For Your Benefit

A newsletter on current legal issues impacting employee benefits and executive compensation

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SPRING 2016

DOL Releases Final Fiduciary Rule

By Harvey M. Katz, Brian G. Belisle and Michael McGovern

On April 6, 2016, the U.S. Department of Labor (DOL) released the final version of the investment advice fiduciary regulations that were proposed last April. The rule is aimed at addressing conflicts of interest in retirement advice by redefining fiduciary investment advice and expanding its application to include investment advice provided to plan sponsors and participants of retirement plans, including 401(k) plans, and individual retirement accounts (IRAs). Labor Secretary Thomas Perez indicated that the DOL had received more than 300,000 comments since the proposed version of the rule was release last April and, ultimately, the final rule provides significant concessions to the financial industry.

In This Issue:

Under the expanded final rule, it is a fiduciary function to render the following types of investment advice for a fee or other compensation: (1) a recommendation as to the advisability of buying, selling or holding investments; (2) a recommendation as to the advisability of taking a distribution and the investment of the distributed assets; (3) a recommendation as to the management of investments; and (4) a recommendation on the selection of other persons to provide investment advice or investment management services. Thus, the rule may significantly affect rollovers from 401(k) and other defined contribution plans to IRAs, as the recommendation of a distribution or a rollover to an IRA will now be considered a fiduciary act.

Because the provision of investment advice is a fiduciary function under the final rule, absent a specific exception, receipt by a fiduciary adviser of commissions, revenue sharing or other payments is a prohibited transaction section 406(b) of ERISA. Under the new regulatory scheme, fiduciary advisers will be allowed to receive such "conflicted compensation" only if their compensation arrangement meets the specific requirements of one of the series of prohibited transaction exemptions issued in conjunction with the regulations.

The new set of prohibited transaction exemptions and amendments to existing exemptions are designed to permit receipt of compensation for the covered investment advice, albeit under more narrowly prescribed requirements. Advisers providing such covered investment advice to retirement plan participants and beneficiaries, IRA owners and non-institutional fiduciaries are expected to utilize the "best interest contract" exemption, which has been significantly modified from the original proposal. In essence, the exemption requires giving advice that is in their clients' "best interests" and requires disclosure of any potential conflicts of interest, and limits the fiduciary's remuneration to no more than "reasonable compensation." The adviser must also enter into contracts with clients that acknowledge the adviser's fiduciary status.

Primarily as a result of the extensive comments, activities such as marketing, investment education, appraisals, ESOP valuations and fairness opinions, and advice to health and welfare plans have generally been carved out from the definition of covered investment advice and, thus, are not considered fiduciary functions under the new rule.

Another major concession by the DOL to the retirement community is that the effective date for the final rule has been delayed. The proposed rule called for an eight-month compliance period. The new rule, however, calls for compliance of certain provisions by April 2017, and total compliance by January 1, 2018. Accordingly, we expect to see continued comments and potentially some clarifications or modifications on the final rule in the coming months.

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Cross-Tested Plans Survive a Major Challenge

By Susan Foreman Jordan

In general, the favorable tax treatment afforded to the participants and sponsor of a qualified retirement plan are contingent upon the plan satisfying certain statutory and regulatory requirements, including the prohibition against discrimination in favor of highly compensated employees. Compliance with this requirement can be tested by any of a number of alternative methods prescribed by the regulations.

Typically, defined contribution plans are evaluated with reference to the allocation of contributions. However, they may be tested by converting the contributions allocated to participants to equivalent benefits, using a permissible interest rate. Likewise, defined benefit pension plans and defined contribution plans may be aggregated and tested as a single plan using similar methodology. This is referred to as "cross-testing."

One popular cross-tested plan design often is referred to as "new comparability." This, typically, is a defined contribution plan that assigns participants to allocation or rate groups for allocation purposes and thereby is able to provide greater contribution amounts for older and more highly compensated employees while nevertheless satisfying the non-discrimination requirement by converting those contributions to equivalent benefits and testing on that basis. Over time, the IRS has imposed additional requirements on new comparability plans, including a "minimum gateway" requirement with higher minimum contribution amounts for non-highly compensated employees, while granting additional flexibility, even extending to the assignment of each participant to a separate allocation group. These plan designs have proven to be enormously popular.

At the same time, the growing trend has been a transition away from traditional defined benefit pension plans toward defined contribution plans (including new comparability plans) and cash balance pension plans. Many employers that previously maintained traditional defined benefit plans have closed those plans to new employees while allowing those who previously participated to continue to accrue benefits. However, it becomes increasingly difficult for these closed plans to continue to satisfy the nondiscrimination requirements as the group of grandfathered employees (who continue to accrue benefits under the plan) tends to become more highly compensated, as compared to the total workforce, based on ordinary demographic changes and the passage of time.

In January of this year, the IRS issued *proposed* regulations that were designed to make it easier for these closed plans to meet the nondiscrimination requirements. While welcomed in those situations, the proposed regulations could adversely impact all cross-tested plans, particularly new comparability plans, because they require that, for nondiscrimination testing purposes, each allocation group must satisfy the "reasonable classification" requirement.

