Q&A from Assurex Global Webinar "Employer ACA Reporting Requirements"	October 23, 2014
Question	**Answer**
Q: Where will these forms come from? will the IRS provide them?	A: IRS has provided draft Forms 1094 and 1095 along with draft instructions. We expect final forms to be issued in the next month or so.
Q: If the company has a 30 day delay before offering new employees coverage, but was set up as all 12 months on the 1094C what do we do about the new employee?	A: The employer would indicate on Line 14 that coverage was not offered for the first month, but would indicate on Line 16 that the employee was in a limited non-assessment period (i.e. waiting period) and would therefore not be penalized.
Q: My office has less than 50 employees who are eligible for coverage, but I go over 50 employees when I include my Union employees.	A: When counting the number of full-time equivalents (FTEs) for the purpose of determining if an organization is an "applicable large employer" (ALE) , a specific formula is used. For each month (Jan - Dec) of the previous calendar year: (a) Count each employee with hours of service of 120 or more as 1 (b) Then add aggregate hours of service for all other employees divided by 120 Then add totals for each of the 12 months and divide by 12 to get average FTEs. This calculation DOES include union employees.
Q: What about people who are hired in June? How do we cover Line 16 from Jan to May?	A: According to the draft forms and instructions, for Jan thru May, the employer would indicate on Line 14 that coverage was not offered, but the employer would indicate on Line 16 that the individual was not employed during that time.
Q: How will the IRS track small group plans that offer coverage so that participants can't qualify for a subsidy?	A: Insurance carriers are required to report coverage related information to the IRS for all fully-insured plans, including those offered by small employers.
Q: Self funded groups have to provide the same reporting information as the fully insured plan plus some or just those items that were listed under the self funded plan section only?	A: All applicable large employers have to report on full-time employees, whether they were offered coverage or not (regardless of whether it was accepted or waived) and what contribution amount was required for such coverage. Self-funded employers have the additional obligation to report information regarding covered individuals (those that actually accepted coverage).
Q: are 1095 forms required on every employee that was offered coverage for the calendar year, or only to employees who are still employed at the end of the plan year? In other words, are these forms required to be sent to employees who are no longer employed?	A: The 1095 forms will be required to be sent to any individuals who were full-time at any point during the year (for applicable large employers) and/or who were covered by a self-funded plan at any point during the year, regardless of whether they were employed the whole year or not. In principle, this is very similar to the requirement to provide W-2s even to employees who are no longer with the company at the end of the year.
Q: do you know if the on-line reporting will feature any upload options to import files with applicable information?	A: At this point, we don't yet have that information. It's possible that more information about how to report will be provided with the final forms and instructions.

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Q: Are companies going to be required to offer spouse coverage? We have heard only children. We currently have a spousal carve out on our plan.	A: The ACA only requires that coverage be offered to employees and their dependent children. Offering coverage to spouses is not required.
Q: Are there any exemptions for Tribal Governments in regards to reporting? There was at one point an exemption from W-2 reporting.	A: We are unaware of any exemption for tribal governments on the reporting requirements because they are subject to the employer shared responsibility rules under Section 4980H. In addition, they would still need to provide information on covered individuals if offering self-funded plans.
Q: are these forms done in arrears or in advance?	A: The forms are completed on a retrospective basis (i.e. reporting due early in 2016 for the 2015 calendar year plan and coverage information).
Q: Are union employees covered under a collective bargaining unit counted int the total number of f/t employees when calculating the 70% that have to be offered heath coverage?	A: Yes. Union employees must be included when calculating total number of full-time equivalents (FTEs) to determine whether the employer is subject to the Section 4980H rules and must be included when determining whether coverage was offered to at least 70% of full-time employees and their dependents to avoid potential penalties under 4980H(a) in 2015. However, if the employer contributes to the plan and allows the union to make an offer of coverage that provide minimum value and is affordable to the employee on its behalf, that would satisfy the
Q: Can we ask our HRIS or payroll provider to include this form in their payroll system Q: could the payroll companies work with the insurance brokers for filing?	A: It is likely that vendors will either come up with software to track the necessary data or offer to track the data and report on behalf of employers. However, we are unaware of anything definite so far. In many cases, there will need to be coordination across several systems that are typically used today (i.e. hours and contributions from payroll, coverage information from carriers, offer information and full-time status determinations from HR systems).
