Part VIII: Required Disclosures and Information Reporting

W-2 Reporting Beginning 2013

311. What is the W-2 reporting requirement and when is it effective?

Employers, including those with grandfathered plans,[[1]](#footnote-1) must report the “aggregate cost” of “applicable employer sponsored coverage” on an employee’s Form W-2.[[2]](#footnote-2) This cost generally consists of employer-sponsored coverage under a group health plan (insured or self-funded) that is excludable from the employee's gross income.[[3]](#footnote-3) IRS Notice 2012-9 supersedes earlier notices[[4]](#footnote-4) that delayed and created exceptions to the PPACA W-2 reporting requirement, which originally was to apply for 2011 W-2s that normally would be issued by employers in January 2012. The W-2 reporting requirement, which was delayed by the IRS, first applies to 2012 W-2s that generally will be issued in January 2013 unless an exception (discussed in Q 315) applies.

312. What is the income tax impact of this requirement to employers and employees?

None. This requirement is merely designed to provide information to the federal government. It does not change any rules regarding the employer's deductions or the taxation to the employee. Failure to properly report will not cause coverage that is excludible from gross income under Code section 106 or any other Code provision to become taxable or to be reported in any other box on Form W-2.[[5]](#footnote-5)

313. Which employers must comply with the expanded W-2 reporting?

This requirement includes employers that are federal, state and local government entities, churches and other religious organizations, and employers that are not subject to the COBRA continuation coverage requirements under Code section 4980B.[[6]](#footnote-6)

314. Is the amount reported on the W-2 the amount for health coverage paid by the employer?

No. The reportable cost generally includes the amounts paid by both the employer and employee, regardless of whether paid through pre-tax or after-tax contributions. The aggregate reportable cost is reported on Form W-2 in Box 12, using Code DD.[[7]](#footnote-7)

315. Which employers are exempt from the W-2 reporting requirement?

The W-2 reporting requirement does not apply to the following:

* Employers with fewer than 250 W-2s issued for the prior calendar year until further notice.[[8]](#footnote-8)
* An employer that would have filed only 100 Forms W-2 for the previous year had it not used an agent under Code section 3504[[9]](#footnote-9) will not be subject to the reporting requirement for the year, nor will an agent under Code section 3504 with respect to that employer's Forms W-2 for the year. In contrast, if the same employer would have filed 300 Forms W-2 for the previous year had it not used an agent under Code section 3504, that employer would be subject to the reporting requirement for the year. If an agent under Code section 3504 is used again, the information will need to be provided to the agent and reported on the Form W-2. [[10]](#footnote-10)
* An employer is not required to report any amount in Box 12 using Code DD for an employee who, pursuant to §31.6051-1(d)(1)(i), has requested to receive a Form W-2 before the end of the calendar year during which the employee terminated employment.[[11]](#footnote-11)
* Coverage under a flexible spending arrangement if contributions occur only through employee salary reductions.[[12]](#footnote-12)
* “Excepted benefits,” which include dental and vision plans offered under a separate policy, certificate, or contract of insurance, or if the participants have the right to elect the dental or vision benefits and, if they do, pay an additional premium or contribution.[[13]](#footnote-13)
* Excess reimbursements that are includible in the income of highly compensated individuals under Code section 105(h) or payments or reimbursements of health insurance premiums for a 2 percent shareholder-employee of an S corporation.[[14]](#footnote-14)
* The cost of hospital or other fixed indemnity coverage, or coverage only for a specified disease or illness, is not reportable if the coverage is offered as an independent, noncoordinated benefit and is includible in the employee’s income or paid for on an after-tax basis. However, the cost of such coverage is reportable when paid for on a pre-tax basis under a cafeteria plan or with employer contributions that are excludable from income.

316. What about related employers that each employ and pay the same person?

Related employers that do not use a common paymaster can either provide the full reportable cost to an employee on a single Form W-2 or allocate the cost and reporting among the employers.[[15]](#footnote-15) The notice does not define the term “related employers.” Presumably, it means related employers as defined for W-2 purposes.[[16]](#footnote-16) This definition includes the following types of corporations if they satisfy any one of the following four tests at any time during a calendar quarter:

(i) The corporations are members of a “controlled group of corporations”, as defined in Code section 1563, or would be members if Code section 1563(a)(4) and (b) did not apply and if the phrase “more than 50 percent” were substituted for the phrase “at least 80 percent” wherever it appears in Code section 1563(a)

(ii) In the case of a corporation that does not issue stock, either 50 percent or more of the members of one corporation's board of directors (or other governing body) are members of the other corporation's board of directors (or other governing body), or the holders of 50 percent or more of the voting power to select such members are concurrently the holders of more than 50 percent of that power with respect to the other corporation

(iii) Fifty percent or more of one corporation's officers are concurrently officers of the other corporation

(iv) Thirty percent or more of one corporation's employees are concurrently employees of the other corporation[[17]](#footnote-17)

317. How is the amount of reportable cost determined?

Employers that use a composite rate to determine premiums for active employees and another method to determine COBRA premiums may use either rate to determine the reportable cost, but they must use that method consistently when reporting the cost for each applicable group.[[18]](#footnote-18) An employer may also include in the reportable cost of coverage certain amounts that need not be reported, such as the cost of coverage for a Health Reimbursement Account.

The reportable cost of coverage may be based on the information available to the employer on December 31, and need not be adjusted for later elections or notifications, such as a divorce or other change in family status that retroactively affects coverage during the prior year.[[19]](#footnote-19)

318. How do employers with self-insured health plans calculate the aggregate cost of applicable employer-sponsored coverage?

