EMPLOYER IRS REPORTING REQUIREMENTS

WHO? WHAT? WHEN? WHERE?

AUGUST 2015

PRESENTED BY:
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WHO?

ALL LARGE EMPLOYERS

Employers with 50 or more full time and / or full time equivalent employees (FTE).

Must report annually the Medical Coverage they offer to their full time employees and their dependents.

WHAT?

INFORMATION PROVIDED WILL CONFIRM THE EMPLOYER'S COMPLIANCE WITH THE "EMPLOYER MANDATE" INCLUDING:

- Did the employer offer all full time employees and their dependents to enroll in "Minimum Essential Coverage" (MEC)?
- What was each full time employee's required contribution to the cost of the **Lowest Cost** plan providing the "Minimum Value"?

IRS REPORTING FORMS WILL INCLUDE THE FOLLOWING DATA:

- Certify that all full time employees and dependents were given the opportunity to enroll in Minimum Essential Coverage (MEC) by each calendar month.
- The number of full time employees for each month “MEC” was available.
- The full time employee’s cost-share of the lowest cost monthly premium for **Employee Only** coverage by calendar month.
- Name, Address & SSN for every full time employee and each month of coverage.

WHEN?

WHEN IS REPORTING DUE:

Statements to Individual Employee due by January 31, 2016 for 2015 Calendar Year.

Employer reporting must be submitted to the IRS by March 31, 2016 if filing Electronically or February 28, 2016 if filing by **Paper**.

NOTE: Electronic filing is required if filing at least 250 forms.

WHERE?

Q. WHERE TO GO FOR ADDITIONAL INFORMATION AND HELP?

TANYA L. BURNS AND ASSOCIATES, INC.
2519 East South Street
Orlando, FL 32803
(407) 896-9886
www.tanyalburns.com

CIGNA
www.informedonreform.com

Internal Revenue Service
1-877-829-5500
www.irs.gov/instructions

Payroll Processing Plus
Debbie Fekany, CPA
debbie@payrollprocessingplus.com
(407) 282-5117

Your Payroll Company / CPA or Accountant

SUMMARY

EMPLOYER REPORTING REQUIREMENTS

Small Employer (Less Than 50 Full Time Employees)

- Small Employer does NOT file
- Insurance Company Provides Form 1095-B

Applicable Large Employer (ALE) WITH 50-99 Full Time Employees (FTEs)

For those with Health Insurance:

- ALE Files form 1095-C, Parts I and II (NOT Part III)
- Insurance Company provides form 1095-B

Applicable Large Employer (ALE) with 100+ FTEs

ALE files form 1095-C, Parts I and II (NOT Part III)

SAMPLE

1094-B

1115

Form **1094-B**

Department of the Treasury
Internal Revenue Service

Transmittal of Health Coverage Information Returns

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

OMB No. 1545-2252

2014

1 Filer's name	2 Employer identification number (EIN)
3 Name of person to contact	4 Contact telephone number
5 Street address (including room or suite no.)	6 City or town
7 State or province	8 Country and ZIP or foreign postal code
9 Total number of Forms 1095-B submitted with this transmittal . . . . . ▶	

For Official Use Only

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

▶ Signature _____ ▶ Title _____ ▶ Date _____

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 61570P Form **1094-B** (2014)

SAMPLE

1094-C

120115

Form **1094-C**

Department of the Treasury
Internal Revenue Service

Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

▶ **Information about Form 1094-C and its separate instructions is at *www.irs.gov/f1094c*.**

☐ CORRECTED

OMB No. 1545-2251

2014

Part I Applicable Large Employer Member (ALE Member)

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

For Official Use Only

17 Reserved . . . . . ☐

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

Part II ALE Member Information

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

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

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

If "No," do not complete Part IV.

