For Your Benefit

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

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Some Small Employers May Now Offer Special Health Reimbursement Arrangements

By Pamela A. Thein

The Affordable Care Act (ACA) prohibition on stand-alone health reimbursement arrangements has been lifted for certain small employers, which may now offer employees a "Qualified Small Employer Health Reimbursement Arrangement" (QSEHRA). The 21st Century Cures Act, signed by President Obama on December 13, 2016, allows a small employer to fund a QSEHRA that pays all or a portion of the premiums for an employee's individual health insurance policy coverage or reimburses an employee for other eligible medical expenses. The specific QSEHRA requirements are described below.

QSEHRAs are only for "small employers." These arrangements may not be sponsored by an Applicable Large Employer (as defined under the ACA) so only an employer that employed fewer than 50 full-time employees (including full-time equivalent employees) in the prior year may adopt a QSEHRA. Employer size is based on the controlled group (for example, an employer with 40 full-time employees that is a member of an ERISA controlled group with 30 other full-time employees may not sponsor a QSEHRA).

The employer cannot offer any other group health plan (such as medical, dental, vision and health flexible spending account plans). If the employer is part of an ERISA controlled group, it may not adopt a QSEHRA if any other controlled group member sponsors a group health plan.

Only the employer may fund the QSEHRA – No employee contributions are allowed.

The employer must offer the QSEHRA to all eligible employees. The plan may exclude from QSEHRA participation an employee who:

- is under age 25;
- has not completed 90 days of service;
- is classified as part-time or seasonal;
- is a union employee (unless the collective bargaining agreement requires QSEHRA coverage); or
- is a non-resident alien with no U.S. source income.

QSEHRAs must be offered on the same terms to all eligible employees. The amount of a premium reimbursement under the QSEHRA may, however, vary based on: (1) the ages of the employee and family members covered by the insurance policy; and (2) the number of family members covered by the policy.

A QSEHRA may reimburse an eligible employee for eligible medical expenses (defined in Internal Revenue Code section 213(d)). This extends to the employee and the employee's eligible family members, including premiums for individual health insurance coverage, subject to the following:

- The employee must provide proof of the medical expense before receiving the reimbursement.
- In order to receive tax-free QSEHRA reimbursements, the

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employee must prove he or she has health insurance that provides "minimum essential coverage" as defined under the ACA (otherwise, reimbursements are taxable).

- For 2017, the maximum annual reimbursement amount for a QSEHRA is $4,950 (for employee only coverage) and $10,000 (for family coverage). These limits are pro-rated if an employee is not covered by the QSEHRA for the entire year. The employer could design its QSEHRA with lower reimbursement amounts.

Other QSEHRA considerations include the following:

- A QSEHRA may prevent the employee from being eligible for a "Health Savings Account" and may reduce or eliminate the premium subsidy or tax credit the employee might otherwise be eligible to receive on the Health Insurance Marketplace.
- A QSEHRA is treated as an "excepted benefit" and not considered a "group health plan" for certain provisions under the Internal Revenue Code and ERISA (*e.g.*, a QSEHRA is not subject to federal COBRA requirements and is not considered "minimum essential coverage" under the ACA).
- A QSEHRA is an ERISA welfare benefit plan, so it must have a plan document and summary plan description and ERISA's fiduciary and other rules apply.
- A QSEHRA is subject to HIPAA privacy and security rules, although, if it covers fewer than 50 employees and is self-administered by the employer, the employer may not be required to comply with the HIPAA rules with respect to its administration of the QSEHRA. This exception does not apply if the employer engages a third party to administer the QSEHRA.

