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Employee Benefits & Executive Compensation ADVISORY ■

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ACA Administrative Simplification Provisions for Health Plans: Time to Apply for an HPID & Prepare for Certification of Compliance

While much has been written about Affordable Care Act (ACA) compliance obligations for employer-sponsored plans–such as the "pay or play" rules, various fees and taxes and insurance reforms–the ACA's changes to the administrative simplification rules in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) have received less attention. As deadlines approach, however, it is important for plans to ensure compliance with these requirements. This article discusses two major developments applicable in 2014 and 2015: the requirements to obtain a unique health plan identifier (HPID) and file a certification of compliance with the Department of Health and Human Services (HHS).

Section 1104(c)(1) of the ACA requires HHS to promulgate rules regarding HPIDs for health plans.[1] The HPID is a standardized 10-digit number assigned to health plans, which is designed to increase standardization and help covered entities verify information from other covered entities. The level of control a plan has over its own activities determines whether it must apply for its own HPID or whether it might be able to rely on the HPID of another health plan. If the HPID requirement applies, large health plans must obtain one by **November 5, 2014**, and small health plans must do so by **November 5, 2015**.

In addition, HHS has issued proposed regulations regarding the "certification of compliance" with HIPAA's electronic transaction standards required by ACA § 1104(h). Most health plans must file the first of two certifications with HHS by **December 31, 2015**. While much detail regarding this certification remains to be developed, health plans should begin planning so that they can complete the certification's required testing process when final regulations are issued.

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[1] This requirement is described in Social Security Act § 1173(b). This rule was required to be based on input from the National Committee on Vital and Health Statistics and be effective no later than October 1, 2012.

HPID

On April 27, 2012, HHS issued a proposed rule about HPIDs.[2] The final regulations, issued on September 5, 2012, modified the implementation dates originally set forth in the April rulemaking, but did not substantively modify them.[3]

Who Needs an HPID?

The regulations draw a distinction between Controlling Health Plans and Subhealth Plans based on the level of control the entity has over its activities. Under these regulations, a Controlling Health Plan (CHP) is required to obtain an HPID. A Subhealth Plan (SHP) is not required to obtain an HPID, but may do so, or a CHP can obtain an HPID on its behalf.

A CHP is defined as a health plan that (i) controls its own business activities, actions, or policies; or (ii) is controlled by an entity that is not a health plan and, if it has one or more SHPs, exercises sufficient control over them to direct their business activities, actions or policies. The regulations list the following considerations in determining whether an entity is a CHP: 1) Does the entity itself meet the definition of a health plan at 45 C.F.R. § 160.103? 2) Does either the entity itself or a nonhealth plan control the business activities, actions, or policies of the entity? If the answer to both questions is yes, the entity meets the definition of a CHP. This includes self-insured plans that satisfy the definition of a CHP.

A SHP, by contrast, is defined as a health plan whose business activities, actions, or policies are directed by a CHP. In determining whether an entity is a SHP, the following considerations are relevant: 1) Does the entity meet the definition of health plan at 45 C.F.R. § 160.103? 2) Does a CHP direct the business activities, actions, or policies of the health plan entity? If the answer to both questions is yes, the entity meets the definition of a SHP.

While it is not entirely clear from the regulations, it appears that insurers may apply for HPIDs on behalf of fully-insured plans.[4] Specifically, the insurer's health plan would be considered the CHP because it controls its own business activities, actions, and policies, while the employer's fully-insured health plan would be considered a SHP because its business activities, actions, and policies are controlled by the insurer's CHP. Nonetheless, more guidance to clarify this issue would be welcome.

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2 Department of Health and Human Services, Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for ICD–10–CM and ICD–10–PCS Medical Data Code Sets, 77 Fed. Reg. 22950, April 17, 2012.

3 Department of Health and Human Services, Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the International Classification of Diseases, Tenth Revision (ICD–10–CM and ICD–10–PCS) Medical Data Code Sets; Final Rule, 77 Fed. Reg. 54664, September 5, 2012.

4 As written, HHS's rules could be read to indicate that even a health plan that is fully insured with no self-insured options must apply for its own HPID. However, HHS has typically excluded fully-insured employer health plans from many of HIPAA's requirements if they do not have access to protected health information and have shifted the primary compliance burden, such as the responsibility for providing a Notice of Privacy Practices, to the insurer. Although it is not clear, it appears that HHS may have done the same regarding HPIDs.

Practice Pointer: A "health plan," as defined in 45 C.F.R. § 160.103, includes, among other entities, a group health plan, health insurance issuer, or HMO. Thus, for example, even excepted benefits such as dental or vision only coverage and health flexible spending accounts would be required to obtain HPIDs. Likewise, HRAs and retiree only health plans would be required to obtain HPIDs as well. However, it appears that plans may file for one HPID for bundled plans (e.g., if the plan constitutes one plan for Form 5500 filings), so some of these types of coverage may be bundled with other coverage for HPID purposes, depending on the structure of the plan.

For example, the following plan arrangements would likely have the HPID responsibilities discussed below:

Plan Description	HPID Responsibility
A single medical plan with three self-insured options	Employer obtains one HPID for the entire plan
Medical plan with two self-insured options and one fully-insured option	Employer obtains HPID for self-insured options, but insurer also obtains HPID for the fully-insured option.
Medical plan with three fully-insured options and no self-insured options (e.g., no health FSA or HRA)	Insurer obtains HPID. Employer's medical plan is a SHP and may be able to rely on the insurer's CHP HPID.
Medical plan with three fully-insured options and a health flexible spending account (FSA)	Employer obtains HPID for health FSA, but insurer obtains HPIDs for the fully-insured options. Employer may have until November 5, 2015 to apply for HPID if health FSA qualifies as a small plan as discussed below.

Are any health plans excluded from the HPID requirement?

HIPAA's definition of health plan is broad and includes any "individual or group plan that provides, or pays the cost of, medical care."[5] However, plans that are not subject to HIPAA's administrative simplification rules are not required to obtain an HPID. HIPAA's administrative simplification rules do not apply to the excepted benefits described in PHSA §2791(c), including:

- Coverage only for accident, or disability income insurance, or any combination thereof;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- Coverage for on-site medical clinics; and
- Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.[6]

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5 45 C.F.R. § 160.103.

6 The regulations do not currently specify any "[o]ther similar medical coverage."

In addition, the HPID requirement and HIPAA's administrative simplification rules do apply to any self-funded, self-administered health plans with fewer than 50 participants.

Practice Pointer: Not all excepted benefits under HIPAA's portability rules are excepted benefits under the administrative simplification rules. For example, although health flexible spending accounts, stand-alone dental and vision policies, and retiree-only plans might be excepted benefits under HIPAA's portability rules, they are not excepted benefits under the administrative simplification rules and must obtain an HPID.

Obtaining an HPID

A national enumeration system, known as the Health Plan and Other Entity Enumeration System (HPOES), assigns unique HPIDs through an online application process. HPOES became available within the Centers for Medicare & Medicaid Services' (CMS) Health Insurance Oversight System (HIOS) in late March 2013. As noted above, large health plans must obtain an HPID by November 5, 2014, and small health plans must do so by November 5, 2015. For this purpose, a "small health plan" is defined as a health plan with annual receipts (i.e., benefits for a self-funded plan or premiums for an insured plan) of $5 million or less.[7] Thus, many excepted benefit coverages (e.g., FSAs, dental or vision only coverage) should be eligible for a one-year extension. By the full implementation date of November 7, 2016, all health plans must use the HPID in their standard transactions.[8]

Practice Pointer: Many individuals consider Employee Assistance Programs (EAPs) to be self-insured plans because they are not generally subject to state insurance laws, but other individuals consider EAPs to be insured. Assuming that an EAP is treated as a self-insured plan, an employer must apply for an HPID if it offers an EAP even if all of its other benefits are fully-insured. However, most EAPs will qualify as small health plans and have until November 5, 2015 to do so. EAP providers should work with counsel to determine if they must obtain an HPID. Additional guidance on this issue would be helpful.

How does the application process work?

To sign up for an HPID, entities must first be registered for HIOS at https://portal.cms.gov/wps/portal/unauthportal/home/. First, users must sign up as individuals and request to be linked to the relevant company. The user will then select whether the application is for an HPID (SHP or CHP) or Other Entity Identifier (OEID), which, as described below, may be obtained by entities like third-party administrators (TPAs) who are not required to obtain HPIDs. Keep in mind that plans must sign up for a CHP before signing up for any SHPs (although, as discussed above, HPIDs are permissive, not required, for SHPs). The data elements requested in the application for employer-sponsored plans include company information (including name, employer identification number (EIN) and address), authorizing official information (including name and contact information) and the plan's NAIC number or payer ID for standard transactions. Although not defined by HHS, it is generally expected that health plans will use the plan sponsor's EIN for the payer ID since they do not have a NAIC number.[9]

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7 Fully-insured plans should use the total premiums that they paid for health insurance during the plan's last fiscal year to determine their annual receipts. Self-insured plans should use the total amount of claims paid by the employer, plan sponsor or benefit fund, as applicable, on behalf of the plan during the plan's last full fiscal year.

8 45 C.F.R. § 162.504. This was corrected from a mistake in the original regulations by 77 Fed. Reg. 60629, Oct. 4, 2012.

9 Similarly, although also not clear, we expect that a health plan that pays benefits through a voluntary employee beneficiary association (VEBA) should use the VEBA's EIN since the VEBA is the payer.

After the information is submitted, an "authorizing official" within the company must approve the application. CMS has created several videos, presentations, and explanatory slides to guide plans through the application process.[10]

Practice Pointer: It will be important to secure an HPID well before the mandatory compliance dates so that there is sufficient time to work out any administrative issues that may arise with multiple entities implementing the new system. Companies that have not previously signed up within HIOS should allow several days for the various internal approvals that must take place before they can obtain an HPID.

Penalties if HPID not obtained

HHS' HPID regulations do not specify a separate penalty for failing to obtain an HPID. Although not clear, it appears that the same civil monetary penalty that applies to violations of HIPAA's administrative simplification rules would apply to a plan that failed to obtain an HPID. Thus, a plan that by willful neglect does not obtain an HPID would be subject to a penalty of at least $50,000 for failing to obtain an HPID, plus at least $50,000 each time a standard transaction occurs that requires an HPID but fails to include an HPID. This penalty is capped at $1.5 million for violations of an identical requirement or prohibition within the same calendar year.

How an HPID will be used

A covered entity is required to use an HPID when it identifies a health plan in a standard transaction. Note that this requirement also applies to business associates when they conduct standard transactions on a covered entity's behalf. While multiple standard transactions apply to health plans, a transaction employer-sponsored plans may directly perform (rather than relying on TPAs) is the eligibility for a health plan standard (270/271), which applies to inquiries between health care providers and health plans regarding a participant's eligibility, coverage or benefits under a plan.

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[10] CMS, "Health Plan Identifier," March 30, 2014, *available at* http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html.

Practice pointer: Covered entities, including health plans, are required to comply with HIPAA's standard transaction rules when they communicate electronically with each other. The following electronic transactions are subject to HIPAA's rules for standard transactions:

- health care claims or equivalent encounter information
- eligibility for a health plan
- referral certification or authorization
- health care claim status
- enrollment and disenrollment in a health plan
- health care electronic funds transfer and remittance advice
- health plan premium payments
- coordination of benefits
- first report of injury (e.g., to initiate workers' compensation actions)
- health claims attachments (effective January 1, 2016)
- other transactions specified by HHS regulations (e.g., Medicaid pharmacy subrogation)

There are also several uses for which an entity is permitted, but not required, to use an HPID. CMS has stated that the HPID can be used for "any other lawful purpose" (in addition to a standard transaction).[11] The regulations list the following potential uses of an HPID, which CMS believes will increase efficiency: in internal files, to facilitate the processing of transactions; on an enrollee's health insurance card; as a cross-reference in health care fraud and abuse files and other program integrity files; in patient medical records to help specify health care benefit packages; in electronic health records to identify health plans; in federal and state health insurance exchanges; and for public health data reporting purposes.

Practice Pointer: While none of these uses currently require an HPID, they are helpful in that they illustrate how CMS intends the HPID to be used. In addition, CMS may decide to mandate some of these uses of HPIDs in the future.

Other Entity Identifiers

The HPID regulations also introduce the concept of an OEID for non-health plan entities that may engage in, and thus must be identified in, standard transactions. The possible users of OEIDs include third-party administrators, transaction vendors, clearinghouses, and other payers. Non-health plan entities are permitted, but not required, to obtain an OEID. However, health plans will want to require their business associates to obtain OEIDs in contractual agreements, particularly any TPAs handling eligibility or claim status issues on the plan's behalf.

Entities are eligible to apply for an OEID if they need to be identified in a transaction for which a standard has been adopted by HHS, are not eligible to obtain an HPID or a National Provider Identifier (NPI) and are not an individual. Because the adoption of an OEID is voluntary, there is no required compliance date.

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[11] CMS, HPID and OEID System Overview, February 13, 2013, *available at* http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Downloads/HPOESTrainingSlides02132013.pdf.

Practice Pointer: For employers, the HIPAA standard unique identifier is the employer's EIN. For providers, the NPI is the standard unique identifier.

Certification requirement

Another important requirement imposed on plans by HIPAA's administrative simplification rules is the certification of compliance. Section 1104(h)(1) of the ACA requires CHPs to file two separate statements with HHS certifying that their data and operating systems are in compliance with the applicable standards and operating rules.[12] The first "certification of compliance" applies to eligibility for a health plan, health care claim status; and health care electronic funds transfers and remittance advice. It is due by **December 31, 2015** for plans that have applied for an HPID by **January 1, 2015** (i.e., most large health plan CHPs), and **within a year of applying for an HPID** for plans that apply for an HPID between January 1, 2015, and December 31, 2016 (i.e., small and new CHPs). Thus, as a practical matter, many health plans that provide excepted benefits or otherwise qualify as a small health plan will have an additional year for compliance.

The second certification of compliance—applicable to health claims or equivalent encounter information, enrollment or disenrollment in a health plan, health plan premium payments, health claims attachment and referral certification and authorization transactions—is, according to the statute, also due on December 31, 2015. However, there are currently no standards or operating rules for these transactions.

HHS issued proposed rules on January 2, 2014, setting forth the requirements for the first certification of compliance.[13] While much remains to be worked out in the final rules, the proposed rules give a sense of what compliance obligations CHPs should prepare for by the end of 2015. HHS stated in the proposed rules that it intends for the certification to serve as a "snapshot" of compliance, so this is likely a one-time compliance obligation for each required certification.

