Employment LawScene Alert:
Eighth Circuit Holds that an SPD Can Function as a Plan Document

A federal appellate court has ruled, in *MBI Energy Services v. Hoch*, decided in July 2019, that a single document may serve as both the summary plan description (SPD) and the formal plan document for an ERISA welfare benefit plan.

In this case, the plan sponsor of a self-insured group health plan paid benefits on behalf of a participant for medical injuries sustained in an accident. Subsequently, the participant settled a tort claim with a third party who allegedly caused the accident. The settlement amount exceeded the amount of the plan-paid medical expenses and the plan sponsor sought reimbursement.

ERISA Requires a Plan Document

Under ERISA, the requirement that "every employee benefit shall be established and maintained pursuant to a written instrument" is understood to mean that the terms of each benefit program must be memorialized in a written plan document. ERISA further requires the plan sponsor to provide to each plan participant an SPD that briefly and clearly summarizes the terms of the plan document.

In some cases, plan sponsors do not offer two separate documents (a plan document and an SPD), but rely, instead, on a single combined document that purports to function both as the plan document and as the SPD.

Several courts have argued that a combined Plan document and SPD is unacceptable on the grounds that it is not possible for a document to summarize itself. Nonetheless, in the self-insured medical plan context (where coverage exclusions and limitations are difficult to summarize), it is common to have a single document that serves as both the plan document and the SPD.

Where's the Plan?

While the employer in the *MBI Energy Services* case could point to no document clearly identified as the "plan," there was an administrative services agreement (ASA) between the employer and the plan's claims administrator indicating that the plan benefits, terms, and conditions were set forth in an attached exhibited – the SPD. Along with the benefit provisions and ERISA-mandated language, the SPD contained sections addressing the rights of subrogation, reimbursement, and assignment. The SPD stated, in part, that if a participant "makes any recovery from a third party . . . whether by judgment, settlement or otherwise," the participant must reimburse the plan sponsor "to the full extent of any benefits paid" by the plan.

The Arguments

The participant argued that the SPD was not a valid plan document and that the employer therefore had no right to reimbursement. Instead, the participant asserted that the SPD was only a summary of, and in conflict with the terms of, the ASA, which the participant contended was the controlling plan document. The participant's argument was rooted in the Supreme Court's reasoning, in its 2011 *CIGNA v. Amara* ruling, that "'summary documents, important as they are, provide communication with beneficiaries *about* the plan, but that their statements do not themselves constitute the *terms* of the plan."

The plan sponsor, on the other hand, argued that the SPD functioned as both the SPD and the plan document and that the SPD's reimbursement language gave the plan an equitable lien on the participant's recovery proceeds.

The Ruling

The Eighth Circuit disagreed with the participant's contention that the SPD was unenforceable because it conflicted with the ASA, pointing out that the ASA was silent as to reimbursement and expressly incorporated the terms and conditions of the SPD. The court thereby joined other circuits in distinguishing *CIGNA v. Amara* (a retirement plan matter in which both a plan document *and* an SPD were present) and concluding that, absent a formal plan document, the SPD may function as the plan document.

Specifically, the court rejected as "nonsensical" any interpretation that renders no plan document at all under the terms of ERISA and concluded that the label of SPD is not dispositive. Where no other source of benefits exists, the SPD *is* the formal plan document.

The court also pointed out that it would be inequitable to allow the participant to receive benefits according to the SPD but not hold him to the reimbursement responsibilities set forth in that same document. It concluded that, since the SPD was the plan's written instrument, the participant was bound by its terms and obligated to reimburse the plan.

As a result, the participant was required to reimburse the self-funded employee benefit plan for $45,474 in medical benefits the plan had paid.

Implications

Since the U.S. Supreme Court's *CIGNA v. Amara* ruling, plan sponsors of self-insured plans have wondered whether the common practice of using a single document as both the plan and the SPD may permissibly continue. The Eighth Circuit's *MBI Energy Services* ruling adds to a growing list of cases finding that an SPD can function as an enforceable ERISA welfare plan document in the absence of a separate additional document.

Plan sponsors should take note that identifying the controlling language relevant to a given employee benefit plan is not always clear cut. In some cases (as here), the plans terms may

be contained within a single document. In other instances, the terms of an ERISA plan may be inferred from a series of documents, none of which is clearly labeled as a plan.

