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RECENT DEVELOPMENTS IN EMPLOYEE BENEFITS AND EXECUTIVE COMPENSATION

(Note that this Outline is not intended as legal advice for any particular situation.)

I. Annual Reporting Required by the ACA; Forms 1094 and 1095

Background. The ACA added two reporting requirements to the Internal Revenue Code which are designed to aid the IRS in its enforcement of the individual and employer mandate requirements under the ACA and to administer the premium tax subsidies for exchange coverage.

Code Section 6055 provides that every provider of minimum essential coverage (MEC) (including health insurance insurers and plan sponsors of self-insured plans) must report coverage information by filing an information return with the IRS and providing a statement to relevant individuals. This reporting is intended to aid the IRS in its enforcement of the ACA's individual coverage mandate.

Code Section 6056 requires applicable large employers (ALEs) that are subject to the "play or pay" requirements, to file information returns with the IRS and provide statements to their full-time employees about the health insurance coverage the employer offered. This reporting is intended to aid the IRS in its enforcement of the ACA's employer mandate and to help the IRS administer the premium assistance tax credit.

Form 1095-B (Health Coverage) and Form 1094-B (Transmittal of Health Coverage Information). Form 1095-B is the return used for reporting MEC under Code Section 6055 to the IRS and for furnishing coverage information to covered individuals. Form 1094-B is the transmittal form filed with the IRS along with all of the Form 1095-Bs. The 1095-B and 1094-B forms are required to be filed by insurance companies to report individuals covered by insured employer-sponsored group health plans and by small employers with self-funded health plans.

Form 1095-C (Employer-Provided Health Insurance Offer and Coverage) and Form 1094-C (Transmittal of Employer-Provided Health Insurance Offer and Coverage). Form 1095-C is the return used to report information required under Code Section 6056 to the IRS and for furnishing information about the employer's offer of health coverage to its full-time employees. Form 1094-C is the transmittal form filed with the IRS along with all of the Form 1095-Cs, and provides information to the IRS regarding potential employer mandate penalties. The Form 1095-C and 1094-C forms are required to be filed by ALEs (i.e., employers having on average at least 50 full-time employees, including full-time employee equivalents, during the preceding calendar year). Small employers with fewer than 50 full-time employees (including full-time employee equivalents) will be required to file Forms 1095-C and 1094-C if they are members of a controlled group or affiliated service group that collectively has at least 50 full-time employees (including full-time employee equivalents). Applicable large-employer-group members must prepare a Form 1095-C for each full-time employee regardless of whether the employee is participating in an employer group health plan. In addition, a Form 1095-C must be completed for each non-full-time employee who is enrolled in the employer's self-insured health plan.

The information required to be reported on the Form 1095-C is extensive and includes the following: (1) identifying information for the ALE member and the employee (including the employee's Social Security number); (2) month-by-month information as to whether the employee and family members were offered health coverage that met the minimum value standard; (3) whether the employee was a full-time employee each month; (4) the employee's share of the monthly premium for the lowest-cost minimum value health coverage offered; and (5) whether one of the three safe harbor affordability measures applied with respect to the coverage offered to the employee or whether the employer relied on one of the employer mandate transition rules. In addition to serving as the transmittal form for the submission of the Form 1095-Cs, the Form 1094-C includes the following information: (1) employer's name, address, EIN contact person and the names and EINs of other employers that are in the employer's controlled group or affiliated service group; (2) total number of Forms 1095-Cs filed with transmittal; (3) certification by month as to whether the employer offered its full-time employees and their dependents the opportunity to enroll in minimum essential coverage; (4) the number of full-

time employees for each month; (5) the total number of employees for each month; and (6) whether transition relief applies to the employer.

Filing Deadline. The due date for filing the Forms with the IRS and providing information to employees track the Form W-2 rules. The information must be filed with the IRS by February 28 (March 31, if filed electronically), and the individual statement must be provided to employees by January 31 of the year following the year in which coverage is provided. Reporting will be required in early 2016 with respect to calendar year 2015. Note that employers with non-calendar year plans who qualify for delayed implementation of the employer mandate rules until the start of their 2015 plan year must still report for the entire 2015 calendar year. Also, reporting for 2015 is required for ALEs who qualify for the one-year delay in the employer mandate rules because they have more than 50, but fewer than 100 full-time employees.