Practice Pointer: The certification requirements will take some time to satisfy because they require external testing, so plans should be prepared to act when the final regulations are issued by HHS. In most cases, plans will need to rely on their business associates to conduct this testing, so plans should consider adding provisions to new business associate agreements that require the business associate to conduct this testing on their behalf.

Details of certification requirement

The proposed rules would require CHPs to submit to HHS:

- Number of covered lives, including covered lives in SHPs, on the date the certification is submitted; and
- Documentation that the CHP has obtained one of two permissible certifications:
  - HIPAA Credential, or
  - The Phase III Core Seal.

CHPs will report this information on their own behalf and on behalf of SHPs and business associates conducting standard transactions on their behalf. The term "covered lives" means individuals (including spouses and dependents) covered by major medical policies of a CHP and its SHPs.

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12 This requirement is described in Social Security Act § 1173(h).

13 Department of Health and Human Services, Administrative Simplification: Certification of Compliance for Health Plans; Proposed Rule, 79 Fed. Reg. 298, January 2, 2014.

Practice Pointer: The use of the term "policy" in the definition of covered lives suggests that the proposed rules only contemplate reporting enrollment counts for fully-insured plans; further guidance on this subject would be welcome.

The HIPAA Credential certification is still under development, but as currently envisioned by HHS, would involve:

- Attestation about completing certain external testing of operating rules (although no specific testing process is specified),
- Application form, and
- Attestation of compliance with HIPAA's security, privacy and electronic transaction standards by a senior level executive.

The Phase III CORE Certification Seal would involve a:

- Specified external testing process through a CORE-authorized vendor to obtain the Seal,
- Application form, and
- Attestation by a senior level executive of compliance with HIPAA's security, privacy and electronic transaction standards.

Plans should watch for further developments on these methods of certification in the final rules.

Potential penalties

Plans that fail to comply with the certification and documentation of compliance requirements (either by submitting the required information late or not at all) may face penalties of $1 per covered life per day, up to a maximum of $20 for covered life or $40 per covered life if the plan knowingly provides incomplete or inaccurate information.[14]

Practice Pointer: The penalties for violations of these provisions are less draconian than other ACA penalties, such as for violations of the "pay or play" rules (under IRC § 4980H) and the PHSA Mandates. However, this penalty will likely be very easy for HHS to enforce, as HHS states that it can compare the list of entities that applied for an HPID with the list of entities that complied with the certification requirement.

ICD-9 to ICD-10 code change delay

HIPAA requires standardized code sets to be used in certain electronic communications of medical data. Currently, HHS has adopted the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), for diseases, injuries, impairments, health problems and their causes, as well as inpatient hospital services. However, the final HPID regulations adopted the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for diseases, injuries, impairments, health problems and their causes, as well as the International Classification of Diseases,

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[14] Language in the proposed rules suggests that this penalty only applies to a "major medical policy," which is defined as "an insurance policy that covers accident and sickness and provides outpatient, hospital, medical, and surgical expense coverage." 79 Fed. Reg. 313 (Jan. 2, 2014). Although self-insured plans must obtain certification, the proposed rules do not specify a penalty for those that fail to do so. We expect this will be clarified in the final regulations.

Tenth Revision, Procedure Classification System (ICD-10-PCS) for inpatient hospital services, beginning October 1, 2014. However, the Protecting Access to Medicare Act of 2014 delayed implementation of the ICD-10-CM and ICD-10-PCS code sets until at least October 1, 2015. In a final rule issued August 4, 2014, HHS stated that covered entities must continue to use ICD-9-CM through September 30, 2015, and that compliance with ICD-10-CM and ICD-10-PCS will be required beginning October 1, 2015.[15]

Generally, this delay will not impact employers or third-party administrators of flexible spending accounts and health reimbursement arrangements, but third-party administrators of self-insured major medical plans and insurers (who have already incurred costs related to the transition to ICD-10) must hold off using the new standard until October 1, 2015.

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15 79 Fed. Reg. 45128 (August 4, 2014).

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AUGUST 28, 2014

Looming HIPAA Deadline for Business Associate Agreements and Security Risk Assessment

As we catch our breath from the latest Affordable Care Act changes, health plan sponsors should refocus on a couple of important HIPAA requirements that may have previously moved to the back burner—HIPAA security risk assessments and business associate agreement updates. These requirements may create significant risk for employer plan sponsors that fail to comply.

September 23 Deadline for Business Associate Agreement Updates

The HIPAA Omnibus Final Rule (the "Omnibus Rule")[1] became effective March 26, 2013, with a general compliance deadline of September 23, 2013. Compliance with the Omnibus Rule required changes to several HIPAA documents and related compliance practices, including business associate agreements, the HIPAA notice of privacy practices and breach assessment policies and procedures. For more information about other aspects of the Omnibus Rule that apply to employer-sponsored group health plans, see our advisory from March 11, 2013.[2]

With respect to business associate agreements, however, the Omnibus Rule included transition relief that allowed certain health plans an extended transition period within which to make necessary changes to their business associate agreements if certain conditions were met.

To qualify for the transition relief, you must meet two requirements:

- You must have entered into the business associate agreement prior to January 25, 2013 (*the date the Omnibus Rule was issued*); and
- The contract must not have been modified or renewed between January 25, 2013, and September 22, 2014.

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1 *Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules,* 45 Fed. Reg. 5566 (January 25, 2013)

2 Alston & Bird Employee Benefits & Executive Compensation Group, "New HIPAA Omnibus Rule: Issues for Employer Plan Sponsors and Group Health Plans," March 11, 2013, at http://www.alston.com/advisories/HIPPA-Omnibus-Rule.

That transition relief will now expire September 23, 2014 (if it has not already). As of September 23, 2014, all business associate agreements must be updated as necessary to reflect the Omnibus Rule requirements.

Accordingly, covered entities should review their business associate agreements to ensure they have all been updated.

Practice Pointer: Business associate agreement provisions that may require review and updating for compliance with the Omnibus Rule include:

- An update to the definition of PHI;
- Updated subcontractor provisions;
- Provision requiring business associate to comply with the HIPAA Security Rule;
- Breach identification and/or reporting obligations;
- The forms in which documents must be provided following a request to access PHI; and
- Limitations on the use of PHI for marketing.

HIPAA Security Risk Assessments

In light of the recent increase in HIPAA audit/investigation activity and recent large-scale data breaches, employer plan sponsors should redouble their efforts for self-funded health plan HIPAA security compliance. The HIPAA Security Rule requires that each covered entity (i.e., the Plan) and its business associates (i.e., TPAs and other service providers) conduct a thorough and accurate risk assessment of the potential risks and vulnerabilities to the confidentiality, integrity and availability of electronic protected health information (ePHI) held by the covered entity or business associate.[3]

Completion of the risk assessment will likely require input from a number of business functions within the employer plan sponsor or TPA, including Benefits, HR, IT security, HR information systems, Payroll and Legal. The Privacy Officer and the Security Officer (if someone other than the Privacy Officer) are responsible for ensuring that the risk assessment is performed and documented. However, elements of the assessment will likely need to be completed by other groups outside the Plan/TPA's normal workforce (legal, HRIS, IT, privacy office, payroll, etc.).

Practice Pointer: The Security Officer will need to coordinate with many different business groups within the covered entity or business associate. Obtaining buy-in from all these groups will be critical to the successful completion of the HIPAA risk assessment.

[3] 45 C.F.R. § 164.308(a)(1)(ii)(A)

General Security Risk Assessment Requirements

There are numerous methods for performing a risk assessment, and there is no single method or best practice that guarantees compliance. However, there are several elements that a risk assessment must incorporate, regardless of the method employed.

1. ***Scope of the Assessment***

   The covered entity or business associate must perform a thorough risk assessment to determine the potential risks and vulnerabilities to ePHI[4] created, received, maintained or transmitted by the covered entity or business associate.[5]

   For this purpose, risk can be defined[6] as the net mission impact considering (1) the probability that a particular threat will exercise a particular vulnerability and (2) the resulting impact if this should occur. Risk may arise from legal liability or negative impact on the business.

2. ***Data Collection***

   The covered entity or business associate must identify where the ePHI is stored, received, maintained or transmitted.

   The covered entity or business associate can accomplish this by reviewing past and present projects, performing interviews with personnel utilizing PHI, reviewing documentation or using other data gathering techniques.

3. ***Identify and Document Potential Threats and Vulnerabilities***

   The covered entity or business associate must identify and document reasonably anticipated threats to ePHI and system vulnerabilities.[7] For this purpose, threats and vulnerabilities can be defined as:

   - **Threat** – the potential for a person or thing to exercise (accidentally trigger or intentionally exploit) a specific vulnerability, including natural disasters (e.g., floods, earthquakes and tornadoes), human threats (e.g., malicious software, hackers) and environmental threats (e.g., power failures, pollution and liquid leakage).
   - **Vulnerability** – a flaw or weakness in system security procedures, design, implementation or internal controls that could be exercised (accidentally triggered or intentionally exploited) and result in a security breach or a violation of the system's security policy.

4. ***Assess Current Security Measures***

   The covered entity or business associate should assess and document the security measures it uses to safeguard ePHI.[8]

   The security measures implemented to reduce risk will vary among organizations based on factors such as the size and complexity of the organization. As a result, the appropriate security measures needed to reduce the likelihood of risk to the security of ePHI will vary from covered entity to covered entity or business associate to business associate.

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4 This includes ePHI held in forms such as hard drives, CDs, DVDs, smart cards or other storage devices or portable electronic media.

5 45 C.F.R. § 164.306(a).

6 Based on recommendations of the National Institute of Standards and Technology (NIST). Use of definition is not mandatory.

7 45 C.F.R. §§ 164.308(a)(1)(ii)(A) and 164.316(b)(1).

8 45 C.F.R. §§ 164.306(b)(1), 164.308(a)(1)(ii)(A), and 164.316(b)(1).

5. Determine the Likelihood of Threat Occurrence

The Security Rule requires covered entities and business associates to take into account the probability of potential risks to ePHI.[9] The results of the risk assessment, combined with the initial list of threats, will influence the determination of which threats the Security Rule requires protection against because they are reasonably anticipated.

The output in the report for this element should be documentation of all threat and vulnerability combinations with associated likelihood estimates that may impact the confidentiality, availability and integrity of ePHI.

6. Determine the Potential Impact of Threat Occurrence

The Security Rule requires consideration of the impact of potential risks to the security of ePHI.[10] Accordingly, the covered entity or business associate must assess the magnitude of the potential impact resulting from a threat triggering or exploiting a specific vulnerability. The covered entity or business associate can use a qualitative or quantitative method or a combination of the two to measure the impact on the covered entity or business associate.

The covered entity or business associate should document all potential impacts associated with the occurrence of threats triggering or exploiting vulnerabilities that affect ePHI held by the organization.

7. Determine the Level of Risk

The covered entity or business associate must assign risk levels for all threat and vulnerability combinations identified during the risk analysis. The level of risk should factor both the likelihood that the threat occurs and the resulting impact if the threat occurs.

The output on the report for this part should be documentation of the assigned risk levels and a list of corrective actions to be performed to mitigate each risk level.

8. Finalize Documentation

The covered entity or business associate must document the risk assessment, but HIPAA does not require a specific format.[11]

9. Periodic Review and Update to the Risk Assessment

The covered entity or business associate must continue to monitor its risk assessment in light of new developments.[12] HIPAA does not specify the frequency with which such updates must occur, but they should be driven by circumstances and changes to the environment that could impact ePHI.

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9 45 C.F.R. § 164.306(b)(2)(iv).

10 45 C.F.R. § 164.306(b)(2)(iv).

11 45 C.F.R. § 164.316(b)(1).

12 45 C.F.R. § 164.316(b)(2)(iii).

HHS Online Security Risk Assessment Tool

One available method for conducting the security risk assessment is to use the Security Risk Assessment Tool ("SRA Tool") offered by the Department of Health and Human Services (HHS). The SRA Tool can be found at http://www.healthit.gov/providers-professionals/security-risk-assessment-tool. The SRA Tool is a software application that is one resource (among other tools and processes) the covered entity or business associate may use to conduct the security risk assessment (or review an existing security risk assessment). Although the SRA Tool was designed for small and medium sized medical practices, the questions are generally applicable to any type of covered entity or business associate.

The SRA Tool is composed of 154 questions covering 12 different compliance categories, including:

- Maintaining your security program;
- Identifying your assets;
- Managing access to your assets;
- Managing the integrity of your ePHI;
- Managing your media;
- Managing your facilities;
- Managing your workforce;
- Educating your workforce;
- Managing your vendors;
- Continuing operations when emergencies occur;
- Auditing your operations; and
- Managing incidents.

The SRA Tool produces a report after questions are completed and can be used to form part of the documentation for your risk assessment. While HHS has made clear that completion of the SRA Tool does not guarantee compliance with the HIPAA security risk assessment requirement, use of this tool should generally assist the organization in conducting, reviewing and documenting risk assessment compliance efforts.

If you would like to receive future *Employee Benefits & Executive Compensation Advisories* electronically, please forward your contact information to **employeebenefits.advisory@alston.com.** Be sure to put "**subscribe**" in the subject line.

If you have any questions or would like additional information, please contact your Alston & Bird attorney or any of the following:

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WASHINGTON, DC: The Atlantic Building ■ 950 F Street, NW ■ Washington, DC, USA, 20004-1404 ■ 202.756.3300 ■ Fax: 202.756.3333

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.

Caution: *DRAFT—NOT FOR FILING*

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2014 Instructions for Forms 1094-C and 1095-C

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 Form 1094-C, Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns, and Form 1095-C, Employer-Provided Health Insurance Offer and Coverage, and instructions, such as legislation enacted after they were published, go to www.irs.gov/form1094c and www.irs.gov/form1095c.

Reminders

Forms 1094-C and 1095-C are not required to be filed by any employer for 2014. However, in preparation for the first required filing of these forms (that is, filing in 2016 for 2015), employers may, if they wish, voluntarily file in 2015 for 2014 in accordance with the forms and these instructions. For more information about voluntary filing for 2014, visit IRS.gov. No employer shared responsibility payments under section 4980H will apply for 2014 for any employer, regardless of whether they voluntarily file for 2014. For more information on transition relief from the reporting requirements and employer shared responsibility payments for 2014, see Notice 2013-45, 2013-31 I.R.B. 116, at www.irs.gov/irb/2013-31_IRB/ar08.html.

