



FAQs on Employer Reporting

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Introduction to Employer Reporting

Certain employers, plan sponsors, and insurers are required to report health plan information and participant coverage data to the IRS on Forms 1094 and 1095. The IRS uses this information to administer and regulate various aspects of the Affordable Care Act (ACA), including an individual’s eligibility for a premium tax credit when purchasing health insurance through a public Marketplace and the §4980H employer shared responsibility rules.

There are a lot of moving pieces when it comes to completing the required employer reporting. This guide has compiled some of the more common questions that plan sponsors have as they navigate fulfilling their obligation to complete this reporting.

Frequently Asked Questions (FAQs)

- Q1 – How Does An Employer Determine Ale Status? 3
- Q2 – How Is Full-Time Status Measured? 4
- Q3 – How Is Affordability Determined? 5
- Q4 – How Does An Ale Pick An Affordability Safe Harbor? 6
- Q5 – What Is The Difference Between Offer Codes 1a And 1e? 7
- Q6 – How Is Reporting Handled For Aggregated Ale Groups? 8
- Q7 – How Are Offers Of Cobra Reported? 10
- Q8 – What Is Reported For The Plan Start Month On Form 1095-C? 12
- Q9 – What Is Required For Collecting Ssns/Tins For Covered Individuals? 13
- Q10 – What Are The Most Common Employer Reporting Errors? 14
- Q11 - How Are §4980h Offer Of Coverage §6056 Reporting Requirements Enforced? 15

Q1 – How Does an Employer Determine ALE Status?

All applicable large employers (ALEs) are required to offer medical coverage to full-time employees and their dependents and then report annually on such offers of coverage using Forms 1094-C and 1095-Cs. ALEs are employers who averaged 50 FTEs in the previous calendar year.

General Calculation Steps for Determining ALE Status

Step 1: Calculate the number employees with 120 or more hours of service for each calendar month.

Step 2: Aggregate hours of service for each month for any other employees and divide the total by 120.

Step 3: Add the numbers obtained in Steps 1 and 2 for each month.

Step 4: Add up the totals for each month from Step 3 and divide the sum by 12.

An employer that averaged 50 or more FTEs during 2022, either alone or as part of a larger controlled group or affiliated service group (an “aggregated ALE group”), was required to offer medical coverage to full-time employees and their dependent children as required by §4980H in 2023, and then must report on such offers of coverage early in 2024.

Tips to Keep in Mind

- ✓ Count hours of service for all employees, including seasonal employees and union employees, when going through the above steps. Do not count hours for owners or independent contractors.
- ✓ If an employee only worked a partial month, still enter the number of hours of service for that month.
- ✓ If the employer is part of a larger controlled group or affiliated service group under §414 rules due to common ownership or shared management/services, it is necessary to aggregate FTEs across all related entities for purposes of determining ALE status.
- ✓ After going through Steps 1 - 4, if it's determined that the employer only exceeded 50 FTEs for 120 days or less due to seasonal workers, the employer may qualify for the seasonal worker exception.

Q2 – How is Full-Time Status Measured?

For purposes of reporting full-time employee counts on the Form 1094-C, as well as reporting full-time versus part-time status by month on Form 1095-Cs, applicable large employers (50 or more FTEs) are permitted to choose between two different methods of measuring full-time status: (i) the monthly measurement method; and (ii) the look-back measurement method.

- Under the monthly measurement method, employees with 130 or more hours of service in a month are full-time.
- Under the look-back measurement method, employees who averaged full-time hours during the previous measurement period (a measurement period between 3-12 months may be used) are generally full-time for the entire corresponding stability period (matching the length of the measurement period), even if there is a reduction in hours or leave of absence.

For employers with mostly regular full-time and part-time employees, the monthly measurement method is simplest and therefore generally the best choice. But for employers with a significant number of variable hour or seasonal employees, it may be worth using the more complicated look-back measurement method because it generally allows the employer to treat fewer employees as full-time, and it also makes tracking eligibility for variable hour employees easier (e.g., annually rather than monthly).

If an applicable large employer wishes to use the look-back measurement method, it cannot be used only for part-time, variable hour, or seasonal employees. It must be used for all employees, or at least all hourly employees. An employer is permitted to use different measurement methods and periods in general, but only for the following categories of employees:

- Collectively bargained employees and non-collectively bargained employees;
- Salaried employees and hourly employees; and
- Employees whose primary places of employment are in different states.

NOTE: The look-back measurement method cannot be used solely for variable hour or seasonal employees.

Q3 – How is Affordability Determined?

