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Questions and Answers on Information Reporting by Health Coverage Providers (Section 6055)

Information reporting under section 6055 is voluntary for calendar year 2014. Reporting is first required in early 2016 for calendar year 2015. For more information see question 2. More information is available on the information reporting for providers of minimum essential coverage page.

Basics of Provider Reporting

1. What are the information reporting requirements for providers of health coverage?

The Affordable Care Act added section 6055 to the Internal Revenue Code, which provides that every provider of minimum essential coverage will report coverage information by filing an information return with the IRS and furnishing a statement to individuals. The information is used by the IRS to administer and individuals to show compliance with the individual shared responsibility provision in section 5000A.

2. When do the information reporting requirements go into effect?

The information reporting requirements are first effective for coverage provided in 2015. Thus, health coverage providers will file information returns with the IRS in 2016, and will furnish statements to individuals in 2016, to report coverage information in calendar year 2015.

Notice 2013-45 provides transition relief for 2014 from the section 6055 reporting requirements for health coverage providers. Accordingly, the reporting requirements do not apply for 2014. However, coverage providers are encouraged to provide information returns for coverage provided in 2014, which are due to be filed and furnished in early 2015. Returns filed voluntarily will have no impact on the tax liability of the health coverage provider or the individuals affected. For more information about voluntary filing in 2015, see IRS.gov.

3. Is relief available from penalties for incomplete or incorrect returns filed or statements furnished to employees in 2016 for coverage provided in calendar year 2015?

Yes. In implementing new information reporting requirements, short-term relief from reporting penalties frequently is provided. This relief generally allows additional time to develop appropriate procedures for collection of data and compliance with the new reporting requirements. Accordingly, the IRS will not impose penalties under sections 6721 and 6722 for 2015 returns and statements filed and furnished in 2016 on reporting entities that can show that they have made good faith efforts to comply with the information reporting requirements. Specifically, relief is provided from penalties under sections 6721 and 6722 for returns and statements filed and furnished in 2016 to report coverage in 2015 for incorrect or incomplete information reported on the return or statement. No relief is provided in the case of reporting entities that cannot show a good faith effort to comply with the information reporting requirements or that fail to timely file an information return or furnish a statement. However, consistent with the existing information reporting rules, reporting entities that fail to timely meet the requirements still may be eligible for penalty relief if the IRS determines that the standards for reasonable cause under section 6724 are satisfied. See question 29, below, for more information about penalties under sections 6721 and 6722.

4. Where can I find more information about the information reporting requirements for health coverage providers?

The regulations under section 6055 provide further guidance on the information reporting requirements for health coverage providers. Employers that are health coverage providers (for example, employers with self-insured health plans) may also be interested in reviewing regulations under section 6056 and our questions and answers regarding information reporting requirements for certain large employers.

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Who is Required to Report

5. Who must report under section 6055?

Any person that provides minimum essential coverage to an individual must report to the IRS and furnish statements to individuals, including the following:

- Health insurance issuers, or carriers, for insured coverage (but see questions 13 and 14 regarding certain limited exceptions),
- Plan sponsors of self-insured group health plan coverage, and
- The executive department or agency of a governmental unit that provides coverage under a government-sponsored program.

6. What is minimum essential coverage?

Minimum essential coverage includes the following:

- Eligible employer-sponsored coverage, including self-insured plans, COBRA coverage and retiree coverage
- Coverage purchased in the individual market, including a qualified health plan offered by the Health Insurance Marketplace
- Medicare Part A coverage and Medicare Advantage plans
- Most Medicaid coverage
- Children's Health Insurance Program (CHIP) coverage
- Certain types of veterans health coverage administered by the Veterans Administration
- Most types of TRICARE coverage under chapter 55 of title 10 of the United States Code
- Coverage provided to Peace Corps volunteers
- Coverage under the Nonappropriated Fund Health Benefit Program
- Refugee Medical Assistance supported by the Administration for Children and Families
- Self-funded health coverage offered to students by universities for plan or policy years that begin on or before Dec. 31, 2014 (for later plan or policy years, sponsors of these programs may apply to HHS to be recognized as minimum essential coverage)
- State high risk pools for plan or policy years that begin on or before Dec. 31, 2014 (for later plan or policy years, sponsors of these program may apply to HHS to be recognized as minimum essential coverage)
- Other coverage recognized by the Secretary of HHS as minimum essential coverage

More information about minimum essential coverage is provided in section 5000A(f), in regulations under section 5000A, and in our section 5000A questions and answers.

