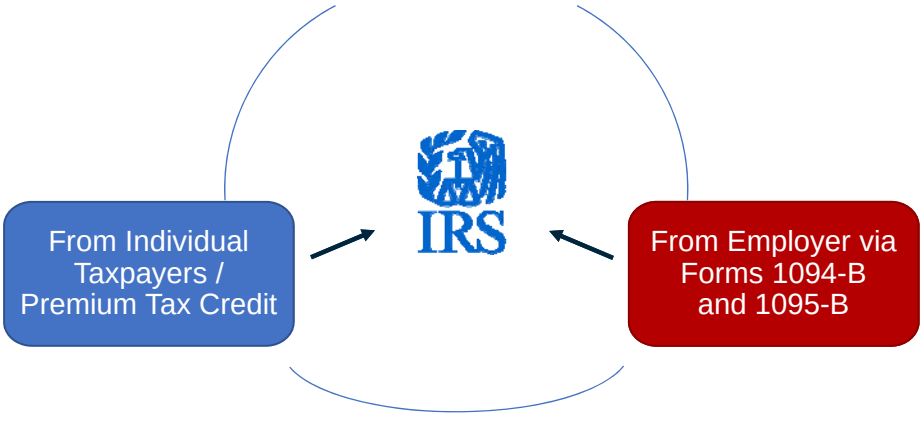
6055 Reporting: Form 1095-B

- The IRS requires all entities providing MEC health plan coverage information to report individuals enrolled in that coverage.
- Reporting is on a month-by-month basis.
- While generally filed by an insurance or coverage provider, VEHI and its Members, as self-insured group health plans, are considered a 'providing entity'. NEW
- Copy provided to the covered individual/family.
- Large employers include this detail by filing Form 1095-**C**

 3

Why? Because the IRS needs information…



 4

What is enforced through reporting?

VEHI Member Reports
(Coverage)

Individual mandate requires all individuals must have Minimum Essential Coverage (MEC)

Report shows who has coverage (including non-employees such as spouses, dependents, COBRA, retirees)

Who is reported and *why?*

Enrolled Employees	• Individual Mandate • Premium Tax Credit Eligibility
Enrolled Spouses, Dependents, and Non-EEs (COBRA)	• Individual Mandate • Premium Tax Credit Eligibility

When are forms due?

Individual statements sent to employees	January 31, 2019	Filing statements in 2019 for 2018 calendar year
Reports submitted to IRS	Annually by February 28 (paper) or April 1 (electronic)	Filing statements in 2019 for 2018 calendar year
30 day extension	Form 8809**	Note: Form must be submitted on/before due date

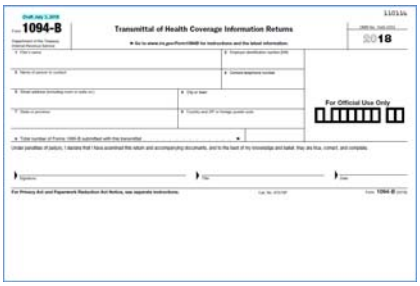
** Form 8809 applies to employer filings with the IRS only, and individual statements are not included in the extension. Extensions must be applied for and granted through a formal process, and granted extensions aren't automatic.

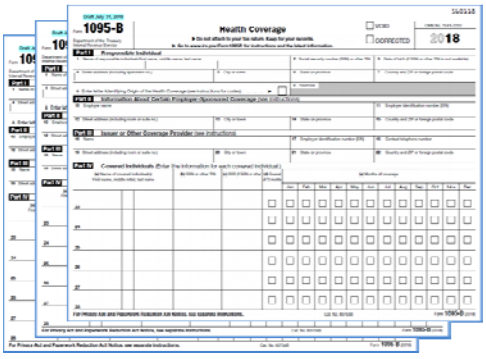
7

Understanding the submission process

One transmittal form will have multiple information forms attached

Example: A District with 95 full-time employees will submit one 1094-B and at least 95 1095-B's