Additional Information

For information related to the Affordable Care Act, visit www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions-Home. For the final regulations under section 6056, see T.D. 9661, 2014-13 I.R.B. 855, at www.irs.gov/irb/2014-13_IRB/ar09.html. For the final regulations under section 6055, see T.D. 9660, 2014-13 I.R.B. 842, at www.irs.gov/irb/2014-13_IRB/ar08.html. For the final regulations under section 4980H, see T.D. 9655, 2014-9 I.R.B. 541, at www.irs.gov/irb/2014-9_IRB/ar05.html. For answers to frequently asked questions regarding the employer shared responsibility provisions, visit IRS.gov.

General Instructions for Forms 1094-C and 1095-C

See *Definitions*, later, for key terms used in these instructions.

Purpose of Form

Employers with 50 or more full-time employees (including full-time equivalent employees) use Forms 1094-C and 1095-C to report the information required under sections 6055 and 6056 about offers of health coverage and enrollment in health coverage for their employees. Form 1094-C must be used to report to the IRS summary information for each employer and to transmit Forms 1095-C to the IRS. Form 1095-C is used to report information about each employee. In addition, Forms 1094-C and 1095-C are used in determining whether an employer owes payments under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used in determining eligibility of employees for premium tax credits.

Employers that offer employer-sponsored self-insured coverage also use Form 1095-C to report information to the IRS and to taxpayers about individuals who are covered by minimum essential coverage under the employer plan and therefore are not liable for the individual shared responsibility payments.

The employer is required to file Forms 1094-C and 1095-C with the IRS and to furnish a copy of Form 1095-C to the employee.

Who Must File

An employer subject to the employer shared responsibility provisions under section 4980H must file one or more Forms 1094-C (including an Authoritative Transmittal, whether or not filing multiple Forms 1094-C), and must file a Form 1095-C (or a substitute form) for each employee who was a full-time employee of the employer for any month of the calendar year. Each employer has its own reporting obligation related to the health coverage the employer offered (or did not offer) to each of its full-time employees. An employer subject to the employer shared responsibility provisions under section 4980H generally refers to an employer with 50 or more full-time employees (including full-time equivalent employees) during the prior calendar year. For more information on which employers are subject to the employer shared responsibility provisions of section 4980H, see *Employer*, later.

An employer that provides health coverage through an employer-sponsored self-insured health plan must also complete Form 1095-C, Part III, for any individual (including any full-time employee, non-full-time employee, employee family members, and others) who enrolled in the self-insured health plan. If an employer offers health coverage through a health plan, and some of the enrollment options under the plan are employer-sponsored self-insured health arrangements while others are not (for example, some of the enrollment options are insured arrangements), the employer must only complete Form 1095-C, Part III, for the employees who enrolled in the self-insured enrollment option(s) under the plan.

An employer that provides health coverage through an employer-sponsored self-insured health plan must complete Form 1095-C, Parts I and III, for any employee who enrolls in the health coverage, whether or not the employee is a full-time employee for any month of the calendar year. If the employee is a full-time employee for any month of the calendar year, the employer must also complete Part II. If, for all 12 months of the calendar year, the employee is not a full-time employee, the employer must complete only Part II, line 14, by entering code 1G in the “All 12 Months” column.

If an employer is providing health coverage in another manner, such as through an insured health plan or a multiemployer health plan, the issuer of the insurance or the sponsor of the plan providing the coverage will provide the information about their health coverage to any enrolled employees, and the employer should not complete Form 1095-C, Part III, for those employees.

An employer that provides employer-sponsored self-insured health coverage but is not subject to the employer shared responsibility provisions under section 4980H, is not required to file Forms 1094-C and 1095-C and reports instead on Forms 1094-B and 1095-B for employees who enrolled in the employer-sponsored self-insured health coverage.

Authoritative Transmittal for Employers Filing Multiple Forms 1094-C

A Form 1094-C must be attached to any Forms 1095-C filed by an employer. An employer may choose to submit multiple Forms 1094-C, each accompanied by Forms 1095-C for some of its employees, provided that, in combination, Forms 1095-C are filed for each employee for whom the employer is required to file. An employer must file a single Form 1094-C reporting aggregate employer-level data for all full-time employees of the employer and identify the form, on line 19 of Part II, as the Authoritative Transmittal. One Authoritative Transmittal must be filed for each employer, even in cases in which multiple Forms 1094-C are filed by and on behalf of the employer (including in the case of a Governmental Unit that has delegated its reporting responsibilities for some of its employees to another Governmental Unit). For example, if an employer has prepared a separate Form 1094-C for each of its 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 all full-time employees of the employer (the employees of both divisions).

One Form 1095-C for Each Employee of Each Employer

For each full-time employee of an employer, there must be only one Form 1095-C for employment with that employer. For example, if an employer separately reports for the full-time employees of its two divisions, the employer must combine the information for any employee who worked at both divisions during the calendar year so that there is only a single Form 1095-C for that employee which reports information for all twelve months of the calendar year.

In contrast, a full-time employee who works for more than one employer that is a member of the same Aggregated ALE Group (that is, works for two separate ALE Members) must receive a separate Form 1095-C from each employer.

When To File

You will meet the requirement to file if the forms are 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.

You must file Forms 1094-C and 1095-C by February 28 if filing on paper (or March 31 if filing electronically) of the year following the calendar year to which the return relates. For calendar year 2014, there is no filing requirement, but employers may voluntarily file Forms 1094-C and 1095-C.

For calendar year 2015, Forms 1094-C and 1095-C are required to be filed by February 29, 2016, (or March 31, 2016, if filing electronically).

Form 1095-C must be furnished to the individual by January 31 of the year following the year to which the return relates. The first Forms 1095-C are due to individuals by February 1, 2016.

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-C and Form 1095-C are subject to the requirements to file returns electronically. Filers of 250 or more information returns must file the returns electronically. The 250-or-more requirement applies separately to each type of return and separately to each type of corrected return.

Pub. 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 Pub. 5165 along with the Extensible Markup Language (XML) Schemas published on IRS.gov. See Pub. 5165 for more information.

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

Corrected Forms 1094-C and 1095-C

Reserved.

Furnishing Forms 1095-C To Employees

You will meet the requirement to file if the forms are 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.

An employer must furnish a Form 1095-C to each of its full-time employees by January 31 of the year following the year to which the Form 1095-C relates.

The first Forms 1095-C are due to individuals by February 1, 2016.

For more information on alternative furnishing methods for employers, see the *Qualifying Offer Method* and the *Qualifying Offer Method Transition Relief for 2015*, later.

Filers of Form 1095-C may truncate the social security number (SSN) of an individual (the employee or any family member of the employee receiving coverage) on Form 1095-C statements furnished to employees 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 filing employer's EIN may not be truncated on either the statement furnished to the employee 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 employee's last known permanent address, or if no permanent address is known, to the employee'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. An individual may consent on paper or electronically, such as by email. If consent is on paper, the individual must confirm the consent electronically. A statement may be furnished electronically by email or by informing the individual how to access the statement on the employer's website.

Specific Instructions for Form 1094-C

Part I—Applicable Large Employer Member (ALE Member)

Line 1. Enter employer's name.

Line 2. Enter the employer's employer identification number (EIN). A social security number (SSN) may not be entered in lieu of an EIN. Enter the 9-digit EIN including the dash.

If you are filing Form 1094-C, a valid EIN is required at the time it is filed. If a valid EIN is not provided, the Form 1094-C will not be processed. 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 more information.

Lines 3–6. Enter the employer's complete address (including room or suite no., if applicable). This address should match the employer's address used on the Form 1095-C.

Lines 7 and 8. Enter the name and telephone number of the person to contact who is responsible for answering any questions.

Note. If you are a Designated Governmental Entity (DGE) filing on behalf of an employer, complete lines 9–16. If you are not a DGE filing on behalf of an employer do not complete lines 9–16. Instead skip to line 18.

Line 9 If a DGE is filing on behalf of the employer, enter the name of the DGE.

Line 10. Enter the DGE's EIN. A social security number (SSN) may not be entered in lieu of an EIN.

If you are a DGE that is filing Form 1094-C, a valid EIN is required at the time the return is filed. If a valid EIN is not provided, the return will not be processed. If the DGE does not have an EIN when filing Form 1094-C it can get an EIN by applying online at IRS.gov or by faxing or mailing a completed Form SS-4, Application for Employer Identification Number. See Publication 1635, Employer Identification Number, for more information.

Lines 11–14. Enter the DGE's complete address (including room or suite no., if applicable).

Lines 15 and 16. Enter the name and telephone number of the person to contact who is responsible for answering any questions.

Line 17. This line is reserved for future use.

Line 18. Enter the total number of Forms 1095-C submitted with this Form 1094-C transmittal.

Part II—ALE Member Information

Line 19. If you are using this Form 1094-C transmittal as the Authoritative Transmittal to report aggregate

employer-level data for the employer, check the box on line 19 and continue completing Part II.

There must be only one Authoritative Transmittal filed for each employer. If only one Form 1094-C is being filed for the employer, that Form 1094-C must report aggregate employer-level data for the employer and be identified on line 19 as the Authoritative Transmittal. If multiple Forms 1094-C are being filed for an employer so that Forms 1095-C for all full-time employees of the employer are not attached to this transmittal (because Forms 1095-C for some full-time employees of the employer are being transmitted separately), one of the Forms 1094-C must report aggregate employer-level data for the employer and be identified on line 19 as the Authoritative Transmittal.

Note. Lines 20–22 should be completed only on the Authoritative Transmittal for the employer. For more information, see *Authoritative Transmittal for Employees Filing Multiple Forms 1094-C*, earlier. If this is not the Authoritative Transmittal for the employer, do not complete lines 20–22, Parts III or IV. Sign Form 1094-C.

Line 20. Enter the total number of Forms 1095-C that will be filed by and/or on behalf of the employer. This includes Forms 1095-C for the employer's full-time employees that are filed with this transmittal, those that will be filed with another transmittal filed by or on behalf of the employer, and Forms 1095-C filed for non-full-time employees who enroll in the employer's employer-sponsored self-insured health plan.

Line 21. If during any month of the calendar year the employer was a member of an Aggregated ALE Group, check "Yes." If you check "Yes," you must also complete the "Aggregated Group Indicator" in Part III, column (d), and Part IV to list the other members of the Aggregated ALE Group. If, for all 12 months of the calendar year, the employer was not a member of an Aggregated ALE Group, check "No," and do not complete Part III, column (d), or Part IV.

Line 22. If the employer meets the eligibility requirements and is using one of the Offer Methods and/or one of the forms of Transition Relief indicated, it must check each applicable box. See the description of the *Offer Methods* and *Section 4980H Transition Relief*, later.

Note. For 2014, Forms 1094-C and 1095-C are not required to be filed by any employer, and no employer shared responsibility payment will apply for 2014 for any employer.

A. Qualifying Offer Method. Check this box if the employer is eligible to use and is using the Qualifying Offer Method for one or more full-time employees. To be eligible to use the Qualifying Offer Method, the employer must certify that, for all months during the year in which the employee was a full-time employee for whom a section 4980H employer shared responsibility payment could apply, the employer made a Qualifying Offer.

If the employer uses this method, it must not provide on Form 1095-C, line 15, the dollar amount required as an employee contribution for the lowest-cost employee-only coverage providing minimum value. It instead must use the Qualifying Offer code 1A on Form 1095-C, line 14, to indicate that the employee received a Qualifying Offer for all 12 months. Use of this method is optional and an employer may, rather than report using this method and the Qualifying Offer code 1A , report on line 14 the applicable offer code and on line 15 the dollar amount required as an employee contribution for the lowest-cost employee-only coverage providing minimum value for that month. An employer may not, for any month, use code 1A and also report the dollar amount required as an employee contribution for the lowest-cost employee-only coverage providing minimum value.

If the employer is eligible to use the Qualifying Offer Method, it may use the Qualifying Offer code 1A for any month for which it made a Qualifying Offer to an employee, even if the employee did not receive a Qualifying Offer for all 12 months. However, the employer must furnish a copy of Form 1095-C to any employee who did not receive a Qualifying Offer for all 12 months, unless the Qualifying Offer Method Transition Relief applies.

Alternative Method of Furnishing to Employees under the Qualifying Offer Method. An employer that is eligible to use the Qualifying Offer Method meets the requirement to furnish the Form 1095-C to its full-time employees who received a Qualifying Offer for all 12 months of the calendar year if it furnishes each of those full-time employees either a copy of Form 1095-C as filed with the IRS or a statement containing the following information.

- Employer name, address, and EIN.
- Contact name and telephone number.
- A statement indicating that, for all 12 months of the calendar year, the employee and his or her spouse and dependents, if any, received a Qualifying Offer and therefore are not eligible for a premium tax credit. See Pub. 974, Premium Tax Credit (PTC), for more information on eligibility for the premium tax credit.

B. 2015 Qualifying Offer Method Transition Relief. Check this box if the employer is eligible for and is using the Qualifying Offer Method Transition Relief for 2015. For the 2015 calendar year, to be eligible to use the Qualifying Offer Method Transition Relief the employer must certify that it made a Qualifying Offer for one or more months of calendar year 2015 to at least 95% of its full-time employees.

If an employer uses this method, it must not provide on Form 1095-C, line 15, the dollar amount required as an employee contribution for the lowest-cost employee-only coverage providing minimum value and instead must use either the Qualifying Offer code 1A or the Qualifying Offer Method Transition Relief code 1I on Form 1095-C, line 14, to indicate the months in 2015 for which the employer is eligible for the Qualifying Offer Method Transition Relief code 1I or the months for which the employee received a Qualifying Offer code 1A. For any months for which the employee received a Qualifying Offer, the employer must report using the Qualifying Offer code 1A to indicate that the employee received a Qualifying Offer for that month. For any month, use of this method is optional, and an employer may, rather than report using this method and the Qualifying Offer code 1A or the Qualifying Offer Method Transition Relief code 1I, report on line 14 the

applicable offer code and on line 15 the dollar amount required as an employee contribution for the lowest-cost employee-only coverage providing minimum value for that month. An employer may not, for any month, use code 1A or code 1I and also report the dollar amount required as an employee contribution for the lowest-cost employee-only coverage providing minimum value.

Alternative Furnishing Methods Under the Qualifying Offer Method Transition Relief for 2015. Solely for 2015, for any employee of an employer eligible for the Qualifying Offer Method Transition Relief who does not receive a Qualifying Offer for all 12 calendar months, including employees who receive no offer, the employer may, in lieu of providing the employee with a copy of Form 1095-C, furnish a statement containing the following information.