Under §4980H, applicable large employers (50 or more full-time equivalents (FTEs)) must offer coverage to full-time employees that is affordable to avoid potential §4980H(b) penalties. In addition, individuals enrolling for coverage through a public Exchange will not qualify for subsidized coverage if they are eligible for employer-sponsored group health plan coverage that is affordable.

Coverage is generally “affordable” if the employee contribution for employee-only (single) coverage does not exceed a set percentage of household income. Coverage is considered “affordable” under §4980H(b) requirements if the employee contribution satisfies at least one of three available safe harbors (i.e., federal poverty level (FPL), rate of pay, or Form W-2).

Effective for plan years beginning in 2023, the percentage to be used in affordability calculations is 9.12%. For calendar year plans, 9.12% applies for all months of 2023, but for a non-calendar year plan that renews in September, 9.12% applies beginning in September 2023 and 9.61% (the 2022 affordability percentage) should be used for January – August 2023.

If an employer offered coverage that was not affordable to some full-time employees, the employer risks a penalty of approximately \$350/month if the employee waived the coverage and instead enrolled in subsidized coverage through a public Marketplace.

Q4 – How Does an ALE Pick an Affordability Safe Harbor?

Affordability is generally calculated off an individual's household income, but an employer is unlikely to know an employee's household income, so the IRS provided three employer affordability safe harbors. When setting employer contribution rates, employers have the option to use one of three affordability safe harbors to provide more predictability when determining whether the coverage will be affordable. So long as minimum value coverage is affordable under one of the three recognized safe harbors, the employer will meet §4980H(b) requirements. Note that the use of an affordability safe harbor does not change an individual's possible eligibility for subsidies toward Marketplace coverage, which is tied to household income.

Employers may use any of the three affordability safe harbors for any reasonable category of employees, provided the same safe harbor is used on a uniform and consistent basis for all employees in a category. The regulations provide that reasonable categories for this purpose generally include specified job categories, nature of compensation (hourly or salary), geographic location, and similar bona fide business criteria. The following are the three available affordability safe harbors:

FPL - Employee contribution does not exceed 9.12% (in 2023) of FPL for a single individual.

Rate of Pay - Employee contribution does not exceed 9.12% (in 2023) of hourly rate x 130 (or monthly salary).

Form W-2 - Employee contribution does not exceed 9.12% (in 2023) of 2023 Box 1 wages.

TIP: When determining which affordability safe harbor to use, employers should first consider the FPL safe harbor because it is the simplest and guarantees affordability for all employees. If the monthly employee contribution for single coverage does not meet the FPL safe harbor, then the employer should consider the rate of pay or Form W-2 safe harbor.

Q5 – What is the Difference Between Offer Codes 1A and 1E?

When reporting offers of coverage in Part II, Line 14 of Form 1095-C, both codes 1A and 1E indicate an offer of minimum value coverage that is made available to the employee, spouse and children. The difference is tied to whether the employee contribution meets the FPL safe harbor.

1E = a minimum value offer of coverage to employee, spouse and children

1A = 1E + the offer meets the FPL safe harbor (also referred to as a “qualifying offer”)

If the employer offers minimum value coverage to employees, spouses and children that meets the FPL safe harbor, it is considered a "qualifying offer". When that is the case, the employer has two options for coding offers of coverage on Line 14 the Form 1095-C:

1. Mark the "Qualifying Offer Method" on Line 22 of the Form 1094-C, and then use Code 1A on Form 1095-C (Line 14) and leave Lines 15 and 16 blank; or
2. Use Code 1E on Form 1095-C (Line 14), enter the contribution amount on Line 15, and enter Code 2G on Line 16.

Either way is correct. Using 1A just simplifies the reporting a bit in that Lines 15 and 16 can then be left blank.

If 1E is used, 1E can be paired with any of the affordability safe harbor codes (i.e., 2F, 2G, or 2H).

Q6 – How is Reporting Handled for Aggregated ALE Groups?

Entities that are part of the same controlled group or affiliated service group under IRC §414 rules due to common ownership or shared management or services are generally viewed as a single employer for various benefit compliance purposes, even though they have separate EINs. Whether entities are part of the same controlled group or affiliated service group matters for purposes of §4980H offer of coverage requirements and §6056 reporting requirements as well.

To start with, full-time equivalents (FTEs) of all entities within the controlled group or affiliated service group are aggregated for purposes of determining whether the entities averaged 50 or more FTEs. If together the entities averaged 50 or more FTEs in the previous calendar year, then each entity in the controlled group or affiliated service group is an applicable large employer (ALE), even if individually an entity averaged less than 50 FTEs. Together they form an “Aggregated ALE Group”, and each entity is considered an “ALE Member”.

