ACA: FAQs ON FORM 1095-C

This FAQ provides information about ACA reporting requirements under IRC Sections 6055 and 6056. Specifically, it provides guidance to applicable large employers (ALEs) on how to complete Part II (Lines 14, 15 and 16) and Part III of Form 1095-C. The ACA defines ALEs as those with 50 or more full-time employees (FTEs), including full-time-equivalent employees, in the preceding calendar year. For purposes of this FAQ publication, it is assumed that all employers are ALEs unless otherwise noted.

Section 6056 requires employers to use Forms 1094-C and 1095-C to fulfill the annual ACA reporting requirements. Form 1094-C is used for transmitting Form 1095-C. Self-insured (including level-funded) employers will combine Sections 6055 and 6056 reporting on Form 1095-C.

Immediately below is a quick reference guide to help clarify the meaning of codes and acronyms used throughout the FAQ. This is followed by a series of FAQs that pertain equally to both fully insured and self-insured employers or specifically to employers with only one or the other funding arrangement, as indicated. For further information about ACA reporting requirements, as well as a helpful compendium of additional FAQs, see the NFP publications **ACA: Employer Mandate Reporting Requirements** and **ACA: FAQs for Employer Reporting Under Sections 6055 and 6056**.

A QUICK REFERENCE GUIDE TO REPORTING CODES

Line 14 Indicator Codes for Employee Offer of Coverage (Series 1 Codes)

Line 14 requires employers to enter the applicable Series 1 code that identifies the type of health coverage actually offered to the employee, their spouse or domestic partner and any dependents. This information also relates to eligibility for marketplace coverage subsidized by the premium tax credit.

1A: Qualifying offer, for all months during which the employee was employed full-time, employer offered minimum essential coverage (MEC) providing minimum value (MV) that was affordable according to the federal poverty line (FPL) safe harbor. At least MEC offered to spouse or domestic partner and dependent(s).

1B: MEC providing MV offered to employee only. No coverage offered to spouse or domestic partner and dependents.

1C: MEC providing MV offered to employee. MEC offered to dependent(s). No coverage offered to spouse or domestic partner.

1D: MEC providing MV offered to employee. MEC offered to spouse or domestic partner. No coverage offered to dependent(s).

1E: MEC providing MV offered to employee. MEC offered to spouse or domestic partner and dependent(s). Since most employers offer coverage to employee, spouse/domestic partner, and other dependents, 1E is the most commonly-used Line 14 code.

1F: MEC not providing MV offered to employee and spouse or domestic partner and/or dependent(s).

1G: Offer to employee who was not full-time and enrolled in self-insured plan for one or more months.

1H: No offer of coverage.

1J: MEC providing MV offered to employee and at least MEC conditionally offered to spouse or domestic partner; MEC not offered to dependent(s).

1K: MEC providing MV offered to employee; at least MEC offered to dependents; and at least MEC conditionally offered to spouse or domestic partner.

New codes applicable for employers that offer Individual Coverage HRAs (ICHRAs) effective for 2020 reporting and thereafter

1L: ICHRA offered to employee only; affordability determined by using employee's primary residence location ZIP code.

1M: ICHRA offered to employee and dependent(s) (not spouse or domestic partner); affordability determined by using employee's primary residence location ZIP code.

1N: ICHRA offered to employee, spouse or domestic partner and dependent(s); affordability determined by using employee's primary residence location ZIP code.

1O: ICHRA offered to employees only using the employee's primary employment site ZIP code affordability safe harbor.

1P: ICHRA offered to employee and dependent(s) (not spouse or domestic partner) using the employee's primary employment site ZIP code affordability safe harbor.

1Q: Individual coverage HRA offered to the employee, spouse or domestic partner and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.

1R: Individual coverage HRA that is NOT affordable offered to the employee; employee and spouse or domestic partner or dependent(s); or employee, spouse or domestic partner and dependents.

1S: Individual coverage HRA offered to an employee who was not a full-time worker.

Line 15 Entry

If code 1B, 1C, 1D or 1E is entered on Line 14, employers are required to enter on Line 15 the dollar amount (including cents) of the employee monthly cost-share for the lowest-cost self-only MEC providing MV that is offered to the employee. This is true regardless of the employee's actual enrollment status, such as waiver of coverage or enrollment in a plan or tier with a higher employee cost-share requirement.