As explained by the regulations, reasonable classifications generally include specified job categories, nature of compensation (i.e., salaried or hourly), geographic location and similar bona fide business criteria. An enumeration of employees by name or other specific criteria having substantially the same effect as an enumeration by name is not considered a reasonable classification.

A plan that places each employee in a separate allocation classification or group, by its very nature, cannot satisfy the reasonable classification requirement. Likewise, no classification that has the same effect as naming individuals could satisfy the requirement. Consequently, the proposed regulations, were they to be implemented, would necessitate substantial restructuring of most new comparability plans (and other cross-tested plans) and, no doubt, would result in significantly higher employer contribution rates, making those plan designs far less effective and desirable.

Understandably, the benefits community was alarmed and quickly mobilized its members to lobby the Treasury Department, IRS and Congressional staff and engaged plan sponsor groups in petition and letter-writing campaigns. These efforts were rewarded with the publication, on April 14, of Announcement 2016-16, by which the Treasury Department and IRS announced that they would withdraw the provisions of the proposed regulations relating to the nondiscrimination rules while retaining the relief for closed pension plans.

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Supreme Court Rules ERISA Pre-empts Vermont All-Payer Claims Database

By T.J. Lang

In a decision handed down on March 1, 2016, the United States Supreme Court (the Court) ruled 6-2 that ERISA pre-empts a Vermont statute requiring entities that provide and pay for health care to report information to the state insofar as the statute applies to ERISA plans. The case is *Gobeille v. Liberty Mutual Insurance Company*.

In 2005, Vermont passed a statute requiring "health insurers" to report to state officials information on health care costs, prices, quality, claims and enrollment for use in evaluating the cost and quality of care provided to Vermont residents. Under the law, "health insurers" included self-insured benefit plans and third-party administrators of such plans. Health insurers serving 200 or more Vermont residents are required to remit plan information to state officials for consolidation into what is known as an all-payer claims database.

Liberty Mutual Insurance Company (Liberty Mutual) sponsors a self-funded medical plan to some 137 Vermont residents and was only a voluntary reporter under the Vermont law. Its third-party plan administrator, Blue Cross Blue Shield of Massachusetts (Blue Cross), however, serves several thousand Vermont residents. As a result, Blue Cross was a mandatory reporter under the law. In 2011, Liberty Mutual ordered Blue Cross not to provide the requested information to state officials out of concern that disclosure of participant and plan information would violate its duties as a plan fiduciary. Liberty Mutual subsequently filed an action in federal court seeking an injunction to prevent Vermont from compelling Blue Cross to provide the information and a declaration that ERISA pre-empted the Vermont statute.

ERISA Section 514 expressly pre-empts "any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." The Supreme Court has, in a series of cases, interpreted the words "relate to" so as to pre-empt state laws that (1) make "reference to" ERISA plans or (2) have a "connection with" ERISA plans. Liberty Mutual contended the Vermont statute violated the latter prong as having an impermissible connection to ERISA plans.

An impermissible connection with an ERISA plan exists when a state statute "governs a central matter of plan administration" or "interferes with nationally uniform plan administration." The majority, led by Justice Kennedy, stated "ERISA's reporting, disclosure, and recordkeeping requirements … are extensive." Noting that ERISA requires plans to make regular disclosures to plan participants and file reports with the Department of Labor, the majority concluded that "reporting, disclosure and recordkeeping are central to, and an essential part of, the uniform system of plan administration contemplated by ERISA."

The majority reasoned that without pre-emption, differing state reporting requirements would impose burdensome reporting requirements on plans. Justice Breyer, in a concurring opinion, further elaborated on this concern, stating that allowing each state to impose its own reporting requirements could result in "unnecessary, duplicative, and conflicting reporting requirements, any of which can mean increased confusion and increased cost." The majority and Justice Breyer both noted that the Department of Labor has authority to mandate plan reporting requirements and it alone should have authority to require plan reporting. Justice Breyer further suggested that states could continue to collect information using the all-payer claims databases if they were to seek approval from the Department of Labor to do so and would share such information with the agency.

The majority further noted that in evaluating prior similar cases, the Court considered (1) the objectives of ERISA and (2) the nature of the effect of the state law on ERISA plans when determining if pre-emption was necessary. The Court acknowledged that the objective of Vermont's law was different from ERISA's, a factor weighing against pre-emption. Nevertheless, the Court determined that the law regulated a matter central to plan administration, its differing objective did not transform the reporting requirements into an "innocuous and peripheral set of additional rules."

While concurring, Justice Thomas questioned whether ERISA's pre-emption clause is a valid exercise of Congressional power in this case. Specifically, Justice Thomas expressed concern whether the Commerce Clause permits Congress to pre-empt state laws that do not impact interstate commerce. Justice Thomas admitted that such a question was not posed before the Court and hence, until it is, the Court must rule based on current jurisprudence.

In their dissent, Justices Ginsburg and Sotomayor challenged the majority's decision asserting that an analysis of ERISA's objectives and the nature of the Vermont statute's effects on ERISA plans demonstrated that the law "does not impermissibly intrude upon ERISA's dominion of employee benefit plans."