II. Form 8928 Obligations of Employers

A. Background. The Internal Revenue Code imposes excise taxes for failures to comply with various health plan-related Code requirements. Persons liable for an excise tax under one of these Code provisions (e.g., employers, third party administrators or the plan itself) are required to self-report the failures using IRS Form 8928.

B. Form 8928 Compliance Failures. The compliance failures subject to Form 8928 reporting include the following:

1. COBRA administration errors. (Special rules are provided concerning how to report multiple COBRA notice and other operational failures occurring in a single year.)
2. Failures to provide required pediatric vaccine coverage.
3. Failures relating to HIPAA portability and nondiscrimination requirements.
4. Failures relating to minimum hospital stays for mothers and newborns under the Newborns' and Mothers' Health Protection Act.
5. Failures relating to required benefits under the mental health/substance abuse parity rules.
6. Failures under the HSA comparability rules.
7. Failures under the Genetic Information Nondiscrimination Act (GINA)
8. Failures under Michelle's Law.
9. Failures relating to various Affordable Care Act group health plan reforms, including, but not limited to: no waiting periods in excess of 90 days, rules on access to primary care providers and emergency room, coverage of preventative care without cost-sharing, uniform SBC requirements, improved claims and appeal rules, including external review requirements, and removal of annual dollar limits and removal of pre-existing condition limits.

The excise tax amounts vary depending upon the violation. Generally, the excise tax for noncompliance with rules related to COBRA, ACA's group health plan reforms, HIPAA, GINA, Newborns' and Mothers' Health Protection Act and Michelle's Law is $100 per day per affected individual. There are some exceptions to the excise taxes. Excise taxes may not apply if the employer can demonstrate that it did not know (and in exercising reasonable diligence, would not have known) that there was a compliance failure, or if the compliance failure was due to reasonable cause and was corrected within 30 days after the employer knew (or in exercising reasonable diligence, should have known) that the failure existed. A compliance failure is "corrected" if it is retroactively undone to the extent possible and the affected individual is placed in a financial position as good as he or she would have been in had the failure not occurred.

C. Filing Obligations. In general, Form 8928 must be filed on or before the filer's due date for filing its federal income tax return (without extensions). However, if the Form 8928 relates to the failure to comply with the comparable HSA contributions requirement, the deadline for filing the Form 8928 is the 15th day of the fourth month following the calendar year in which the noncomparable contributions were made. An automatic 6-month extension is available by filing IRS Form 7004 on or before the deadline for the IRS Form 8929. However, obtaining the extension to file the Form 8928 does not extend the time to pay any excise taxes due. Note that compliance failures which meet the requirements for exemption from excise taxes (e.g., failures attributable to reasonable cause and corrected within 30 days) still must be reported on Form 8929. Failure to timely file the Form 8928 results in a penalty of 5% of the unpaid excise tax per month late, up to 25%. Failure to timely pay any excise taxes due results in a penalty of .5% of the unpaid excise tax amount per month late, up to 25%. Both of these penalties may be waived for reasonable cause. Late excise tax payments are also subject to interest at the variable underpayment rate set by the IRS.

D. Next Steps. The Form 8928 self-reporting obligation makes compliance with group health plan requirements more

important than ever. Because the IRS and CPAs that audit plans and employers have "discovered" the Form 8928 requirement, and because the excise taxes paid with the filing of the Form and the late penalties for not filing the Form are so onerous, employers have no practical alternative other than ensuring that their health plans satisfy all of the compliance requirements the failure of which could be reported on the Form. The compliance obligations which are the subject of the Form create a useful "self-diagnostic checklist" for employers that sponsor employee health plans. This "checklist" should be used to implement procedures and processes that are designed to reasonably ensure compliance. Of course, if a compliance failure occurs nonetheless, the employer and other responsible parties must take prompt action to correct the failure within 30 days.