7. What is eligible employer-sponsored coverage?

Eligible employer-sponsored coverage is:

- A self-insured group health plan under which coverage is offered by or on behalf of an employer to an employee, or
- Group health insurance coverage offered by or on behalf of an employer to an employee that is –
  - a governmental plan,
  - a plan or coverage offered in the small or large group market within a state, or
  - a grandfathered health plan offered in a group market.

Eligible employer-sponsored coverage includes COBRA coverage and retiree coverage.

8. Is an employer required to report under section 6055 if it sponsors a health plan that provides coverage by purchasing insurance from a health insurance issuer?

No. An employer that sponsors an insured health plan (a health plan that provides coverage by purchasing insurance from a health insurance issuer) will not report as a provider of health coverage under section 6055. The health insurance issuer or carrier is responsible for reporting that health coverage. However, if the employer is subject to the employer shared responsibility provisions in section 4980H, it is responsible for reporting information under section 6056 about the coverage it offers to its full-time employees. For further information about the employer shared responsibility provisions under section 4980H and the reporting requirements under section 6056, see the section 4980H regulations and our section 4980H questions and answers and the section 6056 questions and answers.

9. For self-insured group health plan coverage, who is the plan sponsor that must to report under section 6055?

- For a self-insured group health plan maintained by a single employer, the plan sponsor is the employer. For a plan maintained by more than one employer that is not a multiemployer plan (as defined in ERISA) the plan sponsor is each participating employer. For purposes of identifying the employer, the section 414 employer aggregation rules do not apply. See question 10 for more information about self-insured plans maintained by more than one employer.
- For a plan that is a multiemployer plan (as defined in ERISA), the plan sponsor is the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.
- For a plan maintained solely by an employee organization, the plan sponsor is the employee organization.
- For any plan for which a plan sponsor is not identified above, the plan sponsor is the person designated by plan terms or, if no person is designated, each entity that maintains the plan.

10. How do the reporting requirements under section 6055 apply to reporting entities that are part of a controlled group?

Plan sponsors in a controlled group that is not an applicable large employer under section 4980H, and providers (such as issuers) that are not reporting as employers, may report under section 6055 as separate entities, or may have one entity report for the controlled group. See our section 6056 FAQs for additional information on reporting by applicable large employers that are providers of self-insured group health plan coverage.

11. Must a government employer report under section 6055 if it maintains a self-insured health plan?

Yes. However, unless prohibited by other law, a government employer that maintains a self-insured group health plan may designate a related governmental unit, or an agency or instrumentality of a governmental unit, as the person to file the returns and furnish the statements for some or all individuals covered under that plan.

12. For a government-sponsored program, who must report under section 6055?

- For Medicaid and CHIP coverage, the state agency that administers the program must report. For Medicare, TRICARE, benefits administered by the Department of Veterans Affairs, and benefits for Peace Corps volunteers, the executive department or agency of the governmental unit that provides the coverage must report.
- For health insurance coverage under a government-sponsored program (such as Medicaid, CHIP, or Medicare) obtained through an issuer, the executive department or agency of the governmental unit that provides the coverage and not the issuer must report.
- For the Nonappropriated Fund Health Benefits Program, the Secretary of Defense may designate the Department of Defense components that must report.

13. Should a health insurance issuer report under section 6055 for coverage in a qualified health plan in the individual market enrolled in through a Marketplace?

No. An issuer should not report on coverage under a qualified health plan in the individual market enrolled in through a Marketplace. The Marketplaces will separately report information on enrollments in a qualified health plan to the IRS and individuals under section 36B(f)(3). Issuers must report, however, on qualified health plans in the small group market enrolled in through the Small Business Health Options Program (SHOP).

14. Must a health coverage provider report under section 6055 for arrangements that provide benefits in addition or as a supplement to an arrangement that is minimum essential coverage?

