CDS
CONWAY, DEUTH & SCHMIESING

CDSA
CDS ADMINISTRATIVE SERVICES

CERTIFIED PUBLIC
Accountants & Consultants

Employer Shared Responsibility Provisions of the ACA

Agenda

- Part 1
  - Key elements of the employer shared responsibility provisions and reporting requirements
- Part 2
  - Forms 1094-C & 1095-C Filing Compliance

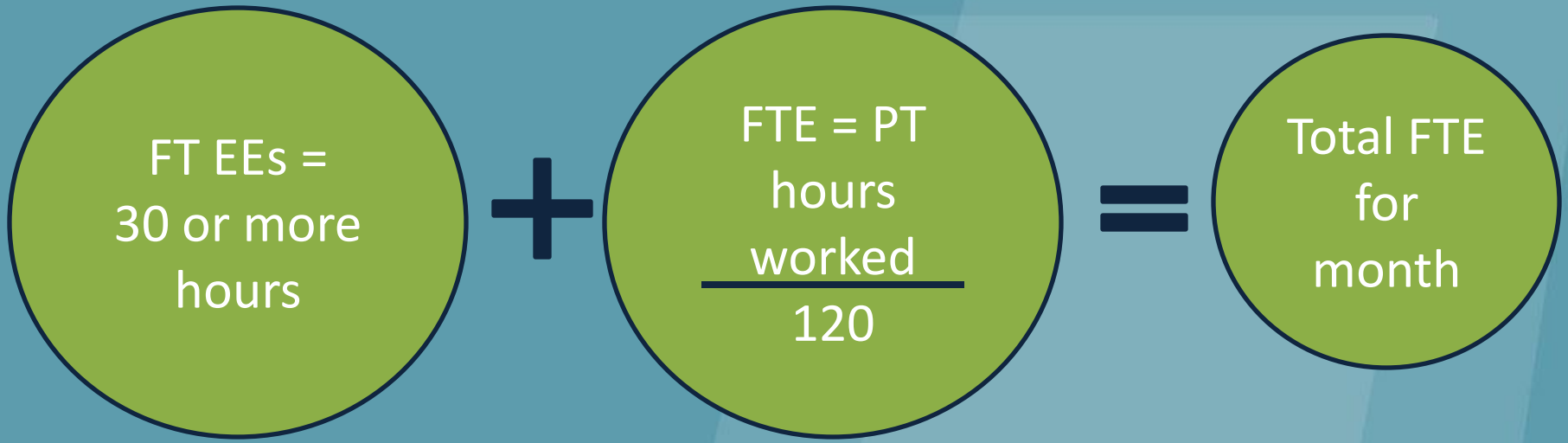
ACA Acronyms and Definitions

- EE: Employee
- ER: Employer
- ALE: Applicable Large Employer subject to ER mandate.
- FTE: Full-Time Equivalent
  - Number used to determine how many EEs are in an organization.
- MEC: Minimum Essential Coverage
  - Coverage that meets ACA penalty A and the individual mandate.
- ACA Full-Time: An EE working more than 130 hours/month or who averages 30 hours/week.
- FPL: Federal Poverty Line
  - Basis to determine if ER coverage is universally affordable for EEs.
  - EE coverage cost is less than 9.5% of FPL.
- LNP: Limited Non-Assessment Period
  - ACA term for waiting period and includes EEs in a measurement period or new hire waiting period.

Are You a Large or Small Employer?

An ALE employs an average of 50 FTEs over the course of the preceding calendar year.

