Employer Reporting

October 2021

Legislation and regulations are subject to change. This guidance is current as of the date of this publication.

Reporting Forms

Version A – Form 1094-A and Form 1095-As

Version A is used only by public Marketplaces to report coverage information for those enrolled in individual health coverage through a public Marketplace.

Version B – Form 1094-B and Form 1095-Bs

Version B is used by insurance carriers to report coverage information for those enrolled in a fully-insured group health plan.

Version B is also used by small employers (<50 full-time equivalents) to report coverage information for those enrolled in a self-funded, level-funded or partially self-funded group health plan offered by the small employer.

Version C – Form 1094-C and Form 1095-Cs

Version C is used by applicable large employers (50 or more full-time equivalents) to report:

- Offer of coverage information for full-time employees; and
- Coverage information for those enrolled in a self-funded group health plan offered by the applicable large employer.

Reporting Deadlines

IRS Reporting

Due February 28th, 2022 if the 1094 and 1095s are submitted by mail.

Due March 31st, 2022 if the 1094 and 1095s are submitted electronically (electronic submission is required if 250 or more Form 1095s are submitted).

Copies to Individuals (full-time employees and covered individuals)

Copies of the Form 1095s must be provided by January 31st, 2022. The forms may be delivered by hand, mail, or electronically if consent is given.

Minor Changes for 2021 Reporting

- New individual coverage HRA (ICHRA) offer of coverage codes (1T and 1U).
- The good faith relief for inaccurate or incomplete reporting that was available for 2015 – 2020 reporting is no longer available. Penalties of up to $280/form may apply for failure to provide complete, accurate information.
- Copies of Form 1095-Bs must be delivered to individuals rather than simply posting their availability on the internet.

Employers Subject to Reporting Requirements

Applicable Large Employers (ALEs – 50 or more full-time equivalents)

All ALEs are required to report annually via the Form 1094-C and Form 1095-Cs. ALEs are required to report offer of coverage information for any employees who were full-time for at least one month during the calendar year. Reporting is required whether the ALE offered fully-insured medical coverage, self-funded medical coverage, or no medical coverage.

For ALEs that are part of a larger aggregated ALE group (part of a controlled group due to common ownership or an affiliated service group due to shared management or services), reporting should always be prepared separately for each separate EIN, but the Form 1094-C should indicate that the employer is part of a larger aggregated ALE group (on Line 21) and should list the names and EINs of the other members (in Part IV).

Any Employer Offering Self-Funded Group Health Plan

Any size employer offering a self-funded, level-funded, or partially self-funded group health plan must report coverage information for any individuals who enrolled in the employer's self-funded group health plan.

- Small employers should report coverage information on Form 1094-B and Form 1095-Bs.
- ALEs will typically report coverage information in Part III of the Form 1095-C (the same form used to report offer of coverage information for full-time employees).

When reporting coverage information for several members of the same family, generally the covered dependents can be listed on the same Form 1095 as the primary subscriber.

If there is a change in funding mid-plan year, from fully-insured to self-funded or vice versa, coverage information should be reported only for the months the individuals were enrolled in self-funded coverage. The carrier will report coverage information for the portion of the year the individuals were enrolled in a fully-insured plan.

ALE Offer of Coverage Reporting Tips – Form 1095-C, Part II

Line 14 (Offer of Coverage) – Series 1 Codes

- Line 14 must be coded for all 12 months indicating whether coverage was offered for the month.
- It may only be coded as an offer of coverage if coverage was available for the entire month.
- A waived offer of coverage is generally valid for 12 months, and COBRA also counts as an offer of coverage.
- The coding on Line 14 is not affected by whether an employee enrolled or waived.
- Most employers use one code to indicate an offer (e.g., 1E) and one to indicate no offer (1H).
- Codes 1A – 1K are for traditional group medical plans, and Codes 1I – 1U are for individual coverage HRAs (ICHRAs).

Line 15 (Employee Contribution) – Enter dollar and cents

- Use the employee contribution for the lowest cost minimum value employee-only (single) coverage offered to the employee. It doesn't matter which coverage or tier the employee may have enrolled in.
- Adjust the monthly amount if the employee contribution changes for active coverage or COBRA.
- HSAs and HRAs generally do not affect the employee contribution.
- Be careful with opt-out incentives and flex credits. Opt-out incentives (or cash-in-lieu of benefits) that are not designed to meet the requirements of an "eligible opt-out arrangement" will increase the employee contribution. Flex credits (or defined contributions) that can be used toward non-health benefits do not count as an employer contribution and will not reduce the employee contribution.
- If a wellness incentive affects the employee contribution, use the non-wellness rate (unless it is tobacco-related). This includes COVID vaccination surcharges, in which case the higher, unvaccinated rate must be used to determine affordability.
- The employee contribution for individual coverage HRAs (ICHRAs) = lowest cost silver Marketplace plan – monthly ICHRA contribution.