III. Controlled Group/ASG/Predecessor Employer Determinations

A. Statutes and regulations provide numerous ways in which regulators can aggregate employers for purposes of various legal requirements. As they pertain to health and welfare benefits, a few of these legal requirements include:

1. In order to perform annual nondiscrimination testing for a Section 125 plan or for a welfare benefit plan, the Plan sponsor must know whether it is part of a "controlled group" or "affiliated service group" with any other entities. If it is, then all entities must be included in the testing.

2. In order to count employees for purposes of the health care reform 50 full-time employee test, a Plan sponsor must know whether it is part of a "controlled group" or "affiliated service group". If it is, then all members of the controlled group or affiliated service group have to be included in determining the employee count. Health care reform also requires aggregation of a "predecessor employer" for that purpose (see E, below).

3. In order to determine eligibility for the small employer health insurance credit, a Plan sponsor must know whether it is part of a "controlled group" or "affiliated service group". If it is, then all members of the controlled group or affiliated service group have to be included in determining the employee count.

4. For purposes of answering the questions on its Form 5500 filing, a Plan sponsor must know whether it is part of a "controlled group" or "affiliated service group".

B. Determining its controlled group, affiliated service group or predecessor employer status is the Plan sponsor's responsibility. In an IRS or DOL audit, the auditor will expect that the Plan sponsor knows whether it and any related entities are a "controlled group" or "affiliated service group". Sometimes this determination has already been done for retirement plan purposes. If not, with health care reform mandates and DOL/IRS audits of welfare plans looming, now is the time.

C. A controlled group of entities includes the following (note: this is a generalized description of extremely complex rules):

1. A parent/subsidiary controlled group exists if an entity owns (directly or indirectly) 80% or more of another entity (or entities).

2. A brother /sister controlled group exists if the same 5 or fewer persons own (directly or indirectly) 80% or more of two or more entities and, taking into account only identical ownership, those persons own more than 50% of the entities.

D. An affiliated service group of entities includes the following (again note: this is a generalized description of even more complex rules):

1. An A-Org affiliated service group consists of a service organization (the FSO) and any other service organization (the A-Org) which is a shareholder or partner in the FSO and which either regularly performs services for the FSO or is regularly associated with the FSO in performing services for third parties.

2. A B-Org affiliated service group consists of a service organization (the FSO) and any other organization (the B-Org) if a significant portion of the B-Org's business is the performance of services for the FSO of a type historically performed by employees and 10% or more of the B-Org is owned by highly compensated employees of the FSO.

3. A management service organization consists of an organization the principal business of which is performing management functions for another organization (or group or related organizations) (or group of related organizations).

E. Health care reform picked up "predecessor employers" in the rules for counting employees. The current IRS regulations do not define "predecessor employer". The regulations do suggest that eventual regulations will adopt rules similar to the rules for identifying successor employers in the employment tax context. Until further guidance is issued, employers may rely on a reasonable, good faith determination of the statutory provision on predecessor employers for purposes of determining whether there are 50 FTEs.

IV. Independent Contractors, "Contingent Workers," Temporary Employees: Issues for Employers

Under the employer mandate, a large employer, subject to the mandate, must offer employer mandate-compliant coverage to each "full-time employee" and his or her dependents or potentially face a penalty if a full-time employee receives subsidized exchange coverage. For this purpose, the IRS looks at each common law employee of an employer, regardless of whether the individual in question has been categorized by the employer as an independent contractor, contingent worker, or temporary employee.

A. Independent contractors (individuals that perform services for an entity but who are not treated by that entity as common law employees) have long been an issue of serious interest to the IRS. In an audit, an IRS agent often asks to see all 1099 forms that the business wrote to individuals, rather than entities.

B. Contingent Workers. In order to avoid an employer mandate penalty with respect to a contingent worker, the staffing company – and not the worksite employer - must be the common law employer.

C. Temporary Employees. Many welfare plans have long excluded "temporary employees". As a result, many employers are used to having flexibility to label an individual as "temporary" and exclude him/her from coverage.