Counting Employees to Determine ALE Status



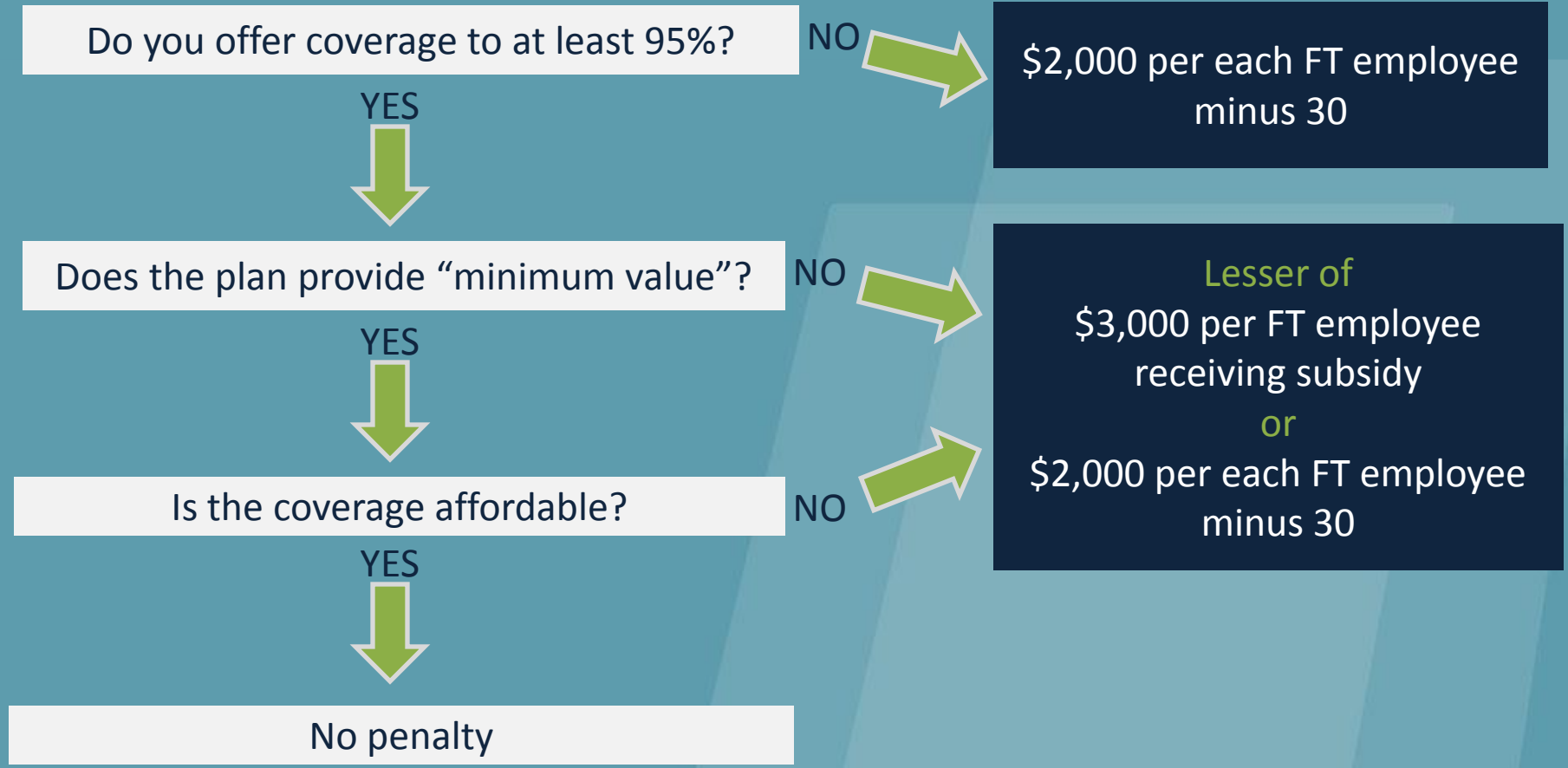
Counting Employees to Determine ALE Status

- 12 month lookback period to determine if ALE

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Full-Time Employees	37	36	36	37	31	35	39	38	39	35	36	38	
Subject Hours non FT	1740	1670	2250	1900	1773	1640	1922	1950	2077	1850	1373	1530	(Note 1)
FTE Conversion	14.50	13.92	18.75	15.83	14.78	13.67	16.02	16.25	17.31	15.42	11.44	12.75	(Note 2)
Total Employees	51.50	49.92	54.75	52.83	45.78	48.67	55.02	54.25	56.31	50.42	47.44	50.75	617.62
							617.62/12 months = 51.47 employees						

- Note 1: Count only the first 120 paid hours per EE per month.
- Note 2: Divide the previous line item by 120, regardless of the actual number of days or working days in the month.