The dissent argued that ERISA's objective is to govern the "design and administration of employee benefit plans" and that "[i]ts reporting requirements are geared towards those functions." ERISA's reporting requirements, according to the dissent, are meant to help the Department of Labor "evaluate plans' management and solvency." The Vermont law, on the other hand, focuses on improving the quality and reducing the cost of health care provided to Vermont residents. Because the laws request different information and serve different purposes, the dissent concluded the objectives of ERISA are not impacted by the Vermont law.

Further, the dissent argued Liberty Mutual failed to show details of the economic burden Vermont's law would impose. Justice Ginsburg noted that *amicus* briefs submitted in support of Liberty Mutual indicated that compliance with the law would amount to "no more than everyday facets of modern regulatory reporting" – such as implementing software systems to collect and send data to state officials.

As a practical matter, the dissent noted that there are 18 states that currently use similar all-payer claims databases. In Vermont, approximately 20 percent of the data submitted relates to self-insured plans. Further, across the country approximately 50 percent of Americans get health insurance through their employers, and 61 percent of these employer plans are self-insured. Exempting self-insured employer plans would have a significant impact on the information available and would impair states' ability to assess the quality and cost of health care.

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HIPAA Audits: Ready or Not, Here They Come!

By Jessica Forbes Olson and T.J. Lang

On March 21, 2016, the Office of Civil Rights (OCR) announced it will launch a second round of HIPAA audits in 2016. As with the first round of audits, in round two, OCR will be reviewing compliance with HIPAA privacy, security and breach notification rules. New for this round, the 2016 audits will focus on both covered entities, including group health plans, *and their business associates*.

The round two audits will occur in three phases: (1) desk audits of covered entities; (2) desk audits of business associates; and, finally (3) onsite reviews. It is reported that OCR will conduct about 200 total audits, the majority of which will be desk audits.

OCR has already begun the process of identifying the audit pool by contacting covered entities and business associates via email. Group health plans should be on the lookout for automated emails from OCR, which are being sent to confirm contact information. A response to the OCR email is required within 14 days. OCR instructed covered entities and business associates to check their spam or junk email folders to verify that emails from OCR are not erroneously identified as spam.

After the initial email, OCR will send a pre-audit questionnaire to entities it may choose to audit. Receiving a pre-audit questionnaire does not guarantee your group health plan will be audited. The purpose of the questionnaire is to gather information about entities and their operations (e.g., number of employees, level of revenue, etc.). The questionnaire will also require a group health plan to identify all of its business associates. Therefore, plan administrators who have not inventoried business associates should do so now.

Entities that fail to respond to the initial OCR email or questionnaire will still be eligible for audit. OCR will use publicly available information for unresponsive entities to create its audit pool.

OCR will then, in the "coming months," randomly select entities to audit and notify them via email that they have been selected for audit.

Group health plans and business associates should check their HIPAA compliance status before they are contacted by OCR. Once selected for an audit, entities will only have 10 business days to provide the requested information to OCR.

Recent OCR enforcement activity has shown that noncompliance with HIPAA standards and specifications can be costly:

- A Minnesota-based hospital entered into a $1.55 million settlement for failure to implement one business

associate agreement and failure to conduct a HIPAA security risk analysis;

- A teaching hospital of a university in Washington entered into a $750,000 settlement for failure to conduct an enterprise-wide HIPAA security risk analysis;
- An insurance holding company based in Puerto Rico entered into a $3.5 million settlement for failure to implement a business associate agreement, conduct a HIPAA security risk analysis, implement security safeguards and for an improper disclosure of protected health information (PHI); and
- A radiation oncology physician practice in Indiana entered into a $750,000 settlement for failure to conduct a HIPAA security risk analysis and implement security policies and procedures.

If you receive any communications from OCR, we strongly recommend that you contact a member of the Fox Rothschild Employee Benefits & Compensation Department immediately. A proactive review of your HIPAA compliance status can identify potential gaps and minimize the risk of potential penalties. For reference and to use as a guide, the following is a HIPAA compliance checklist for group health plans:

- ❑ Identify all your self-insured group health plans (e.g., medical, dental, vision, EAP, health FSA, HRA).
- ❑ Identify all your fully insured group health plans and ensure that they do not receive protected health information, other than for limited purposes (PHI).
- ❑ Determine whether for HIPAA purposes the group health plans are a hybrid entity, part of an affiliated covered entity or part of an organized health care arrangement. Document that status.
- ❑ Ensure the self-insured group health plans were amended to put in place a firewall between the plan and plan sponsor and that the list of workforce members who can access PHI on behalf of the plan is accurate.
- ❑ Ensure that a certification of plan amendment is in place.
- ❑ Appoint a HIPAA privacy official.
- ❑ Appoint a HIPAA security official.
- ❑ Appoint a HIPAA privacy contact person who will handle complaints and respond to the exercise of participant rights.
- ❑ Determine where PHI is located, whether hard copy, electronic or spoken.
- ❑ Determine the reasons why PHI is used or disclosed (e.g., payment, health care operations, public health reasons, public policy reasons, to government agencies or officials).
- ❑ Determine which departments and workforce members have access to PHI, why they have such access and the level of access needed.
- ❑ Identify and document the routine requests, uses and disclosures of PHI and the minimum necessary for those requests, uses and disclosures.
- ❑ Identify all business associates: vendors that create, maintain, use or disclose PHI when performing services for the group health plan.
- ❑ Have executed business associate agreements with all business associates.
- ❑ Have and follow written HIPAA privacy, security and breach notification policies and procedures.
- ❑ Train all workforce members who have access to PHI on the policies and procedures and document the training.
- ❑ Distribute a notice of privacy practices to participants and post it on an intranet site if benefits information is commonly posted there.
- ❑ Establish and document reasonable administrative, technical and physical safeguards for all PHI, including hard copy and spoken PHI.
- ❑ Conduct and document a HIPAA security risk analysis for all electronic PHI (e.g., PHI on desktops, laptops, mobile phones, iPads and other electronic notebooks, copy machines, printers, discs and thumb drives).
- ❑ Address risks to ePHI that are identified in the HIPAA security risk analysis.
- ❑ Update your HIPAA security risk analysis periodically or when there is a material change in your environment that does or could impact PHI or if there are changes in the law impacting PHI.
- ❑ Encrypt PHI to fall within the breach safe harbor.
- ❑ Have written disaster recovery and contingency plans.
- ❑ Prepare for and respond to security incidents and breaches.
- ❑ Maintain HIPAA compliance documentation in written or electronic form for at least six years from the date the document was created or last in effect.

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SEC's Proposed Incentive Compensation Clawback Rule

By Brian G. Belisle

On July 1, 2015, the SEC issued proposed Rule 10D-1, as required by Section 954 of the 2010 Dodd-Frank Act. The Rule would direct national securities exchanges to establish listing policies that require companies to adopt a policy requiring recovery from executive officers of any erroneously awarded incentive compensation. Under the Rule, listed companies must adopt a written policy requiring, in the event of a material accounting restatement, the "clawback" (or recovery) from current or former executive officers of any incentive compensation they would not have received based on the restatement, regardless of their fault or other responsibility for the error.

Summary of the Proposed Rule

Each national securities exchange will have 90 days after publication of the SEC's final version of Rule 10D-1 to file their proposed listing rules, which must become effective within 12 months of publication of the final rule. Each listed company will then have 60 days to adopt a compliant clawback policy.

A company would be subject to delisting if it does not: (1) adopt a compliant clawback policy; (2) disclose the policy in accordance with SEC rules; and (3) comply with the policy's recovery requirements.

Under the Rule, each listed company required to prepare an accounting restatement because of a material financial error must recover certain excess incentive compensation awarded to current or former executive officers (Section 16 executive officers) during the preceding three fiscal years based on a "financial reporting measure" reported in error. These financial reporting measures include most accounting-based measures, stock price and total shareholder return. Incentive compensation does not include compensation based on non-financial reporting measures, such as the closing of a sale of a company division.

The recoverable amount is the excess over the incentive compensation that otherwise would have been earned had it been determined based on the accounting restatement. The company is required to recover the gross amount of the incentive compensation, not the net amount received by the executive after payment of taxes.

The Rule contemplates that the means of recovery may vary by issuer and type of compensation arrangement; however, the means should provide recovery reasonably promptly. Actions may include:

- Forfeiture of earned but unpaid amounts;
- Cancellation of unvested awards;
- Offset from amounts otherwise payable to the executive officer; or
- Executive officer's repayment.

Planning Considerations

Companies should: (1) review their current clawback policy and revise the policy to include a general provision that will pick up any new requirements of the final rule; (2) put executives on notice of the new, no-fault recovery requirements; and (3) revise existing compensation plans, award agreements and employment agreements to clearly permit enforcement of the clawback policy, including any future changes required to comply with the final rule.

Listed companies may also want to revise their executive compensation mix and performance metrics to minimize the potential clawback implications in the event of a material financial restatement. For example, a redesign of 162(m) awards could significantly reduce the likelihood of a required clawback.

Tax Considerations

Enforcement of a clawback policy can have significant tax implications for an impacted executive, particularly for amounts that have been deferred under a nonqualified deferred compensation arrangement subject to Internal Revenue Code Section 409A (409A). Compliance with the policy can impact the amount subject to the deferral election, can cause forfeitures under the arrangement and can create offset, acceleration and substitution concerns under 409A. A company will need to tailor enforcement of its clawback policy to ensure satisfaction of the requirements of 409A. In addition, companies should work closely with impacted executives to minimize the adverse tax consequences of a required repayment.

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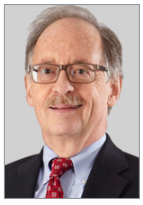

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Required Minimum Distributions: Did You Miss Your Required Beginning Date?

By Seth I. Corbin

Last month, the IRS reminded taxpayers who turned 70-½ during 2015 that, in most cases, they need to start receiving a distribution from the IRAs and employer-sponsored retirement plans by April 1, 2016. This mandated distribution is referred to as a "required minimum distribution" or "RMD."