For an Aggregated ALE Group that may share employees between entities, the hours of service must be aggregated across the ALE Members to prevent an employee who would otherwise be considered full-time from being reported as part-time. For employees who are full-time based on aggregated hours, and therefore required a Form 1095-C, only one entity should report for the employee each month. The entity that employs the employee for the most hours for the month should report for the employee for that month. See the example below:

Example

Companies A, B and C are part of an Aggregated ALE Group and all employ Joe in January (Company A – 25 hours per week, Company B – 5 hours per week, Company C – 5 hours per week). Joe is full-time because he has 30 or more hours per week of service when aggregated between the entities. Company A should technically claim Joe as a full-time employee, offer coverage and report on Joe for the month of January. NOTE – So long as an offer of coverage is made by one of the entities, it will be considered an offer of coverage on behalf of whichever entity is responsible (Company A in this example); but if an offer is not made, Company A would be liable for the potential penalty for January.

Although the entities of a controlled group or affiliated service group are combined for purposes of determining ALE status and the full-time employee status of shared employees, each ALE Member is separately responsible for offering coverage in accordance with §4980H or facing potential penalties. The penalty is applied on an individual basis to each entity rather than applying across the whole Aggregated ALE Group, except that the waiver of 30 (for purposes of calculating penalty §4980H(a)) is applied on a pro rata basis. See the example below:

Example

Aggregated ALE Group with 100 full-time employees in total (Company A – 50 full-time employees, Company B – 30 full-time employees, Company C – 20 full-time employees). Company A and B offer coverage to all full-time employees, but Company C chooses not to offer any coverage. The penalty under §4980H(a) would be calculated as follows:

- Company A – No penalty
- Company B – No penalty
- Company C – $.20 \times 30 = 6$ waived (20-6) x §4980H(a) penalty

Similarly, because each ALE Member is separately responsible for compliance with §4980H offer of coverage requirements, each ALE Member is required to file Form 1094-C and Form 1095-Cs reporting offers of coverage information for its own full-time employees. Employer reporting is always required to be handled on a per EIN basis, even for an Aggregated ALE Group. Each ALE Member (or separate EIN) will submit its own Form 1094-C marked as the authoritative transmittal along with Form 1095-Cs for its own full-time employees and covered individuals. The only difference in reporting for entities that are part of an Aggregated ALE Group (i.e., a controlled group or affiliated service group) is that on the Form 1094-C, each ALE Member will mark the “yes” box on Line 21 of the Form 1094-C indicating they are part of an Aggregated ALE Group, and then also complete Part III, column (d) and Part IV listing the other members and their tax IDs; otherwise each ALE Member reports separately.

Q7 – How Are Offers of COBRA Reported?

How to report offers of COBRA and actual enrollment in COBRA continuation coverage depends upon (i) whether the employee was full-time for at least one month during the year; and (ii) whether the plan offered was fully-insured or self-funded. See the various scenarios addressed below:

Scenario 1 – Employee was full-time for part of the year, and then offered COBRA mid-year due to termination of employment.

- Fully-Insured and Self-Funded Plans – In Part II (Lines 14-16) of Form 1095-C, for the months following termination of employment, Code 1H (no offer of coverage) is used on Line 14, and Code 2A (not employed) is used on Line 16.
- Self-Funded Plans – If the former employee enrolled in COBRA under a self-funded plan, coverage information should be reported in Part III of the Form 1095-C for the months covered as an active employee and for the months covered as a COBRA participant.

Scenario 2 – Employee was full-time for part of the year, and then was offered COBRA mid-year because of a reduction in hours.

- Fully-Insured and Self-Funded Plans – In Part II (Lines 14-16) of the Form 1095-C, for the months following the reduction in hours, the offer of COBRA continues to be coded as an offer of coverage, similar to the way in which coding an offer of coverage is handled for a full-time eligible employee. However:
 - On Line 14, indicate who was offered COBRA. For example, if only the employee was enrolled prior to the reduction in hours, Code 1B is used; if the employee and spouse were enrolled, Code 1D is used.
 - On Line 15, the cost of single COBRA coverage (generally 102% of the premium) should be used.
 - On Line 16, Code 2C is used if the employee enrolled. If COBRA was waived, Code 2B may be used if the employee was part-time. If the employee was still full-time due to a stability period, Line 16 would likely be left blank since the cost will not typically be affordable.
- Self-Funded Plans – If the former employee enrolled in COBRA under a self-funded plan, coverage information should be reported in Part III of the Form 1095-C for the months covered as an active employee and for the months covered as a COBRA participant.

