

## Information Reporting on Minimum Essential Coverage

Notice 2015-68

### PURPOSE

This notice advises taxpayers that the Treasury Department and the Internal Revenue Service intend to propose regulations under § 6055 of the Internal Revenue Code (1) providing that health insurance issuers must report coverage in catastrophic health insurance plans described in § 1302(e) of the Affordable Care Act enrolled in through an Affordable Insurance Exchange (Exchange, also known as a Health Insurance Marketplace), (2) allowing electronic delivery of statements reporting coverage under expatriate health plans unless the recipient explicitly refuses consent or requests a paper statement, (3) allowing filers reporting on insured group health plans to use a truncated taxpayer identification number (TTIN) to identify the employer on the statement furnished to a taxpayer, and (4) specifying when a provider of minimum essential coverage is not required to report coverage of an individual who has other minimum essential coverage. This notice also invites comments on issues relating to solicitation of taxpayer identification numbers (TINs) of covered individuals; advises that the governments of United States possessions or territories, namely American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands, are not required to report coverage under Medicaid and the Children's Health Insurance Program (CHIP); and provides that the state government agency sponsoring coverage under the Basic Health Program is required to report Basic Health Program coverage.

### BACKGROUND

### Requirement to have minimum essential coverage

Under § 5000A, nonexempt individuals have the choice of maintaining minimum essential coverage or making an individual shared responsibility payment with their income tax returns. Minimum essential coverage is defined in § 5000A(f) and includes health insurance coverage offered in the individual market (such as a qualified health plan offered through an Exchange), an employer-sponsored plan, and government-sponsored programs such as Medicare, Medicaid, CHIP, and TRICARE. The Secretary of Health and Human Services, in coordination with the Secretary of the Treasury, may designate health benefits coverage not specified in § 5000A as minimum essential coverage. Under § 5000A(f)(4), bona fide residents (within the meaning of § 937(a) and accompanying regulations) of U.S. possessions or territories are treated as having minimum essential coverage.

### Information reporting of minimum essential coverage

Section 6055 requires all persons providing minimum essential coverage to file annual information returns with the IRS reporting information about the coverage and about each covered individual, including each covered individual's TIN and months of coverage, and to furnish a statement to the taxpayer. This reporting allows taxpayers to establish and the IRS to verify that individuals have minimum essential coverage.

Under § 1.6055-1(c)(1)(i), (c)(3)(ii), and (d)(1) of the Income Tax Regulations, health insurance issuers or carriers must report on most insured minimum essential coverage. However, under § 36B(f)(3) and § 1.36B-5, Exchanges must report information on coverage in individual market qualified health plans enrolled in through an Exchange, including each covered individual's SSN and months of coverage, and

must furnish a statement to a taxpayer. Because Exchange reporting under § 36B(f)(3) includes the information reported and furnished under § 6055, regulations provide that health insurance issuers are not required to report on coverage in individual market qualified health plans enrolled in through an Exchange. See § 1.6055-1(d).

If a group health plan is self-insured, the plan sponsor (generally the employer) must report the coverage for all covered individuals. See § 1.6055-1(c)(1)(ii) and (c)(2).

Section 1.6055-1(c)(1)(iii) requires that the executive department or agency of a government unit that provides coverage under a government-sponsored program must file the information return under § 6055. Section 1.6055-1(c)(3)(i) provides that the state agency that administers the Medicaid program under Title XIX of the Social Security Act or the CHIP program under Title XXI of the Social Security Act, must report the coverage under § 6055.

#### Employer's EIN

Section 6055(b) and § 1.6055-1(e) require that health insurance issuers and carriers reporting coverage under insured group health plans report information about the employer sponsoring the plan, including the employer's EIN, to the IRS. Section 6055(c) and § 1.6055-1(g) require that health insurance issuers and carriers reporting information to the IRS furnish a statement to a taxpayer providing information about the filer and the covered individuals. Section 301.6109-4(a)(1) of the Procedure and Administration Regulations provides that the TIN of a person other than the filer, including an EIN, may be truncated on statements furnished to taxpayers, unless otherwise prohibited by statute or regulations. Section 1.6055-1(g)(3) allows filers to truncate the TINs of individuals identified on the statement, but does not address the

use of a TIN for the employer.

### Expatriate health plans

Section 1.6055-2 allows filers of information returns under § 6055 to furnish a statement to an individual in electronic format only if the individual affirmatively consents. However, under § 3(b)(2) of the Expatriate Health Coverage Clarification Act of 2014, Division M of the Consolidated and Further Continuing Appropriations Act, 2015, Public Law 113-235 (EHCCA), a recipient of the Form 1095-B reporting minimum essential coverage under an expatriate health plan (defined in EHCCA § 3(d)(2)) is deemed to consent to delivery in electronic format unless the recipient explicitly refuses consent.

