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Q&A FROM ASSUREX GLOBAL WEBINAR

ACA 1094/1095 EMPLOYER REPORTING - YEAR 3

OCTOBER 26, 2017

Q. If the Federal poverty level applies to all regular full-time but not to regular part-time, is that OK? Can use safe harbor for FT and not for PT?

A. Under §4980H requirements, employers are only required to offer affordable coverage to full-time employees. There is no requirement to offer coverage to part-time employees at all, or to make it affordable if choosing to offer coverage to part-time employees.

For employers who meet the federal poverty level (FPL) safe harbor because the employee contribution toward single coverage does not exceed 9.69% of FPL (approx. $96-97/month), then the employer is protected by the safe harbor, regardless of how much an employee works or gets paid.

Q. If a wellness incentive is a one time cash payment, then does it have to be reported? Or where can I find more information about wellness incentives?

A. No, this would not be included. Wellness incentives only need to be considered if they affect the amount the employee contributes toward medical coverage. If the wellness incentive affects the amount the employee contributes for coverage (i.e. the premium), when calculating affordability under §4980H rules, and reporting on Line 15 of Form 1095-C, the employee contribution is based off the non-wellness rate (the higher rate); however, when the incentive is tobacco-related, the employee contribution is based off the non-tobacco rate (the lower rate).

Q. Please remind us what the abbreviations stand for - MV and MEC

A. MEC = minimum essential coverage. Individuals must have MEC to avoid the individual mandate, and applicable large employers (50 or more FTEs) must offer MEC to full-time employees and dependent children to avoid the bigger penalty under §4980H(a). Most employer-sponsored group health plans will be considered minimum essential coverage (MEC) plans as there is very little guidance or specific requirements. Even plans referred to as "limited medical" or preventive-only will meet this requirement. The definition includes any coverage under an "eligible employer-sponsored plan"—a term that means a group health plan or group health insurance coverage offered by an employer to an employee that is (a) a governmental plan, or (b) any other plan or coverage offered in a state's small or large group market. In addition, IRS regulations clarify that self-funded employer coverage qualifies as an eligible employer-sponsored plan.

MV = minimum value. The requirement to provide "minimum value" is a higher standard. An applicable large employer must offer minimum value coverage to avoid potential penalties under §4980H(b). A plan provides minimum value if the plan's share of the total allowed cost of benefits provided to an employee is at least 60% (actuarial value of 60% or better). Whether or not a plan provides minimum value is required information in the summary of benefits and coverage (SBC).

So fully insured plan is not the Employer's mandate to report this to IRS but the Insurance provider? Do only self-funded plans have to report then?

A. All applicable large employers (50 or more FTEs) have to report information about what type of coverage was offered to full-time employees. Applicable large employers have to report whether the employer offers fully-insured or self-funded coverage (or no coverage at all).

Separately, any employer who offers a self-funded plan must report information about who was covered/enrolled in the self-funded plan. For a fully-insured plan, the insurance carrier will report information about who was covered/enrolled in the fully-insured plan.

Q. So if we are an ALE and have employees who are offered coverage but don't take it, we don't need to provide a 1095 to those employees?

A. An applicable large employer (50 or more FTEs) must provide a Form 1095-C to all full-time employees, regardless of whether or not they enrolled in the plan. The employer fills out Parts I and II of Form 1095-C for each full-time employee. Part III is only completed if the employee enrolled in a self-funded plan. If the employee enrolled in a fully-insured plan, the employee will receive a Form 1095-C from the employer showing offer of coverage information in Part II, and a separate Form 1095-B from the insurance carrier showing months of coverage under the fully-insured plan.

Q. Hi! I am so sorry if this was already mentioned but it's a lot to take in. Can we not use the Section 4980H Transition Relief anymore on 1094-C forms?

Correct. Relief from §4980H penalties, available to some mid-size employers and those with non-calendar year plans, was available only in 2015 and part of 2016. There is no further transition relief available other than for multi-employer (union) plans.

Q. I always used 2G for employees who declined coverage. Is that wrong?

A. If the employee was offered coverage and waived, and the offer of coverage was affordable under the federal poverty level (FPL) safe harbor, it would be correct to use code 2G on Line 16 of Form 1095-C. However, if the employer is using code 1A on Line 14, indicating a qualifying offer, it would also be correct to leave Line 16 blank.

