The Essential ACA Guide for Employers
2018 Edition
At the time it was enacted in 2010, the implementation of the Patient Protection and Affordable Care Act (the “ACA”), (Public Law No. 111-148), represented the largest set of tax law changes in more than 20 years and affected millions of taxpayers.

In 2016, the Congressional Budget Office projected $228 billion from employers who failed to offer coverage or offered inadequate coverage to their full-time employees. Enforcement of the employer mandate by the IRS began in November 2017 with Letter 226J tax penalty notices being issued to employers who failed to comply with the ACA in providing information applicable to the 2015 tax reporting year. With 98% of all employers that have 200 or more employees, 96% with 100 or more employees, and 89% with 50-99 employees providing some form of health coverage, it is critical for these employers to navigate carefully the ACA’s complex regulatory landscape to ensure that their offers of coverage satisfies the ACA and that their healthcare costs are minimized. Implementing ACA best practices requires a working understanding of the risks and costs of the ACA. To that end, an overview of ACA regulations relating to tax penalties and reporting and disclosure obligations is provided in this guide.

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The Employer Mandate under the Affordable Care Act

II: THE EMPLOYER MANDATE

Who Does It Cover?

Applicable Large Employers with at Least 50 Full-time and Full-time Equivalent Employees

The “Employer Responsibilities” set forth in the ACA apply to all “Applicable Large Employers” (ALEs). These are companies that employed an average of at least 50 full-time or full-time equivalent employees on business days during the preceding calendar year. See 26 U.S.C. §4980H(c)(2)(A). Notably, employers must look back to the preceding year to determine whether they are deemed ALEs. Certain exceptions may apply if the workforce (a) exceeds 50 full-time or full-time equivalent employees for 120 days or less per calendar year and (b) the employees that cause the workforce to exceed 50 are “seasonal workers.”

Solely for determining whether an employer is an ALE, both full-time and “full-time equivalent” employees are counted. A “full-time” employee is an individual who has an average at least 30 hours of service per week. The calculation of total full-time equivalent employees is determined on a monthly basis by totaling the hours for that month of all of the hours serviced by all non-full-time employees and then dividing those hours by 120.

For a particular calendar year, the employer will determine whether it is an ALE based on the number of full-time plus full-time equivalent employees it had in the preceding year. For example, an employer’s ALE status in 2016 is determined based on the employer’s 2015 employee count data.

An important consideration in determining ALE status is that the ALE includes all “persons” who are treated as being employed by one employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 (“IRC”). See IRC Section 414(b), (c), (n), and (o). That means that employees of related companies, e.g., within the same controlled group of corporations, trades or businesses under common control, within the same affiliated service group, will be treated as employees of one employer. Accordingly, if two or more companies are related and have a combined total of 50 full-time or full-time equivalent employees, they will be treated as one ALE, with each such component company an ALE member.

Another consideration are predecessors and successors. All “predecessor” and “successor” of an employer must be included as part of the ALE. See 26 C.F.R. Section (“IRC Rule”) 54.4980H-1(a)(16). However, the terms “predecessor” and “successor” are not defined by the IRS Final Regulations and instead are left as reserved. See IRC Rule 54.4980H-1(a)(36); see also Fed. Reg. Vo.79, No. 29 (Feb. 12, 2014) (“Final Regulations”), at 8548. “The Treasury Department and the IRS continue to consider development of rules for identifying a predecessor employer (or the corresponding successor employer), and until further guidance is issued, taxpayers may rely upon a reasonable, good faith interpretation of the statutory provision on predecessor (and successor) employers for purposes of the ALE determination. For this purpose, use of the rules developed in the employ-

Note the term “full-time” for purposes of the determining eligibility for an offer of coverage is distinct from the term “full-time” for purposes of ALE status determination. See Section II.A.
ment tax context for determining when wages paid by a predecessor employer may be considered as having been paid by the successor employer (see § 31.3121(a)(1)–(b)) is deemed reasonable.” See Final Regulations, at 8548. An IRC Rule in the employment wages context reflect that in a corporate acquisition, the acquirer may be a deemed predecessor. See IRS Publication 15 (2017) (noting under “successor employer” that “[w]hen corporate acquisitions meet certain requirements, wages paid by the predecessor are treated as if paid by the successor for purposes of applying the social security wage base and for applying the Additional Medicare Tax withholding threshold …”)

A. DETERMINING “FULL-TIME” STATUS FOR VARIABLE HOUR EMPLOYEES

The IRS has provided method guidance for employers to use to determine whether any employee is “full-time,” i.e., averaging at least 30 hours per week. These consist of the Monthly Measurement Method and the Look-Back Measurement Method. See Fed. Reg. Vol. 79, No. 29 (Feb. 12, 2014).

