GLOSSARY

Children means an employee’s biological and adopted children (including children placed with the employee for adoption), from birth, adoption, or placement through the end of the month in which the child reaches age 26.

Full-Time Employee or FTE means a common-law employee of the employer who was a full-time employee for purposes of the Affordable Care Act’s (ACA) employer play-or-pay rules for at least one month in the reporting year.

Minimum Essential Coverage or MEC means employment-based coverage more robust than an excepted benefit such as most dental, vision, or health flexible spending account coverage.

Minimum Value or MV means health insurance coverage with at least a 60 percent actuarial value, determined under the play-or-pay rules.

Spouse means, with respect to an employee, an individual, either same- or opposite-sex, to whom the employee is legally married.
LINE 14 CODES (1A–1K)

There are 10 “Series 1” codes, codes 1A–1K (code 1I is reserved), available for use on line 14. We might refer to these codes as “offer codes.” Generally, these codes indicate whether the employer offered coverage to the FTE at all, and if so, the robustness (e.g., minimum value versus MEC) of the coverage and whether it was offered to just the employee or to the employee and family members.

Codes 1A–1F indicate the robustness of a coverage offer, and to whom it was offered (i.e., just the FTE, or the employee and one or more categories of dependents). In the case of code 1A, the code also indicates that the employee’s cost for employee-only coverage did not exceed a given percentage of the federal mainland poverty level.

Code 1G is used where an individual (part-time employee, partner, outside director, contractor, etc.), who was not a full-time employee for at least a month during the reporting year nevertheless had coverage for at least a day under the employer’s self-insured health plan.

There is a code (code 1H) indicating that for at least a portion of the month, the employer did not offer at least MEC to the FTE.

Codes 1J and 1K denote offers to employees and their spouses, where the offer to the spouse is conditional on one or more reasonable objective conditions, such as the spouse not having a coverage offer elsewhere. Note that while the IRS instructions suggest that a conditional offer might include an offer to the spouse conditioned on the spouse not being eligible for coverage under another employer plan or Medicare, conditioning an offer on not being eligible for Medicare raises issues under Medicare coordination rules.

The employer may take credit for an offer of coverage if the coverage is offered by the employer, through a plan sponsored by an affiliate, or through a multiple employer welfare arrangement (MEWA) in which the employer participates. The employer may not take credit for an offer of coverage through a union-affiliated multiemployer plan even if the employer is contributing to the cost of such coverage provided to its employees (but see the discussion below regarding how the employer may avoid potential penalties by inserting Code 2E on line 16).
Here is more information on the Series 1 codes, in alphanumeric order.

1A **Qualifying Offer: MV coverage offered to FTE for no more than 9.69 percent of poverty level, and at least MEC offered to spouse and children.**

For every day of the calendar month, (i) the FTE was offered MV coverage, the employee’s cost for which, for employee-only coverage, did not exceed 9.69 percent of the mainland single federal poverty level, and (ii) at least MEC was offered to the children and spouse.

Code 1A buys the employer three advantages. If the employer uses Code 1A for a month, it does not—in fact, must not—complete line 15 for that month.

Second, the instructions to the reporting forms say that where the employer inserts Code 1A on line 14, completion of line 16 is optional, even if the employee is enrolled (the general rule is that Code 2C is required on line 16 where the employee is enrolled).

Third, Code 1A, if applicable for all 12 months of the calendar year, allows the employer the choice of giving the employee, in lieu of a copy of the Form 1095-C, a statement saying that for all 12 months of the year the employee received an offer of minimum value and affordable health insurance, and, therefore, the employee and his or her spouse and dependents are not eligible for subsidies in an online public health insurance exchange.

But the employer is not permitted to use this abbreviated disclosure and must supply the employee with a Form 1095-C if the employee was, for even a single day during the year, enrolled in self-insured coverage offered by the employer. Regardless, the employer must still send the 1095-C to the IRS.

1B **Offer of MV coverage to employee only.**

For every day of the calendar month, MV coverage was offered to the FTE only. No offer to spouse and children.

1C **Offer of MV coverage to employee, at least MEC to children.**

For every day of the calendar month, MV coverage was offered to the FTE and at least MEC offered to the employee’s children (but not the spouse).

1D **Offer of MV coverage to employee, at least MEC to spouse.**

For every day of the calendar month, MV coverage was offered to the FTE and at least MEC offered to the employee’s spouse (but not his or her children).

1E **Offer of MV coverage to employee, at least MEC to spouse and children.**

For every day of the calendar month, MV coverage was offered to the FTE and at least MEC offered to the employee’s spouse and children.