By way of background, employer-sponsored defined contribution retirement plans, IRAs and individual retirement annuities are subject to the RMD rules. Generally, RMDs must begin by the April 1 following the later of the calendar year in which the individual reaches age 70-½ or retires; however, the required beginning date for 5 percent owners from employer-sponsored retirement plans is April 1 following the year in which the individual reaches 70-½. Typically, the RMD for each year is determined by dividing the account balance as of the end of the prior year by a distribution period prescribed by uniform tables in IRS regulations.

Failure to take the RMD triggers a 50 percent excise tax, payable by the plan participant or IRA owner or, if deceased, the beneficiary. In some cases, the tax may be waived by the IRS, if the distribution occurred because of reasonable error and if reasonable steps are taken to remedy the violation. The failure of a qualified plan sponsor to make a RMD could also threaten the tax-qualified status of the retirement plan.

Individuals

If you are an individual who turned 70-½ in 2015 and did not take your RMD, you are subject to an excise tax of 50 percent on the underpayment under Internal Revenue Code Section 4974. This amount is supposed to be added to your individual income taxes due for the year in which the distribution is required. Luckily, all is not lost because you can request a waiver of the 50 percent excise tax by filing Form 5329 with the IRS. While the IRS does not grant a waiver in all circumstances, it retains significant flexibility to waive the excise tax when the facts and circumstances support it (i.e., when there is "reasonable cause").

As a practical matter, and before filing the Form 5329, it is advisable that you take immediate action by withdrawing the RMD as soon as possible. Next, in order to avoid paying the 50 percent excise, you should complete Form 5329 and attach a brief explanation stating why you failed to take the RMD and that you have already taken steps to correct it by requesting and, hopefully, receiving the appropriate distribution. Following submission, the IRS will review the information provided and decide whether to grant the request for the waiver.

Employers

As noted above, the RMD rules are qualification requirement applicable to employer-sponsored defined contribution plans, meaning they must be written into the plan document. Failing to follow the terms of the plan document can result in the loss of the plan's tax qualified status (in addition to the individual penalties levied against the participant).

The IRS, through the Employee Plans Compliance Resolution System (EPCRS), offers employers an opportunity to correct this qualification failure through either its Self-Correction Program (SCP) or its Voluntary Correction Program (VCP). SCP allows an employer to self-correct the RMD errors so long as the violations are corrected within the two plan years following the plan year in which the violations occur. In such a case, an employer will not need to submit a formal application to the IRS and, instead, will fully correct the failure by making all of the missed RMDs and adopting procedures to ensure the failure does not occur again. When the failures have occurred beyond the time available for SCP, a plan sponsor should correct the failures through VCP.

Under VCP, a plan sponsor submits a formal application to the IRS that, generally, identifies the failures, describes the corrective actions taken (i.e., shows that the RMDs have been made) and outlines the procedures adopted to ensure that the failures do not occur again. There is a fee associated with submitting an application to the IRS under VCP that is typically based on the number of participants in the plan. However, in circumstances where the only failure identified in the VCP application is the missed RMDs, a reduced fee is available depending on the number of participants affected ($500 if 150 or fewer participants are affected; $1,500 if 151 to 300 participants are affected). Additionally, and unlike SCP, submitting through VCP allows an employer to request the waiver of any excise tax associated with the missed RMDs. Therefore, in addition to preserving the tax-qualified status of the plan, the employer is able to request waiver of the additional taxes that are otherwise paid by the participant who failed to take the RMD.

While RMD failures are not uncommon, it is important that plan sponsors take appropriate steps to monitor the age of all participants who are approaching age 70 to avoid making this otherwise preventable mistake. Fortunately, even when an error has occurred, the correction programs made available by the IRS allow employers to resolve these issues in a manner that both protects the underlying plan and eliminates the excise tax imposed on affected participants and beneficiaries.

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HIPAA Implications of Form 1095-C Reporting

By Elizabeth R. Larkin and Jessica Forbes Olson

Employers need to keep HIPAA compliance at top of mind when doing Internal Revenue Code §§ 6055 and 6056 reporting on Forms 1095-C. Form 1095-C is used by employers to report offers of minimum essential medical coverage to employees (Parts I and II of the Form) and by employers that offer self-insured minimum essential coverage to report employee enrollment in such coverage (Part III of the Form).

An employer's medical plan is a covered entity subject to HIPAA privacy, security and breach notification rules (HIPAA). If the medical plan is insured, the insurance company is generally responsible for compliance with HIPAA (provided the employer does not receive any protected health information (PHI), except for limited purposes). If the employer's medical plan is self-insured, the plan itself – and not the employer – is subject to HIPAA. Nevertheless, since the plan has no employees, it must rely on those workforce members of the employer who are involved in plan administration and various third party administrators to administer the plan.

Even for a self-insured plan, if the employer obtains the employee information from general employment records (e.g., from the employer's database that has employee demographic information not connected to the medical plan), instead of from the self-insured medical plan records, the employee information is not considered PHI. In addition, enrollment information in the hands of an employer that is performing medical plan enrollment activities on behalf of the employees (for the benefit of the employees) is not PHI and thus not subject to HIPAA. We call this the "enrollment exception." It can be difficult to determine the parameters of the enrollment exception since enrollment information in the hands of the plan is PHI, so we advise caution in its use.

