



ACA REPORTING WEBINAR QUESTIONS AND ANSWERS

The following questions on ACA reporting requirements to the IRS make up parts one and two of an eBook series. **Contact us for part three, in which we cover questions specific to forms 1094-C and 1095-C.**

Introduction

The Affordable Care Act (ACA) added two employer reporting requirements to the Internal Revenue Code (Code) taking effect for 2015:

- › Code § 6056 requires **applicable large employers (ALEs)** to provide an annual statement to each **full-time employee** detailing the employer's health coverage offer (or lack of offer).
- › Code § 6055 requires employers (any size) that provide **minimum essential coverage (MEC)** under a self-funded (uninsured) plan to provide an annual statement to covered employees and former employees (including information about covered dependents).

The IRS has issued Form 1095-C, *Employer-Provided Health Insurance Offer and Coverage*, for ALEs to satisfy the requirement under Code § 6056. If the employer self-funds its plan(s), the employer also will use Form 1095-C to satisfy the additional requirement under Code § 6055. Employers providing any Forms 1095-C also must file copies with the IRS using a transmittal form, Form 1094-C, *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*. In addition, the transmittal form requests aggregated information.

Glossary of Acronyms

The following acronyms are used throughout this document. All terms are written out on first use, with acronyms used thereafter. Refer to this list as needed.

- › ACA — Affordable Care Act
- › ALE — applicable large employer
- › COBRA — Consolidated Omnibus Budget Reconciliation Act
- › EIN — federal Employer Identification Number
- › FPL — federal poverty level (also federal poverty line, federal poverty guideline, or federal poverty threshold)
- › FTE — full-time equivalent (employee)
- › HRA — health reimbursement arrangement

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- › HSA — health savings account
- › HRIS — human resource information system
- › IRS — Internal Revenue Service
- › LLC — limited liability company
- › LNP — limited non-assessment period
- › MEC — minimum essential coverage
- › MV — minimum value (coverage)
- › PEO — professional employer organization
- › SSN — Social Security number
- › TIN — taxpayer identification number
- › TPA — third party administrator

General Definitions

Q What is an insured health plan?

An insured or fully-insured health plan is one where the plan sponsor (employer) secures coverage through a group policy of insurance issued by an insurance carrier or HMO. The employer pays the policy premiums and the carrier assumes all financial risk for providing the benefits described in the policy.

Q What is a self-funded or self-insured health plan?

A self-funded, or self-insured, health plan is one where the plan sponsor (employer) assumes the financial risk of providing benefits directly instead of purchasing a group policy of insurance. To protect against catastrophic risk, many self-funded employers purchase stop-loss insurance. Stop-loss insurance, however, is not group insurance and does not insure the plan participants (employees) but rather is financial risk insurance for the employer.

The most common self-funded health plans are flexible spending accounts (FSAs) or non-medical plans such as self-funded dental and vision plans. These plans are exempt from the ACA reporting requirements. The reporting requirements for self-funded plans apply only to plans that provide minimum essential coverage (MEC), such as major medical plans.

Q What is the definition of a controlled group for the Affordable Care Act (ACA) reporting requirements?

The same definitions for controlled groups apply to the ACA reporting requirements as they do for other types of reporting under the Internal Revenue Service (IRS) regulations. The IRS defines a controlled group as a group of related businesses that have common ownership or control. If a controlled group exists as defined by the applicable Internal Revenue Code (Code) sections, the employees of those businesses are considered together for certain plan requirements. The relevant IRS codes include Code § 414(b) for controlled groups consisting of corporations and Code § 414(c) for all other controlled groups.

A controlled group exists if there is:

- › A parent-subsidary controlled group (Code § 1563(a)(1) and Treas. Reg. § 1.414(c)-2(b)), which is generally defined as a parent business owning 80 percent or more of a subsidiary business or businesses. There can also be multiple tiers of entities connected to a common parent. The parent company only needs to control one of the companies, since a lower level company could control other companies.
- › A brother-sister controlled group (Code § 1563(a)(2) and Treas. Reg. § 1.414(c)-2(c)), which is typically defined as groups where five or fewer persons who are individuals, estates, or trusts own (directly and with the application of the attribution rules) a controlling interest (80 percent) in each organization, and the ownership interests of each person are defined with respect to these companies and the persons are in effective control of (more than 50 percent) of each organization; OR
- › A combination of the above (Code § 1563(a)(3) and Treas. Reg. § 1.414(c)-2(d)).