Q: Can you define how full-time seasonal employees come into play with the ACA?	A: It depends upon whether the employer is using the monthly measurement method or the look-back measurement method. • Under the monthly measurement method, employers determine full-time status on a monthly basis and would need to offer coverage to employees for any months in which they average 30 hours of service per week or achieve 130 hours of service for the month (full-time). Under this method, regardless of job category (even seasonal), full-time is simply determined on a monthly basis and coverage must be offered accordingly. • Under the look-back measurement method, employers may average hours of service over a period of 3-12 months (the employer's choice) to determine full-time status. If the employee achieves full-time status, the employee must then be treated as eligible for coverage for a corresponding stability period (generally matching the length of the measurement period). Under this method, new hires that are variable hour or seasonal may be subjected to an initial measurement period of up to 12 months prior to a determination as to full-time or part-time. If the employer chooses this method, seasonal employees are unlikely to ever average full-time over a 12-month period, and even if that does occur, the employee is unlikely to still be employed by the time the offer of coverage is required. In other words, seasonal employees don't generally have to be treated as full-time under this method.

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Q: Can you do a quick re-cap re: what a fully insured carrier is responsible for vs. an ASO employer?	A: For purposes of reporting on "covered" individuals (those that accept coverage from the employer), the carrier will report on behalf of fully-insured plans, but the employer/plan sponsor will have to report on behalf of self-funded plans.
Q: Do all employers in the control group need to report all other companies on their forms? Or does this need to be filed by the parent company for all employers in the control group	A: Each employer within a controlled group or affiliated service group is responsible for reporting individually only on their own full-time employees, but will need to list all other entities/employers within the controlled group or affiliated service group. The rules also allow an option for one filing to be done on behalf of the entire controlled group or affiliated service group, but ultimately each individual employer is responsible to ensure that the reporting takes place.
Q: Do we need SSN's for dental as well or just the medical plan?	A: Reporting is only required for employer-sponsored plans that meet the definition of "minimum essential coverage". In general, stand-alone dental and vision plans are considered excepted benefits and do not meet the definition of "minimum essential coverage".
Q: For Line 14 what if employer only offers a MEC?	A: If the employer does not offer minimum value coverage (only MEC), then the employer would use Code 1F according to the draft forms and instructions
Q: Where employer provides coverage to employees working 20 or more hours/week, do you count the employees 20-29 hours/week in the reporting number on Form 1094-C?	A: Such employees would be counted when determining TOTAL employee count for each month, but would not be counted when determining total full-time employees for each month
Q: how are COBRA employees counted	A: Based on limited guidance so far, it appears that only information for employees and their dependents will be reported on Form 1095-C and that information for individuals who are not employees (i.e. COBRA participants that are no longer employed) will be reported using Form 1095-B. Further guidance on this would be welcome.
Q: How are J-1 visa employees counted in the calculations?	A: Applicable large employers (50 or more FTEs) must count all common law employees who legally reside in the U.S. (including those here on visa) and paid with U.S. source income when determining total FTEs and determining which employees must be offered coverage to avoid potential penalties under Section 4980H.
Q: How different are the forms 1094-B/1095-B from the forms 1094-C/1095-C that were reviewed?	A: Forms 1094 and 1095-B require much less information. They require the same employer and employee contact information, but then only require information in regards to "covered" individuals - name, SSN and months in which the individuals were actually covered

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Q: How do you report an employee if they are offered coverage but then waive it? Q: We offer all full time employees and dependents coverage, if they waive our insurance - how would this be reported?	A: Applicable large employers (50 or more FTEs) report for each full-time employee whether coverage was "offered" each calendar month; it doesn't matter whether the coverage was accepted or declined. For example, if the employer offers coverage at open enrollment for a calendar plan year, the employer could mark that coverage was offered for all 12 months (regardless of whether the coverage was accepted or waived). The employer shared responsibility rules are not concerned with how many full-time employees are actually "covered" by the plan, but rather with how many full-time employees were "offered" coverage - given the opportunity to accept or waive coverage.