Line 16 Indicator Codes (Series 2 Codes: Section 4980H Safe Harbor Codes and Other Relief for Employers)

Line 16 provides the IRS with information to administer the employer mandate penalties. The purpose of Line 16 is to indicate that under a rule or safe harbor, the employer is not subject to Penalty B for that month (i.e., that the health coverage offered is deemed affordable for that month). Note that safe harbor codes 2F, 2G and 2H apply only if the employee waived coverage and the coverage met one of the affordability safe harbors.

2A: Employee not employed during the month.

2B: Employee was employed, but not full-time.

2C: Employee enrolled in coverage offered. If employee enrolled in non-multiemployer coverage, code 2C takes precedence over other Series 2 codes. If employee enrolled in multiemployer coverage, see code 2E.

2D: Employee is in a limited non-assessment period (measurement period, waiting period).

2E: Multiemployer interim rule relief. This code is used for an employee whose fee is paid by the employer pursuant to a collective bargaining agreement.

2F: Form W-2 affordability safe harbor.

2G: FPL affordability safe harbor.

2H: Rate of Pay affordability safe harbor.

FREQUENTLY ASKED QUESTIONS

At a high level, both fully insured and self-insured (including level-funded) employers need to report in Part II (Lines 14-16) that an employee was an FTE during each month of the year when the employee was an active employee. For fully insured employers, the reporting obligation ends upon termination of employment, even if the employee was offered and elected COBRA continuation coverage. Self-insured employers, however, must also report the employee (and any covered dependents) as covered individuals in Part III during any month(s) of the year when the employee (and any covered dependents) was enrolled in the plan as an active employee, a COBRA participant or a retiree.

Different codes will apply depending on the facts of an employee's date of hire, coverage start date, employment termination date, and benefits end date. In addition, different codes will apply for COBRA, retiree and dependent enrollments.

The FAQs below address the most common Form 1095-C reporting questions related to these variables.

1. GENERAL REPORTING INFORMATION FOR BOTH FULLY INSURED AND SELF-INSURED (INCLUDING LEVEL-FUNDED) EMPLOYERS

Q1. When do employers check the box "authoritative transmittal" on Line 19 of Form 1094-C?

A. Generally, the answer is "always." A single entity (one EIN) has the option to submit more than one Form 1094-C but then designate one of the forms as the authoritative transmittal in which the information is aggregated. This option has limited application and will likely be used only by very large companies with multiple divisions under one EIN. For the majority of employers, one Form 1094-C will be sufficient, and thus it will be the authoritative transmittal.

Q2. How do controlled group members report?

A. If an employer is a controlled group member, then it is separately responsible for offering coverage, ensuring that it is affordable and complying with the related reporting obligations. Specifically, each controlled group member is responsible for filing Forms 1094-C and 1095-C with the IRS as well as distributing a Form 1095-C to each FTE. Members in a controlled group can identify one member to file on behalf of all other members. However, that doesn't shift liability for a filing failure from the individual member to the identified filing member. The individual member remains exposed to IRS penalties if the filing member fails to file properly. This is because the employer mandate penalties are determined on a single-employer level per EIN. Further, each employer in the controlled group must identify the other employers in the group on Part IV of 1094-C.

Q3. How are mid-month new hires reported?

A.

- Line 14 – 1H
- Line 15 – No Entry
- Line 16 – 2D

For the first partial month of employment, employers should report that the FTE was not offered coverage by entering code 1H on Line 14. Again, unless the offer of coverage extended to every day of that calendar month for the FTE, the offer is not considered to have been made for that month. No entry is required on Line 15 for that first partial calendar month. Although employers report that no offer of coverage was made, they are entitled to relief from employer mandate penalties for that calendar month. For the first three months after an employee first becomes an FTE, the employee may be treated as being in a limited non-assessment period if all applicable conditions are satisfied. This is reported as code 2D on Line 16.

For example, if a newly hired FTE starts employment on January 15, and the offer of coverage (if accepted) provides coverage starting on January 15 (i.e., date of hire), then the employer should indicate that the FTE was not offered coverage for the month of January.

