The Affordable Care Act: What Governmental Employers Need to Know for 2015

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The Idea of the Employer Mandate

The Affordable Care Act[1] is broad-based legislation that places new obligations on employers, health insurers, and individual citizens. These materials focus on one aspect of those obligations—the so-called "employer mandate."

Beginning in 2015, employers with 100 or more full-time equivalent employees (50 or more beginning in 2016) must offer health insurance coverage that is affordable and provides "minimum value" to full-time employees and dependents or face penalties. This is the employer mandate of the ACA—also called "shared responsibility" or, sometimes, "pay or play."

These new employer obligations seem as strange to us now as the obligations of the Family and Medical Leave Act seemed to employers in 1993 when they were new or as the overtime payment obligations of the Fair Labor Standards Act seemed when they first were made fully applicable to governmental employers in the 1980s.

Yes, the FMLA and FLSA obligations are still tricky, but they at least they no longer seem foreign. The ACA and its obligations seem foreign now—What is "minimum value?" What is a standard look-back period? How does it relate to a stability period? What is a grandfathered health care plan? What is "minimum essential coverage?"

Maybe, before long, these terms will be as familiar to governmental employers as "serious health condition" is under the FMLA or "non-exempt" is under the FLSA.

But for the moment, it's all new. After all, the employer mandate has not even fully kicked in yet.

[1] The Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act (Pub. L. 111-152), both enacted by Congress and signed by President Obama in 2010, are commonly referred to together as the "Affordable Care Act" or "ACA."

The Basic Requirement of the Employer Mandate

The thrust of the employer mandate of the ACA can be stated in one paragraph.

Stating that paragraph is easy, and we have done it many times in these materials. Wrapping your mind around this one paragraph is also relative easy. Once you grasp it, you have a basic understanding of what employers must do.

Here it is:

Beginning in 2015, employers with 100 or more full-time equivalent employees (50 or more beginning in 2016) must offer health insurance coverage that is affordable and provides "minimum value" to full-time employees and dependents or face penalties.

Basics of the Affordable Care Act

Beginning in 2015, employers with 100 or more full-time equivalent employees (50 or more beginning in 2016) must offer health insurance coverage that is affordable and provides "minimum value" to full-time employees and dependents or face penalties. This is the "employer mandate" of the ACA—also called "shared responsibility" or, sometimes, "pay or play."

While this employer mandate kicks in in 2015, a number of provisions of the ACA have already become effective. The following eight already-effective provisions are of special importance to employers. [*See* the discussion on "grandfathered" plans beginning on page 7 for some special exceptions.]

1. Elimination of pre-existing condition exclusions

In a major change from prior practice, the ACA provides that coverage offered by group health plans or individual health plan coverage may not be limited or denied because of a person's pre-existing health condition. This provision applies fully to grandfathered plans as it does to other plans.

2. Coverage for children up to age 26

As the ACA was enacted, all health plans under the employer mandate would have been required to offer coverage to children (to age 26) of employees (as well as the employees themselves). Special transition relief rules, however, have softened the impact of this requirement for the moment for some employers. *See* page 12.

3. Elimination of lifetime benefits caps

It has been common practice for health coverage offered by employers to include a lifetime cap. Once an employee (or an employee's family, depending on how the cap worked for a particular plan) had received a pre-set level of benefits (say, $2 million) under the plan, then no further benefits would be available.

Starting in 2010, this kind of lifetime cap is no longer lawful as they apply to "essential health benefits:

Ambulatory patient services
Emergency services
Hospitalization
Maternity and newborn care
Mental health and substance use disorder services
Prescription drugs

Rehabilitative services and devices
Laboratory services
Preventative and wellness services and chronic disease management services
Pediatric services, including oral and vision care

The prohibition on lifetime caps does not apply to most dental and vision benefits or to Medicare supplemental plans.

In addition to the employer mandate, the ACA regulates the substance of both group health insurance policies issued by insurance companies and self-insured group health policies. All plans except self-insured plans and insured plans in the large employer market[2] must offer all ten essential health benefits without any annual or lifetime limits.

4. Elimination of annual benefits caps

Beginning in 2014, plans have been prohibiting from imposed annual benefits caps on essential health benefits (as described in the section above). Employers of more than 50 employees (100 in 2016) and grandfathered plans are subject to the prohibition on annual benefits caps, but, as discussed in the section just above, they are not required to offer coverage of essential health benefits.

5. Enhanced claims review processes

Under the ACA, plans must provide an internal claims process, provide appropriate notice to employees, allow employees to review their file and present evidence and testimony as part of the review process, and all employees to receive continued coverage during the appeals process.

These requirements do not apply to grandfathered plans. *See* page 8.

6. Coverage of specified preventative care benefits without cost to the employee

Starting in 2010, the ACA has required that health plans must provide certain in-network preventive health care and screenings free of any cost to the employee—no copays, no deductibles, no coinsurance—for employees and dependents.

Generally speaking, the federal Preventive Services Task Force, the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention, and the health Resources and Services Administration are authorized to determine the preventive health care and screenings that are subject to this no-cost requirement. The coverage includes immunizations for many kinds of diseases and screenings for many kinds of disorders.

[2] Effective January 1, 2016, for purposes of health insurance policy regulation, a large employer will be one that has more than 100 employees. Before then, states may define large and small employers as they choose. North Carolina General Statutes § 58-50-110 does not define "large employer" but does define "small employer" as one with 50 or fewer employees.

If you got a free flu shot, that's because it's on the list. If you had to pay for a shingles shot, that's because it's not and your plan decided not to provide it for free anyway.

Grandfathered plans are not subject to this requirement. *See* page 7.

7. Elimination of enrollment waiting periods in excess of 90 days

Beginning in 2014, employees and their dependents must not be required to wait more than 90 days for coverage to begin. *See* page 34.

Grandfathered plans are subject to this requirement. *See* p. 7.

8. Elimination of coverage "recession"

Before the ACA, the practice existed of removing individuals from the coverage of a health plan, with the removal effective back to a prior date, because the individual engaged in activities detrimental to the plan or the employer, as detailed in the plan. Now, such retroactive disenrollment, typically called "recession" is prohibited except in cases where the individual is guilty of fraud or intentional misrepresentation.

9. Employee payment responsibility caps

The ACA limits the amount that an employee may be required to contribute toward health costs under an employer's plan for deductibles, coinsurance, copays, and other expenditures to $6,250 for individuals and $12,500 for families, adjusted for inflation annually.

This limitation applies to employers who are subject to the employer mandate, but not to grandfathered plans. *See* page 7. Freedom from this limitation is one of the major differences between grandfathered and non-grandfathered plans.

For employers with no more than 100 employees (or 50 if a state has said less, as North Carolina has), in addition there is a cap on deductibles themselves. That cap is $2,000 for employee and $4,000 for family, adjusted for inflation annually.

9. **Automatic enrollment**

The ACA requires employers with 200 or more employees automatically to enroll their employees in their group plan, if offered. Employees must be give notice of the enrollment and the opportunity to opt out of coverage. Enforcement of the automatic enrollment requirement has been suspended until the relevant federal agencies issue rules governing this provision of the ACA.

Grandfathered Plans

Some health insurance plans, including plans offered to employees by employers, are not subject to a few of the rules that relate to all other health plans. If a plan was in effect on March 23, 2010 and has provided continuous coverage ever since, it is considered a "grandfathered" plan and enjoys exemption from a few rules, as long as it retains its grandfathered status.

Rules that do apply to grandfathered plans

Even grandfathered plans are subject to most of the new rules that affect other employer-sponsored health insurance plans.

Dependent coverage. As discussed at page 4 above, the ACA requires that group health plans must offer coverage for employees' children up to age 26. This requirement applies equally to grandfathered plans.

Waiting period limitation. As discussed at page 6 above, the ACA provides that employees who are eligible for an offer of coverage must receive that offer within 90 days of beginning employment. This provision applies equally to grandfathered plans.

Pre-existing conditions. As discussed at page 4 above, the ACA requires that group health plans must eliminate exclusions for pre-existing conditions entirely. This provision applies equally to grandfathered plans.

Lifetime and annual caps. As discussed at pages 4 and 5 above, the ACA requires that group health plans must impose no annual caps on the essential health benefits that an employee or dependent may be eligible for. This provision applies equally to grandfathered plans.

Rules that do not apply to grandfathered plans

The value of being grandfathered as a plan is that the plan sponsor—that is, employers subject to the employer mandate—may offer plans that do not meet some of the ACA requirements.

Employee co-payment limits. As discussed at page 6 above, the ACA imposes limits on the amounts of co-pays, co-insurance, deductibles and other "cost-sharing" payments that an employee may be required to pay. In general, those limits are $6,250 for an individual for a year and $12,500 for a family for a year, subject to adjustment for inflation. As long as a grandfathered plan retains its grandfathered status, it is not bound by this limitation and may impose co-pays and deductibles and other employee payments in excess of these amounts.

Preventive care without employee cost. As discussed at page 5 above, the ACA requires that group health plans must provide coverage for certain preventive health care and screenings without imposing any cost on the employee. As long as a grandfathered plan retains its grandfathered status, it is not bound by this requirement and may impose co-pays and deductibles and other employee payments for preventive health care and screenings.

OB-GYN choice. The ACA requires that health plans permit female employees who are participants in the plan to select the obstetrics and gynecological professionals of their choice. Grandfathered plans do not have to meet this requirement, as long as they retain their grandfathered status.

Claims. As discussed at page 5 above, the ACA requires that group health plans must provide certain appeals rights and allow employees to continue to receive coverage during the appeals process. As long as a grandfathered plan retains its grandfathered status, it is not bound by the ACA's claims requirements.

Highly paid executives. There is one final rule that grandfathered plans are free from that is not likely to be of interest to local government employers in North Carolina. The IRS has long required that employer self-funded group health plans may not discriminate in favor of higher compensated individuals. That is, top executives could not receive health care benefits that were better than those received by other employees. This rule did not apply to employer health coverage that was not self-funded; that is, where an employer purchased insurance for its employee health coverage, it could discriminate in coverage in favor of highly compensated employees. The ACA extends the non-discrimination provision to such non-self-funded employer health coverage. So, now, all employer-provided health plans must not discriminate in favor of highly compensated individuals, except for health plans that are grandfathered. If an employer had a non-self-funded plan that did in fact discriminate and the plan qualifies as a grandfathered plan, the employer may continue to use the discriminatory provisions as long as the plan retains its grandfathered status.

Losing grandfathered status

A plan that is grandfathered retains its grandfathered status, and thus continues to enjoy its exemptions, as outlined above, from some of the ACA requirements.

A plan loses it grandfathered status if one of the following six things happen.

Benefits for a particular condition eliminated. A plan loses its grandfathered status if all (or substantially all) benefits to diagnose or treat a particular condition are eliminated. The elimination of benefits for any significant diagnosis or treatment element related to a condition is enough to trigger the loss of grandfather status. Maybe the plan formerly provided benefits for mental health counseling but those benefits were eliminated. The grandfathered status is lost.

Increase in coinsurance percentage. Any increase in the percentage upon which a coinsurance payment is based triggers the loss of grandfather status. Maybe the plan formerly provided that employees must pay a 15% coinsurance payment for certain kinds of procedures. The percentage is increased to 20%. The grandfathered status is lost.

Increase in cost-sharing other than a copayment above a certain percentage. If a fixed-amount payment requirement other than a copayment is increased by more than the rate of medical inflation plus 15 percentage points, grandfathered status is lost. That would include, for

example, increases in deductibles or out-of-pocket limits. The government determines the medical inflation rate.

Increase in fixed-amount copayment above a certain amount. If a copayment amount is increased by more than the rate of medical inflation plus 15 percentage points, or by more than $5 plus $5 times the rate of medical inflation, grandfathered status is lost.

