

# Affordable Care Act Tax Reporting Forms and Questions

## Webinar Questions & Answers

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*This frequently asked questions document is a companion piece to the [webinar hosted on January 11, 2016](#). Plan-specific answers in this FAQ apply to medical plans sponsored by NRECA and to 125 plan health flexible spending accounts and health reimbursement arrangements administered by Cooperative Benefit Administrators (CBA). Cooperatives in non-NRECA plans may be affected by the Affordable Care Act differently. Answers reflect NRECA’s interpretation of agency guidance. NRECA cannot provide legal advice to co-ops. Speak with your co-op tax or legal counsel before making any decisions about how to meet requirements of the Affordable Care Act.*

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## Completing Forms (Lines, Codes and Sections)

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- 1. Can we leave line 16 on Form 1095-C blank if the options don't apply? For example, do we need to put a code in each month when it's the same code for multiple months?**

Yes, you can leave line 16 blank. However, please remember that the purpose of line 16 is to signal to the IRS that no employer mandate "B Penalty" is owed with regard to that employee- for whatever reason. Therefore, on line 16, an applicable large employer member wants to enter a code that will let the IRS know that no penalty applies with regard to that employee.

Leaving line 16 blank doesn't necessarily result in an applicable large employer member incurring an employer mandate penalty for that month, but if the employee in question happens to be eligible for a premium tax credit for that month, then it will likely trigger a potential penalty in the IRS system. Therefore, it's preferable to enter some code in line 16, if one applies.

As with other lines on the form, there is an "All 12 Months" column for line 16 that can be used if the same code would apply for all 12 months of the year.

- 2. What should co-ops enter on Form 1095-B, line 8 since we have NRECA coverage (e.g., E. Multiemployer Plan)?**

No, NRECA is a multiple employer plan, not a multiemployer plan. You should put "B" on line 8 to reflect "Employer-sponsored coverage." (Generally, a multiple employer plan is a plan maintained by two or more unrelated employers, while a multiemployer plan is a plan maintained under one or more collective bargaining agreements to which more than one employer contributes. They're two distinct types of plans under federal benefits law.)

- 3. What's the difference between codes 1A and 1E on Form 1095-C, line 14? Which code would we use if we offer coverage to all employees?**

Code 1A corresponds with the "Qualifying Offer Method," which can be used if an applicable large employer member can certify that for a full-time employee, it (1) offered minimum essential coverage providing minimum value at an employee cost for employee-only coverage not exceeding 9.55 percent of the mainland single federal poverty line, and (2) offered minimum essential coverage to the employee's spouse and dependents (if both conditions are met, it's considered a "Qualifying Offer"). Employers that use the Qualifying Offer Method for an employee shouldn't report the employee share of the lowest cost monthly premium for self-only minimum value coverage on line 15 of Form 1095-C.

Code 1E reflects that an applicable large employer member offered minimum essential coverage that provides minimum value to its employees and minimum essential coverage to spouses and dependents. If you use code 1E, you must complete line 15 of Form 1095-C.

Which code you use depends on the coverage you offer and the employee cost for employee-only coverage. Please remember that code 1A can only be used if your employee cost for employee-only coverage doesn't exceed 9.5% of the mainland single federal poverty line.

**4. How do we report the cost of employee only coverage on line 15 of Form 1095-C? Do we report the cost for the plan in which each specific employee is enrolled in the case of multiple plans being offered, or do we report the cost of the lowest priced plan offered?**

You report the employee cost of the lowest-cost monthly premium for self-only coverage providing minimum value that was offered to an employee. Whether or not the employee actually enrolled in the coverage isn't relevant.

**5. What's the difference on Form 1094-C, line 22, between the Qualifying Offer Method and the 98% Offer Method? Is there anything else I need to consider to complete this section?**

Please refer to the Instructions for Form 1094-C and our previous webinars for detailed information on line 22, but here's a very brief summary of the different options:

**Qualifying Offer Method:** Check this box if you're using the Qualifying Offer Method, which is described in the answer to question 8 in this FAQ document.

**Qualifying Offer Method Transition Relief:** This is a variation on the Qualifying Offer Method that can be used if you make a Qualifying Offer to at least 95% of all full-time employees in any particular month. It allows you to use a special code for the 5% of full-time employees that didn't receive a qualifying offer.