If the employer offers a self-insured health plan and the FTE enrolls in the plan and obtains coverage for any day during the first partial month of employment, the FTE (and any other individuals such as a spouse or domestic partner and dependents who obtained coverage through the FTE's enrollment) should be reported as having coverage for that month on Part III of Form 1095-C, but that doesn't change what the employer reports on Lines 14-16.

Q4. How are mid-month terminations reported?

A.

- Line 14 – 1H (No offer of coverage)
- Line 15 – No Entry
- Line 16 – 2B

If an FTE terminates employment on any day other than the last day of a calendar month and the coverage or offer of coverage expires upon termination of employment, then the employer should report that the FTE was not offered coverage for the final month of employment by entering code 1H on Line 14. No entry is required on Line 15 for that final month. However, if the terms of the plan stipulate that coverage ends on the last day of the calendar month in which employment ends, then the applicable offer of coverage should be reported on Line 14, with corresponding entries for Lines 15 and 16.

Q5. Are employers always required to enter a code on Line 16 of Form 1095-C in order to avoid a penalty under the employer mandate?

A. No. Employers are not required to make an entry on Line 16. So, if no code is applicable for a given month, Line 16 should be left blank. However, employers should enter the appropriate Series 2 code on Line 16, if applicable, to indicate whether they qualified for an exception from the assessable employer mandate penalty for a given month.

Q6. On Part II of Form 1095-C, how should employers report whether an offer of coverage was made to an FTE?

A. Employers should use Line 14 to report whether an offer of coverage was made to an FTE for each calendar month of the year by entering the Series 1 indicator code that reflects the type of coverage offered. Importantly, an offer of coverage is considered to have been made for a calendar month only if it would provide coverage for every day of that month. If an FTE was offered the same coverage for the entire calendar year, then an ALE would enter the applicable indicator code in the "All 12 Months" column on Line 14 or in each of the 12 boxes for the calendar months.

Q7. How should an employer report an FTE who waives coverage?

A.

- Line 14 – 1E
- Line 15 – Enter employee monthly cost-share for the lowest-cost self-only coverage
- Line 16 – 2F, 2G or 2H (depending on affordability safe harbor used), or if unaffordable, leave blank

The employer should still enter code 1E on Line 14 and should enter one of the affordability safe harbors represented by codes 2F, 2G and 2H on Line 16 to report that the FTE did not enroll in coverage under the plan. The employer should still report on Line 15 the employee contribution for the lowest-cost monthly premium for self-only MEC providing MV offered under the plan to the FTE to show that the FTE was an active employee who was offered coverage.

Q8. If an employer is required to recognize paid FMLA leave for an FTE and makes an offer of affordable, MV coverage to the FTE, spouse or domestic partner and dependents, how does the employer report when only the FTE enrolls in coverage for a calendar month during the leave of absence?

A.

- Line 14 – 1E (MEC providing MV offered to employee. MEC offered to spouse or domestic partner and dependents)
- Line 15 – Enter employee monthly cost-share for the lowest-cost self-only coverage
- Line 16 – 2C (Employee enrolled in coverage)

For the month during the paid FMLA leave of absence, the employer should enter code 1E on Line 14 and code 2C on Line 16 to report that the FTE was enrolled in coverage under the plan. The employer should report on Line 15 the employee monthly cost-share for the lowest-cost self-only MEC providing MV offered under the plan.

Since the FTE is being paid for hours worked and the compensation is treated similarly to other employees (subject to W-2 reporting, employment taxes, etc.), then the FTE would appear to be an employee and treated similarly. This means that if the FTE is expected to regularly work an average of 30 hours or more per week, then they would be treated as an FTE and offered coverage, which must be reported on Form 1095-C.

Q9. If an employer offers affordable MV MEC to FTEs, their spouses or domestic partners and dependents, and only an FTE enrolls, how should the employer report this?

A.

- Line 14 – 1E
- Line 15 – Enter employee monthly cost-share for the lowest-cost self-only coverage
- Line 16 – 2C

The employer should enter code 1E on Line 14 and code 2C on Line 16 to report that the FTE enrolled in coverage under the plan.