1. Final pay or play regulations provide that any individual who is reasonably expected to work 30 or more hours per week must be treated as a full-time employee, even if the employer knows or anticipates that he or she will not be a long term employee. In other words, the fact that the employee has a fixed termination date is ignored.

2. Under the waiting period rules, such a temporary employee can be excluded for up to 90 days without triggering a penalty. However, all applicable nondiscrimination rules have to be considered in deciding whether some employees can be excluded for 90 days if other employees have a shorter waiting period.

3. An exception to this general rule is that "seasonal employees" can be treated as variable hour employees, which means most of them will never have to be offered coverage.

V. ACA "Change in Employee Status" Rules. Employers often have employees who move from full-time to part-time status during the employee's period of employment. This presents a challenge for employers who are subject to the employer mandate because of the general rule that requires that the employer treat an employee who is determined to be a full-time employee during a measurement period as a full-time employee during the entire following stability period - even if the employee's hours are reduced significantly during the stability period. However, there is an optional change in status rule that employers may choose to utilize for employer mandate purposes. This optional rule permits an employer to cease offering employer mandate-compliant coverage to an employee following his or her change to part-time status as long as (i) the employer has offered a full-time employee health plan coverage that provides minimum value by the first day of the fourth calendar month following the employee's date of hire through the calendar month in which the employee has a change to part-time status and (ii) the employee actually averages less than 30 hours of service per week during the three full calendar months following the change from full-time to part-time employment.

Assuming the above two requirements are satisfied, the employer may apply the monthly measurement period rules to the employee as of the first day of the fourth full calendar month following the change in status through the end of the first full measurement period (plus administrative period) following the change in status. In other words, once the employee is subject to the monthly measurement period rules, the employer does not need to offer the employee employer mandate-compliant coverage to the employee for any month as long as the employee does not average 30 or more hours a week during that month.

VI. Recent Cadillac Tax Guidance. The IRS recently issued guidance on the ACA's "Cadillac plan" excise tax that becomes effective in 2018. (One survey estimated that 17% of U.S. employers will be affected if they do not-re-design their plans before 2018.) This ACA provision imposes a non-deductible excise tax on these Cadillac plans equal to 40% of the excess of the "value" of the plan over the ACA's Cadillac plan limit of $27,500 family/$10,200 self-only (as adjusted). For current planning purposes, this guidance makes clear that employers may use the COBRA rate (less the 2% administrative charge) as the "value" for Cadillac tax purposes, but employers should monitor future guidance which could change this. The most disappointing provision of the guidance states that "employer contributions to Health Savings Accounts, including salary reduction contributions" are included in amounts that need to be valued for Cadillac tax purposes. (This is in addition to other guidance suggesting that employee HFSA contributions will need to be counted, as well.)

VII. New Summary of Benefits and Coverage Guidance. Since late 2012, the ACA has required employers to provide health plan participants a new overview document -- the so-called "Summary of Benefits and Coverage". The SBC was designed to allow for an "apples to apples" comparison of the key features of health coverage. The regulators recently issued rules to make the SBC more "user-friendly". For example, while the new SBC template has been streamlined to remove outdated references such as to annual limits and pre-existing condition exclusions, it also adds a new coverage example regarding a broken foot to show how the plan might operate when the participant has an emergency. (This example is in addition to the two current examples of having a baby and managing diabetes.) Importantly, the regulations (among other things) would end the enforcement safe harbor for information regarding MEC and MV and allow for electronic delivery of the SBC in certain circumstances.

The regulations also clarify the rules surrounding when a plan must provide the SBC again if the plan already provided the SBC prior to application (e.g., if a plan provides the SBC prior to application for coverage, the plan is not required to provide another copy automatically unless there is a change in the information).

