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Q&A from Assurex Global Webinar:
"Employer 1095 and 1094 Reporting"

Q: If you offered MEC to all employees for all year can you just check this line or is there any reason to list out each month?	A: If an employer makes an offer of MEC all 12 months of 2015 to 70% of their full-time employees (this will be 95% in 2016), the employer would check the "yes" box for all 12 months on line 23 of column (a). The employer could choose instead to mark "yes" for each individual month, but there is no reason to do so.
Q: Is 1094-C, Part IV (for ALE groups) something that only has to be completed in the authorativie transmittal, or must each 1094-C have this information?	A: Each separate EIN in a aggregated ALE group of employers must complete their own authoritative transmittal 1094-C for that particular employer, including completion of part IV listing the other EINs in the aggregated group. However, if any one employer (EIN) decides to use more than one 1094-C (e.g. for different divisions within the same EIN), then it is only necessary to complete Parts II, III, and IV on the 1094-C that is marked as the authoritative transmittal for that particular employer.
Q: Are non-applicable large employers required to file if they have combined over 50 FTEs as an aggregate?	A: If a group of employers is considered a controlled group or affiliated service group based on IRS code §414 rules, the full-time equivalents (FTEs) are aggregated across all member employers. If together the employers have 50 or more FTEs, then each separate employer that is part of the group is considered an applicable large employer and must report, even if individually the employer has less than 50 FTEs.
Q: If your plan provides different insurance cost based on the type of employee, do you enter the cost based on the type of employee or the lowest cost overall?	A: The information should be specific to each employee (i.e. based on the type of employee).

Q: Can you use 2014 premium rates for line 15?	A: No. All reporting is based on coverage provided during calendar year 2015.
Q: On line 15, can we factor in the employer contribution to an employee's HSA account?	A: No. Employer HSA contributions are not considered for purposes of reporting on line 15. Line 15 should only reflect what the employee is required to contribute for single coverage in the lowest cost minimum value plan offered to that employee.
Q: Does "full-time employee" in column B require a full-time equivalent employee head count?	A: No, the total number of full-time employees reported in column B on page 2 of the 1094-C should be the number of employees who are actually considered full-time that month. Full-time for these purposes is defined as 30 or more hours of service per week, or 130 per month, and determined by using either the monthly measurement method or look-back measurement method.
Q: Are retired employees required to be reported? If yes, how are they reported when they were on an active self-insured plan for part of the year and a retiree fully-insured (or Medicare supplement) plan for the rest of the year?	A: Only those that were a full-time employee for at least one month during the year OR enrolled in a self-funded plan. * If the individual was full-time for a portion of the year and retired for a portion of the year, use the appropriate offer code for the time they were active and then 1H for the time they were retired on Line 14 of the 1095-C. Use 2A on Line 16 for the months of retirement. Also complete Part III for any months the individual was enrolled in a self-funded plan. * If the individual was retired all year, but enrolled in a self-funded plan, use 1G in "all 12 months" on Line 14 of the 1095-C and complete Part III for any months the individual was enrolled.

Q: Does 1095-C, Part 3, need to be completed for all dependents? Do you have to report dependent information, even if they are not covered?	A: Only employers offering self-funded plans complete Part III of the 1095-C. Only covered (enrolled) dependents should be listed.
Q: Can we opt to give everyone a 1095-C for all employees whether or not they were full time for any month?	A: Yes, but it would be necessary to report accurately for each employee as to whether coverage was actually offered or not (e.g. 1E versus 1H) on Line 14, and if offered, whether such employee enrolled in coverage (Code 2C) on Line 16. And for a part-time employee, if not enrolled in coverage, Code 2B would need to be entered on Line 16. In addition, unless the employer qualifies for the 98% Offer Method, the full-time employee count must be provided in column (b) of 1094-C. In other words, simply reporting on all employees does not save the employer from having to understand which employees were full-time or part-time each month, who was offered coverage, and who enrolled.
Q: Would code 1E still be used if the employee does not have a spouse and/or dependent?	A: Yes, if the employer offers coverage to employees, spouses, and dependents, then code 1E should be used even for single employees who do not have a spouse or dependent.
Q: Because of this new reporting, do we still have to fill in the insurance cost of the employee and employer information in box 12 on the W2?	A: Yes, those employers who filed 250 or more W-2s the prior year are still required to report health plan costs on the W-2. This new reporting requirement does not change that rule.
Q: Does this reporting apply to dental plans as well?	A: No, the reporting is generally only concerned with medical coverage.