Small employer requirements include the following:

- ERISA Form 5500 filing requirements should not apply if the QSEHRA is not funded because the plan will normally have less than 100 participants. An employer could, however, exceed 100 participants by allowing part-time or seasonal employees to participate in the QSEHRA.
- The employer must provide a notice to all eligible employees at least 90 days before the beginning of each year (or, if later, before an individual is first eligible to participate in the QSEHRA). Going forward, the notice should be provided no later than the hire date to each new employee who becomes eligible to participate in the QSEHRA. The penalty for failing to provide the notice is $50 per employee up to a maximum of $2,500 for the year.
- The employer must report the QSEHRA amount available for reimbursement on each eligible employee's Form W-2 and must report any taxable reimbursements made under the QSEHRA.
- The employer must review receipts and other documents from eligible employees to verify medical expenses are eligible for reimbursement under the QSEHRA.

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ESOP Light: A Creative Succession Strategy for the Small Business

By Harvey M. Katz

In reality, ESOP "light" is not an employee stock ownership plan (ESOP) at all. It is a way of structuring a retirement plan to provide many of the benefits of an ESOP, while avoiding all of the complexities and costs of implementing an ESOP. It is designed to address the needs of the retiring owner of a small business that is too small to implement an ESOP in a cost-effective manner and has limited third-party suitors for the business.

The most viable business succession option for many of these small businesses is to sell to one or more key employees who have been instrumental to the success of the business or who have been hired with the promise and/or expectation of earning an equity position through their efforts. Aside from the possibility that the key employee may decide to seek greener pastures, the problem with this strategy is that many do not

have the funds to purchase any significant portion of the business. Most expect to be "awarded" the shares in exchange for their past and future efforts.

Even in those cases in which the current business owner is willing to transfer the shares to the employee for nominal (or no) consideration, there is a flaw in this strategy that is often overlooked. Simply stated, equity transferred to any individual in a compensation environment, (i.e. to an employee or independent contractor) is taxable, ordinary compensation income to that employee. In other words, the employee will be liable for federal, state and local income tax on the fair market value of the shares transferred even when little to no value is paid. Additionally, the amount is subject to FICA taxation and both the employer and employee must pay their respective shares of that tax. Many employees also expect to receive a bonus or loan from the employer to enable him or her to pay their share of the tax.

The solution is to create a fund to provide dollars to the business owner that becomes the source of funds to serve as the equivalent of an ESOP. A specific kind of a defined benefit or cash balance plan will serve that purpose. Unlike an ESOP that purchases the shares from the owner, the defined benefit plan will simply provide additional dollars to the owner, which can be rolled into an IRA. However, defined benefit plans and cash balance plans are not a new concept, and a natural question is: what makes this idea different? The answer lies with the design of the plan, the source of the funds contributed and the use of those same funds.

The typical design of a pension plan in a closely-held corporation is to maximize contributions for all of the key employees, including the owner, while minimizing contributions for rank and file employees. Inclusion of all key employees in the "favored" class of employees increases the cost of the plan and increases the difficulty of passing IRS discrimination rules, which require a certain level of benefits for rank and file employees. In the case of an ESOP "light," the goal of the pension plan is to favor only the owner. Other key employees are excluded from the plan by design. In other words, the plan is designed to favor only the owner and minimize benefits for all others. In doing so, the plan and its assets can be used for the primary purpose of "buying out" the owner's interest in the company.

The source of funds to fund the plan is also critical to the plan design. Undoubtedly, part of the source will come from dollars that otherwise would have otherwise been paid to the owner as additional salary or profits distribution. However, an essential element of the plan design is that the other key employees fund the plan by foregoing what would otherwise be paid to them in raises, bonuses and other forms of incentive compensation during the period it takes to fund the plan. In essence, the other key employees are "paying" for their interest in the company by foregoing a portion of their compensation during this period. At the end of the pre-defined period (usually around five years), the owner will sell the shares to the employee for a relatively modest price, retire from the company and take his pension from the plan. Another advantage to using this strategy is that the benefit can be paid to the owner in a lump sum, rolled directly into an IRA and is not taxed to the owner until withdrawn.