The Monthly Measurement Method is readily applied to the straightforward circumstance of a salaried employee. However, the determination of “full-time” can be complicated for variable-hour employees. For such variable-hour employees, the Look-Back Measurement Method with its measurement and stability periods methodology may be more appropriate.

Under the Look-Back Measurement Method, the employer would determine each employee’s full-time status by looking back at a defined period of not less than 3, but not more than 12, consecutive calendar months, as chosen by the employer (the measurement period), to determine whether the employee averaged at least 30 hours of service per week (or at least 130 hours of service per calendar month) during the measurement period.

If the employee was determined to be full-time during the measurement period, then the employee would be treated as full-time during a subsequent “stability period.” This is regardless of the number of the employee’s actual hours of service during the stability period, so long as he or she remained an employee.

For an employee who was determined to be full-time during the measurement period, the stability period would cover at least 6 consecutive calendar months immediately following the measurement period and can be no shorter than the measurement period. If the employee was determined not to be full-time during the measurement period, the employer may treat the employee as not full-time during a stability period that followed the measurement period, but the stability period could not exceed the measurement period. For example, if the employer chose a measurement period of 8 months to determine its full-time employees, the stability period would immediately follow the measurement period and would also be 8 months long.

All employees, including part-time, seasonal and variable hour, must be analyzed to determine whether an employer is an applicable large employer.
What kind of coverage must be provided?
If Coverage is Offered, What Kind of Coverage Must Be Offered?

Employer sponsored plans must offer “Minimum Essential Coverage” that has “Minimum Value” and is “Affordable.”

To avoid penalties, the Employer Mandate requires an ALE to offer “Minimum Essential Coverage” to “all” employees and their dependents and that such offer of coverage satisfy “Minimum Value” and “Affordability” for the employee for each month.

Minimum Essential Coverage is specifically defined to include Government Sponsored Programs, Eligible Employer Sponsored Programs, Plans in the Individual Market and Grandfathered Health Plans that were in effect on the date of the ACA’s enactment (2010). See 26 U.S.C. §5000A(a) and (f); 26 U.S.C. §36B.

Government Sponsored Programs include the Medicare program under Part A of Title 18 of the Social Security Act, the Medicaid program under Title 19 of the Social Security Act, medical coverage under chapter 55 of Title 1, including TRICARE, veteran’s health care under chapter 17 of Title 38, and a health plan under Section 2504(e) of Title 22 (relating to Peace Corps volunteers).

Failure to satisfy Minimum Essential Coverage subjects the ALE to penalties under 26 U.S.C. §4980H(a). This is further discussed in Section VI below.

A. MINIMUM VALUE:
Employers offering Minimum Essential Coverage must also satisfy “Minimum Value” standards to avoid penalties under 26 U.S.C. §4980H(b). Minimum Value means that the “plan’s share of the total allowed costs of benefits provided under the plan” is at least “60% of such costs.”

B. AFFORDABLE
Employers offering Minimum Essential Coverage must also ensure that the em-

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4 Despite the clear wording of the statute, the IRS has signaled that “all” is contemplated to mean “substantially” all employees — i.e., 95%, for purposes of avoiding penalties, with the exception of 2015, when “all” was set at 70% as transition relief.

5 Under the Employer Mandate, an ALE is obligated to offer Minimum Essential Coverage to full-time employees, defined as employees who average at least 30 hours of service per week, and their “dependents.” However, “dependents” do not include spouses. If, the ALE offers spousal coverage, but does not contribute to the premium (which the ALE is not obligated to do), the spouse would not be eligible for a tax credit subsidy. Moreover, although the Employer Mandate requires the ALE to offer dependent coverage, the ALE is not required to contribute to paying for the premium. In other words, the “affordability” requirement is based solely on self-only coverage.
The Employer Mandate under the Affordable Care Act

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What is considered “Affordable” coverage?

Employee's portion of the insurance premium is “affordable.” See 26 U.S.C. §36B. To be “affordable,” the “employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan” may not exceed “9.5 percent of the applicable taxpayer's household income.” The Exchanges6 use such metric of “affordability” based on Household Income7 to determine whether an individual who seeks health coverage through the Exchange is eligible for a tax subsidy.

