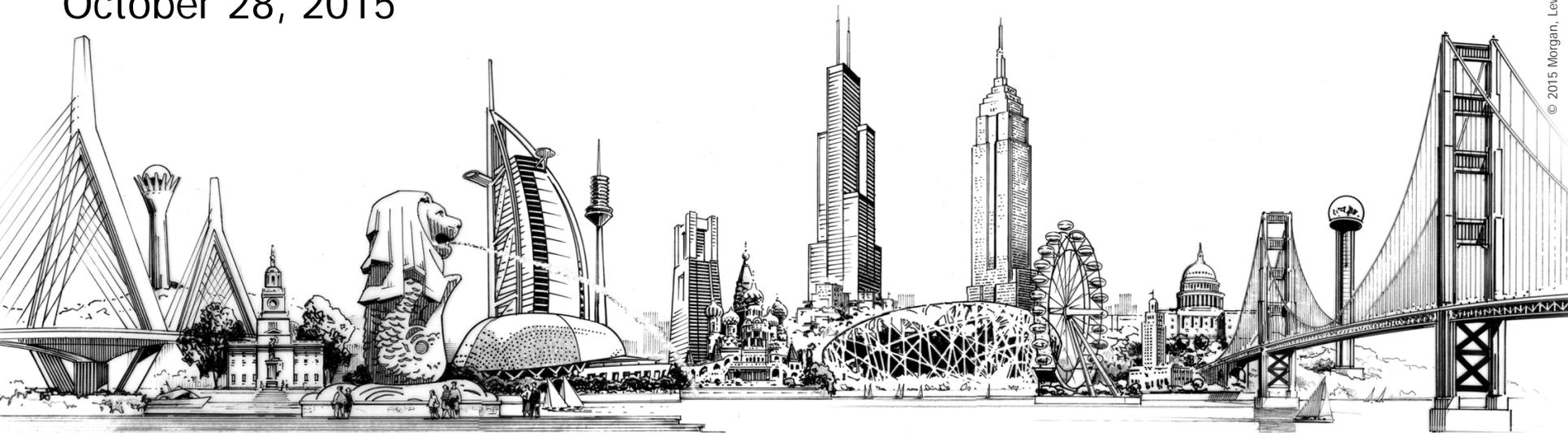


Morgan Lewis

ACA REPORTING— NUTS AND BOLTS

Presenters: Andy Anderson and Kimberly Boggs

October 28, 2015



ACA REPORTING – OVERVIEW

Dual Enforcement Objectives

- Reporting the offer of coverage
 - Employer shared responsibility enforcement (§6056)
 - §4980H(a) penalty – offer MEC to substantially all ACA full-time employees
 - §4980H(b) penalty – minimum value (MV), affordability
 - **Part II of Form 1095-C**
 - All ACA full-time employees regardless of enrollment in coverage
 - Non-ACA full-time employees if they were offered and enrolled in coverage
 - No need to report offer of coverage to non-ACA full-time employees *if not enrolled in coverage*
 - Potential enforcement gap since mere offer makes individual ineligible for subsidy

Dual Enforcement Objectives

- Reporting minimum essential coverage (MEC)
 - Individual shared responsibility enforcement (§6055)
 - §5000A individual mandate penalty
 - **Part III of Form 1095-C**
 - Self-insured employer-sponsored coverage
 - Active employee - Combined with offer of coverage reporting for self-insured plans
 - Year of termination or retirement – complete all months
 - **Form 1095-B**
 - Fully-insured coverage (Insurer completes)
 - Multiemployer Fund
 - Self-insured employer-sponsored coverage
 - Year 2 Retirees (including stand-alone retiree-only HRAs)
 - Year 2 COBRA participants
 - Non-employees

MEC Coverage Reported

- Almost all employer-sponsored group health plans are MEC
 - Includes stand-alone retiree-only HRAs
- Not required to report for:
 - Integrated HRAs
 - Separate reporting no longer required regardless of whether integrated health plan is fully-insured or self-insured
 - Supplemental coverage
 - Very specific definition – supplemental to Medicare or same sponsor
 - Medigap/Med Supp
 - Medicare being primary not enough

Transmitting to IRS

- Transmittal Forms
 - **Form 1094-C**
 - Employer shared responsibility enforcement (§6056)
 - Include copies of Forms 1095-C
 - Common law employer, being common paymaster not enough
 - One authoritative transmittal must be filed for each “employer” subject to §4980H
 - Signed under penalties of perjury by authorized person
 - **Form 1094-B**
 - Individual shared responsibility enforcement (§6055)
 - Include copies of Forms 1095-B
 - Insurer will file for fully-insured coverage
 - Employer must file for Year 2 retiree/COBRA/non-employee self-insured coverage

Basic Scenarios – Which Form?