**Section 4980H Transition Relief:** Co-ops may want to check this box if it has more than 50 but less than 100 full-time employees (based on your co-op's 2014 full-time employee count). It advises the IRS that you qualify for the transition relief that exempts you from employer mandate penalties for 2015.

**98% Offer Method:** This provides that if the employer offered minimum value, affordable coverage to 98% of its full-time employees for each month of the calendar year, the employer can perform employer mandate reporting without determining whether each employee offered coverage is a full-time employee and without specifying the number of the employer's full-time employees on Form 1094-C.

## **Effects of Employment Statuses, Declining Coverage and Union Contracts**

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**6. How do we report employees who left the co-op voluntarily (e.g., retirement) or involuntarily (e.g., termination) during 2015?**

Every employer's situation is different, so there's no "one size fits all" answer to this question, but here are some principles to keep in mind:

- A. The Instructions for Form 1095-C provide that if an employee terminates coverage and you offer him or her COBRA coverage, you should use code 1H on line 14 (and Code 2A on line 16, regardless of whether or not the employee elects COBRA).
- B. Unfortunately, the IRS has provided no clear guidance on how to report individuals who retire mid-year. We have noted to our clients that there's a reasonable argument that offers of retiree coverage should be reported similarly to offers of COBRA coverage to

terminated employees. Since they're conceptually similar offers of continuation coverage, it seems they could be reported in the same manner. If you want to take the "COBRA approach," the code is 1H for any month in which retiree coverage is offered; otherwise, use whichever code (1B through 1F) accurately describes the coverage offered. For line 16, if you want to take the "COBRA approach," use code 2A.

To reiterate, there's no clear guidance on this issue, and we believe other approaches would be perfectly reasonable.

**7. If insurance coverage starts mid-month (e.g., on date of hire or after a waiting period) how do we report that individual? What codes do we use for months they weren't covered, covered for part of the month or covered for the entire month?**

An applicable large employer member reports that an employee was offered coverage for a month under line 14 of Form 1095-C only if the offer of coverage provides coverage for all days of the calendar month. Therefore, if an individual enrolls in coverage mid-month, use code 1H for that month.

The Instructions for Form 1095-C specifically provide that if the employee's first day of employment is a day other than the first day of the calendar month, then the employee's first calendar month of employment is a "Limited Non-Assessment Period," so use code 2D on line 16 for that month.

If an employee starts coverage mid-month after a waiting period, don't use code 2C on line 16, because you are only permitted to use code 2C for a month in which the employee was enrolled in coverage for each day of the month. In this scenario, you likely will use code 2D for the month, since in most cases, the waiting period will be considered a "Limited Non-Assessment Period."

**8. How do we report a full-time employee who was offered coverage but didn't elect it (e.g., he or she may be covered on a spouse's policy)? What about directors or retirees who didn't elect coverage offered to them?**

For your full-time employees, consider entering either code 2F, 2G or 2H on line 16. These codes correspond with the "affordability safe harbors."

As noted in the answer to question 1 of this FAQ document, the purpose of line 16 is generally to signal to the IRS that no employer mandate "B Penalty" is owed with regard to that employee. No "B Penalty" could apply with regard to an employee if you made him or her an offer of coverage that was both affordable and provided minimum value. On line 14, you have (presumably) told the IRS that you've made the employee an offer of coverage that met the minimum value standard. So in this scenario, on line 16 you want to tell the IRS that the offer of coverage was affordable, as well (assuming none of the other codes apply). Therefore, if a full-time employee declines coverage, most employers are looking to use one of the "affordability safe harbor" codes of 2F, 2G or 2H on line 16.

For directors and retirees, assuming that they weren't your full-time employees for any part of the year, you have no obligation to report on their behalf if they didn't enroll in coverage.

**9. What about an employee that the union contract excludes from insurance coverage. Should we be offering them coverage? We are a small employer.**

Since you're a small employer, we're assuming you aren't subject to the employer mandate. If that's the case, you have no obligation to offer coverage to any of your employees.