Scenario 3 – Employee, or former employee, was not full-time for any month of the year, but was covered under the employer's group health plan as a COBRA participant.

- Fully Insured Plans – If the plan was fully insured, no reporting is required by the employer. The insurance carrier will provide a Form 1095-B showing coverage.

- Self-Funded Plans – If the plan was self-funded, reporting coverage information is required. On Form 1095-C, use Code 1G in the “all 12 months” box on Line 14, skip Lines 15 and 16 completely, and then complete Part III showing the months of coverage (or alternatively, use Form 1095-B).

Scenario 4 – Non-employee (e.g., owner, retiree, ex-spouse, overaged dependent) was covered under the employer’s group health plan as an active participant or COBRA participant.

- Fully Insured Plans – If the plan was fully insured, no reporting is required by the employer. The insurance carrier will provide a Form 1095-B showing coverage.

Self-Funded Plans – If the plan was self-funded, reporting coverage information is required. On Form 1095-C, use Code 1G in the “all 12 months” box on Line 14, skip Lines 15 and 16 completely, and then complete Part III showing the months of coverage (or alternatively, use Form 1095-B).

Q8 – What is Reported for the Plan Start Month on Form 1095-C?

This field, which was made mandatory beginning in 2020, is looking for the employer's group medical plan year. It is not referring to when the employee may join the plan.

Employers should enter a two-digit number corresponding to the first calendar month of the plan year under which the employee was offered coverage (or would have been offered coverage if the employee were eligible). This will be the same code for all Forms 1095-C, as an employer's group health plan year does not vary based on the timing of individual employee enrollment. For example, an employer with a calendar year medical plan should use 01 on all forms; and an employer with a July – June plan year would use 07 on all forms.

The instructions indicate that if there is more than one plan year that could apply (e.g., if an employer changed the plan year during the year), then the earliest applicable month should be used. For example, if an employer switched its plan year from 2/1 to 8/1, the employer should use a two-digit code corresponding to the earlier of the two plan years (02) for all Form 1095-Cs. In cases where no health plan is offered, the employer should enter 00.

Q9 – What is Required for Collecting SSNs/TINs for Covered Individuals?

Employers who offer self-funded or level-funded group health plan coverage are required to report coverage information for all individuals who were enrolled in the employer's group health plan during the year. This includes employees and non-employees (e.g., retirees, owners, COBRA participants) and their spouses and dependents. Small employers (<50 FTEs) report coverage information on Form 1095-Bs. Applicable large employers (50 or more FTEs) generally report coverage information in Part III of Form 1095-Cs.

When reporting coverage information, employers must report names, SSNs/TINs, and months of coverage. There is an option to report date of birth (DOB) instead of a SSN or TIN, but the employer is first required to establish reasonable cause for not using the SSN or TIN. Below is a summary of the IRS guidance on how to establish reasonable cause (the process differs slightly for missing versus incorrect information).

For a missing TIN/SSN, the following 3 steps are required:

1. Make an initial solicitation at the individual's first enrollment (i.e., on the application for coverage).
2. If the first solicitation is unsuccessful, make a second solicitation within 75 days of the initial solicitation.
3. If the second solicitation is unsuccessful, make a third solicitation by December 31 of the following year.

If the employer is not able to obtain a TIN/SSN using the above process, a DOB may be used, at least for spouses and dependents, but the employer should document the process for audit purposes.

For an incorrect TIN/SSN (typically discovered when the reporting is submitted and then returned with an error), the following 3 steps are required:

1. Make an initial solicitation at the individual's first enrollment (i.e., on the application for coverage).
2. Assuming the initial solicitation took place and resulted in incorrect information, make a second solicitation by December 31 of the year in which the error is discovered.
3. If the second solicitation is unsuccessful, make a third solicitation by December 31 of the year following the first solicitation.

If at any point the employer discovers correct information, the 1095 should be corrected as soon as possible. But if the employer follows the process and is unable to obtain better information, there is nothing further to do other than to internally document the process for audit purposes.

Q10 – What Are the Most Common Employer Reporting Errors?

As we've been reviewing reporting for many employers, there are certain errors that we consistently run into. These errors may result in reporting penalties of up to \$310/form (in 2023) for failure to provide the IRS with complete and accurate reporting, but more importantly, these errors may result in significant §4980H penalties because they suggest the employer did not offer coverage to full-time employees and dependents as required.

Error #1 – Failure to mark “Yes” for all 12 months in Part III, column (a) of the Form 1094-C.