Of course most key employees will be reluctant to "buy-in" to this concept unless they are protected with an agreement that gives them the right to purchase the company – at the right price – after the plan is funded. While this agreement should be protective of the key employee, it is important to note that in the event of a subsequent "falling out" between the owner and any key employee, the funds contributed to the plan cannot be disturbed and the owner will be in an advantageous position.

There are other challenges and issues that may arise in the context of designing an arrangement like this, many of which go beyond the scope of this article. However, the ESOP "light" concept clearly represents an alternative method to compensate an owner for the value of the small business when the traditional ESOP option may not be available.

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Supreme Court To Rule on Church Plan Status

By Susan Foreman Jordan

In early December, the United States Supreme Court announced that it will hear three consolidated cases to decide whether pension plans established by religiously-affiliated employers are entitled to the same treatment as plans established by churches. All three cases involve defined benefit pension plans maintained by church-affiliated healthcare systems; in each case, lower courts have ruled that the plans are not exempt from ERISA and must comply with all plan qualification requirements.

A provision has been included in ERISA since its enactment in 1974 exempting from most requirements pension plans established and maintained by churches for their own employees. In 1980, Congress amended the law, expanding the exemption to include plans maintained by religiously-affiliated groups, including church-affiliated hospitals, schools and other non-profit organizations. Based on this expansion, the IRS has issued rulings to hundreds of organizations recognizing church plan status. Defined benefit pension plans that received these rulings and were deemed to be church plans are exempt from plan funding requirements and other mandates of ERISA and need not pay premiums to the Pension Benefit Guaranty Corporation (PBGC) to insure benefits.

Three years ago, participants, concerned about their benefits (and knowing that PBGC guarantees will not be available), began to file lawsuits claiming that the plans maintained by their religiously-affiliated employers should not be church plans and should not be exempt from ERISA. The Supreme Court agreed to hear these cases because the appellate courts in the Third, Seventh and Ninth Circuits have ruled in favor of the plaintiff employees, while district courts in other circuits have taken the contrary position.

The issue to be considered by the Supreme Court is largely one of statutory interpretation. Under ERISA, an exempt church plan is defined as one established and maintained "by a church or by a convention or association of churches which is exempt from tax." What the Court must determine is whether the exemption applies if a plan is maintained by a (tax exempt) church-affiliated organization or is available only when a church, per se, established the plan. The opinion of the IRS, which dates back to a 1983 General Counsel Memorandum, is that church plan status extends to plans maintained by church-affiliated organizations, regardless of the entity that established the plan. The United States Department of Labor and the Pension Benefit Guaranty Corporation have subscribed to interpretation consistent with that of the IRS.

While the plans at issue in these consolidated cases are defined benefit pension plans, the question of whether ERISA applies is much broader, as it has implications for defined contribution retirement plans, welfare benefit plans, and even for health care continuation obligations under COBRA, which similarly exempts church plans. A decision that plans maintained by religiously-affiliated employers are not church plans reportedly could affect millions of employees across the country and trigger pension funding liabilities in the billions of dollars.

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DOL Finalizes New ERISA Disability Claims and Appeal Procedures

By Brian G. Belisle

On December 19, 2016, the Department of Labor issued final regulations revising the minimum required claims procedures for disability benefit claims. Although the regulations become effective January 18, 2017, the new rules generally apply to claims for disability benefits filed on or after January 1, 2018. (Under a special transition rule, for disability benefit claims filed under a plan from January 18, 2017 through December 31, 2017, denial letters must disclose reliance on internal rules or other similar limitations, and the process must generally comply with the group health plan claims procedures.)

The new rules apply to disability benefit claims which, in addition to claims under disability benefit plans, includes claims under other plans, such as pension or 401(k) plans, where the availability of a benefit is conditioned upon the participant being disabled unless the finding is conditioned on another party's determination of disability (such as the Social Security Administration or the insurer under the employer's LTD policy).