- Employer name, address, and EIN.
- Contact name and telephone number.
- A statement indicating that the employee and his or her spouse and dependents, if any, may be eligible for a premium tax credit for one or more months of 2015.

See Pub. 974 for more information on eligibility for the premium tax credit.

An employer that is eligible for the Qualifying Offer Method Transition Relief for any employee who receives a Qualifying Offer for all 12 months of the calendar year may, in lieu of furnishing the employee a copy of Form 1095-C, furnish a statement as described in *Alternative Method of Furnishing to Employees Under the Qualifying Offer Method*, earlier.

C. Section 4980H Transition Relief. Check this box if either (1) 2015 Section 4980H Transition Relief for ALEs with Fewer Than 100 Full-Time Employees, Including Full-Time Equivalent Employees (50-99 Transition Relief) or (2) 2015 Transition Relief for Calculation of Assessable Payments Under Section 4980H(a) for ALEs with 100 or More Full-Time Employees, Including Full-Time Equivalent Employees (100 or More Transition Relief) apply. For a description of the relief, including which employers are eligible for the relief, see *Section 4980H Transition Relief for 2015*, later. If an employer checks this box, it must also complete Form 1094-C, Part III, column (e), Section 4980H Transition Relief Indicator, to indicate the type of section 4980H transition relief for which it is eligible.

D. 98% Offer Method. Select this box if the employer is eligible for and is using the 98% Offer Method. To be eligible to use the 98% Offer Method, an employer must certify that it offered, for all months of the calendar year, affordable health coverage providing minimum value to at least 98% of its employees and their dependents for whom it is filing a Form 1095-C employee statement. The employer is not required to identify which of the employees for whom it is filing were full-time employees, but the employer is still required to file Forms 1095-C on behalf of all of its full-time employees. (For this purpose, the health coverage is affordable if the employer meets one of the section 4980H affordability safe harbors.)

Note. If an employer uses this method, it is not required to complete the "Full-Time Employee Count" in Part III, column (b).

Part III—ALE Member Information—Monthly (Line 23-35)

Column (a) Minimum Essential Coverage Offer Indicator. If the employer offered minimum essential coverage under an eligible employer-sponsored plan to at least 95% of its full-time employees and their dependents for the entire calendar year, enter "X" in the "Yes" checkbox on line 23 for "All 12 Months". If the employer offered minimum essential coverage to at least 95% of its full-time employees and their dependents only for certain calendar months, enter "X" in the "Yes" checkbox for each applicable month. For the months, if any, for which the employer did not offer minimum essential coverage to at least 95% of its full-time employees and their dependents, enter "X" in the "No" checkbox for each applicable month, or enter "X" in the "All 12 Months" box on line 23 if the employer did not offer minimum essential coverage to at least 95% of its full-time employees and their dependents for any of the 12 months. However, an employer that did not offer minimum essential coverage to at least 95% of its full-time employees and their dependents but is entitled to certain transition relief described in the instructions later under *Section 4980H Transition Relief for 2015* should enter an "X" in the "Yes" checkbox for Part III, line 23, column (a), as applicable. See the instructions later under *Section 4980H Transition Relief for 2015*.

Note. For purposes of column (a), an employee in a Limited Non-Assessment Period is not counted in determining whether minimum essential coverage was offered to at least 95% of an employer's full-time employees and their dependents.

For purposes of column (a), if the employer offered minimum essential coverage to all but five of its full-time employees and their dependents, and if five is greater than 5% of the number of full-time employees of the employer, the employer may report in column (a) as if it offered health coverage to at least 95% of its full-time employees and their dependents (even if it offered health coverage to less than 95% of its full-time employees and their dependents, for example to 75 of its 80 full-time employees and their dependents).

See *Definitions*, later, for more information on an offer of health coverage.

Column (b) Full-Time Employee Count for ALE Member. Enter the number of full-time employees for each month, but do not include any employee in a Limited Non-Assessment Period. (If the number of full-time employees (excluding employees in a Limited Non-Assessment Period) for a month is zero, enter 0.)

Note. If the employer certified that it was eligible for the 98% Offer Method by selecting box D, on line 22, it is not required to complete column (b).

Column (c) Total Employee Count for ALE Member. Enter the total number of employees, including full-time employees and non-full-time employees, for each calendar month. An employer must choose to use either the first day of each month or the last day of each month to determine the number of employees per month and must use the same day (first or last day of the month) for

all months of the year. If the total number of employees was the same for every month of the entire calendar year, enter that number in line 23 "All 12 months." If the number of employees for any month is zero, enter 0.

Column (d) Aggregated Group Indicator. An employer must complete this column if it checked "Yes" on line 21, indicating that, during any month of the calendar year, it was a member of an Aggregated ALE Group. If during each month of the calendar year the employer was a member of an Aggregated ALE Group, enter "X" in the "All 12 months" box. If the employer was not a member of an Aggregated ALE Group for all 12 months but was a member of an Aggregated ALE Group for one or more month(s), enter "X" in each month for which it was a member of an Aggregated ALE Group. If an employer enters "X" in one or more months in this column, it must also complete Part IV.

Column (e) Section 4980H Transition Relief Indicator. If the employer certifies by selecting box D on line 22, that it is eligible for Section 4980H Transition Relief and is eligible for the 50 to 99 Relief, enter code A. If the employer certifies by selecting box C on line 22, that it is eligible for Section 4980H Transition Relief and is eligible for the 100 or More Relief, enter code B. An employer will not be eligible for both types of relief.

Part IV—Other ALE Members of Aggregated ALE Group (Lines 36-65)

An employer must complete this section if it checks "Yes" on line 21. If the employer was a member of an Aggregated ALE Group for any month of the calendar year, enter the name(s) and EIN of up to 30 of the other Aggregated ALE Group members. If there are more than 30 members of the Aggregated ALE Group, enter the 30 with the highest monthly average number of full-time employees (as reported in Part III, column (b)) for the year or for the number of months during which the ALE Member was a member of the Aggregated ALE Group. Regardless of the number of members in the Aggregated ALE Group, list the members in descending order listing first the member with the highest average monthly number of full-time employees. The employer must also complete Part III, column (d), to indicate which months it was part of the Aggregated ALE Group

Specific Instructions for Form 1095-C

Part I—Employee

Line 1. Enter the name of the employee.

Line 2. Enter the 9-digit SSN of the employee without the dashes.

Lines 3–6. Enter the employee's complete address (including apartment no., if applicable).

Part I—Applicable Large Employer Member (Employer)

Line 7. Enter the name of the employer.

Line 8. Enter the employer's EIN. Do not enter a SSN in lieu of an EIN. Enter the 9-digit EIN including the dash.

If you are filing Form 1095-C, a valid EIN is required at the time it is filed. If a valid EIN is not provided, the Form 1095-C will not be processed. 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 9 and 11–13. Enter the ALE Member's complete address (including room or suite no., if applicable). This address should match the address reported on lines 3–6 of the Form 1094-C.

Line 10. Enter the telephone number of the person to contact whom the recipient may call about the information reported on the form.

Part II—Employee Offer and Coverage

Line 14. For each calendar month, enter the applicable code from Code Series 1. If the same code applies for all 12 calendar months, enter the applicable code in the "All 12 Months" box and do not complete the individual calendar month boxes.

A code must be entered for each calendar month January through December, even if the employee was not a full-time employee for one or more of the calendar months. Enter the code identifying the type of health coverage actually offered by the employer (or on behalf of the employer) to the employee, if any. Do not enter a code for any other type of health coverage the employer is treated as having offered under the dependent coverage transition relief, non-calendar year transition relief, or multiemployer arrangement interim guidance (if the employer is contributing on behalf of an employee but the employee is not eligible for coverage under the multiemployer plan) under Form 1094-C, Part III, column (a).

Indicator Codes for Employee Offer and Coverage (Form 1095-C, Line 14)

Code Series 1, Offer of Coverage.

- **1A.** Qualifying Offer: Minimum essential coverage providing minimum value offered to full-time employee with employee contribution for self-only coverage equal to or less than 9.5% mainland single federal poverty line and at least minimum essential coverage offered to spouse and dependent(s).

This code may be used to report for specific months for which a Qualifying Offer was made, even if the employee did not receive a Qualifying Offer for all 12 months of the calendar year. However, an employer may not use the Alternative Furnishing Method for an employee who did not receive a Qualifying Offer for all 12 calendar months.

- **1B.** Minimum essential coverage providing minimum value offered to employee only.

- **1C.** Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) (not spouse).
- **1D.** Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to spouse (not dependent(s)).
- **1E.** Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse.
- **1F.** Minimum essential coverage NOT providing minimum value offered to employee, or employee and spouse or dependent(s), or employee, spouse and dependents.
- **1G.** Offer of coverage to employee who was not a full-time employee for any month of the calendar year and who enrolled in self-insured coverage for one or more months of the calendar year. Enter code 1G in the "All 12 Months" box and do not complete the monthly boxes.
- **1H.** No offer of coverage (employee not offered any health coverage or employee offered coverage that is not minimum essential coverage).
- **1I.** Qualified Offer Transition Relief 2015: Employee (and spouse or dependents) received no offer of coverage, received an offer that is not a qualified offer, or received a qualified offer for less than 12 months.

Line 15. Complete line 15 only if the coverage offered to the employee provided minimum value and code 1B, 1C, 1D, or 1E is entered on line 14 either in the "All 12 Months" box or in any of the monthly boxes. Enter the amount of the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that is offered to the employee. Enter the amount including any cents. If the employee is not required to contribute any amount towards the premium, enter "0.00." If the employee share of the lowest-cost monthly amount was the same amount for all 12 calendar months, enter that monthly amount in the "All 12 Months" box and do not complete the monthly boxes. If the employee share of the lowest-cost monthly amount was not the same for all 12 months, enter the amount in each calendar month for which the employee was offered minimum value coverage. If the employer did not offer health coverage, or it offered health coverage that was not minimum essential coverage or did not provide minimum value, do not complete this line.

Line 16. For each calendar month, enter the applicable code from Series 2, but enter only one code from Code Series 2 per calendar month. The instructions below address which code to use for a month if more than one code from Series 2 could apply. If the same code applies for all 12 calendar months, enter the applicable code in the "All 12 Months" box and do not complete individual calendar month boxes. If none of the codes apply for a calendar month, leave the line blank for that month. These codes indicate that under a rule or safe harbor the employer will not be subject to an assessable payment under section 4980H(b) for the month, or that the health coverage offered will be treated as affordable for purposes of section 4980H(b).

Code Series 2—Section 4980H Safe Harbor Codes and Other Relief for Employers

- **2A.** Employee not employed during the month. Enter code 2A if the employee was not employed on any day of the month. Do not use code 2A for a month if the individual is an employee of the employer on any day of the month. Do not use this code for the month during which an employee terminates employment with the employer.
- **2B.** Employee not a full-time employee. Enter code 2B if the employee is not a full-time employee for the month and did not enroll in minimum essential coverage, if offered for the month.
- **2C.** Employee enrolled in coverage offered. Enter code 2C for any month in which the employee enrolled in health coverage offered by the employer, regardless of whether any other code in Code Series 2 might also apply.

Note. If the employee enrolled in the minimum essential coverage offered for the month, enter code 2C (employee enrolled in coverage offered), and not any other in Code Series 2 that might also apply.

- **2D.** Employee in a section 4980H(b) Limited Non-Assessment Period. Enter code 2D for any month during which an employee is in a Limited Non-Assessment Period for section 4980H(b).

If an employee is in an initial measurement period, enter code 2D (employee in a section 4980H(b) Limited Non-Assessment Period) for the month, and not code 2B (employee not a full-time employee). For an employee in a section 4980H(b) Limited Non-Assessment Period for whom the employer is also eligible for the multiemployer interim rule relief for the month code 2E, enter code 2E (multiemployer interim rule relief) and not code 2D (employee in a Limited Non-Assessment Period).

- **2E.** Multiemployer interim rule relief. Enter code 2E for any month for which the multiemployer interim guidance applies for that employee. This relief is described in the *Definitions* under *Offer of Health Coverage*.

Although employers may use the section 4980H affordability safe harbors to determine affordability for purposes of the multiemployer interim guidance, an employer eligible for the relief provided in the multiemployer interim guidance for a month for an employee should enter code 2E (multiemployer interim rule relief), and not a code for the section 4980H affordability safe harbors (codes 2F, 2G, or 2H).

- **2F.** Section 4980H affordability Form W-2 safe harbor. Enter code 2F if the employer used the section 4980H Form W-2 safe harbor to determine affordability for purposes of section 4980H(b) for this employee for the year. If an employer uses this safe harbor for an employee, it must be used for all months of the calendar year for which the employee is offered health coverage.
- **2G.** Section 4980H affordability federal poverty line safe harbor. Enter code 2G if the employer used the section 4980H federal poverty line safe harbor to determine affordability for purposes of section 4980H(b) for this employee for any month(s).
- **2H.** Section 4980H affordability rate of pay safe harbor. Enter code 2H if the employer used the section 4980H rate of pay safe harbor to determine affordability for purposes of section 4980H(b) for this employee for any month(s).

• **2I.** Non-calendar year transition relief applies to this employee. Enter code 2I if non-calendar year transition relief for section 4980H(b) applies to this employee for the month. See the instructions later under *Section 4980H Transition Relief for 2015* and *2015 Section 4980H(b) Transition Relief for Employers with Non-Calendar Year Plans (Form 1095-C, line 16, code 2I)*, for a description of this relief.

Part III—Covered Individuals (Lines 17-22)

Complete Part III ONLY if the employer offers employer-sponsored self-insured health coverage in which the employee enrolled. This part must be completed by an employer offering self-insured health coverage for any employee who enrolled in the coverage, regardless of whether the employee is a full-time employee. If the employer is completing Part III, enter "X" in the check box in Part III. If the employer is not completing Part III, do not enter" X" in the check box in Part III.

For this purpose, employer-sponsored self-insured health coverage does not include coverage under a multiemployer plan.

TIP *Employers that offer employer-sponsored self-insured health coverage to non-employees (for example, non-employee directors) who enroll in the coverage will complete Forms 1094-B and 1095-B, rather than Part III, for those individuals.*

Columns (a) through (d), as applicable, must be completed for each individual enrolled in the coverage, including the employee reported on line 1. A date of birth will be entered in column (c) only if a 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, complete one or more additional Forms 1095-C, Part III.

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

Column (b). Enter the 9-digit SSN for each covered individual without the dashes.

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

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 12 months of the calendar year, check the applicable box(es) for the months in which the individual was covered for at least one day.