Q. Why is it optional to leave Line 16 blank if you use 1A in line 14? If you leave it blank it will appear that the employee has waived coverage.

By using code 1A on Line 14 of Form 1095-C, the employer indicates to the IRS that the offer of coverage provided minimum value and was affordable to the family based on the most conservative affordability safe harbor (FPL). In other words, regardless of whether the employee enrolled or waived, the employer is safe from any potential penalty under §4980H, and the employee (and family members) were not eligible for a tax subsidy toward coverage through a public Exchange.

Q. When you say looking back at the past calendar year...Is that an average over the 12 months? Or looking at first month or last month within that plan year?

A. Status as an applicable large employer (ALE) is determined based on data from the previous calendar year, regardless of plan year. It doesn't matter whether or not the employer exceeded 50 FTEs in any given month, but rather considers whether or not the employer *averaged* 50 or more FTEs over all 12 months *of the previous calendar year*. Therefore it's necessary to consider hours of service from each month separately and then take the average over the 12 months.

Q. We have summer interns (law school students) who work 40 hours a week for 6-12 weeks. We have never offered coverage to them and have not reported to or about them; should we be offering coverage to them and/or reporting on them? Thank you

A. Assuming this involves an applicable large employer (50 or more FTEs) subject to §4980H offer of coverage requirements, there are no special rules/exemptions for short-term, temporary or intern employees. A temporary employee (e.g. summer intern) who works full-time hours needs to be treated just like any other full-time employee and offered coverage accordingly to avoid potential penalties under §4980H. This is the case unless the temporary employee meets the definition of "seasonal" AND the employer is using the look-back measurement method.

"Seasonal employee" is defined as an employee in a position for which the customary annual employment is six months or less. The reference to customary means that by the nature of the position an employee in this position typically works for a period of six months or less, and that period should begin each calendar year in approximately the same part of the year, such as summer or winter.

If the employer is using the look-back measurement method and the temporary employee meets the definition of seasonal, the temporary will be considered part-time and no offer of coverage is required. However, if the position does not fit the definition of seasonal, or if the employer is using the monthly measurement method, then the temporary employee is considered full-time in any month the employee achieves 130 or more hours of service, and coverage would need to be offered no later than the first of the month following three full calendar months after the date of hire to avoid potential penalties under §4980H.

Q. Is common ownership the only requirement to be considered a part of an ALE group?

A. A controlled group or an affiliated service group, as defined under §414 rules, creates an aggregated ALE group (assuming together they have 50 or more FTEs). At a very high level, the two concepts may described as follows:

- A "controlled group" is formed when there is common ownership of 80% or more; either one entity or person owns 80% or more of another entity, or 5 or less individuals/entities own 80% or more of each entity.
- An "affiliated service group" is formed when there are shared services (regardless of common ownership); for example, one entity is a service organization which provides regular operational activities among the members of the group involving that service.

The rules and various arrangements can often become complicated, so we recommend working with legal counsel or a tax advisor in determining whether or not a controlled group or affiliated service group exists.

Q. What is FPL affordable monthly premium amount for 2017? Is is more than $87.54 per month?

A. The federal poverty level (FPL) safe harbor based on the 2016 FPL guidelines ($11,880 for a single household) = $95.93

The FPL safe harbor based on 2017 FPL guidelines ($12,060 for a single household) = $97.38.

NOTE - this is based off mainland FPL. The FPL for Hawaii and Alaska is higher.

When calculating the FPL safe harbor, the employer may use the FPL guidelines in place within 6 months prior to the beginning of the employer's plan year. HHS generally releases the FPL guidelines for the year in late January, so calendar year plans will generally need to rely on the FPL from the previous calendar year.

Q. We are an ALE self-funded company. When we have an employee that is hired and then termed before 90 days, do we need to send them a 1095?

A. If the employee would have been offered coverage after the plan waiting period if employment had continued, no Form 1095-C is required. However, if there was no intention to offer coverage and the employee was full-time for at least one month, then a Form 1095-C is required.

An employee in a waiting period who is offered coverage after the waiting period (or would have been if employment had continued), is considered to be in a limited non-assessment period during the waiting period. The instructions indicate that an employee in a limited non-assessment period is not considered to be full-time, and therefore would not require reporting if not employed beyond the limited non-assessment period.