VIII. Update on Opt-out Credit Guidance. Last year, the regulators published guidance regarding employers who provide opt-out bonuses to high claim health plan participants. In very general terms, these employers were approaching high claim participants in their health plan and providing them with an additional benefit not available to low claim participants; namely, an unrestricted, taxable cash opt-out bonus if they decide not to participate in the employer's health plan. In the guidance, the DOL, the IRS and the HHS announced their view that this large claimant variation on the opt-out concept violates several laws. In essence, the regulators concluded that offering this additional option to large claimants actually "discriminates" against them (rather than in favor of them) by "increasing" their required contribution for plan participation. The regulators supported their position by arguing that these large claimants have to "effectively pay more" to participate in the plan than low claimants not offered the bonus, because the large claimants have to make the same contribution as the low claimants in order to participate in the plan, plus "forego" their bonus amount, which the regulators characterize as an "additional contribution" imposed only on them.

In November, the regulators issued additional guidance generally interpreted to provide that amounts paid by employers to employees who opt-out of the employer's health plan must be treated as additional employee contributions for purposes of the affordability component of the ACA's employer mandate rules. This position is a radical departure from conventional notions of "employee cost," and therefore it is unlikely that employers with these arrangements have considered the cash-out amount available to employees who waive coverage as part of the cost calculation for employees who do not waive coverage. (These rules are also applicable to many arrangements where the employer makes available consideration (e.g., "benefits credits") other than cash to employees who waive health plan coverage.) The unfortunately convoluted text of the regs is best illustrated by the following example:

-An employee's required contribution for individual coverage under the employer's health plan is $90 per month. The employer offers a cash opt-out payment of $50 per month to the employee if health plan coverage is declined. The "cost" to the employee for purposes of determining ACA affordability is $140 (not $90).

IX. Rules Regarding Health Expense Reimbursement Plans. The IRS has issued a series of pronouncements (starting with IRS Notice 2013-54) concluding that employer payment plans (i.e., generally the reimbursement by employers of employee-paid health premiums, or the direct payment by employers of premiums for individual health policies for employees), violate the ACA and subject the employer to significant penalties. In late February, the IRS released Notice 2015-17 reaffirming its prior position and providing some "limited transitional relief" from this rule for small employers. (For this purpose a small employer is an employer with fewer than 50 "full-time employees" as measured under the

complex employer mandate rules.) The new relief provides that small employers with plans reimbursing or paying individual health policy premiums or Medicare Part B or Part D premiums will not incur ACA penalties for 2014 and for the period January 1-June 30, 2015. This relief does not extend to stand-alone HRAs. While the IRS also created a special exception for plans that reimburse or pay premiums for 2% or greater S corporation shareholders, exempting them for the applicable ACA penalties through December 31, 2015, the IRS indicated that it is considering publishing additional guidance on this issue, as well as the federal tax treatment of such arrangements.

X. Recent Case Law on SPDs v. Governing Plan Documents. In CIGNA v. Amara (2011), the Supreme Court muddied the on-going, and often perplexing, controversy concerning what controls when the terms of an ERISA plan document are different than statements contained in SPDs, employee communications, benefit statements, and the like. Although the language of the opinion in CIGNA v. Amara is often ambiguous, the case seems to stand for two, potentially conflicting concepts. First, the Court concluded that summary materials about a plan are not the legally binding plan itself, appearing to reinstate the longstanding, but occasionally recently ignored, rule that the formal plan document controls the SPD in the event of any conflict. However, the Court sent the case back to the lower courts for those courts to determine if some act or omission of the employer – presumably including faulty participant communications – caused harm to the plaintiff and therefore entitles the plaintiff to recover money damages from the employer.

A handful of post-Amara cases have held that the terms of a SPD are enforceable so long as they do not conflict with the governing plan documents. Recently, in Stiso v. Int'l Steel Group (6th Cir. 2015), a participant sued both his employer and the insurance company with respect to a long-term disability ("LTD") policy that had been purchased by the employer. The participant alleged an ERISA breach of fiduciary duty for the failure to increase LTD benefits in accordance with the terms of the summary plan description. The U.S. Court of Appeals for the Sixth Circuit ruled that the employer (1) functioned as an ERISA fiduciary when it prepared and distributed the SPD to participants, and (2) breached its fiduciary duty by furnishing the participant with a misleading SPD. The court remanded the case back to the district court with instructions to grant the increase in benefits to the participant.