Employer Mandate Penalty Structure for 2016

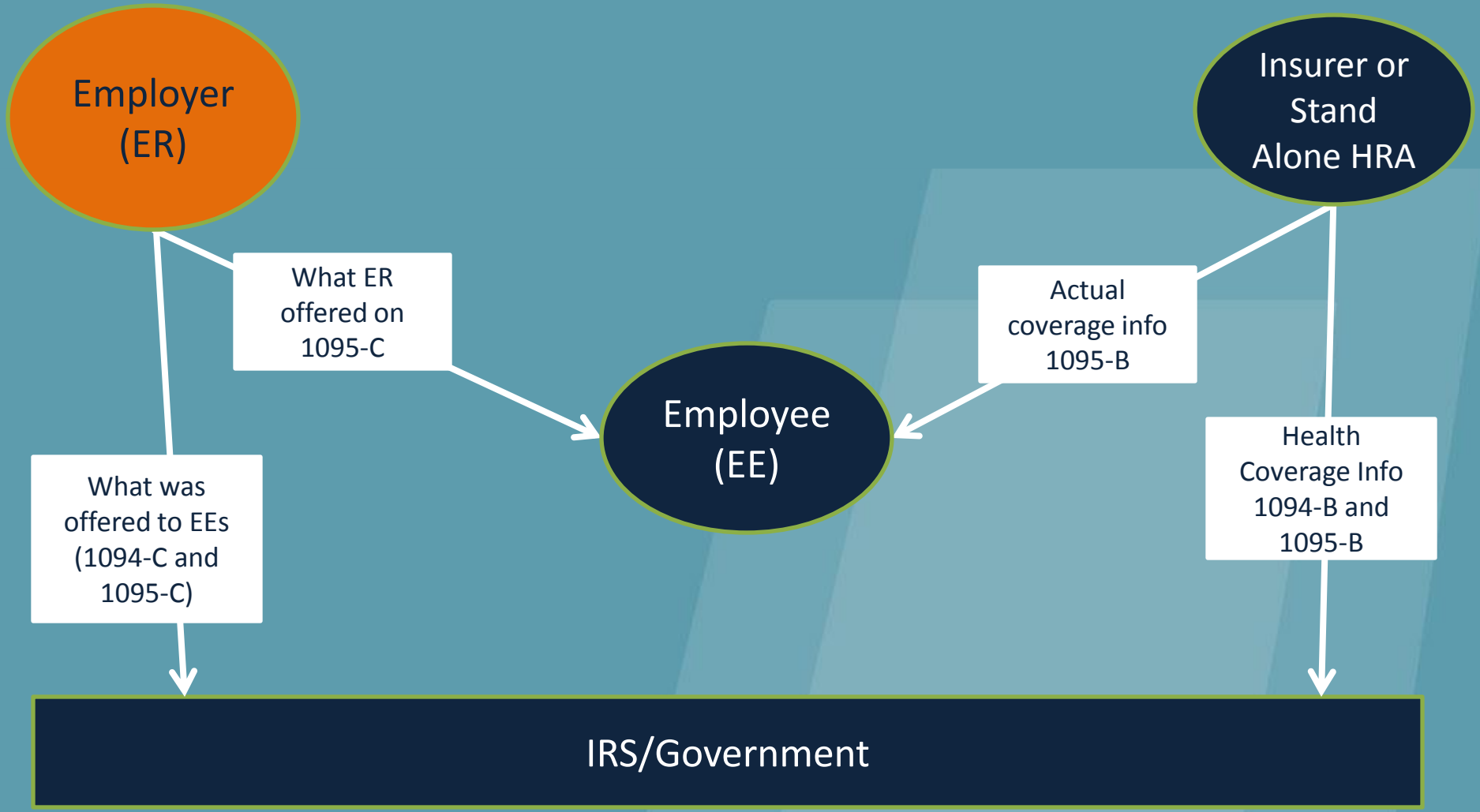


Premium Tax Credit

- Employer gets notice from the applicable Exchange starting first quarter 2016
  - Must dispute within 90 days
  - Prove offer of coverage, etc.