Q. If we have a part-time employee who, during the look back period, meet the full-time hour requirement, what do we report during the stability period? We have a 6 month look back period, so it sounds like we would use 2D during the look back and admin. Periods, how does that look for the stability period?

A. If a variable hour or part-time employee, subject to an initial measurement period upon hire, is determined to be full-time during the initial measurement period, code 1H on Line 14 and code 2A on Line 16 could be used during the initial measurement period and the administrative period. Then during the stability period the employee should be considered full-time and the appropriate offer of coverage code and safe harbor code should be used. If the full-time employee was not offered coverage during the stability period, code 1H would be used on Line 14 and Lines 15 and 16 would be left blank.

Q. If we were self funded for 3 months Jan-mar then switched to a Fully insured Apr-Dec. What form or forms will we be filing?

A. If this involves an applicable large employer (50 or more FTEs), Part III of Form 1095-C would be completed for those enrolled January - March 2017, and the rest of the months would be left blank (a separate Form 1095-B will be provided by the insurance carrier showing coverage for April - December 2017).

If this involves a small employer (less than 50 FTEs), Form 1095-B will be completed by the employer showing coverage for January - March 2017, and the rest of the months would be left blank (a separate Form 1095-B will be provided by the insurance carrier showing coverage for April - December 2017).

Q. Does the dollar amount indicated in line 15 mean that the employee has coverage and that is what they pay, or just that they were offered and if they elected it that is the amount they would have to pay? My employees think if there is a dollar value there, that is what they have paid.

A. Line 15 indicates the required employee contribution for an employee to elect single coverage (for the lowest cost minimum value option, if there are multiple options). It does not necessarily show what the employee actually contributed if, for example, the employee waived, enrolled in a buy-up option, or enrolled in family coverage.

Q. Are the penalties still in place and must they be paid is a specific time frame?

A. Although there was proposed legislation that could have changed things, the legislation did not pass and therefore there are still penalties in place for violations of the employer mandate (§4980H offer of coverage requirements) and the individual mandate (requiring individuals to have coverage all 12 months). In addition, there are penalties that apply for employers who fail to report as required on Forms 1094 and 1095.

Individual mandate penalties, if applicable, are paid on personal tax returns.

Employer mandate penalties, if applicable, are paid after Form 1094-C and Form 1095-Cs are reconciled by the IRS and the employer receives a notice and request for payment (Notice 226J and/or Notice CP 220J. See IRS FAQ (Q&As 55-58), just recently updated at https://www.irs.gov/affordable-care-act/employers/questions-and-answers-on-employer-shared-responsibility-provisions-under-the-affordable-care-act.

Q. Line 14: Is there really a difference between the codes 1A and 1E? (That is if we offer MEC for the family)

A. The difference between codes 1E and 1A is that code 1A adds an affordability requirement (the offer must meet the FPL safe harbor). If an employer makes a qualifying offer, either code 1A or 1E may be used on Line 14, but using code 1A allows the employer to leave Lines 15 and 16 blank.

Q. Looking for some guidance on how to handle retirees who are still eligible for benefits. Are they required to receive forms? They no longer have a salary so it makes it difficult.

A. For those who are not full-time employees, reporting is required only if they have coverage under a self-funded plan offered by the employer (e.g. part-time employees, retirees, COBRA participants, owners). Reporting coverage information under a self-funded plan for such individuals may be done using Form 1095-B, or Part III of Form 1095-C.

Q. Employee waives all coverage what do you enter on line 14? 1H? And do you leave line 16 blank?

A. If a full-time employee was offered coverage, the employer uses the appropriate offer code (e.g. code 1E or 1A) on Line 14, regardless of whether the employee actually enrolled or waived coverage. If the employee enrolled, then code 2C is entered on Line 16. If the employee waived, then the employer should enter the applicable affordability safe harbor code (i.e. code 2F, 2G or 2H), or leave Line 16 blank; there is no code designated specifically for a waiver of coverage for Line 16.

Q. Is code 1G used for Cobra participants and retirees?

A. Yes, as well as for others who were covered under the employer's self-funded plan, but who were not full-time for any month of the year (e.g. part-time employees, owners).