A 2015 COMPLIANCE CHECKLIST FOR HEALTH AND WELFARE PLANS

The following are some important 2015 compliance tasks for sponsors of health and welfare benefit plans. (Naturally, this Checklist is not meant to provide a comprehensive list of all compliance requirements.)

___1. Review plan documents, SPDs and other communications to be sure there are no conflicts among these documents, in light of CIGNA v. Amara and its progeny.

___2. Confirm procedures in place for required Forms 1094/1095 reporting.

___3. Identify any controlled group/ASG/ /predecessor employer situations, and independent contractor/contingent worker/temporary employee issues.

___4. Confirm compliance with all applicable ACA obligations to date, and prepare for future changes. (Note the numerous, and often onerous, penalties for non-compliance.)

___5. Confirm especially compliance with 30-hour employee determination rules/change of status rules.

___6. Ensure compliance with any Form 8928 reporting obligations.

___7. Monitor ongoing compliance with health and welfare plan nondiscrimination rules (e.g., ACA, Section 125, Section 105(h), Section 129, Section 79, etc.).

___8. Begin planning for ACA Cadillac tax.

___9. Ensure compliance with new SBC rules.

___10. Consider recent guidance on opt-outs, benefit dollars, no-benefit employees, contractor cash-in-lieu, etc.

___11. Eliminate non-compliant health reimbursement plans.

___12. Ensure compliance with ERISA, Code, FMLA and Title VII requirements in light of same sex marriage rulings.

A 2015 COMPLIANCE CHECKLIST FOR QUALIFIED RETIREMENT PLANS

The following are some important 2015 compliance tasks for sponsors of qualified retirement plans. (Naturally, this Checklist is not meant to provide a comprehensive list of all compliance requirements.)

___1. Ensure compliance of cash balance/hybrid plans with most current regulations.

___2. Ensure ongoing compliance of frozen or closed defined benefit pension plans.

___3. Review procedures against fiduciary best practices standard.

___4. Review plan documents, SPDs and other communications to be sure there are no conflicts among these documents, in light of CIGNA v. Amara and its progeny.

___5. Review the plan's hardship documents and procedures (if applicable).

___6. Review and document, on a regular basis, all participant-directed retirement plans' compliance with the 404(c), QDIA and fee disclosure requirements.

___7. Consider de-risking strategies for defined benefit pension plans.

___8. If 401(k) ADP and/or ACP challenges, or 403(b) ACP challenges, consider an auto-enrollment feature.

___9. If appropriate, consider whether a defined benefit pension plan is desired, either in lieu of or in addition to a defined contribution plan.

___10. Consider plan design features that focus employer retirement plan budgets on key performers.

___11. Consider a self-diagnostic to determine if qualified retirement and 403(b) plans are in full compliance with all applicable requirements. If any operational or document failures are discovered, consider correction programs (IRS and DOL) for bringing the plan back into full compliance, especially the expanded EPCRS program and the options for employers that remit employee contributions late. Use this process to anticipate increased likelihood of DOL and IRS qualified retirement and 403(b) plan audits.

___12. Defined benefit plans should ensure compliance with final funding notice rules.

___13. If applicable, consider developments in "governmental plan" and "church plan" definitions.

___14. Confirm compliance with DOL position on revenue sharing proceeds/ERISA spending accounts.

___15. Review guidance and procedures on lost participants, plan floats, uncashed checks.

___16. Ensure compliance with electronic distribution rules.

___17. Ensure compliance with ERISA, Code, and Title VII requirements in light of same sex marriage rulings.

A 2015 COMPLIANCE CHECKLIST FOR EXECUTIVE COMPENSATION PLANS

The following are some important 2015 compliance tasks for sponsors of executive compensation plans. (Naturally, this Checklist is not meant to provide a comprehensive list of all compliance requirements.)

___ 1. Review Section 409A document and operational compliance. Pay particular attention to separation from service issues, executive employment agreements, split-dollar life insurance, severance arrangements, the 2-1/2 month bonus exemption, post-employment reimbursements and in-kind benefits, "disability" deferred compensation, and the like.