Decrease in employer contribution beyond a certain level. If employer contributions toward the cost of any tier of coverage for any class of similarly situated individuals decreases by more than a specified amount, grandfathered status is lost. For a self-funded plan, for example, where the contribution rate is determined by the cost of coverage, the decrease cannot be more than 5%.

New or decreased overall annual limits. If previously neither a lifetime nor an annual limit existed and an annual limited is imposed, grandfathered status is lost. If previously there was a lifetime limit but no annual limit, grandfather status is lost if an annual limit is imposed that is less than the lifetime limit. If previously there was an annual limit and that limit is decreased, grandfathered status is lost.

Special Transition Relief Rules Make Things a Little Easier in 2015

The employer mandate—"pay or play"—was originally scheduled to come into effect on January 1, 2014, but a directive from the United States Department of the Treasury delayed its effective date to January 1, 2015. *See* http://www.irs.gov/pub/irs-drop/n-13-45.pdf

As that 2015 effective date was approaching, the Internal Revenue Service issued short-term rules that make things a little bit easier for employers who come under the employer mandate starting in 2015. These new rules offer what the IRS calls "transition relief."

Remember that no employer is literally required to offer health insurance coverage employees. Rather, covered employers must offer affordable health insurance coverage to avoid having the pay penalties. The special transition relief rules, applicable only for 2015, will help some employers avoid penalties in that year only.

This transition relief rules have eight principal provisions. The entirety of the regulations can be found at https://www.federalregister.gov/articles/2014/02/12/2014-03082/shared-responsibility-for-employers-regarding-health-coverage

Here are the eight principal provisions.

1. Employers between 50 and 100 employees are not subject to penalties in 2015

The employer mandate applies to employers of 50 or more full-time employees (or full-time equivalent employees). For such employers, the "pay or play" employer mandate applies. These employers must offer coverage that is affordable and provides minimum value to all full-time employees or face no-coverage penalties or inadequate-coverage penalties. Employers under 50 are not obligated by the Affordable Care Act to offer health insurance coverage at all.

The transition relief rules raise the threshold for 2015 to 100 employees (or full-time equivalent employees).

Most employers that have between 50 and 100 full-time employees will be able to take advantage of this higher ceiling and delay offering coverage, if they choose, (Of course, any employer who is not required to offer coverage that meets the requirements of the ACA may choose to offer such coverage nonetheless. The mere fact that an employer is not required to offer it does not mean that the employer is prohibited from offering it or should not offer it.) But some employers of between 50 and 100 employees will not be able to take advantage.

First, the employer may not have reduced the size of its workforce in order to get under 100 to take advantage of this transition relief rule. If, on the other hand, an employer has reduced its workforce to under 100 for legitimate reasons not related to trying to take advantage of the rule, the employer may still use the rule to delay offering coverage through 2015.

Second, the employer may not have materially reduced the health insurance coverage that it was offering to employees on February 9, 2014 (the date the transition relief rules were

issued). Special rules spell out what it means to "materially reduce" coverage and therefore give up the opportunity to use this transition relief rule.

2. Employers must offer coverage to 70% of their employees, not 95%, in 2015

To avoid the no-coverage penalty, employers must offer coverage to all full-time employees and their dependents or face no-coverage penalties. That statement is actually not quite true. The employer will not face a no-coverage penalty if it offers coverage to 95% of its employees and their dependents. Perfection is too much to ask. Employees come and go. Employers make administrative errors. As far as the ACA is concerned, an offer to 95% of full-time employees is good enough.

The transition relief rules, for 2015 only, drop that requirement to 70%. As long as a covered employer is offering coverage that is affordable and provides minimum value to 70% of its full-time employees and their dependents during 2015, it is not liable for the no-coverage penalty.

3. The maximum no-coverage penalty is reduced for 2015

To avoid the no-coverage penalty, employers with at least 50 full-time employees (100 for 2015, as explained above) must offer to coverage that is affordable and provides minimum value to all full-time employees and their dependents. If an employer fails to do so, it will face the no-coverage penalty. That penalty is assessed every month, and every month it is one-twelfth of $2,000 per employee who should have been offered coverage but was not. So, on its face it would seem that if an employer failed to offer coverage to 12 employees, then the monthly no-coverage penalty would be $2,000. That is, however, not quite right. No penalty is imposed with respect to the first 30 employees who should have been offered coverage but were not. So if an employer should have offered coverage to 225 employees, but in fact offered coverage to only 200, the employer is not subject to the no-coverage penalty for that month. If, on the other hand, the employer should have offered coverage to 225 employees but in fact offered coverage to only 150, then it is liable for the penalty on 45 employees (75 minus 30). The penalty for that month (and every month where the same was true) would be one-twelfth of $2,000 times 45, or $7,500.

The transition relief rules, for 2015 only, exclude the first 80—rather than 30—employees. So the same employer with 225 full-time employees who offered coverage to only 150 would not face a penalty. It failed to offer coverage to 75 employees, and that number is less than 80.

4. Extra relief for coverage plans that do not run on calendar years

Some employers offer health coverage on plans that run on a 12-month basis that is not a calendar year basis. For example, a plan year may run from July 1, 2014 through June 30, 2015, to be followed by a plan year that runs from July 1, 2015 through June 30, 2016.

The transition relief rules provide that in such a case an employer will not be liable for penalties with respect to employees who are eligible under the plan for the non-calendar year beginning in 2014 and ending in 2015 if all full-time employees are offered coverage that is affordable and provides minimum value by the first day of the 2015 plan, which, in the case of the example above, would be July 1, 2015.

This transition relief delays the possibility of application of penalties with respect to full-time employees not offered coverage from January 2015 to the start of the plan year sometime in 2015 (July 1 in the example above). For this transition relief to apply, the employer must not have changed its plan year after December 27, 2012 to have the plan start at a later date in the year than previously was set and must have offered coverage under the old plan to set proportions of its employees, as set out in the transition relief rules.

5. **Shorter measurement periods for stability period starting during 2015**

Employers may use stability periods of less than one year for stability periods beginning in 2015. For purposes of stability periods beginning in 2015, employers may adopt a transition measurement period that is shorter than 12 months but not less than six months and that ends no earlier than 90 days before the first day of the plan year that begins on or after January 1, 2015.

6. **Shorter period for determining whether you are a large employer**

The employer mandate—"pay or play"—applies only to employers who have at least 50 full-time equivalent employees (100 in 2015). Usually, it will be an easy question whether an employer is over the threshold. But some employers may be near the threshold and so it may not be clear. In such a case, the general rule is that the employer must have averaged 50 full-time equivalent employees on business days over the preceding calendar year.

The transition relief rules provide that for 2015 only, an employer may look back to any period of six consecutive months in 2014 (of its choosing) to take the average and determine whether it meets the threshold.

7. Coverage for dependents

An employer of 50 or more full-time employees (100 in 2015 only) must offer health insurance coverage that is affordable and provides "minimum value" to full-time employees and dependents or face penalties.

The ACA and its regulations define "dependent" to mean the full-time employee's children under age 26. The term does not include spouses, stepchildren, or foster children. So, the general rule is the coverage must be offered to full-time employees and their biological or adopted children.

The transition relief rules, for 2015 only, provide that plans need not cover dependents who have not previously been covered if they take steps to implement coverage in 2016. That is,

for 2015, if in 2013 and 2014 the employer did not offer dependent coverage, it will not face no-coverage penalties for not offering dependent coverage in 2015.

If, however, coverage in 2013 or 2014 did in fact cover some dependents, then in 2015 the offer of coverage musts include those dependents previously covered.

8. Special rule for the month of January 2015

As a general rule, if a full-time employee is not offered coverage for any one day of a month, the employer is treated for penalty purposes as if the employee had not been offered coverage for the full month. The transition relief rules provide that for the one month of January 2015 only, the employee is treated as covered for the full month if he or she is offered coverage in the month of January 2015 no later than the first day of the first payroll period that month.

Penalties

An employer of 50 or more full-time employees (100 in 2015 only) must offer health insurance coverage that is affordable and provides "minimum value" to full-time employees and dependents or face penalties.

These penalties are referred to in the regulations as Employer Shared Responsibility payments. They are also sometime referred to in the regulations as "assessable payments."

Keep in mind that there is no requirement that any employer offer any health insurance coverage at all. It's just that if an employer of 50 or more (100 or more in 2015 only) does not offer coverage that is affordable and provides "minimum value" to at least 95% of its full-time employees (70% in 2015 only), it can face penalties.

There are two kinds of penalties.

The no-coverage penalty

The first is the no-coverage penalty. If an employer fails to offer coverage at all, or offers it to less than 95% of its full-time employees (70% in 2015 only), the employer is liable for the no-coverage penalty. The no-coverage penalty kicks in only if at least one employee receives a premium tax credit to help pay for coverage purchased on the exchanges set up under the ACA. The IRS will know which individuals have received such a tax credit and, because of reporting requirements under the ACA, it will know which of those individuals are employees of a particular employer. It will contact the employer to see whether a no-coverage penalty should be assessed.

Calculation of the penalty. Here is how the no-coverage penalty works. The penalty is assessed every month, and every month it is one-twelfth of $2,000 per employee who should have been offered coverage but was not. So, on its face it would seem that if an employer failed to offer coverage to 12 employees, then the monthly no-coverage penalty would be $2,000. That is, however, not quite right. No penalty is imposed with respect to the first 30 employee who should have been offered coverage but were not. So if an employer should have offered coverage to 225 employees, but in fact offered coverage to only 200, the employer is not subject to the no-coverage penalty for that month. If, on the other hand, the employer should have offered coverage to 225 employees but in fact offered coverage to only 150, then it is liable for the penalty on 45 employees (75 minus 30). The penalty for that month (and every month where the same was true) would be one-twelfth of $2,000 times 45, or $7,500.

Special rules for 2015. There is special relief for 2015. Transition relief rules adopted by the IRS applicable for 2015 only, exclude the first 80—rather than 30—employees. So the same employer with 225 full-time employees who offered coverage to only 150 would not face a penalty. It failed to offer coverage to 75 employees, and that number is less than 80.

The inadequate-coverage penalty

An employer of 50 or more full-time employees (100 in 2015 only) must offer health insurance coverage that is affordable and provides "minimum value" to full-time employees and dependents or face penalties.

If the employer fails to (or chooses not to) offer coverage to at least 95% of its full-time employees (70% in 2015), it is open to the no-coverage penalty described above. But even if the employer does offer coverage to 95% of its employees (70% in 2015), there is a second possible penalty which kicks in if the coverage that is offered either is not "affordable" or does not provide "minimum value."

This second kind of penalty is the inadequate-coverage penalty. (Like the no-coverage penalty described above, this inadequate-coverage penalty kicks in only if at least one employee receives a premium tax credit to help pay for coverage purchased on the exchanges set up under the ACA.)

Affordable. To avoid the inadequate-coverage penalty, the employer must offer coverage that is affordable. To be affordable with respect to any particular employee, the employee's required contribution toward the cost of coverage for self-only coverage must not exceed 9.5% of the employee's household income for the year.

How is the employer to know whether the required contribution for an employee exceeds 9.5% of the employee's household income? The employer is, almost surely, not going to know what the employee's household income is. Given that reality, the regulations provide three options for employers to use to make sure that each employee's required contribution is affordable within the meaning of the ACA. Each of these options is termed a "safe harbor." That is, if the employer can determine that the employee's required contribution is affordable using one of these options, then the employer is "safe" in believing that the coverage it offers is "affordable."