This 9.5%8 cap translates to an affordable premium cap for self-only coverage at $123.50 per month for a $10 per hour “full-time” employee who is assumed to work 30-hour week, 52 weeks a year. That employee (assuming a household size of one) would earn an annual salary would translate to $15,600, which is below 138% of the Federal Poverty Level (“FPL”) (at $16,243).9

Note, the affordability analysis also applies to an employee’s spouse and anyone else eligible to enroll in the plan by virtue of his/her relationship to the employee. See 26 U.S.C. §36B(c) (2)(i) (“This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.”). However, for purposes of determining whether any penalties will be assessed on an ALE, it is only the employee’s self-only coverage that is relevant for the affordability analysis.

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6 The Health Insurance Marketplace exchanges (“Exchanges”) include an exchange established by a state to make available qualified health plans to qualified individuals and qualified employers, facilitate the purchase of qualified health plans, and provides for the establishment of a Small Business Health Options Program (“SHOP”) that is designed to assist small employers in enrolling employees in qualified health plans offered by the Exchange. Those states that have not established their own Exchange can elect to join the federal Exchange.

7 “Household Income” depends on the total income of the household. The term specifically is defined as the total of (a) the modified adjusted gross income of the taxpayer and (b) the aggregate of the modified adjusted gross income of all individuals who were taken into account in determining the taxpayer's “Family Size” and were required to file a tax return. Family Size means the number of individuals for whom the taxpayer is allowed a deduction.

8 This percentage is adjusted annually. For plan years beginning in 2015, the threshold is 9.56 percent. See IRS Rev. Procedure 2014-37. For plan years beginning in 2016, the threshold is 9.56 percent. See IRS Rev. Procedure 2014-62. For plan years beginning in 2017, the threshold is 9.69 percent. See IRS Rev. Procedure 2016-24.

9 Starting January 1, 2014, certain states expanded Medicaid to cover those with Household incomes at or below 138% of the FPL. See ACA §2000(a) (amending Section 1902(a)(10)(A))(ii) of the Social Security Act (42 U.S.C. §1396a)(10)(A))(ii) (VIII) and 42 C.F.R. §435.603 (defining “Household Income” as the sum of the modified adjusted gross income minus 5% of the FPL)). As of November 8, 2017, 32 states and the District of Columbia have adopted Medicaid expansion to 138% FPL. The Supreme Court's decision in National Federation of Independent Business et al. v. Sebelius (June 28, 2012) effectively gave states the choice as to whether to adopt Medicaid. See https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/
Which Employees Are Subject to Tax Penalties?

All citizens or lawful residents subject to certain exemptions must have Minimum Essential Coverage. The ACA’s Individual Mandate requires an applicable individual to have Minimum Essential Coverage for himself/herself and dependents. See IRC Section 5000A(a). Failure to do so will subject the applicable individual to a tax penalty. This tax penalty started for 2014 at the greater of $95 per adult and $47.50 per child with a family maximum of $285 or 1% of income above the filing threshold. For 2015, the tax penalty was the greater of $325 per adult and $162.50 per child with a family maximum of $975 or 2% of income above the filing threshold. For 2016 and 2017, the tax penalty was the greater of $695 per adult and $347.50 per child with a family maximum of $2,085 or 2.5% of income above the filing threshold. See https://www.irs.gov/affordable-care-act/individuals-and-families/aca-individual-shared-responsibility-provision-calculating-the-payment. The individual tax penalty is assessed for every month of the reporting year without Minimum Essential Coverage. Starting in 2019, new tax reform legislation makes the Individual Mandate penalty $0, essentially repealing that provision of the ACA.

The Exchanges offers health coverage to all individuals. Moreover, the Exchanges offers applicable individuals tax subsidies to offset the cost of coverage.

The applicable individuals who are eligible for a tax subsidy are those with an annual Household Income of at least 100% and no more than 400% of the FPL. See Section 36B(c). For example, using the Department of Health and Human Services (“HHS”) 2016 figures, for an individual with no dependents, the range of applicable salaries is $11,880 to $47,520 and with a non-working spouse and two children, this range of applicable salaries is $24,300 to $97,200. Thus, on the lower end, this range would capture virtually all full-time employees that are paid at the federal minimum wage. For example, an individual with no dependents who works at $8.50 per hour, 30 hours per week, and 48 weeks per year (to exclude 4 weeks of unpaid holidays, sick or vacation days) would fall within the 100% to 400% FPL.