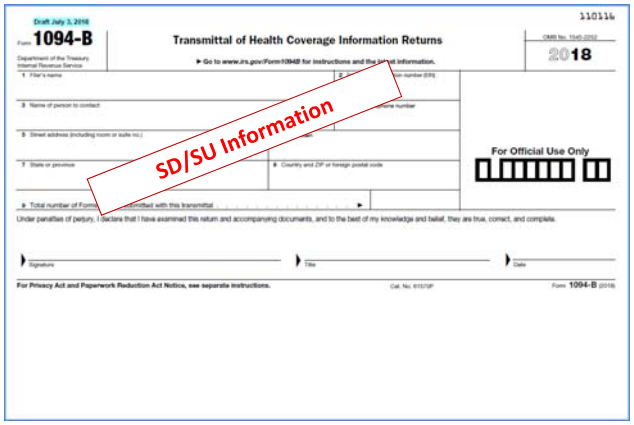


8

6055 Reporting: Form 1094-B

Form 1094-B

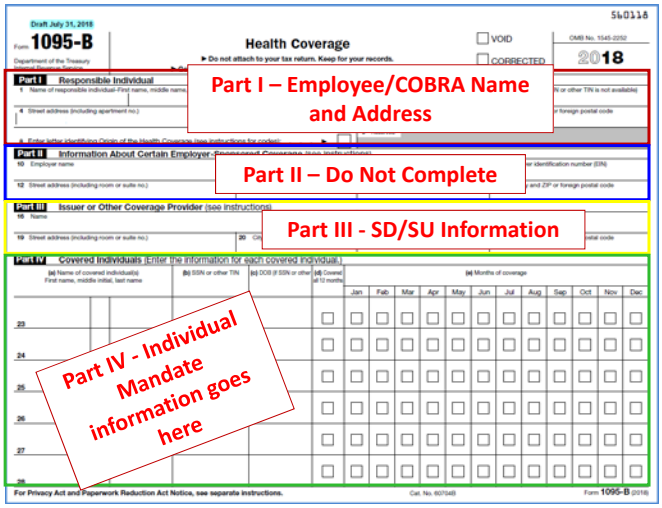
This is the transmittal form you will submit with Forms 1095-B



6055 Reporting: Form 1095-B

Form 1095-B

This is the form you will submit on behalf of each enrolled VEHI member



What's so difficult about reporting?

- Finding and organizing all of the needed employee data and *coverage information*
- Having the confidence that you're reporting correctly
- Working month by month for each employee, including those who terminated during the prior year
- Keep an eye on the deadlines

