employees either for determining employer status as a large employer or for calculating liability under section 4980H. However, all hours of service with U.S. source income are hours of service for section 4980H.
Given the complexity of expatriate coverage issues, temporary transitional relief was granted to insured expatriate health plans. An expatriate plan is defined as an insured group health plan with enrollment limited to participants living outside the United States (or their home country) for at least six months of the year. As a condition of transition relief, expatriate plans must comply with the pre-Affordable Care Act version of Title XXVII of the Public Health Service Act and other applicable law under ERISA and the Internal Revenue Code.
Coverage provided under an insured expatriate health plan is considered to provide minimum essential health coverage.
Additional guidance is expected; however, new regulations that are more restrictive will not be applicable to plan years ending on or before December 31, 2016.
Resources:
Shared Responsibility for Employers Regarding Health Coverage; Proposed Rule, 26 CFR Parts 1, 54 and 301, January 2, 2013
FAQs about the Affordable Care Act Implementation Part XIII, Department of Labor, March 8, 2013
FAQs about Affordable Care Act Implementation (Part XVIII) and Mental Health Parity Implementation, Department of Labor, January 9, 2014

Question:
How does an applicable large employer (ALE) determine whether a temporary worker, not hired through an agency, has to be offered health coverage?
Answer:
The final regulations do not adopt any special provisions applicable to short-term employees (an employee that averages at least 30 hours per week in a position expected to last less than 12 months; not to be confused with a seasonal employee).
If a new temporary employee is expected to work an average of at least 30 hours per week (or 130 hours per month) then the new hire is considered to be full-time and must be offered health coverage no later than the first day of the fourth month of employment (90 days).
If it cannot be determined at the employee's start date whether the new temporary employee will average at least 30 hours of service per week, then the new hire can be classified as a variable hour employee. A variable hour employee will have his or her status as a full-time employee determined after an initial measurement period. If the employee averages at least 30 hours per week during the initial measurement period, the employee will be considered full-time and eligible for coverage during the entire following stability period. Expected termination before the end of a measurement period is not relevant to the classification and not to be considered.
Resources:
Shared Responsibility for Employers Regarding Health Coverage; Final Rule, 26 CFR Parts 1, 54, and 301, February 12, 2014
Excluding Certain Classes of Employees from your Health Plan May Increase Risk of Penalty, Warner Norcross & Judd, October 7, 2015

Question:

What is the difference between part time employees and variable hour employees?

Answer:

When determining whether they will be penalized, and if so by how much, employers subject to the Affordable Care Act's shared responsibility provisions must identify their full-time employees. One method that can be used is the look-back measurement method.

For the initial measurement period used under the look-back measurement method:

 The term *part-time* applies to a new employee who, at the employee's start date, is not expected to be a full-time employee (and who is not a variable hour or seasonal employee).

 The term *variable* applies when it cannot be determined, at the employee's start date, whether a new employee will be employed on average of at least 30 hours of service per week because hours are variable or uncertain.

The definition for part-time employee was added to the final regulations issued February 12, 2014.

Resources:

Shared Responsibility for Employers Regarding Health Coverage; Final Rule, 26 CFR Parts 1, 54, and 301, February 12, 2014

Question:

How does an employer determine when a part-time worker who becomes a full-time worker must be offered health coverage?

Answer:

Using the following example periods, we will answer this question for new employees and ongoing employees.

Example periods

Measurement period: November 1, 2015 – October 31, 2016

Administrative period: November 1, 2016 – December 31, 2016

Stability period: January 1, 2017 – December 31, 2017

New employee

If a new employee started working in a part-time position and changed to a full-time position during the initial measurement period, then coverage must be offered effective no later than (1) the first day of the fourth full month following the employment status change, or (2) if earlier, the start of the stability period. For example, an employee is hired in a part-time position on November 1st and changes to a full-time position on March 1st. The employee must be offered coverage no later than June 1st. June 1st is earlier than the stability period start date which is January 1st of the following year.

Ongoing employee

The employee retains part-time status for the remainder of the current stability period. The employer should offer coverage effective the first day of the stability period (January 1, 2017) following the measurement period (November 1, 2015 – October 31, 2016) in which the employee worked 30 or more hours per week.

Note: The coverage offer must be affordable and of minimum value to avoid possible penalties. The employer may provide more generous eligibility rules, and offer coverage sooner than government regulations require.

Resources:

Shared Responsibility for Employers Regarding Health Coverage Final Rule Federal Register, February 12, 2014 (Change in Employment Status)

Question:
How does an employer determine when an ongoing full-time employee who becomes part-time can be taken off health insurance?
Answer:
If an ongoing employee, who has completed a full standard measurement period, has a change in status from full-time to part-time, the employee retains coverage at least through the end of the stability period in which the change in status occurs. If the change in status occurs during a measurement period and if an employee averages at least 30 hours per week (attains full-time status) during the measurement period, coverage would be required throughout the following stability period.
However, if the ongoing employee has a change in status to a position that would have been considered part-time at the hire date, then an employer can choose to switch to the monthly measurement period for that employee, starting with the first day of the fourth full month after the change to part-time. This method can be used only if an employer is able to determine that the ongoing employee was offered minimum value coverage since employed (or within a three-month eligibility period) and averaged fewer than 30 hours per week for three full months after the change in status.
Resources:
Shared Responsibility for Employers Regarding Health Coverage; Final Rule, 26 CFR Parts 1, 54, and 301, February 12, 2014