Q: How is the penalty calculated if an employee comes in the middle of the year and the large group employer decided not to offer a group plan? Is the penalty pro-rated? Or is each employee subject to the $2000 no matter when the employee was hired?	A: The penalty under 4980H(a) is calculated on a monthly basis. For each month that the employer does not offer coverage to substantially all full-time employees and their dependent children, the penalty is approx. $166.67 x each full-time employee minus a waiver for the first 30 (or 80 in 2015). Therefore, the employer will only be penalized for the months the employee was actually full-time and eligible for an offer of coverage.
Q: How would you report an employee if he has medical coverage for himself but his wife has coverage for herself and the children, but the employee has them on his dental plan with his employer?	A: As an applicable large employer (50 or more FTEs), the employer is only required to report as to whether "minimum essential coverage" was "offered" to full-time employees and dependents. It doesn't matter whether the employee and/or dependents accepted or waived the coverage. If the employer has a self-funded plan providing "minimum essential coverage" (generally stand-alone dental or vision plans do not meet this definition), the employer will have to report as to which months the employee and/or dependents were actually enrolled in such plan.
Q: I just want to make sure I understand. We have less than 50 employees, however we are part of a group that is self funded for insurance. Do we have to report.	A: Yes. Employers with less than 50 FTEs that sponsor a self-funded plan will have to report for each "covered" individual (employees and any applicable dependents) - name, SSN and months which the individuals were actually covered under the plan.
Q: If a group has 55 employees and does not offer coverage must he fill out the 1094-c because they fall under the Safe Harbor that they don't have to offer coverage until 2016.	A: All "applicable large employers" (50 or more full-time equivalents (FTEs)) are required to report beginning in 2016 for the 2015 calendar year. Even though employers with 50-99 FTEs were given a pass until 2016 in regards to compliance with Section 4980H, such employers will still have to report for 2015 and use the appropriate transition relief codes.

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Q: If employee is part time do we have to submit a form 1095-C to them and the IRS?	A: All applicable large employers (fully-insured and self-funded) must report on employees who were full-time for any month during the calendar year. If the employee was part-time all year, then the applicable large employer would not have to report eligibility information for such individual. However, employers offering coverage under a self-funded plan also need to report on all "covered" individuals. Therefore, if an employer with a self-funded plan offers coverage to part-time employees, it will be necessary to report on any such employees and their dependents that accept the coverage.
Q: if someone declines coverage, and we offer a waiver stipend, does that need to be included in any sort of fashion?	A: No. Applicable large employers must report as to whether coverage was "offered" to full-time employees and their dependents. It doesn't matter whether the coverage was accepted or waived. And employers offering self-funded plans must only report on individuals that actually accept and are "covered" under the plan.
Q: If we are applying under 6056, do we have to report all the covered individuals on the plan or is that only to be reported if you are reporting under 6055, self funded?	A: Section 6055 requires employers offering a self-funded "minimum essential coverage" plan to report on individuals that are covered. Section 6056 requires applicable large employers (50 or more FTEs) to report on whether or not coverage was offered to full-time employees and their dependents. Applicable large employers that also offer a self-funded plan will need to report on whether coverage was offered in Part II and then whether the individual was covered in Part III. Applicable large employers that offer only a fully-insured plan will only need to report on whether coverage was offered in Part II.