### Supplemental coverage

To ensure that the IRS receives a report for every individual with minimum essential coverage, every provider of minimum essential coverage generally must report information for every covered individual. However, § 1.6055-1(d)(2) provides that reporting is not required for minimum essential coverage that supplements or provides benefits in addition to other minimum essential coverage if (1) the primary and supplemental coverage have the same plan sponsor, or (2) the coverage supplements government-sponsored coverage such as Medicare.

### TIN solicitation and penalties

Information reporting under § 6055 is subject to the penalty provisions of §§ 6721 and 6722 for failure to file a correct information return or to furnish a correct statement. See § 1.6055-1(h). Penalties may be waived under § 6724(a) if the failure is due to reasonable cause and not willful neglect; that is, if a reporting entity demonstrates that it

acted in a responsible manner and that the failure is due to significant mitigating factors or events beyond the reporting entity's control. See § 301.6724-1(a)(1). Under § 301.6724-1(e), a reporting entity acts in a responsible manner in soliciting a TIN if the reporting entity makes (1) an initial solicitation when an account is opened or a relationship is established, (2) a first annual solicitation by December 31 of the year the account is opened (or January 31 if the account is opened in December), and (3) a second annual solicitation by December 31 of the following year.

### Basic Health Program

Section 1331 of the Affordable Care Act allows states to establish a Basic Health Program, which provides an additional option to provide health coverage to certain individuals not eligible for Medicaid. See 42 CFR Part 600. The Basic Health Program is designated as minimum essential coverage under 42 CFR 600.5.

### GUIDANCE

#### 1. Anticipated regulations

##### a. Coverage in catastrophic health plans

Section 1302(e) of the Affordable Care Act provides for catastrophic health plans. These plans are minimum essential coverage and qualified health plans, may be offered only in the individual market, and may be enrolled in through an Exchange, but taxpayers may not claim the premium tax credit for this coverage. See § 36B(c)(3)(A).

For purposes of reporting by Exchanges under § 36B(f)(3) on coverage in a qualified health plan, the term qualified health plan has the same meaning as in § 1301(a) of the Affordable Care Act except that it does not include a catastrophic plan described in § 1302(e) of the Affordable Care Act. Section 1.36B-1(c). Accordingly,

Exchanges do not report on catastrophic coverage. Section 1.36B-1(c), -5(a). The § 6055 regulations, however, provide that health insurance issuers need not report on coverage in a qualified health plan in the individual market enrolled in through an Exchange, because that information is generally reported by Exchanges under § 36B(f)(3). As a result, at present neither the Exchanges nor health insurance issuers have the responsibility for reporting minimum essential coverage under a catastrophic plan.

To ensure that there is reporting of catastrophic health plans enrolled in through an Exchange, the Treasury Department and the IRS intend to propose regulations under § 6055 requiring issuers of these plans to report the coverage on Form 1095-B. The Treasury Department and the IRS anticipate that the regulations will apply to coverage in 2016 and to returns and statements filed and furnished in 2017. Health insurance issuers may report on 2015 catastrophic coverage (on returns and statements filed and furnished in 2016) and are encouraged to do so. An issuer that reports on 2015 catastrophic coverage will not be subject to penalties for these returns.

b. Employer's EIN

The Treasury Department and the IRS anticipate publishing regulations under § 6055 to clarify that health insurance issuers and carriers reporting on insured group health plans may use the TIN of the employer sponsoring the plan on the statement furnished to the taxpayer.

c. Statements to individuals covered by expatriate health plans

Proposed § 6055 regulations also will provide that statements reporting coverage under an expatriate health plan may be furnished in electronic format unless the

recipient affirmatively refuses consent or requests a paper statement. Reporting entities may apply these rules for coverage under expatriate health plans that are issued or renewed on or after July 1, 2015, and may rely on Notice 2015-43, 2015-29 I.R.B. 73, which addresses the definition of “expatriate health plans” and provides transition relief.

d. Supplemental coverage

The supplemental coverage rule in § 1.6055-1(d)(2) is intended to eliminate duplicate reporting of an individual’s minimum essential coverage under circumstances when there is reasonable certainty that the provider of the “primary” coverage will report. This rule has proven to be confusing. Accordingly, the Treasury Department and the IRS anticipate proposing regulations that would replace this rule with rules providing that (1) if an individual is covered by multiple minimum essential coverage plans or programs provided by the same provider, reporting is required for only one of them; and (2) reporting generally is not required for an individual’s minimum essential coverage for which an individual is eligible only if the individual is covered by other minimum essential coverage for which § 6055 reporting is required.

These rules would apply month by month and individual by individual. Thus, under the first rule (that is, the rule for reporting multiple minimum essential coverage plans or programs of the same provider), if for a month an individual is enrolled in a self-insured group health plan and also has a self-insured health reimbursement arrangement (HRA) from the same employer, the provider (the employer) is required to report only one type of coverage for that individual. If an employee is covered under both arrangements for some months of the year but retires or otherwise drops coverage under the non-HRA group health plan and is covered only under the HRA, the employer

must report coverage under the HRA for the months after the employee retires or drops the non-HRA coverage. The employer must report the coverage in an arrangement of any individual who is covered by only one arrangement.