1F **Offer of MEC (but not MV coverage) to employee or employee and any combination of family members.**

For every day of the calendar month, at least MEC (but NOT coverage providing MV) was offered to the FTE alone or to the FTE and any combination of the FTE’s spouse and children.
1G Non-full-time employee with self-insured coverage.

The individual identified in Part I of the Form 1095-C was not an FTE for even a single month during the year, but was enrolled in self-insured coverage for at least one day.

*Lockton Comment:* Examples include covered part-time employees, partners, non-employee directors, independent contractors, retirees, and persons purchasing COBRA coverage. Insert Code 1G in the “All 12 Months” box of line 14. Do not complete lines 15 and 16, but complete Parts I and III of the 1095-C.

1H No offer of coverage for all or part of the month.

For one or more days of the calendar month the FTE did not receive an offer of at least MEC. For example, the employee was not employed for at least part of the month and therefore did not receive a coverage offer for at least part of the month; the employee was in a waiting period or initial measurement period for at least part of the month; or coverage began or ended mid-month due to being hired or terminated or otherwise gaining or losing eligibility mid-month.

Use Code 1H for a terminated employee even though the employer may have offered COBRA coverage. Also use Code 1H when coverage is offered not by the employer but through a multiemployer (i.e., union-affiliated) plan even if the employer makes contributions to the plan on behalf of the employee.

1I [RESERVED]
1J Offer of MV coverage to employee, at least MEC conditionally offered to spouse

For every day of the calendar month, MV coverage was offered to the FTE, and at least MEC offered conditionally to the spouse (but not the employee’s children). A conditional offer is an offer of coverage that is subject to one or more reasonable, objective conditions (e.g., the spouse not being eligible for coverage under another employer’s group plan). Use this code if the offer to the spouse is conditional, whether or not the spouse meets the condition(s); do not use code 1D.

1K Offer of MV coverage to employee, at least MEC to children, and MEC conditionally offered to spouse

For every day of the calendar month, MV coverage was offered to the FTE, at least MEC offered to the employee’s children, and at least MEC offered conditionally to the spouse. A conditional offer is an offer of coverage that is subject to one or more reasonable, objective conditions (e.g., the spouse not being eligible for coverage under another employer’s group plan). Use this code if the offer to the spouse is conditional, whether or not the spouse meets this condition(s); do not use code 1E.
LINE 15

Line 15 is completed only if one of the following codes is used in Line 14: 1B, 1C, 1D, 1E, 1J, or 1K.

In those cases, enter the amount of the employee’s share of the lowest-cost monthly premium for self-only coverage providing minimum value offered to the employee.

**Lockton Comment:** This amount will often not be the amount the employee is actually paying. For instance, the employee might have declined coverage or might have elected more expensive coverage (e.g., family coverage or a buy-up option with a higher employee-only premium).

The premium amount should not be rounded. If the employee is not required to pay a premium for self-only coverage supplying minimum value, then enter $0.00 on Line 15.

Employers may, but are not required to, use for a given month the average premium for the plan year. For example, if the plan is a calendar year plan and the applicable monthly premium is $100 per month for January through June, but increases to $120 for July through December, the employer may use $110 for each month. Similar averaging rules apply for non-calendar year plans. For a plan with a plan year beginning March 1, for example, the employer may average the monthly premium for March 2016 through February 2017 and use that average for the months of January and February, 2017, on line 15. The employer may then average the monthly premium for the months of March 2017 through February 2018 and use that average as the monthly premium for the months of March through December, 2017, on line 15.

The employer must not complete line 15 for any month with respect to which the employer inserted code 1A on line 14.

Wellness and opt-out incentives, and health reimbursement arrangement (HRA) and flex credits that can be used to pay premium, pose additional wrinkles.

Where there is a wellness incentive or penalty that is unrelated to tobacco use, for line 15 purposes the employer must assume that, for employees subject to the incentive or penalty, nobody wins the incentive, or everyone suffers the penalty. But for incentives or penalties related to tobacco use, the employer must take
the opposite approach for line 15: everybody is considered a tobacco non-user, so everyone wins the incentive (or, where there’s a penalty involved, nobody is considered a tobacco user, so nobody suffers the penalty).

For opt-out incentives (i.e., cash or coverage incentives) that were installed after December 16, 2015, the value of the opt-out incentive is considered part of the “cost” of coverage to the employee, unless the employee attested at enrollment that he or she, and the employee’s dependents with respect to whom the employee expected to claim an exemption on his or her federal tax return, had or intended to have other group coverage elsewhere. For example, if the employer offered a new $50 opt-out incentive to employees for 2017, and offered MV coverage to the employee at an employee-only rate of $100 per month, the employer would report $150 on line 15 unless the employee attested at enrollment that he or she, and his or her dependents, had or intended to have other group coverage elsewhere.