Q: Our plan year runs February 1st through January 31st. Would we need to apply for the transition relief? Or do we report the last month of the 2014 plan year and then the 11 months of the 2015?	A: All employers required to report will report on a calendar year basis, regardless of plan year. For January through December: • applicable large employers will report each month whether coverage was offered and what contribution was required for each full-time employee; • employers offering a self-funded plan will report each month which individuals were actually covered under the plan. Such information may actually be pulled from two separate plan years if the employer has a non-calendar year plan.
Q: How about employees who are working through a temporary agency for us? They work 40 hours per week. Do we count them?	A: The answer depends upon who is the common law employer. The common law employer is responsible for counting and offering coverage to all full-time employees or facing potential penalties under the rules, as well as reporting on such employees. It is possible the contract between the employer and the staffing agency will designate who is considered the common law employer. If not, it will be necessary to discuss and potentially get some advice from an employment law attorney based on the circumstances.
Q: What if the employee is enrolled in their spouses plan? Is that the line 16 safe harbor 2C?	A: No. In Part II, the applicable large employer is responsible for reporting as to whether coverage was "offered" to the employee (regardless of whether the coverage was accepted or waived for the spouse's plan).

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Q: If we are self-funded and have more than 100 employees so does that mean that we need to file both the 6055 and 6056?	A: Such an employer is subject to the requirements under both Section 6055 and 6056, but will be able to report the information on one form rather than 2 separate forms. An applicable large employer offering a self-funded plan will report using the Forms 1094 and 1095-C, but will complete all three parts of Form 1095-C rather than just Parts I and II.
Q: Also, for an employee...if they work 40 hours one week, but 129 or less for the entire month, are they still considered part-time?	A: Assuming an employer is determining full-time status on a month-by-month basis (and not using the measurement period approach), an applicable large employer subject to the rules under Section 4980H can choose to define full-time as 30 hours of service per week or 130 hours of service per month. In using an average of 30 hours of service per week, it is possible that such employees would be treated as full-time. If using 130 hours of service per month as the definition, such employees would not be considered full-time in this example.
Q: What if we hire seasonal workers, i.e. Summer Help and they work full time, but we offer them no benefits... we would mark them as 1H on the 1095C, correct?	A: Yes. If an employee is full-time and no offer of coverage is provided, 1H would be the correct code for Line 14 according to the draft forms and instructions.
Q: If we offer an HSA Plan and also a Personal Option Plan, do we list the premium share for the HSA for all employees as the share is lower than the personal option plan?	A: When providing information in regards to the contribution required, the employer should provide the amount for the lowest cost "minimum value" plan offered to the employee (regardless of which option the employee actually chooses).
Q: If you are using a 12 month look back and the employee does not reach full time status, do you still have to file a 1095C for that employee?	A: Generally, no. An applicable large employer (50 or more FTEs) is only required to provide a 1095-C for full-time employees, and any covered part-time employees if an employer voluntarily chooses to offer coverage to part-time employees.
Q: When determining i an employer is an applicable large employer, if you're using a 1 year look back period and you have new hires that have worked full time for two months of that look back period, are the considered full time automatically, or do you factor their hours into the " Full Time Equivalent" bucket from the total payroll hours of part time employees?	A: For purposes of counting total FTEs to determine whether the employer is subject to Section 4980H, each individual that has 120 or more hours for the month is counted as 1 and all others are aggregated and divided by 120. The look-back measurement method does not apply.

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Q: Do we have to report on the employees that terminate between the time if the stability period and the reporting period?	A: Yes, if the individuals were considered full-time at any point during the calendar year, it will be necessary to report on them, regardless of whether they are still employed when the reporting takes place.
Q: If your work force is 100% union, what special rules apply?	A: Assuming the employer is an applicable large employer (50 or more FTEs), the employer is still on the hook for compliance with 4980H and for reporting on full-time employees, but the rules allow for the union to make an offer of coverage on behalf of the employer as well as report on behalf of the employer.