Do your Plan's Documents Protect You?

All plan sponsors are advised to review whether their documents for ERISA welfare plans (such as group health, dental, vision, disability, and life plans) not only comply with ERISA, but also whether they reflect the employer-specific disclosure requirements and employer-protective statements, which are typically *not* included in documents prepared by insurers or third-party administrators.

In many cases, it is advisable to streamline multiple separate ERISA benefits into a single so-called Wrap Plan document, which 'wraps around' and supplements the other documents to become the SPD. A Wrap Plan can help employers to minimize the risk of financial penalties and lawsuits and streamlines certain reporting and amendment requirements.

The attorneys of the Employment Law Group of O'Neil, Cannon, Hollman, DeJong & Laing can assist in reviewing and providing counsel relating to the documentation and operation of all employer-sponsored employee benefit and compensation plans.

Employment LawScene Alert:
IRS Expands List of HSA-Compatible Preventive Care Services

The IRS recently issued guidance expanding the types of preventive care services that can be provided by a high-deductible health plan (HDHP), before the deductible is met, without eliminating a covered individual's eligibility to participate in a Health Savings Account (HSA). The new guidance was published on July 17, 2019 and took legal effect on that same day.

Employers who sponsor HDHPs should now consider whether any plan documentation or communication changes are required to implement the expanded preventive care coverage rules. Alternately, employers who have not previously adopted a HDHP should assess whether the new rules may now make the HDHP/HSA model a more attractive way to control health care costs.

Background

An HSA is a tax-favored account that may receive contributions from an employee, an employer, or both. HSAs are subject to various rules that govern the individual account holder's eligibility to make and receive contributions and whether or not withdrawals are

taxable.

To be eligible for HSA contributions, an individual must be covered under a HDHP and may generally not have any health coverage other than HDHP coverage. Certain preventive care services, however, are not considered to constitute health coverage so as to disqualify an individual from HSA eligibility.

Previously, preventive care (within the meaning of the HSA and HDHP rules) has not included any service or benefit intended to treat an *existing* illness, injury, or condition.

The IRS is aware, however, that cost barriers for care have resulted in the failure by some individuals who are diagnosed with certain chronic health conditions to seek or to use effective and necessary care that would prevent exacerbation of such conditions. Accordingly, and in consultation with the U.S. Department of Health and Human Services (HHS), the IRS determined that certain medical care services received and items purchased, including prescription drugs, should now be classified as preventive care for someone with the corresponding chronic condition.

Newly Established HSA-Compatible Preventive Care

To address the stated concerns, the expanded list of HSA-Compatible preventive care expenses includes fourteen cost-effective items and services that are likely to prevent the worsening of eleven specified chronic conditions, as follows:

Preventive Care for Specified Conditions	**For Individuals Diagnosed with**
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, or coronary artery disease
Anti-resorptive therapy	Osteoporosis or osteopenia
Blood pressure monitor	Congestive heart failure or coronary artery disease
Inhaled corticosteroids	Asthma
Insulin and other glucose-lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and diabetes

The IRS and HHS will together review the list approximately every five to ten years to determine whether any items or services should be removed or added.

Changes Arose from Executive Order and Policy Advocacy

The immediate impetus of the change is Section 6 of Executive Order 13877, "Improving Price and Quality Transparently in American Healthcare to Put Patients First," which was signed by President Trump on June 24, 2019, and which mandated the issuance of guidance permitting HSAs to cover low-cost preventive care to help "maintain health status for individuals with chronic conditions."

The change also reflects the efforts of various health-policy advisors and advocates, who have long called for allowing first-dollar HDHP coverage for targeted, evidence-based, preventive services that prevent chronic disease progression and related complications.