Definitions

This section contains the definitions of key terms used in Forms 1094-C and 1095-C and these instructions. For definitions of terms not included in this section, see the final regulations under section 4980H, T.D. 9655, 2014-9 I.R.B. and section 6056, T.D. 9661, 2014-13 I.R.B.

Aggregated ALE Group. An Aggregated ALE Group refers to a group of ALE Members treated as a single employer under section 414(b), 414(c), 414(m), or 414(o). An ALE Member is a member of an Aggregated ALE Group for a month if it is treated as a single employer with the other members of the group on any day of the calendar month. If an ALE is made up of only one person or entity, that one ALE Member is not a part of an Aggregated ALE Group. Government entities and churches or conventions or associations of churches may apply a reasonable, good faith interpretation of the aggregation rules under section 414 in determining their status as an ALE or member of an Aggregated ALE Group.

Applicable Large Employer (ALE). An ALE is, for a particular calendar year, any single employer, or group of employers treated as an Aggregated ALE Group, that employed an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the preceding calendar year. A new employer (that is, an employer that was not in existence on any business day in the prior calendar year) is an ALE for the current calendar year if it reasonably expects to employ, and actually does employ, an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the current calendar year.

Applicable Large Employer Member (ALE Member). An ALE Member is a single person or entity that is an ALE, or if applicable, each person or entity that is a member of an Aggregated ALE Group. A person or entity that does not have employees or only has employees with no hours of service (for example, only employees whose entire service consists of work outside of the United States that does not count as hours of service under section 4980H) is not an ALE Member.

Bona fide volunteer. A bona fide volunteer is an employee of a government entity or tax-exempt organization whose only compensation from that entity or organization is (1) reimbursement for (or reasonable allowance for) reasonable expenses incurred in the performance of services by volunteers, or (2) reasonable benefits (including length of service awards), and nominal fees, customarily paid by similar entities in connection with the performance of services by volunteers.

Dependent. A dependent is an employee's child, including a child who has been legally adopted or legally placed for adoption with the employee, who has not reached age 26. A child reaches age 26 on the 26th anniversary of the date the child was born and is treated as a dependent for the entire calendar month during which he or she reaches age 26. For this purpose, a dependent does not include stepchildren, foster children, or a child that does not reside in the United States (or a country contiguous to the United States) and who is not a United States citizen or national. For this purpose, a dependent does not include a spouse.

Designated Government Entity (DGE). A DGE is a person or persons that are part of or related to the Governmental Unit that is the ALE Member and that is

appropriately designated for purposes of these reporting requirements.

Eligible Employer-Sponsored Plan. An eligible Employer-Sponsored Plan refers to group health insurance coverage for employees under (1) a governmental plan, such as the Federal Employees Health Benefits Program (FEHB), (2) an insured plan or coverage offered in the small or large group market within a state, (3) a grandfathered health plan offered in a group market, or (4) a self-insured group health plan for employees.

Employee. For this purpose, an employee is an individual who is an employee under the common-law standard for determining employer-employee relationships. An employee does not include a sole proprietor, a partner in a partnership, a 2-percent S corporation shareholder, or a worker that is a qualified real estate agent or direct seller. If an employee is an employee of more than one employer of the same Aggregated ALE Group during a calendar month, the employee is treated as an employee of the employer for whom the employee has the greatest number of hours of service for that calendar month; if the employee has an equal number of hours of service for two or more employers of the same Aggregated ALE Group for the calendar month, those employers can treat one of the employers as the employer of that employee for that calendar month and if the employers do not select one employer, or select in an inconsistent manner, the IRS will select an employer to be treated as the employer of that employee for that calendar month. See Publication 15-A, Employer's Supplemental Tax Guide, for more information on determining who is an employee.

Employer. For purposes of these instructions, an employer is the person that is the employer of an employee under the common-law standard for determining employer-employee relationships and that is subject to the employer shared responsibility provisions of section 4980H (these employers are referred to as ALE Members). For more information on which employers are ALE Members, see the definition of Applicable Large Employer Member (ALE Member).

Full-time employee. A full-time employee is an employee who, for a calendar month, is employed an average of at least 30 hours of service per week with the employer. For this purpose, 130 of service hours in a calendar month is treated as the monthly equivalent of at least 30 hours per week. An employer must complete information for all twelve months of the calendar year for any of its employees who were full-time employees for one or more months of the calendar year. For more information, see Regulations sections 54.4980H-1(a)(21) and 54.4980H-3.

Note. A retiree (meaning an individual who was not an employee during the applicable period) is not a full-time employee. However, if the retiree was a full-time employee for any month of the calendar year (for example, before retiring mid-year), the employer must complete information for all twelve months of the calendar year.

Full-time equivalent employee. A combination of employees, each of whom individually is not treated as a full-time employee because he or she is not employed on average at least 30 hours of service per week with an employer, but who, in combination, are counted as the equivalent of a full-time employee solely for purposes of determining whether the employer is an ALE. For rules on how to determine full-time equivalent employees, see Regulations section 54.4980H-2(c).

Governmental Unit and Agency or Instrumentality of a Governmental Unit. A Governmental Unit is the government of the United States, any State or political subdivision thereof, or any Indian tribal government (as defined in section 7701(a)(40)) or subdivision of an Indian tribal government (as defined in section 7871(d)). For purposes of these instructions, references to a Governmental Unit include an Agency or Instrumentality of a Governmental Unit. Until guidance is issued that defines the term Agency of Instrumentality of a Governmental Unit for purposes of section 6056, an entity may determine whether it is an Agency or Instrumentality of a Governmental Unit based on a reasonable and good faith interpretation of existing rules relating to agency or instrumentality determinations for other federal tax purposes.

Health coverage. As used in these instructions, refers to minimum essential coverage, unless otherwise indicated.

Hours of service. An hour of service is each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer, and each hour for which an employee is paid, or entitled to payment, for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. An hour of service does not include any hour of service performed as a Bona Fide Volunteer of a government entity or tax-exempt entity, as part of a Federal Work-Study Program (or a substantially similar program of a State or political subdivision thereof) or to the extent the compensation for services performed constitutes income from sources without the United States. See *www.irs.gov/irb/2014-13_IRB/ar09.html* for a discussion of determination of hours of service for categories of employees for whom the general rules for determining hours of service may present special difficulties (including adjunct faculty and commissioned salespeople) and certain categories of work hours associated with some positions of employment, including layover hours (for example, for certain airline employees) on-call hours, and work performed by an individual who is subject to a vow of poverty as a member of a religious order.

Limited Non-Assessment Period. A Limited Non-Assessment Period generally refers to a period during which an ALE Member will not be subject to an assessable payment under section 4980H(a), and in certain cases section 4980H(b), for a full-time employee, regardless of whether that employee is offered health coverage during that period.

The first five periods described below are Limited Non-Assessment Periods only if the employee is offered

health coverage by the first day of the first month following the end of the period, and are Limited Non-Assessment Periods for section 4980H(b) only if the health coverage that is offered at the end of the period provides minimum value. For more information on Limited Non-Assessment Periods and the application of section 4980H, see Regulations section 54.4980H-1(a)(26).

- First Year as ALE Period. January through March of the first calendar year in which an employer is an ALE, but only for an employee who was not offered health coverage by the employer at any point during the prior calendar year. For this purpose, 2015 is not the first year an employer is an ALE, if that employer was an ALE in 2014 (notwithstanding that transition relief provides that no employer shared responsibility payments under section 4980H will apply for 2014 for any employer).
- Waiting Period under the Monthly Measurement Method. If an employer is using the monthly measurement method to determine whether an employee is a full-time employee, the period beginning with the first full calendar month in which the employee is first otherwise (but for completion of the waiting period) eligible for an offer of health coverage and ending no later than two full calendar months after the end of that first calendar month.
- Waiting Period under the Look-Back Measurement Method. If an employer is using the look-back measurement method to determine whether an employee is a full-time employee and the employee is reasonably expected to be a full-time employee at his or her start date, the period beginning on the employee's start date and ending not later than the end of the employee's third full calendar month of employment.
- Initial Measurement Period and Associated Administrative Period under the Look-Back Measurement Method. If an employer is using the look-back measurement method to determine whether a new employee is a full-time employee, and the employee is a variable hour employee, seasonal employee or part-time employee, the initial measurement period for that employee and the administrative period immediately following the end of that initial measurement period.
- Period Following Change in Status that Occurs During Initial Measurement Period Under the Look-Back Measurement Method. If an employer is using the look-back measurement method to determine whether a new employee is a full-time employee, and, as of the employee's start date, the employee is a variable hour employee, seasonal employee or part-time employee, but, during the initial measurement period, the employee has a change in employment status such that, if the employee had begun employment in the new position or status, the employee would have reasonably been expected to be a full-time employee, the period beginning on the date of the employee's change in employment status and ending not later than the end of the third full calendar month following the change in employment status. If the employee is a full-time employee based on the initial measurement period and the associated stability period starts sooner than the end of the third full calendar month following the change in employment status, this Limited Non-Assessment Period ends on the day before the first day of that associated stability period.
- First Calendar Month of Employment. 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.

Minimum essential coverage (MEC). Although various types of health coverage may qualify as minimum essential coverage, for purposes of these instructions, minimum essential coverage refers to health coverage under an eligible employer-sponsored plan. For more details on *Minimum essential coverage*, see Minimum essential coverage in Pub. 974.

Minimum value. A plan provides minimum value if the plan pays at least 60 percent of the costs of benefits.

Offer of health coverage. An offer to an employee providing the employee an effective opportunity to enroll in the health coverage (or to decline that coverage) at least once for each plan year. An employer makes an offer of health coverage to an employee for the plan year if it continues the employee's election of coverage from a prior year but provides the employee an effective opportunity to opt out of the health coverage. If an employer provides health coverage to an employee but does not provide the employee an effective opportunity to decline the coverage, the employer is treated as having made an offer of health coverage to the employee only if that health coverage provides minimum value and does not require an employee contribution for the coverage for any calendar month of more than 9.5 percent of a monthly amount determined as the mainland federal poverty line for a single individual for the applicable calendar year, divided by 12.

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, if an employee's employment terminates before the last day of a calendar month and the health coverage also ends before the last day of that calendar month, the employer will still have 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.

An employer offers health coverage to an employee if it, or another employer in the Aggregated ALE Group, or a third party such as a multiemployer or single employer Taft-Hartley plan, a multiple employer welfare arrangement (MEWA), or, in certain cases, a staffing firm, offers health coverage on behalf of the employer.

Interim Guidance Regarding Multiemployer Arrangements. An employer is treated as offering health coverage to an employee if the employer is required by a collective bargaining agreement or related participation agreement to make contributions for that employee to a multiemployer plan that offers, to individuals who satisfy the plan's eligibility conditions, health coverage that is affordable and provides minimum value, and that also offers health coverage to those individuals' dependents. For more information, see section XV.E of the preamble to the final section 4980H regulations.

Qualifying offer. A qualifying offer is an offer of MEC providing minimum value to one or more full-time employees for all calendar months during the calendar year for which the employee was a full-time employee for whom a section 4980H assessable payment could apply, at an employee cost for employee-only coverage for each month not exceeding 9.5 percent of the mainland single federal poverty line divided by 12, provided that the offer includes an offer of MEC to the employee's spouse and dependents (if any).

Section 4980H Transition Relief for 2015

This section describes various types of section 4980H transition relief and how an employer reports its eligibility for any particular type of relief. For more details regarding this, and other, section 4980H transition relief, see section XV of the preamble to the final regulations under section 4980H.

The transition relief described in this section is solely for the employer for purposes of section 4980H and does not affect the employee's potential eligibility for the premium tax credit. Accordingly, regardless of whether the employer is eligible for relief under section 4980H for an employee for one or more months, the Form 1095-C for that employee must accurately reflect the health coverage offered to that employee (if any) during that period, including, if applicable, the required employee contribution.

An employer eligible for this relief is still subject to the Forms 1094-C and 1095-C reporting requirements for 2015.

2015 Section 4980H Transition Relief Based on Number of Full-Time Employees (Form 1094-C, Line 22, Box C, and Form 1094-C, Lines 23-35, Column (e))

An employer may be eligible for one of the two types of 2015 transition relief under section 4980H based on the employer's number of full-time employees (and full-time equivalent employees) if certain conditions described below are met. One of these two types of 2015 transition relief under section 4980H is for employers with 50 to 99 full-time employees and the other type of relief is for employers with 100 or more full-time employees (in each case including full-time equivalent employees). Eligibility for this transition relief is reported on Form 1094-C, line 22, box C, and the specific form of relief for which the employer is eligible must be reported on Form 1094-C, Lines 23-35, column (e), using either code A (50-99 Transition Relief) or code B (100 or more Transition Relief).

For purposes of determining eligibility for either of these types of section 4980H transition relief, the number of full-time employees (including full-time equivalent employees) for 2015 is determined in the same way that an employer determines whether it is an ALE (including using employment and hours of service data from 2014) and is calculated for the Aggregated ALE Group (rather than for each employer).

1. **2015 Section 4980H Transition Relief for ALEs with Fewer Than 100 Full-Time Employees, Including Full-Time Equivalent Employees (50-99 Transition Relief)**. For an employer that is eligible for this 2015 transition relief, no assessable payment under section 4980H(a) or (b) will apply for any calendar month during 2015 and, if the employer has a non-calendar-year plan, will not apply for the portion of the 2015 plan year that falls in 2016. To certify that an employer is eligible for this transition relief it must have met the following conditions:

- The employer is an ALE or is part of an Aggregated ALE Group that had 50 to 99 full-time employees, including full-time equivalent employees, on business days in 2014;
- During the period of February 9, 2014, through December 31, 2014, the ALE or the Aggregated ALE Group of which the employer is a member did not reduce the size of its workforce or reduce the overall hours of service of its employees in order to qualify for the transition relief; and
- During the period of February 9, 2014, through December 31, 2015, (or, if the employer has a non-calendar-year plan(s)), ending on the last day of the 2015 plan year) the ALE or Aggregated ALE Group of which the employer is a member does not eliminate or materially reduce the health coverage, if any, it offered as of February 9, 2014.