Q: In reporting full and part time employee counts - How do I classify a variable hour employee that is in their look back period? They may work well over 130 one month and well under the next. Q: Do variable hour employees, for whom we are using the look back period get reported as full time or part-time - given that it will vary month to month for them.	A: An employer using the look-back measurement method would not report a variable hour, seasonal or part-time employee as full-time until such time as the individual is determined to be full-time after averaging over the initial measurement period. For example, an individual hired in May and subject to a 12-month initial measurement period would not be considered full-time until the following July (13 months later) - assuming the individual achieves 1560 or more hours of service during the initial measurement period.
Q: Is the number of employees based on hours worked or hours paid in a given month. If work in one month and get paid in the next, which month are hours counted in?	A: For purposes of the employer shared responsibility rules under Section 4980H, "hours of service" are counted. Hours of service include all time for which employees are paid or entitled to pay (including vacation, sick pay, etc.) and not just time worked. The hours would generally be counted for the month in which they are worked rather than the month in which they are paid.
Q: Isn't the individual mandate in place for 2014 so employers must create 1095C for employees by January 31, 2015 for 2014 calendar year?	A: For the first year of the individual mandate (2014), the IRS will have to use other methods to verify coverage because the employer reporting is not required until 2016 for the 2015 calendar year. Employers can voluntarily report 2014 data to the IRS in 2015 but are not required to do so.

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Q: Just to clarify the requirement of minimum coverage - I thought it was nor more than 9.5% of income for EE's only but you mentioned dependents as well. Does the 9.5% limit apply to the cost of both EE and Dependent premium costs? Q: Regarding the minimum essential coverage which has to be offered to spouse and dependents are there any parameters regarding how much coverage to dependents can cost? Meaning what if the dependent coverage is so costly that the coverage of dependents is unaffordable.	A: Affordability for both employee-only coverage AND dependent coverage is based on 9.56% of employee-only coverage. In other words, if the employee contribution for employee-only (single) coverage does not exceed 9.56% of household income, the coverage will be considered affordable for the employee and any dependents that are offered coverage, regardless of what amount the employer contributes to dependent coverage (even if the employer contributes $0).
Q: You mentioned the employer's responsibility to notify EE's that they may or may not be eligible for a subsidy. If we don't know their income or dependent situations, how would we be able to comply with the requirements if we don't those all the conditions that affect an EE's circumstance?	A: The employer is only required to make such statement to the employees if the employer chooses to provide an alternative statement rather than providing a copy of the 1095-C (one of the simplified reporting options). In order to be able to provide such alternative statement, the employer must make a "qualifying offer", which requires that the employee contribution not exceed 9.5% of federal poverty level. If such threshold is met, the coverage is considered affordable for employer shared responsibility rule purposes.
Q: Line 16 do you use only one code? Q: On line 16, can two codes be entered? For example 2C applies (eel is enrolled in coverage) and also 2H (rate of pay affordable safe harbor).	A: According to the draft forms and instructions for Line 16, only one code should be entered. In the situation in which multiple codes may apply, the instructions help to determine which code should be used. For example, if the employee actually enrolls in the coverage offered, Code 2C is used because it is no longer relevant whether or not the coverage is affordable (individual cannot qualify for a subsidy if the individual is enrolled in other minimum essential coverage).
Q: when you list the employees and family, do you check based on their new hire date or when actually covered after the 1 month waiting period? Q: our offer is made at hire and then they have to wait for the waiting period before coverage comes into effect, does we include the waiting period as a covered period	A: Employers offering a self-funded plan providing minimum essential coverage should mark only the months in which the individuals were actually covered by the plan (not including the waiting period).

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Q: if you offer coverage to 100% of full time employees and their family's and included in the offer is a plan that meets minimum value and the cost is affordable, then do you still have to show all the people individually.	A: Such employer likely meets the criteria for the simplified reporting under the 98% offer method. In reporting on 1094-B, the employer would not be required to tally total full-time employees for each month of the calendar year. However, this would not relieve the employer of the requirement to provide a 1095-C on behalf of any employees that are full-time for any month during the calendar year or to report which months individuals were covered if the employer offers a self-funded plan providing minimum essential coverage.