Question:
If an ongoing full-time employee goes on disability leave during the stability period under the look-back measurement method, how long is the employer required to continue offering health coverage?
Answer:
The employer must offer coverage through the end of the stability period, as long as the employee remains an employee. All current employees who were counted as full-time employees during the previous measurement period are considered full-time employees, for purposes of health coverage, for the entire stability period.
For example, if a plan's stability period is January 1 through December 31, and a full-time employee becomes disabled and stops working in July 2016, the employer must continue offering health coverage to that employee through the end of the stability period, December 31, 2016. However, if the employment relationship ends before December 31, 2016, the employer could stop offering coverage at the time of termination. This could trigger COBRA coverage. An employer should obtain comprehensive legal advice on all the issues involved when considering terminating employment of a disabled employee.
Resources:
Shared Responsibility for Employers Regarding Health Coverage; Final Rule, Federal Register, 26 CFR Parts 1, 54, and 301, February 12, 2014
Identifying Full-time Employees, Internal Revenue Service, as visited June 17, 2016
Under the ACA, do employers need to offer health plan coverage to individuals receiving short-term disability or long-term disability?, Graydon Head, February 12, 2016 (see final paragraph)

Offering coverage

Question:
Does the ACA require an annual open enrollment period for large, self-funded employer plans?
Answer:
To avoid penalties under the ACA's employer shared responsibility requirements, applicable large employers must offer an opportunity, at least annually, to full time employees to elect health coverage for themselves and their dependents, or to decline coverage that is not affordable or of minimum value. For most plans, this means annual open enrollment.
Whether an employee has an effective opportunity to enroll or to decline to enroll is determined based on all the relevant facts and circumstances, including adequate notice of the offer of coverage, the period of time during which acceptance of the offer of coverage may be made, and any other conditions on the offer. An affirmative election that "rolls over" is permitted, meaning the employer could continue coverage automatically from year to year unless the employee affirmatively elects to opt out of coverage.
Resources:
Shared Responsibility for Employers Regarding Health Coverage; Final Rule, Federal Register, February 12, 2014

Question:
Under the Affordable Care Act (ACA), can an employee waive coverage without the employer being penalized?
Answer:
Yes. Employers are only penalized if an employee applies for and receives a subsidy to purchase coverage through the public exchanges. An employer is not penalized for an employee declining coverage as long as the coverage is offered to at least 95 percent of all full-time employees and the offered coverage is both affordable and has minimum value.
If an employer-sponsored health plan covers at least 60 percent of the total allowed cost of benefits, then the plan is said to provide minimum value.
A plan is determined to be affordable if the employee's required contribution for self-only coverage does not exceed 9.66 percent of the employee's household income for the year (for plan years beginning in 2016), 9.56 percent (for plan years beginning in 2015), or if one of three safe harbors is met. Because an employer does not typically know an employee's household income in making the affordability determination, the safe harbors are allowed. Employers are allowed to use Form W-2 wages, an employee's rate of pay, or the federal poverty line, instead of household income in determining affordability.
Resources:
Employer Shared Responsibility Provisions, IRS, September 14, 2015
Minimum Value and Affordability, IRS, December 7, 2015
IRS Revenue Procedure 2014-62
Employees Declining Coverage under the Affordable Care Act, FrankCrum, February 4, 2014
FAQ: Affordable Care Act's Employer Mandate: Deciding Whether Your Organization Should Pay or Play (See Q&A 1 on page 2, right column), WorldatWork, May 2013

Question:
Can we offer a stipend for employees to use to purchase their own individual health insurance policies?
Answer:
It depends on the design of the stipend. It is permissible to increase an employee's compensation to help the employee afford individual health insurance as long as the employee is not required to use the additional money for that purpose. Receipt of additional wages cannot be conditioned on the purchase of health coverage. The employee can choose what to do with the extra money.
Note, offering an employee cash reimbursement for individual health insurance premiums, regardless of whether the payment is treated as pre-tax or post-tax to the employee, constitutes an "employer payment plan" that violates ACA.
Resources:
IRS Notice 2015-17, February 18, 2015, Questions 4-5.
ACA Implementation Frequently Asked Questions Part XXII, November 6, 2014, Question 1.

Question:
Under the Affordable Care Act (ACA), may an employer still offer different health plan benefits to different groups of employees?
Answer:
The ACA does not contain a rule stating all employees must be offered the same benefits. Under existing federal laws and regulations, different groups of employees may be offered different benefits, as long as the different groups are based on bona fide employment-based classifications of similarly situated employees, consistent with the employer's usual business practice. Examples of bona fide employment-based classifications include salaried vs. hourly, part-time vs. full-time, length of service, and geographic locations of work. The different classifications must not be based on health factors.
Note: Internal Revenue Code (IRC) Section 125 cafeteria plans must follow their own set of nondiscrimination rules.
Highly compensated employees
IRC Section 105 prohibits self-funded health plans from discriminating in favor of highly compensated employees. The ACA extends this requirement to nongrandfathered insured plans. However, no rules prescribing the requirement have been issued, and the Internal Revenue Service will not enforce this non-discrimination provision for insured plans until after rules are issued.
Discrimination in general
When designing a benefits program, employers need to carefully consider the ramifications of the benefits offered to and accepted by employees. Overlapping federal and state laws prohibit many types of discrimination such as age, gender, gender identity, sexual orientation, race, ethnicity, country of origin, religion, pregnancy, genetics, health status, and military service. Obtaining legal counsel is recommended when designing or redesigning employee benefit plans to make sure they are not discriminatory and do not violate federal or state laws.
Resources:
HIPAA Nondiscrimination Requirements, U.S. Department of Labor
IRS Notice 2011-1, ACA Nondiscrimination Provisions Applicable to Insured Group Health Plans
Internal Revenue Code Section 105

Question:
For purposes of the employer mandate, are employer health plans required to cover an employee's spouse and/or dependents?
Answer:
Final regulations issued in February 2014 indicate that beginning in 2015, a penalty will be incurred if applicable large employers (ALEs) do not offer full-time employees (and their dependents) minimal essential health coverage.
Employers are not required to offer health care coverage to an employee's spouse.
The final regulations define *dependent* as an employee's natural or adopted child under age 26. Dependent coverage must be continued the entire calendar month in which age 26 is attained. Removed from the final regulations' definition of dependents are stepchildren, foster children and children who are non- US citizens or nationals (with exceptions).
Transition relief is offered to employers who do not already offer dependent coverage, whose dependent coverage did not meet minimum essential coverage requirements, or whose dependent coverage was only offered to some (not all) dependents. These employers have until the start of their 2016 plan year, and will not be subject to the penalty, as long as they take steps in their 2015 plan year to meet dependent coverage requirements. Employers that dropped dependent coverage in 2013 or 2014 cannot utilize the transition relief.
Resources:
Shared Responsibility for Employers Regarding Health Coverage; Final Rule, 26 CFR Parts 1, 54, and 301, February 12, 2014