The employer should report on Line 15 the employee monthly cost-share for the lowest-cost self-only MEC providing MV offered under the plan to active FTEs. Employers will complete Line 15 only if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, or 1Q is entered on Line 14 in either the "All 12 Months" box or in any of the monthly boxes.

The employer should enter code 2C on Line 16 for any calendar month in which the FTE enrolled in health coverage offered by the employer for each day of the month, regardless of whether any other Series 2 code might also apply.

Q10. If an employer offers affordable MV MEC to FTEs, and conditionally offers at least MEC to spouses or domestic partners, how should the employer report this?

A.

- Line 14 – 1J (if MEC not offered to dependents); 1K (if MEC offered to dependents)
- Line 15 – Enter employee monthly cost-share for the lowest-cost self-only coverage
- Line 16 – 2C

The employer will enter 1J on Line 14 if MV coverage is offered to the employee, no MEC is offered to dependents, and a conditional offer of MEC if made to the spouse or domestic partner. On the other hand, if MV coverage is offered to the employee, MEC is offered to dependents, and a conditional offer of MEC is made to the spouse or domestic partner, then the employer will enter 1K on line 14.

Under both scenarios, the employer will report the employee monthly cost-share for the lowest-cost self-only coverage in Line 15 and will enter 2C in Line 16 to indicate that the employee is enrolled in coverage.

Q11. If an employer hires variable-hour or seasonal employees for a temporary period (such as for the summer) and uses look-back measurement periods to determine FTE status, should the employer report on those employees?

A. An employer needs to report on a variable-hour or seasonal employee only if the employee finished their initial measurement period and was subsequently determined to be an FTE for any month of the year. In that situation, for the months the employee was in the measurement period, the employer would use code 1H on Line 14 and code 2D on Line 16.

For any months a variable-hour or seasonal employee was treated as an FTE and offered coverage, the employer would use codes 1B through 1F (depending on the type of coverage offered) on Line 14 and 2C on Line 16 if they enrolled in coverage. If the employee waived coverage, the employer would enter one of the affordability safe harbor codes (2F, 2G or 2H), if applicable, on Line 16. The employer would not report on a variable-hour or seasonal employee who was determined not to be an FTE based on the hours worked during the measurement period.

Additionally, on Part III, column (b), of Form 1094-C, the employer would only include the FTE count for each month, meaning the employer would not include employees who were then in their initial measurement periods. However, for Part III, column (c), which reflects the total count, the employer would include all employees, including part-time, full-time, variable-hour and seasonal employees.

2. SPECIFIC REPORTING INFORMATION FOR FULLY INSURED EMPLOYERS

Q12. How should fully insured employers report on an FTE who terminates employment during a calendar year and receives an offer of COBRA continuation coverage?

A. Fully insured employers need to report in Part II, Lines 14-16, that the employee was an FTE during each month of the year when the employee was an active employee. The reporting obligation ends upon termination of employment, even if the employee is offered and elects COBRA continuation coverage.

Example 1:

The FTE receives an offer of coverage providing MV for an employee, spouse or domestic partner and dependents (family coverage) under an employer's fully insured health plan. The FTE enrolled in family coverage under the plan effective January 1. In May of the same calendar year, the FTE terminated employment with the employer; in accordance with the employer's benefit end date rule, benefits terminated at the end of May. The employee received an offer of COBRA continuation coverage effective June 1.

For the months January through May, the employer should enter code 1E on Line 14 and code 2C on Line 16 to report that the FTE enrolled in coverage under the plan. The employer should report on Line 15 the employee monthly cost-share for the lowest-cost self-only MEC providing MV offered under the plan to active FTEs.

- Line 14 – 1E
- Line 15 – Enter employee monthly cost-share for the lowest-cost self-only coverage
- Line 16 – 2C

If the employer's benefit end date rule instead produced a mid-month benefits termination in May, then the employer should enter code 1H on Line 14 and code 2B on Line 16. No entry is required on Line 15 for that final partial calendar month of coverage, because a partial month of coverage does not constitute an offer of coverage, and there's no obligation to report on employee contribution amounts where there's no offer of coverage.