The IRS controlled groups are complex and employers are strongly encouraged to work with their corporate legal and tax experts to ensure that the controlled group definitions and attribution rules are carefully considered and reported appropriately.

Organizations that are part of a controlled group must manage reporting of the Forms 1094 and 1095 with these IRS rules in mind.

Q What is the FPL?

The Federal Poverty Line (FPL), also called the Federal Poverty Guideline, is used to determine qualification for financial assistance (subsidies) when individuals purchase insurance through public health insurance Marketplaces (Exchange), determine eligibility for Medicaid (state rules also apply), and provide individual exemptions from the requirement to purchase insurance. Under § 6056, the employer may report that it made a "qualifying offer" to the employee if it offered coverage providing minimum value at an employee cost for employee-only coverage not exceeding 9.5 percent of the mainland single federal poverty line*.

***Mainland single federal poverty line** is the annual dollar amount in the federal poverty guideline chart for a single-member household in any of the 48 contiguous states: \$11,670 (2014) or \$11,770 (2015). Therefore, **qualifying offer** means the employee's cost for employee-only coverage does not exceed \$92.38 per month (2014) or \$93.17 per month (2015).

Q What does authoritative transmittal mean?

The authoritative transmittal Form 1094-C "rolls up" the other Forms 1094-C that an employer may file for certain divisions or other aggregated applicable large employer (ALE) groups that are accompanied by Forms 1095-C for each employee for whom the ALE is required to file. Although an employer may file multiple Forms 1094-C, one authoritative transmittal Form 1094-C, identified on line 19, Part II as the Authoritative Transmittal, must be filed for each employer reporting aggregate employer-level data for all full-time employees of the employer. For example, if an employer has two separate company

divisions and intends to file a separate Form 1094-C for each of the two divisions to transmit Forms 1095-C for each division's full-time employees, one of the Forms 1094-C filed must be designated as the Authoritative Transmittal and report aggregate employer-level data for both divisions, as required in Parts II, III, and IV of Form 1094-C.

Q What is the definition of full-time employee for purposes of ACA reporting?

A **full-time employee** is a common-law employee averaging at least 30 hours of service per week (or 130 hours per month). An hour of service is each hour for which payment is made or due (e.g., performance of duties, vacation, holidays, paid absence, or leave).

Q What is an FTE, and how are FTEs calculated?

Full-time equivalent (FTE) employees are counted to determine whether the employer is an applicable large employer (ALE). The employer's size each year determines the employer's ALE status for the following calendar year. An employee with 120 or more hours of service per month counts as one FTE. For all other employees (e.g., part-time), divide their total hours of service by 120 hours per month to determine the number of FTEs.

Q What is the definition of ALE?

An **applicable large employer (ALE)** is an employer that had an average of 50 or more full-time employees (including full-time-equivalent employees) in the prior year. The employer's size in 2014 determines whether employer is an ALE for 2015. Related employers in a controlled group must be counted together.

Q What is MEC and MV?

Minimum essential coverage (MEC) means an employer-sponsored group health plan with medical benefits. Excepted benefits (e.g., most types of dental and vision plans, flexible spending accounts (FSAs), employee assistance programs (EAPs), and fixed indemnity plans) are not MEC.

Minimum value coverage (MV) means that the minimum essential coverage plan's share of total allowed cost of benefits is at least 60 percent of such costs. The plan's Summary of Benefits and Coverage (SBC) states whether the plan provides minimum value coverage.

Q What is the definition of affordable coverage?

Affordable means that the employee's required contribution for self-only coverage does not exceed 9.5 percent of the employee's income from the employer.

General

Q Are ALEs required to file both forms 1094 and 1095?

Yes, the ALE must provide Form 1095-C (annual statement) to each full-time employee and file copies along with Form 1094-C (transmittal form) to the IRS.

Source: <http://www.irs.gov/instructions/i109495c/ar01.html#d0e71>

Q For completion of these forms, there are references to all 12 calendar months. If an employer is a non-calendar plan with an April 1st renewal date, how would it mark the boxes for January through March?

Forms 1094-C and 1095-C track information on a calendar year basis, regardless of an employer's fiscal year or health plan year. This means that, for employers with a non-calendar year plan, the information reported on the forms will cross plan years. In the example above, the information for January through March would reflect information from the employer's previous plan year.

Q If we are a small employer and are not required to file Forms 1094 and 1095, what do we tell our employees if they ask for the form?