Q. Wait! Self-insured people need to report. Does that mean that HRA plans are included in this, regardless of size?

A. Generally, no. Reporting for coverage under an HRA is not required for those individuals who are enrolled in a major medical plan sponsored by the same employer. Reporting is required for the HRA only if the individuals are not also enrolled in the employer's major medical plan (e.g. HRA integrated with another employer's major medical plan or a retiree-only HRA).

Q. What is big picture difference between 2F and 2H?

A. Code 2F = the Form W-2 safe harbor. Coverage is affordable under the Form W-2 safe harbor if the annual employee contribution for single coverage does not exceed 9.69% (in 2017) of the wages reported in Box 1 of Form W-2.

Code 2H = the rate of pay safe harbor. Coverage is affordable under the rate of pay safe harbor if the monthly employee contribution for single coverage does not exceed 9.69% (in 2017) of the hourly rate multiplied by 130, regardless of the number of hours worked (for hourly employees); or the monthly salary (for salaried employees).

Q. If you do not have 50 or more FTE's and your plans are not self funded...I want to confirm that NO reporting, not even to the IRS is required.

A. That is correct.

Q. Do you enter a code on #14 for the months an employee is not working for us or do you leave those boxes blank?

A. If a Form 1095-C is being completed because the employee was full-time at least one month during the year, it is necessary to provide a code in all 12 months on Line 14. For those months the individual was not employed, the coding would be 1H (no offer of coverage) on Line 14, and 2A (not employed) on Line 16.

Q. What code would you use when an offer of coverage is made and the employee waived coverage for Line 16?

A. For those months coverage was offered to a full-time employee, on Line 16:

- Use Code 2C if the employee enrolled
- Use Code 2F, 2G or 2H if the employee waived and coverage was affordable under one of the affordability safe harbors. If the coverage was not affordable, leave it blank.

Q. If we just use the 1A instead of 1E then we don't have to worry about the other lines, correct?

A. If the employer's offer meets the criteria for a "qualifying offer", and the employer marks Box A on Line 22 of Form 1094-C, the employer may then use code 1A on Line 14 for months an offer of coverage was made, and leave Lines 15 and 16 blank.

An employer's offer is considered a qualifying offer if the employer offers coverage at an employee-only cost not exceeding 9.69% of the mainland single federal poverty line (FPL) - approximately $96-97/month, and an offer of at least minimum essential coverage (MEC) to spouses and dependents.

Q. Are the full time employees who are in a waiting period for 2 months, hired in October 2017 and eligible in next January, do those employees need to be reported in 1095c?

A. No reporting would be required. Reporting is required only for those individuals determined to be full-time for at least one month during the year, and this employee would not be considered full-time for any months during 2017.

For the first partial month of employment, as well as during the waiting period (so long as coverage is actually offered at the end of the waiting period), an employee is considered to be in a limited non-assessment period, and the instructions indicate that an employee in a limited non-assessment period is not considered full-time.

Q. For the 1094 reporting, we are a municipality that has the self-funded insurance plan. We have allowed our public library to be part of this plan even though they have their own federal id. How would we handle the 1094 for the municipality and for the library?

A. Typically reporting is handled on a per EIN (per entity) basis, regardless of whether the entities may share benefit plans. See Q&A 9 and 10 in the IRS FAQ found at https://www.irs.gov/affordable-care-act/questions-and-answers-on-information-reporting-by-health-coverage-providers-section-6055.

Q. Do we have to report on retirees who are 65+ and covered under medicare and our SI plan is only a medicare supplement type plan?

A. No…*"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."* (IRS FAQ Q&A 14 - https://www.irs.gov/affordable-care-act/questions-and-answers-on-information-reporting-by-health-coverage-providers-section-6055).

Q. Because we use variable hour employees, we have a 180 waiting period to determine if they will be able to maintain a 30 hr. average. Would Code 2D still be applicable for the 180 days?

A. Under the waiting period rules, it's not possible to use a waiting period in excess of 90 calendar days unless the employer is using the look-back measurement method. If the employer is using the look-back measurement period, it would be possible to use a 6-month (or 12-month) initial measurement period for variable hour new hires and then use code 2D (indicating a limited non-assessment period) on Line 16 for the months during the initial measurement period and corresponding administrative period.

Q. Can you mark two categories for Line 22 on the 1094-C?

A. Yes. While it is not necessary to mark any of the boxes on Line 22, an employer who meets the criteria for both the qualifying offer method and the 98% offer method could mark both.