___ 2. If Section 409A non-compliance is discovered, utilize (if applicable) the IRS "amnesty" program.

___ 3. If employer-sponsor is in financial "distress," ensure that nonqualified plans are not funded in violation of PPA distressed employer rules.

___ 4. Consider offering executives voluntary deferred compensation and/or phantom stock/stock appreciation plans.

___ 5. Where applicable, ensure that nonqualified plans are properly coordinated with 401(k) plans.

___ 6. If a 501(c)(3) or 501(c)(4) employer, perform self-diagnostic to ensure that intermediate sanctions rules are being complied with – including the reporting of taxable fringe benefits and the inclusion of benefits in market comparability testing -- and that the compliance is well-documented, and ensure that extensive new executive compensation questions on the annual Form 990 are answered completely in the manner that best portrays the "optics" of the nature of, and care taken with respect to, the employer's executive compensation programs. Have ERISA counsel review Form 990 disclosures before they are filed with the IRS.

___ 7. Review participants in executive deferred compensation plans to ensure that they are limited to members of your top-hat group.

___ 8. Ensure that all nonqualified plans – whether 451 plans, 457(b) plans, 457(f) plans, etc. -- have up-to-date administrative forms, and that comprehensive and correct procedures are in place for their use.

___ 9. Review documentary and operational compliance of any 457(b) plan in light of nationwide IRS field review. Governmental 457(b) plan sponsors should consider whether EPCRS provisions are applicable.

___ 10. Review Domestic Relations Order procedures of nonqualified plans.

___ 11. Review compliance with tax reporting rules applicable to nonqualified plans, with special attention to FICA/Medicare issues.

___12. Ensure compliance with Code and Title VII requirements in light of same sex marriage rulings.

6055/6056 ACA REPORTING – A SUMMARY OVERVIEW

For these purposes, "small" and "large" mean, for all years, under 50 "FT" and 50 or more "FT," as defined in the employer mandate rules.

B SERIES: Both of the B series of Forms (1094-B and 1095-B) deal with MEC reporting. These forms are used only:

(a) by employers for small self-funded plans; and

(b) by carriers for fully insured plans of any size.

C SERIES: Both of the C series of Forms (1094-C and 1095-C) are only used by large employers. Large self-funded employers complete Part III of the 1095-C to report MEC. Large fully insured employers do not complete Part III of the 1095-C.

I. ***SMALL FULLY INSURED EMPLOYER*** – No reporting. (Carrier does everything – files the 1094-B and 1095-B with the IRS and provides a copy of the Form 1095-B to each applicable employee.)

II. ***SMALL SELF-FUNDED EMPLOYER*** –

1. Provide 1095-B for calendar 2015 to each covered employee and non-employee (e.g., retirees, non-employee COBRA beneficiaries, etc.) by 1/31/16 (actually 2/1/16 because 1/31 is a Sunday).

2. File 1094-B and 1095-B for calendar 2015 with IRS by 2/29/16, or by 3/31/16 if filing electronically. (Must file electronically if 250 or more 1095-Bs are issued.)

III. ***LARGE FULLY INSURED EMPLOYER*** –

1. Provide 1095-C for 2015 (with Part III blank) to each FT by 1/31/16 (actually 2/1/16 because 1/31 is a Sunday). (Carrier must provide 1095-B, reporting MEC, to each insured employee.)

2. File 1094-C and 1095-C for calendar 2015 with IRS by 2/29/16, or by 3/31/16 if filing electronically (but with 1095-C, Part III blank)

IV. ***LARGE SELF-FUNDED EMPLOYER*** –

1. Provide 1095-C for 2015 to each FT, and to each other covered employee and non-employee, by 1/31/16 (actually 2/1/16 because 1/31 is a Sunday). (The requirement to provide the 1095-C to each covered employee and non-employee, rather than only to FTs, is only implied at this point.)

2. File 1094-C and 1095-C for calendar 2015 with IRS by 2/29/16, or by 3/31/16 if filing electronically. (Complete Part III to report MEC for any individual who had coverage under the plan. This includes FTs, PTs, family members and others, including "non-employees", such as retirees and non-employee COBRA beneficiaries.)