 11

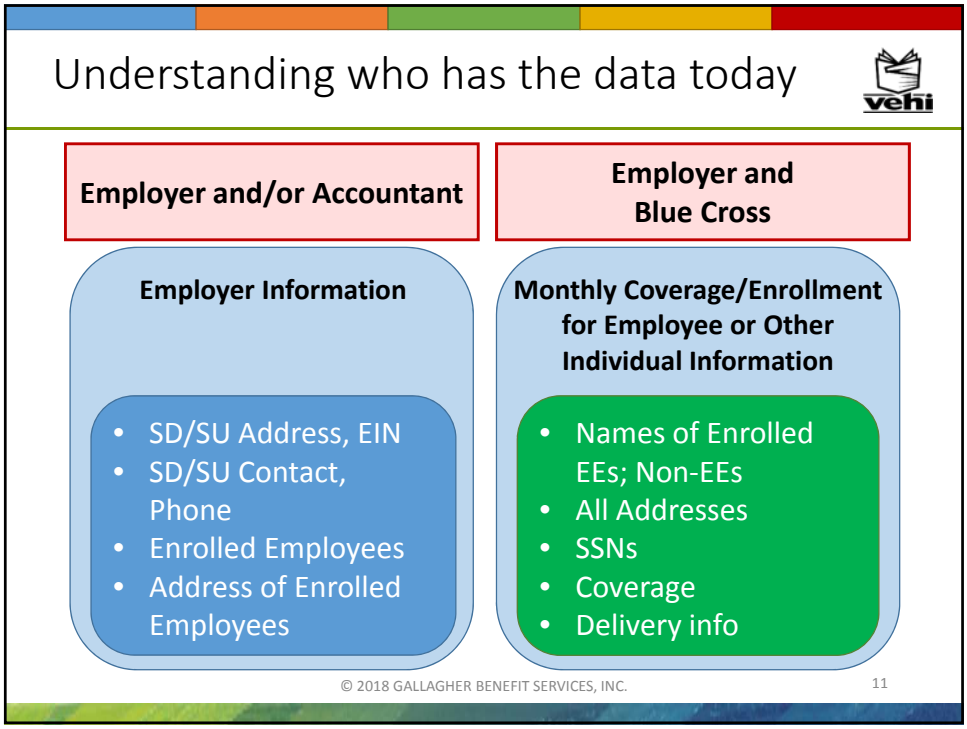
Getting Ready to Report

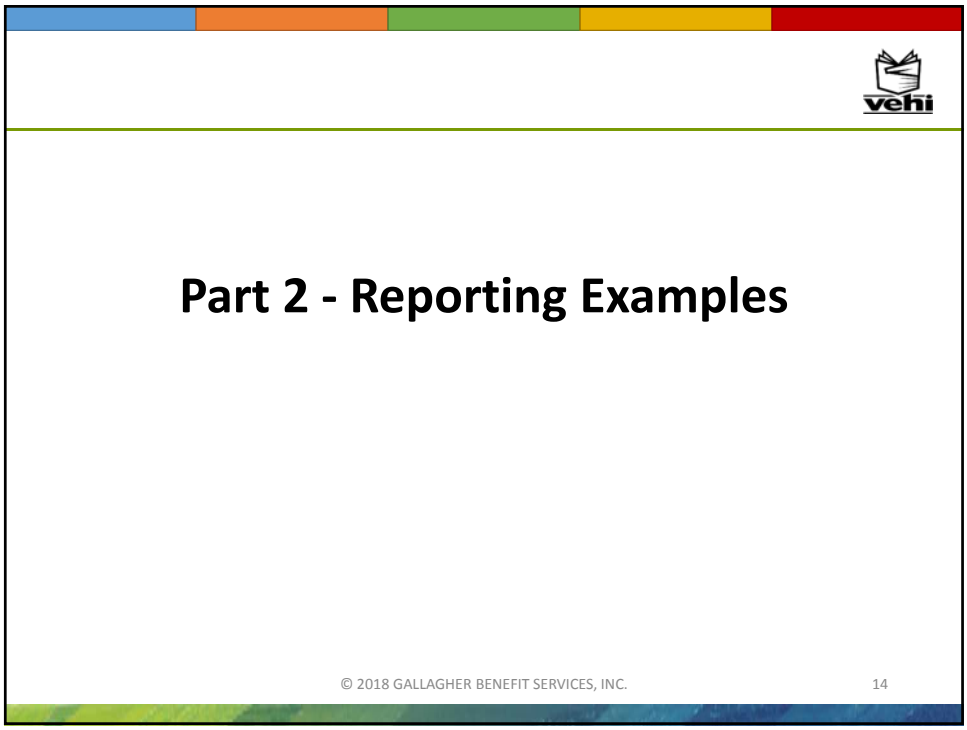
*** Reminder ***

Reporting is based on a calendar year, not your Fiscal Year or Plan Year

- Know where to go to find the data
- Identify employees where coverage changes occurred during the year (add dependents, drop dependents, new hire, terminations, COBRA, etc.)
- Start with full-year coverage employees/COBRA and move to others
- If you get stuck, reach out and ask for help at VEHIhelp@ajg.com

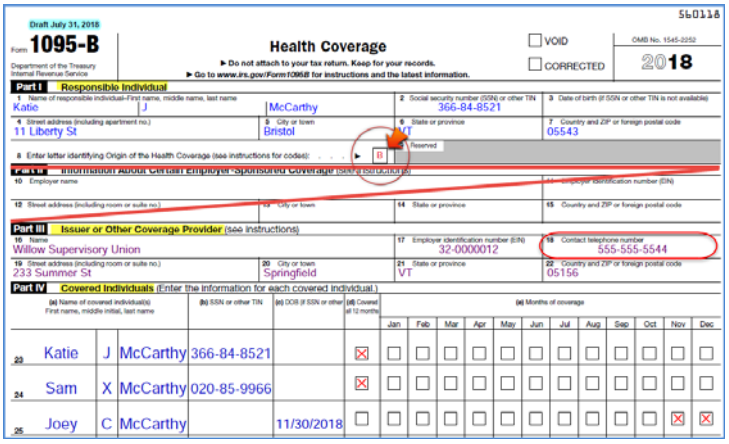
 12


Understanding who has the data today
Employer and/or Accountant
Employer and Blue Cross
Employer Information
• SD/SU Address, EIN
• SD/SU Contact, Phone
• Enrolled Employees
• Address of Enrolled Employees
Monthly Coverage/Enrollment for Employee or Other Individual Information
• Names of Enrolled EEs; Non-EEs
• All Addresses
• SSNs
• Coverage
• Delivery info
© 2018 GALLAGHER BENEFIT SERVICES, INC.
11


Part 2 - Reporting Examples
© 2018 GALLAGHER BENEFIT SERVICES, INC.
14

Reporting Example - 1

Katie – Full year of coverage, New Dependent



Draft July 31, 2018 — Form 1095-B — Health Coverage — 560118

► Do not attach to your tax return. Keep for your records.
► Go to www.irs.gov/Form1095B for instructions and the latest information.