22 Certifications of Eligibility (select all that apply):

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

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

▶ Signature ▶ Title ▶ Date

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 61571A Form **1094-C** (2014)

Part III **ALE Member Information—Monthly**

		(a) Minimum Essential Coverage Offer Indicator		(b) Full-Time Employee Count for ALE Member	(c) Total Employee Count for ALE Member	(d) Aggregated Group Indicator	(e) Section 4980H Transition Relief Indicator
		Yes	No				
23	All 12 Months	☐	☐			☐	
24	Jan	☐	☐			☐	
25	Feb	☐	☐			☐	
26	Mar	☐	☐			☐	
27	Apr	☐	☐			☐	
28	May	☐	☐			☐	
29	June	☐	☐			☐	
30	July	☐	☐			☐	
31	Aug	☐	☐			☐	
32	Sept	☐	☐			☐	
33	Oct	☐	☐			☐	
34	Nov	☐	☐			☐	
35	Dec	☐	☐			☐	

Part IV Other ALE Members of Aggregated ALE Group

Enter the names and EINs of Other ALE Members of the Aggregated ALE Group (who were members at any time during the calendar year).

	Name	EIN		Name	EIN
36			51		
37			52		
38			53		
39			54		
40			55		
41			56		
42			57		
43			58		
44			59		
45			60		
46			61		
47			62		
48			63		
49			64		
50			65		

SAMPLE

1095-C

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

► Information about Form 1095-C and its separate instructions is at *www.irs.gov/f1095c.*

☐ VOID
☐ CORRECTED

600115

OMB No. 1545-2251

2014

Part I Employee

1 Name of employee	2 Social security number (SSN)
3 Street address (including apartment no.)	
4 City or town	**5** State or province	**6** Country and ZIP or foreign postal code

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
9 Street address (including room or suite no.)	**10** Contact telephone number
11 City or town	**12** State or province	**13** Country and ZIP or foreign postal code

Part II Employee Offer and Coverage

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)													
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)													

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual. ☐

	(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

1095-C INSTRUCTIONS

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

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

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

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

Part I. Employee

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

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

If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN.

Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

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

Part III. Covered Individuals, Lines 17–22

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

PAYROLL COMPANY SURVEY

JULY 2015

PAYROLL COMPANY SURVEY
for
ACA 2016 IRS REPORTING REQUIREMENTS

COMPANY NAME	FILING	COST	COMMENTS
ADP	Yes	Based on employees and products.	For current payroll clients only.
Ceridian	No		
Paychex	Yes	Based on employees and products.	For current payroll clients only.
Paycor	Yes	Based on employees and products.	For current payroll clients only.
Pay Day	Yes	Based on employees and products.	For current payroll clients only.
Payroll One	No		
Payroll Processing Plus	Yes	Based on employees and products.	For current payroll clients only. ***
Prime Pay	Yes	Based on employees and products.	For current payroll clients only.
SunTrust Bank	No		

2016 HSA LIMITS ANNOUNCED

IRS ISSUES 2016 HSA LIMITS

The limits effective for the calendar year 2016 are:

- The maximum **annual HSA contribution for self-only** HDHP coverage **$3,350 "No Change"**.

- The maximum **annual HSA contribution for family** HDHP coverage will **increase from $6,650 to $6,750.**

- The **Age 55 catch-up contribution continues to be $1,000**

- The minimum HDHP deductible limit

Self – only coverage $1,300 "No Change"
Family coverage $2,600 "No Change"

The annual maximum for HDHP out-of-pocket expenses (deductibles, co-payments and other amounts but not premiums) **will increase from:**
$6,450 for self-only coverage to $6,550
$12,900 for family coverage to $13,100

THANK YOU

FOR ATTENDING OUR WEBINAR

Please Feel Free to Contact Us with ANY Questions:

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Desiree@tanyalburns.com

Make Sure to VISIT Our Website:

www.tanyalburns.com

DISCLAIMER

CMS AND IRS ARE CONTINUALLY MAKING CHANGES / AMENDMENTS TO THE AFFORDABLE CARE ACT (ACA).

INFORMATION PROVIDED IN THIS WEBINAR IS SUBJECT TO CHANGE AS THESE AGENCIES MAKE CHANGES.