	Form 1095-C	Form 1095-B
Active employee offered and enrolled in self-insured coverage	✓	N/A
Active employee offered and enrolled in fully-insured coverage	✓ (Part III blank)	✓ (from insurer)
Active ACA full-time employee NOT offered coverage (Caution)	✓ (Part III blank)	N/A
Active non-ACA full-time employee either NOT offered coverage or offered coverage but not enrolled	N/A	N/A
Year of termination COBRA participant or retiree enrolled in self-insured coverage	✓	N/A
Year of termination COBRA participant or retiree enrolled in fully-insured coverage	✓ (Part III blank)	✓ (from Insurer)
Year 2 COBRA participant or retiree enrolled in self-insured coverage	N/A	✓ (from Employer)
Year 2 COBRA participant or retiree enrolled in fully-insured coverage	N/A	✓ (from Insurer)
Union employees for which Employer contributes to multiemployer fund	✓ (Part II transition relief) (Part III blank)	✓ (from Fund)

FORM 1095-C

Form 1095-C

- Part I – Employee and Employer Information
 - Lines 1 - 13
 - Each FEIN with employees will file
 - “Employee” field may be used for former or non-employees covered under the plan when using Form 1095-C
 - Employee transfers mid-year within controlled group – must receive one form from each employer
 - if transfer occurs mid-month, is the employee of the employer for whom the employee worked the most hours that month

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/form1095c			<input type="checkbox"/> VOID <input type="checkbox"/> CORRECTED	600116 OMB No. 1545-2251 2015
Part I Employee				Applicable Large Employer Member (Employer)		
1 Name of employee		2 Social security number (SSN)	7 Name of employer		8 Employer identification number (EIN)	
3 Street address (including apartment no.)			9 Street address (including room or suite no.)		10 Contact telephone number	
4 City or town	5 State or province	6 Country and ZIP or foreign postal code	11 City or town	12 State or province	13 Country and ZIP or foreign postal code	

Form 1095-C

- Part II – Employee Offer of Coverage (all)
 - Plan Start Month – Start of plan year (01 for calendar year plans) *Optional for 2015*
 - Line 14 – Codes for type of offer
 - Line 15 – Employee’s contribution for lowest-cost MV coverage offered
 - Line 16 – Codes for affordability safe harbors and transition relief

Part II Employee Offer and Coverage

Plan Start Month (Enter 2-digit number):

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

Form 1095-C Part II Codes

- Line 14 – Offer Codes

1A	Qualifying offer (FPL safe harbor)	1E	MEC MV ee + spouse and dependents
1B	MEC MV employee (ee) only	1F	MEC that is not MV
1C	MEC MV ee + dependents (not spouse)	1G	Offer to non-ACA full-time employee
1D	MEC MV ee + spouse (not dependents)	1H	No offer of coverage

- Only report as offered coverage if offered for full month
 - New hires
 - Month of termination
 - Differs from reporting MEC for the month in Part III – even one day
- May only use Code 1A if using federal poverty limit (FPL) affordability safe harbor
- For months of COBRA/retiree status in year of termination, enter 1H
- Use 1G for offers to non-ACA full-time employees but only if they enroll

Form 1095-C Part II Codes

- Line 15 – Cost
 - Lowest cost employee-only coverage offered regardless of option selected
 - Complete only if Code 1B, 1C, 1D, or 1E is entered on line 14 either in the “All 12 Months” box or in any of the monthly boxes
 - Not required to be reported for months of COBRA/retiree/non-employee coverage – leave Line 15 blank