Q: On line 14, what if ER offered, but EE declined coverage? Is there a code on 1095C for that?	A: No. Part II is not concerned with whether or not coverage was accepted or declined. Regardless of whether the coverage was accepted or declined, the employer would use the code indicating that coverage was offered on Line 14 (according to the draft forms and instructions).
Q: On your slide about Self Funded Large employer Information required. I think you said we only report on our covered employees. Do we report on all employees even if they declined the coverage - maybe because they are covered under another plan or maybe they are choosing to remain un insured.	A: Self-funded (and fully-insured) applicable large employers (50 or more FTEs) are required to complete a portion of the forms that show if an employee was offered coverage. Additionally, employers offering a self-funded plan providing minimum essential coverage will report on individuals that actually accept the offer of coverage and are "covered" under the plan (not those that decline). If the individuals are covered under another plan, that plan will report accordingly (keep in mind that carriers report coverage details on behalf of fully-insured plans). If the individuals are not covered elsewhere, the lack of reporting will show that the individual did not obtain the required coverage for the year for purposes of enforcing the individual mandate.
Q: "No offer of coverage currently available to dependents, but taking steps to extend coverage going forward." I thought we were only required to provide coverage on our employees. Where can I get more info on dependent requirements? Does that also have to be in 9.5% of salary?	A: The employer shared responsibility rules under Section 4980H require applicable large employers (50 or more FTEs) to offer coverage to full-time employees and their dependent children - coverage does not need to be offered to spouses. So long as the coverage is affordable for the employee, the coverage is considered affordable for dependents, regardless of whether the employer contributes to the dependent coverage or not. In other words, the coverage does not really have to be affordable for the dependent child.
Q: We are 50-99 FTEs under a self-funded plan reporting Qualifying Offer Method. May we provide a Simple Statement to the employee and their dependents. If we may, what kind of information we must indicate on that Simple Statement.	A: If the employer is providing a "qualifying offer" to employees for all 12 months of the calendar year, the employer can provide a statement with the following information rather than providing a copy of 1095-C: • Employer name, address and EIN; • Contact name and telephone number; and • A statement indicating that, for all 12 months of the calendar year, the employee and his or her spouse and dependents, if any, received a Qualifying Offer and therefore are not eligible for a premium tax credit.

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Q: We are 50-99 FTEs under a self-funded plan, we offer 100% to our full time employees but 10% of these employees decide not enrolled in coverage plan. What box must we select under the 22. Certifications of Eligibility ?	A: According to the draft form and instructions, on Line 22 of 1094-C, if taking advantage of one of the simplified reporting methods, mark accordingly. Also, the employer may as well mark the section 4980H Transition Relief so that there is no chance of penalty since an employer with 50-99 FTEs is not subject to the 4980H shared responsibility rules until 2016.
Q: Seasonal employees who may work over 30 hours but for less than 120 days are not reported?	A: The answer depends upon whether the employer is using the monthly measurement method or the look-back measurement method. • If the employer is using the monthly measurement method, it will be necessary to consider the seasonal employee as full-time for any month in which hours of service are 130 or more • If the employer is using the look-back measurement method, it will not be necessary to consider the seasonal employee as full-time until completion of the initial measurement period (assuming the individual averages full-time hours).
Q: So if all my employees receive a qualifying offer all 12 months, I only need to submit the 1094? (simple statement to employee only)	A: Not quite. According to the draft forms and instructions, applicable large employers (50 or more FTEs) must report to the IRS (i) a 1094 transmittal form and (ii) a 1095 for each full-time employee. Generally a copy of the 1095 provided to the IRS must be provided to each full-time employee; however if meeting the qualifying offer method criteria, the employer may provide a simple statement in lieu of a copy of the 1095 to the employee (but it is still required to be provided to the IRS).
