

Introduction

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

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

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

Glossary of Acronyms

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

- ACA – Affordable Care Act
- ALE – applicable large employer
- COBRA – Consolidated Omnibus Budget Reconciliation Act
- EIN – federal Employer Identification Number
- FPL – federal poverty level (also federal poverty line, federal poverty guideline, or federal poverty threshold)
- FTE – full-time equivalent (employee)
- HRA – health reimbursement arrangement
- HSA – health savings account
- HRIS – human resource information system
- IRS – Internal Revenue Service
- LLC – limited liability company
- LNP – limited non-assessment period
- MEC – minimum essential coverage
- MV – minimum value (coverage)
- PEO – professional employer organization
- SSN – Social Security number
- TIN – taxpayer identification number
- TPA – third party administrator

General Definitions

Q: What is a fully-insured health plan?

A fully-insured health plan is one where the plan sponsor (employer) contracts with an insurance carrier and pays a fixed premium to the carrier for an annual contract based upon the types of benefits coverage selected. The monthly premiums change during the year if the number of enrolled participants in the plan changes and the insurance carrier collects the premiums and pays the claims based on the benefits covered in the policy.

Q: What is a self-insured health plan?

A self-funded, or self-insured, plan is one where the plan sponsor (employer) operates its own health plan instead of purchasing a fully-insured plan from the insurance carrier. Employers select this option after careful consideration of the potential savings by only paying for the claims incurred without the carrier's profit margin added versus the potential risk if higher or more claims than expected must be paid. There are a variety of options available to self-funded employers to assist them in managing claims administration and to cover excess claims loss. When considering self-funding, employers should work with their insurance brokers to ensure that benefits strategies are achieved and risks are mitigated.

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

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

A controlled group exists if there is:

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

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

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

Q: What is the FPL?

The Federal Poverty Line (FPL), also called the Federal Poverty Guideline, is used to determine qualification for financial assistance when individuals purchase insurance through the state or federal health insurance Marketplaces, determine eligibility for Medicaid (state rules also apply), and provide individual exemptions from the requirement to purchase insurance. Under § 6056, the employer may report that it made a qualifying offer to the employee if it offered coverage providing minimum value at an employee cost for employee-only coverage not exceeding 9.61 percent for 2022 (as adjusted) of the mainland single federal poverty line*.

*Mainland single federal poverty line is the annual dollar amount in the federal poverty guideline chart for a single-member household in any of the 48 contiguous states: \$12,760 (2021) or \$12,880 (2022). Therefore, qualifying offer means the employee's cost for employee-only coverage does not exceed \$104.53 per month (2021) or \$103.14 per month (2022).

Q: What does authoritative transmittal mean?

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

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

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

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

All full-time equivalent (FTE) employees are counted for purposes of the employer shared responsibility mandate. To determine the number of FTEs at a company, employers calculate the number of employees working less than full time (those working less than 30 hours of service per week) by dividing the total number of hours of service for the month of the employees who are not full time by 120. This is the calculation associated with the term applicable large employer, and such employers are subject to the employer shared responsibility mandate.

Q: What is the definition of ALE?

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

Q: What is MEC and MV?

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

Minimum value coverage (MV) means that the minimum essential coverage plan's share of total allowed cost of benefits is at least 60 percent of such costs.

Q: What is the definition of affordable coverage?

Affordable means that the employee's required contribution for self-only coverage does not exceed 9.61 percent for 2022 (as adjusted) of the employee's income from the employer.