The Form W-2 wages safe harbor. The employer knows how much it has paid each employee, of course, and reports that amount on the employee's Form W-2 for income tax purposes. If the amount of the employee's required contribution is less than 9.5% of the income that the employer itself has pays the employee, then the affordability requirement is met. The employee's income from the employer is part of the employee's household income, obviously, so if the 9.5% provision is met by that income it is met for the total household income as well. This is a month-by-month calculation

The rate of pay safe harbor. For hourly-paid employees, this safe harbor allows the employer to take the employee's hourly rate of pay (the lowest rate that the employee works under) and multiply it by 130, which is the number of hours treated as a full working month. If the employee's contribution to health coverage is less than 9.5% of that total, then the coverage is "affordable." This is also a month-by-month calculation. For salaried employees, question is whether the employee's contribution is less than 9.5% of that month's salary.

The federal poverty line safe harbor. This safe harbor is designed to allow an employer to know for certain that the contribution required of any employee is "affordable." The employer takes the published federal poverty line for a single individual for the applicable year and divides it by 12 to get a monthly figure. If a required contribution is less than 9.5% of that figure, it is affordable.

Minimum value. For the coverage to avoid the inadequate-coverage penalty, it must be affordable, as described above, and it must provide "minimum value." This is a calculation that may be beyond the capacity of individual employers to make. Employers may have to rely on brokers to insure that the plans offered by the employer do in fact provide minimum value, but employers will have to report to the IRS that their plan provides minimum value and make the same statement to employees.

In general, a plan provides minimum value if it covers at least 60% of the total allowed costs of benefits that could be expected to be incurred under the plan if the plan applied to a statistically standard population. HHS and the IRS have provided a minimum value calculator. (To download the minimum value calculator, google "aca minimum value calculator" and click on the XLS link for the cms.gov website.) Employers who wish to determine for themselves whether a plan provides minimum value may enter certain information into the calculator, such as deductibles and co-pays, and the calculator will apply the data related to the statistically standard population and determine whether the plan provides minimum value.

Calculation of the penalty. The employer is assessed the inadequate-coverage penalty if the coverage offered is not affordable or fails to provide minimum value, and if at least one full-time employee purchases coverage on an exchange and receives a premium tax credit. The penalty is one-twelfth of $3000 (to get a monthly amount) each month for every employee who receives the premium tax credit.

There is a cap on the amount of the inadequate-coverage penalty which is designed to ensure that an employer who offers coverage (although inadequate or below minimum value) will never pay a greater penalty than an employer who offers no coverage at all.

Considerations for Employers with Fewer than 50 Employees

An employer of 50 or more full-time employees (100 in 2015 only) must offer health insurance coverage that is affordable and provides "minimum value" to full-time employees and dependents or face penalties. That is the employer mandate.

The employer mandate does not apply to employers under the 50-employee threshold. That means that employers of that small size do not have to offer health insurance at all, and are not subject to any penalties if they chose to offer no insurance.

ACA requirement that apply even to employers under 50 full-time employees

But some ACA requirements do apply to health insurance plans that smaller employers offer.

1. There are limits on co-pays and deductibles for essential health benefits. *See* p. 6.

2. If the employer offers coverage, the plan must cover essential health benefits. *See* p. 5.

3. If the employer offers coverage, it must abide by 90-day waiting period limit. *See* p. 34.

4. If the employer offers coverage, the plan may impose no lifetime or annual limits. *See* pp. 4-5.

5. If the employer offers coverage, it must offer coverage to children up to 26. *See* p. 4.

6. If the employer offers coverage, the plan must provide preventive services without employee cost. *See* p. 5.

Grandfathered plans

As discussed in the section beginning on page 7, some health plans are "grandfathered" and by virtue of that exception are exempted from some ACA rules that would otherwise apply. Employers under 50 full-time employees may have grandfathered plans, and, if so, they are not bound by co-pay and deductibles limits and the provision requirement the coverage of preventative services without cost.

Affordable Care Act Definitions Relevant to the Counting of Employees

The ACA introduces some new terms of its own (like "applicable large employer") and puts its own meaning or some more familiar terms (like "full-time employee").

Applicable Large Employer: Any employer who has employed an average of 50* or more *full-time equivalent* employees during the preceding calendar year. *See* 26 USC § 4980H(c)(2)(A); 26 CFR § 54.4980H-1(a)(4). For 2015 only, the threshold is 100, not 50.) In these materials, an "applicable large employer" is referred to as a "covered employer."

Bona Fide Volunteer: An employee of a government or nonprofit entity whose only compensation is in the form of either (1) a reimbursement or allowance for reasonable expenses incurred in the performance of services by volunteers, or (2) reasonsable benefits and nominal fees of a type customarily paid by similar entities in connection with the performance of services by volunteers. *See* 26 CFR § 54.4980H-1(a)(7).

Employee: An individual who is an employee under the common law standard. *See* 26 CFR § 54.4980H-1(a)(15).

Full-time Employee: An employee is works an average of at least 30 hours of service per week in any given calendar month. *See* 26 CFR § 54.4980H-1(a)(21).

Full-time Equivalent Employee (FTE): A combination of employees, each of whom individually does not qualify as a full-time employee because s/he does not work an average of least 30 hours per week but who in combination are counted as the equivalent of a full-time employee solely for the purposes of determining whether an employer is an applicable large employer. *See* 26 CFR § 54.4980H-1(a)(22).

Hour of Service: Hours of services include both (1) each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer, and (2) each hour for which an employee is paid, or entitled to payment by an employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military leave or leave of absence. *Excluded from hours of service* are hours of service performed by volunteers and hours of service performed for an educational institution as part of the Federal Work-Study Program. *See* 26 CFR § 54.4980H-1(a)(24).

New Employee: An employee who either not previously been employed by the employer or has previously been employed by the same employer but is treated as a new employee because he or she has not had any hours of service for a period of 13 consecutive weeks or more (26 consecutive weeks if the employer is a university, four-year college, community college or public school system). *See* 26 CFR § 54.4980H-1(a)(30); § 54-4980H-3(c)(4)(i).

Part-time Employee: A new employee whom the employer reasonably expects to work on average fewer than 30 hours of service per week during the initial measurement period. *See* 26 CFR § 54.4980H-1(a)(32).

Seasonal *Employee*: An employee who is hired into a position for which the customary annual employment is six months or less. *See* 26 CFR § 54.4980H-1(a)(38). The term *seasonal employee* is used when discussing which employees must be offered affordable coverage.

Seasonal *Worker*: A worker who performs labor or provides services on a seasonal basis as defined by the Secretary of Labor, including but not limited to workers covered by 29 CFR § 500.20(s)(1), and retail workers employed exclusively during the holiday seasons. Employers may apply a reasonable, good faith interpretation of the term seasonal worker and a reasonable good faith interpretation of 29 CFR § 500.20(s)(1), including applying it by analogy to workers and employment positions not otherwise covered by that section. The term *seasonal worker* is used when discussing whether an employer is an applicable large employer covered by the ACA. *See* 26 CFR § 54.4980H-1(a)(39).

> **29 CFR § 500.20(s)(1) reads:**
>
> On a seasonal or other temporary basis means:
> (1) Labor is performed on a seasonal basis where, ordinarily, the employment pertains to or is of the kind exclusively performed at certain seasons or periods of the year and which, from its nature, may not be continuous or carried on throughout the year. A worker who moves from one seasonal activity to another, while employed in agriculture or performing agricultural labor, is employed on a seasonal basis even though he may continue to be employed during a major portion of the year.

Special Unpaid Leave: Either (1) unpaid FMLA leave; (2) unpaid military leave under USERRA; or (3) unpaid leave for jury duty. *See* 26 CFR § 54.4980H-1(a)(44).

Terms Associated with the Use of the Look Back Measurement method:

New Employee: An employee who has been employed for less than one complete standard measurement period. *See* 26 CFR § 54.4980H-1(a)(30).

Ongoing Employee: An employee who has been employed by an employer for at least one complete standard measurement period. *See* 26 CFR § 54.4980H-1(a)(31).

Variable Hour Employee: An employee whose hours of service cannot reasonably be determined on the employee's start date. Factors relevant to the question of whether or not an employee's hours of service can be reasonably determined at the start date include, but are not limited to:

- whether the employee is replacing an employee who was a full-time employee;
- the extent to which the hours of current employees in the same or comparable positions have fluctuated above and below 30 hours of service per week during recent measurement periods; whether the job was advertised as requiring 30 or more hours of service per week; and

- whether the employee was told that the job required 30 or more hours of service per week.

This term is only used in the context of the look-back method of measurement.
See 26 CFR § 54.4980H-1(a)(49).

Standard Measurement Period: A period of between three and twelve months used to measure an employee's hours of service under the look-back measurement method. The first standard measurement period for a new employee is called the **initial measurement period**. *See* 26 CFR § 54.4980H-1(a)(46).

Stability Period: A period that immediately follows an initial or standard measurement period and any associated administrative period during which an employee's status as full-time or part-time is fixed. *See* 26 CFR § 54.4980H-1(a)(45).

How Do I Know Whether the ACA Applies to My Organization?
or
How Do I Know Whether My Organization is an Applicable Large Employer Who Must Offer Coverage or Pay a Penalty?

Beginning on January 1, 2015, "applicable large employers" will be subject to a penalty if they fail to offer their employees the opportunity to participate in an affordable group health plan that offers minimum value. What is an "applicable large employer?" An applicable large employer is any employer who has employed an average of 50 or more *full-time equivalent* employees during the preceding calendar year. *See* 26 USC § 4980H(c)(2)(A); 26 CFR § 54.4980H-1(a)(4).

The ACA defines "full-time employee" as an employee who is averages 30 or more hours per week. The monthly equivalent is 120 hours of service per calendar month. Hours are not only hours physically worked, but any hours for which employees use accrued paid leave.

In order to determine whether an organization is an "applicable large employer" (let's call that a "covered employer"):

1. Count the number of actual full-time employees, including any temporary and seasonal workers for each month;
2. Add together the number of hours worked by part-time employees each month; divide by 120; the result is the number of FTEs for that month;
3. Add together the total number of actual full-timers and the total number of FTEs for each month; divide by 12; the result will show whether the employer averaged 50 or more FTEs during the previous calendar year. *See* 26 USC § 4980H(c)(2)(E); 26 CFR § 54.4980H-2(c)(2).
4. Example: An employer that has 39 full-time employees and 20 part-time employees who average 17 hours per week would be treated as having 50 full-time employees. 17 x 20 x 4 = 1360; 1360/120 = 11.33 FTEs. 39 F/T employees + 11.33 FTEs = 50 employees (round down if the number of FTEs is fractional).

Note that FTEs are only used for determining applicable large employer status and are not counted when determining the number of employees for the purpose of the no-coverage penalty [4980(a)] or the inadequate-coverage penalty [4980(b)]. *See* p. 25.

Do Volunteers Count?

Generally speaking, volunteers do not count toward a governmental employer's total.

Although local governments typically reward volunteers with some form of recognition for their service -- usually in the form of a cash award, reimbursement of expenses or payment on a per call (for public safety) or per game (for parks and recreation officials) basis—this does not turn volunteers into employees for the purposes of determining whether an employer is covered by the ACA. The ACA uses the term "bona fide volunteer" to describe positions that need not be counted in determining the number of employees an employer has. A bona fide

volunteer is a person who performs services for a government entity whose only compensation is in the form of either (1) a reimbursement or allowance for reasonable expenses incurred in the performance of services by volunteers, or (2) reasonable benefits and nominal fees of a type customarily paid by similar entities in connection with the performance of services by volunteers. *See* 26 CFR § 54.4980H-1(a)(7); 26 CFR § 54.4980H-1(a)(24)(ii)(A).

Do Elected Officials Count?

No. It's true that elected officials who receive a stipend in return for their services are considered employees by the IRS for income-tax reporting purposes and must be issued a W-2 each January. But do elected officials count as employees for the purpose of determining whether an employer must offer health insurance or pay a penalty? *The regulations do not expressly address this question, but the answer seems to be no.* Elected officials are not employees. To the extent that they must have a category, they are more akin to volunteers.