If the additional or supplemental benefits are not minimum essential coverage (for example, if they are excepted benefits like coverage at an on-site medical clinic), no reporting is required for the additional or supplemental benefits. In addition, no reporting is required under section 6055 for additional or supplemental benefits that are minimum essential coverage if the primary and supplemental coverages have the same plan sponsor or the coverage supplements government-sponsored coverage such as Medicare.

15. Must a health coverage provider report under section 6055 if some or all of its covered individuals may be exempt from the individual shared responsibility provision?

Yes. A health coverage provider may not have the information necessary to determine whether an individual is exempt from the shared responsibility provision. To ensure complete and accurate reporting, providers must report under section 6055 for all their covered individuals.

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What Information Must Providers Report

16. What information must a health coverage provider report to the IRS?

The information that a provider must report to the IRS includes the following:

- The name, address, and employer identification number (EIN) of the provider;
- The responsible individual's name, address, and TIN, or date of birth if a TIN is not available. If the responsible individual is not enrolled in the coverage, providers may, but are not required to, report the TIN of the responsible individual (See question 23 for more information on who is a responsible individual);
- The name and TIN, or date of birth if a TIN is not available, of each individual covered under the policy or program and the months for which the individual was enrolled in coverage and entitled to receive benefits; and
- For coverage provided by a health insurance issuer through a group health plan, the name, address, and EIN of the employer sponsoring the plan and whether the coverage is a qualified health plan enrolled in through the SHOP and (except for 2014 coverage reported in 2015) the SHOP's identifier.

17. Will a health coverage provider collect TINs from individuals, including dependents, covered under its plan or policy?

Yes. Reporting of TINs for all covered individuals is necessary for the IRS to verify an individual's coverage without the need to contact the individual.

If health coverage providers are unable to obtain a TIN after making a reasonable effort to do so, the covered individual's date of birth may be reported in lieu of a TIN. See question 18, below, for additional information on what is a reasonable effort to obtain a TIN.

18. If a health coverage provider does not furnish a TIN, will it be subject to penalties?

A health coverage provider will not be subject to a penalty it demonstrates that it properly solicits the TIN but does not receive it. Under these rules, the reporting entity must make an initial solicitation at the time the relationship with the payee is established. (However, the reporting entity is not required to make this initial solicitation if it already has the payee's TIN and uses that TIN for all relationships with the payee.) If the reporting entity does not receive the TIN, the first annual solicitation is generally required by December 31 of the year in which the relationship with the payee begins (January 31 of the following year if the relationship begins in December). Generally, if the TIN is still not provided, a second solicitation is required by December 31 of the following year. If a TIN is still not provided, the reporting entity need not continue to solicit a TIN.

19. What information must a health coverage provider furnish to individuals?

In addition to the information it reported to the IRS for each covered individual listed on the information return, a health coverage provider must include a phone number for the provider's designated contact person (if any) that the recipient of the statement can contact with questions about information on the statement.

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How and When to Report the Required Information

20. When must a health coverage provider file the information return with the IRS?

A health coverage provider must file the information return and transmittal form with the IRS on or before February 28 (March 31 if filed electronically) of the year following the calendar year in which it provided minimum essential coverage to an individual. Because Notice 2013-45 provides transition relief for section 6055 reporting for 2014, the first section 6055 returns required to be filed are for the 2015 calendar year and must be filed no later than February 29, 2016, or March 31, 2016, if filed electronically. Regulations under section 6081 address extensions of time to file information returns.

21. What type of return must a health coverage provider file with the IRS?

Generally, a health coverage provider must file Form 1094-B and Form 1095-B (or other form that IRS designates, or a substitute form). However, if the provider is also an applicable large employer member as defined in the employer shared responsibility provisions under section 4980H and provides coverage to its employees through a self-insured group health plan, the provider must file Form 1094-C and Form 1095-C (or other form that IRS designates, or a substitute form), instead of Forms 1094-B and 1095-B, to report information with respect to its employees. For further information about the employer shared responsibility provisions and who is an applicable large employer member, see the section 4980H final regulations and our section 4980H questions and answers.