Under the second rule (that is, the rule for reporting minimum essential coverage for which an individual is eligible only if the individual is covered by other minimum essential coverage), reporting would not be required for Medicare or TRICARE supplements and Medicaid coverage providing benefits only to an individual enrolled in other coverage for which reporting is required, such as employer coverage or a qualified health plan. Reporting also would not be required under the second rule for an HRA that is available only to employees and other individuals who enroll in an employer's insured group health plan for months that the individual is enrolled in the insured group health plan. It is anticipated that, for employer coverage, this rule will apply only if the two types of coverage are eligible employer-sponsored coverage of the same employer. For example, if an employee is enrolled in both his employer's HRA and insured group health plan, the employer is not required to report the employee's coverage under the HRA. However, if an employee is enrolled in an employer's HRA and in a spouse's non-HRA group health plan, the employee's employer would be required to report for the HRA, and the employee's spouse's employer (or the health insurance issuer or carrier, if the plan is insured) would be required to report for the non-HRA group health plan coverage.

## 2. Other guidance

### a. Relief from penalties for reasonable cause

A reporting entity that fails to comply with the filing and statement furnishing



requirements of § 6055 may be subject to penalties for failure to file a correct information return (§ 6721) or to furnish a correct payee statement (§ 6722). The preamble to the § 6055 regulations (T.D. 9660, 79 FR 13220) provides short-term relief from reporting penalties for 2015 coverage. Specifically, the IRS will not impose penalties under §§ 6721 and 6722 on reporting entities that can show that they have made good faith efforts to comply with the information reporting requirements. This relief applies to incorrect or incomplete information, including TINs or dates of birth, reported on a return or statement.

The preamble to the § 6055 regulations also notes the general rule that, under § 6724 and the related regulations, the §§ 6721 and 6722 penalties may be waived if a failure is due to reasonable cause, that is, the reporting entity demonstrates that it acted in a responsible manner and the failure is due to significant mitigating factors or events beyond the reporting entity's control. Section 301.6724-1(e) provides specific procedures for soliciting TINs which, if followed, establish that a reporting entity that does not report a TIN has acted in a responsible manner.

Nonetheless, reporting entities have expressed concerns that § 6055 reporting has significant differences from other information reporting provisions that are not adequately addressed by the regulations under § 6724 for establishing reasonable cause. For example, reporting entities asserted that the requirements for TIN solicitation under § 301.6724-1(e) are not practical in the context of § 6055 reporting.

The Treasury Department and the IRS request comments on the application of the reasonable good cause rules under § 6724 to § 6055 reporting, and in particular the rules under § 301.6724-1(e) relating to TIN solicitation and reporting. Pending the

issuance of additional guidance, reporting entities will not be subject to penalties for failure to report a TIN if they comply with the requirements of § 301.6724-1(e) with the following modifications: (1) the initial solicitation is made at an individual's first enrollment or, if already enrolled on September 17, 2015, the next open season, (2) the second solicitation is made at a reasonable time thereafter, and (3) the third solicitation is made by December 31 of the year following the initial solicitation. Additionally, a reporting entity is not required to solicit a TIN from an individual whose coverage is terminated.

b. Bona fide residents of U.S. possessions or territories

The governments of American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands provide Medicaid and CHIP coverage to their eligible residents. Because bona fide residents of U.S. possessions or territories are treated as having minimum essential coverage under § 5000A(f)(4), reporting of Medicaid and CHIP coverage for these taxpayers is not needed for administration of the individual shared responsibility requirement. Therefore, Medicaid and CHIP agencies in U.S. possessions or territories are not required to report that coverage under § 6055.

c. Basic Health Program

Section 5000A(f) does not identify the Basic Health Program as a government-sponsored program, but it closely resembles government-sponsored coverage such as Medicaid and CHIP. Accordingly, like Medicaid and CHIP, the state agency that administers the Basic Health Program is the entity that must report that coverage under § 6055.

## REQUEST FOR COMMENTS

Comments may be submitted in writing on or before November 16, 2015.

Comments should be submitted to Internal Revenue Service, CC:PA:LPD:PR (Notice 2015-68), Room 5203, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044, or electronically to [Notice.Comments@irs.counsel.treas.gov](mailto:Notice.Comments@irs.counsel.treas.gov). Please include "Notice 2015-68" in the subject line of any electronic communications. Alternatively, comments may be hand delivered between the hours of 8:00 a.m. and 4:00 p.m. Monday to Friday to CC:PA:LPD:PR (Notice 2015-68), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue NW, Washington, D.C. All comments will be available for public inspection and copying.

## FURTHER INFORMATION

For further information on this notice, contact Andrew Braden at (202) 317-7006 (not a toll-free call).