If you are a small employer that offers group insurance to employees (or does not offer any health coverage), you are not required to file Forms 1094-C and 1095-C, your employees will still receive Form 1095-B from your insurance carrier, if any. They will be able to use the information from this form to show proof of minimum essential coverage for purposes of the Individual Mandate.

Q Isn't there transitional relief from this reporting?

No. The ACA's employer shared responsibility provision (so-called Employer Mandate) has two parts: play-or-pay rules that may impose penalties on employees that fail to offer health coverage to full-time employees, and the reporting requirements. While an employer might be eligible for transition relief from the play-or-pay rules, that relief does not extend to these reporting requirements. The IRS needs the information contained in the reports in order to validate and assess penalties under both the Individual Mandate and the Employer Mandate.

Source: <http://www.irs.gov/instructions/i109495c/ar01.html#d0e71>

Q Would we report for an employee who only has family dental or vision coverage?

“Excepted benefits,” such as, stand-alone dental and vision plans, are not reported. However, we suspect an offer of medical coverage was made which is subject to reporting if the employee is a full-time employee.

Employers with 50 or more full-time employees use both Forms 1094-C (transmittal to IRS) and 1095-C (furnished to the employee) to report the information about offers of minimum essential health coverage (e.g., medical), whether or not the employee enrolled.

The purpose of reporting is to document that an offer of health coverage was made.

On line 14, an employer will use the Code Series 1 indicator codes to specify the type of coverage, if any, offered to an employee, the employee’s spouse, and the employee’s dependents.

From the Regulatory Guidance:

The information related to whether the full-time employee was offered coverage (generally meaning the employee was eligible for coverage under the plan) must be accurate to facilitate administration of the premium tax credit, including in the case of coverage offered by a plan such as a multiemployer plan or a plan sponsored by a staffing firm or similar entity for which the client employer pays an additional amount for enrolled employees.

Source: <http://www.irs.gov/instructions/i109495c/ar01.html#d0e250>

Q Do we need to report COBRA participants?

The employer reports about whether coverage was offered (or not offered) with respect to each full-time employee for each month. If the employee terminated employment before the end of the calendar year, you can report the coverage offer for the whole month in which the separation occurred under § 6056. However, after the separation, the full-time employee reporting on Form 1095-C ceases.

Q How will we prove we offered benefits to an employee?

The [Shared Responsibility for Employers Regarding Health Coverage final regulations](#) do not apply any specific rules for demonstrating that an offer of coverage was made. The otherwise generally applicable substantiation and recordkeeping requirements in § 6001 apply, including Rev. Proc. 98-25 (1998-1 CB 689).

It is considered a best practice to retain records indicating acceptance or declination of health coverage, such as enrollment forms that include a section for employees to waive coverage with a signature line. This offer of coverage will be noted on Forms 1095-C (and the transmittal to the IRS) using box 14 and reported to both the employee and IRS.

In many cases, this information can be housed in the employer's human resource information system (HRIS) or benefits enrollment recordkeeping systems. Because these reports are part of the employer's IRS reporting requirements for the year, employers are encouraged to consult with their tax professionals regarding best methods to satisfy recordkeeping and record retention.

Q If an employee misses the deadline for the initial enrollment period, are we required to allow them to sign up after the deadline has passed?

Generally no; the employee is given a set timeframe to enroll, as outlined in your plan materials. Once this date has passed, this can be treated as waiving coverage, whereby the employee may not enroll into the plan until he or she has a qualifying event or the next annual enrollment period. Keep good documentation for each employee of the reason for no coverage for the year-end reporting requirement.

Q We have fewer than 50 employees and provide each employee with a benefit credit. Are we required to report?

We assume the benefit credit is used to purchase various benefit options in a cafeteria plan including group health insurance. Employers with insured plans (or no plan) are not required to report for 2015 if they had fewer than 50 full-time or full-time equivalent employees in 2014.

Q Can we enroll an employee in basic coverage if he or she doesn't sign the enrollment form?

Note that the ACA's automatic enrollment provision is delayed until further guidance, so there is no need to automatically enroll someone. Additionally, if the employee declines coverage, you cannot require the employee to join the plan. When the automatic enrollment provision takes effect, certain large employers will be required to continue enrollment of current employees, automatically enroll new full-time employees in a group health plan when eligible, and provide employees with adequate notice to opt out. Keep good documentation for each employee of the reason for no coverage for the year-end reporting requirement.