Key HDHP Sponsor Issues and Next Steps

- In preparation for the 2020 open enrollment season, employer-sponsors of HDHPs should work to educate employees and dependents to assist them in understanding and benefitting from the new pre-deductible preventive care services.
- Sponsors of HDHPs should review whether or not existing plan documentation should be amended to encompass the expanded categories of covered care (or whether the current definitions remain legally sufficient).
- Because the out-of-pocket costs for some types of chronic care will now shift to the employer, sponsors of HDHPs should analyze whether the current deductible and premium levels are sufficient to meet the increased benefit expenses, or whether adjustments are warranted.
- Employers who offer both HDHPs/HSAs and on-site health clinics may provide only preventive care services in the on-site clinic in order to avoid jeopardizing employee HSA eligibility. Affected employers may now reconsider and expand the types of pre-deductible services to be provided to employees in the on-site clinic.
- Increased coverage of chronic condition expenses may increase the attractiveness of HDHP coverage to participants who are managing chronic conditions. The new rules may provide an opportunity to either increase future employee participation in, or to newly adopt, HDHP/HSA coverage.

Employment LawScene Alert: New Rule Will Permit Employer Reimbursement of Employees' Individual ACA Coverage Premiums

Beginning January 1, 2020, employers will have the option to reimburse employees' individual ACA Exchange (or Marketplace) health insurance premiums under an employer-sponsored Health Reimbursement Arrangement (HRA).

This is a significant change from current rules, which generally permit an HRA to reimburse

only group (not individual) health insurance coverage, and which prohibit employer reimbursement of any health insurance coverage provided through the ACA Exchange.

HRA Overview

An HRA is a type of account-based plan that an employer may use to provide pre-tax reimbursement, up to employer-determined annual limits, of certain employee medical care expenses. Under applicable law, an HRA is a self-funded health care plan, which may be funded only by employer (not employee) dollars. An HRA is subject to ERISA, HIPAA, and certain IRS rules, including the nondiscrimination requirements that prohibit discrimination in favor of highly compensated employees.

What's Old is New Again

Under final regulations issued jointly, last week, by the United States Departments of Treasury, Labor, and Health & Human Services (the Departments), Employers can once again reimburse certain individual employee health insurance expenses on a pre-tax basis. This practice was broadly permitted under IRS rules in effect from 1961 through January of 2014, when the IRS put a sudden halt to the practice on the grounds that it violated the Affordable Care Act.

With Some Twists

Prior to 2014, employers could directly reimburse an employee for the cost of that employee's individual insurance coverage premiums. No additional benefit plan or plan document was required. Under the new rules, employer reimbursements of individual insurance premiums may not be made directly, but must instead flow through a documented HRA program. The HRA must conform in form and operation with applicable Department rules.

Under the law in effect over the last few years, an HRA could reimburse group health plan insurance premiums only if it were "integrated with" an ACA-compliant employer-sponsored group health plan. Under the rules that will take effect January 1, 2020, HRA "integration" with ACA-compliant individual coverage will be available for the first time.

Why are the HRA Rules Changing?

The final regulations issued jointly by the three Departments last week ultimately result from an October 2017 Presidential Executive Order intended to expand "healthcare choice" and flexibility. HRAs were one of three priorities identified in President Trump's Executive Order 13813, which directed the Departments to consider proposing regulations or revising guidance as needed "to expand employers' ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with non-group coverage."

Key Requirements

The final regulations exceed 200 pages and provide extensive detail on the requirements applicable to the new individual coverage HRAs (ICHRAs). Among these are the following six key conditions, which must be satisfied in order to successfully integrate an HRA with individual health insurance coverage:

- All individuals covered by an ICHRA must be enrolled in individual coverage through the Exchange.
- The employer may not offer an ICHRA to the same class of employees to whom it offers group health plan coverage. This means that an employee in a particular classification may not be given a choice between a traditional group health plan and an ICHRA. Under a related rule, employers are prohibited from steering participants with adverse health factors into individual, rather than into group, coverage.
- An ICHRA must be offered in both the same amount and under the same terms and conditions to all employees. The HRA may not be more generous or less generous to some individuals based on an adverse health factor.
- The ICHRA must offer an opt-out provision so that an employee may choose to waive ICHRA HRA coverage. This condition is intended to preserve an individual's eligibility for a premium tax credit for coverage obtained on the Exchange under certain circumstances, such as when the ICHRA offered is either unaffordable or does not provide minimum value in accordance with ACA standards.
- Claims for reimbursement under an ICHRA must be substantiated and confirmed to relate to the cost of individual Exchange health insurance premiums. An employer may rely on an employee's attestation to this effect, and model attestation forms have been provided by the Departments. If an ICHRA sponsor learns of an incorrect or false attestation, future reimbursements relating to the relevant period may be denied.
- Participants potentially eligible to participate in an ICHRA must be provided with a written notice at least 90 days before the beginning of each plan year (with some exceptions for a shorter notice period in for an initial year of eligibility). The final regulations specify the content that must be provided in the notice.