A: Reporting is only really required for full-time employees (unless the employee is actually enrolled in the self-funded plan). Therefore, reporting is not generally required for part-time employees unless the employee is actually enrolled in a self-funded plan. For such a situation, on 1095-C 1G is used on Line 14 of Part II and coverage information is provided in Part III.
On the other hand, if the employee is full-time for part of the year and part-time for part of the year, or the employer is choosing to report for part-time and full-time employees for some reason, the appropriate offer code would be used on Line 14 and either 2C (enrolled) on Line 16 or 2B (part-time) is waived.

Q: If a part-time employee works less than 30 hours, but is eligible for coverage, do we use 2B in box 15? If they decline their coverage, do we report that on a 1095C form? If so, how is that coded?

A: 1A indicates a "qualifying offer", minimum essential coverage providing minimum value offered to full-time employee with employee contribution for self-only coverage equal to or less than 9.5% mainland single federal poverty line ($93.18/month for 2015) and at least minimum essential coverage offered to spouse and dependents. 1A is a slightly higher threshold because it has a contribution level requirement as well as a requirement to provide minimum value. If the plan provides minimum value, but the monthly employee contribution for single coverage exceeds $93.18, then 1E should be used, assuming coverage is also offered to spouses and children.

Q: Can you please clarify the difference between 1A and 1E? If you offer something greater than minimal coverage, but it costs more than the ~ $90, then is it a qualifying offer?

A: It would be necessary to use 1H for the time prior to the effective date (i.e. first 90 days). On line 16 for such months, use 2D to indicate a limited non-assessment period.

Q: Can we use line 14 and code 1A when we hire a new employee, but they don't get insurance until 90 days of work?

A: Employers have two options for determining full-time status under Section 4980H rules:
1. If using the monthly measurement method, it would be necessary to provide a Form 1095-C for employees that achieve 130 or more hours of service in any given month.
2. If using the look-back measurement method, those that achieve full-time status based on the previous measurement period are considered full-time for the entire corresponding stability period unless employment is terminated. Such employee should be treated as full-time for any months of the stability period that occur during 2015. For those that are considered part-time during the previous measurement period, they are considered part-time for the entire stability period, even if hours of service exceed 130 in some months. During the initial measurement period, the employee is not considered full-time. Such employees must only be counted as full-time once they have completed a measurement period and have been determined to average full-time hours (i.e. during the stability period).

Q: Do covered individuals (i.e. dependents) need to receive a copy of their own 1095-C?

A: No. For those individuals enrolled in a self-funded plan, the employer only needs to provide a Form 1095 for the primary subscriber. In other words, if an employee enrolls himself, his spouse and children. One Form 1095 should be provided to the employee with the employee, spouse and children all listed in Part III.

Q: Are employers exempt from filing 1096s on contract employees?

A: Assuming they are correctly categorized as independent contractors (leased employees), there is no requiremen to report on such individuals using a 1095. However, we caution employers to be careful as misclassification of such individuals is common.

Q: Can you hand 1095Cs to working employees and mail it to those who are not currently working?	A: Mail or hand delivery are both acceptable methods of distribution. Electronic distribution is also allowed if consent is obtained in accordance with the reporting instructions.
Q: Does line 15 on 1095-c include just major medical premium, or does it also include dental/prescription?	A: Line 15 should generally report the employee contribution amount required for medical coverage only (unless the contribution amount is bundled with other benefits and the employee does not have the option to choose them separately)
Q: On form 1094-C, do we need to list the unions that offer unionized employees their insurance coverage?	A: No. Part IV of 1094-C is for other entities that are considered part of the same controlled group or affiliated service group due to shared ownership or services under Section 414 rules (members of an aggregated ALE group).
Q: On form 1094-C (Part III), there appears to only be a checkbox in column D. Can we add additional infomation?	A: If an employer checks the "yes" box on Line 21 of 1094-C indicating membership in an aggregated ALE group, then it is necessary to complete which months the employer was a member of such group in column (D) of Part II. If an employer checks the "no" box on Line 21, then column (D) can be left blank.
Q: How do we report that we switched from fully-insured to self-funded in the middle of 2015?	A: For any individuals covered under the plan while self-funded, a 1095 will be required. The employer will check the boxes for coverage only during the months in which the plan was self-funded and leave any months of coverage while the plan was fully-insured blank.
Q: How do you complete form 1095 C, for an employee who waives coverage and receives cash in lieu of benefits?	A: The code for coverage type should be entered on Line 14, the amount of the employee contribution required for such coverage should be listed on Line 15 (unless it was a qualifying offer), and Line 16 can either be left blank or tindicate that a safe harbor applies. Cash in lieu of benefits may need to be considered when determining the employee contribution amount on Line 15.