Form 1095-C Part II Codes

- Line 16 – Safe Harbors / Transition Relief
 - Do not use Code 2A for a month if the employee was employed on even one day of the month
 - First or last month of employment ≠ Code 2A
 - Use Code 2B if coverage ends before the last day of the month due to termination of employment
 - If enrolled in coverage, Code 2C trumps other series 2 codes
 - Except COBRA/retiree (2A)
 - Except non-ACA full-time employees enrolled for *any month of the year* (leave blank)
 - For COBRA/retiree coverage in year of termination, enter Code 2A
 - But use Code 2B in month of termination if coverage ends mid-month and COBRA not elected, not 2C

2A	Employee not employed during the month	2E	Multiemployer interim rule relief
2B	Employee not a full-time employee	2F	W-2 affordability safe harbor
2C	Employee enrolled in coverage offered	2G	FPL affordability safe harbor
2D	Employee in limited non-assessment period	2H	Rate of pay affordability safe harbor

Form 1095-C

- Part III – Covered Individuals (if self-insured)
 - Lines 17-22
 - List covered employee, spouse and all covered dependents
 - SSN/TIN “reasonable effort” to obtain (IRS Notice 2015-68 relief for 2015)
 - Check box for month if covered for at least one day

Part III Covered Individuals

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

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

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form 1095-C (2015)

FORM 1095-B

Form 1095-B

- Part I – Responsible Individual
 - Lines 1 - 9
 - Line 8 code will be 'B' for employer-sponsored plans

A – small business health options program	D – individual market insurance
B – employer-sponsored coverage	E – multiemployer plan
C – government-sponsored plan	F – other designated MEC

- Line 9 will not usually apply

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.

VOID

CORRECTED

560115

OMB No. 1545-2252

2015

Part I Responsible Individual

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

Form 1095-B

- Part II – Employer Sponsored Coverage
 - Lines 10 - 15
 - Employers/self-insured plan sponsors and multiemployer plans leave Part II blank

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

- Part III – Issuer or Other Coverage Provider
 - Lines 16 - 22
 - Insurer or employer/self-insured plan sponsor

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

Form 1095-B

- Part IV – Covered Individuals

- List former employee (or other non-employee), spouse and all covered dependents
- SSN/TIN “reasonable effort” to obtain
- Check box for month if covered for at least one day

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

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60704B

Form **1095-B** (2015)

TRANSMITTAL FORMS

Form 1094-C Transmittal

- Transmittal to IRS with Forms 1095-C
- Part I – Applicable Large Employer (ALE) Member

Form 1094-C Department of the Treasury Internal Revenue Service		Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns ▶ Information about Form 1094-C and its separate instructions is at www.irs.gov/form1094c		<input type="checkbox"/> CORRECTED	120116 OMB No. 1545-2251 2015
Part I Applicable Large Employer Member (ALE Member)					
1 Name of ALE Member (Employer)		2 Employer identification number (EIN)			
3 Street address (including room or suite no.)					
4 City or town		5 State or province		6 Country and ZIP or foreign postal code	
7 Name of person to contact			8 Contact telephone number		
9 Name of Designated Government Entity (only if applicable)			10 Employer identification number (EIN)		
11 Street address (including room or suite no.)					
12 City or town		13 State or province		14 Country and ZIP or foreign postal code	
15 Name of person to contact			16 Contact telephone number		
17 Reserved <input type="checkbox"/>					
18 Total number of Forms 1095-C submitted with this transmittal ▶					
19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions <input type="checkbox"/>					



Form 1094-C Transmittal

- Part II – ALE Member Information

Part II ALE Member Information

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

21 Is ALE Member a member of an Aggregated ALE Group? Yes No
If "No," do not complete Part IV.

22 Certifications of Eligibility (select all that apply):

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

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

▶ Signature ▶ Title ▶ Date

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 61571A Form **1094-C** (2015)

- Line 22 Certifications

- Not required to select one
- Questionable whether these help or are a solution in search of a problem

Form 1094-C Transmittal

- Part III – Monthly ALE Member Information

120216

Page 2

Form 1094-C (2015)

Part III ALE Member Information – Monthly

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

Form 1094-C (2015)

Form 1094-C Transmittal

- Part IV – Other ALE Members of Aggregated ALE Group
 - IRS needs to be able to connect the dots (size, hours, penalty reductions, etc.)