Question:
Are church plans exempt from the ACA's Employer Shared Responsibility (pay-or-play) provisions?
Answer:
No.
The employer shared responsibility final regulations reserved space for special rules for determining the applicable large employer status of churches, and conventions and associations of churches. However, until additional guidance is issued, all large employers with 50 or more full-time employees (including full-time equivalents) are subject to the pay-or-play mandate, including church employers.
Resources:
Shared Responsibility for Employers Regarding Health Coverage; Final Rule, 26 CFR Parts 1, 54, and 301, February 12, 2014 (See especially page 8582)

Question:
If an employer offers one plan of minimum value that is affordable, can they also offer one that does not meet those requirements?
Answer:
Yes, only one employer health coverage option must satisfy the affordability and minimum value requirements in order to avoid an employer shared responsibility penalty.
According to attorney authors of the Jones Day publication Deciding Whether to Play or Pay Under the Affordable Care Act - 2014 Updates, "[I]f one health coverage option meets these requirements, other available health coverage options need not. In other words, all other health coverage options could ... be unaffordable or not provide minimum value or both…. This creates a planning opportunity for an employer to simultaneously offer coverage that protects it from an employer mandate penalty while also offering coverage that is better aligned with the needs of its workforce."
The nonpartisan Center on Budget and Policy Priorities provides a helpful example: "[A]n employer could offer three plans: Plan 1 that meets both affordability and minimum value, Plan 2 with comprehensive benefits but high premiums that is not considered affordable for all employees, and Plan 3 that has very low premiums but limited coverage that fails to meet minimum value. The employer can offer, and the employee can select, any of these plans. Regardless of which plan employees choose, they will not qualify for premium tax credits in the Marketplace because the employer offers at least one plan (Plan 1) that meets both affordability and minimum value. For the employee, any employer plan he accepts qualifies as minimum essential coverage to meet his obligation to obtain coverage, even if the plan's benefits don't meet the minimum value test."
Resources:
Deciding Whether to Play or Pay Under the Affordable Care Act - 2014 Updates, Jones Day, June 2014 (See Q&A 7 planning consideration section)
Key Facts: Employer-Sponsored Coverage and Premium Tax Credit Eligibility, Health Reform: Beyond the Basics, a project of the Center on Budget and Policy Priorities, updated December 3, 2015 (See question "Is all employer-sponsored insurance required to meet the affordability and minimum value tests?")

Question:
Do employers with fewer than 50 full-time equivalent employees have to offer health coverage to employees working 30 or more hours per week?
Answer:
No. The law defines full-time for purposes of the employer shared responsibility provision. Small employers with fewer than 50 full-time equivalent employees are not affected by this provision or its definition of full-time. The title of IRS Notice 2012-58, "Determining Full-Time Employees for Purposes of Shared Responsibility for Employers Regarding Health Coverage," indicates that this definition doesn't affect small employers. Small employers do not face a penalty for not offering health coverage. The U.S. Small Business Administration website states, "Businesses with fewer than 50 employees are generally not affected by the Employer Shared Responsibility rules... These smaller employers do not have to pay an assessment if their full-time employees receive premium tax credits in the new Marketplace."
Resources:
Key Provisions Under the Affordable Care Act for Employers with 50 or More Employees, Small Business Administration. See bullet point for Employer Shared Responsibility Provisions.

Question:
Does the Affordable Care Act obligate large employers to continue offering health coverage to retirees if they currently do?
Answer:
No. According to the DOL's Employee Benefits Security Administration, when employers offer retiree health benefits, nothing in federal law prevents them from cutting or eliminating those benefits unless the plan document or summary plan description contains a specific promise to maintain those benefits. However, plan documents may instead contain language that gives the employer the right to change or terminate the plan.
Resources:
Can the Retiree Health Benefits Provided By Your Employer Be Cut? Employee Benefits Security Administration Compliance Assistance Publications

Question:
If an employer is considered an applicable large employer based on its part-time employees in addition to its full-time employees, must the employer offer health coverage to its part-time employees?
Answer:
No. An employer must count both part-time and full-time employees to determine whether it is considered an applicable large employer subject to the Affordable Care Act's employer shared responsibility provisions. Beginning January 1, 2015, the Affordable Care Act requires applicable large employers to offer health coverage to full-time employees and certain dependents, or face possible penalties. (There is transition relief in 2015 for employers with 50 to 99 full-time equivalent employees. These employers may wait until 2016 to comply.)
To determine the number of full-time equivalent employees in a month, an employer takes the total number of hours worked that month by all employees who are not full-time, divides it by 120, and adds that number to the number of employees who are full-time.
The Internal Revenue Service website states:
"For 2015 and after, employers employing at least a certain number of employees (generally 50 full-time employees or a combination of full-time and part-time employees that is equivalent to 50 full-time employees) will be subject to the Employer Shared Responsibility provisions under section 4980H of the Internal Revenue Code (added to the Code by the Affordable Care Act). As defined by the statute, 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 threshold is referred to as an applicable large employer.
Under the Employer Shared Responsibility 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 Employer Shared Responsibility payment if at least one of its **full-time employees** receives a premium tax credit for purchasing individual coverage on one of the new Affordable Insurance Exchanges, also called a Health Insurance Marketplace."
The Affordable Care Act does not require health coverage to be offered to part-time employees (in general, those working less than 30 hours per week on average).
Resources:
Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act - IRS
Shared Responsibility for Employers Regarding Health Coverage; Final Rule
Federal Register, February 12, 2014 (See especially pages 8544, and 8546, third column)
Determine your Full-Time Equivalent Employees under PPACA - Healthcare Exchange

Question:
Can an employer offer a health plan to part-timers that is not necessarily affordable, as long as they offer a compliant plan to substantially all full-time employees?
Answer:
An employer will not be subject to an employer shared responsibility (ESR) payment for offering an unaffordable health plan to part-time employees. According to the IRS overview on ESR payments, part-time employees do not factor into the calculations. The payments hinge on offering minimum essential coverage (MEC) to full-time employees (and their dependents), specifically:

- Failure to offer MEC to full-time employees, or
- Failure to offer MEC to full-time employees that is affordable and provides minimum value.