VOID ☐ CORRECTED ☐ — OMB No. 1545-2252 — 2018

Department of the Treasury — Internal Revenue Service

Part I Responsible Individual

1 Name of responsible individual–First name, middle name, last name			2 Social security number (SSN) or other TIN	3 Date of birth (if SSN or other TIN is not available)
Katie	J	McCarthy	366-84-8521	
4 Street address (including apartment no.)		5 City or town	6 State or province	7 Country and ZIP or foreign postal code
11 Liberty St		Bristol	VT	05543

8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): ► B

Part II Information About Certain 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
Willow Supervisory Union			32-0000012	555-555-5544
19 Street address (including room or suite no.)		20 City or town	21 State or province	22 Country and ZIP or foreign postal code
233 Summer St		Springfield	VT	05156

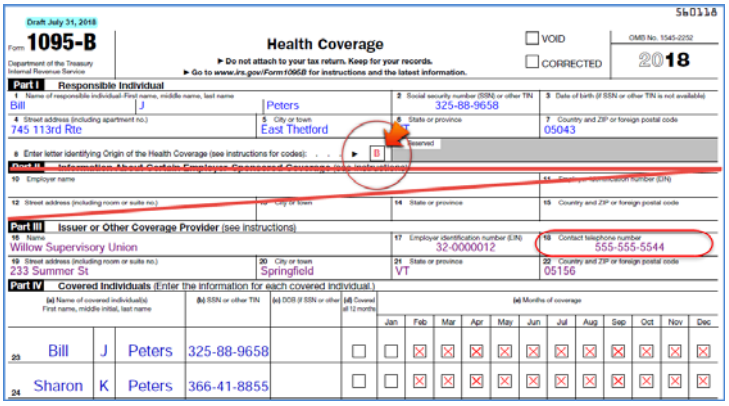
Part IV Covered Individuals (Enter the information for each covered individual.)

	(a) Name of covered individual(s) First name, middle initial, last name			(b) SSN or other TIN	(c) DOB (if SSN or other TIN 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	Katie	J	McCarthy	366-84-8521		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24	Sam	X	McCarthy	020-85-9966		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25	Joey	C	McCarthy		11/30/2018	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒

15

Reporting Example - 2

Bill – Hired in January



Draft July 31, 2018 — Form 1095-B — Health Coverage — 560118

► Do not attach to your tax return. Keep for your records.
► Go to www.irs.gov/Form1095B for instructions and the latest information.

VOID ☐ CORRECTED ☐ — OMB No. 1545-2252 — 2018

Department of the Treasury — Internal Revenue Service

Part I Responsible Individual

1 Name of responsible individual–First name, middle name, last name			2 Social security number (SSN) or other TIN	3 Date of birth (if SSN or other TIN is not available)
Bill	J	Peters	325-88-9658	
4 Street address (including apartment no.)		5 City or town	6 State or province	7 Country and ZIP or foreign postal code
745 113rd Rte		East Thetford	VT	05043

8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): ► B

Part II Information About Certain 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
Willow Supervisory Union			32-0000012	555-555-5544
19 Street address (including room or suite no.)		20 City or town	21 State or province	22 Country and ZIP or foreign postal code
233 Summer St		Springfield	VT	05156

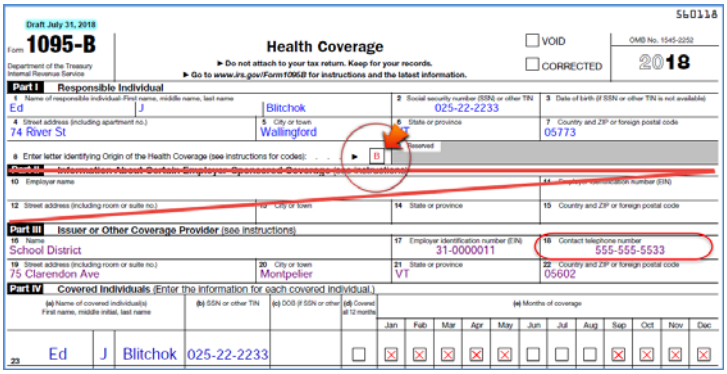
Part IV Covered Individuals (Enter the information for each covered individual.)