Under the ACA, a single streamlined process is made available to allow for application of both the Exchanges and certain federal assistance programs, including Medicaid and the state’s children’s health insurance program (CHIP). See ACA §1413 (codified in 42 U.S.C. §18083).

10 This Individual Mandate penalty is subject to certain exemptions, including an individual (a) for whom Minimum Essential Coverage would cost more than 8% of their Household Income, (b) with Household Income below the filing threshold, (c) who is a member of an Indian tribe, (d) who has a coverage gap for a continuous period of less than 3 months, and (e) hardship.
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What are Employees Required to Do?
Obtain Health Coverage or Face Risk of Individual Tax Penalty

Employees who do not have access to Minimum Essential Coverage, or such Minimum Essential Coverage does not meet Affordability and/or Minimum Value requirements, may be eligible to receive premium assistance to offset the cost of coverage through an Exchange. See ACA §1411 (codified as 42 U.S.C. §18081).

The amount of the monthly premium assistance is determined by the lesser of (a) the monthly premiums to cover a taxpayer and his/her dependents under a Qualified Health Plan (defined infra) enrolled in the Exchange or (b) the excess (if any) of (i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer over (ii) any amount equal to ½ of the product of the Applicable Percentage and the taxpayer’s Household Income. See IRC Section 36B(b).

The Applicable Percentages are determined based on Household Income (expressed as a percent of the FPL) within each income tier as set forth below the table and chart to the right:

To determine whether an employee qualifies for premium assistance credits, the employee’s Household Income will need to be calculated. To qualify, the Household Income must be between 100%-400% of the FPL. See IRC Section 36B(c).

Additionally, the ALE must either (a) have failed to offer Minimum Essential Coverage to the employee and his/her dependents or (b) offered coverage but the self-only coverage was not Affordable and/or did not meet Minimum Value.

Certain applicable individuals enrolled in a Qualified Health Plan on the Exchange may also be entitled to a “Reduction in Cost-Sharing.” This program first requires reductions of the out of pocket limit according to the following schedule: (a) reduction by two-thirds for those with Household Incomes between 100% and 200% (b) reduction by one half for 200-300% and (c) reduction by one third for 300-400%. See ACA §1402 (codified in 42 U.S.C. §18071). An additional reduction is available for lower income insureds of a Qualified Health Plan such that

<table>
<thead>
<tr>
<th>Household Income of poverty line</th>
<th>Initial Premium %</th>
<th>Initial Premium %</th>
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<tbody>
<tr>
<td>Up to 133%</td>
<td>2.0%</td>
<td>2.0%</td>
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<tr>
<td>133% up to 150%</td>
<td>3.0%</td>
<td>3.0%</td>
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<tr>
<td>150% up to 200%</td>
<td>4.0%</td>
<td>4.0%</td>
</tr>
<tr>
<td>200% up to 250%</td>
<td>6.3%</td>
<td>6.3%</td>
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<tr>
<td>250% up to 300%</td>
<td>8.05%</td>
<td>8.05%</td>
</tr>
<tr>
<td>300% up to 400%</td>
<td>9.5%</td>
<td>9.5%</td>
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See Section 36B(3)(A).
Understanding the Individual Mandate

the plan covers (a) 94% of the costs for insureds whose Household Incomes are between 100-150%, (b) 87% of the costs for insureds whose Household Incomes are between 150-200%, and (c) 73% of the costs for insureds whose Household Incomes are between 200-250%. In other words, individuals with incomes between 100% and 400% of the FPL may be eligible for tax credits to reduce the cost of their monthly premiums. In addition, individuals with incomes between 100% and 250% of the FPL may qualify for cost-sharing subsidies that will reduce their deductibles, co-payments and coinsurance.

An individual can enroll on the Exchange by completing the application online via the Exchange’s website. Enrollment may also be accomplished in person, by mail and by telephone.

Once an application is submitted to the Exchange, the Exchange may initial assess or determine eligibility and enrollment for certain federal assistance, including Medicaid. Such determination includes a verification of certain information by the Secretary of Homeland Security, Secretary of the Treasury and Commissioner of Social Security.

The Exchange will determine eligibility for advance payments of premium tax credits as well as cost sharing reductions. As part of that determination, the Exchange will verify household income and family size through tax return information from the Treasury. Upon verification of eligibility, the Exchange is required to provide notice to the employee and employer. As part of the notice to the employer, the Exchange must provide the following:

(a) identification of the employee;

(b) indication that the employee has been determined to be eligible for advanced payments of the premium tax credits;

(c) indication that the employer may be liable for payment under Section 4980H if the employer is an Applicable Large Employer; and;

(d) notice of the employer’s right to appeal.