Form 1094 & 1095 Filing Compliance

- 1094-B and 1095-B Stand Alone HRA
- 1094-C
  - Transmittal form for ALE to report coverage
- 1095-C
  - One for each employee that works over 30 hours


Employer (ER)
Insurer or Stand Alone HRA
What ER offered on 1095-C
Actual coverage info 1095-B
Employee (EE)
What was offered to EEs (1094-C and 1095-C)
Health Coverage Info 1094-B and 1095-B
IRS/Government

Due Dates for 2015 Forms

- February 1, 2016
  - 1095-Cs to Employees
- February 29, 2016
  - Paper filed returns to IRS
- March 31, 2016
  - Electronically filed returns to IRS
    - Required if 250 or more 1095-Cs
- Extensions available

Penalties

- Penalties for not filing
  - $250 per 1095-C
  - Maximum of $3 Million

Form **1094-C**

Department of the Treasury
Internal Revenue Service

Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

▶ Information about Form 1094-C and its separate instructions is at www.irs.gov/form1094c

Part I Applicable Large Employer Member (ALE Member)

1 Name of ALE Member (Employer)

2 Employer identificatio

3 Street address (including room or suite no.)

5 State or province

6 Country and ZIP or

4 City or town

7 Name of person to contact

8 Contact teleph

9 Name of Designated Government Entity (only if applicable)

10 Employer ident

11 Street address (including room or suite no.)

13 State or province

14 Country a

12 City or town

15 Name of person to contact

16 Contact

17 Reserved . . . . . .

18 Total number of Forms 1095-C submitted with this transmittal . . . . . .

19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No,"

Part II ALE Member Information

20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member . . . . . .

21 Is ALE Member a member of an Aggregated ALE Group?

If "No," do not complete Part IV.

22 **Certifications of Eligibility (select all that apply):**

☐ **A.** Qualifying Offer Method ☐ **B.** Qualifying Offer Method Transition Relief

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and to the

Signature Title

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Form **1095-C**

Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

☐ VOID ☐ CORRECTED

600116

OMB No. 1545-2251

2015

Part I Employee

1 Name of employee

2 Social security number (SSN)

3 Street address (including apartment no.)

4 City or town

5 State or province

6 Country and ZIP or foreign postal code

Applicable Large Employer Member (Employer)

7 Name of employer

8 Employer identification number (EIN)

9 Street address (including room or suite no.)

10 Contact telephone number

11 City or town

12 State or province

13 Country and ZIP or foreign postal code

Part II Employee Offer and Coverage

Plan Start Month (Enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)													
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)													

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual. ☐

	(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage: Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2015)

Form 1094-C

Part I **Applicable Large Employer Member (ALE Member)**

1 Name of ALE Member (Employer)		2 Employer identification number (EIN)	
3 Street address (including room or suite no.)			
4 City or town	5 State or province	6 Country and ZIP or foreign postal code	
7 Name of person to contact		8 Contact telephone number	
9 Name of Designated Government Entity (only if applicable)		10 Employer identification number (EIN)	
11 Street address (including room or suite no.)			
12 City or town	13 State or province	14 Country and ZIP or foreign postal code	
15 Name of person to contact		16 Contact telephone number	

For Official Use Only

17 Reserved . . . . . ☐

18 Total number of Forms 1095-C submitted with this transmittal . . . . . ▶

19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions . . . . . ☐

Form 1094-C

- Line 19 – Controlled Group
  - All employees in controlled group are counted when determining whether related employers are ALE members
  - Each employer in controlled group needs to check the box

19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions

Form 1094-C

Part II **ALE Member Information**

20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member . . . . . ▶

21 Is ALE Member a member of an Aggregated ALE Group? . . . . . ☐ Yes ☐ No

If "No," do not complete Part IV.