	(a) Name of covered individual(s) First name, middle initial, last name			(b) SSN or other TIN	(c) DOB (if SSN or other TIN 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	Bill	J	Peters	325-88-9658		☐	☐	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
24	Sharon	K	Peters	366-41-8855		☐	☐	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒

16

Reporting Example - 3

Ed – Leave of Absence



Draft July 31, 2018 — Form 1095-B — Health Coverage — 2018 — 560118

Part I Responsible Individual: Ed J Blitchok; 025-22-2233; 74 River St; Wallingford; VT; 05773; Enter letter identifying Origin of the Health Coverage (see instructions for codes): B

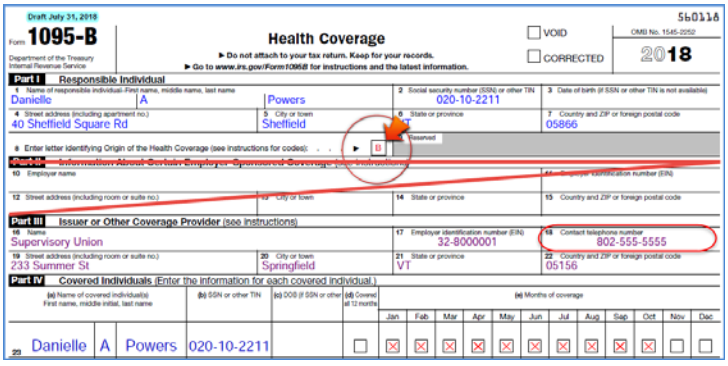
Part III Issuer or Other Coverage Provider (see instructions): School District; 31-0000011; 555-555-5533; 75 Clarendon Ave; Montpelier; VT; 05602

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

	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN)	(d) Covered all 12 months	(e) Months of coverage											
					Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23	Ed J Blitchok	025-22-2233		☐	☒	☒	☒	☒	☒	☐	☐	☐	☒	☒	☒	☒

Reporting Example - 4

Danielle – Termination August 31, 2018



Draft July 31, 2018 — Form 1095-B — Health Coverage — 2018 — 560118

Part I Responsible Individual: Danielle A Powers; 020-10-2211; 40 Sheffield Square Rd; Sheffield; VT; 05866; Enter letter identifying Origin of the Health Coverage (see instructions for codes): B

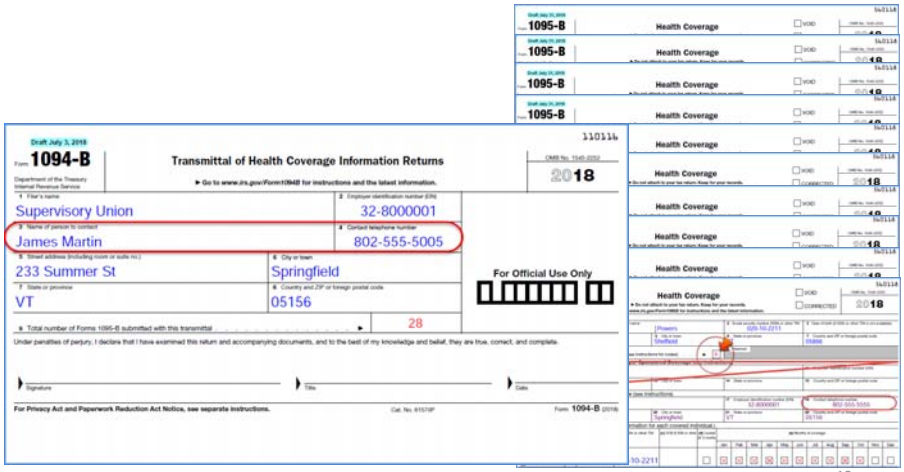
Part III Issuer or Other Coverage Provider (see instructions): Supervisory Union; 32-8000001; 802-555-5555; 233 Summer St; Springfield; VT; 05156

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

	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN)	(d) Covered all 12 months	(e) Months of coverage											
					Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
25	Danielle A Powers	020-10-2211		☐	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☐	☐

Reporting Example – Form 1094-B

Form 1094-B



How can we help?

- **VEHI's Small SD/SU 2018 Reporting Resource Guide is posted on on www.VEHI.org**
  - Sample Forms (currently only draft forms)
  - Information on obtaining consent to electronically distribute Forms 1095-B to employees
  - Information on the requirement to obtain all enrollees Social Security number and the safe harbor
- **Send us an e-mail with a specific question**
  - Gallagher's VEHI team - VEHIhelp@ajg.com