- Line 14 – 1H
- Line 15 – No Entry
- Line 16 – 2B

For June through December, the employer should enter code 1H on Line 14 and code 2A on Line 16 since the individual is no longer an employee. No entry is required on Line 15 for those remaining months of the calendar year.

- Line 14 – 1H
- Line 15 – No Entry
- Line 16 – 2A

Part III: Covered Individuals

- Not applicable

Example 2:

The same facts as Example 1 for Q12, except that the FTE chooses to enroll in family COBRA coverage for themselves, their spouse or domestic partner and their dependents under the plan.

For the months January through December, the employer should enter the same information as in Example 1. Fully insured employers are not required to report COBRA coverage for a terminated employee.

Q13. How should a fully insured employer report on an FTE who enrolls in COBRA continuation coverage due to a non-FMLA reduction in hours, i.e., a change from full-time to part-time status that results in a loss of eligibility for coverage under the plan?

A. The answer depends on whether the FTE elects COBRA coverage. The employer should report the offer of COBRA continuation coverage as an offer of coverage.

Example 1:

An FTE elects to receive coverage providing MV, including an offer of MEC to their spouse or domestic partner and dependents. The FTE enrolls in self-only coverage offered from January 1 through September 30 of the same calendar year. The employee monthly cost-share for the lowest-cost self-only coverage under the plan is $100. On October 1 the FTE transfers to a part-time position (for non-FMLA reasons) and, as a result, loses eligibility for coverage under the plan's terms as of that date. The FTE receives an offer of COBRA continuation coverage due to the loss of eligibility for coverage, with a COBRA premium of $500 per month for the lowest-cost self-only COBRA coverage. The FTE elects to enroll in the COBRA continuation coverage for October through December.

For January through September, the employer should enter code 1E on Line 14, should report $100 as the employee contribution on Line 15 and should enter code 2C on Line 16 to report that the FTE enrolled in the coverage offered.

- Line 14 – 1E
- Line 15 – Enter employee monthly cost-share for the lowest-cost self-only coverage
- Line 16 – 2C

For October through December, the employer should enter code 1E on Line 14, should report $500 on Line 15 and should enter code 2C on Line 16.

- Line 14 – 1E
- Line 15 – Enter COBRA premium amount (inclusive of any administrative fee associated with the COBRA premium amount)
- Line 16 – 2C

Example 2:

The same facts as Example 1 for Q13, except the FTE chooses not to enroll in the COBRA continuation coverage.

- Line 14 – 1E
- Line 15 – Enter COBRA premium amount (inclusive of any administrative fee associated with the COBRA premium amount)
- Line 16 – 2B, 2F, 2G or 2H

The employer should complete Lines 14 and 15 in the same manner as Example 1. However, the applicable indicator code, if any, for Line 16 is determined as it would be for any other active employee. The indicator code will depend on whether the FTE is treated as an FTE for purposes of the employer mandate. If they're not, then the employer can use 2B. If they are, then the appropriate code for Line 16 depends on whether the offer of COBRA continuation coverage for the FTE satisfies one of the affordability safe harbors (code 2F, 2G or 2H).

Q14. How should a fully insured employer report coverage of an FTE's spouse or domestic partner who separately elects to receive COBRA coverage?

A. The reporting obligation for fully insured employers ends upon termination of employment, even if the employee's spouse or domestic partner separately elects to receive COBRA coverage. The carrier is responsible for post-termination reporting on the covered spouse or domestic partner.

3. SPECIFIC REPORTING INFORMATION FOR SELF-INSURED (INCLUDING LEVEL-FUNDED) EMPLOYERS

Q15. How should a self-insured employer report on an FTE who terminates employment during a calendar year and receives an offer of COBRA continuation coverage?

A. Same answer as Q12 above, except that the employer must report that coverage for any former employee, spouse, domestic partner, or dependent who enrolls in COBRA continuation coverage in Part III of Form 1095-C.

Q16. How should a self-insured employer report on an FTE who enrolls in COBRA continuation coverage due to a non-FMLA reduction in hours, i.e., a change from full-time to part-time status that results in a loss of eligibility for coverage under the plan?

A. Same answer as Q13 above, except that the employer must report that coverage for the employee, spouse, domestic partner or dependent who enrolls in COBRA continuation coverage in Part III of Form 1095-C.