Credits allocated for 2017 to an employee’s HRA can be ratably applied to reduce premium for line 15 purposes if they can be used by the employee to pay premium, or to pay premium and to reimburse out-of-pocket healthcare expenses. For example, if an employer credited $1,200 to an employee’s HRA for 2017, and the employee could apply the credits to pay premium, or to pay premium and to reimburse out-of-pocket healthcare expenses, the employer may reduce the employee’s line 15 amount by $100 per month.

Flex credits may be ratably applied by an employer to reduce premium costs for line 15 purposes if the flex credits are considered “health flex contributions.” A health flex contribution is an amount that can be used toward the cost of health coverage and must be used for anything that qualifies as tax-free medical care under the Tax Code. Thus, a flex credit is not a health flex contribution if it can be taken as cash, any other type of taxable benefit (e.g., contribution to a 401(k) plan), or to pay for non-medical care, such as life insurance.

The upshot of all this is that, for employers offering wellness or opt-out incentives, or HRA or flex credits, the line 15 amount may bear little resemblance to the amount the employee is actually paying, or even the amount for employee-only coverage the employer described to employees, in open enrollment materials.
LINE 16 CODES

There are eight “Series 2” codes, codes 2A–2H, available for use on line 16. Generally, these codes: (i) reflect that the employee had employer-based coverage for the entire month (code 2C), (ii) where the employer has used code 1H (i.e., no offer of coverage) on line 14, explain why coverage was not offered for the entire month (codes 2A, 2B, 2D and 2E) or, (iii) where the employee waived coverage, indicate an affordability safe harbor the employer may be using (Codes 2F–2H).

Please note that Code 2C (i.e., the employee was enrolled for the entire month in the employer’s plan supplying at least MEC) is the “trump code” among these Series 2 codes. That is, it trumps other Series 2 codes that might otherwise apply, except in two cases: where a terminated employee was enrolled in COBRA coverage, or where the employer used “1G” on line 14.

If an employee was enrolled in union-affiliated coverage and not the employer’s plan, the employer won’t use Code 2C—after all, it wasn’t the employer’s plan in which the employee was enrolled—but will typically use Code 2E. See the discussion about Code 2E below.

Here are the Series 2 codes, in alphanumeric order:
2A The employee was not employed by the employer on any day of the calendar month.

**Lockton Comment:** For example, the employer hired an FTE on March 1, 2017, and offers coverage that day. For the months of January and February, the employer uses Code 1H (no offer of coverage) on line 14, and uses Code 2A on line 16 to explain why no coverage offer for those months.

Similarly, suppose an FTE terminates on Sept. 30, 2017, and coverage ceases that day. For the months of October through December, the employer uses Code 1H on line 14 (even if it offered, and even if the former employee elected, COBRA coverage) and Code 2A on line 16 to explain why no coverage offer for those months. Even if the former employee elected COBRA coverage, use Code 2A and not 2C. This is one case where code 2C does not operate as a trump code.

2B The employee was employed but was not an FTE with respect to that calendar month, or terminated employment mid-month and coverage lapsed before the end of the month.

**Lockton Comment:** There are several common situations with respect to which this code is used, including:

- The employee is an FTE for part of the month but terminated employment during the month, and his or her coverage also ended (ignoring any COBRA coverage) before the end of the month, but would have continued to month’s end had the employment not ended.

- The employer uses the look-back measurement method, and during the year the FTE begins to be considered a non-FTE, such as where an FTE begins a new stability period in July, during which he or she is considered a part-time employee. The employer would use Code 2B for the months of July through December, unless the employee continued to be enrolled in at least MEC offered by the employer, in which case Code 2C would apply. If an employee is not yet considered full-time because he or she is in an initial measurement period, use Code 2D rather than 2B.

- The employer uses the monthly measurement method, and the employee does not qualify as an FTE for the month. Note again that if the employee is enrolled for the entire month under a healthcare plan of the employer supplying at least MEC, the employer will use Code 2C unless the employer used code 1G on line 14.
2C The employee was enrolled in at least MEC on every day of the calendar month.

Lockton Comment: This code generally trumps any other series 2 code that might apply. Do NOT use this code, however, for a terminated employee for full months he or she is purchasing COBRA coverage under the employer’s plan during the year of termination. For such a former full-time employee, use Code 1H (no offer of coverage) on line 14, and Code 2A on line 16, for those months. Also, do not use 2C if 1G is inserted on line 14; in that case, lines 15 and 16 should not be completed at all.

