



Commonwealth Benefits Group

2 Barlo Circle
Suite C
Dillsburg, Pennsylvania 17019
(717) 432-1010

<http://www.commonwealthbenefitsgroup.com>



What Employers Need to Know Right Now
About Health Care Reform

IRS Releases Proposed PPACA Reporting Rules

On Sept. 5, 2013 the Internal Revenue Service (IRS) released the long awaited rules that describe the reporting that plans, employers and insurers will need to provide in support of the individual shared-responsibility and employer shared-responsibility requirements of the Patient Protection and Affordable Care Act (PPACA). The rules are proposed, so some changes may occur when the rules are finalized.

Separate reporting will be needed with respect to providing minimum essential coverage (which affects both the individual shared-responsibility requirement/individual mandate and the "offer" part of the employer shared-responsibility/play or pay requirement) and offering affordable, minimum value coverage (which affects the "adequacy" part of the play or pay requirement and individuals' eligibility for a premium subsidy.) The reporting will occur with the same timing as W-2/W-3 reporting - the individual's report will be first due Jan. 31, 2016 based on 2015 coverage and the employer "roll-up" report will be due by Feb. 28 (or March 31 if filed electronically).

The minimum essential coverage report (which is sometimes called the 6055 requirement) will be prepared by the insurer for insured plans and the plan sponsor for self-funded plans. (A plan sponsor generally is the employer for employer-provided coverage and the board of trustees or

Our access to PPACA Advisor resources can help you clear up PPACA questions and better craft your company's benefit strategy for the future.



This information is general and is provided for educational purposes only. It reflects UBA's understanding of the available guidance as of the date shown and is subject to change. It is not intended to provide legal advice. You should not act on this information without consulting legal counsel or other knowledgeable advisors.

06-Sep-2013

committee for a multiemployer plan.) 6055 reporting is only required on individuals who actually elect coverage. The insurer or plan sponsor will need to report:

- The insurer's or plan sponsor's name, address and employer identification number;
- The name, address and Social Security Number of the named insured;
- The name and Social Security Number (or date of birth if a Social Security Number is not available) of each covered spouse and dependent;
- The number of months each covered person was covered for at least one day;
- The name, address and EIN of an employer sponsoring the plan;
- Whether coverage is through a SHOP exchange, and if so the SHOP's unique identifier.

The minimum value/affordable coverage report (which is sometimes called the 6056 requirement) must be filed by all large employers. (An employer is considered "large" if it has 50 or more full-time or full-time equivalent employees.) All employers in a controlled or affiliated service group are combined for purposes of deciding if the employer is "large," but each employer in the group will file the 6056 report separately.

Each large employer will need to report:

- The employer's name, address and EIN;
- The name and telephone number of a contact person;
- The calendar year for which the information is being reported (even non-calendar year plans must report on a calendar year basis);
- A certification, by calendar month, as to whether minimum essential coverage was offered to employees (and dependents);
- The number of full-time employees for each month;
- For each full-time employee:
 - The months during the year that minimum value coverage was offered;
 - The employee's share of the cost of self-only coverage for the least expensive minimum value plan offered to the employee, by calendar month;
 - The employee's name, address and Social Security Number and the number of months, if any, that the employee was actually covered

In addition, it is likely that employers will be required to use a series of codes to indicate:

- Whether the offered coverage meets minimum value (60 percent);
- Whether the employee's spouse and/or children are eligible for coverage;
- If a full-time employee was not offered coverage, whether the employee was excluded due to a permissible waiting period, because the employee was not full-time for the month, because the person was not employed for the month, or for another reason;
- If coverage was offered to an employee who is not full-time;
- Whether the coverage met an affordability safe harbor;
- The total number of employees, by calendar month;
- If the employer was not conducting business in any month(s);
- If a member of a controlled or affiliated service group, the name and EIN of all other employers in the group;
- If a member of a controlled or affiliated service group, if the employer expects to remain in the group the next year;

- The name, address and EIN of anyone filing on behalf of the employer;
- If a contributing employer to a multiemployer plan, whether the employee is eligible for that plan because of the employer's contributions, and the name, address and EIN of the administrator of the multiemployer plan.

The IRS has proposed several safe harbors to reduce or eliminate the 6056 reporting, but as it seems unlikely that many employers will be able to meet the criteria, the proposed safe harbors will not be discussed in this Alert.

Interested parties may file comments on the proposed rules until Nov. 8, 2013. Public hearings are scheduled for Nov. 18. Final rules likely will be published in late 2013 or early 2014. The proposed rules are here:

[Proposed Minimum Essential 6055 Rule.pdf](#)

[Proposed Large Employer 6056 Rule.pdf](#)

DOL Issues FAQ

On Sept. 4, 2013 the Department of Labor (DOL) issued FAQ XVI. The FAQ clarifies that another entity, such as an insurer, third party administrator or multiemployer plan, may issue the exchange notice to some or all employees on behalf of the employer.

The FAQ also reiterates that although final regulations have not been issued yet, plans must follow the proposed rules regarding eligibility waiting periods starting with their 2014 plan year. Under the proposed rule, the maximum waiting period is 90 days, generally measured from the date the person becomes eligible.

The FAQ is here: [Frequently Asked Questions - The Affordable Care Act Implementation Part XVI](#)

Jofa M. Kauffman, HIA, MHP | Executive Account Manager | Commonwealth Benefits Group



2 Barlo Circle | Suite C | Dillsburg, PA 17019
717-432-1010 | 717-432-2334 | Jofa@commonwealthbenefitsgroup.com |
www.commonwealthbenefitsgroup.com



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