Q: How do you report coverage for an employee whom is on sick leave for consecutive months, but still has full-time coverage?

A: If the employee is still being offered coverage, the coding doesn't change; rather, it is handled the same way it is for an active employee.

Q: How does an employer report coverage for retirees covered by the plan?

A: If the retiree was not a full-time employee for any month during the year, but enrolled in a self-funded plan, either complete a 1095-B or on Line 14 of 1095-C use Code 1G for "all 12 months" and then complete Part III.

Q: How is reporting handled for employers who have a plan year that is mid-year, and therefore don't need to offer coverage until their plan year begins in 2015?

A: Assuming the employer qualifies for non-calendar year transition relief, for the months prior to the plan year renewal, if the employer either didn't make an offer of coverage (1H) or made an offer that did not provide affordable minimum value coverage, then use 2I on Line 16 of 1095-C.

Q: I thought the affordability was calculated based on 9.5% of a minimum wage income. Did it change, based on FPL?

A: Generally, affordability is no more than 9.56% (9.66% in 2016) of an employee's household income. Because an employer is unlikely to know an employee's household income, the IRS provided 3 possible safe harbors...(i) no more than 9.5% of federal poverty level (FPL); (ii) no more than 9.5% of Form W-2 wages; or (iii) no more than 9.5% of rate of pay. If the coverage is affordable using one of these safe harbors, then the employer can avoid potential penalties.

Q: If employee is offered coverage, but waived it because they are covered under a spouse's health insurance, would we report it on 1095-C?

A: On Line 14 of 1095-C, the employer is reporting whether or not coverage was offered, it doesn't matter whether the coverage was accepted or waived. If accepted, code 2C is used on Line 16. If coverage is waived, either leave Line 16 blank or use one of the affordability safe harbors if applicable.

Q: If a employee waives coverage at time of hire, is it still reported that coverage is offered even though the employee must now wait for open enrollment?	A: So long as the employer provides at least one opportunity annually for an employer to elect or waive coverage, it is considered an offer of coverage for the year.
Q: When an employee becomes benefits-eligible mid-month, do code Line 14 as both 1H and 2C on form 1095-C?	A: If an employee becomes eligible mid-month, enter Code 1H on Line 14 and 2D on Line 15, because the instructions indicate that this qualifies as a "limited non-assessment period."
Q: If an employee is in their initial waiting period and was offered coverage, do I supply a 1095-C?	A: A 1095-C must be provided to any employee that is considered full-time for at least one month during the year, regardless of whether the individual was actually offered coverage or not. So yes, it would be necessary to provide a 1095-C to someone in a waiting period; use Code 1H on Line 14 and 2D on Line 16 for such months.
Q: Should we provide a 1095-C to an employee if they usually average less than 130 hours per month for 11 months of the year, but have 1 month where they exceed 130 hours?	A: If using the monthly measurement method, it is necessary to provide a 1095-C for any employee that achieves 130 or more hours of service in any month. If using the look-back measurement method, rather than considering any individual month, it is based on whether or not the employee averaged full-time during the previous measurement period. If full-time, based on the previous measurement period, the employee is generally considered full-time for the entire stability period; and if part-time based on the previous measurement period, the employee is generally considered part-time for the entire stability period.
Q: If LLC/Limited Partner owner/members are paying the entire cost of their insurance, do they also get a 1095-C form?	A: Sole proprietors, partners in a partnership and 2% or more shareholders in an S-Corp are not considered "employees" and do not require a 1095-C. Other owners that do not fit into these exceptions would require a 1095-C if considered full-time.

Q: What is the correct code when a MEC is offered to employee, spouse and children (the EE only plan does not meet MV standard)?

A: Code 1F is appropriate when only a MEC plan is offered that does not meet minimum value standards (at least 60% actuarial value).

Q: If the employer offers a subsidy for wellness participants, is the subsidy taken into consideration when reporting the cost of MV coverage on line 15? If our smoking employees pay an additional amount each month as a surcharge, do we include that amount in the cost of our monthly premium in determining the cost of our minimum value plan?

A: Affordability for wellness incentives should be determined assuming that each employee fails to satisfy the requirements of the wellness program, except for the requirements of a nondiscriminatory wellness program related to tobacco use. Therefore, other than wellness incentives for tobacco use, coverage is affordable only if the higher premium or contribution level (prior to consideration of the wellness program deduction) is affordable for the employee.