If you were a large employer (subject to the employer mandate), you would have to offer coverage to your full-time employees or risk being assessed a penalty under the employer mandate. Collective bargaining obligations don't impact employer mandate rules. In other words, even if a collective bargaining agreement provides that you cannot offer coverage to a certain class of employees, you could still incur employer mandate liability for those employees if they're considered full-time.

## **Directors, Retirees and Seasonal and Temporary Workers**

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**10. Do we send C forms to employees and B forms to directors, part-time employees, retirees, surviving spouses and seasonal workers, such as interns, if we offer them coverage? What if we reimburse directors for their Medicare coverage? What about retirees with coverage through OneExchange? What if directors or retirees have opted out of coverage?**

If you're a large co-op and have a "C Form" reporting requirement, you must always use the "C Form" for:

- A. Full-time employees
- B. Any other employees who were enrolled in your self-funded coverage or the NRECA Medical Plan, including part-time employees and seasonal workers/interns who don't qualify as full-time employees.

If you provide minimum essential coverage to retirees, directors or surviving spouses (all of whom are non-employees), you have a minimum essential coverage reporting obligation for those individuals but can report them on either the "B Forms" or the "C Forms." You don't have a reporting requirement for directors or retirees that you didn't provide coverage to during the year (assuming they weren't employed by you for any portion of the year).

**11. How do we treat individuals hired through a temporary staffing agency? For example, if they work over 30 hours a week, do we have to offer them health insurance after 90 days?**

It's not clear from the question whether the individuals are employees of the staffing agency, or whether the co-op was using the workers through the staffing agency and then opted to hire them as employees of the co-op. The entity that's the common law employer of the individuals could have an obligation to offer them coverage under the employer mandate rules.

If the co-op was using a worker through a staffing agency and then opted to hire him or her as an employee, the co-op would have to treat the worker as a full-time employee under the employer mandate, and might have to offer him coverage after three months, if the co-op

reasonably expected the worker to work more than 30 hours a week at the time the individual became an employee of the co-op.

On the other hand, if the worker remains the employee of the temporary staffing agency and is considered a temporary placement with the co-op, the staffing agency (as common law employer of the employee) would retain the employer mandate obligation.

**12. How do you determine if coverage is affordable for a retired director who pays 100% of the premium?**

Assuming the retired director wasn't an employee of the co-op for any portion of the year, the "affordability" of the coverage is actually irrelevant. The employer mandate penalties are related to whether the employer offered affordable coverage to its full-time employees.

## **Medicare-eligible Retirees**

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**13. If a co-op sponsors a premium-only health reimbursement arrangement (HRA) to cover retirees' premiums for Medicare, dental and vision coverage, does the co-op need to report these individuals on form 1095-B or 1095-C? How about for an HRA that covers more than just the premiums?**

You don't have an employer mandate reporting obligation for retirees (because they aren't full-time employees and you have no obligation to offer them coverage) but there's an open question as to whether you have to perform "minimum essential coverage" reporting for them if you sponsor a health reimbursement arrangement (HRA) that allows retirees to purchase coverage through OneExchange. Keep in mind that those HRAs do constitute minimum essential coverage; the question is whether there's an exception from having to report them as minimum essential coverage because they're considered "supplemental" to other minimum essential coverage.

The most recent IRS guidance on when minimum essential coverage reporting isn't required (Notice 2015-68) provides that "reporting generally is not required for an individual's minimum essential coverage for which an individual is eligible only if the individual is covered by other minimum essential coverage for which... reporting is required." Under this rule, reporting isn't required for Medicare supplemental coverage providing benefits only to an individual enrolled in other coverage for which reporting is required. We have interpreted that to mean that reporting isn't required on most Medicare supplements. Therefore, if a retiree HRA is only available to individuals on Medicare and can only be used to pay premiums for Medicare supplemental coverage, we think it would fall under this exception and reporting wouldn't be required.

Many co-op retiree HRAs, however, also allow retirees to purchase Medicare Advantage or (like in your situation) reimburse other medical expenses. (Medicare Advantage isn't Medicare supplemental coverage.) To the extent that your co-op's HRA can be used to purchase Medicare Advantage through OneExchange or be used to reimburse other medical expenses (even if not used for that purpose), it doesn't fall under this exception. The IRS would likely take the position that reporting is required.