120315
Page 3

Form 1094-C (2015)

Part IV Other ALE Members of Aggregated ALE Group

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

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

Form 1094-C (2015)

Form 1094-C Transmittal

- May contract with third party to submit forms
- May complete multiple Forms 1094-C for one employer (e.g., geographic, division) but only one “authoritative transmittal” per employer
- Authorized signer
 - Officer, President, Vice-President – similar to authority to sign tax return

Form 1094-B Transmittal

- Transmittal to IRS for Forms 1095-B

Form 1094-B		Transmittal of Health Coverage Information Returns		1115 OMB No. 1545-2252
Department of the Treasury Internal Revenue Service		▶ Information about Form 1094-B and its separate instructions is at www.irs.gov/form1094b .		2015
1 Filer's name		2 Employer identification number (EIN)		For Official Use Only 
3 Name of person to contact		4 Contact telephone number		
5 Street address (including room or suite no.)		6 City or town		
7 State or province		8 Country and ZIP or foreign postal code		
9 Total number of Forms 1095-B submitted with this transmittal ▶				

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

▶ Signature _____ ▶ Title _____ ▶ Date _____

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 61570P

Form **1094-B** (2015)

ACA REPORTING EXAMPLES

Active Employee Examples

- ACA Full-Time Employee Offered Coverage
 - Employed full year
 - Covers self and spouse all year
 - Added new baby 11/20/2015 (does not have SSN yet)
 - Line 14: 1E offered to all but not FPL affordability safe harbor
 - Line 15: Cost of lowest cost self-only option
 - Line 16: 2C Enrolled

Part II Employee Offer and Coverage							Plan Start Month (Enter 2-digit number):						
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$ 250	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)	2C												

Part III Covered Individuals				If Employer provided self-insured coverage, check the box and enter the information for each covered individual. <input checked="" type="checkbox"/>											
(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 John Q. Employee	333-44-5555		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18 Sally Q. Employee	333-55-4444		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19 Baby A. Employee		11/20/2015	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Active Employee Examples

- ACA Full-Time Employee Offered Coverage
 - Mid-year hire
 - Hired April 5, eligible for coverage 1st day of the month after hire date
 - **Remember:** Offer only counts if for full month in Part II but covered even one day of the month counts as MEC for the box in Part III
 - Line 14: 1H No offer /1A Employer using FPL affordability safe harbor
 - Line 15: Blank
 - Line 16: 2A Not employed / 2D Assessment period / 2C Enrolled

Part II Employee Offer and Coverage							Plan Start Month (Enter 2-digit number):						
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1A	1A	1A	1A	1A	1A	1A	1A
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)		2A	2A	2A	2D	2C	2C	2C	2C	2C	2C	2C	2C

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 John Q. Employee	333-44-5555		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>							

Active Employee Examples

- ACA Full-Time Employee Offered Coverage
 - Reduction in hours, loss of eligible status on June 15
 - COBRA coverage offered
 - For reduction in hours, offer is reported even if not enrolled in COBRA
 - Keep ACA measurement rules in mind – does a stability period apply?
 - Line 14: 1E Report offer of COBRA coverage through COBRA election period
 - Line 15: Lowest cost COBRA option for self-only coverage
 - Line 16: 2B if no COBRA election; 2A if COBRA election

Part II Employee Offer and Coverage

Plan Start Month (Enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1H	1H	1H	1H							
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$ 250	\$ 250	\$ 250	\$ 250	\$ 250	\$ 650	\$ 650	\$ 650	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)		2C	2C	2C	2C	2C	2B	2B	2B	2B	2B	2B	2B

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 John Q. Employee	333-44-5555		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				

Active Employee Examples

- Non-ACA FT Employee covered under the plan
 - Employer offers coverage to employees working 20-30 hours per week
 - Employee did not average 30 hours/wk during measurement period
 - Employee covers self, spouse and child
 - Line 14: 1G Not a full-time employee during any month of the calendar year
 - Line 15 and 16: Blank

Part II Employee Offer and Coverage							Plan Start Month (Enter 2-digit number):						
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
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. <input checked="" type="checkbox"/>																
(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 John Q. Employee	333-44-5555		<input checked="" type="checkbox"/>	<input type="checkbox"/>												
18 Sally Q. Employee	444-33-5555		<input checked="" type="checkbox"/>	<input type="checkbox"/>												
19 Richard A. Employee	555-44-3333		<input checked="" type="checkbox"/>	<input type="checkbox"/>												