Whether Form 1095-C contains PHI and thus the use, disclosure and safeguarding of information on it is subject to HIPAA depends on where the employer obtains the information to complete the Form and what information is included on the Form.

Part III of Form 1095-C (Covered Individuals) contains information on whether an employee is enrolled in medical plan coverage and this mere enrollment information is enough to be PHI. If this information is obtained from the plan (e.g., obtained from a database that has medical plan information or from the medical plan third-party administrator), as opposed to from employment records, the information is subject to HIPAA.

Employee demographic information (Part I of the Form) and offer of coverage information (Part II of the Form) may not be subject to HIPAA, depending on where the employer obtained the information.

For self-insured employers (who must complete Part III of the Form regarding enrollment in coverage), we recommend treating the Forms and the data needed to complete the Forms as PHI. (Even for employers with insured plans where Part III of the Form is not completed, the Form and the data used to complete it may be PHI.) We recommend that employers with self-insured plans do the following to ensure compliance with HIPAA with respect to Forms 1095-C and the data used to complete the Forms:

1. Provide HIPAA training to all in-house employees involved in preparing the Forms;
2. Enter into a HIPAA business associate agreement with outside consultants and vendors that are assisting in completing the Forms, distributing them to employees or filing them with the IRS;
3. Apply HIPAA safeguards to the Forms and the data (e.g., make sure they are in a secure place and limit access to those who need to know); and
4. If you experience a potential breach with respect to the Forms (e.g., delivered to the wrong employees, lost or stolen, viewed by someone who doesn't need access to them), notify the HIPAA privacy and security officials for the plan, who should consult with legal counsel as needed, perform and document a HIPAA breach analysis, and if it qualifies as a breach, provide required notices (to affected employees, the Department of Health and Human Services and possibly the media).

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IRS Okays Mid-Year Changes to Safe Harbor Plans

By Susan Foreman Jordan

For many years, the IRS has taken the position that a plan sponsor may not make mid-year amendments to safe harbor 401(k) plans. This was based on regulations requiring that, subject to specific exceptions, the safe harbor provisions, once adopted, must remain in effect for an entire 12-month plan year.

Most practitioners had interpreted this regulation to prevent mid-year changes to the safe harbor contribution election itself and, perhaps, to those plan provisions described in the annual safe harbor notice, including eligibility requirements, entry dates and vesting. The IRS, on the other hand, had taken the position that the regulations prevent any *mid-year* change to the plan unless specific exception has been granted by regulation or other formal pronouncement, precluding any change to the plan once the plan year has commenced. The concern, of course, has been that a mid-year amendment could cause loss of safe harbor status, making the 401(k) deferral subject to nondiscrimination testing.

On January 29, 2016, the IRS issued Notice 2016-16, which vastly expands the types of changes that may be made to a safe harbor plan during the plan year and given retroactive effect. The Notice includes a short list of prohibited mid-year changes but, in general, permits any other modifications, as long as eligible employees are advised of the amendment and given a reasonable opportunity thereafter to modify their deferral elections.

If the amendment alters the information included in the initial safe harbor notice, an updated safe harbor notice must be provided at least 30 days, but not more than 90 days, in advance of the effective date of the amendment. If notice cannot be provided within that time frame, as would be the case when an amendment is to become effective retroactively, the notice must be provided within 30 days of the date on which the amendment is adopted.

By making it clear that employers retain the flexibility to make mid-year changes to their plans, significant uncertainty is eliminated. Employers that previously have been reluctant to utilize one of the safe harbors may wish to reconsider that decision.

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The Hidden Dangers of Staffing Agencies Under the ACA

By Michael M. McGovern

The employer shared responsibility provisions under the Affordable Care Act (the ACA) require applicable large employers, which are generally employers with 50 or more full-time equivalent employees, to offer group health plan coverage to substantially all of their full-time employees. In a two-party employment relationship, it is fairly easy to identify both the employer and employee for purposes of complying with the employer shared responsibility rules. However, when the employer retains the services of a third-party staffing agency to provide temporary or contract employees, the determination can be more difficult.

To assist with this determination, the ACA employs the common law test to identify the employer. The common law test focuses on whether "the person for whom services are performed has the right to control and direct the individual who performs the services, not only as to the result to be accomplished by the work but also as to the details and means by which that result is accomplished." The common law employer is the entity that has the power to, among other things, assign work, set hours, supervise, hire, fire and discipline employees.

However, when an employer retains a staffing agency, both entities may retain some of the hallmarks of control over the employee, indicating that both may potentially be the common law employer. While the IRS has stated that both entities may be considered co-employers for purposes of the common law test in "unique circumstances," its stated position is that in the typical case, the staffing agency is not the common law employer. This is not to say that a staffing agency is never required to offer coverage to its worksite employees, but rather that employers that utilize staffing agencies will most likely be required to offer coverage to their contract employees.

