The FAQs to Understanding ACA 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.

Determining ALE Status

Question 1 – How does an employer determine ALE status?

Answer 1 –

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**. It does not matter whether the employer exceeded 50 FTEs in any given month, but rather whether the employer averaged 50 or more FTEs over the previous calendar year.

Here are the general calculation steps for purposes of determining average FTEs from the previous calendar year:

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 from each month from Step 3 and divide the sum by 12

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 couple days during a 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 is 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.
- ✓ An employer that averaged 50 or more FTEs during 2022, either along or as part of a larger controlled group or affiliated service group (an “aggregated ALE group”), must 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.

Reporting for Aggregated ALE Groups

Question 2 – How is reporting handled for aggregated ALE groups?

Answer 2 –

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 in the previous calendar year. 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."

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 1

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*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.

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 the employee for each month. The entity that employs the employee for the most hours for the month should report the employee for that month. See the example below:

Example 2

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 of January.

Note – So long as an offer of coverage is made by one of the entities, it will be considered an offer 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.

Affordability Requirements

Question 3 – How is affordability determined for an employer's group health plan?

Answer 3 –

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 Marketplace will not qualify for a premium tax credit to assist with the cost of coverage if they are eligible for employer-sponsored group health plan coverage that is affordable.

For purposes of eligibility for a premium tax credit toward coverage through a public Marketplace:

- Coverage is generally considered "affordable" for the employee if the employee contribution for employee-only (single) coverage does not exceed a set percentage (9.12% in 2023) of household income.
- Effective January 1, 2023, coverage is considered "affordable" for family members if the employee contribution for the family to participate in the employer-sponsored plan does not exceed a set percentage (9.12% in 2023) of household income.

An applicable large employer will meet §4980H(b) requirements if the employee contribution for employee-only (single) coverage is affordable; there is no requirement for an employer to make coverage affordable for family members. In addition, even if single coverage is unaffordable for an employee based on their 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).

Each year, the IRS adjusts the percentage used to determine affordability. The percentage can go up or down from one year to the next, potentially requiring employers to adjust employee contributions to meet affordability each year. The affordability percentage applies based on plan year (not always on a calendar year basis), allowing employers to then adjust employee contributions upon plan renewal rather than non-calendar year plans having to make adjustments each January. For example, the 9.12% for 2023 for a September through August plan year would have to use 9.12% to calculate affordability beginning in September 2023.

Affordability Safe Harbors

Question 4 – How does an applicable large employer choose an affordability safe harbor?

Answer 4 –

To avoid §4980H penalties, the coverage offered must be affordable to employees. Coverage is affordable if the employee contribution for employee-only (or single) group health plan coverage does not exceed the set affordability percentage of household income. However, an employer is unlikely to know the 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 considered affordable. So long as minimum value coverage is affordable under one of the three recognized safe harbors, the employer will be in compliance for purposes of avoiding a potential penalty under §4980H(b). Note that the use of an affordability safe harbor does not change an individual's possible eligibility for a premium tax credit 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 2022 Box 1 wages.

> TIP
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> 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.

Determining Full-Time Status

Question 5 – How does an applicable large employer determine full-time status?

Answer 5 –

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.

Measurement Methods

- Under the monthly measurement method, employees with 130 or more hours of service in a month are full-time. Status as full-time or part-time is determined for each month (an employee is part-time for any month the employee achieves <130 hours of service.)
- Under the look-back measurement method, employees who averaged full-time hours during the previous measurement period are generally full-time for the entire corresponding stability 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 may allow 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). The look-back measurement method is described in more detail in the following paragraphs.

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.

While the look-back measurement method cannot be used solely for variable hour or seasonal employees, using the look-back measurement method won't really impact full-time employees if they continue to average full-time hours each measurement period. However, if a full-time employee moves

to a part-time or variable hour position, it may be necessary to continue offering coverage through the end of the current stability period and consider their average hours during the most recent measurement period matter for purposes of subsequent offers of coverage.

Employers may choose to apply measurement and stability periods from 3-12 months in length. Most employers choose to use a 12-month cycle to align with the group health plan.

Example – 12-month cycle

Ongoing employees are measured during a 12-month standard measurement period prior to the group health plan's open enrollment. Those employees who earn 1,560 or more hours of service during the standard measurement period (or average 30 or more hours of service per week) are offered coverage for the following plan year, even if there is a reduction in hours.

New hire full-time employees who are expected to average 30 hours of service or more per week are offered coverage according to the waiting period rules and measured monthly until they can be transitioned into the standard measurement period with the rest of the ongoing employees to determine ongoing eligibility.