The ACA regulations define an "employee" as "an individual who is an employee under the common law standard." *See* 26 CFR § 54.4980H-1(a)(15). An elected official does **not** meet the IRS common law test for determining whether a worker is an employee or an independent contractor, notwithstanding their inclusion as employees for tax withholding purposes. Under the common law standard for determining whether someone is an employee of an organization, the relevant factors that the IRS and the courts would look to are (a) whether the employer has control over how and when the individual's work is done, control being characteristic of employee status; (b) the employer's right to fire the individual; (c) whether the individual is engaged in an independent business, calling or occupation; (d) whether the individual is doing the work at a fixed price or for a lump sum or upon a quantitative basis, payment on a quantitative basis being characteristic of an employee; and (f) whether the individual is free to use such assistants as he may think proper and has full control over such assistants. Elected officials have complete control over how and when they do the work, cannot be fired, generally have other employment (or other sources of income, if retired), are paid a lump-sum stipend regardless of the amount of time the officials spend on the work, and are free to hire assistants to help in the work at their own expense.

Do Temporary Employees Count?

Yes. There is no exception for temporary employees. They must be counted in the months in which they work.

Do Seasonal Employees Count?

It depends. The ACA regulations instruct employers to include seasonal workers when counting the number of full time employees it employs each calendar month for the purpose of determining whether it is a-covered employer. *See* 26 CFR § 54.4980H-2(a). The regulations then allow employers to subtract its seasonal workers if – and only if – (1) the employer had a full-time workforce exceeding 50 employees *on only 120 or fewer days* (or 4 or fewer calendar

months) in the preceding year, and (2) the employer only had 50 or more full-time employees during those 120 or fewer days because it was employing seasonal workers. *See* 26 CFR § 54.4980H-2(b). Note that the ACA regulations refer to individuals who have seasonal employment as "seasonal workers" for purposes of determining whether an employer is covered by the ACA and as "seasonal employees" for the purpose of determining which employees must be offered affordable coverage.

Example 1: Paradise Beach, NC, has 40 full-time, year-round employees and 45 full-time employees who work only during the months of June, July, August and September.

40 F/T employees x 8 months = 320 F/T employees for eight months of the year.

85 F/T employees x 4 months = 340 F/T employees for four months of the year.

320 + 340 = 660 full-time employees / 12 months = average of 55 employees

Paradise Beach has 55 full-time employees for only four months, and the five employees in excess of 50 are attributable solely to the presence of seasonal beach employees. It will therefore not be treated as a covered employer for that calendar year.

Example 2: Paradise Beach, NC, has 40 full-time, year-round employees and 45 full-time employees who work only during the months of June, July, August and September. In 2014, Paradise Beach also has 60 FTEs during the month of October to assist in the clean-up work following a major hurricane.

40 F/T employees x 7 months = 280 F/T employees for seven months of the year.

85 F/T employees x 4 months = 340 F/T employees for four months of the year.

100 FTE employees x 1 month = 100 FTE employees for one month of the year

280 + 340 + 60 = 720 full-time employees / 12 months = average of 60 employees.

Here, the seasonal worker exemption does not apply. The seasonal worker exemption applies only if the sum of an employer's full-time employees (including seasonal employees) exceeds 50 for 4 months (or 120 days) or fewer. Here, Paradise Beach has more than 50 full-time and FTE employees for 5 months.

What Happens When an Employer "Turns 50" for the First Time?

Employers sometimes add employees. An employer who maintained a workforce that varied between 42 and 48 full-time employees for years may suddenly find that is has averaged 53 full-time employees in the previous year. If the employer has always provided affordable health insurance to all of its full-time employees, it will not be liable for either the 4980H(a) no-coverage penalty or the 4980(b) inadequate-coverage penalty, although it may now be subject to increased reporting requirements. If, however, the employer has not offered affordable health insurance to all or to any of its employees, it will have to do so by April 1st of the next calendar year following the year in which it first averaged 50 or more full-time employees. The regulations essentially give employers a three-month window in which to realize that they are covered by the ACA's employer mandate and to find affordable coverage. For example, any employer who does not offer coverage in 2015, but then realizes that it had an average of 50 or more employees in 2015 and is thus an ACA-covered employer, will have until April 1st, 2016 to

begin providing its employees with affordable coverage before it will be liable for either the no-coverage or inadequate-coverage penalties. *See* 26 CFR § 54.4980H-2(b)(5).

How Do I Know to Which Employees I Must Offer Health Insurance Coverage?

Covered employers must determine the full-time status of each employee and offer affordable coverage to each employee averaging 30 hours of service per week in order to comply with the ACA.

I. ***New employees who an employer reasonable expects to work an average of 30 hours per week* must be offered affordable health coverage no later than the first day of the fourth full calendar month of employment.** *See* 26 CFR § 54.4980H-3(c)(2) and (d)(2)(iii). Factors include:

   a. whether the employee is replacing an employee who was a full-time employee;

   b. the extent to which the hours of current employees in the same or comparable positions have fluctuated above and below 30 hours of service per week during recent measurement periods;

   c. whether the job was advertised as requiring 30 or more hours of service per week; and

   d. whether the new hire was told that the job required 30 or more hours of service per week.

   See 26 CFR §§ 54.4980H-1(a)(49); 54.4980H-3(d)(2)(iii).

II. ***For those employees whose average weekly hours of work an employer cannot accurately predict,* the ACA regulations provide two methods of calculating whether or not an employee averages 30 hours of service per week: the monthly measurement method and the look-back measurement method.**

   It can happen that an employer does not know whether an employee is going to average 30 hours a week over a particular work period. That's a small problem, because if the employee does average 30 hours, the employer must offer health coverage or pay a penalty. So how is the employer to know?

   The ACA provides two different methods to figure it out. One is the monthly measurement method and the other is the look-back measurement method.

   Under the monthly measurement method, the employer tracks the employee's hours actually worked each month. If in any month the employee averages 30 hours or more, then the employer must offer health coverage, as described below. If an employee subsequently falls below 30 hours, the employer could, theoretically, discontinue the employee's coverage. But the employer should be sure that the employee will in fact remain below 30 hours in order to avoid the administrative costs of taking that employee on and off the policy and of offering COBRA continuation coverage multiple times.

   Under the look-back measurement method, the employer tracks the employee's hours over a measurement period, as described below, to see whether over that measurement period the employee is averaging 30 hours. The measurement period is followed by a stability period, as described below. If the employee did in fact average 30 hours in the measurement period, s/he must be offered health coverage to be effective throughout the stability period. If the employee did not average 30 hours in the measurement period, the employer is entitled not to offer

coverage during the stability period no matter how many hours the employee actually averages in the stability period. Once the stability period is ending, a new measurement period begins, unless the employer chooses to go ahead and treat the employee as a full-time employee, offer coverage, and stop all this measuring.

The final regulations allow employers to use different measurement and stability periods for salaried and hourly employees. Employers may use measurement periods of different lengths or periods with different starting and ending dates, or it may use the monthly measurement period for one group and the look-back measurement period for the other.

Employers may change from one measurement method to the other and may change the duration or start date of a measurement period under the look-back method. There are detailed rules about how to treat employees in this situation.

A. Rules for counting hours of service that are applicable to both the monthly measurement method and the look-back measurement method:

1. *Hourly employees*. Employers must calculate ***actual hours of service as reflected in payroll records*** for all employees paid on an hourly basis (remember, some nonexempt employees are paid on a salaried basis.
2. *Salaried employees*. Employers may choose from among the following methods for calculating the hours of service for salaried employees:
   a. Actual hours of service;
   b. A days-worked equivalency method: the employer credits an employee who has worked at least one hour on a given day with eight (8) hours of service;
   c. A weeks-worked equivalency method: the employer credits an employee who has worked at least one hour in a given week with forty (40) hours of service.

   See 26 CFR § 54.4980H-3(b).
3. Employers may use different methods for calculating the hours of different categories of salaried employees so long as the categories are reasonable and consistent. Employers may change the method they use for calculating the hours of a given group of salaried employees each calendar year, but not more frequently. *See* 26 § 54.4980H-3(b)(3)(ii).

4. A note about public safety and other employees with fluctuating schedules and employees with flex-time schedules: the rules do not permit employers to use the days-worked or the weeks-worked equivalency methods where the result would be to substantial undercount an employee's hours of service. For example, employees who worked three 10-hour shifts per week would only be credited with 24 hours of work per week if the employer used the days-worked equivalency. As a result, those employees would be denied full-time status when they in fact worked 30 hours per week and were entitled to participate in the employer's health insurance plan. The rules do not permit this. *See* § 54.4980H-3(b)(3)(iii).

B. Monthly Measurement Method: The employer counts the actual hours or service that a variable hour employee works for each calendar month. If the employee averages 30 hours of service per week in any month, the employer must offer coverage beginning with the first

day of the first calendar month following a three-month period beginning with the first full calendar month in which the employee averages 30 hours a week. For example, if an employee begins work on November 15th, the employer would begin to count that employee's hours on December 1st and, assuming that the employee averages 30 hours of service per week in December, the employer must offer that employee health insurance coverage effective the following March 1st. *See* 26 CFR § 54.4980H-3(c)(1) and (2).

Using the weeks-worded equivalency with the monthly measurement period:

1. An employer may begin to measure hours of service on the first day of the week that *includes* the first day of the calendar month. If it uses this method, it cannot include the week in which the last day of the calendar month falls unless the week ends with the last day of the month. For example, if December 1st falls on a Wednesday, the employer may start the monthly measurement period on Sunday, November 28th. December 31st would fall on a Friday, so that last week of December would not be included in that monthly measurement period, but would begin the next monthly measurement period. Under the weekly rule, an employee must be treated as full-time if s/he works a minimum of 120 hours during that measurement period (30 hours per week x 4 weeks). *See* § 26 CFR 54.4980H-3(c)(3)(i) and (c)(5)(Example 3).

2. An employer may begin to measure hours of service on the first day of the week that *follows* the first day of the calendar month. If it uses this method, it must include the week in which the last day of the calendar months falls. If December 1st falls on a Wednesay, the employer may start the monthly measurement period on Monday, December 6th. The week of December 31st (which would be a Friday) would be included in the monthly measurement period. Under the weekly rule, an employee must be treated as full-time if s/he works a minimum of 120 hours during that measurement period. *See* 26 CFR § 54.4980H-3(c)(3)(ii) and (c)(5)(Example 3).
3. If use of the weekly rule results in a monthly measurement period of five weeks, then an employee is treated as a full time employee if s/he works at least 150 hours of service for that monthly measurement period (30 hours per week x 5 weeks). *See* 26 CFR § 54.4980H-3(c)(5)(Example 3).

Treatment of employees rehired after termination or resuming employment after a leave of absence under the monthly measurement method:

1. For local government employees, an employee who did not have any hours of service for a period of 13 consecutive weeks or more may be treated as a new employee for the purpose of determining hours of service. *See* 26 CFR § 54.4980H-3(c)(4)(i).

2. For community college and public school employees, an employee who did not have any hours of service for a period of 26 consecutive weeks or more may be treated as a new employee for the purpose of determining hours of service. *See* 26 CFR § 54.4980H-3(c)(4)(ii).

3. An employee who has not had any hours of service for a period of ***fewer*** than 13 weeks (or 26 weeks, if an educational institution) is considered a **continuing employee**. A continuing employee must be offered the resumption of coverage by no later than the first full day of the calendar month following the day on which the employee returned to work.

Example: Frank is a full-time employee during 2014 and 2015.

- During March and April 2015, Frank takes special unpaid leave (see definitions on p. 19) for nine consecutive weeks. When Frank returns to work, he may not be treated as a "new hire" and subject to a "new" monthly measurement period because his leave for was fewer than 13 consecutive weeks.