There are COBRA rules governing how a self-insured plan determines its applicable premium, generally requiring that such plans calculate the applicable premium through the actuarial method or the past cost method.[[20]](#footnote-20) Presumably these are the methods used, as the IRS notices provide no special guidance.[[21]](#footnote-21)

319. How is the cost for EAPs, wellness programs, and on-site medical clinics reported?

The cost of EAPs (employee assistance programs), wellness programs, and on-site medical clinics is includible in the reported cost of coverage to the extent that the program is a group health plan. However, such coverage is not reportable if the employer does not charge a premium for that coverage for purposes of COBRA (or other federally required continuation coverage) or if the employer is not subject to COBRA.[[22]](#footnote-22)

320. What is the penalty for failure to follow the W-2 reporting requirements?

There is no special penalty for failure properly to report healthcare costs. Presumably, the normal W-2 penalties will apply.[[23]](#footnote-23)

321. What about health costs paid for retirees not entitled to a W-2?

Employers are not required to issue a W-2 to report health plan costs to persons not otherwise required to receive a W-2.[[24]](#footnote-24)

322. Has the IRS provided a chart summarizing the W-2 health cost reporting requirements?

Yes. It is as follows:[[25]](#footnote-25)

|  |
| --- |
| **Form W-2 Reporting of Employer-Sponsored Health Coverage** |
| **Coverage Type** | **Form W-2, Box 12, Code DD** |
| **Report** | **Do Not Report** | **Optional** |
| Major medical | X |  |  |
| Dental or vision plan not integrated into another medical or health plan |  |  | X |
| Dental or vision plan which gives the choice of declining or electing and paying an additional premium |  |  | X |
| Health Flexible Spending Arrangement (FSA) funded solely by salary-reduction amounts |  | X |  |
| Health FSA value for the plan year in excess of employee’s cafeteria plan salary reductions for all qualified benefits1 | X |  |  |
| Health Reimbursement Arrangement (HRA) contributions |  |  | X |
| Health Savings Arrangement (HSA) contributions (employer or employee) |  | X |  |
| Archer Medical Savings Account (Archer MSA) contributions (employer or employee) |  | X |  |
| Hospital indemnity or specified illness (insured or self-funded), paid on after-tax basis |  | X |  |
| Hospital indemnity or specified illness (insured or self-funded), paid through salary reduction (pre-tax) or by employer | X |  |  |
| Employee Assistance Plan (EAP) providing applicable employer-sponsored healthcare coverage | Required if employer charges a COBRA premium |  | Optional if employer does not charge a COBRA premium |
| On-site medical clinics providing applicable employer-sponsored healthcare coverage | Required if employer charges a COBRA premium |  | Optional if employer does not charge a COBRA premium |
| Wellness programs providing applicable employer-sponsored healthcare coverage | Required if employer charges a COBRA premium |  | Optional if employer does not charge a COBRA premium |
| Multi-employer plans |  |  | X |
| Domestic partner coverage included in gross income | X |  |  |
| Governmental plans providing coverage primarily for members of the military and their families |  | X |  |
| Federally recognized Indian tribal government plans and plans of tribally charted corporations wholly owned by a federally recognized Indian tribal government |  | X |  |
| Self-funded plans not subject to Federal COBRA |  |  | X |
| Accident or disability income |  | X |  |
| Long-term care |  | X |  |
| Liability insurance |  | X |  |
| Supplemental liability insurance |  | X |  |
| Workers' compensation |  | X |  |
| Automobile medical payment insurance |  | X |  |
| Credit-only insurance |  | X |  |
| Excess reimbursement to highly compensated individual, included in gross income |  | X |  |
| Payment/reimbursement of health insurance premiums for 2 percent shareholder-employee, included in gross income |  | X |  |
| **Other Situations** | **Report** | **Do Not Report** | **Optional** |
| Employers required to file fewer than 250 Forms W-2 for the preceding calendar year (determined without application of any entity aggregation rules for related employers) |  |  | X |
| Forms W-2 furnished to employees who terminate before the end of a calendar year and request, in writing, a Form W-2 before the end of that year |  |  | X |
| Forms W-2 provided by third-party sick-pay provider to employees of other employers |  |  | X |
| 1. X's cafeteria plan offers permitted taxable benefits (including cash), qualified nontaxable benefits (including a health FSA), and an employer flex credit of $1,000. John makes a $2,000 salary reduction election for several qualified benefits under the plan, including a health FSA for $1,500. The cost of his qualified benefits under the plan for the year is $3,000. The amount of John’s salary reduction election for the plan year ($2,000) equals or exceeds the amount of the health FSA for the plan year ($1,500), so none of the health FSA amount is taken into account when determining the aggregate reportable cost. See IRS Notice 2012-9 Q&A 19 (Example 2). |

Exchange Notice Required Beginning October 1, 2013

323. What is the Exchange Notice that employers must give and when is the requirement effective?

The health insurance exchanges will be operational on January 1, 2014. PPACA requires employers to provide a notice prior to the beginning date of the exchange. Originally required March 1, 2013, this notice must be provided by all employers, regardless of size, that are subject to the Fair Labor Standards Act (virtually all employers, as discussed below) to employees by Oct. 1, 2013.[[26]](#footnote-26) Notices must be provided by employers, including those without a group health plan, to both active part-time and full-time employees (not spouses or dependents), regardless of whether eligible for the employer’s health plan, if any.[[27]](#footnote-27)

New employees hired on and after October 1, 2013, must receive the notice within fourteen days of hire. This fourteen-day notification period for new hires is in effect from October 1, 2013, through 2014 (the timing to be revisited at that point).

The employer’s health plan year is not relevant in regard to the required delivery of this exchange notice. Notice may be sent first class mail or electronically.

There are two model notices. For employers with a health plan, see <http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf>. For employers with no health plan, see <http://www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf>. These model notices are reproduced in Appendix B. Part B of the notice for employers with health plans is optional and complicated. Many employers with health plans will not use it, preferring instead to customize the information on the Part B notice for employers with no health plans.

 Most firms under $500,000 in annual dollars received from “sales made or business done” are exempt from the FLSA and thus exempt from the notice requirement, other than those specifically included regardless of annual income. Those included regardless are hospitals; institutions primarily engaged in the care of the sick, aged, mentally ill, or disabled who reside on the premises; schools for children who are mentally or physically disabled or gifted; preschools, elementary and secondary schools, and institutions of higher education; and federal, state, and local government agencies.

 In addition, only employers with $500,000 or more in annual dollars received from “sales made or business done” who are also engaged in interstate commerce are subject to the FLSA. Examples of engaging in interstate commerce include:

• An employee uses a telephone, facsimile machine, the U.S. mail, or a computer e-mail system to communicate with persons in another state for the business

• An employee who drives or flies to another state while performing his or her job duties

• The business uses goods from an out-of-state supplier; or

• The business uses an electronic device that authorizes a credit/debit card purchase

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***A simplified but acceptable Sample Notice follows***.

|  |
| --- |
| **State Health Insurance Marketplace (Exchange) Health Insurance Coverage Options & Your Coverage** |

**PART A: General Information.** When key parts of the health care reform law take effect in 2014, there will be a new way to buy health insurance - the Health Insurance Marketplace or Exchange that will exist in every state. To assist you evaluate options for you and your family, this notice provides basic information about the new state Marketplaces (Exchanges).