Example. As of February 9, 2014, Employer A (which is an ALE with only one ALE Member) sponsors a group health plan with a calendar year plan year under which 40 of its full-time employees are offered health coverage that provides minimum value and with an employer contribution of $300 per month for employee-only coverage. The offer of health coverage is affordable for some, but not all, of Employer A's full-time employees. During the period from February 9, 2014, through December 31, 2014, two of Employer A's employees voluntarily terminate employment and Employer A terminates three employees because of the non-renewal of a customer contract but does not otherwise reduce the size of its workforce or reduce any employee's hours of service. Had those five employees continued in employment throughout 2014, the employer would have had an average of 100 full-time employees (including full-time equivalent employees) on business days in 2014. However, as a result of the terminations, it had an average of only 97 full-time employees (including full-time equivalent employees) for business days in 2014. During the period of February 9, 2014, through December 31, 2015, Employer A does not change the eligibility requirements for the group health plan (including not amending it to eliminate its existing health coverage for dependents) and continues to make an employer contribution of $300 per month toward the cost of employee-only coverage that provides minimum value. Employer A certifies in a timely manner as to its eligibility for the transition relief; Employer A is eligible for the transition relief.

2. **2015 Transition Relief for Calculation of Assessable Payments Under Section 4980H(a) for ALEs with 100 or More Full-Time Employees, Including Full-Time Equivalent Employees (100 or More Transition Relief).** As 2015 transition relief, for each month in 2015 (and, in addition, for the portion of the 2015 plan year that ends in 2016 if the employer has a

non-calendar year plan), if an employer is an ALE or is part of an Aggregated ALE Group that had 100 or more full-time employees (including full-time equivalent employees) on business days in 2014, and is subject to an assessable payment under section 4980H(a), the assessable payment under section 4980H(a) is calculated by reducing the employer's number of full-time employees by that employer's allocable share of 80 (rather than by the employer's standard allocable share of 30). For the rules on how the 80 employee reduction is allocated among the employers in an Aggregated ALE Group, see Regulations section 54.4980H-4(e).

2015 Section 4980H(a) Transition Relief if an Offer of Health Coverage is Made to at least 70 Percent of Full-Time Employees (Form 1094-C, Lines 23–35, Column (a))

For each calendar month during 2015 (and any calendar months during the 2015 plan year that occur in 2016, if the employer has a non-calendar year plan), an employer that offers health coverage to at least 70 percent of its full-time employees (and their dependents) may, on Form 1094-C, lines 23–35, column (a), enter an "X" in the "Yes" checkbox either for "All 12 months" or for the month(s) during which it met that 70-percent threshold, as applicable.

2015 Section 4980H(a) Transition Relief for Certain Arrangements that do not Offer Health Coverage for Dependents (Form 1094-C, Lines 23–35, Column (a))

For the 2014 and 2015 plan years, for an employee who was not offered dependent health coverage during the 2013 or 2014 plan years, an employer may treat, solely for purposes of section 4980H, an offer of health coverage to a full-time employee but not his or her dependents, as an offer of health coverage to the full-time employee and his or her dependents, if the employer takes steps during the 2014 or 2015 plan year (or both) to extend coverage under the plan to dependents not offered coverage during the 2013 or 2014 plan year (or both). An employer using this transition relief for a calendar year is not eligible to report using the Qualifying Offer Method (or the Qualifying Offer Transition Relief Method) for that calendar year.

2015 Section 4980H(a) Transition Relief for Employers with Non-Calendar Year Plans (Form 1094-C, Lines 23–35, Column (a))

An employer that sponsored a non-calendar year health plan as of December 27, 2012, (or two or more health plans with the same non-calendar year plan year) may be eligible for certain transition relief. The relief would apply for some or all of its employees for the period during 2015 before the beginning of the 2015 plan year (for example, the months January, February, and March 2015 for an employer with a plan year starting April 1, 2015). In certain circumstances described below, this relief applies so that an employee and his or her dependents may be treated for purposes of section 4980H(a) as offered minimum essential coverage during that period even if not actually offered minimum essential coverage. An employer that is eligible for the relief may treat the employee and his or her dependents as offered minimum essential coverage for purposes of Form 1094-C, Part III, column (a), (and specifically for purposes of determining whether to enter an "X" in the "Yes" or "No" checkbox for the months during that period). See instructions for *2015 Section 4980H(b) Transition Relief for Employers with Non-Calendar Year Plans (Form 1095-C, line 16)*, later.

Treatment of full-time employees eligible for the non-calendar year plan. For an employee of the employer (whenever hired) who was eligible for health coverage under that non-calendar year health plan effective beginning on the first day of the 2015 plan year under the eligibility terms of the plan as in effect on February 9, 2014, for purposes of Form 1094-C, Part III, column (a), the employer may treat the employee (and his or her dependents) as having been offered coverage for the months in 2015 prior to the 2015 plan year if the employee was offered health coverage no later than the first day of the 2015 plan year.

Treatment of full-time employees not eligible for the non-calendar year plan—Significant percentage transition guidance (all employees). If an employer otherwise eligible for the relief described in this section (1) had at least 1/4 of its employees enrolled in health coverage under the non-calendar year plan as of any date in the 12 months ending on February 9, 2014, or (2) offered health coverage under the non-calendar year plan to at least 1/3 of its employees during the open enrollment period that ended most recently before February 9, 2014, for purposes of Form 1094-C, Part III, column (a), Minimum Essential Coverage Offer Indicator, the employer may treat an employee who was not offered coverage for the months in 2015 prior to the 2015 plan year (and his or her dependents) as having been offered coverage for that period if the employee was offered health coverage no later than the first day of the 2015 plan year.

Treatment of full-time employees not eligible for the non-calendar year plan—Significant percentage transition guidance (full-time employees). If an employer otherwise eligible for the relief in this section (1) had at least 1/3 of its full-time employees enrolled in health coverage under the non-calendar year plan as of any date in the 12 months ending on February 9, 2014, or (2) offered health coverage under the plan to at least 1/2 of its full-time employees during the open enrollment period that ended most recently before February 9, 2014, for purposes of Form 1094-C, Part III, column (a), Minimum Essential Coverage Offer Indicator, the employer may treat an employee (and his or her dependents) as having been offered coverage for the months in 2015 prior to the 2015 plan year if the employee was offered health coverage no later than the first day of the 2015 plan year.

2015 Section 4980H(b) Transition Relief for Employers with Non-Calendar Year Plans (Form 1095-C, Line 16, Code 2I)

Relief under section 4980H(b) for an employee for the months in 2015 prior to the 2015 plan year is available for an employer that met the conditions described above under 2015 Section 4980H(a) Transition Relief for Employers with Non-Calendar Year Plans (Form 1094-C,

Lines 23-35, column (a)), if the coverage offered to the employee by the beginning of the 2015 plan year was affordable and provided minimum value. In that case, the employee may be treated for purposes of section 4980H(b) as offered minimum essential coverage providing minimum value that is affordable for the months prior to the 2015 plan year. An employer that meets these requirements reports its eligibility on the Form 1095-C, line 16, code 2I for each full-time employee for which the employer is eligible for this relief.

Section 4980H Transition Relief for Health Coverage for January 2015 (Form 1094-C, Lines 23-24, column (a) and Form 1095-C, Line 14)

Solely for January 2015, if an employer offers health coverage to an employee no later than the first day of the first payroll period that begins in January 2015, the employer is treated as having offered health coverage for January 2015. An employer that is eligible for this transition relief for an employee for January 2015 should treat that employee as having been offered minimum essential coverage for January 2015 for purposes of Form 1094-C, line 23 or 24 (whichever is applicable), column (a). An employer that is eligible for this transition relief would report on Form 1095-C, line 14 that it offered its employee health coverage for the month of January. There is not a specific indicator code to reflect this transition relief.

Interim Guidance Regarding Multiemployer Arrangements. For a description of the treatment of certain coverage provided through a multiemployer arrangement, see the definition of offer of health coverage in the *Definitions* section.

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 Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224. Do not send the form to this office. Instead, see *Where To File* earlier.

IRS

Affordable Care Act Topics

- Individuals and Families
- Employers
- Other Organizations
- List of Tax Provisions
- Legal Guidance and Other Resources
- Questions and Answers
- Health Care Tax Tips
- Affordable Care Act Tax Provisions Home

- Disposiciones Tributarias de la Ley de Cuidado de Salud a Bajo Precio

Questions and Answers on Reporting of Offers of Health Insurance Coverage by Employers (Section 6056)

Information reporting under section 6056 is voluntary for calendar year 2014. Reporting is first required in early 2016 with respect to calendar year 2015. For more information, see question 2.

Basics of Employer Reporting

1. What are the information reporting requirements for employers relating to offers of health insurance coverage under employer-sponsored plans?

The Affordable Care Act added section 6056 to the Internal Revenue Code, which requires applicable large employers to file information returns with the IRS and provide statements to their full-time employees about the health insurance coverage the employer offered. (For a definition of applicable large employer, see question 5, below.)

Under the regulations implementing section 6056, an applicable large employer may be a single entity or may consist of a group of related entities (such as parent and subsidiary or other affiliated entities). In either case, these reporting requirements apply to each separate entity and each separate entity is referred to as an applicable large employer member (ALE member). See question 7 for more information about the treatment of related entities.

The IRS will use the information provided on the information return to administer the employer shared responsibility provisions of section 4980H. The IRS and the employees of an ALE member will use the information provided as part of the determination of whether an employee is eligible for the premium tax credit under section 36B.

ALE members that sponsor self-insured group health plans also are required to report information under section 6055 about the health coverage they provide (See our section 6055 FAQs). Those ALE members that sponsor self-insured group health plans file with the IRS and furnish to employees the information required under sections 6055 and 6056 on a single form. The IRS and individuals will use the information provided under section 6055 to administer or to show compliance with the individual shared responsibility provisions of section 5000A.

2. When do the information reporting requirements go into effect?

The information reporting requirements under section 6056 are first effective for coverage offered (or not offered) in 2015. An ALE member must file information returns with the IRS and furnish statements to employees beginning in 2016, to report information about its offers of health coverage to its full-time employees for calendar year 2015.

Notice 2013-45 provides transition relief for 2014 from the section 6056 reporting requirements and the section 6055 reporting requirements for health coverage providers and, thus, the section 4980H employer shared responsibility provisions as well. Accordingly, neither the reporting requirements nor the employer shared responsibility provisions apply for 2014. The transition relief applies to all ALE members including for-profit, non-profit, and government entity employers. However, in preparation for the application of the employer shared responsibility provisions beginning in 2015, employers and other affected entities may comply voluntarily for 2014 with the information reporting provisions and are encouraged to maintain or expand coverage in 2014. Returns filed voluntarily will have no impact on the tax liability of the employer. For more information about voluntary filing in 2015, including the requirements for filing electronic returns, see IRS.gov.

3. Is relief available from penalties for incomplete or incorrect returns filed or statements furnished to employees in 2016 for coverage offered (or not offered) in calendar year 2015?

Yes. In implementing new information reporting requirements, short-term relief from reporting penalties frequently is provided. This relief generally allows additional time to develop appropriate procedures for collection of data and compliance with the new reporting requirements. Accordingly, the IRS will not impose penalties under sections 6721 and 6722 on ALE members that can show that they have made good faith efforts to comply with the information reporting requirements. Specifically, relief is provided from penalties under sections 6721 and 6722 for returns and statements filed and furnished in 2016 to report offers of coverage

in 2015 for incorrect or incomplete information reported on the return or statement. No relief is provided in the case of ALE members that cannot show a good faith effort to comply with the information reporting requirements or that fail to timely file an information return or furnish a statement. However, consistent with existing information reporting rules, ALE members that fail to timely meet the requirements still may be eligible for penalty relief if the IRS determines that the standards for reasonable cause under section 6724 are satisfied. See question 24 for more information about penalties under sections 6721 and 6722.

4. Where is more detailed information available about these reporting requirements?

The regulations under section 6056 provide further guidance on the information reporting requirements for applicable large employers, and the regulations under section 6055 provide guidance on the information reporting requirements for insurers and other health coverage providers. Regulations on the employer shared responsibility provisions under section 4980H provide guidance on determining applicable large employer status and determining full-time employee status, including defining and providing rules for calculating hours of service.

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Who is Required to Report

5. Who is required to report under section 6056?

Applicable large employers that are subject to the employer shared responsibility provisions under section 4980H are required to report under section 6056. An applicable large employer is an employer that employed an average of at least 50 full-time employees on business days during the preceding calendar year. A full-time employee generally includes any employee who was employed on average at least 30 hours of service per week and any full-time equivalents (for example, 40 full-time employees employed 30 or more hours per week on average plus 20 employees employed 15 hours per week on average are equivalent to 50 full-time employees). For purposes of the reporting requirements under section 6056, an ALE member is any person that is an applicable large employer or a member of an aggregated group (determined under section 414(b), 414(c), 414(m) or 414(o)) that is determined to be an applicable large employer. See question 7 for information about aggregated groups.

Additional information about who is an applicable large employer and transition relief under section 4980H is available in regulations issued under section 4980H and in related FAQs on the employer shared responsibility provisions (see questions 4 through 17 and 29 through 39 of those FAQs).

6. Are nonprofit and government entities required to report under section 6056?

Yes. Section 6056 applies to all employers that are ALE members, regardless of whether the employer is a tax-exempt or government entity (including federal, state, local, and Indian tribal governments).

7. If two or more related companies together are an applicable large employer under section 4980H, how do they comply with the information reporting requirements?

For purposes of the information reporting requirements under section 6056, each ALE member must file an information return with the IRS and furnish a statement to its full-time employees, using its own EIN. All persons treated as a single employer under section 414(b), (c), (m), or (o) are treated as one employer for purposes of determining applicable large employer status under section 4980H. Under those rules, companies will be 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 will be an applicable large employer. Each of the companies that is combined is referred to as an ALE member. When the combined total of full-time employees (including full-time equivalents) meets the threshold, each separate company or ALE member is subject to the employer shared responsibility provisions even if a particular company or companies individually do not employ enough employees to meet the 50-full-time-employee threshold. See questions 15 through 17 of the employer shared responsibility provision FAQs for more information about calculating the number of full time employees (including full time equivalents).

For purposes of section 6056 reporting, government entities, churches, and a convention or association of churches should use the same interpretation of section 414(b), (c), (m) and (o) as that used for purposes of section 4980H in determining whether a person or group of persons is an applicable large employer and whether a particular entity is an ALE member.

8. Who is not required to report under section 6056?

Employers that are not subject to the employer shared responsibility provisions of section 4980H are not required to report under section 6056. Thus, employers that employed fewer than 50 full-time employees (including full-time equivalents) during the prior year are not subject to the reporting requirements. (However, any employer that sponsors a self-insured health plan is required to report under section 6055, even if the employer has fewer than 50 full-time employees.)

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Methods of Reporting

9. Are different methods available to ALE members for reporting required information to the IRS and furnishing statements to employees?