- His employer may, however, treat him as if he were no longer a full-time employee during March and April 2015 – in other words, his employer need not offer him health insurance, although it would have to offer him COBRA continuation coverage.

- But if Frank's "special unpaid leave" were FMLA leave, his employer would be obligated to continue his health insurance and to continue contributing to it on the same basis as it would were he working and not on leave.

C. Look-back Measurement Method: Under this method, an employer chooses a period of not less than three months to serve as its standard measurement period. *See* 26 CFR § 54.4980H-1(a)(46). The employer records and then averages the number of hours of service per week that each employee worked during that standard measurement period.

1. An employee who worked an average of 30 hours per week during the standard measurement period must be treated as a full-time employee and offered health insurance coverage during the subsequent stability period, whether or not the employee actually works an average of 30 hours per week during the stability period. The stability period must be at least six months long and cannot be shorter than the standard measurement period that preceded it. *See* 26 CFR § 54.4980H-3(d)(1)(iii).

2. If an employee does not work an average of 30 hours during a standard measurement period, then the employee may be treated as part-time during the subsequent stability period and need not be offered health insurance coverage. The stability period cannot be longer than the standard measurement period that preceded it. *See* 26 CFR § 54.4980H-3(d)(1)(iv).

3. A stability period must overlap to some extent with a new standard measurement period, so that if an employee who is treated as full-time during a stability period (because s/he worked an average of 30 hours per week during the preceding measurement period) does not actually work 30 hours per week during the stability period, s/he will probably not be treated as full-time during the next stability period and will not have to be offered health insurance coverage then. Similarly, if an employee who is not treated as full-time during a stability period (because s/he did not work an average of 30 hours per week during the preceding measurement period) begins to work an average of 30 hours per week or more

during the stability period, s/he will likely be full-time during the next stability period and will be offered health insurance coverage.

4. Employers may use an optional administrative period between the end of a standard measurement period and the beginning of a stability period. An administrative period cannot be longer than 90 days. Generally, the purpose of the administrative period is to give employers time to offer and enroll employees in health insurance coverage for the next stability period. The administrative period must overlap with the prior stability period so that any employee being treated as a full-time employee based on an earlier measurement period continues to be covered by health insurance until the start of the next stability period. *See* § 26 CFR 54.4980H-3(d)(1)(vi).

> ***Example***: An employer could use a standard measurement period that begins on October 15 of each year, a stability period that begins on January 1 of each year, and an administrative period that runs from October 15 to January 1 of each year. An employee who is treated as a full-time employee for the stability period beginning on January 1, 2015 and running through December 31, 2015, will be offered health insurance for the entire period even if the employee averages fewer than 30 hours per week during the period October 14, 2014 through October 13, 2015. The employee will continue to be covered through December 31, 2015, but the employer will use the period from October 15 – December 31, 2015 to advise the employee of his or her COBRA rights and effect disenrollment of the employee for the period after January 1, 2016. *See* 26 CFR § 54.4980H-3(d)(1)(viii) for another example.

5. Some Rules about Standard Measurement Periods:

a. Employers can choose the months in which a standard measurement period runs. If the employer chooses to use a twelve-month or yearly measurement period, it may have the year begin on January 1, July 1, May 15, November 15 or on any day that it chooses so long as the standard measurement period is the same for all employees in the same category. *See* 26 CFR § 54.4980H-3(d)(1).

b. Different standard measurement periods and different stability periods may be designated for salaried employees and for hourly employees. The regulations do not recognize any other distinctions for measurement and stability period purposes for non-unionized employees. *See* 26 CFR § 54.4980H-3(d)(1)(v)(C).

c. Employers who use a weekly or bi-weekly payroll period may treat a standard measurement period as ending on the last day of the payroll period preceding the payroll period in which the date that would otherwise be the end of the measurement period falls, if the measurement period begins on the first day of the payroll period in which the date that would otherwise be the date on which the beginning of the measurement period falls.

d. Employers with weekly or bi-weekly payrolls may also treat a standard measurement period as beginning on the first day of the payroll period that follows the payroll period in which the date that would otherwise be the date on which the beginning of the measurement period

falls, if the measurement period ends on the last day of the payroll period in which the date that would otherwise be the date on which the end of the measurement period falls. *See* 26 CFR § 54.4980H-3(d)(1)(iii).

e. An employee who starts a stability period as a full-time employee but experiences a reduction in hours such that s/he no longer averages 30 hours of service per week continues to be treated as a full-time employee covered by health insurance until the end of that stability period.

f. An employee who starts a stability period as a part-time employee working an average of fewer than 30 hour per week and experiences an increase in hours of service during the stability period remains a part-time employee for ACA purposes until the start of the next stability period, at which time the employee may enroll in the employer's health insurance plan. *See* 26 CFR § 54.4980H-3(d)(1)(vii).

6. Treatment of New Employees under the Look-Back Measurement Method

***New employees whom an employer reasonably expects to work an average of 30 hours per week* must be offered affordable health coverage no later than the first day of the fourth full calendar month of employment.** *See* 26 CFR § 54.4980H-3(d)(2)(iii). Factors include:

a. whether the employee is replacing an employee who was a full-time employee;

b. the extent to which the hours of current employees in the same or comparable positions have fluctuated above and below 30 hours of service per week during recent measurement periods;

c. whether the job was advertised as requiring 30 or more hours of service per week; and

d. whether the new hire was told that the job required 30 or more hours of service per week.

See 26 CFR § 54.4980H-3(d)(2)(ii).

For new employees with variable hours, new seasonal employees and new part-time employees, employers may use the look-back method to determine whether the employee must be offered health coverage. To do so, employers measure the average hours of service by using an initial measurement period of between three (3) and twelve (12) consecutive months that begins either

a. on the employee's start date; or

b. on any day up to and including the first day of the first calendar month following the employee's start date; or

c. on the first day of the first payroll period starting after the employee's start date.

See 26 CFR § 54.4980H-3(d)(3)(i) and (ii).

If the employee averages 30 hours of service per month, the employer must offer affordable coverage beginning with the first day of the first calendar month of the following stability period (regardless of whether there is an administrative period between the initial measurement period and the stability period). *See* 26 CFR § 54.4980H-3(d)(3).

The stability period that follows an initial measurement period must be the same length as the stability period for ongoing employees, namely, at least six months long and no shorter than the preceding measurement period that preceded it. *See* 26 CFR § 54.4980H-3(d)(3)(i) and (iii).

As is the case with ongoing employees, different initial measurement periods and different stability periods may be designated for salaried employees and for hourly employees. The regulations do not recognize any other distinctions for measurement and stability period purposes for non-unionized employees. *See* 26 CFR § 54.4980H-3(d)(3)(v).

As is the case with ongoing employees, employers may use an optional administrative period between the end of the initial measurement period and the beginning of a new employee's stability period. The administrative period cannot be longer than 90 days in total. In other words, the 90-day maximum includes all days between an employee's start date and the day on which he or she begins health care coverage, less the number of days in the initial measurement period.

For example, if a new variable-hour employee began work on November 15, but the employer did not begin the initial measurement period until December 1st, the sixteen days from November 15 – 30th would count against the 90-day administrative period maximum and the maximum amount of time that the administrative period that followed the initial measurement period could run would be 74 days. *See* 26 CFR § 54.4980H-3(d)(3)(vi)(A).

In addition, there is a limit on the length of time that the combined initial measurement period and administrative period for a new employee can last: the combined period cannot extend beyond the last day of the first calendar month beginning on or after the first anniversary of the employees start date (in other words, it can never last more than thirteen months under any circumstances). *See* 26 CFR § 54.4980H-3(d)(3)(vi)(B).

If an employee does not work an average of 30 hours during the initial measurement period, then the employee may be treated as part-time during the following stability period and need not be offered health insurance coverage. The stability period cannot be longer than the initial measurement period that preceded it and cannot exceed the remainder of the first entire standard measurement period (plus any associated administrative period for which the new employee has been employed). *See* 26 CFR § 54.4980H-3(d)(3)(iv).

An employee who is a full-time employee on his or her start date, but experiences a reduction in hours such that s/he no longer averages 30 hours of service per week continues to be treated as a full-time employee covered by health insurance until the end of the stability period associated with the initial assessment period.

An employee who is a variable hour employee on his or her start date and experiences an increase in hours of service during the initial measurement period such that the employer should reasonably expect that employee to average at least 30 hours of services must be offered health insurance coverage by the first day or the fourth full calendar month following the change in employment status. *See* 26 CFR § 54.4980H-3(d)(3)(vii)(A).

7. Transition from New Variable Hour Employee to Ongoing Employee:
Once a new employee has been employed for the entire initial measurement period, the employer must begin testing the employee for full-time status at the same time as ongoing employees beginning with the standard measurement period that is currently running.

For example, a new variable hour employee begins work for an employer who uses a one-year initial measurement period that begins on an employee's first day of work and a calendar-year assessment period for ongoing employees. The employee begins work on November 15, 2014. The initial measurement period runs through November 14, 2015. The employer would measure the employee's hours to see if they averaged 30 hours per week during the preceding year on November 15, 2015. On January 1, 2016, the employer would be measuring the hours of its ongoing employees to see if they averaged 30 hours per week during the 2015 calendar year. It would, at that same time, measure A's hours for the period January 1, 2015 – December 31, 2015 to determine whether A averaged 30 hours per week during the 2015 calendar year.

If A averaged 30 hours per week during the initial assessment period ending on November 14, 2015, the employer would have to offer A health insurance coverage beginning on November 15, 2015 and lasting for a stability period of at least a year (until November 15, 2016) or until the beginning of the stability period associated with the first full standard measurement period after the employee's start date (until January 1, 2016), whichever is later. If A averages 30 hours per week during the first full standard measurement period (January 1, 2015 – December 31, 2015), then A's health insurance coverage will continue through the stability period beginning on January 1, 2016. If for some reason A's average number of hours per week falls below 30 for the first standard administrative period, then A's health insurance coverage will cease as of January 1, 2016. *See* 26 CFR § 54.4980H-3(d)(4).

***8.* Seasonal and Part-Time Employees**
The same rules that apply to variable-hour employees apply to seasonal and part-time employees. If an employer has a one-year initial assessment period that begins on the employee's first day, and Lisa the Lifeguard begins work on May 15, 2015, Lisa's initial assessment period will run until May 14, 2016. The employer town, however, no longer stations lifeguards on its beaches after October 1st, which is when Lisa's employment ends. The ACA defines a seasonal employee (as opposed to a seasonal worker) as one who is hired into a position for which the customary annual employment is six months or less. *See* 26 CFR § 54.4980H-1(a)(38). Lisa the Lifeguard is a seasonal employee during the initial assessment period and does not end up averaging 30 hours per week during that time and is no longer an employee at the time the initial assessment period ends and the stability period begins. *See* 26 CFR § 54.4980H-3(d)(5)(Example 11).

***9.* Treatment of Employees Rehired after Termination or Resuming Employment after a Leave of Absence under the Look-Back Measurement Method:**

a. For local government employees, an employee who did not have any hours of service for a period of 13 consecutive weeks or more may be treated as a new employee for the purpose of determining hours of service. *See* 26 CFR § 54.4980H-3(d)(6)(i).

b. For university, four-year college, community college and public school employees, an employee who did not have any hours of service for a period of 26 consecutive weeks or more may be treated as a new employee for the purpose of determining hours of service. *See* 26 CFR § 54.4980H-3(d)(6)(ii).

c. A continuing employee – one who has not had any hours of service for a period of fewer than 13 weeks (or 26 weeks, if an educational institution) retains the status of full-time or part-time for the remainder of the stability period during which the leave occurred and must be offered the resumption of coverage by no later than the first full day of the calendar month following the day on which the employee returned to work. *See* 26 CFR § 54.4980H-3(d)(6)(iii).

d. In using the look-back method to measure the hours of service of a continuing employee who has been on special unpaid leave, an employer must either exclude the period of unpaid leave from the computation of the average number of hours for that measurement period and use the resulting average as the average for the entire measurement period or credit the employee with the same average number of hours for the weeks of special unpaid leave as he or she had been averaging in the weeks preceding the leave. This is true for both local government employers and educational employers. *See* 26 CFR § 54.4980H-3(d)(6)(i)(B) and (d)(6)(ii)(B).

