

### **CDSA**

CONWAY, DEUTH & SCHMIESING

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

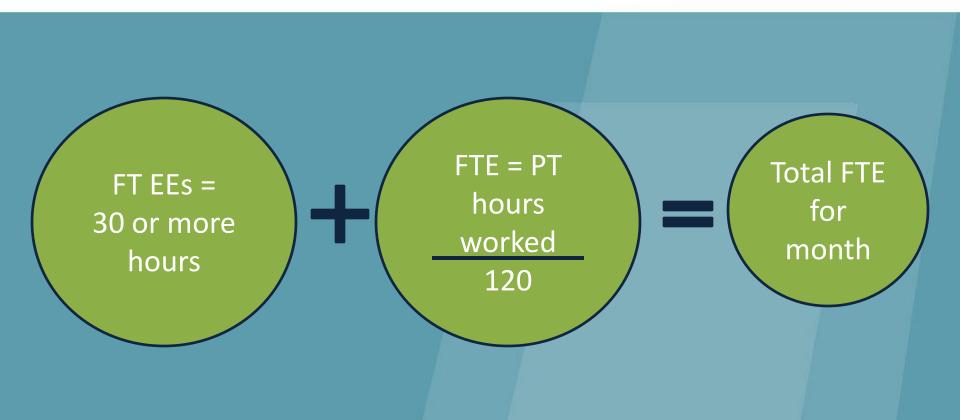
### ACA Acronyms and Definitions

- 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



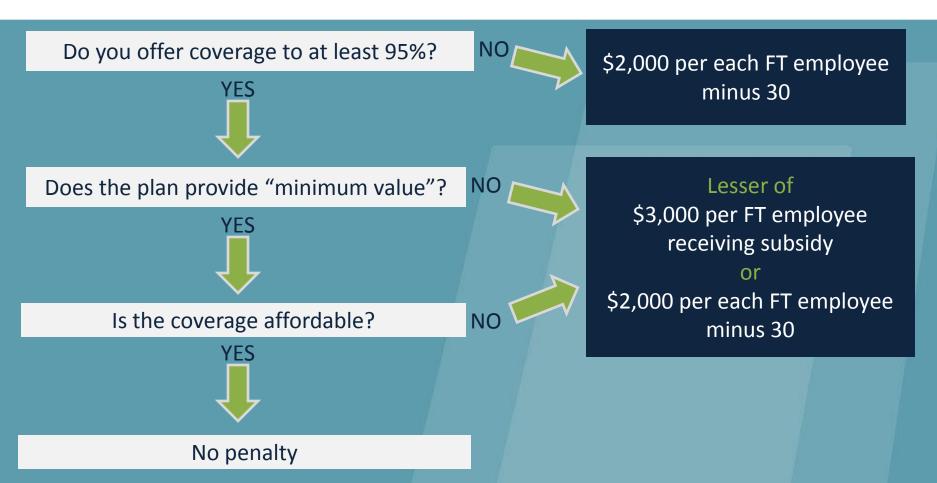
#### Counting Employees to Determine ALE Status

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
								6:	17.62/12	months =	51.47 empl	oyees	