**14. Do we need to report individuals for whom Medicare was primary in 2015?**

If you're a large co-op, you would still have to report on those individuals if they were full-time employees for any portion of the year, or if they were enrolled in other minimum essential coverage through your co-op. (Please see the answer to question 17 on situations where you may not have to report on Medicare supplemental coverage).

If you're a small co-op, you would still have to report on those individuals if they were enrolled in other minimum essential coverage through your co-op. (Again, see the answer to question 17 for situations where you may not have to report on Medicare supplemental coverage).

**15. I have a retiree that is no longer covered under the insurance due to being Medicare eligible, but his spouse is still covered. Should I fill out the 1095-C in the previous employee's name, or should the recipient be the spouse?**

The answer to this question isn't entirely clear. You're only responsible for minimum essential coverage reporting in this situation. The rules state that minimum essential coverage should go to the "responsible individual," which the IRS describes as "the person who enrolls one or more individuals, which may include him or herself, in minimum essential coverage." In this situation, we think the IRS would say the previous employee is the "responsible individual," since the coverage is provided due to the previous employee's relationship with you as the employer. That leads us to conclude that the Form 1095-C should be in the previous employee's name. However, we believe it would be defensible if you decide to issue Form 1095-C in the spouse's name.

## **Disability and Workers Compensation**

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**16. If an employee goes out on long-term disability and the co-op's policy says that insurance coverage ends, should we change the policy according to the new guidelines?**

As discussed during [the webinar](#), recent IRS guidance provides that an employer must credit "hours of service" for employees receiving short- or long-term disability, unless payments are made from an arrangement to which the employer didn't contribute directly or indirectly. Therefore, most employees receiving disability payments (whether insured or self-funded) will have to be credited with hours of service for periods during which they receive the payments.

Because of that, if the individual on disability is still treated under your policies as an employee, and if long-term disability is considered employer-paid, then you would have to credit him or her with "hours of service" during the period of disability. This could result in you having to treat the individual as a full-time employee for purposes of the employer mandate and ACA tax reporting (and may require you to offer him or her health coverage).



The rule about crediting a disabled employee with hours of service only affects individuals who are still an “employee.” Therefore, if your policy provides that you sever your employment relationship with an employee when he or she becomes disabled, you don’t have to count hours of service for him or her for any reason.

**17. Is it acceptable under the ACA guidelines to require employees receiving disability payments to pay 100% of their health insurance premium?**

As noted in the answer to question 16 in this FAQ document, if you treat an employee on disability as a “full-time employee,” then under the employer mandate you may be subject to a penalty for that employee if you don’t offer him or her coverage that meets the minimum value and affordability standards. There’s nothing in the guidelines that requires employers to pay 100% of the premiums.

**18. How is counting hours of service affected if an employee is on worker's compensation and is being paid by the insurance carrier for worker’s comp? What if the individual is part of an excluded class (e.g., intern, seasonal worker, part-time)?**

The IRS guidance referenced in the answer to question 20 in this FAQ document provides that periods during which an employee isn’t performing services but is receiving payments in the form of workers’ compensation wage replacement benefits under a program provided by the state or local government don’t result in hours of service. So, an employee who is receiving workers’ compensation benefits doesn’t have to be treated in the same manner as an employee receiving disability benefits, as described in the answer to question 20.

## **Incentives to Opt-out of Coverage**

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**19. We offer an opt-out incentive for employees or their dependents, but they must provide proof of other insurance coverage. How does this affect the total cost calculation?**

As discussed during [the webinar](#), the IRS recently affirmed its position that if an employee is offered additional compensation to decline coverage in a group health plan, it’s no different than requiring an employee to reduce his or her compensation to pay for employer-provided health coverage. For example, if an employee is offered an additional \$1,000 in compensation if he or she declines coverage, the employee is foregoing \$1,000 in compensation if he or she elects coverage. To the IRS, that’s the same as if the employee had to reduce his or her compensation by \$1,000 to pay for coverage.