Retiree and COBRA Examples

- Retiree/COBRA year of termination on Form 1095-C
 - Retirement/termination occurs on September 10, retiree/COBRA begins
 - Active employee coverage ends on last day of employment
 - Line 14: 1E Offer / 1H No offer
 - Line 15: No cost for months of COBRA coverage
 - Line 16: 2C Enrolled / 2A Not an employee

Part II Employee Offer and Coverage

Plan Start Month (Enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1H	1H	1H	1H							
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$ 250	\$ 250	\$ 250	\$ 250	\$ 250	\$ 250	\$ 250	\$ 250	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)		2C	2A	2A	2A	2A							

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 John Q. Employee	333-44-5555		<input checked="" type="checkbox"/>	<input type="checkbox"/>											
18 Sally Q. Employee	444-33-5555		<input checked="" type="checkbox"/>	<input type="checkbox"/>											
19 Richard A. Employee	555-44-3333		<input checked="" type="checkbox"/>	<input type="checkbox"/>											

Retiree and COBRA Examples

- Family member elects COBRA separate from employee (still employed)
- Qualifying event (divorce) occurs July 15
- Employee's Form 1095-C will report coverage of spouse through month of divorce in Part III
- Former spouse will receive separate Form 1095-B or 1095-C reporting COBRA coverage as a non-employee

Part II Employee Offer and Coverage

Plan Start Month (Enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$ 250	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)	2C												

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 John Q. Employee	333-44-5555		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18 Sally Q. Employee	444-33-5555		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				
19 Richard A. Employee	555-44-3333		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>				

Form 1095-B Retiree and COBRA

- Year 2 and beyond reporting MEC only
- Remember:
 - Stand-alone retiree account plans (HRAs) are MEC and must be reported
 - Medicare supplement plans are not MEC
 - If your retiree coverage and COBRA coverage is fully-insured, plan sponsors are not responsible for this reporting in Year 2 and beyond

Part I Responsible Individual																
1 Name of responsible individual Sally A. Retiree					2 Social security number (SSN) 345-55-6789			3 Date of birth (If SSN is not available)								
4 Street address (including apartment no.) 1800 N. Apple Street				5 City or town Anytown		6 State or province IL		7 Country and ZIP or foreign postal code 60600								
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 (see instructions)																
10 Employer name [Leave this section BLANK for self-insured coverage]										11 Employer identification number (EIN)						
12 Street address (including room or suite no.)				13 City or town		14 State or province		15 Country and ZIP or foreign postal code								
Part III Issuer or Other Coverage Provider (see instructions)																
16 Name ABC Company					17 Employer identification number (EIN) 37-124567			18 Contact telephone number 555-444-2222								
19 Street address (including room or suite no.) 1000 Hightower Avenue				20 City or town Anytown		21 State or province IL		22 Country and ZIP or foreign postal code 60601								
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 Sally A. Retiree	345-55-6789		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24 John R. Retiree, Jr.	345-55-4332		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form 1095-C Multiemployer Fund Example

- Form 1095-C multiemployer transition relief
- Employer reports offer on Part II, Fund reports MEC on Form 1095-B
- Line 14: 1H
- Line 15: Blank
- Line 16: 2E

Part II Employee Offer and Coverage

Plan Start Month (Enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H												
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)	2E												

Part III Covered Individuals

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

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

Morgan Lewis

QUESTIONS?

Biography



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Leader of Morgan Lewis's health and welfare task force, Andy R. Anderson is often recognized for his work in counseling clients on employer, individual, and insurer issues created by the Affordable Care Act, and regulatory compliance issues in relation to the Internal Revenue Code, ERISA, COBRA, HIPAA, and Mental Health Parity. Tax-exempt organizations and Fortune 500 companies turn to Andy for handling their benefit plans, and legal review surrounding welfare benefit plans, government self-correction programs, cafeteria plans, and VEBAs.