Permissible Waiting and Orientation Periods under the Affordable Care Act

The ACA allows employers to require a waiting period of up to 90 days before an otherwise eligible employee begins coverage under the employer's group health plan. The concept of "otherwise eligible" refers to requirements that the employer may impose for an employee to participate in the employer's health insurance plan, such as being in a particular job classification (for example, all administrative or management employees, or all public safety employees), or working a certain number of hours per week, or satisfying all licensure requirements for the position, or completing a probationary period. Once a new employee satisfies all of the requirements to participate in the health plan, he or she cannot be required to wait more than 90 calendar days (including weekends and holidays) after the date upon which the employee satisfies the prerequisites to enroll in the health plan. *See* 26 CFR § 54.9815-2708(a) – (c); 29 CFR 2590.715-2708(a) – (c); 45 CFR § 147.116(a) – (c).

Measurement Periods for Variable Hour Employees and the 90-Day Waiting Period:

When an employer uses the look-back measurement method to determine whether a newly hired employee is working an average of 30 hours per week, it is permitted to use an initial measurement period of up to 12 months. An employer may **not**, however, tack on a 90-day waiting period to a 12-month look-back measurement period. An employer must make an offer of coverage effective no later than 13 months from the employee's start date, unless the employee's start date was not the first day of the month, in which case coverage may begin the first day of the next calendar month. *See* 26 CFR § 54.9815-2708(c)(3)(i); 29 CFR 2590.715-2708(c)(3)(i); 45 CFR § 147.116 (c)(3)(i).

Cumulative Hours of Service Requirements:

When it is not clear at the time of hire that an employee will be working an average of 30 hours per week, an employer may impose a requirement that a new employee complete a specified number of hours of service in order to become eligible to participate in its group health insurance plan. In such a case, the waiting period would not begin until the employee had worked the required number of hours and fulfilled that prerequisite to eligibility. The rules limit the number of cumulative hours of service that an employer may require as a condition of eligibility to 1,200 hours. *See* 26 CFR § 54.9815-2708(c)(3)(ii); 29 CFR 2590.715-2708(c)(3)(ii); 45 CFR § 147.116 (c)(3)(ii). When a new hire is reasonably expected at the time of hire to be full-time, by contrast, this cumulative service condition is likely not available to the employer.

Orientation (Probationary) Periods.

The ACA regulations refer to what North Carolina public employers usually call probationary periods as "orientation periods." These are initial periods of work during which the employee undergoes any orientation or training that is needed and the employer evaluates whether the employee seems likely to be able to do the job successfully. Under the ACA regulations, employers may adopt an orientation period of no longer than one month as part of

the process of an employee's becoming otherwise eligible for participating in an employer's group health plan. In other words, an employer may require a one month probationary period before determining that an employee will continue in employment and is otherwise eligible for health insurance. The 90-day waiting period would then begin on the first day after the conclusion of the one-month orientation period.

Measuring the One-Month Orientation Period:

Because months are of different lengths, the rules provide that for orientation period purposes, a month is to be measured as one calendar month minus one calendar day from the employee's start date in a position otherwise eligible for coverage. Where the month in which the start date falls is longer than the following month, the one month is measured as the last day of the following month. Thus, for an employee beginning work on January 30th or 31st, the one-month orientation period will end on February 28th (29th in a leap year). *See* 26 CFR § 54.9815-2708(c)(3)(iii).

Intersection with the No-coverage Penalty:

In most cases, use of a one-month orientation period followed by a 90-day waiting period will result in an employee's beginning health insurance coverage on the first day of the fourth month of employment as a full-time employee and the employer will not be liable for the no-coverage penalty. But not always. It is possible for the first day of the fourth month of employment to fall before the date that corresponds to one month of orientation plus 90-days of waiting. In that case, there is no exemption for the employer, who would be liable for the no-coveage penalty for that month. *See* 26 CFR § 54.9815-2708(c)(3)(iii) and (f)(Example 11); 29 CFR § 2590.715-2708(c)(3)(iii) and (f)(Example 11); and 45 CFR § 147.116(c)(3)(iii) and (f)(Example 11).

Affordable Care Act Reporting Requirements

***1. Reporting Required by 26 U.S.C. § 6055 (also referred to as IRC § 6055)*:**

Health insurance plans sponsors – that is, insurance companies and **self-insured employers** – **must report to the IRS certain information about employees and dependents covered by its group health plan** for 2015 in 2016.
See 26 CFR § 1.6055-1(c)(2)(i)(A).

Section 6055 reports must include:

1. the name, address, and employer identification number (EIN) of the employer sponsoring the plan,
2. the portion of the premium (if any) paid by the employer,
3. the name, address and taxpayer identification number (**TIN**; usually social security number) of each employee insured under the plan and the *name and TIN of each other individual obtaining coverage under the policy* (that is, spouses and dependent children), ***and***
4. the months during which each individual was covered by minimum essential coverage for at least one day during the reporting year.

See 26 CFR § 1.6055-1(e)(1).

For employers who purchase group health plan coverage from an insurer, the insurers will report this information.

Self-insured plans and insurers must also give **a statement to plan participants** including:

1. the name and address of the person required to make such return and the phone number of the information contact for such person, and
2. the information about that participant that must be shown on the return.

See 26 CFR § 1.6055-1(e)(2).

The purpose of this requirement is to give individuals and the IRS the information needed for enforcement of the individual mandate. It is the self-insured employer's or group health insurer's responsibility to make reasonable efforts to obtain TINs for each spouse and dependent covered through an employee. Spouses and dependents who are not identified through their TIN on Form 1095-B will be identified by the IRS as not having coverage and will be required to show proof of coverage in order to avoid being assessed a penalty under the individual mandate.

Reports must be filed on IRS Forms 1094-B and 1095-B (draft forms attached). **Form 1095-B** must be given to each employee participating in the employer's group health plan and to the IRS. **Form 1094-B** is the summary form that goes to the IRS along with copies of each Form 1095-B. *See* 26 CFR § 1.6055-1(f)(2). **Form 1095-B** must be sent to employees by January 31st of the following year. *See* 26 CFR § 1.6055-1(g)(4)(i)(A). **The first report must be sent to**

employees on January 31, 2016 for the year 2015. Forms may be sent to employees electronically if they consent. *See* 26 CFR § 1.6055-2(a).

Forms must be filed with the IRS on or before February 28 of the following year (March 31 if filed electronically). Employers who must file 250 or more of a form will be required to file electronically. *See* 26 CFR § 1.6055-1(f)(1).

2. Reporting Required by 26 U.S.C. § 6056 (also known as IRC § 6056):

Covered employers must report to the IRS offers of coverage made to full-time employees in 2015 in January 2016. *See* 26 CFR § 301.6056-1(a).

Section 6056 reports must include:

1. the name, date, and employer identification number of the employer, and
2. a certification as to whether the employer offered to its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan during each calendar month of the preceding calendar year; and
3. the months of the reporting calendar year during which minimum essential coverage was available.

If the employer offered its full-time employees and their dependents the opportunity to enroll in minimum essential coverage, the report must also include:

1. the number of full-time employees for each month during the calendar year;
2. the name, address, and TIN of each full-time employee during the calendar year and the months (if any) during which the employee was covered under the employer's health benefits plans; and
3. each full-time employee's share of the monthly premium for the lowest cost employee-only option offering minimum essential coverage for each calendar month,

See 26 CFR § 301.6056-1(d)(1).

Covered employers must also give **a statement to plan participants** including:

1. the name and address of the person required to file the § 6056 return and the phone number and contact information for that person, and
2. the information about that participant that is shown on the return.

See 26 CFR § 301.6056-1(f)(2).

The purpose of the report is to provide the IRS with the information necessary to assess payments due under § 4980H(a) and (b) (the no-coverage and the inadequate-coverage penalties) and to determine whether an employee has received an offer of affordable minimum essential coverage, which would make them ineligible for a premium tax credit.

Reports must be filed on IRS Forms 1094-C and 1095-C (draft forms attached). **Form 1095-C** must be given to each employee participating in the employer's group health plan and the IRS. *See* 26 CFR § 301.6056-1(f)(1). **Form 1094-C** is the summary form that goes to the IRS along with copies of each Form 1095-C. *See* 26 CFR § 301.6056-1(c)(1) and (d)(2). **Form 1095-C** must be sent to employees by January 31st of the following year. *See* 26 CFR § 301.6056-1(g)(1). Forms may be sent to employees electronically if they consent. *See* 26 CFR § 301.6056-2(a). **The first report will have to be sent to employees on January 31, 2016 for the year 2015.**

Forms must be filed with the IRS on or before February 28 of the following (March 31 if filed electronically). *See* 26 CFR § 301.6056-1(e). Self-insured employers who are also applicable large employers will be required to report under both Sections 6055 and 6056. These employers will be able to file both sets of required information on a single **Form 1095-C**.

HRAs, HSAs, FSAs, EPPs and EAPs

As counterintuitive as it may seem, health reimbursement accounts (HRAs), health savings accounts (HSAs), health flexible spending accounts (FSAs), employer payment plans (EPPs) (whereby an employer deducts amounts from an employee's wages on a pre-tax basis and used the money to pay for health insurance premiums) and employee assistance programs (EAPs) all qualify as employer-sponsored group health insurance plans under the Affordable Care Act. This means that they are all subject to the rule prohibiting group health plans from establishing any annual dollar limits on essential benefits and to the rule prohibiting cost-sharing for preventive health services. As a direct result of their new "status" as health plans, the rules governing HRAs, HSAs, FSAs, EPPs and even EAPs have changed, in some cases dramatically, in others less so. The impact of the ACA on each of these arrangements is outlined below.

Health Reimbursement Accounts

A health reimbursement arrangement, sometimes called a health reimbursement account, is a tax-favored employer-sponsored plan through which employees and retirees may be reimbursed for qualified medical expenses for themselves, their spouses and dependents. HRAs are funded solely by employer contributions, which are excludable from employees' gross income for tax purposes. Unlike contributions to a flexible spending account (FSA), the money that accumulates in an HRA may be carried over from year to year and funds contributed to the account in one year may be used to reimburse expenses incurred in a later year. Funds may never be used for anything but qualified medical expenses, as they are defined in Internal Revenue Code § 213(d). This includes payments of health insurance premiums for current employees and retirees. There are no contribution limits on an HRA other than what an employer is willing to contribute on a yearly basis. The employer may, however, establish maximum reimbursement amounts for any coverage period.

Because a HRA by its very terms cannot meet the requirement that there be no lifetime or annual dollar limits on essential health benefits, or the requirement that there be no cost-sharing on preventive health measures, an employer may not establish a HRA in place of offering a health insurance plan. It may only establish a HRA in addition to sponsoring a group health plan. In other words, HRAs are generally only lawful where the employer limits their availability to employees who are also covered by an employer group health plan that has no annual dollar limits on essential health benefits and provides minimum value. Because a free-standing HRA may no longer lawfully be established, HRAs cannot be used as a vehicle for funding employee purchases of individual plans on the individual market. This is true both for covered employers and for small employers not subject to the ACA.

As a practical matter, a HRA either must provide that employees forfeit their rights to any balances in their HRA accounts once their medical coverage under that employer plan ends or the HRA must give employees the opportunity to waive their rights in their account balance on an annual basis. As long as an employee has an HRA account balance, the IRS will consider that employee to have minimum essential coverage through the employer, which will prohibit the employee from applying for a premium tax credit. This could pose a significant hardship on an employee whose hours are reduced or who elects to go from full-time to part-time status.