An employer may be subject to only one of the above payments.
Resources:
Types of Employer Payments and How They Are Calculated, IRS, 2/11/15 (See Question, "How is This Payment Calculated?" in both sections)
Employer Shared Responsibility Q&A, Aetna (See Question, "Do these penalties apply to employers employing part-time employees?")
ACA Frequently Asked Questions, ADP, January 2015 (See Question 23)

Question:
Do applicable large employers have to offer health coverage to full-time H-2B visa workers under the ACA's employer shared responsibility requirements?
Answer:
Yes. The final regulations for employer shared responsibility for health coverage do not exempt holders of H–2A and H–2B visas from the definition of employee for purposes of section 4980H.
Starting January 1, 2015, the employer shared responsibility requirement generally requires applicable large employers to offer their full-time employees (and their dependents) the opportunity to enroll in "minimum essential coverage" under an eligible employer-sponsored healthcare plan or face a tax penalty. The definition of "full-time employee" for this purpose is not limited to U.S. citizens. Instead, determining who is a full-time employee for the purpose of offering coverage is based on the number of hours an employee works for U.S.-source income under the Internal Revenue Code. As a result, applicable large employers that employ foreign workers in the U.S. must take them into account when determining who is offered health coverage.
These rules are distinct from those that determine whether an employer is an applicable large employer, which are not addressed in this FAQ.
Resources:
Shared Responsibility for Employers Regarding Health Coverage; Final Rule, Federal Register, February 12, 2014 (see p. 8568, second and third columns)
Implementing Health Reform: The Employer Responsibility Final Rule, Timothy Jost, Health Affairs Blog, February 12, 2014

Question:
When determining whether health coverage is affordable, does an employer make the determination on a person-by-person basis?
Answer:
In a sense, yes. An applicable large employer (ALE) will be penalized up to $3,000 per year for any employee that qualifies for and receives subsidized coverage on the public health exchange, if the reason the employee qualified for the subsidy is that the employer's lowest-cost health coverage was unaffordable for that employee.
A health plan is "affordable" for an employee if the full-time employee's required contribution for the lowest-cost, self-only coverage does not exceed 9.5 percent of his or her household income for the taxable year. Affordability is based on cost of self-only coverage even if the employee purchases family coverage. Because it is difficult for employers to determine household income, the employer shared responsibility rules include three safe harbors that can be used to determine affordability: Form W-2; rate of pay and/or the Federal poverty line safe harbor.
The safe harbors are optional. An employer may use one or more of the safe harbors for all employees or for any reasonable category of employees, provided it is consistently applied to all employees in a particular category. Calculating affordability using the various safe harbors is beyond the scope of this FAQ.
Some employers use their lowest-paid employee as a sort of benchmark or threshold to determine whether the coverage they are offering is affordable to most or all of their employees. If the dollar amount of the required contribution for the lowest-cost self-only coverage is the same for all employees, then presumably it would be affordable for all if it were affordable for the lowest-paid employee.
Resources:
Shared Responsibility for Employers Regarding Health Coverage; Final Rule, 79 FR 8543, February 12, 2014

Question:
Are self-insured stand-alone dental and vision plans that are provided solely through employer contributions, with no employee contributions to premiums, subject to the ACA?
Answer (*updated January 2014*):
No. Regulations proposed in December 2013 eliminated the requirement that self-funded stand-alone dental and vision plans must require employee contributions in order to be considered "excepted benefits" not subject to the Affordable Care Act. However, the proposed regulations retain the requirement that participants be allowed to waive the benefit.
So, whether self-insured stand-alone dental and vision plans incorporate employee contributions or not, they are not subject to the Affordable Care Act as long as they allow participants to opt out of the benefit.
Likewise, fully insured plans providing stand-alone dental and vision benefits are generally not subject to the Affordable Care Act.
Resources:
Amendments to Excepted Benefits, Proposed Rules, Federal Register, December 24, 2013
Frequently Asked Questions about the Affordable Care Act Implementation Part II, Department of Labor (See Question and Answer 6)

Question:
How can a plan meet the W-2 affordability safe harbor if its plan year is not a calendar year?
Answer:
Affordability is determined by household income which is unknown to employers. The W-2 safe harbor allows the employer to compare 9.5% of the employee's W-2 wages (an amount known to the employer) for the calendar year to the employee contribution toward the lowest cost self-only minimum value health coverage for the calendar year. The regulations provide for two types of offers of coverage, "full-year" and "partial-year".
Noncalendar year plans need to adjust the employee wages and employee contribution for the calendar year by using the "partial-year" rules for an employee who is not offered coverage for an entire calendar year. According to Spencer's Benefits Reports, "Affordability is determined separately … for the portions of an employer's plan year that fall in different taxable years of an applicable taxpayer". This has the effect of separately annualizing the portions of the employer's plan year.
For an employer to use this safe harbor, the employee's required contribution must remain a consistent dollar amount or percentage of Form W–2 wages during the calendar year (or during the plan year for plans with noncalendar plan years).
Partial-year adjustment
The safe harbor is applied by adjusting the W–2 wages to reflect the period for which coverage was offered and then determining the employee's total contribution for the period during which coverage was offered.
Example of Form W-2 wages safe harbor with noncalendar year plan
Facts:

- Employer's 2015 plan year is September 1, 2014 to August 31, 2015.
- Employee A is an ongoing employee from January 2014 through December 2015, and is offered coverage for all 12 months of the plan year.
- A's contribution is consistent for the plan year at $100 per month ($1200 for the plan year of September 2014 through August 2015).
- A's W-2 wages are $24,000 in the 2014 calendar year, and $24,720 in the 2015 calendar year.