- 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

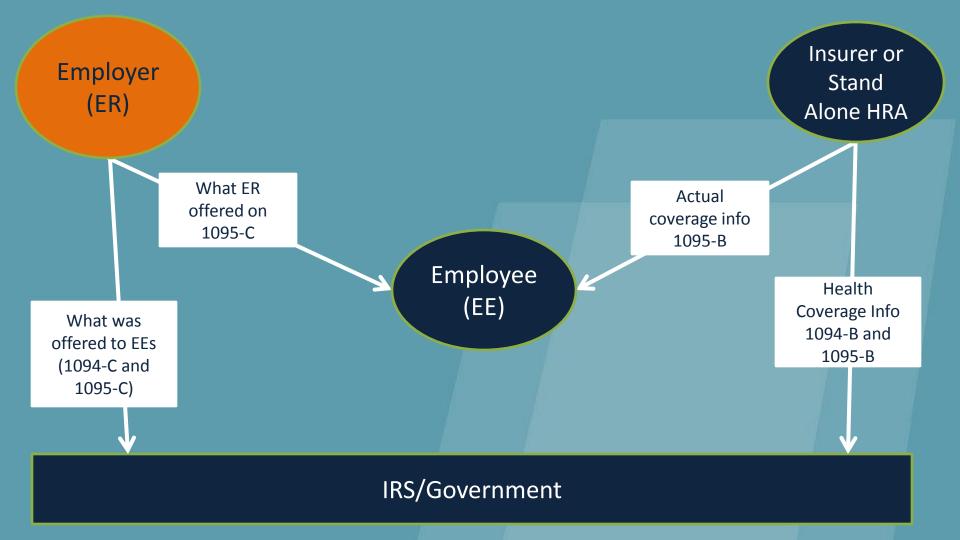
- Employer gets notice from the applicable
   Exchange starting first quarter 2016
  - Must dispute within 90 days

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



### 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



-- 11.

Transmittal of Employer-Provided Health Insurance Offer  Coverage Information Returns  Coverage Information is at www.irs.gov/iromit  Member (ALE Member)  2 Employer de	1094c
Transmittal of Employer-Province	10940
Transmittal of Englange Informations is at which	
	lentificati
2 Employer of	
COVERTION 1094-C  Information about Form 1094-Q and its separate 2 Employer of Another (ALE Member)	
Information about Form 1094-0 white the Treasury before a revenue service before the Treasury before a revenue service.  Port Applicable Large Employer Member (ALE Member)  Service of ALE Member (Employer)  Service of ALE Member (Employer)  Service of ALE Member (Employer)	
Department of the Insurance Service Internal Revenue Service Internal R	and ZIP of
1 Name of AE Member (Employee)  1 Name of AE Member (Employee)  1 Of State or province  8 Contact	
1 Name of ALE Member (Employer)  or suste no.)  5 State or province  8 Contact	ct telepri
Name of N.E. sm.     State or prosum.     State or prosum.     State or prosum.     State or prosum.	use ident
	yes -
4 City or town	
7 Name of person to contact  9 Name of Designated Government Entity (only if applicable)  14 Co.  15 State or provinces  16 Co.	untry as
- pointaged Government	
Name of Designated Government     N	ontact
address (notuding room ut us	_
11 Street and	
12 Cây or town	•
12 Chy	
15 Name of person to contact	
	o." !
17 Reserved	_
17 Hesers 4095-C submitted with "Yes," check the state of	_
17 Reserved  18 Total number of Forms 1085-C submitted with this transmittal  18 Total number of Forms 1085-C submitted with this ALE Member? If "Yes," check the box and continue. If "No	
18 Total normative transmittal 10	_
19 Is this the authoritative transmission  Portio  ALE Member Information  20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member .  20 Total number of Forms 1095-C filed by and/or on behalf of ALE Group?	
ALE Member	
Forms 1095-C filed by	_
20 Total number of Forms 1085-1 incompared ALE Group?  21 Is ALE Member a member of an Aggregated ALE Group?	
	,
1 is ALE Member a turned to the second secon	
w "No." do not complete all that appears and Method Transition House	
21 Is ALE Member of complete Part IV.  If "No," do not complete Part IV.  22 Certifications of Eligibility (select all that apply):  B. Qualitying Offer Method Transition Relief	,
22 Certification and accompanying designation accompanying designation and accompanying designation accompanying designation accompanying designation accompanying designation accompanying designation and accompanying designation accompanying d	
Oualifying Offer Meditor     A Qualifying Offer Meditor	
Tele	
If "No," do not complete:  22 Certifications of Eligibility feelect all that appropriate the complete section of Eligibility feelect all that appropriate the complete section of Eligibility feelect all that appropriate the complete section of Eligibility feelects all that appropriate all that appropria	
and separate instructions.	
Production Act Notice, see 55,	
Signature	
For Privacy Act	