Q17. How should a self-insured employer report coverage of an FTE's spouse or domestic partner who separately elects to receive COBRA coverage?

A. Self-insured employers should report coverage of each non-employee spouse that separately elects COBRA continuation coverage on a separate Form 1095-B (or Form 1095-C; see Q18 below).

If an employee's spouse or domestic partner, or former spouse or domestic partner, receives COBRA continuation coverage because an FTE elected COBRA continuation coverage that also provides coverage to the spouse or domestic partner (e.g., family coverage), then the coverage of the FTE and spouse or domestic partner should be reported together on the same Form 1095-C or Form 1095-B that is provided to the FTE.

> **Example:**
>
> An FTE elects to receive self-plus-spouse/domestic partner coverage under the self-insured employer's health plan effective for the plan year beginning January 1. On June 15 of the same year, the FTE gets divorced and their spouse loses eligibility for coverage under the plan as of the date of divorce. The employer makes an offer of COBRA continuation coverage to the former spouse, who elects to enroll in the COBRA continuation coverage and remains enrolled from June 15 through December 31 of the same year.

The employer should report the FTE's enrollment on Part III of Form 1095-C by reporting that the FTE was enrolled in MEC for January through June, and that their spouse had coverage, due to the FTE's enrollment in coverage that provided coverage to a spouse, for the months January through June.

For the period July through December, the former spouse should receive a separate Form 1095-B or Form 1095-C reporting the former spouse's enrollment in MEC under the employer's plan.

Q18. How should a self-insured employer report coverage provided to an FTE's former spouse or domestic partner who was not an employee on any day of the prior calendar year?

A.

- Line 14 – 1G
- Line 15 – No Entry
- Line 16 – No Entry

The employer may report enrollment information for an FTE's former spouse or domestic partner by entering code 1G on Line 14 for all 12 months and completing Part III of Form 1095-C. No entry is required on Lines 15 or 16 for this non-employee.

Form 1095-C requires the recipient's SSN on Line 2 in all instances, so Form 1095-C cannot be used for the FTE's former spouse or domestic partner if they have not previously provided an SSN to the ALE, regardless of whether the ALE has properly requested the SSN. In that case, the ALE would use Form 1095-B rather than Form 1095-C to report on the FTE's spouse or domestic partner.

Form 1095-B allows for the use of the spouse's or domestic partner's date of birth instead of an SSN when proper request procedures are followed by the ALE.

4. SIMPLIFIED METHODS OF REPORTING FOR BOTH FULLY INSURED AND SELF-INSURED (INCLUDING LEVEL-FUNDED) EMPLOYERS

Qualifying Offer Method

Q19. How does an employer qualify for the Qualifying Offer Method?

A. If an employer can certify that it made a qualifying offer of coverage to all FTEs for all 12 months of the year (or, for mid-year hires/terminations, for all months in which the employee was an FTE), and the FTE did not enroll in self-insured coverage for any months during which the FTE was eligible for the employer's qualifying offer, then the employer may use an alternate reporting method for the FTE.

A qualifying offer is an offer that satisfies all of the following criteria:

- Offer of MEC that provides MV
- Employee monthly cost-share for the lowest-cost self-only coverage is affordable according to the FPL safe harbor
- An offer of MEC is also made to the employee's spouse or domestic partner and any dependents

Q20. How does an employer report under the Qualifying Offer Method?

A. On Form 1094-C, Line 22, "Certifications of Eligibility", the employer should check box A, "Qualifying Offer Method." On Form 1095-C, Line 14, the employer should enter code 1A. No entry is required on Line 15. If the employee waives coverage, the employer should enter code 2G on Line 16 to reflect that the employer satisfied the FPL safe harbor, which is one of the criteria of a qualifying offer (see the second bullet in the answer to Q19). If the employee actually enrolled for coverage, the employer should enter 2C on Line 16 (or Line 16 could be left blank, per the Instructions).

- Line 14 – 1A
- Line 15 – No Entry
- Line 16 – 2G, 2C or Blank

The Form 1095-C must be filed with the IRS. However, the employer may provide the FTE with a general statement in lieu of a copy of the Form 1095-C containing certain information and stating that the FTE is not eligible for the premium tax credit because they received a qualifying offer.