The new regulations mimic the claims and appeals requirements added to group health plans by the Affordable Care Act (ACA) and implemented by the DOL. The new rules add the following requirements to the claims and appeals process for disability benefits:

1. Plans must ensure that claims and appeals are decided independently and impartially. For example, there may not be any incentives based on the level of claim denials and a plan may not contract with a medical expert based on the expert's reputation for outcomes in contested cases.
2. Denial letters must include the following:
   - An explanation as to why the plan did or did not agree with the views of health care and vocational professionals, or with the disability determination made by the Social Security Administration.
   - Notice of a claimant's right to access their claim file and other relevant documents.
   - Disclosure of any internal rules, guidelines, protocols, standards or similar criteria relied upon in deciding the claim, or that no such criteria exist.
   - Culturally and linguistically appropriate language, including in certain cases, a prominent statement about the availability of language services. This rule adopts the standards that apply to group health plans under the ACA claims and appeal rule.
   - Description of any applicable plan imposed time limits on filing a lawsuit, as well as the date any contractual limitations period expires.
3. If an appeal denial is based on new or additional rationales, or evidence, the claimant must be given notice and a fair opportunity to respond before a final decision is made.
4. If the plan fails to comply with its claim procedures, claimants are not barred from suing the plan for failure to exhaust the plan's claim procedures.
5. Coverage rescissions, including retroactive terminations due to alleged misrepresentations of fact, must be treated as an adverse benefit determination triggering the plan's appeal procedures.

In light of the new rules, employers should be proactive in 2017 and review their plan documents, SPDs and procedures, including claim denial letters, and, as appropriate, work with their service providers to ensure compliance with the new rules for claims made on or after January 1, 2018.

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ACA Isn't Over Yet: New Section 1557 Nondiscrimination Rules

By Jessica Forbes Olson

While the fate of the Affordable Care Act (ACA) remains to be seen, in 2016 the Department of Health and Human Services (HHS) published a final rule implementing ACA Section 1557 nondiscrimination provisions which covered entities need to continue to be mindful of in 2017 (and, possibly, beyond). The final rule prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities and imposes obligations on covered entities.

The final rule was effective on July 18, 2016. However, to the extent the rule requires changes to the design of a benefit plan (e.g., changes to covered benefits) those changes were not required until the first day of the plan year beginning on or after January 1, 2017 (January 1, 2017 for a calendar year plan).

Who Must Comply?

The following are "covered entities" subject to Section 1557 rules:

- Any "health program or activity" that receives "federal financial assistance" from HHS;
- Any health program or activity that HHS administers (e.g., CMS, National Institutes of Health, Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration); or
- Any health program or activity administered by federal or state-run health insurance marketplaces.

A "covered entity" is liable for compliance of "an employee health benefit program" it offers to "its employees and/or their dependents" if:

- The employer is principally engaged in providing or administering health services, health insurance coverage; or other health coverage (e.g., a hospital);
- The employer receives federal financial assistance, a primary objective of which is to fund the employee health benefit program (e.g., a company which sponsors a retiree prescription drug plan and receives Medicare Part D subsidies); or
- The employer is not principally engaged in providing or administering health services or insurance, but operates a health program or activity (that is not an employee health benefit program) that receives federal financial assistance.

Section 1557 Compliance.

In order to assist with compliance, here is a general ACA Section 1557 self-compliance checklist:

- Do not discriminate with respect to benefit design or coverage on the basis of race, color, national origin, age, disability and sex (with sex discrimination defined broadly to include discrimination based on an individual's sex, pregnancy, childbirth or related medical condition, gender identity, sex stereotyping (but not sexual orientation)). It should be noted, however, that under a December 31, 2016 nationwide injunction issued by a U.S. District Court judge in the Northern District of Texas, HHS is not allowed to enforce the prohibition in the regulations against sex discrimination in the context of gender identity or termination of pregnancy.
- Do not deny or limit health services that are ordinarily or exclusively available to individuals of one sex on the basis of their gender identity or identification as transgender (although HHS is enjoined from enforcing this under the nationwide injunction discussed above).
- Although the regulations do not mandate coverage for gender transition, they prohibit having a categorical exclusion for all health services related to gender transition. The nationwide injunction only extends to HHS and not to other agencies such as the EEOC.
- Adopt grievance procedures that allow for resolution of complaints received. A model grievance procedure is available at http://www.hhs.gov/sites/default/files/section1557-sample-grievance-procedure.pdf.