Line 16 (Safe Harbors) – Series 2 Codes

- No code is necessary if no code applies. Unlike for Line 14, it is okay to leave Line 16 blank, but most often a code on Line 16 should be included as well.
- Code 2C is always used when the employee enrolled, unless the employer is using Code 2E to indicate multiemployer (union) transition relief.
- Code 2D is used for the first partial month of employment, for a waiting period and for an initial measurement period.
- There is no specific code for when an employee waived. If coverage was waived, use Code 2B if the employee was part-time, or one of the affordability safe harbor codes (i.e., Code 2F, 2G or 2H) if the coverage was affordable.

Line 17 (Zip Code) – Only required if an ICHRA was offered

The zip code should reflect the zip code of the employee's residence or the employee's primary site of employment depending upon which one the employer is using to determine affordability.

Coding Combinations

- For an employee who was NOT offered coverage for the month:
    - Line 14 – Code 1H
    - Line 15 – Leave it blank
    - Line 16 – 2A (not employed), 2B (part-time), 2D (in a waiting period), or blank if none of those apply.

- For an employee who WAS offered coverage for the month:
    - Line 14 – Applicable offer code matching the employer's offer (typically Code 1A or 1E)
    - Line 15 – Monthly employee contribution for single, minimum value coverage
    - Line 16 – 2C (enrolled), an affordability safe harbor code (2F, 2G or 2H), 2B (part-time), or blank if coverage was waived by a full-time employee and the offer was not affordable

SSN/TIN Reporting for Self-Funded Group Health Plans

Application

Employers must report a social security number (SSN) or tax identification number (TIN) for each individual covered under the employer's self-funded group health plan.

Solicitation Process

Employers are required to make at least 3 attempts or solicitations to obtain accurate SSN/TIN information for enrolled employees and their dependents. Soliciting the information from the employee is adequate; it isn't necessary to also contact enrolled spouses or children. The first attempt should take place when the individuals enroll (e.g., on the application for coverage). If the SSN/TIN is not provided for all enrolled individuals, or is found to be inaccurate, the employer should request the information again within 75 days following the first solicitation (or enrollment). Then if that attempt is not successful, the employer should request the information a third time by December 31st of the following year.

If the employer goes through this process and is unable to obtain accurate an SSN/TIN for all enrolled individuals, the employer may use the date of birth for reporting, but should also keep records of going through this 3-step process.

IRS Enforcement

Letter 226J

The reporting submitted by ALEs via Form 1094-C and Form 1095-Cs tells the IRS whether the ALE met §4980H offer of coverage requirements for full-time employees. The IRS compares this reporting against the list of individuals who enrolled in coverage through a public Marketplace and qualified for a premium tax credit. If it appears the ALE owes an assessment under §4980H, the IRS will send

the employer a Letter 226J with a proposed assessment. Employers generally have 30 days to appeal such assessments if coverage was offered as required under §4980H, but the reporting did not accurately reflect what was offered. However, it is unclear whether the IRS will be as lenient with this appeal process now that the good faith relief from reporting penalties for inaccurate or incomplete information is no longer in place. Therefore, we recommend that employers be extra careful in reviewing and approving submissions to the IRS to make sure the reporting is as complete and accurate as possible when first submitted.

Letter 5699

For ALEs who fail to report, the IRS is reaching out via Letter 5699 and asking the employer to confirm ALE status and let the IRS know when the Form 1094-C and Form 1095-Cs can be expected. The IRS is finding ALEs who may have failed to report by considering the number of Form W-2s filed by the employer for the year.

Letter 972CG

If reporting is late, incomplete or inaccurate, the IRS may send a Letter 972CG assessing a penalty of up to $280/form. This penalty can double if the failure also affects copies that should have been sent to full-time employees and covered individuals.

State Individual Mandate Reporting

Federal vs. State Individual Mandate

The federal individual mandate was reduced to $0, so individuals who fail to have minimum essential coverage in place will no longer face any penalty at the federal level. However, several states have implemented individual mandates requiring state residents to have coverage in place or face a penalty when filing their state tax return. To help enforce this requirement, such states require coverage reporting to state level agencies. For fully-insured plans, this state reporting will often be handled by the carrier, but for self-funded plans, the responsibility must be handled by the employer. See the details for the state-level reporting summarized in the table below:

	Required Forms	Reporting Deadlines
California	Form 1094 and Form 1095s	• Statements to covered individuals due January 31st • Filing with FTB due March 31st
Massachusetts	Form 1099-HC	• Statements to covered individuals due January 31st • Filing with DOR due March 31st
New Jersey	Form 1094 and Form 1095s	• Statements to covered individuals to be determined • Filing with DORES due March 31st
Rhode Island	Form 1094 and Form 1095s	• Statements to covered individuals due January 31st • Filing with DOT due March 31st
Washington D.C.	Form 1094 and Form 1095s	• Statements to covered individuals due January 31st • Filing with OTB due 30 days after federal reporting

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