Q. Do employers need to report full-time contract employees?

A. Employers are required to report for all full-time common law employees. Reporting is not required for independent contractors. But we warn employers to be careful as there is often misclassification in this area. Unfortunately, the ultimate distinction between "employee" and "independent contractor" is far from black or white. It would be advisable to work with an employment law attorney if there is any question as to the relationship. Both the Fair Labor Standards Act (FLSA) and IRS rules contain requirements and restrictions as to who can be treated as an independent contractor versus an employee.

Q. Do I have to report for an employee that was terminated Nov 2016 and was on Cobra all of 2017?

A. Only if the former employee was covered as a COBRA participant under a self-funded plan.

Q. Does the IRS give an extension for electronic filing of the 1095-Cs?

A. Companies can complete Form 8809 and submit to the IRS to request a 30-day filing extension.

Q. For Line 15 amounts, what if the plan the employee receives is determined by their residence? Our PPO plan is more costly than our HMO, but employees are placed in one plan or the other based on their address. Do we always report the more affordable plan, or report based on the plan that employee is eligible to receive?

A. Employers should report the employee cost of single coverage for the plan in which the employee is actually eligible to enroll. For example, if the employee is only eligible for the PPO based on the employee's address, then the employee contribution for single coverage under the PPO should be listed on Line 15.

Q. I thought the rule was they had to have the average of 30/ week for the entire year not just one month. So you're saying if we have an employee who only works 19 hours per week for 11 months but they have one month they averaged 30 hours per week they have to be offered coverage?

A. The answer depends upon whether an employer is using the monthly measurement method or the look-back measurement method:

- Under the monthly measurement method, an employee is considered full-time for any month in which the employee achieves 130 or more hours of service.
- Under the look-back measurement method, an employee is considered full-time if the employee averaged full-time hours over the previous measurement period.

Q. If cost for single coverage is $132.00/month, it's NOT "affordable"!?

A. It would not be affordable based on the federal poverty level (FPL) safe harbor, but may be affordable based on in the individual's actual household income and/or under either the rate of pay safe harbor or Form W-2 safe harbor.

Q. If there is a dependent who aged out they will receive their own 1095 or they would be listed on the same 1095 as the employee/ parent?

A. While generally dependents will be listed on the same form as the primary subscriber (responsible individual), a spouse or dependent who loses coverage and elects COBRA independently (e.g. due to loss of dependent status after turning age 26 or getting divorced, or following the death of an employee) should receive a separate Form 1095 showing months of COBRA coverage.

Q. If we do qualify for the FPL safe harbor and a person waves coverage, are we better off leaving blank or putting 2G on line 16?

A. Either is okay and tells the IRS the same thing.

Q. If you offer family coverage to all employees can you use the same offer of coverage code (line 14) regardless of the level of benefits they elect?

A. Yes. On Line 14 the employer should use the code indicating what type of coverage was actually offered rather than what the employee may have elected.

Q. We will calculate affordability now for 2018 year employee cost. Can we use the employee W-2 wages now to do that calculation?

A. An employer choosing to use the Form W-2 safe harbor to help set 2018 employee contributions will need to use a "guesstimate" of what will be reported in Box 1 of the W-2 for the 2018 calendar year. Whether or not the coverage is actually affordable based on the Form W-2 safe harbor will have to be reconciled at the end of 2018 when the information is available.

Q. On 1094 C Part 3 - is the column B required to be completed?

A. Yes, unless the employer meets the criteria for the 98% offer method and marks Box D on Line 22 of Form 1094-C.

Q. On the who has to report, is that 50 employees at one time? We only have 23 full time at one time but may have employed 50 total employees in a year.

A. An employer who averaged 50 or more full-time equivalents (FTEs) in the previous calendar year is considered an applicable large employer and is required to report offer of coverage information on Form 1094-C and 1095-Cs. Both full-time and part-time hours are considered. Here are the general calculation steps for purposes of determining ALE status:

- Step 1: Calculate the number employees with 120 or more hours of service for each calendar month
- Step 2: Aggregate hours of service for each month for any other employees and divide by 120
- Step 3: Add the numbers obtained in Steps 1 and 2 for each month
- Step 4: Add up the totals from each month from Step 3 and divide the sum by 12

For each month, count all hours of service for any employee employed for at least one day during the month. When there is more than one entity/employer involved due to common ownership or shared services (i.e. a controlled group or affiliated service group under §414 rules), the entities must aggregate FTEs to determine the average for the previous calendar year.

