# AFFORDABLE CARE ACT Reporting and Recordkeeping Requirements

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# ULTIMATE GOAL

- IRC 6055 - Reporting of health insurance coverage
- IRC 6056 - Certain employers required to report

# IRC 6055
# General Requirements

- Requirements to maintain MEC
- Shared Responsibility Payment
- Individual Penalty

# IRC 6055
# Who Must Report?

- Depends on coverage provided
- HRAs and MERPs
- Effective Date
- Fully insured plans

# IRC 6055 Information Reported

- Employee information
- Employer information
- Months in which covered
- Filing duties and dates

# IRC 6056 Reporting of Offers of Health Insurance Coverage

- ALE
- IRC 4980H "Pay or Play" Penalty
- Effective dates

# IRC 6056
# Who Must Report

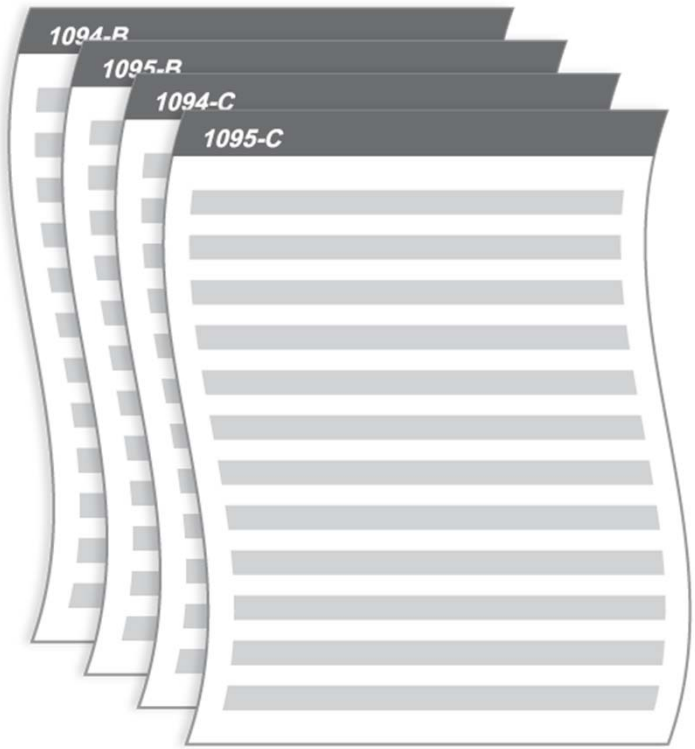
- ALE
- Controlled group reporting
- Reporting to employees

# IRC 6056
# Methods of Reporting

- General Method
- Alternative methods
- Information reported
- When to report

# IRS Reporting Forms

- Forms 1094-B / 1095-B
- Forms 1094-C / 1095-C



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Form **1095-B**

Department of the Treasury
Internal Revenue Service

## Health Coverage

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

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OMB No. 1545-2252

**2014**

**Part I Responsible Individual** (Policy Holder)

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

**Part II Employer Sponsored Coverage** (If Line 8 is A or B, complete this part.)

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

**Part III Issuer or Other Coverage Provider**

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

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

| | (a) Name of covered individual(s) | (b) SSN | (c) DOB (If SSN is not available) | (d) Covered all 12 months | (e) Months of coverage | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| 23 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 24 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 25 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 26 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 27 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 28 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60704B Form **1095-B** (2014)

Form **1095-C**
Department of the Treasury
Internal Revenue Service

**Employer-Provided Health Insurance Offer and Coverage**

► Information about Form 1095-C and its separate instructions is at *www.irs.gov/f1095c.*

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600115
OMB No. 1545-2251
**2014**

**Part I Employee**

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

**Applicable Large Employer Member (Employer)**

| 7 Name of employer | 8 Employer identification number (EIN) |
|---|---|
| 9 Street address (including room or suite no.) | 10 Contact telephone number |
| 11 City or town | 12 State or province / 13 Country and ZIP or foreign postal code |

**Part II Employee Offer and Coverage**

| | All 12 Months | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 14 Offer of Coverage (enter required code) | | | | | | | | | | | | | |
| 15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ |
| 16 Applicable Section 4980H Safe Harbor (enter code, if applicable) | | | | | | | | | | | | | |

**Part III Covered Individuals**

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

| | (a) Name of covered individual(s) | (b) SSN | (c) DOB (If SSN is not available) | (d) Covered all 12 months | (e) Months of Coverage | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec |
| 17 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 18 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 19 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 20 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 21 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 22 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

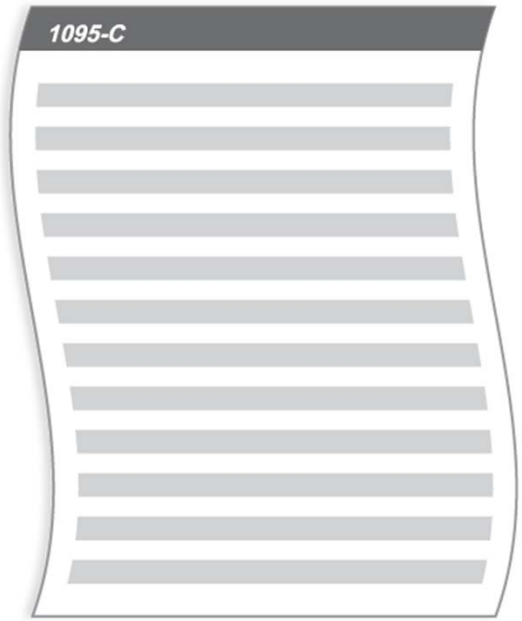
**For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.** Cat. No. 60705M Form **1095-C** (2014)

# IRS Reporting Forms

- When to file
- How to file
- 2015 Special Rule

# IRS Reporting Form 1095-C

- Fully insured – Division
- Fully insured – Controlled Group
- Self-insured
- Information to report



# W-2 Reporting Requirements for Health Insurance

- Effective dates
- What to report
- Who must report
- Controlled groups

# Tracking Hours

- Form 1095-C
- Variable hour employees
- Full-Time employees

# Disclosures to Employees

- Form 1095-B / 1095-C
- W-2 Reporting
- ERISA Summary Plan Description