Q: When using the 98% Offer Method, should we skip or fill out column C?

A: If an employer meets the criteria for the 98% Offer Method, the employer may skip completion of column B, but needs to complete column C.

Q: Do we check box C (line 22) on the 1094-C, if we use a measurement period and determine full-time status based on variable hour or seasonal?

A: Not necessarily. Box C on Line 22 of 1094-C only needs to be checked for 2 situations:
(1) Employer qualifies for 50-99 FTE transition relief and needs penalty relief because the employer is not yet in compliance with Section 4980H requirements; or
(2) Employer has 100 or more FTEs and has failed to offer coverage to at least 70% of full-time employees in one or more months and wants to take advantage of the waiver for the first 80 full-time employees when calculating penalty 4980H(a).

Q: If we offer insurance to retirees, do we have to complete a 1095-C for them?

A: A 1095 would only be required for those retirees that actually enroll in a self-funded plan. Nothing is required if offered and waived. If enrolled in a fully-insured plan, the insurance carrier will handle the reporting.

Q: If we pay 100% of the premium cost for employees, spouses, and dependents, is the line 15 amount equal to $0?	A: There are two options: use Code 1A (qualifying offer) on Line 14 and leave Line 15 blank; or use Code 1E on Line 14 and enter $0.00 on Line 15.
Q: If we were self-funded for January, and then went to fully insured, do we need to complete self-funded forms for just January (we are under 99 FTEs)?	A: All applicable large employers (50 or more FTEs) must provide a 1095-C to full-time employees, even if the employer is in the 50-99 FTE range and qualifies for transition relief from Section 4980H penalties. If a self-funded plan is offered for only a portion of the year, the employer checks the boxes only for those months the individuals were enrolled in the self-funded plan. The insurance carrier will report showing coverage for the months the plan was fully-insured.
Q: If we're fully insured, do we need to do anything for COBRA participants?	A: No. If the individuals were not full-time for any month during the year, no reporting would be required.
Q: If you provide a qualifying offer but choose not to send an alternative statement (and instead just send them a 1095-C), should you use Code 1A or 1E?	A: Employers who make a qualifying offer may choose to report using Code 1A or 1E on Line 14. It is okay to use 1A regardless of whether the employer is choosing to provide alternative statements to some employees. If using 1A, the employer doesn't have to enter anything in on Line 15.
Q: Do the member companies of a controlled group do consolidated reporting, or individually (based on the employees in each EIN)?	A: Although entities within a controlled group must aggregate FTEs to determine whether they reach the threshold of 50 or more (applicable large employer), each entity/EIN is required to report individually in regards to their own respective full-time employees and/or individuals covered under a self-funded plan.
Q: If employee starts on February 10, for example, and medical coverage starts on the hire date, would line 16 for February be 2D?	A: Yes, exactly. Code 1H on Line 14 and 2D on Line 16.

Q: Do only employers with 50 or more employees participate in the MEWA?	A: All employers that participate in the MEWA that have 50 or more FTEs (either alone or as part of a controlled group) must report offer of coverage information for full-time employees. In addition, if the MEWA offers self-funded coverage, each participating employer must report on their own respective covered (enrolled) individuals.
Q: Do we have to report employee and dependents by name, SSN, and date of birth in self-funded plans?	A: When reporting coverage information in a self-funded plan, the employer must include name and SSN of all covered individuals, including dependents. If the SSN cannot be obtained after reasonable attempts in accordance with the instructions, then the DOB may be used instead.
Q: If an employer becomes an ALE during the year, do they have to report just the months when they surpass the 50 employee-threshold, or the whole year?	A: Status as an "applicable large employer" – 50 or more FTEs - is always determined based on data from the previous calendar year. In other words, status during 2015 is dependent on average total FTEs during 2014. Staffing changes during 2015 will only affect status for 2016.
Q: Under ALE Fully-Insured Plans, will the insurance carrier send the coverage information on fully-insured plan via Form 1094/1095B directly to the employee?	A: For a fully-insured plan, the insurance carrier will report to the IRS using 1094-B and 1095-B and will send a copy of 1095-B directly to the primary insured.
Q: We have 52 FTEs and offer no insurance. Do I have to file or report?	A: Regardless of whether an employer chooses to offer coverage or not, if the employer has 50 or more FTEs, reporting is required using 1094-C and 1095-C.
Q: Will Medicare send form 1095 for those with Part A, B, or D coverage?	A: Yes, individuals covered under government-sponsored programs will receive a 1095 from the government sponsor of such programs.