Q. Our company covers 100% of the employees coverage, but not their dependents/spouses. To be clear, we can check the box 22 - 1A and only have to fill out line 14, and can skip line 15 and 16?

A. So long as the coverage offered to the employees provides minimum value, and coverage is offered to spouses and dependents (even if the employee has to pay 100% of the cost of coverage for spouses and dependents), then yes.

Q. We are partially self-funded. What are those requirements?

A. If the plan is partially self-funded, it is likely the employer is responsible for reporting coverage information for the plan, but it would be advisable to confirm that the carrier is not planning to handle the reporting.

Q. We have always used DOB for spouse's & dependents & have not had any issues?

A. If the employer cannot establish "reasonable cause" for not having the SSNs for covered spouses and dependents, its possible the IRS may impose penalties. To establish reasonable cause, the employer should make 3 reasonable attempts to obtain the SSN and document the process.

Q. What code should be used on line 14 when the employee is in a waiting period?

A. Code 1H indicating no offer of coverage should be used on Line 14. It is only considered an offer of coverage if the coverage is actually available for every day of the month.

Q. What if an employee loses coverage due to a reduction in hours but choses not to elect COBRA. How would you code that? The same as termination of employment?

A. No. Following a reduction in hours, even if the employee does not elect COBRA, the offer of COBRA continues to be coded as an offer of coverage (similar to other active, full-time employees) on Line 14, the COBRA premium for single coverage is entered on Line 15, and the appropriate code for Line 16 depends upon whether the individual enrolls (2C) or not. See IRS FAQ 23 found at https://www.irs.gov/affordable-care-act/employers/questions-and-answers-about-information-reporting-by-employers-on-form-1094-c-and-form-1095-c.

Q. What if we offered two plans and one is affordable and FPL but they choose the one that is not? Can we still mark that we did offer a affordable one?

A. Yes. The employer should report based on the lowest cost minimum value plan offered to the employee.

Q. What should we do with 1095-C forms that are returned to the employer because the employer doesn't have a current address and there is no forwarding address?

A. The best the employer can do is attempt to send the Form 1095 to the last known address.

Q. When an employee is hired mid month we have been advised to code the 1095-C as 1E with a safe harbor code of 2D to indicate the coverage did not begin on the first of the month. Please advise as Regan just advised differently.

A. It is only considered an offer of coverage if the coverage is available for the whole month. Therefore the first partial month of coverage should always be coded 1H (no offer of coverage) on Line 14 and 2D (limited non-assessment period) on Line 16. See the instructions for Line 14 found on pg.10 at https://www.irs.gov/pub/irs-pdf/i109495c.pdf.

Q. When using the W-2 safe harbor, should we be using the 2017 W-2's? The deadline is early in 2018 and W-2s are not available until early 2018.

A. Yes. To determine if coverage was affordable for the 2017 calendar year based on the Form W-2 safe harbor, it is necessary to use the information from Box 1 of the 2017 Form W-2s.

Q. When will you be notified if a penalty will be assessed?

A. This is unknown…the IRS is currently in the process of sending out Letter 226J providing notice to employers of penalties which may be due for the 2015 calendar year (two years ago). Therefore it may be a bit before the IRS is ready to reconcile reporting for the 2016 and 2017 calendar years.

Q. Why is reporting due 2/28 or 4/2, should one of these dates be in March?

A. Electronic reporting is generally due by March 31st, but because that falls on a weekend, the deadline is April 2nd, 2018.

Q. For the W-2 safe harbor, is it still true that you cannot use this if the employee's salary changes during the calendar year?

A. Yes. To qualify for the Form W-2 safe harbor, the employee's required contribution must remain a consistent amount or percentage of all Form W-2 wages during the calendar year (or during the plan year for plans with non-calendar year plan years) so that an applicable large employer member is not permitted to make discretionary adjustments to the required employee contribution for a pay period.

Q. Does commissions get included in rate of pay?

A. No. If using the rate of pay safe harbor, it is necessary to use the base hourly pay or monthly salary. The rules actually suggest that the rate of pay safe harbor is not appropriate for tipped employees or for employees who are compensated solely on the basis of commissions. So assuming tips or commissions significantly impact pay levels and the FPL safe harbor doesn't apply, the Form W-2 safe harbor may need to be used.