Q Is there a specific amount that the employer is allowed to charge for dependent coverage?

In order to avoid the risk of a penalty under the ACA's play-or-pay rules, coverage for the employee-only cost must be affordable (meaning the employee's required contribution for self-only coverage does not exceed 9.5 percent of the employee's income from the employer). Coverage must be extended to dependents (children), but the ACA's guideline on affordable cost does not apply to dependent coverage.

Self-Funded Plans:

Q What do you mean by self-funded coverage?

Employers that offer health and welfare benefits typically will pay for those benefits in one of two ways: either by purchasing health insurance from an insurance company (fully-insured plans), or the employer provides the benefits directly to employees (self-funded plans). Most employers with self-insured plans work with a third party administrator (TPA) to write and administer the plan. The differences between the two types of plans depend on which entity assumes the risk, and certain plan characteristics:

- › **Insured:** The employer pays the entire premium and, in return, transfers all of the risk and responsibility for claims payments to the insurance company.
- › **Self-Funded:** An arrangement under which all or some of the risk associated with providing coverage is not covered by an insurance contract. Self-funded is usually the most appropriate term because true self-insurance means a complete reliance on internal assumption of liability. While many use the term self-insured, self-funding more accurately describes arrangements where some liability is covered directly by the plan sponsor and the plan sponsor purchases a stop-loss policy to limit upper liability.

Q Which forms would a self-funded employer file?

An employer that self-funds a plan providing minimum essential health coverage is subject to the ACA's reporting requirements. If the self-funded employer is not an ALE, the employer would use Forms 1094-B and 1095-B. Self-funded employers who **do** meet the definition of an ALE would use Forms 1094-C and 1095-C. An ALE is an employer who, based on average employee counts in the previous calendar year, had 50 or more full-time, including full-time equivalent, employees.

Q Will there be reporting requirements for small employers in future years?

The IRS has not indicated whether there will be reporting requirements for small employers with insured plans in the future. Currently, only small employers with self-funded plans providing minimum essential coverage are required to report using the 1094-B and 1095-B forms. (Stand-alone dental and vision plans, and most FSAs, do not provide minimum essential coverage and are exempt from reporting.)

Q Is it true that self-funded employers cannot use simplified reporting?

Yes, the simplified reporting option for Form 1095-C can only be used by employers with insured plans.

Q Only self-funded employers are required to capture dependent information, correct?

Yes, only self-funded employers will be required to enter demographic information regarding covered dependents on Form 1095-C.

Q Which forms should we complete if our medical plan is self-funded but the dental and vision are insured?

There is no filing requirement for stand-alone dental and vision coverage. If the employer with a self-funded medical plan had fewer than 50 full-time or full-time equivalent employees in 2014, the employer should file Forms 1094-B and 1095-B. If the employer with a self-funded plan is an ALE, the employer should file Forms 1094-C and 1095-C.

Q What are the reporting requirements for a large employer that changes from an insured plan to a self-funded plan midyear?

Employers that provide MEC through their self-funded health plan are responsible for completing the coverage provider reporting requirements under Code § 6055. For insured coverages, the insurer (carrier) is the coverage provider. The insurer complies with § 6055 by providing Form 1095-B to covered individuals and filing copies with the IRS using transmittal Form 1094-B. In the case of an employer's self-funded plan, the employer is the coverage provider but uses the "C" forms instead of the "B" forms used by traditional insurers. In other words, the employer reports the self-funded plan's coverage information by providing Form 1095-C to covered individuals and filing copies with the IRS using transmittal Form 1094-C.

The self-funded plan coverage information will be reported in Part III of Form 1095-C for the months in which the coverage was provided. For instance, if the self-funded plan provided the coverage for June through December, Part III of Form 1095-C will show information for those months only. If coverage had been provided January through May under an insured plan, the insurer will provide Form 1095-B to covered individuals showing coverage information for those months.

Q What are the reporting requirements for an employer with an insured plan and integrated health reimbursement arrangement (HRA)? Any special reporting for the HRA?

An integrated HRA is a component of a comprehensive health plan and does not stand on its own. The insurer of the primary component (e.g., major medical plan, high deductible health plan) will provide Form 1095-B to covered individuals (and file copies with the IRS using transmittal Form 1094-B) to report the insured plan coverage information. There is no separate coverage reporting requirement with respect to the HRA component.