- Designate at least one employee to coordinate compliance with and investigate complaints of noncompliance with the requirements of Section 1557.
- Provide meaningful access to health programs and activities to individuals with limited English proficiency (LEP) and disabilities.
- Provide free qualified interpreters and translated documents.
- Ensure that all newly constructed or altered facilities are accessible to individuals with disabilities.
- Modify policies, practices and procedures when such modifications are necessary to ensure individuals with disabilities have equal opportunity to participate in and benefit from health programs and activities (e.g., allow paper-based enrollment if an individual with a visual impairment cannot view the enrollment material on the website).
- Ensure effective communication with those with disabilities (e.g., materials in large print, screen reader software, having text telephone services (TTYs), assistive listening services, braille materials).
- Development of a language access plan is encouraged by the regulations, but not required.
- Post a nondiscrimination notice on the company website, assessable from the home page (required as of October 16, 2016). An HHS model notice is available at http://www.hhs.gov/sites/default/files/sample-ce-notice-english.pdf.
- Provide the nondiscrimination notice on an ongoing basis in "significant publications or communications" that are not small in size.
- Post taglines (short statements written in non-English languages informing individuals of the availability of the entity's language assistance services) on the company website in the top 15 languages spoken by individuals with limited English proficiency in the state or states in which the company operates. For a national employer, the top 15 languages are Spanish, Chinese, Vietnamese, Korean, Tagalog, Russian, Arabic, French Creole, Portuguese, French, Cantonese, Mandarin, Polish, Japanese and Italian. HHS created model taglines in 64 non-English languages.
- Include the 15 taglines in all significant publications that are not small in size.
- Small significant publications (brochures, postcards, etc.) must include a nondiscrimination statement and at least two taglines. A sample nondiscrimination statement is provided in the final regulations.
- Provide notice to HHS assuring compliance with Section 1557 when applying for federal financial assistance. HHS Form 690, *Assurance of Compliance*, includes a statement that the entity submitting the form is operating its health programs and activities in compliance with Section 1557 and will continue to do so while it receives federal financial assistance.

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IRS Clarifies Required Minimum Distribution Rules for Roth IRA Beneficiaries

By Susan Foreman Jordan

Traditional IRAs and individual retirement annuities are subject to the required minimum distribution (RMD) rules which generally require that distribution begin by April 1 following the calendar year in which the IRA owner attains age 70-1/2. A 50% excise tax is imposed on any amounts which should have been distributed under the RMD rules but were not distributed on a timely basis, unless the IRS waives the tax.

Roth IRAs are not subject to the RMD rules, insofar as the IRA owner is concerned; however, the *post-death* RMD rules which apply to traditional IRAs also apply to Roth IRAs, except in situations in which the designated beneficiary is the surviving spouse. Thus, the entire interest in a Roth IRA which passes to a non-spouse beneficiary must be distributed: (1) by the end of the fifth calendar year after the year of the owner's death (the "five-year rule"); or (2) over a period not greater than the non-spouse beneficiary's life expectancy, with distribution beginning before the end of the calendar year following the year of death (the "life expectancy rule").

In a recent Information Letter (Information Letter 2016-0071) the IRS clarified that when the Roth IRA permits the (non-spouse) designated beneficiary to select either the life expectancy rule or the five-year rule, the life expectancy rule automatically will apply unless the beneficiary affirmatively elects the five-year rule. Further, the life expectancy rule will apply, without regard to whether distributions, in fact, are made or commenced on a timely basis. So, for example, if the beneficiary elects to take distribution under the life expectancy method (expressly or by default) but fails to take the initial distribution on a timely basis, the distribution will not default to the five-year rule.

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