Part III, column (a) is the “minimum essential coverage offer indicator”. This is the place where applicable large employers indicate to the IRS whether the employer offered minimum essential coverage to at least 95% (or all but 5, if greater) of full-time employees and their dependents as required under §4980H(a). The IRS doesn't tally up offer of coverage information on the various Form 1095-Cs and compare it to the number of employees listed in Part III, column (b) of the Form 1094-C, although they could. Instead, the IRS appears to be fully relying on the employer's attestation of “yes” or “no” in column(a) for this purpose. Therefore, it is very important that employers ensure that the Form 1094-C, Part III, column (a) is completed in accordance with how coverage was offered during the year.

Error #2 – Failure to use a safe harbor code (Series 2 Code) on Line 16 of the Form 1095-C.

On Line 14 of the Form 1095-C, there should be an offer code for every month of the year (or in the “all 12 months” box). An employee was either offered coverage or not for each month. On Line 16, the safe harbor codes are optional, but a blank on Line 16 suggests that there is risk of a §4980H(b) penalty if that employee enrolled in coverage through a public Marketplace and qualified for a premium tax credit.

If an employer indicates 1H – no offer of coverage – on Line 14, without providing a 2 code on Line 16, it suggests that a full-time employee was not offered coverage for the month. Unless that's true, one of the following should be entered on Line 16:

- 2A – not employed for any day of the month.
- 2B – part-time for the month, or partial month of coverage due to termination of employment.
- 2D – limited non-assessment period (used for the first partial month of employment, waiting periods, and initial measurement periods).

If an employer indicates that coverage was offered for the month, typically using 1E or 1A on Line 14, without providing a 2 code on Line 16, it suggests that the offer of coverage was waived and was unaffordable. If that's not the case, then one of the following should be entered on Line 16:

- 2C – employee enrolled for the entire month.
- 2F – employee waived, and the offer was affordable under the Form W-2 safe harbor.
- 2G – employee waived, and the offer was affordable the FPL safe harbor.
- 2H – employee waived, and the offer was affordable under the rate of pay safe harbor.

Q11 - How are §4980H offer of coverage §6056 reporting requirements enforced?

The IRS is actively enforcing both §4980H offer of coverage requirements and §6056 reporting requirements. The IRS is using the following letters in its enforcement efforts:

Letter 5699. The IRS is reviewing the number of Form W-2s filed by employers each year. For employers who appear to be applicable large employers (ALEs) based on the number of Form W-2s filed, the IRS then checks to see if the 1094 and 1095s were submitted. If not, the IRS sends a Letter 5699 asking the employer to confirm status as an ALE, and also to confirm whether reporting was submitted.

Letter 226J. ALEs must self-report via the 1094-C and 1095-Cs whether coverage was offered in accordance with §4980H requirements (the “employer mandate”). The IRS will consider the employer’s reporting alongside the list of employees who received subsidized coverage from a public Marketplace.

- If an ALE indicates on its 1094-C that minimum essential coverage was NOT offered to substantially all full-time employees for each month of the calendar year (in Part III, Column (a)), and the IRS finds at least one full-time employee received subsidized coverage from a public Marketplace, the IRS will assess a penalty under §4980H(a).
- If an ALE indicates via coding on an employee’s 1095-C (Lines 14-17) that a full-time employee was not offered affordable minimum value coverage, and the IRS finds that same employee received subsidized coverage from a public Marketplace, the IRS will assess a penalty under §4980H(b) if the employer is not already subject to a penalty under §4980H(a) for the month.

If the IRS finds that a penalty is owed, the IRS will send the employer a Letter 226J proposing an assessment and offering an opportunity to appeal. Employers have 30 days to either pay the proposed assessment or appeal. Oftentimes there are misunderstandings as to offer of coverage requirements and mistakes in handling the reporting requirements. We strongly recommend that employers work with their benefit advisors in responding to IRS Letter 226J.

Letter 972CG. Employers that fail to file, file late, or file incorrect/incomplete forms with the IRS could face penalties of up to \$310/form (for 2023 filings) under §6721. In addition, failure to provide timely, complete and accurate 1095s to full-time employees and covered individuals could result in penalties of up to \$310/form (for 2023) under §6722. If the IRS finds that a penalty is owed, the IRS will send the employer a Letter 972CG proposing a penalty and offering an opportunity to appeal. NOTE: Beginning with the 2021 reporting, good faith relief for incomplete or inaccurate reporting is no longer available. Employers should be extra careful in reviewing and approving submissions to the IRS, whether the employer self-reports or obtains help from a vendor, to make sure the reporting is as complete and accurate as possible.