Q What are the reporting requirements for a partially self-funded plan (either ALE or non-ALE)?

A group health plan is either insured (the insurer collects premium and assumes risk) or self-funded (the employer assumes risk). The term “partially self-funded” is not defined in law and different carriers and brokers often use the term loosely with different meanings. In our experience, partially self-funded refers to a group insurance arrangement under which the employer pays fixed administration costs (retention) and funds claims expenses up to fixed dollar amounts (usually 110 percent of projected claims), but the employer’s cost does not exceed the contractual premium amounts. That is, the plan is insured since the insurer assumes risk. The terms “flex-funded plan” and “minimum premium plan” are other examples with the same meaning as “partially self-funded plan.” In any case, the employer is not self-funding the group health plan, but rather is purchasing a group insurance policy that offers flexible financing of costs.

Code § 6055 (and corresponding forms 1094-B and 1095-B) pertain only to an insurer (carrier) or to an employer that self-funds a plan providing minimum essential coverage. If the employer is offering only insured plans, including so-called partially self-funded plans, flex-funded plans, or minimum premium plans, the employer has no responsibility under § 6055. The insurance company will handle forms 1094-B and 1095-B (“B forms”) to report the coverage information.

Affordability:

Q Does the 9.5 percent affordability threshold referenced on the forms apply to dependent costs or just the costs for employee-only coverage?

The 9.5 percent threshold referenced in Forms 1094-C and 1095-C refers to the cost of single (employee only) coverage.

Source: <http://www.irs.gov/pub/irs-pdf/i109495c.pdf>

Q Can you qualify for simplified reporting if you used an affordability safe harbor other than 9.5 percent of FPL?

No. While an employer might be able to use one of the other affordability safe harbors to avoid a potential penalty under the employer mandate, the 9.5 percent of FPL safe harbor is the only one which applies in order to qualify for simplified reporting.

Q Is the affordability threshold in the reporting 9.5 percent or 9.56 percent?

The reporting asks specifically about affordability safe harbors which may be used. While the affordability percentage under some provisions of the ACA did increase to 9.56 percent, the safe harbor provision applying to employers remains at 9.5 percent. Thus, for Forms 1094-C and 1095-C reporting purposes, the affordability threshold is 9.5 percent.

Source: <http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act#Liability>

Q Would we use the COBRA rate for an individual employee to set the affordability contribution for that employee?

No. The plan's total premium rate or COBRA rate is not a factor in determining affordability. Affordability refers only to the portion of the plan cost that a full-time employee pays for coverage (i.e., the employee's contribution or payroll deduction). Coverage for an employee under an eligible employer-sponsored plan is affordable if the employee's required contribution for self-only coverage does not exceed 9.5 percent of the employee's income from the employer.

Source: <https://www.federalregister.gov/articles/2014/02/12/2014-03082/shared-responsibility-for-employers-regarding-health-coverage>

ALE Status:

Q Are union employees included when determining ALE status?

Yes, all common-law employees must be included in your employee count. Note, however, that common law employees do not include self-employed individuals under IRS rules, such as:

- › Sole proprietors;
- › Partners in partnerships (LLCs) or members of LLCs;
- › 2 percent or more shareholders in Subchapter S corporations; or
- › Persons correctly classified as independent contractors.

Q Is an employer required to file Forms 1094 or 1095 if it has fewer than 50 FTE?

Only if the employer offers a self-funded MEC plan. In that case the employer would complete forms 1094-B and 1095-B. Otherwise, only ALEs are required to complete forms 1094-C and 1095-C. ALEs are those who had an average of 50 full-time employees (including FTEs) in the previous calendar year.

Q At what point is an ALE required to comply with the reporting? Does this occur as soon as the employer has 50 employees?

ALE status is based on average employee counts in the previous calendar year. For example, ALE status for 2015 is based on 2014 employee counts and ALE status for 2016 will be based on 2015 employee counts. Even if an employer has 50 full-time or FTE employees at some point during the year, if the average for the year doesn't remain that high, it will likely not be an ALE for the next year.

Q Our company has two health plans under the same federal Employer Identification Number (EIN) with a combined 50 FTEs, but each individual plan has fewer than 50. How do we know if we are an ALE? ALE status is based on average employee counts for the employer, not the number of participants in a given health plan. For example, if an employer has an average of 100 or more full-time or FTE employees for calendar year 2014 but only 40 plan participants for that same time period, the employer would still be considered an ALE

Q We are a multilocation employer (multistate) under one EIN number. Each location is under 100 employees but we have 150 employees across all locations. Are we considered an ALE?