Part	5-C ne Treasury Service	•	mployer-P	rovide ut Form 10	d Health 95-C and its so	Insuran	ce Offer	and Co	verage		VOID		1	60011
<ol> <li>Name of emp</li> </ol>	loyee				- and 115 56	parate instru	ctions is at v	www.irs.gov	/form1095c		CORR	ECTED		B No. 1545-2251
				2 So	icial security numb	ner /CCAn		Applicab	le Large E	man I		LOTED	'   8	2015
3 Street address	s (including apar	tment no.)			ny mana	Ser (SSN)	7 Name of	employer	io Large E	mployer	Membe	r (Empl	over)	
							1					8 8	Employer iden	tification number (EIN)
4 City or town		5 State or p	rovince				9 Street add	dress (includin	g room or suite	no.)		.		
				6 Cour	ntry and ZIP or fore	ign postal code	11 Chumi					10 0	Contact teleph	one number
Part II Em	ployee Off	er and Co	Worner				TO CITY OF TOW	vn	12 State	e or province				
	All 12 Months		verage				Diamori					13 0	ountry and ZIP	or foreign postal code
14 Offer of Coverage (enter	All 12 MONTHS	Jan	Feb	Mar	Ann		Plan Star	t Month (i	nter 2-digit	number):				
required code)					Apr	May	June	July		_				
15 Employee Share								July	Aug	S	ept	Oct	Nov	
Monthly Premium,			1										1400	Dec
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	s													
- and -	\$	\$	\$ \$							- 1				
6 Applicable section 4980H Safe larbor (enter code,			+		\$	\$	\$	\$						1
arbor (enter code, applicable)			1 1					Ψ	\$	\$	\$		•	
Part III Cove	red Individ							1			-		\$	\$
If Emm	rea maivid													
	lover provid-	uais												
(a) Name of	loyer provide	uais ed self-insu	ired coverage, c	heck the h	OV and out									
(a) Name of	loyer provide f covered individ	dais ed self-insu lual(s)	ired coverage, c	heck the b	Oox and enter	the informat	ion for each	Covered in	dividual					
(a) Name of	loyer provide f covered individ	ed self-insu	red coverage, c	heck the b	OOX and enter	the informat		covered in	dividual.					
(a) Name of	loyer provide f covered individ	ed self-insu	(b) SSN	heck the b	DOX and enter (c) DOB (If SSN is not available)	the informat (d) Covered all 12 months	ion for each			(e) Months of				
(a) Name of	loyer provide f covered individ	ed self-insu	(b) SSN	heck the b	DOX and enter (c) DOB (If SSN is not available)	(d) Covered all 12 months				(e) Months of		ug Sep	ot Oct	Nov   Dec
(a) Name of	loyer provide	ed self-insu	(b) SSN	heck the b	DOX and enter (c) DOB (If SSN is not available)	the informat (d) Covered all 12 months				(e) Months of		ug Sep	ot Oct	Nov Dec
(a) Name of	loyer provide	ed self-insu	ired coverage, c	heck the b	DOX and enter (c) DOB (If SSN is not available)	the informat (d) Covered all 12 months				(e) Months of		ug Sep	pt Oct	Nov Dec
(a) Name of	loyer provide f covered individ	ed self-insu lual(s)	ired coverage, c	theck the b	DOX and enter (c) DOB (If SSN is not available)	(d) Covered all 12 months				(e) Months of		ug Sep	ot Oct	Nov Dec
(a) Name of	loyer provide	ed self-insu	(b) SSN	heck the b	DOX and enter (e) DOB (if SSN is not available)	(d) Covered all 12 months				(e) Months of		lg Sep	ot Oct	Nov Dec
(a) Name of	loyer provide	ed self-insu lual(s)	(b) SSN	theck the b	DOX and enter (c) DOB (if SSN is not available)	(d) Covered all 12 months				(e) Months of		ng Sep	Dt Oct	Nov Dec
(a) Name of	loyer provide	daiself-insu	red coverage, c	heck the b	DOX and enter (c) DOB (if SSN is not available)	(d) Covered all 12 months				(e) Months of		ng Sep	Dt Oct	Nov Dec
(a) Name of	f covered individ	ed self-insu	red coverage, c	heck the b	DOX and enter (c) DOB (if SSN is not available)	the informat (d) Covered all 12 months				(e) Months of		ug Sep	ot Oct	Nov Dec
(a) Name of	loyer provide	adis adis-insu	(b) SSN	sheck the b	DOX and enter (c) DOB (if SSN is not available)	the informat (d) Covered all 12 months				(e) Months of		ug Sep	pt Oct	Nov Dec
(a) Name of	loyer provide	adiself-insu	red coverage, c	sheck the b	DOX and enter (e) DOB (if SSN is not available)	the informat (d) Covered (a) 12 months				(e) Months of		ag Sep	ot Oct	Nov Dec
(4) Name of	loyer provide	ad self-insu	red coverage, c	heck the b	DOX and enter (c) DOB (f SSN is not available)	the information (d) Covered all 12 months				(e) Months of		ag Sep	ot Oct	Nov Dec
(a) Name of	loyer provide	da self-insu uual(s)	red coverage, c	theck the b	DOX and enter (ic) DOB (if SSN is not available)	(d) Covered all 12 months				(e) Months of		JO Sep	ot Oct	Nov Dec
(a) Name of	loyer provide	da self-insu uual(s)	ired coverage, c	theck the b	DOX and enter	the informati (d) Covered all 12 months				(e) Months of		JO Sep	ot Oct	Nov Dec
	loyer provide	ed self-insu			The available	the information (d) Covered all 12 months				(e) Months of		ag Seg	ot Oct	Nov Dec
(a) Name of	loyer provide	ed self-insu			The available	(d) Covered all 12 months				(e) Months of		ag Seg	ot Oct	Nov Dec