22 **Certifications of Eligibility (select all that apply):**

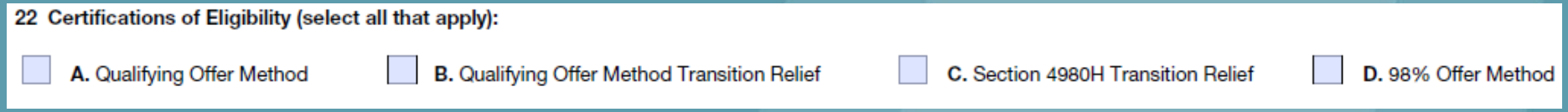
☐ **A.** Qualifying Offer Method ☐ **B.** Qualifying Offer Method Transition Relief ☐ **C.** Section 4980H Transition Relief ☐ **D.** 98% Offer Method

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and to the best of my knowledge and belief, they are true, correct, and complete.

▶ Signature ▶ Title ▶ Date

Form 1094-C

- Line 22: Certifications of Eligibility
  - Boxes A through D



Part III ALE Member Information—Monthly

		(a) Minimum Essential Coverage Offer Indicator		(b) Full-Time Employee Count for ALE Member	(c) Total Employee Count for ALE Member	(d) Aggregated Group Indicator	(e) Section 4980H Transition Relief Indicator
		Yes	No				
23	All 12 Months	☐	☐			☐	
24	Jan	☐	☐			☐	
25	Feb	☐	☐			☐	
26	Mar	☐	☐			☐	
27	Apr	☐	☐			☐	
28	May	☐	☐			☐	
29	June	☐	☐			☐	
30	July	☐	☐			☐	
31	Aug	☐	☐			☐	
32	Sept	☐	☐			☐	
33	Oct	☐	☐			☐	
34	Nov	☐	☐			☐	
35	Dec	☐	☐			☐	

Form 1094-C

- Part III: ALE Member Information – Monthly
  - Detail of coverage offered and employee count by month
  - Column (d) – check if part of a controlled group
  - Column (e) – complete if checked box “C” on Line 22

Part IV Other ALE Members of Aggregated ALE Group

Enter the names and EINs of Other ALE Members of the Aggregated ALE Group (who were members at any time during the calendar year).

	Name	EIN		Name	EIN
36			51		
37			52		
38			53		
39			54		
40			55		
41			56		
42			57		
43			58		
44			59		
45			60		
46			61		
47			62		
48			63		
49			64		
50			65		

1094-C

- Part IV: Other ALE Members of Aggregated ALE Group
  - Only for employers in a controlled group

Form 1095-C

Part I Employee			Applicable Large Employer Member (Employer)		
1 Name of employee		**2** Social security number (SSN)	**7** Name of employer		**8** Employer identification number (EIN)
3 Street address (including apartment no.)			**9** Street address (including room or suite no.)		**10** Contact telephone number
4 City or town	**5** State or province	**6** Country and ZIP or foreign postal code	**11** City or town	**12** State or province	**13** Country and ZIP or foreign postal code

Part II Employee Offer and Coverage													**Plan Start Month** (Enter 2-digit number):
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)													
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)													

1095-C

- Line 14 – Indicates the type of coverage, if any, that was offered to an employee, spouse and/or dependents
  - Cannot be blank
- Line 15 – Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage
  - Complete only for codes 1B, 1C, 1D, or 1E
- Line 16 – Justifies why or why not the employer offered coverage
  - Can be blank

Form 1095-C

Part II Employee Offer and Coverage														**Plan Start Month** (Enter 2-digit number):
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)														
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	$	$	$	$	$	$	$	$	$	$	$	$	$	
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)														

Form 1095-C

Part III **Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each covered individual. ☐

	(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Questions or Comments?

Health Care Reform Resource Center

Check out our websites for online resources on the Health Care Reform!

CDS

- www.cdscpa.com/online-resources/

CDSA

- www.cdsatpa.com/online-resources/

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