**What is the Health Insurance Marketplace (Exchange)?** Each state’s Marketplace (Exchange) is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace (Exchange) offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of federal tax credit that lowers your monthly premium. Open enrollment for health insurance coverage through the Marketplace (Exchange) begins in October 2013 for coverage starting as early as January 1, 2014.

**Can I Save Money on my Health Insurance Premiums in the Marketplace (Exchange)?** You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium for which you may be eligible depends on your household income.

**Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace (Exchange)?** Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace (Exchange) and may therefore wish to enroll in your employer's health plan. However, you may be eligible for a federal income tax credit that lowers your monthly health insurance premium if your employer does not offer health plan coverage to you or does not offer coverage that meets affordability and minimum value standards. If the cost of a plan from your employer that would cover you (but not any other members of your family) is more than 9.5 percent of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

**Note:** If you purchase a health plan through the Marketplace (Exchange) instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to any employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is generally excluded from income that is taxed for Federal and State purposes. Your payments for coverage through the Marketplace (Exchange) are made on an after-tax basis.

**How Can I Get More Information?** The Marketplace (Exchange) can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace (Exchange) and its cost. Please visit <https://www.healthcare.gov> on the internet for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace (Exchange) in your state. There will also be “Navigators” who are person trained to help you use your exchange.

**PART B: Information About Your Employer.** If you decide to complete an application for health insurance in your state Marketplace (Exchange), you will be asked to provide this information below. This information is numbered to correspond to the Marketplace (Exchange) health insurance application.

3. Employer name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Employer Identification Number (EIN)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Employer street address

6. Employer phone number

7. Employer’s City

8. Employer’s State

9. Employer’s ZIP code

10. Who can we contact at your job about information about the employer’s health plan, if any? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Phone number of employer contact person listed in #10 above (if different from above) \_\_\_\_\_\_\_\_\_\_

12. Email address of person listed in #10 above.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

324. Who is an employer for this purpose?

The notice requirement applies to employers that are subject to the Fair Labor Standards Act (FLSA). The term “employer” is defined in the FLSA as “any person acting directly or indirectly in the interest of an employer in relation to an employee.” This broad definition will likely encompass most employers.

325. What is the purpose and content of the Exchange Notice?

The notice is intended to inform the employees about the existence of the health benefit exchange and give a description of the services provided by the exchange. The notice also will explain how the employee may be eligible for a premium tax credit or a cost-sharing reduction if the employer's plan does not meet certain requirements. The notice must inform employees that if they purchase a qualified health plan through the exchange:

* They may lose any employer contribution toward the cost of employer-provided coverage, and
* All or a portion of the employer contribution to employer-provided coverage may be excludable for federal income tax purposes

Lastly, the notice will include contact information for customer service resources within the exchange and an explanation of appeal rights. The regulations clarified that the notice must meet certain accessibility and readability requirements, as well as be in writing.

The DOL is expected to release a model notice, along with additional guidance, prior to the March 1, 2013, effective date.

326. Which employees must receive the notice?

All employees, not just those eligible for health coverage must receive the notice. The FLSA broadly defines an employee as “an individual employed by an employer.”[[28]](#footnote-28)

327. What are the penalties for failure to give the Exchange Notice to employees?

There is no known penalty at this time.

Reporting of Health Insurance Coverage (Insurers and Employers that Self-Insure) for 2015 and Thereafter

328. In addition to the W-2 reporting, what other reporting must employers make to the IRS and covered individuals?

Healthcare reform requires any person who provides “minimum essential coverage”[[29]](#footnote-29) to an individual during a calendar year to report certain health insurance coverage information to the IRS.[[30]](#footnote-30) Reporting is required for grandfathered plans.[[31]](#footnote-31)No reporting is required for “excepted benefits.”[[32]](#footnote-32) The employer must also provide a written statement to the covered individual, as discussed in Q 342.

329. When does this reporting requirement go into effect?

 The requirement for Reporting of Health Insurance Coverage originally was to be effective in 2014. However, IRS Notice 2013-45, issued in July 2013, provided a one-year delay to three reporting requirements under the healthcare reform law.

 The first reporting requirement that was postponed was the annual obligation under section 6055 of the Internal Revenue Code (Code) for insurers, self-insuring employers and other parties that provide “minimum essential coverage” to provide certain information to the IRS.

 The other two requirements that were postponed were

* The annual obligation under Code section 6056 for applicable large employers to report to the IRS and to the employer’s full-time employees as to whether and what healthcare coverage is offered to such employees
* The requirement under Code section 4980H for applicable large employers to offer healthcare coverage to full-time employees or pay penalties, commonly known as the “play-or-pay” penalties (POP)

(See Q 344 through Q 347 for discussions of the Code section 6056 for applicable large employers.)

330. What type of information must be reported to the IRS?

The type of information includes the name and address of the primary insured and other individuals covered under an applicable policy, the dates of coverage, and whether and by what method Minimum Essential Coverage is provided. This information is used to determine various employer and individual penalties, when applicable.

331. Did the July 2013 IRS Notice postpone all elements of the PPACA reporting requirements?

No. The Notice postpones compliance with only these three requirements until 2015. Everything else scheduled to become effective in 2014 will go into effect in 2014. See PPACA Timeline, Part III, Q 98.

332. What new effective dates did the July 2013 IRS Notice provide?

The Notice advises that the IRS will in the summer of 2013 propose regulations for the two information-reporting provisions now effective in 2015. The IRS encourages employers, insurers and other reporting entities to voluntarily comply with the proposed rules for information reporting for 2014, but no penalties for failure to comply with these reporting provisions now exist for 2014.

333. Why were the reporting requirements postponed until 2015?

The information reporting required by Code sections 6055 and 6056 must occur in order for the IRS to enforce and administer the employer mandate requirements under Code section 4980H. The employer mandate penalties are triggered if one or more of an applicable large employer’s full-time employees are entitled to premium tax credits for the purchase of insurance on a state exchange marketplace under Code § 36B and (1) the employer fails to offer 95 percent of full-time employees and their dependents the opportunity to enroll in minimum essential coverage or (2) the employer offers full-time employees and dependents the opportunity to enroll in minimum essential coverage but the coverage is not affordable or does not provide minimum value. The second penalty can never exceed the first penalty.