Q: How do we handle reporting requirements for employees you elect to use coverage through their spouse; or they have other coverage (like TRICARE through the military)? We offer everyone coverage. But we pay them cash-in-lieu if they choose to another plan.	A: For purposes of reporting for all self-funded and fully-insured "applicable large employers" (50 or more FTEs) - it is required that the employer report for each full-time employee whether coverage was "offered" for each month (regardless of whether coverage was accepted or waived). Additionally, for purposes of reporting for a self-funded plan, it is also necessary to report for those individuals that are actually "covered" (accepted the offer of coverage) under the plan.
Q: the cost of coverage (estimated at $92) is that per month and is that the employee cost being considered? or both employer/employee	A: If using the federal poverty line (FPL) affordability safe harbor, an employee's required contribution that is approx. $92 or less per month is considered affordable.
Q: what about the employee who is hired mid year...what would their 1095 c look like or do you do one for them?	A: If an employee is full-time for any month during the calendar year, a 1095 is required. According to the draft forms and instructions, the employer would report no offer of coverage for the months prior to employment on Line 14, but then would enter in the safe harbor code on Line 16 indicating for such months that the individual was not employed.

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Q: Under 4980H, does "offered" mean just employees with coverage or does it include those that were offered coverage but they declined?	A: "Offered" means any employee that was offered coverage... regardless of whether they actually elected to participate in the plan.
Q: Under Timing Requirements -- employee statement -- what is this?	A: In regards to timing requirements, Form 1094 and 1095 must be filed with the IRS no later than Feb 28 annually (or Mar 31 if filed electronically). A copy of Form 1095 or an alternative statement as applicable must be provided to employees no later than Jan 31 annually.
Q: We don't understand the difference between the requirements of the large employer -- why only one day of month on one slide, and everyday of the month on other slide?	A: Two separate standards...one related to an "offer" of coverage and one related to when an individual is considered to be "covered"... • In regards to an offer of coverage for purposes of avoiding a penalty under the employer shared responsibility rules, an applicable large employer is only considered to have offered coverage for a calendar month if coverage was available for the entire month (unless the employee is terminated mid-month). • In regards to whether an individual was actually covered for purposes of the individual mandate, the individual is considered to be covered for the calendar month if the individual was covered for at least one day during that month.
Q: Do we have to use the same "method" for all employees? Or can we use qualifying offer for one group and another method for another?	A: In regards to the simplified reporting allowed under the qualifying offer method, it is possible to use an alternative statement for some employees (those for whom a qualifying offer is made for all 12 months) and provide a copy of Form 1095 to other employees.
Q: We have a self-funded plan the employee contributions are base on a % of pay. how do we report because they are all different.	A: If this is an applicable large employer (50 or more FTEs) required to report on all full-time employees, it is necessary to include the employee contribution amount for minimum value coverage (if offered) on Line 15 according to the draft forms and instructions. For those offering a flat contribution amount for all employees, it will be fairly simple. For those basing contributions on percentage of pay or age or otherwise, it will be a bit more complicated as it will be different for each employee. Each full-time employee will be provided with their own form and the employee contribution for the lowest-costs minimum value plan offered to that particular employee will be used (regardless of which plan may have been elected).

Q&A from Assurex Global Webinar "Employer ACA Reporting Requirements"	October 23, 2014
Question	**Answer**
Q: We have some employees that work full time hours for 9-10 months of the year. We offer them the same coverage as we do to traditional full-time employees. We are considering offering these individuals a different health plan (not giving them access to the plan that our general full time employees have) but that still is affordable and minimum value. Might we run into discrimination issues if we proceed in this direction?	A: Section 4980H does not require that uniform coverage be provided to all full-time employees. However, by offering different waiting periods, contributions, benefits or eligibility, it is necessary to consider whether there is a violation of the nondiscrimination rules. • Self-funded group health plan - Nondiscrimination rules under section 105(h) prohibit self-funded group health plans from discriminating in favor of the highly compensated in regards to benefits/eligibility/contribution. If the plan is self-funded, it is probably necessary to do some discrimination testing to ensure there isn't a problem with the proposed structure before implementing. Note, there are exclusions and the ability to test as separate groups in some cases, so not all differentiation will automatically be considered discriminatory. • Fully-insured group health plan – Under the ACA, fully-insured group health plans are subject to "similar" nondiscrimination rules, but the rules are not being enforced until further guidance is received. In other words, if fully-insured, it is okay to differentiate for now, but be advised that will not likely be the case in the future (perhaps in 2016 or 2017)
Q: What if a small employer <50 goes from fully insured plan to a self funded plan effective 7/1/2015? How would we report on 1094/1095?	A: As of right now, there isn't any clear guidance on this, but it would seem reasonable for the employer to report on "covered" individuals just for the months the employer offers a self-funded plan.