The alternative statement may not be used by self-insured employers with respect to any employee who enrolled in the coverage under the self-insured plan, because the employer is required to report that coverage on Form 1095-C.

Q21. What are the advantages and disadvantages of the Qualifying Offer Method?

Advantages

- The employer has the option to distribute an employee statement, rather than a copy of the Form 1095-C, to each employee who was offered coverage. Thus, the employer could prepare and send identical notices to every FTE who received a qualifying offer for all 12 months (or all months during which the employee was full-time, for mid-year hires or terminations), eliminating the need to match forms to specific employees.
- Under the Qualifying Offer Method, the employer doesn't have to report employee contribution information on Line 15 for all 12 months.

Disadvantages

- The Qualifying Offer Method is only available to employers who used the FPL affordability safe harbor. Many employers do not use the FPL safe harbor as they choose to rely on an affordability safe harbor that allows a higher employer cost-share than the amount permitted under the FPL safe harbor.
- While distributing a uniform statement to employees may sound like a simplification, the statement must meet certain requirements and be substantially similar to Form 1095-C. Therefore, it may be easier to simply distribute Form 1095-C, particularly since the employer still has to file a Form 1095-C for each employee with the IRS.

98% Offer Method

Q22. How does an employer qualify for the 98% Offer Method?

A. If the employer can certify that for all months of the calendar year it offered affordable, MV health coverage to at least 98% of it employees for whom it is filing a Form 1095-C, and offered MEC to those employees' dependents (spouses or domestic partners not required to receive an offer of MEC), then it may be eligible to use the 98% Offer Method.

Q23. How does an employer report under the 98% Offer Method?

A. If eligible, the employer can check box D, "98% Offer Method," on Line 22, Certifications of Eligibility, on Form 1094-C. The employer is not required to determine whether all employees for whom it is filing were FTEs and, therefore, is not required to complete Form 1094-C, Part III (b), Full-Time Employee Count for ALE Member, on its authoritative transmittal. However, the employer is still required to complete Forms 1095-C for all of its FTEs.

On Form 1095-C, for the employees that received the offer, the employer should enter code 1C or 1E on Line 14, as applicable, and should report on Line 15 the employee monthly cost-share for the lowest-cost self-only MEC providing MV offered under the plan.

On Line 16, the employer should enter the code for the applicable affordability safe harbor (code 2F, 2G or 2H); 2C is also an option if the employee actually enrolled in coverage.

- Line 14 – 1C or 1E
- Line 15 – Enter employee monthly cost-share for the lowest-cost self-only coverage
- Line 16 – 2C, 2F, 2G or 2H

Q24. What are the advantages and disadvantages of the 98% Offer Method?

Advantages

- The employer is not required to identify which of the employees for whom it is filing were FTEs (i.e., doesn't have to calculate the hours of each employee), but the employer must still file Forms 1095-C on behalf of all of its FTEs. So, the employer doesn't have to report the total number of FTEs (usually done through column (b) on Part III of 1094-C).

Disadvantages

- The employer must offer MV coverage to at least 98% of all employees it is reporting on.
- The employer isn't allowed to distribute a statement to employees in lieu of a Form 1095-C. Since the employer still must distribute a Form 1095-C to each FTE, there's no simplification.
- The employer may need to complete forms for a part-time employee for whom it is otherwise not required to complete a form.

SUMMARY

The reporting obligations are complex and these FAQs are not meant to provide guidance on every reporting situation. To discuss your employer mandate reporting requirements and other aspects of your employee benefits program, or for copies of NFP publications, contact your NFP benefits consultant. For further information regarding NFP's full range of consulting services, see **NFP.com**.

RESOURCES

IRS Q&As on Reporting of Offers of Health Insurance Coverage by Health Coverage Providers (Section 6055)

IRS Q&As on Reporting of Offers of Health Insurance Coverage by Employers (Section 6056)

IRS Q&As about Employer Information Reporting on Form 1094-C and Form 1095-C

Form 1094-B

Form 1094-C

Form 1095-B

Form 1095-C

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