An employer typically will not know whether a full-time employee has received such a tax credit, and the employer will not have all the information needed to determine whether it owes an employer mandate penalty. Therefore, applicable large employers do not have to calculate employer mandate penalties or file returns submitting payment for such penalties in 2014.

Instead, the IRS, after receiving the information returns filed by applicable large employers under Code section 6056 and the information about employees claiming the premium tax credit for any given calendar year, will determine whether any of the employer’s full-time employees received the premium tax credit and, if so, whether any employer mandate penalty is due. The IRS will thus contact any applicable large employer if the employer owes a penalty, and the employer will have an opportunity to respond to the information provided by IRS before any penalty is assessed. (See Q 344 through Q 347 for information on the Code 6056 requirements affecting certain large employers.)

333.01 What do the final regulations on employer information reporting require?

Sections 6055 and 6056 of the Internal Revenue Code (“Code”) prescribe reporting of healthcare coverage and are effective for 2015, with the first forms to be filed in 2016, an administratively delayed effective date.[[33]](#footnote-33) The employer mandate generally requires employers with 50 or more full-time employees (applicable large employers or “ALEs”) to offer coverage to their full-time employees that meets minimum value and affordability standards under the ACA or pay a penalty. Employers that have fewer than 50 full-time and full-time equivalent employees are exempt from the ACA employer shared responsibility provisions and therefore from the employer reporting requirements. The final March 2014 regulations on this reporting provide for a single, combined form for information reporting under both Code 6055[[34]](#footnote-34) and 6056[[35]](#footnote-35) as well as a simplified option for employer reporting of “qualified offers” of coverage to employees.

For employers subject to a delayed employer mandate, i.e., those with at least 50 full-time employees but fewer than 100 full-time employees (including full-time equivalent employees), in transitioning into compliance with section 4980H, the final regulations provide transition relief from section 4980H for 2015 (plus, in the case of any non-calendar plan year that begins in 2015, the portion of the 2015 plan year that falls in 2016).[[36]](#footnote-36)

Code 6055 describes reporting requirements to the IRS and individuals for self-insuring employers, insurers, government entities, and certain other providers of minimum essential coverage (“MEC”). Wellness programs that are an element of other minimum essential coverage (such as wellness programs offering reduced premiums or cost sharing under a group health plan) do not require separate § 6055 reporting. Code 6056 describes reporting requirements for applicable large employers to provide employees with information so that they can determine whether they can receive a premium tax credit if they purchase insurance from a health care exchange. Section 6056 also requires such employers to report to the IRS information concerning health care coverage. Reporting under these new requirements is similar to the reporting of W-2 information where individual statements are provided to each employee on form W-2 and the W-2s are accumulated and summarized on Form W-3. Employers who sponsor self-insured health care plans, and who are therefore required to report under both sections 6055 and 6056, may file a combined report for the IRS and employees. Electronic reporting is required for employers who have more than 250 employees for whom individual reports are required. Large employers that self-insure (employers that pay their employees’ medical costs directly, instead of joining a traditional plan) will fill out both sections of the form. Large employers that do not self-insure will only fill out the top half of the form, for reporting under Code 6056.

The final regulations under Code 6055 require an employer to report information about the employer, the employees insured, and information on the minimum essential coverage provided, including employee and dependent social security numbers or a date of birth if the SSN is not available after reasonable efforts to obtain it. Code 6056 requires applicable large employers to report information about themselves, such as the number of full-time employees for each month during the calendar year, certify whether they offered coverage to their full-time employees, and provide certain information about the plan offered, including the monthly premium for the plan.

The regulations provide that a qualifying offer of coverage is “an offer of minimum value coverage that provides employee-only coverage at a cost to the employee of no more than about $1,100 (9.5 percent of the estimated federal poverty level in 2015) in 2015” combined with an offer of coverage to the employee’s family, which does not need to meet the cost threshold. An employer makes a qualifying offer if it offered the employee coverage that provides 60 percent minimum value at an employee cost for employee-only coverage of no more than 9.5 percent of the federal poverty line, and also offered minimum essential coverage to employees’ spouses and dependents. For employees receiving a qualified offer for all 12 months, employers will need to report only the names, addresses, and taxpayer identification numbers of such employees. For employees receiving a qualifying offer in fewer than 12 months in the year, employers will be able to report such employees for each of those months by simply entering a code.

335. Is an employees’ ability to receive premium tax credits in 2014 effected by the reporting requirement delay?

No. The Notice states that the transition relief does not affect an individual’s eligibility for a premium tax credit if he or she purchases health insurance through one of the health insurance exchange marketplaces established under the Act. Participants in the exchanges will continue to qualify for premium tax credits if their household income is within the specified range and they are not eligible for other minimum essential coverage. Such other minimum essential coverage includes eligible employer-sponsored group health plans that are affordable and provide minimum value.

336. Were any 2014 requirements of the PPACA affected by the extension of the effective date of these reporting requirements?

No. The Notice makes clear that the 2014 transition relief is limited solely to these three items and has no effect on the effective date or application of other provisions under the Act, many of which go into effect in 2014. For example, the transition relief has no effect on the provisions taking effect in 2014 as to premium tax credits for those purchasing subsidized health insurance on an exchange marketplace or the individual mandate requirements under Code § 5000A for individuals to maintain healthcare coverage for themselves or pay penalties.

337. What are some of the 2014 requirements that were not affected by the postponement of these three reporting requirements?

Provisions taking effect for Plan Years beginning on or after Jan. 1, 2014 include the following:

* Group health plans, whether or not “grandfathered” under the Act, may not impose dollar limits on “essential health benefits.”
* Non-grandfathered health insurance plans in the small group market must offer essential health benefits.
* Group health plans and health insurance issuers offering group health insurance coverage may not establish rules for initial or continued eligibility of an individual to enroll in the plan or discriminate as to coverage based on the individual’s or dependent’s health status-related factors, such as medical condition (both physical and mental illnesses); claims experience; receipt of healthcare; medical history; genetic information; evidence of insurability (including conditions arising out of acts of domestic violence); and disability. Nevertheless, premium or contribution provisions for similarly-situated individuals in connection with a wellness program that satisfies certain requirements are permitted
* Group health plans and health insurance issuers offering group health insurance coverage, including grandfathered plans and policies, may not impose any preexisting condition exclusion.
* Group health plans, including grandfathered plans, cannot apply waiting periods for coverage that are greater than 90 days.
* Non-grandfathered group health plans may not impose annual cost-sharing that exceeds the maximum out-of-pocket expense limits for health savings account-compatible high-deductible health plans.