ALE status is based on average employee counts for the employer as a whole, not the number of employees in a given employer location. For example, if an employer has an average of 100 or more full-time or FTE employees for calendar year 2014 across all their locations, but each location only has 20 employees, it would still be considered an ALE.

Q We have fewer than 50 employees year round but hire an additional 50 – 100 employees seasonally who work full time while employed. Are we considered an ALE?

Possibly. The influx in staffing may cause you to be deemed an ALE if during the previous calendar year, the average number of employees (including FTEs) was 50 or more. In some cases, you may be able to exclude seasonal workers employed less than 120 days. Check [Section V, Determination of Status as an Applicable Large Employer](#), to review the rules regarding this situation.

Temporary Employees, Union Employees, and Professional Employer Organizations (PEO):

Q Is an employer required to offer coverage to full-time temporary employees who it pays directly (not through an agency)?

The employer may need to offer coverage if the temporary employee is a common-law employee ALEs may be subject to potential penalties under the play-or-pay rules if they fail to offer coverage to an employee who meets the definition of full-time employee under the ACA.

Q If an employer uses a professional employer organization (PEO), does the PEO do the filing?

In the case of a PEO arrangement, the workers typically are the common-law employees of the client-employer (not the PEO) because the client employer has authority over how work is performed. Although the PEO may be the group health plan sponsor, the client-employer generally is deemed the employer under the Employer Mandate. An employer who is unsure should review its PEO agreements and consult with legal counsel. The employer would be required to file the forms for all common law employees, including common-law employees who are part of a PEO arrangement. While the PEO may need to provide the employer with information about offers of coverage, the employer is ultimately responsible for reporting the information and filing the forms.

Q Who is responsible for completing forms for multi-employer plans?

Responsibility for the completion and reporting of Forms 1094-C and 1095-C ultimately lie with the employer, even when an employee participates in a multi-employer plan, such as a union trust plan. However, an employer should work directly with the multi-employer plan to come to an arrangement about the best way for the plan to provide the employer with the necessary information to complete the forms. In some cases, the union might even agree to complete the forms on the employer's behalf and send them to the employer. Whatever arrangement is decided upon, the employer is still the party liable for completion and filing of the forms.

Q Can you provide any guidance regarding employer versus staffing agency responsibilities as it relates to the reporting requirement?

An employer is only required to report on individuals who are common law employees. Typically, with a staffing agency, the agency recruits and hires the workers, assigns them to various clients, and assigns them to other clients when projects end. In that case, the workers generally are common law employees of the agency and not of the client. Employers are advised to review their situation with legal counsel and to confirm their understanding in writing with the agency.

Q Would union employees be included when determining whether coverage was offered to 70 percent of our full-time employees?

Yes. Employees represented by collective bargaining (union employees) who are full-time, common-law employees are counted.

Employee Counts:

Q Would a firm partner receiving an IRS Schedule K-1 need to be reported and receive a Form 1095-C?

No, the partner is not a common-law employee, and therefore excluded from reporting requirements.

Source: <http://www.irs.gov/instructions/i109495c/ar01.html#d0e482>

Q Would I count an employee who only worked one hour in a month?

Yes, this partial employee's hours of service would be counted for the purpose of determining status for full-time equivalent employees. While this will not dramatically increase the counts, all hours of service are looked at for counting purposes.

Source: <https://federalregister.gov/a/2014-03082>

Q Are we required to report an employee who was employed for only a week but had benefits during that time?

Yes, if the employee was a full-time employee and offered coverage, the month in which coverage was offered will be reported.

An employer is considered to offer health coverage for a month only if it offers health coverage that would provide coverage for every day of that calendar month. However, under the employer shared responsibility provisions under § 4980H, if an employee terminates employment before the last day of a calendar month and the health coverage offer ends on the date of termination, the employer is treated as having offered the employee health coverage for the month if the employee would have been offered health coverage for the entire month had the employee been employed for the entire month.

Source: <http://www.irs.gov/instructions/i109495c/ar01.html#d0e250>

Q How do we count employees who are not paid by the hour but by miles driven?

In general, an employer should determine an employee's full-time status based on the employee's hours of service. For purposes of the employer shared responsibility provision, an employee is a full-time employee for a calendar month if he or she averages at least 30 hours of service per week or 130 hours of service in a calendar month.