22. Must a health coverage provider file the return with the IRS electronically?

A health coverage provider that is required to file 250 or more Forms 1095-B or 250 or more Forms 1095-C during the calendar year must file the returns electronically. The 250 return threshold applies separately to each type of return required to be filed. Only Forms 1095-B or 1095-C are counted in applying the 250 return threshold for section 6055 reporting. However, if the 250 return threshold applies, Forms 1094-B and 1094-C also must be filed electronically. A provider that is required to file fewer than 250 Forms 1095-B or Forms 1095-C may file on paper or electronically.

23. To whom must a health coverage provider furnish the statement?

A health coverage provider must furnish the statement to a responsible individual. The responsible individual generally is the person who enrolls one or more individuals, which may include him or herself, in minimum essential coverage. The responsible individual may be the primary insured, employee, former employee, uniformed services sponsor, parent, or other related person named on the coverage application.

24. Must a health coverage provider furnish the statement to anyone who is not the responsible individual?

No. A provider is not required to provide a statement to any individual who is not the responsible individual.

25. When must a health coverage provider furnish the statement to the responsible individual?

A health coverage provider must furnish the statement to the responsible individual on or before January 31 of the year following the calendar year in which minimum essential coverage is provided. If the provider applies to the IRS in writing and shows good cause, the IRS may grant an extension of time up to 30 days for the provider to furnish the statement.

26. How must a health coverage provider furnish the statement to the responsible individual?

A health coverage provider generally must mail the statement to the responsible individual's last known permanent address or, if no permanent address is known, to the individual's temporary address. A provider's first class mailing to the last known permanent address, or if no permanent address is known, the temporary address, discharges the provider's requirement to furnish the statement.

A health coverage provider also may furnish the statement electronically to the responsible individual if the responsible individual affirmatively consents to it.

27. Does an employer that must file returns under section 6055 as a provider of self-insured health coverage to its employees and under section 6056 as an applicable large employer file combined information returns and statements?

Yes. An applicable large employer member, as defined in the employer shared responsibility provisions under section 4980H, that provides self-insured coverage is subject to the reporting requirements of both section 6055 and section 6056. To streamline and prevent duplication under each reporting requirement, applicable large employer members with self-insured coverage will combine section 6055 and section 6056 reporting. An applicable large employer member with self-insured coverage will report on Form 1095-C, completing separate sections to report the information required under sections 6055 and 6056. An applicable large employer member that provides insured coverage will complete only the section of Form 1095-C that reports the information required under section 6056. Entities reporting as health insurance issuers, sponsors of self-insured group health plans that are not applicable large employers, sponsors of multi-employer plans, and providers of government-sponsored coverage, will report under section 6055 on Form 1094-B and Form 1095-B.

For further information about the employer shared responsibility provisions under section 4980H and the reporting requirements under section 6056, see the section 4980H final regulations, our section 4980H questions and answers, the section 6056 final regulations, and our section 6056 questions and answers.

28. May a health coverage provider hire a third party to fulfill the provider's reporting responsibilities?

Yes. Reporting arrangements between health care providers and other parties are not prohibited. However, entering into a reporting arrangement does not transfer the potential liability of the provider for failure to report information and furnish statements under section 6055. In addition, if a person who prepares returns or statements under section 6055 is a tax return preparer, that person will be subject to the requirements generally applicable to tax return preparers.

29. For information returns filed and furnished in 2017 for coverage provided in 2016 and later years, what penalties may apply if a health coverage provider fails to comply with the section 6055 information reporting requirements?

The penalty under section 6721 may apply to a provider that fails to file timely information returns, fails to include all the required information, or includes incorrect information on the return. The penalty under section 6722 may apply to a provider that fails to furnish timely the statement, fails to include all the required information, or includes incorrect information on the statement. The waiver of penalty and special rules under section 6724 and the applicable regulations, including abatement of information return penalties for reasonable cause, may apply to certain failures under section 6721 or 6722. See question 2 for more details on when the information reporting is first required (in 2016 for coverage provided in 2015) and on voluntarily complying with those requirements in 2015 for coverage provided 2014. See question 3 for information on relief that applies with respect to these penalties for reporting and furnishing in 2016 for coverage in 2015.

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