Yes. The regulations provide a general method (see question 10, below) that all ALE members may use for reporting to the IRS and for furnishing statements to full-time employees, and also provide alternative reporting methods (see question 11, below) for eligible ALE members. If an ALE member cannot use the alternative reporting methods for certain employees, the ALE member must use the general method for those employees. In any case, the alternative reporting methods are optional so that an employer may choose to report for all of its full-time employees using the general method even if an alternative reporting method is available.

In an effort to simplify the section 6056 reporting process, certain information required to be reported to the IRS and furnished to full-time employees may be reported through the use of indicator codes rather than by providing more detailed information. For further details about the section 6056 reporting process, see the reporting forms and instructions.

10. What is the general method of reporting?

The regulations provide that, as a general method, each ALE member may satisfy the requirement to file a section 6056 return by filing a Form 1094-C (transmittal) and, for each full-time employee, a Form 1095-C (employee statement), or other forms the IRS may designate. An ALE member that maintains a self-insured plan also uses a Form 1095-C to satisfy the reporting requirements under section 6055. The Form 1095-C will have separate sections to allow ALE members that sponsor self-insured group health plans to combine reporting to satisfy both the section 6055 reporting requirements and the section 6056 reporting requirements, as applicable, on a single return. See question 16 for more information about combined reporting on a single return.

For example, an ALE member that sponsors a self-insured plan will complete the transmittal Form 1094-C and both sections of Form 1095-C to report information under section 6055 about health coverage provided and information under section 6056 about offers of health coverage. An ALE member that sponsors an insured plan will complete the transmittal Form 1094-C and the section of Form 1095-C addressing the information under section 6056.

Non-ALE members (meaning employers not subject to the employer shared responsibility provisions under section 4980H and therefore not subject to the information reporting requirements under section 6056) that sponsor self-insured plans will file Forms 1094-B and 1095-B to satisfy the reporting requirements under section 6055.

Under the general method, the section 6056 return (and, if the employer maintains a self-insured plan, the section 6055 return) also may be made by filing a substitute form but the substitute form must include all of the information required on Forms 1094-C and 1095-C or any other forms the IRS designates and satisfy all form and content requirements as specified by the IRS.

Drafts of the forms, including Forms 1094-B, 1095-B, 1094-C, and 1095-C, are available at irs.gov/draftforms, and final versions of the forms will be made available in accordance with usual procedures.

11. What are the alternative methods of reporting?

The regulations contain two alternative methods of reporting under section 6056 that were developed to minimize the cost and administrative tasks for employers, consistent with the statutory requirements to file an information return with the IRS and furnish an employee statement to each full-time employee. The alternative reporting methods, in certain situations, may permit employers to provide less detailed information than under the general method for reporting. These simplified alternative reporting methods and the conditions for using them are described in detail in Subsections A through D of the preamble to the section 6056 regulations. The alternative reporting methods are:

- Reporting Based on Certification of Qualifying Offers
- Option to Report Without Separate Identification of Full-Time Employees if Certain Conditions Related to Offers of Coverage Are Satisfied (98 Percent Offers)

The information provided to the IRS and the employee pursuant to section 6056 is important for administering section 4980H and the premium tax credit. However, in some circumstances, only some of the information required under the general method is necessary. Accordingly, the alternative reporting methods identify specific groups of employees for whom simplified alternative reporting would provide sufficient information.

12. For the methods of reporting, including reporting facilitated by a third party, may an ALE member file more than one Form 1094-C?

Yes. A separate section 6056 transmittal (Form 1094-C) must be filed with any Forms 1095-C filed by each ALE member. If more than one section 6056 transmittal is being filed for an ALE member, one of those transmittals must be a section 6056 authoritative transmittal reporting aggregate employer-level data for all full-time employees of the ALE member, in accordance with forms and instructions.

13. May an ALE member satisfy its reporting requirements for an employee by filing and furnishing more than one employee statement that together provide the necessary information?

No. There must be only one section 6056 employee statement (Form 1095-C) for each full-time employee with respect to that full-time employee's employment with the ALE member, so that all information for a particular full-time employee of the ALE member is reflected on a single Form 1095-C. Further details will be provided in forms and instructions.

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What Information Must ALE Members Report

14. What information must an ALE member report to the IRS to satisfy section 6056?

The regulations provide, under the general method of reporting, that an ALE member must file a separate Form 1095-C (or other form the IRS designates, or a substitute form) for each of its full-time employees, and a transmittal on Form 1094-C (or any other form the IRS designates, or a substitute form) for all of the returns filed for a given calendar year. A more complete discussion of the information that must be reported to the IRS (including simplified methods of reporting) can be found in the final section 6056 regulations at Sections IX.B and C.

15. What information must an ALE member furnish to its full-time employees to satisfy section 6056?

The regulations provide that under the general method, an ALE member generally must furnish to each full-time employee a written statement showing:

- The name, address, and EIN of the ALE member
- The information required to be shown on the section 6056 return with respect to the full-time employee (and his or her spouse and dependents)

Employers are not required to include with the employee statement a copy of the transmittal form (Form 1094-C) that is filed with the IRS.

Under the general method, the required written statement furnished to full-time employees may be either a copy of the Form 1095-C or another form the IRS designates or a substitute form. A substitute form must include the information on the return required to be filed with the IRS and comply with requirements for substitute forms.

16. May an employer combine reporting under sections 6055 and 6056?

The regulations under sections 6055 and 6056 provide for combined reporting for employers that are subject to both reporting provisions (generally ALE members that sponsor self-insured group health plans). To allow these employers to satisfy both the section 6055 and 6056 reporting requirements on a single return form 1095-C will have separate sections for reporting under section 6055 and for reporting under section 6056.

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How and When to Report the Required Information

17. When must an ALE member file the required information return with the IRS?

ALE members must file the return for each employee (Form 1095-C or another form that IRS designates, or a substitute form) and a transmittal form (Form 1094-C or another form that IRS designates, or a substitute form) with the IRS on or before February 28 (March 31 if filed electronically) of the year immediately following the calendar year for which the offer of coverage information is reported. Because transition relief applies for section 6056 reporting for 2014 (see Notice 2013-45), the first section 6056 returns required to be filed are for the 2015 calendar year and must be filed no later than March 1, 2016 (February 28, 2016, being a Sunday), or March 31, 2016, if filed electronically. Regulations under section 6081 address extensions of time to file information returns.

18. When must an ALE member furnish the statements to full-time employees?

ALE members must furnish the statement to each full-time employee on or before January 31 of the year immediately following the calendar year to which the information relates. This means that the first section 6056 employee statements (the statements for 2015) must be furnished to employees no later than February 1, 2016 (January 31, 2016, being a Sunday).

19. Must an ALE member file the return with the IRS electronically?

The regulations require electronic filing with the IRS of section 6056 information returns except for an ALE member filing fewer than 250 section 6056 returns (employee statements) during the calendar year. Each section 6056 return for each full-time employee is counted as a separate return, and only section 6056 returns are counted in applying the 250-return threshold for section 6056 reporting.

20. Must an ALE member furnish the employee statements to full-time employees electronically?

The regulations permit, but do not require, employers to furnish electronically the section 6056 employee statements to full-time employees if notice, consent, and hardware and software requirements modeled after existing rules are met. The regulations require that with respect to each full-time employee to whom the information is furnished, the ALE member must obtain consent from the employee before the section 6056 employee statement may be furnished electronically.

21. Are ALE members required to report information with respect to a full-time employee who is not offered coverage during the year?

Yes. An ALE member is required to report information about the health coverage, if any, offered to its full-time employees, including whether an offer of health coverage was (or was not) made. This requirement applies to all ALE members, regardless of whether they offered health coverage to all, none, or some of their full-time employees. For each of its full-time employees, whether health coverage was or was not offered to the employee, the ALE member is required to file a return with the IRS and furnish a statement to the employee reporting on whether an offer of health coverage was or was not made to the employee, and, if an offer was made, reporting the required information about the offer. Therefore, even if an ALE member does not offer coverage to any of its full-time employees, it must file returns with the IRS and furnish statements to each of its full-time employees to report information specifying that coverage was not offered.

22. May an employer that is a governmental unit designate a third party to file the return and furnish the statements under section 6056 on its behalf?

Yes. The regulations provide that an ALE member that is a governmental unit (defined as the government of the United States, any State or political subdivision thereof, or any Indian tribal government (as defined in section 7701(a)(40)) or subdivision of an Indian tribal government (as defined in section 7871(d)), may report under section 6056 on its own behalf or may appropriately designate another person or persons to report on its behalf. A person may be appropriately designated to file the return and furnish the statements under section 6056 on behalf of the ALE member if the person is part of or related to the same governmental unit as the ALE member.

A separate section 6056 return must be filed for each ALE member for which the appropriately designated person is reporting. The designated entity would provide the name, address and EIN of both the designated entity and the ALE member for which it is reporting. Additionally, the regulations require that there be a single identified section 6056 transmittal (Form 1094-C) reporting aggregate employer-level data for all full-time employees of the ALE member (including full-time employees of the ALE member the reporting for which has been transferred to a designated person), and that there be only one section 6056 employee statement (Form 1095-C) for each full-time employee of the ALE member with respect to employment with that ALE member. Further details will be provided in forms and instructions.

The designated person must agree that it is the appropriately designated person for the governmental unit and that it is responsible for reporting under section 6056 on behalf of the ALE member. Thus, the appropriately designated person must agree that it is responsible for the information reporting under section 6056 and is subject to the information reporting penalty provisions of sections 6721 and 6722. However, the ALE member remains subject to section 4980H.

23. May an employer hire a third party administrator or other third party service provider to file the return with the IRS and furnish the statements to employees required under section 6056?

Yes. Reporting arrangements between ALE members, issuers, and other parties are not prohibited. However, entering into a reporting arrangement does not transfer the ALE member's potential liability under section 4980H and (except in the case of a related entity properly designated by a governmental unit) does not transfer the potential liability for failure of the ALE member to file returns and furnish statements under section 6056. If a person who prepares returns or statements required under section 6056 is a tax return preparer, that person will be subject to the requirements generally applicable to tax return preparers.

ALE members are responsible for reporting under section 6056. Generally, each ALE member must file separate section 6056 returns providing that ALE member's EIN. If more than one third party is facilitating reporting for an ALE member, there must be only one section 6056 authoritative transmittal (Form 1094-C) reporting aggregate employer-level data for all full-time employees of the ALE member. Additionally, there must be only one section 6056 employee statement (Form 1095-C) for each full-time employee with respect to employment with that ALE member. Further details will be provided in forms and instructions.

24. May an administrator of a multiemployer plan prepare the return and furnish the statements under section 6056 for an ALE member that is a participating employer under the multiemployer plan?

Yes. Section 6056 reporting regarding full-time employees on behalf of whom an ALE member contributed to a multiemployer plan is permitted under an approach whereby the multiemployer plan administrator would prepare returns pertaining to the ALE member's full-time employees covered by the collective bargaining agreement who are eligible to participate in the multiemployer plan. The ALE member would prepare returns pertaining to any of its full-time employees who are not eligible to participate in a multiemployer plan. Under this approach, the administrator of the multiemployer plan would facilitate the filing of a separate section 6056 return for each ALE member that is a contributing employer on behalf of whom it files. The administrator of the multiemployer plan also may assist the ALE member in furnishing statements to its full-time employees who are eligible to participate in the multiemployer plan.

The regulations also require that there be a single identified section 6056 authoritative transmittal (Form 1094-C) reporting aggregate employer-level data for all full-time employees of the ALE member (including full-time employees of the ALE member the reporting for which was done by a multiemployer plan administrator), and that there be only one section 6056 employee statement (Form 1095-C) for each full-time employee with respect to employment with that ALE member. Further details will be provided in forms and instructions.

The ALE member remains the responsible person for reporting under section 6056 regarding all of its full-time employees and thus, is subject to any potential liability for failure to file returns and furnish statements under section 6056. If the multiemployer plan administrator that prepares the returns and statements required under section 6056 is a tax return preparer, it is subject to the requirements generally applicable to tax return preparers.

25. For information returns filed and furnished in 2017 for coverage offered (or not offered) in 2016 and later years, what penalties may apply if an ALE member fails to comply with the section 6056 information reporting requirements?

The penalty under section 6721 may apply to an ALE member that fails to file timely information returns, fails to include all the required information, or includes incorrect information on the return. The penalty under section 6722 may apply to an ALE member that fails to furnish timely the statement, fails to include all the required information, or includes incorrect information on the statement. The waiver of penalty and special rules under section 6724 and the applicable regulations, including abatement of information return penalties for reasonable cause, may apply to certain failures under section 6721 or 6722. See question 2, above, for more details on when the information reporting is first required (in 2016 for coverage offered in 2015) and on voluntarily complying with those requirements in 2015 for coverage offered in 2014. See question 3, above, for information on relief that applies with respect to these penalties for reporting and furnishing in 2016 for coverage offered in 2015.

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Questions and Answers on Information Reporting by Health Coverage Providers (Section 6055)

Information reporting under section 6055 is voluntary for calendar year 2014. Reporting is first required in early 2016 for calendar year 2015. For more information see question 2.

Basics of Provider Reporting

1. What are the information reporting requirements for providers of health coverage?

The Affordable Care Act added section 6055 to the Internal Revenue Code, which provides that every provider of minimum essential coverage will report coverage information by filing an information return with the IRS and furnishing a statement to individuals. The information is used by the IRS to administer and individuals to show compliance with the individual shared responsibility provision in section 5000A.

2. When do the information reporting requirements go into effect?

The information reporting requirements are first effective for coverage provided in 2015. Thus, health coverage providers will file information returns with the IRS in 2016, and will furnish statements to individuals in 2016, to report coverage information in calendar year 2015.

Notice 2013-45 provides transition relief for 2014 from the section 6055 reporting requirements for health coverage providers. Accordingly, the reporting requirements do not apply for 2014. However, coverage providers are encouraged to provide information returns for coverage provided in 2014, which are due to be filed and furnished in early 2015. Returns filed voluntarily will have no impact on the tax liability of the health coverage provider or the individuals affected. For more information about voluntary filing in 2015, see IRS.gov.

3. Is relief available from penalties for incomplete or incorrect returns filed or statements furnished to employees in 2016 for coverage provided in calendar year 2015?