However, most employers do not offer group health plan coverage to their contract employees. Instead, it is often the staffing agency that provides coverage. The final employer shared responsibility rule states that an employer may only take credit for a staffing agency's offer of coverage to a contract employee if they pay the staffing agency more for an employee

who enrolls in coverage than if the employee did not enroll in coverage. Thus, if an employer pays a flat rate for all contract employees, it has not made an offer of coverage to such employees. Therefore, any flat fee or other arrangement that does not specifically provide for an additional charge for coverage can expose large employers to penalties under the ACA.

Under Section 4980H(a) of the Internal Revenue Code, applicable large employers that fail to make a qualifying offer of coverage to at least 95 percent of their full-time employees are subject to a penalty if at least one full-time employee receives a subsidy for coverage purchased on the exchange. The amount of this penalty is $2,160 multiplied by the employer's total number of full-time employees excluding the first 30 employees. If the employer is part of a consolidated group, it may only disregard its proportionate share of the first 30 employees. Thus, the penalty can be quite extensive for employers with a large contract employee population.

For example, if an employer has 80 full-time employees to whom it makes qualifying offers of coverage, and an additional 20 full-time contract employees for whom it is the common law employer and who are offered coverage through a staffing agency, then for ACA purposes the employer has 100 full-time employees. If the employer does not pay an additional fee for the coverage offered to the contract employees, it will be subject to a $ 151,200 penalty ($2,160 x (100 employees – the first 30 employees)) under Section 4980H(a) because it only offered coverage to 80 percent of its full-time employees. If an employer has more than 500 total full-time employees including contract employees the penalty will be more than $1 million.

Accordingly, employers that make use of staffing agencies will want to carefully consider the risk that they will be considered the common law employer of the contract employees. To mitigate this risk, employers should track their contract employees' hours to determine which may be considered full-time and should therefore be offered group health plan coverage. Furthermore, employers should review all their agreements with staffing agencies to ensure that the agreements provide for additional compensation for any contract employee who enrolls in the staffing agency's coverage. There is no set amount required for the additional coverage, but it is clear that the cost of coverage may not simply be spread among all contract employees including those that do not enroll in coverage.

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PBGC Issues Updates to Reportable Events

By T.J. Lang

ERISA Section 4043 requires plans or sponsors to notify the Pension Benefit Guaranty Corporation (PBGC) upon the occurrence of certain company or plan events that may put pensions at risk. Reportable events provide PBGC an opportunity to assess a company's or plan's financial problems, encourage plan continuation, or, if necessary, maximize participant recovery upon a termination.

Last fall, PBGC published its final rules, making significant updates to the reportable events structure. Under the new rules, the PBGC believes it is better able to monitor and address situations most likely to result in problems for the pension insurance system. In addition, PBGC predicts 94 percent of plans and sponsors will be exempt from many reporting requirements, resulting in an overall reduction in reporting.

The following is a brief summary of the reportable event triggers and new waivers.

Reportable Events

Effective January 1, 2016, a company or plan must generally report the following events within 30 days of occurrence:

Active participant reduction: The active participant count falls below 80 percent of the count at the beginning of the current plan year or 75 percent of the count from the preceding plan year following a single-cause event or due to attrition.

Missed contributions: A sponsor fails to make minimum funding contributions required by ERISA Sections 302 or 303, or a contribution required as a condition of a funding waiver. However, no report is required if the missing contribution is made within 30 days of the due date, or if it was missed solely because of the sponsor's failure to timely make a funding balance election.

Inability to pay benefits when due: A plan is currently unable or projected to be unable to pay benefits. A plan is "currently unable" when it is unable to provide a participant (or beneficiary) with the full benefits at the time and in the form the benefits are due. A plan is not "currently unable" if it is

unable to locate the participant (or beneficiary), if the payment is limited by IRC Section 436, or if the delay is purely administrative and is less than two months or two benefit payment periods. A plan is projected to be unable to pay benefits if as of the last day of any quarter, the plan's liquid assets are less than two times the amount of disbursements from the plan for that quarter.

Distribution to substantial owner: A sponsor makes distribution to a substantial owner (i.e., greater than 10 percent owner) where:

- Total distributions to the substantial owner made over the previous 12 months exceeds $10,000;
- Distribution is not made on account of the substantial owner's death;
- The plan is underfunded; and
- The sum of all distributions to any one substantial owner within the preceding 12 months is more than one percent of the year-end plan assets for *each* of the previous two years, or the sum of all distributions to all substantial owners over the preceding 12 months is more than five percent of the year-end plan assets for *each* of the previous two years.

If the distribution is in the form of an annuity only, the sponsor only needs to report the event once (at the time of the first payment).

Controlled group change: If a transaction results, or will result, in one or more entities ceasing to be members of a plan's controlled group. However, the merger of one member into another is not a reportable event.

Extraordinary dividends/stock redemption: A member of plan's controlled group declares a dividend or redeems its own stock, the value of which, when combined with other such distributions during the same fiscal year, exceeds the recipient's net income before after-tax gain or loss on any assets for the prior fiscal year, as determined in accordance with generally accepted accounting principles.