(See Part III, Q 98, for a complete PPACA implementation timeline.)

338. What is “minimum essential coverage” that must be reported?

Most employer-provided group health coverage is “minimum essential coverage.” The definition includes any “eligible employer-sponsored plan.” This includes a group health plan or group health insurance coverage offered by an employer to an employee that is a governmental plan or any other plan or coverage offered in a state’s small or large group market.[[37]](#footnote-37)

339. Who is subject to this reporting requirement?

Employers sponsoring insured and self-insured plans must file reports.[[38]](#footnote-38) It is possible that insurers will be required to make this reporting on behalf of employers with insured group health plans. Additionally, these requirements must be coordinated with the additional reporting required for large employers, discussed in Q 344 to Q 347, to prevent redundant reporting.

340. When is this reporting requirement effective?

The Code section 6055 reporting requirement is first required for coverage provided on or after January 1, 2014. The first information returns will be filed in 2015.

341. What information must be reported to the IRS?

The return is on a form provided by the IRS and must contain the following information:

* the name, address, and taxpayer identification number (TIN) of the primary insured (this term is undefined but most likely refers to employees and not family members), and the name and TIN of each other individual obtaining coverage under the policy
* the dates during which the individual was covered during the calendar year
* if the coverage is health insurance coverage, whether the coverage is a qualified health plan (QHP) offered through a health benefit exchange
* if the coverage is health insurance coverage and that coverage is a QHP, the amount of any advance cost-sharing reduction payment or of any premium tax credit with respect to such coverage; and
* any other information required by the IRS[[39]](#footnote-39)

In addition, if health insurance coverage is through an employer-provided group health plan, the return must contain the following information:

* the name, address, and employer identification number (EIN) of the employer maintaining the plan
* the portion of the premium (if any) required to be paid by the employer; and
* any other information the IRS may require to administer the new tax credit for health insurance for eligible small employers[[40]](#footnote-40)

342. What statement must be furnished to covered individuals?

The person who is required to report the health insurance coverage to the IRS (as described above in Q 339) must also furnish a written statement to each individual whose name must be included in the information return. This statement must include:

* the name, address, and contact information of the reporting person; and
* the information required to be shown on the return with respect to that individual (discussed in Q 341)[[41]](#footnote-41)

This statement must be furnished to the covered individual on or before January 31 of the year following the calendar year for which the information was required to be reported to the IRS.[[42]](#footnote-42)

343. What is the sanction for noncompliance with this reporting requirement?

An employer that fails to comply with these reporting requirements is subject to penalties for failure to file an information return and failure to furnish payee statements.[[43]](#footnote-43)

Health Insurance Coverage Reporting by Large Employers and Offering Employers for 2015 and Thereafter

344. In addition to the requirements described above in Q 323 to Q 343 for employers to report to the IRS and employees, what other similar reporting requirements exist?

Internal Revenue Code section 6056 contains requirements similar to those described in Q 341 that are imposed by Code section 6055. The Code section 6056 requirements apply to “applicable large employers” and “offering employers.” The IRS may allow for any return or written statement required under this provision (i.e., large employers and “offering employers”) to be provided as part of a return or written statement required under Code section 6055, discussed above in Q 341.[[44]](#footnote-44)

Applicable Large Employers. “Applicable large employers” are the employers with fifty or more full-time equivalent employees (on average, during the preceding year) that may be liable for the employer mandate penalty tax under Code section 4980H if they provide no health coverage or do not provide affordable health coverage to their full-time employees (and their dependents).[[45]](#footnote-45)

Offering Employers. The reporting requirement also applies to “offering employers,” which are employers that offer “minimum essential coverage” to employees under an eligible employer-sponsored plan and the employee contribution of any employee exceeds 8 percent of the wages paid to that employee by the employer.[[46]](#footnote-46)

345. What information is reported by the applicable large employers and offering employers?

The employer files an information return with the IRS with the following information:

* the employer’s name, date, and employer identification number (EIN)
* a certification of whether the employer offers its full-time employees and their dependents the opportunity to enroll in “minimum essential coverage” under an “eligible employer-sponsored plan”[[47]](#footnote-47)
* the number of full-time employees the employer has for each month during the calendar year
* the name, address, and taxpayer identification number (TIN) of each full-time employee employed by the employer during the calendar year and the months (if any) during which the employee and any dependents were covered under a health benefit plan sponsored by the employer during the calendar year; and
* any other information required by the IRS[[48]](#footnote-48)

Employers that offer the opportunity to enroll in “minimum essential coverage” must also report:

* the months during the calendar year for which coverage under the plan was available
* the monthly premium for the lowest cost option in each of the enrollment categories under the plan
* the employer’s share of the total allowed costs of benefits provided under the plan
* in the case of an employer that is an applicable large employer, the length of any waiting period for such coverage
* for an offering employer, the option for which the employer pays the largest portion of the cost of the plan and the portion of the cost paid by the employer in each of the enrollment categories under such option; and
* any other information required by the IRS[[49]](#footnote-49)

346. Which statements must be furnished to employees by “applicable large employers” and “offering employers?”

Employers required to submit a report of health insurance coverage to the IRS under Code section 6056 must also furnish a written statement to each of their full-time employees whose name was required to be included in the report to IRS. This statement includes:

* the name, address, and contact information of the reporting employer; and
* the information required to be shown on the return with respect to the individual[[50]](#footnote-50)

The written statement must be furnished to full-time employees on or before January 31 of the year following the calendar year for which the information was required to be reported to the IRS.[[51]](#footnote-51)

347. What are the consequences for failure to comply with the Code section 6056 reporting requirements?

An employer that fails to comply with these reporting requirements is subject to penalties for failure to file an information return and failure to furnish payee statements.[[52]](#footnote-52)

Annual Report by DOL about Self-Insured Plans (Using Form 5500 Information)

348. What information must the DOL report to Congress regarding self-insured health plans?

Healthcare reform requires the DOL to prepare and submit to Congress an aggregate annual report that includes general information collected from Form 5500 filings by self-insured group health plans, including plan type, number of participants, benefits offered, funding arrangements, and benefit arrangements.[[53]](#footnote-53)