The IRS indicated in its recent guidance that it plans to issue regulations reflecting that such “unconditional opt-out arrangements” will be counted against the affordability of coverage for an employee. However, this rule generally won’t go into effect until such regulations are applicable, provided that the opt-out arrangement generally was in place before December 16, 2015. Until those regulations are applicable, employers aren’t required to take opt-out payments into account for purposes of Form 1095-C reporting, as they won’t impact the determination of whether an employer is subject to employer mandate penalties. An employee, on the other hand, can take advantage of this rule for purpose of determining eligibility for a premium tax credit.

Also, when it issued this guidance, the IRS suggested that it was possible that opt-out arrangements that are conditioned not only on the employee declining employer-sponsored coverage but also the satisfaction of other conditions (e.g., the employee providing proof of having other coverage) might be subject to different rules under the regulations.

Since your arrangement is conditioned on the employee providing proof of having other coverage, and there's currently a great deal of uncertainty around these issues, our recommendation is to report for 2015 without taking into account the opt-out incentive. You should, however, continue to monitor this issue for future years.

## Subgroup Reporting

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### **20. Can different subgroups with NRECA coverage be combined and reported together or must they be reported separately?**

Under the employer mandate rules, entities in the same controlled group under IRS rules are combined and treated as a single employer for purposes of determining whether or not the employer has at least 50 full-time employees (including full-time equivalents), and together they're referred to as an applicable large employer. Each of the separate entities that are combined is referred to as an applicable large employer member. For purposes of 1095-C filing, each applicable large employer member must file its own Form 1094-C with the IRS and furnish Form 1095-C to its full-time employees, using its own EIN.

It's our understanding that typically, different subgroups don't constitute separate applicable large employer members (i.e., the different subgroups usually operate under the same EIN). Therefore, in most cases, multiple subgroups should be combined together for ACA tax reporting purposes. There are a few instances where a separate subgroup represents a separate employer operating under a distinct EIN. In those instances, the two entities would be aggregated for purposes of determining applicable large employer status, since they're likely in the same controlled group under IRS rules, but they would perform their 1095-C filing independently of each other as distinct applicable large employer members.

## Penalties

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### **21. What are the penalties for missing the June 30, 2016 deadline?**

The general penalty for failing to file the form is \$250 for each return, with the penalty capped for the year at \$3 million. The \$250 penalty can be reduced under some circumstances if the form is filed within a certain amount of time after the deadline.

### **22. Can employees file their taxes without either Form 1095-B or 1095-C? Are there any implications if they do?**

Yes, employees can file their tax returns without these forms. The IRS acknowledged when they extended the deadlines for the forms that the only individuals who will be affected by not having a Form 1095-C are those who enrolled in coverage through the Health Insurance

Marketplace but didn't receive a determination from the Marketplace that the offer of employer-sponsored coverage wasn't affordable. For 2015 only, those individuals can rely upon other information received from employers about their offers of coverage for purposes of determining eligibility for the premium tax credit when filing their income tax returns. They don't need to amend their returns once they receive their Form 1095-C or a corrected Form 1095-C.

Similarly, individuals who rely upon other information received from their coverage providers about their minimum essential coverage for purposes of filing their returns don't have to amend their returns once they receive Form 1095-B or Form 1095-C, or any corrections.

## **Additional Resources**

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Final regulations from the Department of Treasury and the Internal Revenue Service (IRS), as well as links to ACA tax reporting forms and instructions are below:

- [Individual mandate \(Section 6055\) reporting final regulations using Forms 1094-B and 1095-B](#)
- [Form 1094-B](#)
- [Form 1095-B](#)
- [Instructions for B forms](#)
- [Employer mandate \(Section 6056\) reporting final regulations using Forms 1094-C and 1095-C](#)
- [Form 1094-C](#)
- [Form 1095-C](#)
- [Instructions for C forms](#)
- [Deadline extension notice](#)

For ACA Resources, such as FAQ documents, fliers and timelines, **on the Employee Benefits website**, go to Cooperative.com > My Benefits > Help & Resources > Documents for Co-ops > [Insurance Plans](#) (click "Filters" and select "Health Care Reform").

For ACA resources on **NRECA.coop**, go to [NRECA.coop](#) > NRECA on the Issues > Cooperative Business Issues > Health Care Reform.

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