Q: Does the 98% Offer Method require that 98% are on our plan? We offer the same coverage and cost to all employees.	A: The 98% Offer Method requires an offer of coverage that provides minimum value and is affordable to at least 98% of full-time employees. It doesn't matter how many employees are actually enrolled.
Q: If we qualify for the simplified statement, does it only apply to employees who chose that plan, or to all employees (even if they chose a more expensive plan)?	A: If the employer meets the criteria for the qualifying offer method and is choosing to provide an alternate simplified statement in place of 1095-C, it can be provided to all applicable employees, regardless of which plan is actually chosen, except for those enrolled in a self-funded plan. The alternate statement cannot be used for those enrolled in a self-funded plan.
Q: Is there still a transition period where employers can use any 6 consecutive months in 2014 for determining ALE status for 2015?	A: Yes. For applicable large employer status in 2015 only, the employer may average FTEs over any 6 consecutive months in 2014.
Q: What about HSAs and FSAs? Notice 2015-68 and the final instructions have indicated when an HRA is required (and not required) to be reported under 6055.	A: Reporting is not required for HSAs or FSAs as these are not generally considered to be minimum essential coverage.
Q: Can we use 1A for line 14 if we offer insurance to spouses only if they do not qualify at their own employment?	A: Code 1A or 1E is still appropriate for employers that offer coverage to employees, spouses and children, but restrict coverage for spouses that have other coverage available. For purposes of reporting, an offer to a spouse includes an offer that is subject to a reasonable, objective condition, such as the spouse having no other group coverage available.
Q: When filling out Part 2, do I have to fill out the information for months prior to the employee's start date?	A: Yes. When filling the 1095-C, it is necessary to provide information for all 12 months. If not employed until June, for example, use Code 1H for January thru May on Line 14 and Code 2A on Line 16.

Q: We offer different levels of coverage (bronze, silver, gold). Do do we report the employee-only share of the bronze (the lowest-cost level)?	A: Yes. On Line 15, enter the employee contribution for single coverage for the lowest cost minimum value plan offered, regardless of which plan the employee may ultimately choose.
Q: would you use code 2C on line 16 if the employee only had the insurance for part of the month?	A: No. Code 2C is only appropriate if the employee was enrolled for all days during the month. If coverage was not offered for all days in the month, Code 1H should be used. If this is because coverage was effective mid-month (due to newly eligible), Code 2D should be used on Line 16. If this is because coverage was terminated mid-month due to termination of employment, Code 2B should be used on Line 16.
Q: Do we provide the rate of pay when calculating for the rate of pay method?	A: No. If the employer is relying on the rate of pay safe harbor, use Code 2H on Line 16 for any full-time employee who waives an offer of coverage and for whom the rate of pay safe harbor applies.
Q: When counting the number of full-time employees, do you use the count at the first of the month?	A: An employee is either full-time or part-time all month. Therefore, the count doesn't occur on any particular day.
Q: When calculating FTEs, do you report partial employees or round to the nearest whole number?	A: When doing the calculation for each month, don't do any rounding. Add the totals from all months and divide by 12 and then round down only if applicable to determine if the average total FTEs during the previous calendar year is 50 or more.
Q: We provide medical benefits for employees that work 24 or more hours per week. How do we report them, if they maintain 30 hours or less per month?	A: The employer is only required to report on employees that achieve full-time status for at least one month in the calendar year, unless the individuals are actually enrolled in a self-funded plan provided by the employer.

Q: Who is responsible for reporting a MEWA plan that is not self-funded?

A: If the plan offered by the MEWA is fully-insured, the insurance carrier will handle the reporting in regards to any individuals covered under the plan.

Q: What is the code for the non-calendar plan relief?

A: For months prior to the 2015 plan year that the employer qualifies for non-calendar year transition relief, Code 2I can be used on Line 16 for any employees that are not offered coverage or offered non-compliant coverage.

Q: How do we report a 60-day waiting period?

A: During the period of time in which a full-time employee is in a waiting period, use Code 1H on Line 14 and 2D on Line 16.

Q: What code is used if an employee does not qualify for coverage (because they have the qualified number of hours in a look-back period)?

A: If based on the measurement period, the employee is considered part-time, the employee is then part-time for the entire stability period. If the stability period is the calendar year, then no reporting would be required (not full-time for any months during 2015). If the stability period is a non-calendar year, and the employee is full-time for a portion of the year, the employer would report using Code 1H on Line 14 and 2B on Line 16 for the months during which the employee is considered part-time.