Insured Health Plan Transparency in Coverage and Cost-Sharing Reporting

349. What are the transparency in coverage and cost-sharing reporting requirements?

The transparency in coverage reporting and the cost-sharing disclosure rules apply to individual policies and group health plans, both qualified health plans (QHPs), and those outside of the exchanges.[[54]](#footnote-54) The requirements are the same except that non-exchange health plans need not report to the exchange. These health plan reports are made to HHS, the state insurance commissioner, and the public.[[55]](#footnote-55) The rules do not apply to grandfathered plans,[[56]](#footnote-56) although if a QHP sold on an exchange were grandfathered, it would need to make a report to the exchange.[[57]](#footnote-57) In addition, a health plan seeking QHP certification on an exchange must provide certain cost-sharing disclosures to participants.[[58]](#footnote-58)

350. What information must be reported under these rules?

Health plans and insurers subject to the transparency in coverage reporting requirement must disclose all of the following information:

* claims payment policies and practices
* periodic financial disclosures
* data on enrollment and disenrollment
* data on the number of claims denied
* data on rating practices
* information on cost-sharing and payments regarding any out-of-network coverage
* information on enrollee and participant rights under Title I of PPACA; and
* other information as determined appropriate by the Secretary of HHS[[59]](#footnote-59)

351. Must any of this information be disclosed to individuals?

Yes. Health plans and insurers subject to this requirement must provide certain cost-sharing information (including deductibles, copayments, and coinsurance) in a timely manner on request by an individual.[[60]](#footnote-60) The information generally may be provided on a Web site, but for individuals who do not have access to the Internet, the information must be provided another way.[[61]](#footnote-61)

SPD Content Requirements for ERISA Group Health Plans

352. Does health reform make any changes in the SPD requirements for group health plans?

The law does not make changes directly, but it does direct the DOL to update and harmonize its rules governing disclosures to group health plan participants (e.g., plan terms and conditions or periodic financial disclosure) with standards established by HHS.[[62]](#footnote-62) Thus, some additional SPD disclosure requirements are expected.

Quality of Care Reporting by Group Health Plans and Insurers

353. What reporting is required by group health plans and insurers that is designed to improve the quality of care?

Group health plans and health insurance companies must submit an annual report to HHS addressing plan or coverage benefits and provider reimbursement structures that may affect the quality of care in certain specified ways. The reporting requirements are to be developed in consultation with health care quality experts and representatives of care providers, care recipients, insurers, and employers. This requirement will be enforced by “appropriate penalties” developed by HHS.[[63]](#footnote-63) Grandfathered plans are not subject to these rules.[[64]](#footnote-64)

HHS was required to “develop” the reporting requirements and issue regulations no later than March 23, 2012.[[65]](#footnote-65) HHS missed the deadline.[[66]](#footnote-66) As of 2014, HHS has still not issued any guidance.

354. What information must be reported and when?

The quality of care report will address whether plan or coverage benefits as well as provider reimbursement structures satisfy several criteria related to the cost and quality of health care. These will include whether the plan or coverage:

* improves health outcomes for treatment or services under the plan or coverage through such activities as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives (including the medical homes model)
* implements activities to prevent hospital re-admissions using a comprehensive discharge program and post-discharge reinforcement
* improves patient safety and reduces medical errors through best clinical practices, evidence-based medicine, and health information technology; and
* implements wellness and health promotion activities[[67]](#footnote-67)

Cadillac Plan Excise Tax Determination

355. What is the “Cadillac Tax” and what reporting is required?

The “Cadillac Tax” is effective in 2018 and its intent is to discourage expensive health plans that require enrollees to pay little for their own care. It is discussed in more detail in Part IX of this book.

An employer will have to determine whether the following costs for each employee for each year exceed $10,200 (individual) and $27,500 (family):

* Health care coverage
* Employer health FSA contributions and any reimbursements in excess of the employer contributions
* Employer and employee pretax HSA contributions; and
* HRA contributions

If the cost is above the threshold, the employer is required to determine the excess amount and report it to the Secretary of the Treasury and each third-party administrator or insurer, including the excess amounts attributable to each third-party administrator or insurer.

List of Required Disclosures and Notices to Health Plan Participants

356. What are the various notices required to be made to health plan participants?

In addition to the mandates discussed earlier in Part VII of this book that need to be described in the health plan SPD, the following notices must be given:

Grandfather Status (effective for plan years beginning on and after September 23, 2010). Grandfathered plans must include a statement in any plan material provided to participants and beneficiaries each year describing benefits under the plan that the plan believes it is grandfathered and contact information for questions and complaints. See Q 168. The DOL provided model language as follows:

This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]

Rescission Prohibition (effective for plan years beginning on and after September 23, 2010). All plans must provide at least thirty days’ advance written notice to each participant who would be affected by a rescission, whether the rescission applies to the entire group or to an individual.

Primary Care Designation Notice (plan years beginning on or after September 23, 2010). All non-grandfathered plans must provide notice of the following: If a plan requires the designation of a primary care provider, the plan must allow each participant or beneficiary to elect a primary care provider who will accept him/her, including a pediatrician for a child. A plan also must allow direct access to an in-network OB/GYN for female participants or beneficiaries. The following is a model notice:

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].

PPACA Prohibition on Lifetime Dollar Limits; Re-enrollment Right (plan years beginning on or after September 23, 2010). If an individual was no longer eligible for coverage under the plan because of reaching the lifetime dollar limit, the plan must allow the individual into the plan on the first plan year on and after September 23, 2010. The plan must provide notice of the right to reenroll to this individual. The following model notice can be used:

The lifetime limit on the dollar value of benefits under [Insert name of group health plan or health insurance issuer] no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the [insert plan administrator or issuer] at [insert contact information].

Annual Limits (effective for plan years beginning on or after September 23, 2010). For plan years beginning before January 1, 2014, a plan may impose restricted annual dollar limits on essential benefits. However, a plan may obtain a waiver of the dollar limits if it can show that these restrictions would increase cost or limit access to benefits. If a plan receives a waiver, it must provide a notice to all participants that, in a 14-point font:

* states that the plan or policy does not meet the minimum annual limits for essential benefits and received a waiver of this requirement
* specifies the dollar amount of the annual limit
* describes the plan benefits to which the limits apply; and
* states that the waiver is only granted until the last day of the plan year before January 1, 2014

For waivers received for plan years on or after February 1, 2011, the notice must be provided as part of any informational or educational materials and included in the SPD. HHS provided a model notice. Waiver recipients must receive permission to use language that is different from the model notice.