Calculation:

- A's contributions from September through December 2014 total $400.
- A's adjusted W-2 wages for September through December 2014 is $8,000, which is arrived at by dividing annual 2014 wages of $24,000 by 12 to get an average monthly wage of $2,000, and then multiplying by four (four is the number of plan year months falling in the 2014 calendar year).
- A's rate of employee contribution to wages is **5%** in 2014 ($400 is 5% of $8,000).
- A's contributions from January through August 2015 total $800.
- A's adjusted W-2 wages for January through August 2015 is $16,480, found by dividing $24,720 by 12 and then multiplying by eight (the number of plan year months falling in the 2015 calendar year).
- A's rate of employee contribution to wages is **4.9%** in 2015 ($800 is 4.9% of $16,480).

Conclusion: A's coverage is affordable in **both** portions of the plan year.
Resources:
Shared Responsibility for Employers Regarding Health Coverage Final Rule Federal Register, February 12, 2014 (see p. 8599-8600).
Spencer's Benefits Reports: Health Care Reform, 550.-1, Large Employers Have Responsibility For Providing Health Coverage Under Health Reform, Wolters Kluwer, April 9, 2015.
ACA University FAQ - Affordable coverage is defined as costing no more than 9.5% of an employee's household income. How is household income determined? (Posted July 2013)

Question:
When calculating the employer penalty tax "A", is the penalty multiplied by all full-time employees or is it multiplied by the number of employees we should have offered coverage to but didn't?
Answer:
The annual "A" penalty tax applies if an applicable large employer (ALE) fails to offer minimum essential coverage (MEC) to 95% or more of its full-time employees and dependents, and at least one full-time employee enrolls for subsidized exchange coverage.
The penalty calculation is based on all full-time employees (minus the first 30), including full-time employees who have coverage under the employer's plan or from another source.
The penalty tax for 2015 is $2,080 ($2,160 for 2016) per full-time employee per year ($173.33 per month for 2015; $180 per month for 2016). The amount is indexed each year for inflation.
Example: Based on its number of full-time employees in 2015, Company A is an ALE for 2016. Company A has 200 full-time employees for each month of 2016. Company A offers 100 full-time employees (and their dependents) MEC for all months of 2016. At least one employee gets subsidized coverage on the exchange and receives the premium tax credit for each month of 2016.
Because Company A did not offer MEC to at least 95% of its full-time employees (and their dependents) for each month of 2016 and at least one full-time employee received the premium tax credit, Company A is subject to the employer penalty tax "A" described above. For 2016, Company A is subject to an employer shared responsibility payment of $367,200, calculated as follows:
- Number of full-time employees less 30 (200 – 30) x $2,160 = $367,200.

Resources:
Types of Employer Payments and How They Are Calculated, Internal Revenue Service (See "How is This Payment Calculated?" under #1)
Employer Shared Responsibility Provisions, Internal Revenue Service (See #1 under "How Are the Employer Shared Responsibility Payments Calculated?")
Employer Mandate Penalty Amounts Increased for 2015 and 2016, Keenan & Associates

Question:
What five requirements must limited wraparound plans fulfill in order to be considered "excepted benefits" exempt from most ACA provisions?
Answer:
In March 2015, the U.S. Departments of Labor, Health and Human Services (HHS), and Treasury published final rules amending the definition of excepted benefits to include certain limited coverage that wraps around individual health insurance. This coverage must be specifically designed to provide meaningful benefits such as coverage for expanded in-network medical clinics or providers, reimbursement for the full cost of primary care, or coverage of the cost of prescription drugs not on the formulary of the primary plan.
The rules allow group health plan sponsors, in limited circumstances, to offer wraparound coverage to employees who are purchasing individual health insurance in the private market, including on the public exchange.

A limited wraparound plan only qualifies under these rules if:

- it is offered no earlier than January 1, 2016, and no later than December 31, 2018; and
- coverage ends on the later of three years after the date the wraparound coverage is first offered, or when the last collective bargaining agreement relating to the plan terminates after coverage is first offered.

To be considered an "excepted benefit," a limited wraparound plan must meet these five requirements:
1. The plan must provide meaningful benefits specifically designed to supplement individual primary health coverage or multi-state plan coverage, beyond coverage of cost-sharing.
2. Benefits must be limited to the greater of
a. the maximum permitted annual salary reduction contribution for health FSAs, or
b. 15% of the employer and employee cost of the primary plan, determined the same way as COBRA premiums.
3. The plan must not exclude preexisting conditions or discriminate based on health status or in favor of highly compensated employees.
4. The plan administrator must file reports with HHS and/or the Office of Personnel Management (OPM) to determine whether the coverage is adequate.
5. The plan must meet several eligibility requirements, including that plan participants may not be concurrently enrolled in an excepted benefits health FSA.
Resources:
Amendments to Excepted Benefits, DOL, IRS, HHS, Final Rules, Federal Register, March 18, 2015

Reporting and Disclosure Requirements
Information reporting (1094 and 1095 forms)

Question:
Is IRS reporting under Sections 6055 and 6056 required for all size employers, or only those with 50 or more full time equivalent employees?
Answer:
Both sections have different requirements for who must report.
Section 6055: Information Reporting by Providers of Coverage
Reporting is required by anyone that provides minimum essential coverage to an individual. This includes self-funded employers of all sizes. For fully insured plans of all sizes, the health insurance issuer is responsible for reporting.
Section 6056: Reporting on Offers of Health Insurance Coverage
Reporting is required by "applicable large employers" with 50 or more full-time employee equivalent employees.
Reporting begins in January 2016 for the 2015 calendar year.
Resources:
IRS Q&A on Information Reporting by Health Coverage Providers (Section 6055)
IRS Q&A on Reporting of Offers of Health Insurance Coverage by Employers (Section 6056)
Information Reporting by Applicable Large Employers on Health Insurance Coverage Offered Under Employer-Sponsored Plans, Final Regulations Federal Register, March 10, 2014.