Moreover, that liable individual must also report the shared responsibility payment with the individual’s federal tax return for the taxable year, including the month or months for which payment is owed.

The ACA uses both a stick and carrot method to get individuals covered. The stick is the tax penalty for not having insurance. The carrot is the premium tax credits and cost sharing subsidies to help pay for the coverage.

Individuals who do not have Minimum Essential Coverage for each month of the year or who do not qualify for an exemption, are subject to a tax penalty at the time of filing their federal income tax return. The Individual Shared Responsibility Payment (i.e., the Individual Mandate tax penalty) is submitted with the filing of the individual’s federal income tax return.
What Are the Penalties?
Assessable Payment to be Paid by Employer

A. EMPLOYERS WHO DO NOT OFFER MINIMUM ESSENTIAL COVERAGE

Under the ACA, an ALE who does not provide the opportunity to enroll in Minimum Essential Coverage under an Eligible Employer Sponsored Plan for any given month, and has at least one full-time employee certified 11 to the employer as having been enrolled for such month in a health plan through the Exchange and for which he/she is allowed or paid an applicable premium tax credit or cost-sharing reduction, will be obligated to make an “assessable payment equal to the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.” See IRC Section 4980H. With respect to any month for 2017, the “applicable payment amount” is 1/12 of $2,260. Accordingly, the employer who does not provide health insurance for a given month is assessed at a rate of 1/12 of $2,260 for each full-time employee for each such month. However, note that the number of full-time employees “shall be reduced by 30 solely for purposes of calculating” the assessable payment.12 In other words, the first 30 full-time employees are excluded from assessing the $2,260 per employee penalty.

B. EMPLOYERS WHO MINIMUM ESSENTIAL COVERAGE BUT SUCH COVERAGE DOES NOT MEET MINIMUM VALUE AND/OR IS AFFORDABLE.

Employers who offer Minimum Essential Coverage but self-only coverage does not meet affordability and/or minimum value requirements are subject to tax penalty.

The penalty corresponds only to those employees who receive an applicable premium tax credit or cost-sharing allowance. On a monthly basis, if one or more full-time employees have been certified as having enrolled in a qualified health plan through the Exchange for which the employee has received or been allowed an applicable premium tax credit or cost-sharing allowance, the employer will be assessed a payment for all such certified employees. For any month in 2017, the aggregate tax penalty is computed by the product of 1/12 of $3,390 and the number of certified employees.13 However, there is an overall penalty limitation calculated by the Section 4980H(a) penalty times the total number of full-time employees minus 30. See IRC Section 4980H(b) (2).

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11 Such certifications are known as “Section 1411 Certifications.” See 26 C.F.R. Section 54.4980H-4(a).
12 There was transitional relief for 2015 only to increase the 30 “freebie” number to 80. See Final Regulations, at 8076, n.16.
13 This amount increases annually for inflation based on the premium adjustment percentage. For example, for 2015, that percentage was 4.213431463. See Fed. Reg. Vol 79, No. 47 (Mar. 11, 2014). If the amount is not a multiple of $10, the amount is rounded to the next lowest multiple of $10. See IRC Section 4980H(c)(5). For 2015, this translated to a 4980H(a) penalty is $2,080 and the annualized Section 4980H(b) penalty of $3,120. For 2017, the annualized Section 4980H(a) penalty was $2,260 and the annualized Section 4980H(b) penalty was $3,390.
To avoid penalties for failing to offer Eligible Minimum Essential Coverage, an employer must make a lowest cost option available to all full-time employees. A conservative “low-cost option” is likely to be based on the 9.5% affordability ceiling for premium costs corresponding to the lowest earning full-time employee with no dependents. Of course, having a low-cost option does not preclude the employer from providing other more costly plans. The key is making the low-cost option available. In view of the Minimum Essential Coverage requirements, insurers are likely to have that option always available.

Although there were certain transition relief available during 2015, virtually all of such transition relief no longer applied starting in 2016. See Final Regulations.

C. PENALTY ASSESSMENT PROCESS An ALE who has employees who properly obtained premium tax assistance and/or any reductions in cost-sharing through the Exchange may be subject to the penalties under Section 4980H. As contemplated under the ACA, upon notice of such Section 1411 Certification, such employers are allowed a 90-day window to appeal the assessment. The employer will have access to the data used to make the determination to the extent allowable by law, including whether the employee’s income is above or below the threshold for Affordability, and have the opportunity to present information to the Exchange.