Biography



Kimberly J. Boggs

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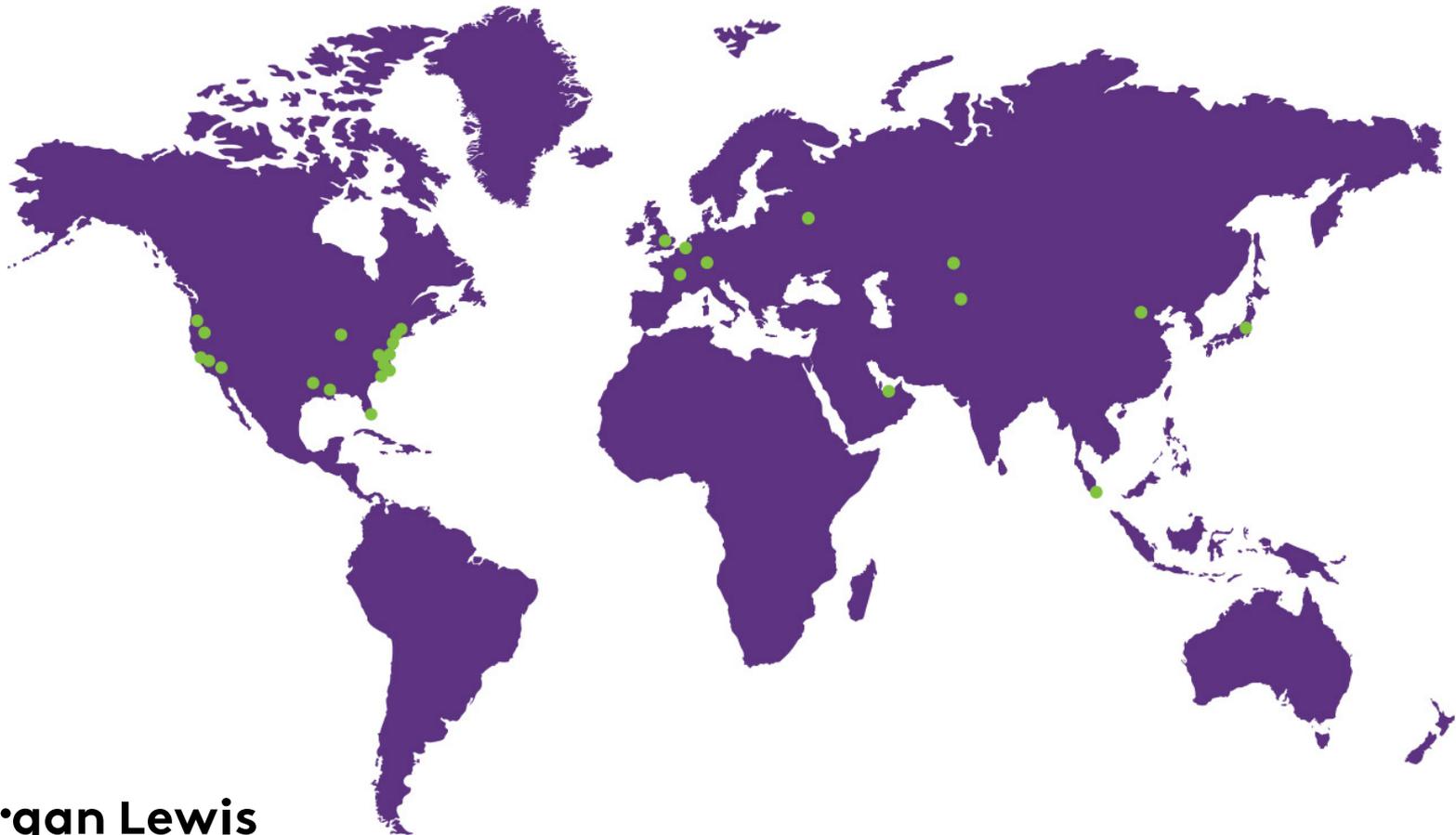
Kimberly J. Boggs focuses her work on tax and ERISA matters related to employee benefit plans and arrangements. Her current primary focus is on welfare benefits plans, and she regularly conducts comprehensive reviews of welfare benefit plans for compliance with operational and form requirements of the Internal Revenue Code, Affordable Care Act (ACA), ERISA, COBRA, and HIPAA.

Our Global Reach

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