Transfer of benefit liabilities: A plan transfers liabilities to a person(s) (or a plan maintained by a person(s)) outside of the transferor's controlled group and the amount of liabilities transferred, combined with the other liabilities transferred during the prior 12-month period, is three percent or more of the plan's total liabilities. Lump-sum payments or purchases of an irrevocable commitment to provide an annuity in satisfaction of a benefit liability are *not* transfers of benefit liabilities.

Loan default: With respect to a loan to a member of the plan's controlled group with an outstanding balance of $10 million or more:

- An acceleration of payment or default under the loan agreement, or
- Waiver or amendment of any covenant in the loan agreement that will cure or avoid a breach that would trigger default.

Liquidation: A member of plan's controlled group is involved in any transaction to implement its complete liquidation, institutes (or has instituted against it) a proceeding to be dissolved or is dissolved, or liquidates in a case under the Bankruptcy code (or any similar law).

Insolvency or similar settlement: A member of the plan's controlled group commences (or has commenced against it) any insolvency proceeding, other than one under the Bankruptcy code; commences (or has commenced against it) a proceeding to effect a composition, extension or settlement with creditors; executes a general assignment for the benefit of creditors; or undertakes to effect any other nonjudicial composition, extension or settlement with substantially all its creditors.

Application for minimum funding wavier: A plan submits an application for a minimum funding wavier.

Reportable Event Waivers

PBGC retained and expanded many of the waivers existing under the old regulations. These waivers (small plan, *de minimis* segment, foreign entity and public entity) now cover more events and sponsors where the risk of default is low.

PBGC added two new safe harbor waivers: (1) the low-default-risk waiver; and (2) the well-funded plan waiver. The new safe harbors cover five of the reportable events: active participant reduction, distribution to substantial owner, extraordinary dividend, transfer of benefit liabilities and change in controlled group.

The low-default-risk safe harbor waives reporting if company financial metrics show the company has adequate financial capacity to meets its obligations on time and in full. Criteria for satisfying the safe harbor are detailed in the regulations and are based on existing financial information companies commonly use for business purposes. Both the company and its highest-level U.S. parent must meet the stated criteria for the safe harbor to apply.

The well-funded plan safe harbor exempts reporting for plans that do not owe a variable-rate premium (VRP) for the plan year preceding the year in which the reportable event occurs. VRPs are not required where plans are 100 percent funded.

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More ROBS Gone Wrong

By Susan Foreman Jordan

In previous newsletters, we have introduced the concept of Rollovers for Business Startup (ROBS), a strategy whereby existing accumulations in qualified retirement plans or IRAs are used as the source of financing business acquisition and startup. The IRS acknowledges that the ROBS strategy is not an abusive tax avoidance transaction and may work as a legitimate tax planning tactic, but cautions that it is questionable and must be assessed on a case-by-case basis.

The general process involves the creation of a new corporation that implements a qualified profit sharing plan or 401(k) plan that allows participants to direct the investment of their accounts in employer stock. The individual forming the new corporation becomes an employee of that entity and enrolls in the plan. He then rolls to the new plan funds that he has accumulated in his personal IRA or in another employer-sponsored retirement plan and directs that his account balance in the new plan be used to purchase employer stock. Finally, the new corporation uses the proceeds of the stock sale to begin the business enterprise.

Rollover for Business Startup can be used as an effective and highly successful strategy when properly structured and implemented.

However, the frequency with which the formalities are disregarded or short-changed only encourages the IRS to view these transactions as suspect. Consider these two recent examples:

In *Fleming Cardiovascular, P.A. v. Commissioner*, decided November 23, 2015, the United States Tax Court issued a declaratory judgment that the IRS had not abused its discretion in revoking the tax qualified status of an employee stock ownership plan created through a ROBS transaction. In addition to the many problems with the operation of the ESOP itself (including failure to obtain independent certified appraisals of the stock, failure to make recurring and substantial employer contributions and allowing individuals who had not yet satisfied the eligibility requirements to participate), the largest issue was the defective rollover. Dr. Fleming had taken distribution from his IRA and remitted the funds to the new corporation in exchange for employer stock to be held in his account in the ESOP. However, the ESOP never established a bank or brokerage account as the interim depository for those funds, so there was no evidence of the receipt of a valid rollover from the individual or his IRA custodian.

Powell v. U.S., the Court of Federal Claims, a decision issued on March 15, 2016, rejected the taxpayers' argument that withdrawals from their IRAs were nontaxable distributions rolled to another retirement account through a ROBS transaction. The taxpayers conceded that, while they had a business plan concerning the real estate purchased with the IRA distributions, there was no written document evidencing the existence of a plan through which the investment was made. Ultimately, the real estate investments were transferred to a corporation, but because that corporation did not exist when the IRA distributions were taken, few if any of the steps required for a valid ROBS transaction were taken.

ROBS transactions have been used successfully countless times, but they continue to be scrutinized by the IRS. Periodic reports of disqualified plans and denial of rollover treatment serve as a reminder that to be successful, one must carefully observe all formalities and adhere strictly to all technical requirements.

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