Q. How are Union employees (that we are making contributions on their behalf) reported?

A. An applicable large employer is responsible for reporting offer of coverage information for any employees (both union and non-union) who are full-time. If the employer is not offering coverage to union employees under the employer-sponsored plan (which is typically the case for union employees), the employer will still need to complete Parts I and II of Form 1095-C. However, based on the interim transition relief in §4980H final rules and the final reporting instructions, so long as the employer is able to obtain reassurances from a reliable union source (someone who would obviously have access to accurate information about the plan offerings) that the plan offered by the union provides minimum value and is affordable based on one of the safe harbors for any employees averaging 30 or more hours of service per week, then the employer may use the simplified coding (1H on Line 14 and 2E on Line 16) for any union employees for whom the employer contributes money to the union without having to get any specific information about the employee and whether/when the employee was actually offered coverage.

Q. Are we reporting the amount we take out of our employees paycheck or the actual amount of the plan?

A. Regardless of which plan or tier of coverage the employee may elect, the employer is always reporting the employee contribution for single coverage for the lowest cost minimum value option offered.

Q. Do we also need to fill out a 1095 for employees who are not full time but are offered coverage?

A. Not unless they actually enroll in a self-funded plan offered by the employer.

Q. Do we need to send a 1095-C each year to retirees that continue on our insurance? They are not FTE.

A. Only if the plan is self-funded.

Q. IF we use a look back period and the employee has a reduction in hours, is it correct that we can not stop their insurance during the stability period? i.e. employee has over 780 hours worked during the look back period, but during the look back period they dropped to on-call hours. If I'm understanding correctly we can not stop their benefits until the end of the next stability period. Is this correct?

A. To avoid potential §4980H penalties under the look-back measurement rules, an employee is generally considered full-time and requires an offer of coverage for the whole stability period following a measurement period in which the employee averaged full-time. In other words, an employee who measured full-time during the 12-month measurement period would be considered full-time and require an offer of coverage for the entire 12-month plan year (stability period), even if there is a drop in hours or leave of absence. This is the case unless employment is actually terminated. However, there is an exception for a regular full-time employee, offered coverage upon hire after the plan waiting period (rather than being subject to an initial measurement period), who later experiences a change in status which results in part-time hours. In such a case, coverage may be dropped 1st of the 4th month following the change in status so long as the employee is actually part-time for the 3 months following the change in status rather than offering through the remainder of the stability period without the employer incurring any penalties.

Q. Line 16: the codes for safe harbor (2F, 2G, 2H). Do we enter these codes to help explain why we should NOT have a penalty if the employee has waived coverage?

A. That is correct.

Q. Part-time employees, what code should we use for line 14 and 16?

A. Reporting is not required for employees who were not full-time employees for at least one month of the year unless they enrolled in self-funded coverage offered by the employer.

If the employee was full-time some months and part-time other months, code 2B should be used on Line 16 for those months the employee was part-time (if the employee was not covered under the plan).

Q. What's the best code for line 14 if MEC for EE + family but not MV?

A. 1F = MEC that is not MV offered to employee. If minimum value coverage is not offered, it's not necessary to indicate whether or not coverage was offered to spouses and children.

Q. I got a "Accepted with Errors" on 7 ee's due to mismatch. There was no guidance on the specifics of the error or how to correct. Best I could figure was a missing name - middle name or 2nd last name for hispanic EEs.

A. The formatting of names may be causing issues. Perhaps the name control information developed by the IRS will be of use (https://www.ftb.ca.gov/professionals/efile/forms/irsforms/namecont.pdf). We have also heard that it is worthwhile to try switching the order of the hyphenated or double last names for those that do not go through the first time (especially Hispanic names). Also, according to the electronic filing instructions, hyphens are allowed, while apostrophes are not.

Q. Filing can be done by mail? Or what is the requirements depending on a company's size for electronic filing?

A. Employers filing less than 250 Form 1095s have the option to file by mail or electronically. Those filing 250 or more Form 1095s are required to file electronically.

Q. Is an ER H.S.A. contribution considered to be a deduction in the EE contribution amount?

A. No. HSA contributions do not affect affordability because the HSA funds cannot be used toward reimbursement of premiums.