

Libbie Farrell

OA/Division of Accounting

ACA REPORTING

AFFORDABLE HEALTHCARE ACT

- ✘ Employer must offer coverage to all full-time employees, defined as working at least 30 hours per week
- ✘ Standard Measurement period – annual period
 - + October 16 – October 15
- ✘ Administrative period – period to elect coverage
- ✘ Stability period – healthcare coverage in effect

SECTION 6056 EMPLOYER MANDATE

- ✘ Requirement intended to help IRS determine individuals eligible for subsidies in public marketplace and if employer subject to penalty
- ✘ Large employers >100 FTEs report information on coverage offered or not offered to full-time employees during calendar year
- ✘ Employer provides 1095-C to employees on or before January 31st
- ✘ Employer provides transmittal information 1094-C to IRS
- ✘ Employee will only receive one 1095-C form per employer. OA will coordinate information between MCHCP, Conservation, MoDot and Patrol.

1095-C FORM

Form **1095-C** **Employer-Provided Health Insurance Offer and Coverage** VOID CORRECTED **2015** OMB No. 1545-2251

Department of the Treasury Internal Revenue Service **600116**

► Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

Part I Employee **Applicable Large Employer Member (Employer)**

1 Name of employee 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN)

3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number

4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code

Part II Employee Offer and Coverage **Plan Start Month** (Enter 2-digit number):

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

Part III Covered Individuals
If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2015)

Part I requires basic information about Employee and Employer. Employee name, address, and ssn will be obtained from SAM II HR

STATE OF MO FORM

600116

VOID

CORRECTED

OMB No. 1545-2251

2015

Form **1095-C**

Employer Provided Health Insurance Offer and Coverage

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Department of the Treasury - IRS

Part I APPLICABLE LARGE EMPLOYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no.

Part II Employee Offer and Coverage

Plan Start Mo. (Enter 2-digit no):	14 Offer of Coverage (enter required code)	15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	16 Applicable Section 4980H Safe Harbor (enter code, if applicable)
All 12 Months			
Jan			
Feb			
Mar			
Apr			
May			
June			
July			
Aug			
Sept			
Oct			
Nov			
Dec			

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

EMPLOYEE'S name, address, ZIP/postal code & country

APPLICABLE LARGE EMPLOYER'S identification number (EIN)

EMPLOYEE'S social security number (SSN)

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 mos.	(e) Months of Coverage												
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
17																
18																
19																

State of Missouri
Office of Administration/Division of Accounting
P.O. Box 809
Jefferson City MO 65102

300 OFFICE ADMINISTRATION-OPER
J31600 IS SYSTEMS & PROG

EXAMPLE

Full-time employee with coverage for the entire year

Part II Employee Offer and Coverage			
Plan Start Mo. (Enter 2-digit no):	14 Offer of Coverage (enter required code)	15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	16 Applicable Section 4980H Safe Harbor (enter code, if applicable)
All 12 Months	1A	\$600.00	
Jan			
Feb			
Mar			
Apr			
May			
June			
July			
Aug			
Sept			
Oct			
Nov			
Dec			

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each covered individual.															
(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 mos.	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Mrs. Reinstein	777-00-0001	1/1/1997	X												
Junior Reinstein	777-00-0002	1/1/2015		X	X	X	X	X	X	X	X	X	X	X	

18

19

EXAMPLE

- ✘ Jane is hired in July 2014
- + Measurement period: Aug 2014 to June 2015
- + Administrative period: July and Aug 2015
- + Sept 2015 enrolled in coverage offered

Part II Employee Offer and Coverage							Plan Start Month (Enter 2-digit number):						
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1A	1A	1A	1A
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)		2D	2D	2D	2D	2D	2D			2C	2C	2C	2C

1095-B FORM

Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

► Information about Form 1095-B and its separate instructions is at www.irs.gov/form1095b.

VOID

CORRECTED

560115

OMB No. 1545-2252

2015

Part I Responsible Individual

1 Name of responsible individual		2 Social security number (SSN)	3 Date of birth (if SSN is not available)
4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
8 Enter letter identifying Origin of the Policy (see instructions for codes): ► <input type="checkbox"/>		9 Small Business Health Options Program (SHOP) Marketplace identifier, if applicable	

Part II Employer Sponsored Coverage (see instructions)

10 Employer name			11 Employer identification number (EIN)
12 Street address (including room or suite no.)	13 City or town	14 State or province	15 Country and ZIP or foreign postal code

Part III Issuer or Other Coverage Provider (see instructions)

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
19 Street address (including room or suite no.)	20 City or town	21 State or province	22 Country and ZIP or foreign postal code

Part IV Covered Individuals (Enter the information for each covered individual(s).)

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of coverage												
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
23			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60704B

Form **1095-B** (2015)

QUESTIONS