The IRS will contact employers to inform them of their potential liability and provide them an opportunity to respond before any tax liability is assessed. The contact for a given calendar year will not occur until after employees’ individual tax returns are due for that year claiming premium tax credits and after the due date for ALEs to file the information returns identifying their full-time employees and describing any healthcare coverage that was offered. Once notified and given opportunity to respond, the IRS will then send notice and demand for payment.

14 Notably, HHS’s Centers for Medicare and Medicaid (“CMS”) indicated that the IRS may impose Section 4980H penalties for 2015 reporting regardless of whether the Exchange provides prior notice (a Section 1411 Certification) to the employers. See CMS FAQs (https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Employer-Notice-FAQ-9-18-15.pdf). This appears to be contrary to Section 4980H and Section 1411, which indicate that Section 4980H penalties require Section 1411 Certification to assess any Section 4980H penalties.
What are the Reporting Requirements?

A. W-2 REPORTING
For tax years after 2011, the ACA has been generally requiring all employers with 250 or more W-2s an obligation to report the total costs for employee health benefits for employer sponsored group health coverage. See ACA §9002 (codified as 26 U.S.C. §6051(a)(14)). The reporting began January 2013. The principle behind this reporting obligation is to provide useful and comparable consumer information on the cost of healthcare coverage to employees.

Specifically, the report requires identification of the aggregate cost of employer sponsored health coverage for that employee and his/her dependents on that employee’s W-2 form, in box 12 with code “DD.” The specific items that are required to be included are listed at http://www.irs.gov/uac/Form-W-2-Reporting-of-Employer-Sponsored-Health-Coverage. Notably, Flex Spending Accounts funded solely by salary reductions to the employee, Health Savings Arrangement (HSA) contributions, and Archer Medical Savings Account (Archer MSA) contributions are not to be reported.

B. COVERAGE REPORTING - APPLICABLE LARGE EMPLOYERS
The ACA imposes certain reporting and disclosure requirements with respect to applicable employees on ALEs. See ACA Section 1513 (codified as 26 U.S.C. §6056); see also IRS Final Reporting Regulations, Fed. Reg. Vol. 79, No. 46 (March 10, 2014). These reporting and disclosure requirements are due on an annual basis for the prior tax year, starting in 2015.

Pursuant to the IRS Final Reporting Regulations, the IRS has provided IRS Schedules 1094-C and 1095-C and accompanying instructions on completing these forms. See IRS Final Instructions on IRS Schedules 1094-C and 1095-C. The 1094-C Schedule is the transmittal form, which requires monthly information about the ALE, including whether certain qualifying offer methods apply, whether Minimum Essential Coverage was offered to 95% of the full-time employees and their dependents, the total employee count, total full-time employee count and identification of all ALE members. ALE member information requires employer aggregation analysis under IRC Section 414(b), (c), (m) and (o).

The 1095-C Schedule requires comprehensive information for each month of the reporting year about each full-time employee, including the nature of the coverage offered to the employee, the lost cost monthly premium for self-only coverage, and applicable safe harbor codes. Reporting on the nature of coverage includes whether the Minimum Essential Coverage was offered to employee, spouse and/or dependents, whether spousal coverage was conditional, enrollment status, employment status, applicability of any affordability safe harbors (FPL, W-2 safe-harbor or rate of pay), application of limited non-assessment periods, and other indicator codes relating to the type of offer of coverage. Self insured ALEs have to additional information requirements pertaining to covered individuals.
The ACA amends the Fair Labor Standards Act to impose certain notice obligations to employers. See ACA Section 1512 (codified as Section 18B of FLSA, 29 U.S.C. §218B).

Under Section 1512, employers must give written notice of the following information about the ACA:

1. Informing the employee of the existence of the Exchange, including a description of the services provided by the Exchange and the manner in which the employee may contact the Exchange to request assistance.

2. If the employer’s plan’s share of the total allowed costs of benefits provided under the plan is less than 60% of such costs, that the employee may be eligible for premium tax credits and a cost sharing reduction if the employee purchases a qualified health plan through the Exchange.

3. If the employee purchases a Qualified Health Plan through the Exchange, the employee will lose the employer’s contribution (if any) to the health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

Although Section 18B of the FLSA was intended to go into effect on March 1, 2013, on January 24, 2013, the Department of Labor announced that the notice requirement would start on October 1, 2013. The scope of employers subject to the notice requirement are those that employ one or more employees with volume of business no less than $500,000 (e.g., subject to FLSA).