Question:
Do applicable large employers that do not maintain a group health plan have any reporting duties under the ACA?
Answer:
Yes. Beginning in 2016, every applicable large employer (ALE) must report to the IRS and to its employees whether or not it offered health coverage during the previous calendar year.
The Internal Revenue Service (IRS) web page titled "Information Reporting by Applicable Large Employers" states, "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."
Other Resources:
IRS Publication 5196, Understanding employer reporting requirements of the health care law, February, 2015
Information Reporting by Applicable Large Employers on Health Insurance Coverage Offered Under Employer-Sponsored Plans, Final Regulations, Federal Register, March 10, 2014

Question:
Is a third party administrator (TPA) for a self-funded health plan required to prepare Section 6055 Minimum Essential Coverage reporting documentation on behalf of the plan?
Answer:
No. A plan sponsor may expand on an existing arrangement or opt to hire a third party to assist with Section 6055 reporting requirements. Ultimately, the plan sponsor is responsible for reporting documentation and retains potential liability for reporting failure(s).
Resources:
Questions and Answers on Information Reporting by Health Coverage Providers (Section 6055) [see Q&A 28], Internal Revenue Service, as visited July 2, 2015

Question:
How long should we keep copies of the Form 1094 and 1095 information returns we filed with the IRS?
Answer:
Keep copies of information returns you filed with the IRS or have the ability to reconstruct the data for at least 3 years from the due date of the returns.
The due dates for 2015 reporting requirements are: March 31, 2016 for furnishing forms to employees and May 31, 2016 for filing with the IRS (or June 30, 2016 if filing electronically with the IRS).
Resources:
2015 Instructions for Forms 1094-B and 1095-B, IRS, 9/16/15 (See p.4, Keeping Copies).
2015 Instructions for Forms 1094-C and 1095-C, IRS, 9/16/15 (See p.3, Keeping Copies).
New Due Dates for Filing Forms 1095-B, 1094-B, 1095-C and 1094-C, IRS, 12/30/15

Question:
Who is responsible for the ACA applicable large employer reporting required under section 6056 when an applicable large employer member is part of a controlled group?
Answer:
For purposes of the information reporting requirements under section 6056*, each applicable large employer (ALE) member must file an information return with the Internal Revenue Service (IRS) and furnish a statement to its full-time employees, using its own Employer Identification Number (EIN). These requirements, which direct all applicable large employers to send information to their full-time employees and the IRS about the health care they offered (or did not offer), apply to each separate entity in a controlled group. In other words, although an entity within a controlled group might not, on its own, meet the qualifications of an ALE (at least 50 full-time equivalent employees), it will be responsible for its own reporting under Section 6056 if all the entities in the controlled group combined meet the qualifications of an ALE.
An ALE member may contract with a third party to file the returns and furnish employee statements, but the ALE member ultimately remains responsible for the reporting. The ALE must ensure there is only one section 6056 authoritative transmittal (Form 1094-C) submitted to the IRS, and that each full-time employee receives only one section 6056 employee statement (Form 1095-C).
Please note: This FAQ does not address minimum essential coverage reporting required under section 6055.
Resources:
IRS Questions and Answers on Reporting of Offers of Health Insurance Coverage by Employers (Section 6056)
(See Questions 5, 7, and 23)
IRS Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act
(See Question 6)
IRS Information Reporting by Applicable Large Employers
(See section called “Controlled Group/Common Ownership”)
Shared Responsibility for Employers Regarding Health Coverage, Internal Revenue Service; Final Rule, Federal Register, February 12, 2014

Question:
Does the ACA require government entities to report to the IRS under sections 6055 and 6056 of the Internal Revenue Code?
Answer:
Yes. Under section 6055 any person who provides minimum essential coverage to an individual must report to the IRS and furnish statements to individuals, including the executive department or agency of a governmental unit that provides coverage under a government-sponsored program.
A government employer must also report under section 6055 if it maintains a self-insured health plan. However, unless prohibited by other law, a government employer that maintains a self-insured group health plan may designate a related governmental unit or agency as the person to file the returns and furnish the statements for some or all individuals covered under that plan.
Section 6056 applies to all employers that are ALE (applicable large employer) members, regardless of whether the employer is a government entity (including federal, state, local, and Indian tribal governments).
Resources:
Questions and Answers on Information Reporting by Health Coverage Providers (Section 6055); Internal Revenue Service, June 26, 2015 (see Q’s 5, 7, and 11)
Questions and Answers on Reporting of Offers of Health Insurance Coverage by Employers (Section 6056); Internal Revenue Service, May 19, 2015 (See Q 6)

Question:
We’re required to file information returns electronically and have now determined that we will be unable to do so. What steps should we take?
Answer:
If an employer is unable to file its 1094-C/1095-C returns electronically, it must file Form 8508, *Request for Waiver from Filing Information Returns Electronically*.
The form must be filed with the IRS no later than 45 days before the return’s due date. Since the e-filing due date is June 30, 2016, Form 8508 should be filed by May 16, 2016. If an employer has already missed this due date, it is probably better to file Form 8508 late than not at all.
Resources:
ACA AIR Working Group Meeting on 4/26/16; Internal Revenue Service (See Slide 17)
Form 8508 - Request for Waiver from Filing Information Returns Electronically; Department of the Treasury, Internal Revenue Service