Yes. In implementing new information reporting requirements, short-term relief from reporting penalties frequently is provided. This relief generally allows additional time to develop appropriate procedures for collection of data and compliance with the new reporting requirements. Accordingly, the IRS will not impose penalties under sections 6721 and 6722 for 2015 returns and statements filed and furnished in 2016 on reporting entities that can show that they have made good faith efforts to comply with the information reporting requirements. Specifically, relief is provided from penalties under sections 6721 and 6722 for returns and statements filed and furnished in 2016 to report coverage in 2015 for incorrect or incomplete information reported on the return or statement. No relief is provided in the case of reporting entities that cannot show a good faith effort to comply with the information reporting requirements or that fail to timely file an information return or furnish a statement. However, consistent with the existing information reporting rules, reporting entities that fail to timely meet the requirements still may be eligible for penalty relief if the IRS determines that the standards for reasonable cause under section 6724 are satisfied. See question 29, below, for more information about penalties under sections 6721 and 6722.

4. Where can I find more information about the information reporting requirements for health coverage providers?

The regulations under section 6055 provide further guidance on the information reporting requirements for health coverage providers. Employers that are health coverage providers (for example, employers with self-insured health plans) may also be interested in reviewing regulations under section 6056 and our questions and answers regarding information reporting requirements for certain large employers.

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Who is Required to Report

5. Who must report under section 6055?

Any person that provides minimum essential coverage to an individual must report to the IRS and furnish statements to individuals, including the following:

- Health insurance issuers, or carriers, for insured coverage (but see questions 13 and 14 regarding certain limited exceptions),

- Plan sponsors of self-insured group health plan coverage, and
- The executive department or agency of a governmental unit that provides coverage under a government-sponsored program.

6. What is minimum essential coverage?

Minimum essential coverage includes the following:

- Eligible employer-sponsored coverage, including self-insured plans, COBRA coverage and retiree coverage
- Coverage purchased in the individual market, including a qualified health plan offered by the Health Insurance Marketplace
- Medicare Part A coverage and Medicare Advantage plans
- Most Medicaid coverage
- Children's Health Insurance Program (CHIP) coverage
- Certain types of veterans health coverage administered by the Veterans Administration
- Most types of TRICARE coverage under chapter 55 of title 10 of the United States Code
- Coverage provided to Peace Corps volunteers
- Coverage under the Nonappropriated Fund Health Benefit Program
- Refugee Medical Assistance supported by the Administration for Children and Families
- Self-funded health coverage offered to students by universities for plan or policy years that begin on or before Dec. 31, 2014 (for later plan or policy years, sponsors of these programs may apply to HHS to be recognized as minimum essential coverage)
- State high risk pools for plan or policy years that begin on or before Dec. 31, 2014 (for later plan or policy years, sponsors of these program may apply to HHS to be recognized as minimum essential coverage)
- Other coverage recognized by the Secretary of HHS as minimum essential coverage

More information about minimum essential coverage is provided in section 5000A(f), in regulations under section 5000A, and in our section 5000A questions and answers.

7. What is eligible employer-sponsored coverage?

Eligible employer-sponsored coverage is:

- A self-insured group health plan under which coverage is offered by or on behalf of an employer to an employee, or
- Group health insurance coverage offered by or on behalf of an employer to an employee that is –
  - a governmental plan,
  - a plan or coverage offered in the small or large group market within a state, or
  - a grandfathered health plan offered in a group market.

Eligible employer-sponsored coverage includes COBRA coverage and retiree coverage.

8. Is an employer required to report under section 6055 if it sponsors a health plan that provides coverage by purchasing insurance from a health insurance issuer?

No. An employer that sponsors an insured health plan (a health plan that provides coverage by purchasing insurance from a health insurance issuer) will not report as a provider of health coverage under section 6055. The health insurance issuer or carrier is responsible for reporting that health coverage. However, if the employer is subject to the employer shared responsibility provisions in section 4980H, it is responsible for reporting information under section 6056 about the coverage it offers to its full-time employees. For further information about the employer shared responsibility provisions under section 4980H and the reporting requirements under section 6056, see the section 4980H regulations and our section 4980H questions and answers and the section 6056 questions and answers.

9. For self-insured group health plan coverage, who is the plan sponsor that must to report under section 6055?

- For a self-insured group health plan maintained by a single employer, the plan sponsor is the employer. For a plan maintained by more than one employer that is not a multiemployer plan (as defined in ERISA) the plan sponsor is each participating employer. For purposes of identifying the employer, the section 414 employer aggregation rules do not apply. See question 10 for more information about self-insured plans maintained by more than one employer.
- For a plan that is a multiemployer plan (as defined in ERISA), the plan sponsor is the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.
- For a plan maintained solely by an employee organization, the plan sponsor is the employee organization.
- For any plan for which a plan sponsor is not identified above, the plan sponsor is the person designated by plan terms or, if no person is designated, each entity that maintains the plan.

10. How do the reporting requirements under section 6055 apply to reporting entities that are part of a controlled group?

Plan sponsors in a controlled group that is not an applicable large employer under section 4980H, and providers (such as issuers) that are not reporting as employers, may report under section 6055 as separate entities, or may have one entity report for the controlled group. See our section 6056 FAQs for additional information on reporting by applicable large employers that are providers of self-insured group health plan coverage.

11. Must a government employer report under section 6055 if it maintains a self-insured health plan?

Yes. However, unless prohibited by other law, a government employer that maintains a self-insured group health plan may designate a related governmental unit, or an agency or instrumentality of a governmental unit, as the person to file the returns and furnish the statements for some or all individuals covered under that plan.

12. For a government-sponsored program, who must report under section 6055?

- For Medicaid and CHIP coverage, the state agency that administers the program must report. For Medicare, TRICARE, benefits administered by the Department of Veterans Affairs, and benefits for Peace Corps volunteers, the executive department or agency of the governmental unit that provides the coverage must report.
- For health insurance coverage under a government-sponsored program (such as Medicaid, CHIP, or Medicare) obtained through an issuer, the executive department or agency of the governmental unit that provides the coverage and not the issuer must report.
- For the Nonappropriated Fund Health Benefits Program, the Secretary of Defense may designate the Department of Defense components that must report.

13. Should a health insurance issuer report under section 6055 for coverage in a qualified health plan in the individual market enrolled in through a Marketplace?

No. An issuer should not report on coverage under a qualified health plan in the individual market enrolled in through a Marketplace. The Marketplaces will separately report information on enrollments in a qualified health plan to the IRS and individuals under section 36B(f)(3). Issuers must report, however, on qualified health plans in the small group market enrolled in through the Small Business Health Options Program (SHOP).

14. Must a health coverage provider report under section 6055 for arrangements that provide benefits in addition or as a supplement to an arrangement that is minimum essential coverage?

If the additional or supplemental benefits are not minimum essential coverage (for example, if they are excepted benefits like coverage at an on-site medical clinic), no reporting is required for the additional or supplemental benefits. In addition, no reporting is required under section 6055 for additional or supplemental benefits that are minimum essential coverage if the primary and supplemental coverages have the same plan sponsor or the coverage supplements government-sponsored coverage such as Medicare.

15. Must a health coverage provider report under section 6055 if some or all of its covered individuals may be exempt from the individual shared responsibility provision?

Yes. A health coverage provider may not have the information necessary to determine whether an individual is exempt from the shared responsibility provision. To ensure complete and accurate reporting, providers must report under section 6055 for all their covered individuals.

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What Information Must Providers Report

16. What information must a health coverage provider report to the IRS?

The information that a provider must report to the IRS includes the following:

- The name, address, and employer identification number (EIN) of the provider;
- The responsible individual's name, address, and TIN, or date of birth if a TIN is not available. If the responsible individual is not enrolled in the coverage, providers may, but are not required to, report the TIN of the responsible individual (See question 23 for more information on who is a responsible individual);
- The name and TIN, or date of birth if a TIN is not available, of each individual covered under the policy or program and the months for which the individual was enrolled in coverage and entitled to receive benefits; and
- For coverage provided by a health insurance issuer through a group health plan, the name, address, and EIN of the employer sponsoring the plan and whether the coverage is a qualified health plan enrolled in through the SHOP and (except for 2014 coverage reported in 2015) the SHOP's identifier.

17. Will a health coverage provider collect TINs from individuals, including dependents, covered under its plan or policy?

Yes. Reporting of TINs for all covered individuals is necessary for the IRS to verify an individual's coverage without the need to contact the individual.

If health coverage providers are unable to obtain a TIN after making a reasonable effort to do so, the covered individual's date of birth may be reported in lieu of a TIN. See question 18, below, for additional information on what is a reasonable effort to obtain a TIN.

18. If a health coverage provider does not furnish a TIN, will it be subject to penalties?

A health coverage provider will not be subject to a penalty it demonstrates that it properly solicits the TIN but does not receive it. Under these rules, the reporting entity must make an initial solicitation at the time the relationship with the payee is established. (However, the reporting entity is not required to make this initial solicitation if it already has the payee's TIN and uses that TIN for all relationships with the payee.) If the reporting entity does not receive the TIN, the first annual solicitation is generally required by December 31 of the year in which the relationship with the payee begins (January 31 of the following year if the relationship begins in December). Generally, if the TIN is still not provided, a second solicitation is required by December 31 of the following year. If a TIN is still not provided, the reporting entity need not continue to solicit a TIN.

19. What information must a health coverage provider furnish to individuals?

In addition to the information it reported to the IRS for each covered individual listed on the information return, a health coverage provider must include a phone number for the provider's designated contact person (if any) that the recipient of the statement can contact with questions about information on the statement.

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How and When to Report the Required Information

20. When must a health coverage provider file the information return with the IRS?

A health coverage provider must file the information return and transmittal form with the IRS on or before February 28 (March 31 if filed electronically) of the year following the calendar year in which it provided minimum essential coverage to an individual. Because Notice 2013-45 provides transition relief for section 6055 reporting for 2014, the first section 6055 returns required to be filed are for the 2015 calendar year and must be filed no later than March 1, 2016 (February 28, 2016, being a Sunday), or March 31, 2016, if filed electronically. Regulations under section 6081 address extensions of time to file information returns.

21. What type of return must a health coverage provider file with the IRS?

Generally, a health coverage provider must file Form 1094-B and Form 1095-B (or other form that IRS designates, or a substitute form). However, if the provider is also an applicable large employer member as defined in the employer shared responsibility provisions under section 4980H and provides coverage to its employees through a self-insured group health plan, the provider must file Form 1094-C and Form 1095-C (or other form that IRS designates, or a substitute form), instead of Forms 1094-B and 1095-B, to report information with respect to its employees. For further information about the employer shared responsibility provisions and who is an applicable large employer member, see the section 4980H final regulations and our section 4980H questions and answers.

22. Must a health coverage provider file the return with the IRS electronically?

A health coverage provider that is required to file 250 or more Forms 1095-B or 250 or more Forms 1095-C during the calendar year must file the returns electronically. The 250 return threshold applies separately to each type of return required to be filed. Only Forms 1095-B or 1095-C are counted in applying the 250 return threshold for section 6055 reporting. However, if the 250 return threshold applies, Forms 1094-B and 1094-C also must be filed electronically. A provider that is required to file 250 or fewer Forms 1095-B or Forms 1095-C may file on paper or electronically.

23. To whom must a health coverage provider furnish the statement?

A health coverage provider must furnish the statement to a responsible individual. The responsible individual generally is the person who enrolls one or more individuals, which may include him or herself, in minimum essential coverage. The responsible individual may be the primary insured, employee, former employee, uniformed services sponsor, parent, or other related person named on the coverage application.

24. Must a health coverage provider furnish the statement to anyone who is not the responsible individual?

No. A provider is not required to provide a statement to any individual who is not the responsible individual.

25. When must a health coverage provider furnish the statement to the responsible individual?

A health coverage provider must furnish the statement to the responsible individual on or before January 31 of the year following the calendar year in which minimum essential coverage is provided. If the provider applies to the IRS in writing and shows good cause, the IRS may grant an extension of time up to 30 days for the provider to furnish the statement.

26. How must a health coverage provider furnish the statement to the responsible individual?

A health coverage provider generally must mail the statement to the responsible individual's last known permanent address or, if no permanent address is known, to the individual's temporary address. A provider's first class mailing to the last known permanent address, or if no permanent address is known, the temporary address, discharges the provider's requirement to furnish the statement.

A health coverage provider also may furnish the statement electronically to the responsible individual if the responsible individual affirmatively consents to it.

27. Does an employer that must file returns under section 6055 as a provider of self-insured health coverage to its employees and under section 6056 as an applicable large employer file combined information returns and statements?

Yes. An applicable large employer member, as defined in the employer shared responsibility provisions under section 4980H, that provides self-insured coverage is subject to the reporting requirements of both section 6055 and section 6056. To streamline and prevent duplication under each reporting requirement, applicable large employer members with self-insured coverage will combine section 6055 and section 6056 reporting. An applicable large employer member with self-insured coverage will report on Form 1095-C, completing separate sections to report the information required under sections 6055 and 6056. An applicable large employer member that provides insured coverage will complete only the section of Form 1095-C that reports the information required under section 6056. Entities reporting as health insurance issuers, sponsors of self-insured group health plans that are not applicable large employers, sponsors of multi-employer plans, and providers of government-sponsored coverage, will report under section 6055 on Form 1094-B and Form 1095-B.

For further information about the employer shared responsibility provisions under section 4980H and the reporting requirements under section 6056, see the section 4980H final regulations, our section 4980H questions and answers, the section 6056 final regulations, and our section 6056 questions and answers.

28. May a health coverage provider hire a third party to fulfill the provider's reporting responsibilities?

Yes. Reporting arrangements between health care providers and other parties are not prohibited. However, entering into a reporting arrangement does not transfer the potential liability of the provider for failure to report information and furnish statements under section 6055. In addition, if a person who prepares returns or statements under section 6055 is a tax return preparer, that person will be subject to the requirements generally applicable to tax return preparers.

29. For information returns filed and furnished in 2017 for coverage provided in 2016 and later years, what penalties may apply if a health coverage provider fails to comply with the section 6055 information reporting requirements?

The penalty under section 6721 may apply to a provider that fails to file timely information returns, fails to include all the required information, or includes incorrect information on the return. The penalty under section 6722 may apply to a provider that fails to furnish timely the statement, fails to include all the required information, or includes incorrect information on the statement. The waiver of penalty and special rules under section 6724 and the applicable regulations, including abatement of information return penalties for reasonable cause, may apply to certain failures under section 6721 or 6722. See question 2 for more details on when the information reporting is first required (in 2016 for coverage provided in 2015) and on voluntarily complying with those requirements in 2015 for coverage provided 2014. See question 3 for information on relief that applies with respect to these penalties for reporting and furnishing in 2016 for coverage in 2015.

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