New hire variable hour, seasonal and part-time employees are subjected to a 12-month initial measurement period beginning 1st of the month following date of hire. Those employees who earn 1,560 or more hours of service during the initial measurement period (or average 30 or more hours of service per week) are offered coverage for a 12-month stability period, even if there is a reduction in hours. Following the initial measurement and stability periods, the employees are measured along with the rest of the ongoing employees during the standard measurement period to determine ongoing eligibility.

Under a 12-month cycle, for longer-term employees, the process is fairly straightforward because they are all measured over the same time frame each year and then offered coverage (or not) for the plan year. But for new hires, the look-back measurement method is a little trickier because each new employee is on their own cycle until they have been employed long enough to transition into the standard cycle. If the employer thinks of it as a 12-month waiting period, that sometimes makes it easier.

While certainly possible to handle administration of the look-back measurement method internally, many employers use a system offered by their payroll vendor or benefit administration platform to help track eligibility. By setting up the system with the appropriate time frames and entering in the hours of

service by month for all employees, the system can then help track full-time status in accordance with the rules for the look-back measurement method.

IRS Enforcement Efforts

Question 6 – How are §4980H offer of coverage §6056 reporting requirements enforced?

Answer 6 –

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, Letter 226J and Letter 972CG.

Letter 5699 - The IRS reviews 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-C and 1095-Cs 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.

The employer must then respond and indicate:

- The employer was not an ALE for the year.
- The employer was an ALE and submitted the reporting (this may require re-submitting the reporting).
- The employer was an ALE and will submit the forms.

Employers have 30 days to respond. It is possible to call or fax the IRS and request an extension if needed. If the forms are not submitted, or are submitted late, the employer may then receive a Letter 972CG indicating that penalties of up to $290/form (for 2022 filings) are due. The penalty is doubled if the employer also failed to provide copies of the 1095s to full-time employees and covered individuals.

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 premium tax credits toward individual coverage through a public Marketplace, the IRS will assess a penalty under §4980H(a).
- If an ALE indicates via coding on a 1095-C that a full-time employee was not offered affordable minimum value coverage (Lines 14-17), and the IRS finds that same employee received premium tax credits toward individual coverage through 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. It is possible to call or fax the IRS and request an extension if needed. 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 $290/form (for 2022 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 $290/form (for 2022) 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: No More Good Faith Relief

Through 2020 reporting, the IRS provided relief from reporting penalties for failing to provide complete, correct information if it was clear the employer made a good faith effort to report and submitted the reporting on a timely basis. Beginning in 2021 reporting, this good faith relief is no longer available, and the IRS could impose penalties of approximately $310/form for missing or inaccurate information on the 1095 or 1095 Forms. Employers should be careful in reviewing and approving submissions to the IRS, whether the employer self-reports or uses a vendor, to make sure the reporting is complete and matches employees' status and offer of coverage information for each month of the year.

Collecting SSNs/TINs for Covered Individuals

Question 7 – For employers offering self-funded group health plan coverage, what if the employer is unable to obtain SSNs/TINs for covered individuals?

Answer 7 –

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 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., application for coverage submitted).
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 instead, 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., application for coverage submitted).

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.

Reporting Offers of COBRA

Question 8 – How is COBRA reported on Form 1095s?

Answer 8 –

The reporting of 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: Former employee was full-time for part of the year, then was offered COBRA mid-year because of a 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, 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:

- When coding the offer of coverage on Line 14, code it according to who was offered COBRA. For example, if only the employee was enrolled prior to the reduction in hours, and therefore only the employee was offered COBRA, Code 1B would be used on Line 14. If the employee and spouse were enrolled prior to the reduction in hours, and therefore both employee and spouse were offered COBRA, Code 1D would be used in Line 14.
- When entering the employee contribution amount on Line 15, the cost of single COBRA (generally 102% of the premium) should be used.

- When coding Line 16, if the employee enrolled in COBRA, Code 2C would be used. But if the employee did not elect COBRA, Code 2B may be entered if the employee was part-time for the month. If the employee was full-time (e.g., 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 alternately, 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 alternately, use Form 1095-B).

Reporting the Plan Start Month on Form 1095-C

Question 9 – What should applicable large employers report for the plan start month in Part II of the Form 1095-C?

Answer 9 –

This field, which was made mandatory 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.

Reporting Offers of Coverage – Code 1A versus 1E

Question 10 – What is the difference between Codes 1A and 1E?

Answer 10 –

When reporting offers of coverage in Part II, Line 14 of the 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.

NOTE: 1E could be paired with any of the affordability safe harbor codes (i.e., 2F, 2G, or 2H).