Part Applicable Large Employer Member (ALE Memb	oer)		
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	
Name of Designated Government Entity (only if applicable)		10 Employer identification number (EIN)	
11 Street address (including room or suite no.)		·	F 045-1-111 0h-
			For Official Use Only
12 City or town	13 State or province	14 Country and ZIP or foreign postal code	
			$\mathbf{n}$
15 Name of person to contact	·	16 Contact telephone number	шшшшш
17 Reserved			
17 heserved			
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	
19 is this the authoritative transmittal for this ALE Member? If Te	s, check the box and continue.	ii ivo, see iristructions	

- 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

Part   ALE Member Information			
20 Total number of Forms 1095-C filed by an	d/or on behalf of ALE Member		•
21 Is ALE Member a member of an Aggregate	ed ALE Group?		Yes No
If "No," do not complete Part IV.			
22 Certifications of Eligibility (select all tha	t 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 exam	ined this return and accompanying documents, and to	o the best of my knowledge and belief, they are true, com	ect, and complete.
) <del>-</del>		) <u>-                                   </u>	
Signature	▼ Title	Date	

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



		er Information—N (a) Minimum Ess Offer In	sential Coverage adicator	(b) Full-Time Employee Count	(c) Total Employee Count	(d) Aggregated Group Indicator	(e) Section 4980H
		Yes	No	for ALE Member	for ALE Member	Group Indicator	Transition Relief Indicator
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						

- 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

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 apar	tment no.)		9 Street address (including room	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 Emp	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																
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

Part II Emp								Month (Ente	r 2-digit num	ber):			
	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	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	(d) Covered							of Covera						
	,,	(5) 55.1	not available)	all 12 months	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/

#### **Contact Information**



Val Amberg, CHRS
CDSA Managing Partner
vamberg@cdscpa.com
320-214-2922



CPP, CHRS
Payroll Manager
mhanson@cdscpa.com
320-214-2947



Kate Sietsema
Employee Benefits
Administrator
ksietsema@cdscpa.com
320-214-2949



Becky Meyer
Payroll Assistant
bmeyer@cdscpa.com
320-214-2920