2D The employee was employed during the calendar month, but was in a limited non-assessment period¹ (and not covered for the entire month).

Lockton Comment: Here is the code that excuses, in most cases, the employer’s failure to offer health coverage for the entire month (reported with Code 1H on line 14) due to the fact that the employee was in a waiting period not extending for more than three full calendar months, or the employee was a new variable hour, part-time, or seasonal employee in an initial measurement or administrative period for the month. Other periods, described in the text to endnote 1, are also considered “limited non-assessment periods,” such as the first partial calendar month of employment.

2E The multiemployer plan rule applied to the employer with respect to the FTE for every day of the calendar month.

The multiemployer plan rule refers to an accommodation under the play or pay regulations for employers that, pursuant to a collective bargaining or similar agreement, are required to contribute on the employee’s behalf toward the cost of coverage under a multiemployer plan (i.e., a union-affiliated plan). The employer enters code 1H (“no offer of coverage”) for the month on line 14 because the multiemployer plan, not the employer, is offering the coverage, and then enters code 2E (“multiemployer plan relief”) on line 16, even if the employee isn’t eligible for the multiemployer plan’s coverage, or even if the employee is enrolled in the coverage (that is, the general rule for line 16—that the employer use code 2C where the employee is enrolled in coverage—doesn’t apply; after all, it isn’t the employer’s coverage). The employer inserts Code 2E instead.

Lockton Comment: Whether the employee is enrolled or even eligible for such multiemployer plan coverage is irrelevant. The employer may use Code 2E simply because it is contributing to the multiemployer plan. Please note that for the multiemployer plan rule to apply, however, the multiemployer plan’s coverage must be MV and affordable to the employee, and the plan must also offer coverage (apparently MEC will do) to the employee’s children. Ideally, the employer should confirm with the multiemployer plan that its coverage is both MV and affordable, and that it includes eligibility for the children of eligible employees.
2F  Waived coverage, “W-2” affordability safe harbor applies.

The FTE waived coverage but was offered MV coverage, and the lowest cost self-only MV coverage was affordable under the W-2 pay safe harbor. Even if this code applies, its use is optional.

2G  Waived coverage, “federal poverty level” affordability safe harbor applies.

The FTE waived coverage but was offered MV coverage, and the lowest cost self-only MV coverage was affordable under the federal poverty line safe harbor. Even if this code applies, its use is optional. Note that if the employer inserted Code 1A on line 14, the employer is implying that the offer met the poverty level safe harbor, and use of code 2G remains optional.

2H  Waived coverage, “rate of pay” affordability safe harbor applies.

The FTE waived coverage but was offered MV coverage, and the lowest cost self-only MV coverage was affordable under the “rate of pay” safe harbor. Even if this code applies, its use is optional.

2I  [Reserved]

1A limited non-assessment period (LNAP) is a time when, although an employee has no offer of coverage, no employer play or pay penalty will apply, even if that employee receives subsidized coverage through a public health insurance exchange. The following are LNAPs:

The first calendar month of employment, but only if the employee’s first day of employment is a day other than the first day of the calendar month.

The waiting period for a new employee who is expected on his or her start date to average 30+ hours of service per week, provided the employee is eligible for employer provided health coverage providing at least MEC no later than the first day of the fourth full calendar month of employment.

For other new employees, where the employer is using the look-back measurement method, the initial measurement period and initial administration period, if:

An employee who measures as an FTE at the end of that initial measurement period is eligible for employer-provided health coverage providing at least MEC when the initial administration period ends, and

This occurs no later than first day of fourteenth full calendar month of employment.

Note that the following are LNAPs only if, in addition to the rules described below, the employee is offered employer-provided health coverage, providing at least MEC, by the first day of the first month following the end of the period:

The period from the date an employee in an initial measurement period has a change in employment status until the first day of the fourth full calendar month after that date, but only if, during the initial measurement period, the employee had a change in employment status such that, if the employee had been employed in the new status on his or her start date, he or she would have been expected to average 30+ hours of service per week. NOTE: If the change in employment status occurs late in the employee’s initial measurement period, and an offer of coverage would be made sooner if the employee completed the initial measurement period and initial administration period, then the offer of coverage must be made by that earlier date.

Jan. 1-Mar. 31 of the reporting year if the employer employed (in the controlled group or affiliated service group) fewer than 50 full-time employees and full-time equivalents during the year two years prior to the reporting year, and first employed 50 or more during the year prior to the reporting year, but only for an employee who was not offered employer-provided health coverage providing at least MEC by the employer at any time during that year prior to the reporting year. This rule is designed to give employers who first become subject to the employer mandate, for the reporting year, the first three months of that year to put compliant coverage in place.