Note that under the ACA, HRAs can be used as a stand-alone plan for retiree benefits without the retirees having to be enrolled in a group health plan, because a retiree-only plan is considered an excepted benefit and is not subject to ACA requirements.

Health Savings Accounts (HSAs)

Health savings accounts (HSAs) allow employees to accumulate funds on a pre-tax basis to pay for specific types of medical expenses, including health insurance co-payments and deductibles. HSAs may only be established, however, in conjunction with a specific form of health insurance plan – a high-deductible health insurance plan (HDHP). A HDHP is defined by the Internal Revenue Code as a health plan having a) for 2015, an annual deductible of at least $1,300 for individual coverage and at least $2,600 for family coverage, and b) a cap of no more than $6,450 on the annual total amount paid by an individual for the deductible and any other out-of-pocket expenses (not including premiums) and a cap of $12,900 on the annual total amount paid under family coverage for the deductible and any out-of-pocket expenses. *See* IRS Rev. Proc. 2014-30. The high-deductible plan may take the form of a traditional major medical indemnity plan, a health maintenance organization (HMO) or a preferred provider plan (PPO). Local government employers who are self-insured may offer HSAs so long as the self-insured health plan meets the definition of a high-deductible health plan.

Health Flexible Savings Arrangements

Healthcare flexible spending accounts (FSAs) are employer-maintained accounts into which employees contribute a percentage of their salary pre-tax for use in paying unreimbursed medical expenses for a given calendar year. Because employees typically use health FSAs to pay the cost of non-reimbursed medical expenses like deductibles, the Internal Revenue Service has always considered FSAs to be *health plans* that pay "first-dollar expenses."

As of January 1, 2014, health FSAs have to conform with one of two models in order for the FSA to be exempt from the ACA's prohibition on annual dollar limits: either the health FSA must provide only "excepted benefits," such as stand-alone dental or vision benefits or it must be integrated with an employer-sponsored group health plan. The IRS, however, will consider a FSA to be one that provides only excepted benefits only if it is offered in conjunction with a group health plan that provides coverage other than excepted benefits and the maximum benefit available to any participant through the FSA does not exceed two times the employee's salary reduction for the FSA for the year or $500 plus the amount of the salary reduction (remember that elsewhere, the ACA limited the annual salary reduction for health FSAs to $2,500.00). In other words, only employees who are eligible to participate in the employer's group health plan may establish a FSA. This does not mean that the employee has to elect coverage under the plan, only that he or she has the ability to do so. Part-time employees (or any other categories of employee) who are not eligible for employer-sponsored health insurance cannot elect a pre-tax deduction from salary into an FSA. Rule prohibiting annual dollar limits does not apply to health FSAs.

Employer Payment Plans: Funding Employee Purchases of Individual Plans on the Individual Market

An employer payment plan is any arrangement whereby an employer facilitates an employee's purchase of health insurance using pre-tax dollars. A health FSA offered through an IRS Section 125 cafeteria plan is an employer payment plan. The IRS has made clear through Notice 2013-54 that employers cannot pay for individual health insurance policies bought through the Exchange or on the open market with pre-tax dollars, whether the employer pays for those policies directly or through pre-tax salary deductions. According to the IRS, such a practice violates the ACA's prohibition on annual dollar limits on essential health benefits and the requirement that non-grandfathered plans provide first dollar coverage of preventive services.

An employer may pay employees higher salaries to facilitate their purchase of individual health insurance policies. An employer may even deduct the cost of an individual premium and make payment to a health insurer on the employee's behalf on an after-tax basis, so long as the employer neither endorses nor limits the employee's choices on the Exchange or open market.

Penalties for Improper Use of a HRA, HSA or Health FSA

Violation of the ACA rules governing the use of HRAs, HSAs and health FSAx will subject an employer to a tax of $100 per day per individual employee – a steep penalty.

Employee Assistance Programs (EAPs)

For the moment (no final regulations on EAPs have been issued), the IRS will not treat employee assistance programs as group health plans, but will instead consider them "excepted benefits" not subject to rules concerning cost-sharing and essential benefits, provided that the EAP does not provide significant medical benefits. What are significant medical benefits? Employers are told to use a "reasonable, good faith interpretation" of the phrase. Presumably, an average EAP – one where the benefits are not better than most – would not be considered a group health plan and an EAP that offered noticeably richer benefits than most might be. Work closely and ask questions of the consultants you use to develop EAP programs.

Caution: *DRAFT—NOT FOR FILING*

This is an early release draft of an IRS tax form, instructions, or publication, which the IRS is providing for your information as a courtesy. **Do not file draft forms.** Also, do not rely on draft instructions and publications for filing. We generally do not release drafts of forms until we believe we have incorporated all changes. However, unexpected issues sometimes arise, or legislation is passed, necessitating a change to a draft form. In addition, forms generally are subject to OMB approval before they can be officially released. Drafts of instructions and publications usually have at least some changes before being officially released.

Early releases of draft forms and instructions are at IRS.gov/draftforms. Please note that drafts may remain on IRS.gov even after the final release is posted at IRS.gov/downloadforms, and thus may not be removed until there is a new draft for the subsequent revision. All information about all revisions of all forms, instructions, and publications is at IRS.gov/formspubs.

Almost every form and publication also has its own easily accessible information page on IRS.gov. For example, the Form 1040 page is at IRS.gov/form1040; the Form W-2 page is at IRS.gov/w2; the Publication 17 page is at IRS.gov/pub17; the Form W-4 page is at IRS.gov/w4; the Form 8863 page is at IRS.gov/form8863; and the Schedule A (Form 1040) page is at IRS.gov/schedulea. If typing in the links above instead of clicking on them: type the link into the address bar of your browser, not in a Search box; the text after the slash must be lowercase; and your browser may require the link to begin with “www.”. Note that these are shortcut links that will automatically go to the actual link for the page.

If you wish, you can submit comments about draft or final forms, instructions, or publications on the Comment on Tax Forms and Publications page on IRS.gov. We cannot respond to all comments due to the high volume we receive, but we will carefully consider each one. Please note that we may not be able to consider many suggestions until the subsequent revision of the product.

2014

Instructions for Forms 1094-B and 1095-B

Department of the Treasury
Internal Revenue Service

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about developments related to Forms 1094-B, Transmittal of Health Coverage Information Returns, and 1095-B, Health Coverage, and the instructions, such as legislation enacted after they were published, go to *www.irs.gov/form1094b* and *www.irs.gov/form1095b*.

Reminders

Forms 1094-B and 1095-B are not required to be filed for 2014. However, in preparation for the first required filing of these forms (that is, filing in 2016 for 2015), reporting entities may, if they wish, voluntarily file in 2015 for 2014 in accordance with the forms and these instructions. For more information about voluntary filing in 2015, visit IRS.gov.

Additional Information

For information related to the Affordable Care Act, visit *www.irs.gov/ACA*.

For the final regulations under section 6055, see T.D. 9660, 2014-13 I.R.B., at *www.irs.gov/irb/2014-13_IRB/ar08.html*

General Instructions for Forms 1094-B and 1095-B

Purpose of Form

Form 1095-B is used to report certain information to the IRS and to taxpayers about individuals who are covered by minimum essential coverage and therefore are not liable for the individual shared responsibility payment.

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and miscellaneous coverage designated by the Department of Health and Human Services. Minimum essential coverage is described in more detail under *Who Must File*, later.

TIP *Minimum essential coverage does not include coverage consisting solely of excepted benefits. Excepted benefits include vision and dental coverage not part of a comprehensive health insurance plan, workers' compensation coverage, and coverage limited to a specified disease or illness.*

Who Must File

Every person that provides minimum essential coverage to an individual during a calendar year must file an information return and a transmittal. Most filers will use Forms 1094-B (transmittal) and 1095-B (return). However, employers (including government employers) subject to the employer shared responsibility provisions sponsoring self-insured group health plans will report information about the coverage in Part III of Form 1095-C, Employer-Provided Health Insurance Offer and Coverage, instead of on Form 1095-B. In general, an employer with 50 or more full-time employees (including full-time equivalent employees) during the prior calendar year is subject to the employer shared responsibility provisions. See the Instructions for Forms 1094-C and 1095-C for more information.

Insured coverage. Health insurance issuers or carriers must file Form 1095-B for most health insurance coverage, including individual market coverage and insured coverage sponsored by employers. However, insurance issuers or carriers will not file Form 1095-B to report coverage under the Childrens' Health Insurance Program (CHIP), Medicaid, and Medicare (including Medicare Advantage) provided through health insurance companies, which will be reported by the government sponsors of those programs.

In addition, insurance issuers or carriers will not file Form 1095-B to report coverage in individual market qualified health plans that individuals enroll in through Health Insurance Marketplaces, which will be reported by Marketplaces on Form 1095-A. Health insurance issuers will file Form 1095-B to report on coverage for employees of small employers obtained through the Small Business Health Options Program (SHOP).

Eligible Employer-Sponsored Plans

Eligible employer-sponsored plans include:

1. Group health insurance coverage for employees under:
   a. A governmental plan, such as the Federal Employees Health Benefit program.
   b. An insured plan or coverage offered in the small or large group market within a state.
   c. A grandfathered health plan offered in a group market.
2. A self-insured group health plan for employees.

Health insurance issuers or carriers will file Form 1095-B for all insured employer coverage. Plan sponsors are responsible for reporting self-insured employer coverage. Plan sponsors that are employers subject to the employer shared responsibility provisions must report the coverage on Form 1095-C and other plan sponsors (such as sponsors of multiemployer plans) report the coverage on Form 1095-B.

Plan sponsors of self-insured employer coverage include:

- Each participating employer (for its own employees) in a plan or arrangement established or maintained by more than one employer;
- The association, committee, joint board of trustees, or similar group of representatives who establish or maintain a multiemployer plan;
- The employee organization for a plan or arrangement maintained solely by an employee organization; and

- Each participating employer (for its own employees) for a plan or arrangement maintained by a Multiple Employer Welfare Arrangement.

A government employer may designate another government entity to report coverage of its employees. A designated government entity will file Form 1095-B on behalf of a government employer that sponsors or maintains a self-insured group health plan for its employees only if that government employer is not subject to the employer shared responsibility provisions, which would require reporting on Form 1095-C.

Government-Sponsored Programs

Government-sponsored programs that are minimum essential coverage are:

1. Medicare Part A.
2. Medicaid, except for the following programs:
   a. Optional coverage of family planning services.
   b. Optional coverage of tuberculosis-related services.
   c. Coverage of pregnancy-related services.
   d. Coverage of medical emergency services.
   e. Coverage of medically-needy individuals.
   f. Coverage under a section 1115 demonstration waiver program.
3. The Children's Health Insurance Program (CHIP).
4. Coverage under the TRICARE program, except for the following programs:
   a. Coverage on a space-available basis in a military treatment facility for individuals who are not eligible for TRICARE coverage for private sector care.
   b. Coverage for a line of duty related injury, illness, or disease for individuals who have left active duty.
5. Coverage administered by the Department of Veterans Affairs that is:
   a. Coverage consisting of the medical benefits package for eligible veterans.
   b. CHAMPVA.
   c. Comprehensive health care for children suffering from spina bifida who are the children of Vietnam veterans and veterans of covered service in Korea.
6. Coverage for Peace Corps volunteers.
7. The Nonappropriated Fund Health Benefits Program of the Department of Defense.

In general, the government agency sponsoring the program will file Form 1095-B. The State agency that administers a Medicaid or CHIP program will file Form 1095-B for coverage under those programs.