Question:
Are there ACA reporting requirements (to the IRS) under Sections 6055 or 6056 for retirees under age 65 receiving health coverage?
Answer:
Section 6055 requires every provider of minimum essential coverage to report coverage information to the Internal Revenue Service (IRS) and to furnish a statement to individuals receiving coverage. This includes retirees receiving coverage. The information is used by the IRS to administer, and by individuals to show compliance with, the ACA's individual shared responsibility provision.
Providers who must report under Section 6055 include health insurance issuers or carriers for insured coverage, and plan sponsors of self-insured group health plan coverage. Reporting starts in 2016 for coverage provided in 2015.
Section 6056 requires each applicable large employer (ALE) to file an information return with the Internal Revenue Service (IRS) and furnish a statement to all its full-time employees reporting the health care the employer offered (or did not offer). This includes any employees who were considered full-time for at least one month of the year. It does not include non-employees, such as someone who was retired the entire year.
Resources:
IRS Questions and Answers on Information Reporting by Health Coverage Providers (Section 6055)
(See Questions 5 and 6)
IRS Information Reporting by Applicable Large Employers
Information Reporting of Minimum Essential Coverage, Internal Revenue Service; Final Rule, Federal Register, March 10, 2014
Information Reporting by Applicable Large Employers on Health Insurance Coverage Offered Under Employer-Sponsored Plans, Internal Revenue Service; Final Rule, Federal Register, March 10, 2014

Question:
If an employee works full-time for several different applicable large employers (ALEs) in the course of a year, would the employee receive multiple 1095-Cs?
Answer:
Yes. The instructions to Form 1095-C state ALEs "must file a Form 1095-C for each employee who was a full-time employee of the employer for any month of the calendar year." They also state that "for each full-time employee of an employer, there must be only one Form 1095-C filed for employment with that employer."
This means that if during the course of a year an employee worked full-time for more than one ALE, each separate employer* should send the employee a 1095-C.
Form 1095-C has three parts. Part I provides information about the employee and employer. Part II provides information about whether there was an offer of coverage, and whether the employee enrolled in coverage. If the employee enrolled in an employer's self-funded plan, Part III reports who received coverage on behalf of the employee, including dependents.
Employers offering fully-insured coverage do not need to complete Part III of 1095-C. The health insurer will separately report the information of who received coverage on behalf of the employee, including dependents.
ALEs who contribute to a multiemployer plan must send a 1095-C to each full-time employee. However, the ALE does not need to complete Part III for its employees covered by the multiemployer plan. For 2015 coverage, the ALE should put Code 2E on line 16 for its employees for which it contributes to the plan, and put code 1H on line 14 for each of those employees. The multiemployer plan sponsor or insurer will identify and report who actually received multiemployer plan coverage and when, and send the appropriate report to its covered members and the IRS.
*Special rules beyond the scope of this FAQ apply to ALE members of aggregated/controlled groups.
Resources:
IRS Information Reporting by Applicable Large Employers
IRS Questions and Answers about Information Reporting by Employers on Form 1094-C and Form 1095-C

Question:
Do 1095 forms need to be completed for employees waiving medical coverage for the entire year, and if so, what codes are used?
Answer:
Yes, an applicable large employer (ALE) with a self-funded health plan needs to complete Form 1095-C for each full-time employee.
There are several possible ways to handle lines 14, 15, and 16 of the 1095-C, depending what type of coverage was offered, to whom, and whether it was affordable.
Here is a reporting method for a fairly typical scenario:
In 2015, the ALE offered minimum essential coverage (MEC) of minimum value (MV) to the employee, spouse, and dependents. The coverage was affordable under one of the three safe harbors. The employee waived coverage.
Line 14: Indicate the offer of coverage by entering code 1E.
Line 15: Report the lowest-cost monthly self-only premium for MEC of MV that was offered under the plan to the full-time employee, even though the employee did not enroll.
Line 16: Enter the affordability safe harbor code that applies (2F, 2G or 2H).
Part III of the 1095-C should not be completed for someone who did not actually enroll in coverage.
Resources:
2015 Instructions for Form 1094-C and 1095-C, Internal Revenue Service
2015 Form 1095-C, Internal Revenue Service
ACA reporting tip 11: Employee waives coverage, Associated Financial Group, September 21, 2015

Question:
How can we explain the health coverage reporting forms, 1095-B or 1095-C, to our employees?
Answer:
These forms are new and employees are often not expecting them. Providing them with answers to frequently asked questions such as the seven below could help clear up confusion:
1. What is this form I'm receiving?
A 1095 form is a little bit like a W-2 form. Your employer or insurer sends one copy to the Internal Revenue Service (IRS) and one copy to you. A W-2 form reports your annual earnings. A 1095 form reports your health insurance coverage throughout the year.
2. Who is sending it to me, when, and how?
Your employer or health insurance company should send one to you either by mail or in person. They may send the form to you electronically if you gave them permission to do so. You should receive it by March 31, 2016. (Starting in 2017, you should receive it each year by January 31, just like your W-2.)
3. Why are you sending it to me?
The 1095 forms will show that you and your family members either did or did not have health insurance coverage during each month of the past year. Because of the Affordable Care Act, every person must obtain health insurance or pay a penalty to the IRS.
4. What am I supposed to do with this form?
Keep it for your tax records. You don't actually need this form in order to file your taxes, but when you do file, you'll have to tell the IRS whether or not you had health insurance for each month of 2015. The Form 1095-B or 1095-C shows if you had health insurance through your employer. Since you don't actually need this form to file your taxes, you don't have to wait to receive it if you already know what months you did or didn't have health insurance in 2015. When you do get the form, keep it with your other 2015 tax information in case you should need it in the future to help prove you had health insurance.

Question:
How many solicitation attempts are required for a good faith effort to obtain an individual's Social Security number for ACA information reporting purposes?
Answer:
IRS guidance for 2015 coverage requires three attempts. As background, minimum essential coverage reporting under Section 6055 on Forms 1095-B/1094-B requires employers, plan sponsors and/or insurers to identify all individuals receiving health coverage by his or her Social Security number. This includes covered dependents.
For 2015 coverage, the IRS stated a reporting entity will not be subject to penalties for failure to report a correct Social Security number if it follows these steps:

1. Request the Social Security number at an individual's first enrollment in health coverage or, if already enrolled on September 17, 2015, at the next open season.
2. Make a second request at a reasonable time thereafter.
3. Make a third request by December 31 of the year following the first request.