Q: What if MEC and MV plans are offered to employee, spouse and dependents?	A: Minimum essential coverage (MEC) basically applies to most employer-sponsored plans, and if offered to substantially all full-time employees and their dependent children, satisfies the requirements under Section 4980H(a). Minimum value (MV) plans - offering at least a 60% actuarial value - satisfy both the requirement under Section 4980H(a) and Section 4980H(b) so long as the coverage is affordable. If the employer offers both types of plans, the employer would report that MV was offered because that is a higher standard than MEC.
Q: What if you offer coverage only to non-working spouses?	A: It will be necessary to use the appropriate offer code for each full-time employee indicating whether coverage was actually offered to the spouse or not.
Q: When terminating an employee do you have to keep them on the insurance the entire month of termination or can you cease coverage on the termination date	A: Under ERISA, that decision is left entirely up to the employer… For an employee to be treated as having been offered coverage for a month under Section 4980H rules, the coverage offered must be applicable for the whole month. Generally, if an employer fails to offer coverage to a full-time employee for any day of a calendar month during which the employee was employed by the employer, the employee is treated as not being offered coverage for the month. However, in a calendar month in which employment is terminated, if the employee would have been offered coverage for the entire month (had they been employed for the entire month), the employee is treated as having been offered coverage during that month.

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Q: What is the difference between offered and waived?	A: I can only "waive" coverage if it has been offered to me... or stated the other way, if nothing has been offered, there is nothing for me to waive.
Q: what if none of the choices in ques 22 apply?	A: According to the draft forms and instructions, if nothing on Line 22 of 1094-C applies, the line can be left blank (none of the boxes checked)
Q: if you have to do the 1095 anyway as you have to file a copy with the irs... why not just give a copy to the ee?	A: The option to provide an alternative statement rather than a copy of the 1095 to the employee based on providing a "qualifying offer" for all 12 months may provide limited value. Regardless of whether the employer satisfies the criteria for a qualifying offer, a 1095-C will have to be filed with the IRS. If a qualifying offer is made, the employer has the option of sending a copy of the 1095-C to the employee or a shortened alternative statement. Perhaps this provides some advantage because the employee statements are due 2 months sooner (Jan 31) or because then the employee may come back with less questions in regards to the details provided on the Form 1095?
Q: isnt 1 A and 1E the same?	A: According to the draft forms and instructions, for Line 14 of Form 1095-C, 1A is a higher standard than 1E because in addition to offering MV to the employee and MEC to dependents, the coverage must also be affordable using the federal poverty line (FPL) affordability safe harbor.
Q: When it's a controlled group, which EIN number should be used?	A: Each employer within a controlled group or affiliated service group is responsible for reporting individually on their own full-time employees, so each employer will generally use their own EIN.
Q: Will there be any kind of testing site to upload you practice form to see if it passes?	A: For employers choosing to voluntarily reporting early in 2015 based on 2014 data, we do not have any information yet as to how the IRS will handle or respond to such reporting. At a minimum, even if the employer chooses not to actually submit the reporting, it will likely still prove useful to understand exactly what information is needed and the general formatting required for the reporting.
Q: Our employees are offered insurance if they are meeting a consistent work flow of 25 hours per week... being more generous. What could be the risk?	A: There really isn't any risk to such an approach. An employer may always choose to be more generous than is required as to who it chooses to offer coverage.