Adult Child Coverage Opportunity (effective for plan years beginning on or after September 23, 2010). The following model notice can be used:

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in [Insert name of group health plan or health insurance coverage]. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to [insert date that is the first day of the first plan year beginning on or after September 23, 2010.] For more information contact the [insert plan administrator or issuer] at [insert contact information].

Claims and Appeals Process. Health reform adds additional requirements for claims and appeals procedures for non-grandfathered plans. These requirements were effective for plan years beginning on and after September 23, 2010, but the DOL provided an enforcement grace period for certain provisions for plan years beginning on and after the date noted below. This notice must:

* be written in a culturally and linguistically appropriate manner (effective January 1, 2012)
* provide the following additional content:
* Information sufficient to identify the claim involved, including the date of service, the healthcare provider, the claim amount, and a statement that the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning are available on request.
* An explanation of the reason for the adverse benefit determination or final adverse benefit determination, including the denial code and its meaning and a description of the plan’s standard that was used in denying the claim or making the final adverse determination (effective July 1, 2011)
* Describe the internal appeals and external review process (effective July 1, 2011)
* Describe the availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman as established under PPACA (effective July 1, 2011)

If a plan does not meet all of the requirements in the regulations, the claimant is deemed to have exhausted the internal claims and appeals process and may initiate any available external review or remedies under ERISA or state law. The strict adherence standard will not apply if the errors were:

* de minimis
* nonprejudicial or nonharmful
* for good cause or because of matters beyond the plan’s control
* in the context of an ongoing, good-faith exchange of information; and
* not a pattern or practice of non-compliance

If a plan asserts the exception, it must provide an explanation in response to a written request from the claimant (effective January 1, 2012).

Summary of Benefits and Coverage (SBC) (effective for open enrollments beginning for plan years beginning on and after September 23, 2012 and new enrollments). The SBC must be provided to employees. The SBC must not exceed eight pages (four sheets front and back), be in 12-point font, be presented in “culturally and linguistically” appropriate language, and include the following:

* A Uniform Glossary, i.e., definitions of standard insurance terms and medical terms
* A description of coverage and any cost sharing (including any deductibles, coinsurance, and copayments, but not premiums)
* Any exceptions, reductions, and limitations on coverage
* Renewability and continuation coverage provisions
* Coverage examples (currently only childbirth and diabetes, but up to four more may be added in the future)
* A statement of whether the plan provides minimum essential coverage and has an actuarial value of at least 60 percent (effective for plan years beginning on and after January 1, 2014)
* A contact number to call and an Internet address or Web site for a copy of the policy or the SPD for self-funded plans)
* If a plan has multiple networks, contact information for obtaining a list of network providers
* If a plan uses a prescription drug formulary, contact information for obtaining information on prescription drug coverage
* An Internet address or Web site for obtaining the Uniform Glossary, a contact number to obtain a paper copy of the Uniform Glossary, and a disclosure that paper copies are available

A sample SBC and Uniform Glossary are provided in the Appendix A of this book. If any material modification of any of the terms of the plan coverage is made and it is not reflected in the most recent SBC, notice of the modification must be provided no later than sixty days before the modification becomes effective.

W-2 Reporting 2012 Calendar Year Health Care Coverage (reportable by January 31, 2013). See Q 311 to Q 327.

Explanation of Exchange, the Exchange Notice. Effective March 1, 2013 and for all new hires thereafter.

Reporting of Health Insurance Coverage Effective for Plan Years beginning on and after January 1, 2014. An employer must file a return with the IRS showing:

* The name, address, and TIN of the participant and the name and TIN of each beneficiary
* The date of coverage
* The employer’s name, address, and EIN
* The portion of the premium paid by the employer

An employer must provide to a participant the following before January 31 of the year following the reporting year:

* The name and address of the employer and a phone number of the contact for the information provided to the participant
* The information that is required to be on the return to the IRS

Automatic Enrollment (presumably plan years beginning on and after January 1, 2014). An employer with more than 200 employees must automatically enroll each new full-time employee and continue such enrollment, unless the employee opts out or changes the coverage. The employer must provide notice of the automatic enrollment and the procedures for opting out. Employers do not have to comply with this provision until the DOL issues regulations, which will not be before 2014.

Disclosure of Plan Data and Financials. The Secretary of Labor will update the participant and plan disclosure requirements to be consistent with the standards established by the Secretary of HHS for exchange plans, relating to the following:

* Claims payment policies and practices
* Periodic financial disclosures
* Data on enrollment
* Data on disenrollment
* Data on the number of claims that are denied
* Data on rating practices
* Information on cost-sharing and payments with respect to any out-of-network coverage
* Information on enrollee and participant rights
* Any other information the Secretary of HHS determines appropriate
1. . PPACA §1251(a) lists the requirements for which an employer is exempt and does not include the W-2 requirement. [↑](#footnote-ref-1)
2. . PPACA §9002. [↑](#footnote-ref-2)
3. . IRC Sec. 6051(a)(14). [↑](#footnote-ref-3)
4. . IRS Notices 2010-69 and 2011-28. [↑](#footnote-ref-4)
5. . Notice 2012-9, Q&A 2. [↑](#footnote-ref-5)
6. . Notice 2012-9, Q&A 3. [↑](#footnote-ref-6)
7. . Notice 2012-9, Q&A 5. [↑](#footnote-ref-7)
8. . Notice 2012-9, Q&A 3. Tribally chartered corporations wholly owned by a federally recognized Indian tribal government are also exempt .Id. [↑](#footnote-ref-8)
9. . This agent is not a payroll service that prepares paychecks for the employer's signature. Rather, an agent under IRC Sec. 3504 performs acts such as the withholding, reporting and paying of federal employment taxes with regard to wages paid by the agent for the employer, as well as the agent’s own employees. A Section 3504 agent agrees to assume liability along with the employer for the employer’s Social Security, Medicare and federal income tax withholding responsibilities. An agent is appointed using IRS Form 2678 and files aggregate returns using the agent’s EIN. The Section 3504 designation does not apply to FUTA tax, with a limited exception provided for certain household workers. See IRS Notice 2003-70. [↑](#footnote-ref-9)
10. . Notice 2012-9, Q&A 3. [↑](#footnote-ref-10)
11. . Notice 2012-9, Q&A 6. [↑](#footnote-ref-11)
12. . Notice 2012-9, Q&A 19. [↑](#footnote-ref-12)
13. . Notice 2012-9, Part II and Q&A 20. [↑](#footnote-ref-13)
14. . Notice 2012-9, Q&A 23. [↑](#footnote-ref-14)
15. . Notice 2012-9, Q&A 7 provides that if two or more related corporations concurrently employ the same individual and compensate such individual through a common paymaster which is one of such corporations, each such corporation shall be considered to have paid as remuneration to such individual only the amounts actually disbursed by it to such individual and shall not be considered to have paid as remuneration to such individual amounts actually disbursed to such individual by another of such corporations. [↑](#footnote-ref-15)
16. . Reg. §31.3121(s)-1. [↑](#footnote-ref-16)
17. . Reg. §31.3121(s)-1. [↑](#footnote-ref-17)
18. . Notice 2012-9, Q&A 34. [↑](#footnote-ref-18)
19. . Notice 2012-9, Q&A 35. [↑](#footnote-ref-19)
20. . ERISA Sec. 604(2); IRC Sec. 4980B(f)(4)(B); PHSA §2204(2). [↑](#footnote-ref-20)
21. . IRS Notices 2011-28 and 2012-9. [↑](#footnote-ref-21)
22. . Notice 2012-9, Q&A 32. [↑](#footnote-ref-22)
23. . IRC Secs. 6721, 6722, and 6674. [↑](#footnote-ref-23)
24. . Notice 2012-9, Q&A 9. [↑](#footnote-ref-24)
25. . See http://www.irs.gov/newsroom/article/0,,id=257101,00.html. [↑](#footnote-ref-25)
26. . DOL Technical Release No. 2013-02; FAQs about Affordable Care Act Implementation Part XI, Q&A 1, available at http://www.dol.gov/ebsa/faqs/faq-aca11.html. [↑](#footnote-ref-26)
27. . FLSA § 18B. [↑](#footnote-ref-27)
28. . FLSA §3(e)(1), 29 USC §203(e)(1). [↑](#footnote-ref-28)
29. . IRC Sec. 5000A. [↑](#footnote-ref-29)
30. . IRC Sec. 6055. [↑](#footnote-ref-30)
31. . IRC Sec.5000A(f)(1)(D). [↑](#footnote-ref-31)
32. . IRC Sec.5000A(f)(3). [↑](#footnote-ref-32)
33. IRS Notice 2013-45 delayed that law’s 2014 effective date until 2015. [↑](#footnote-ref-33)
34. Treas. Reg. § 1.6055-1 and 1.6055-2. [↑](#footnote-ref-34)
35. Treas. Reg. § 301.6056-1 and -2. [↑](#footnote-ref-35)
36. See section XV.D.6 of the preamble to the final regulations under section 4980H for a description of eligibility conditions for transition relief. [↑](#footnote-ref-36)
37. . IRC Sec. 5000A(f)(2). [↑](#footnote-ref-37)
38. . Joint Committee on Taxation, “Technical Explanation of the Revenue Provisions of the ‘Reconciliation Act of 2010,’ as Amended, in Combination with the ‘Patient Protection and Affordable Care Act,’” at p. 35 (2010). [↑](#footnote-ref-38)
39. . IRC Sec. 6055(b)(1). [↑](#footnote-ref-39)
40. . IRC Sec. 6055(b)(2). [↑](#footnote-ref-40)
41. . IRC Sec. 6055(c)(1). [↑](#footnote-ref-41)
42. . IRC Sec. 6055(c)(2). [↑](#footnote-ref-42)
43. . IRC Sec. 6724(d) defines “information return” for the penalty provisions in IRC Secs. 6721, 6722, and 6723. [↑](#footnote-ref-43)
44. . IRC Sec. 6056(d)(2). [↑](#footnote-ref-44)
45. . IRC Sec. 4980H. [↑](#footnote-ref-45)
46. . IRC Sec. 6056(f)(1). [↑](#footnote-ref-46)
47. . Defined in IRC Sec. 5000A(f)(2). [↑](#footnote-ref-47)
48. . IRC Sec. 6056(b). [↑](#footnote-ref-48)
49. . IRC Sec. 6056(b). [↑](#footnote-ref-49)
50. . IRC Sec. 6056(c)(1). [↑](#footnote-ref-50)
51. . IRC Sec. 6056(c)(2). [↑](#footnote-ref-51)
52. . IRC Sec. 6724(d) defines “information return” for the penalty provisions in IRC Secs. 6721, 6722, and 6723. [↑](#footnote-ref-52)
53. . PPACA §1253. [↑](#footnote-ref-53)
54. . PHSA §2715A (plans and insurers outside of the Exchange) and PPACA §1311(e)(3)(A)(requirement for exchange-certified health plans). [↑](#footnote-ref-54)
55. . PHSA §2715A. [↑](#footnote-ref-55)
56. . PPACA §§1251(a), 10103(d)(1). [↑](#footnote-ref-56)
57. . PPACA §1311(e)(3)(A). [↑](#footnote-ref-57)
58. . PPACA 1311(e)(3)(C). [↑](#footnote-ref-58)
59. . PPACA §1311(e)(3)(A). [↑](#footnote-ref-59)
60. . PPACA §1311(e)(3)(C). [↑](#footnote-ref-60)
61. . PPACA §1311(e)(3)(C). [↑](#footnote-ref-61)
62. . PPACA §1311(e)(3)(D). [↑](#footnote-ref-62)
63. . PHSA §2717(a). [↑](#footnote-ref-63)
64. . PPACA §§1251(a) and 10103(d)(1). [↑](#footnote-ref-64)
65. . PHSA §2717. [↑](#footnote-ref-65)
66. . The Government Accountability Office (GAO) released a report on January 13, 2012 stating that HHS has failed to properly supervise the development of quality measures that are required by PPACA. The report, “Health Care Quality Measurement: HHS Should Address Contractor Performance and Plan for Needed Measures” (GAO-12-136), also criticized the National Quality Forum (NQF), a nonprofit group that has a 4-year, $100 million contract with HHS to develop quality measures, for missing deadlines and exceeding contract cost estimates. The 75-page GAO report expresses concern that if HHS does not exert more control over NQF’s performance, it “may be unable to ensure that [HHS] receives the quality measures needed to meet PPACA requirements,” including deadlines for the implementation of new programs and initiatives to control healthcare costs. [↑](#footnote-ref-66)
67. . PHSA §2717(a)(1). [↑](#footnote-ref-67)