Miscellaneous minimum essential coverage. The Department of Health and Human Services has designated the following health benefit plans or arrangements as minimum essential coverage:

1. Self-insured student health plans (for 2014 only).
2. State high risk pools (for 2014 only).
3. Coverage under Medicare Part C (Medicare Advantage).
4. Refugee Medical Assistance.
5. Coverage provided to business owners who are not employees.
6. Coverage under a group health plan provided through insurance regulated by a foreign government if:
   a. A covered individual is physically absent from the U.S. for at least 1 day during the month; or
   b. A covered individual is physically present in the U.S. for a full month and the coverage provides health benefits within the U.S. while the individual is outside the U.S.

Sponsors of these and later designated programs will file Form 1095-B.

When To File

The return and transmittal form must be filed with the IRS on or before February 28 (March 31 if filed electronically) of the year following the calendar year of coverage.

You will meet the requirement to file if the form is properly addressed and mailed on or before the due date. If the regular due date falls on a Saturday, Sunday, or legal holiday, file by the next business day. A business day is any day that is not a Saturday, Sunday, or legal holiday.

Note. The due date applies to forms filed in 2016 reporting coverage provided in calendar year 2015.

Where To File

Send all information returns filed on paper to the following:

If your principal business, office or agency, or legal residence in the case of an individual, is located in: ▼	Use the following address: ▼
Alabama, Arizona, Arkansas, Connecticut, Delaware, Florida, Georgia, Kentucky, Louisiana, Maine, Massachusetts, Mississippi, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Texas, Vermont, Virginia, West Virginia	Department of the Treasury Internal Revenue Service Center Austin, TX 73301
Alaska, California, Colorado, District of Columbia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Utah, Washington, Wisconsin, Wyoming	Department of the Treasury Internal Revenue Service Center Kansas City, MO 64999

If your legal residence or principal place of business or principal office or agency is outside the United States, file with the Department of the Treasury, Internal Revenue Service Center, Austin, TX 73301.

How To File

Form 1094-B and Form 1095-B are subject to the requirement to file returns electronically. Filers of 250 or more information returns (Forms 1095-B) must file Forms 1094-B and 1095-B electronically. The 250-or-more requirement applies separately to each type of return and separately to each type of corrected return. Filers of fewer than 250 returns may file electronically or on paper.

Publication 5165, Affordable Care Act (ACA) Information Returns (AIR) Guide for Software Developers and Transmitters, currently under development, will outline the communication procedures, transmission formats, business rules and validation procedures for returns filed electronically through the AIR system. To develop software for use with the AIR system, transmitters and software developers should use the guidelines provided in Publication 5165 along with the Extensible Markup Language (XML) Schemas published on IRS.gov. See Publication 5165 for more information.

You will receive an electronic acknowledgment once you complete the transaction. Keep it with your records.

Corrected Forms 1094-B and 1095-B

Reserved.

Statements Furnished to Individuals

Filers of Form 1095-B must furnish a copy to the person identified as the responsible individual named on the form. The statement must be furnished on or before January 31 of the year following the calendar year the coverage is provided.

On Form 1095-B statements furnished to recipients, filers of Form 1095-B may truncate the SSN of an individual receiving coverage by showing only the last four digits of the SSN and replacing the first five digits with asterisks (*) or Xs. Truncation is not allowed on forms filed with the IRS. The filer's EIN may not be truncated on either the statement furnished to the recipient or the forms filed with the IRS.

Statements must be furnished on paper by mail, unless the recipient affirmatively consents to receive the statement in an electronic format. If mailed, the statement must be sent to the recipient's last known permanent address, or if no permanent address is known, to the recipient's temporary address.

Consent to furnish statement electronically. The requirement to obtain affirmative consent to furnish a statement electronically ensures that statements are sent electronically only to individuals who are able to access them. A recipient may consent on paper or electronically, such as by e-mail. If consent is on paper the recipient must confirm the consent electronically. A statement may be furnished electronically by e-mail or by informing the recipient how to access the statement on the filer's website.

Specific Instructions for Form 1094-B

Line 1. Enter the filer's complete name.

Line 2. Enter the filer's nine-digit employer identification number (EIN). If you do not have an EIN, you may apply for one online. Go to IRS.gov and enter "EIN" in the search box. You may also apply by faxing or mailing Form SS-4, Application for Employer Identification Number, to the IRS. See the Instructions for Form SS-4 for more information. See Publication 1635, Employer Identification Number, for further information.

Lines 3 & 4. Enter the name and telephone number, including area code, of the person to contact who is responsible for answering any questions.

Lines 5-8. Enter the filer's complete address where all correspondence will be sent. If mail is delivered to a P.O. Box and not a street address enter the box number instead of the street address.

Line 9. Enter the total number of Forms 1095-B that are transmitted with Form 1094-B.

Specific Instructions for Form 1095-B

Part I—Responsible Individual (Policy Holder)

Line 1. Enter the name of the responsible individual. A responsible individual may be a primary insured employee, former employee, parent, uniformed services sponsor, or other person enrolling individuals in coverage. Do not enter the name of a business or business owner that is the policy holder for its employees.

Line 2. Enter the nine-digit social security number (SSN) of the responsible individual (111-11-1111). See *Statements Furnished to Individuals*, earlier, for information on truncating the SSN.

Line 3. Enter the responsible individual's date of birth (MM/DD/YYYY) only if Line 2 is blank.

Line 4-7. Enter the complete mailing address of the responsible individual. If mail is not delivered to the street address and the responsible individual has a P.O. Box, enter the box number instead of the street address.

Line 8. Enter the letter identifying the origin of the policy.
A. Small Business Health Options Program (SHOP).
B. Employer-sponsored coverage.
C. Government-sponsored program.
D. Individual market insurance.
E. Multiemployer plan.
F. Miscellaneous minimum essential coverage.

Line 9. For 2014, leave this line blank.

Part II—Employer Sponsored Coverage

This part is completed only by issuers or carriers of insured group health plans, including coverage purchased through the SHOP.

Insurance companies entering codes A or B on line 8 will complete Part II. Employers reporting self-insured group health plan coverage on Form 1095-B enter code B on line 8 but do not complete Part II. If you entered code B for self-insured coverage, skip Part II and go to Part III.

Lines 10–15. Enter the name, EIN, and complete mailing address for the employer sponsoring the coverage. If mail is not delivered to the street address and the employer has a P.O. Box, enter the box number instead of the street address.

Part III—Issuer or Other Coverage Provider

Lines 16-22. Enter the name, EIN, and complete mailing address of the provider of the coverage. The provider of the coverage is the issuer or carrier of insured coverage, sponsor of a self-insured employer plan, government agency providing government-sponsored coverage, or other entity. Enter on line 18 the telephone number an individual seeking additional information may call to speak to a person.

Part IV—Covered Individuals

Column (a). Enter the name of each covered individual.

Column (b). Enter the nine-digit SSN for each covered individual (111-11-1111). See *Statements Furnished to Individuals*, earlier, for information on truncating the SSN.

Column (c). Enter a date of birth (MM/DD/YYYY) for the covered individual only if column (b) is blank (you were unable to obtain the SSN).

Column (d). Check this box if the individual was covered for at least one day per month for all 12 months of the calendar year.

Column (e). If the individual was not covered for all months check the applicable box(es) for the months in which the individual was covered for at least one day. If there are more than six covered individuals, complete one or more additional Forms 1095-B, Part IV.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on these forms to carry out the Internal Revenue laws of the United States. You are required by the Internal Revenue Code to give us the information. We need it to ensure that you are complying with these laws and to allow us to figure and collect the right amount of tax.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is:

Recordkeeping	.
Learning about the law or the form	.
Preparing the form	.
Copying, assembling, and sending the form to the IRS	

If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can write to the Internal Revenue Service; Tax Forms and Publications Division; SE:W:CAR:MP:T, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224. Do not send the form to this office. Instead, see *Where To File* earlier.

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560115

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

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				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

This Form 1095-B provides information needed to report on your income tax return that you, your spouse, and individuals you claim as dependents had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year. Individuals who do not have minimum essential coverage and do not qualify for an exemption may be liable for the individual shared responsibility payment.

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and miscellaneous coverage designated by the Department of Health and Human Services. For more information on minimum essential coverage, see Pub. 974, Premium Tax Credit (PTC).

TIP *Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to individuals covered under the policy if they request it for their records.*

Part I. Responsible Individual, lines 1–9. Part I reports information about you and the coverage.

Lines 2 and 3. Line 2 reports your social security number (SSN). For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete social security number to the IRS. Your date of birth will be entered on line 3 only if your SSN is not entered on line 2.

CAUTION *If you don't provide your SSN and the SSNs of all covered individuals to the sponsor of the coverage, the IRS may not be able to match the Form 1095-B with the individuals to determine that they have complied with the individual shared responsibility provision.*

Line 8. This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- **A.** Small Business Health Options Program (SHOP)
- **B.** Employer-sponsored coverage
- **C.** Government-sponsored program
- **D.** Individual market insurance
- **E.** Multiemployer plan
- **F.** Miscellaneous minimum essential coverage

Line 9. This line will be blank for 2014.

Part II. Employer-Sponsored Coverage, lines 10–15. This part will be completed by the insurance company if an insurance company provides your employer-sponsored health coverage. It provides information about the employer sponsoring the coverage. If your coverage is not insured employer coverage, this part will be blank.

Part III. Issuer or Other Coverage Provider, lines 16–22. This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form**.**

Part IV. Covered Individuals, lines 23–28. This part reports the name, SSN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if an SSN is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than six covered individuals, you will receive one or more additional Forms 1095-B that continue Part IV.

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1115

Form **1094-B**

Department of the Treasury
Internal Revenue Service

Transmittal of Health Coverage Information Returns

▶ **Information about Form 1094-B and its separate instructions is at *www.irs.gov/form1094b.***

OMB No. XXXX-XXX

2014

1 Filer's name	**2** Employer identification number (EIN)
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 . . . . . ▶	

For Official Use Only

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 _____

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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.***

☐ VOID
☐ CORRECTED

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				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

This Form 1095-C includes information about the health coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

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

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

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

Part I. Employee

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

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

CAUTION *If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision.*

Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. Line 15 will show an amount only if the minimum essential coverage your employer offered provided minimum value. Also, line 15 will be blank if code 1A or code 1I is reported on line 14.

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

Part III. Covered Individuals, Lines 17–22

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

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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/f1094c.***

☐ CORRECTED

120115

OMB No. 1545-2251

2014

Part I Applicable Large Employer Member (ALE Member)

1 Name of ALE Member (Employer)		**2** Employer identification number (EIN)
3 Street address (including room or suite no.)		
4 City or town	**5** State or province	**6** Country and ZIP or foreign postal code
7 Name of person to contact		**8** Contact telephone number
9 Name of Designated Government Entity (only if applicable)		**10** Employer identification number (EIN)
11 Street address (including room or suite no.)		
12 City or town	**13** State or province	**14** Country and ZIP or foreign postal code
15 Name of person to contact		**16** Contact telephone number

For Official Use Only

17 Reserved . . . . . ☐

18 Total number of Forms 1095-C submitted with this transmittal . . . . . ▶

Part II ALE Member Information

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

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

21 Is ALE Member a member of an Aggregated ALE Group? . . . . . ☐ **Yes** ☐ **No**

If "No," do not complete Part IV.

22 Certifications of Eligibility (select all that apply):

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

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

▶ Signature ▶ Title ▶ Date

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	☐	☐			☐	
24	Jan	☐	☐			☐	
25	Feb	☐	☐			☐	
26	Mar	☐	☐			☐	
27	Apr	☐	☐			☐	
28	May	☐	☐			☐	
29	June	☐	☐			☐	
30	July	☐	☐			☐	
31	Aug	☐	☐			☐	
32	Sept	☐	☐			☐	
33	Oct	☐	☐			☐	
34	Nov	☐	☐			☐	
35	Dec	☐	☐			☐	

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		