These steps are in effect until further guidance is issued. The IRS asked for comments on whether this procedure would be practical for Section 6055 reporting. The comment period was closed in November 2015 and we're awaiting further guidance for 2016 coverage and beyond.
Resources:
IRS Notice 2015-68, Information Reporting on Minimum Essential Coverage, 9/17/15.
Got the Social Security Numbers for ACA Reporting Yet?, Word on Benefits, 10/22/15.

Question:
Is use of the IRS electronic system for filing ACA Forms 1094 and 1095 (AIR) optional, or mandatory?
Answer:
Under the Affordable Care Act, insurance companies, businesses that provide self-funded or insured health care to their employees, and all applicable large employers (ALEs) must submit information returns to the Internal Revenue Service (IRS) reporting individuals' health coverage status for the past year.
Any organization filing 250 or more ACA information returns must file them electronically with the IRS. Organizations filing fewer than 250 ACA information returns have the option of using paper forms and submitting them to the IRS via mail, but the IRS encourages electronic filing. The 250 or more threshold applies separately for each type of return and corrected return.
The IRS developed a system called AIR (ACA Information Returns) for receiving electronic transmissions of ACA information returns. The AIR system is different than the FIRE (Filing Information Returns Electronically) system, which is used for other types of IRS information returns. In order to use AIR, software developers, transmitters, and issuers filing electronically must register with IRS e-Services and obtain a Transmitter Control Code (TCC). **Note**: ACA information return issuers using a third party to transmit forms to the IRS on their behalf should not apply for a TCC.
The IRS AIR program website explains four steps to file:

1. Register to use IRS e-Services Tools
2. Apply for Information Return Transmitter Control Code (TCC)
3. Test Communication with AIR System
4. Electronically File through AIR (beginning January 21, 2016)

The copies of Form 1095-C furnished to individuals such as employees and family members must be delivered by mail or hand to the individual, unless the recipient affirmatively consents to receiving it in an electronic format.
Additional Resources:
IRS AIR Program Overview
IRS Publication 5165, Guide for Electronically Filing ACA Information Returns for Software Developers and Transmitters (Process Year 2016)
IRS Information Reporting by Applicable Large Employers
IRS Questions and Answers about Information Reporting by Employers on Form 1094-C and Form 1095-C
IRS Instructions for Forms 1094-C and 1095-C

Question:
What if the post office returns to us a Form 1095-C we sent to a former employee because the address is not valid?
Answer:
The Internal Revenue Service (IRS) instructions to Form 1095-C are a little vague on this issue. On page five, under the section called "Furnishing Forms 1095-C to Employees," the instructions say, "You will meet the requirement to furnish Form 1095-C to an employee if the form is properly addressed and mailed on or before the due date." They go on to say, "Statements must be furnished on paper by mail (or hand delivered), unless the recipient affirmatively consents to receive the statement in an electronic format. If mailed, the statement must be sent to the employee's last known permanent address, or if no permanent address is known, to the employee's temporary address."
What if you have neither a permanent nor a temporary address for the employee?
For now, there is no clear answer. After attempting to send the 1095-C and documenting the attempts, it would be wise to keep copies of each Form 1095-C accessible to provide to individuals who request one at a later date.
A possible solution would be following IRS instructions for undeliverable W-2 forms. The 2016 instructions state on page seven, "Keep for 4 years any employee copies of Forms W-2 that you tried to but could not deliver. However, if the undelivered Form W-2 can be produced electronically through April 15th of the fourth year after the year at issue, you do not need to keep undeliverable employee copies."

Question:
How do I obtain a transmitter control code (TCC) for ACA e-filing with the IRS?
Answer:
The Internal Revenue Service (IRS) designed the ACA Information Return system (also known as AIR) specifically for the electronic filing of Affordable Care Act (ACA) information returns and transmittals. In order to utilize the AIR system, software developers, transmitters, or issuers need to register with IRS e-Services and obtain a transmitter control code (TCC).
Register to become an e-services website user [e-services registration]. A registration confirmation code will be sent via the U.S. Postal Service. Log back into the e-services website with 28 days of your registration submission and enter the confirmation code to complete the registration process. This step must be completed before you can apply for the TCC.
Apply for the Information Return Transmitter Control Code (TCC). In addition to registering for IRS e-Services tools, software developers, transmitters, and issuers must also have a TCC to electronically file AIR Forms 1094/1095-B and 1094/1095-C.
The typical process for completing an application consists of the following:
1. Each responsible official and contact within an organization must be registered and confirmed with e-services.
2. A responsible official will begin the application and designate other individuals in the organization who are authorized to be either a responsible official or contact.
3. All responsible officials must sign the Terms of Agreement and submit the application.
4. After the application is completed and submitted, the IRS will perform checks before assigning the firm or organization the TCC(s).
5. All users authorized to access the application can modify and update the application as necessary. After an application has been submitted and accepted, authorized individuals within the firm or organization may update the application as needed.
When the application is in completed status, the TCC(s) will be visible online and will be mailed to you via U.S. Postal Service.
Each role selected on the application - software developer, transmitter, and issuer - results in a separate TCC. When conducting software testing with the IRS, use the software developer TCC; if you are transmitting information returns you will use the transmitter or issuer TCC.
Electronic filing is required for those submitting 250 or more information returns. If you are an issuer using a third party and you are not transmitting information returns directly to the IRS, do not apply for a TCC.
Resources:
Affordable Care Act Information Returns (AIR) Program website
Tutorial for Affordable Care Act Application for TCC
e-Services - Online Tools for Tax Professionals
Checklist to File ACA Application for TCC, International Foundation Word on Benefits blog, May 18, 2016

This information was provided and developed by International Foundation Information Center staff. This does not constitute legal advice. Please consult your plan professionals for legal advice.