The Department of Treasury and the IRS continue to consider additional rules for the determination of hours of service for certain categories of employees whose hours of service are particularly challenging to identify or track or for whom the general rules for determining hours of service may present special difficulties. For this purpose, until further guidance is issued, employers are required to use a reasonable method of crediting hours of service that is consistent with § 4980H. The preamble to the final regulations includes examples of methods of crediting these hours that are reasonable and that are not reasonable.

Q Our employees work different hours every day. What happens if they qualify one month then not the next, but have already enrolled in coverage?

If these are employees are subject to the look-back measurement method (instead of the monthly measurement method), coverage is maintained during the entire stability period (and reported as an offer of coverage). **Offer** in this case means eligible for the plan.

However, if the employee is subject to the monthly measurement method and loses eligibility due to reduction in hours, you can exclude the months during which coverage was not offered. (COBRA may apply, but COBRA is not reported as an offer of coverage to full-time employees.)

An employer offers health coverage for a month only if it offers health coverage that would provide coverage for every day of that calendar month. However, under the employer shared responsibility provision under § 4980H, if an employee terminates employment before the last day of a calendar month and the health coverage offer ends on the date of termination, the employer is treated as having offered the employee health coverage for the month if the employee would have been offered health coverage for the entire month had the employee been employed for the entire month.

Source: <http://www.irs.gov/instructions/i109495c/ar01.html#d0e482>

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Controlled Groups

- Q If you have several companies under an umbrella ownership, would you still provide each company's federal EIN and name based on which employees work for which company on these reports?**

Yes, the specific company information, including the federal EIN should be included on the report. Please note that while you would complete a Form 1094-C for each company to accompany the employee Forms 1095-C for that company, you will need to be sure to designate one of the Forms 1094-C as the authoritative transmittal for the aggregated ALE group.

- Q How do you know if you are a member of an aggregated ALE group?**

The IRS instructions define an **aggregated ALE group** as a group of ALE members that are treated as a single employer under the Internal Revenue Code's (Code) controlled group and affiliated service group rules. The same definitions for controlled groups apply to the ACA reporting requirements as they do for other types of reporting under the IRS regulations. The IRS defines a **controlled group of businesses** as a group of related businesses that have common ownership. If a controlled group exists as defined by the applicable Code sections, the employees of those businesses are considered together for certain qualified plan requirements. The relevant IRS codes include Code § 414(b) for controlled groups consisting of corporations and Code § 414(c) for all other controlled groups.

A controlled group exists if there is:

- ▶ A parent-subsidiary controlled group (Code § 1563(a)(1) and Treas. Reg. § 1.414(c)-2(b)), which is generally defined as a parent business owning 80 percent or more of a subsidiary business or businesses. There can also be multiple tiers of entities connected to a common parent. The parent company only needs to control one of the companies, since a lower level company could control other companies.
- ▶ A brother-sister controlled group (Code § 1563(a)(2) and Treas. Reg. § 1.414(c)-2(c)), which is typically defined as groups where five or fewer persons who are individuals, estates, or trusts own (directly and with the application of the attribution rules) a controlling interest (80 percent) in each organization, and the ownership interests of each person are defined with respect to these companies and the persons are in effective control of (more than 50 percent) of each organization; OR
- ▶ A combination of the above (Code §1563(a)(3) and Treas. Reg. §1.414(c)-2(d)).

The IRS controlled groups are complex and employers are strongly encouraged to work with their corporate legal and tax experts to ensure that the controlled group definitions and attribution rules apply to their organization's aggregated ALE status.

IRS Resources

IRS Form 1094-C: <http://www.irs.gov/pub/irs-pdf/f1094c.pdf>

IRS Form 1095-C: <http://www.irs.gov/pub/irs-pdf/f1095c.pdf>

IRS Forms 1094-C and 1095-C Instructions: <http://www.irs.gov/pub/irs-pdf/i109495c.pdf>

IRS Overview Brochure on 1094-C and 1095-C: <http://www.irs.gov/pub/irs-pdf/p5196.pdf>

IRS Questions and Answers regarding Employer Reporting of Coverage Offers (Section 6056): <http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Reporting-of-Offers-of-Health-Insurance-Coverage-by-Employers-Section-6056>

IRS Questions and Answers regarding Reporting of Health Coverage (Section 6055): <http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-on-Information-Reporting-by-Health-Coverage-Providers-Section-6055>

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