Limited Time to Prepare

In order for employers to reimburse employees' purchase of individual ACA-regulated health insurance by January 1, 2020, there is much work to do in relatively little time. Before the November 1 start date of the open enrollment period for 2020 ACA coverage:

- Employers must adopt (or amend existing) HRA Plan documents to comply with the new requirements;
- Employers, as well as Exchanges will need to work to communicate the changes to eligible individuals; and
- All separate State-facilitated Exchanges, as well as the Federal Exchanges must implement any required website coding and enrollment procedures.

The State-facilitated Exchanges have been concerned about a possible 2020 rollout since that date was initially mentioned in proposed rules issued late last year. This April, the administrators of all 12 State Exchanges asked the Departments to postpone the effective

date. In response, the Departments have promised to provide technical assistance to the Exchanges to facilitate timely implementation of the new rules. Nonetheless, the final regulations are extremely detailed and complex. Whether, and to what extent, employers (and Exchanges) are able to embrace ICHRA reimbursement of individual health insurance premiums remains to be seen.

The attorneys of the Employment Law team of O'Neil, Cannon, Hollman, DeJong & Laing are closely following these new developments and are prepared to discuss how the change in HRA rules may impact your strategy regarding employee benefits offerings, ACA compliance, or how to amend an existing HRA or MERP (medical expense reimbursement plan) or to adopt a new HRA document to prepare for the reimbursement of individual coverage.

Employment LawScene Alert:
Creation of New Task Force Signals Increased State Scrutiny of Wisconsin Worker Classification

April 15, 2019 marked not only the end of the 2018 personal income tax season, but also the beginning of a new era of enforcement of Wisconsin employment practices. On that date, Governor Tony Evers issued an Executive Order creating a Joint Task Force on Payroll Fraud and Worker Misclassification (the "Task Force"). This Task Force will focus on workers who should be classified as employees but are misclassified as independent contractors.

The Task Force will be chaired by the Secretary of the Department of Workforce Development ("DWD") and will be staffed by representatives from the DWD, including its Worker's Compensation and Unemployment Insurance divisions, the Department of Revenue, and the offices of the Attorney General and the Commissioner of Insurance.

Background

Similar task forces have been implemented in recent years in Connecticut and Massachusetts (2008), New York (2016), Colorado, New Jersey, Tennessee, and Virginia (2018), and Michigan (2019).

One of the catalysts for the Wisconsin Task Force creation was the finding, under DWD audits from January 2016 through April 2019, of 5,841 misclassified employees and the related under-reporting of nearly $70 million in gross wages and $1.8 million in unemployment insurance taxes. Misclassification of employees also results in the underpayment of Social Security and Medicare-related employment law taxes.

Another impetus for the new interagency coordination is the concern that employers who misclassify workers as independent contractors gain an unlawful competitive advantage that allows them to under-bid or out-compete law-abiding employers.

Prior reviews of employer practices reported by the National Employment Law Project posit that audits of Wisconsin employers have typically revealed worker misclassification in 44% of investigated cases.

Task Force Mandates

The new Task Force is required to report annually to the Governor by March to describe its accomplishments and recommendation for the prior year. Specifically, the Task Force report must include the amount of wages, premiums, taxes, and other payments or penalties collected as a result of coordinated agency activities, as well as the number of employers cited for misclassification and the approximate number of affected workers. The Task Force must also identify administrative or legal barriers impeding more effective agency coordination. After consultation with representatives of business, organized labor, members of the legislature, and other agencies, the Task Force will also propose changes to administrative practices, laws, or regulations appropriate to:

- reduce agency coordination barriers;
- prevent worker misclassification from occurring;
- investigate potential violations of laws governing worker classifications;
- improve enforcement where such violations are found to have occurred; and
- identify successful mechanisms for preventing worker misclassification.

Key Take-Away

The Wisconsin Task Force is being implemented at a time when recent federal decisions by the National Labor Relations Board and the United States Supreme Court appear to be permitting some gig economy companies to more easily classify workers as independent contractors, rather than as employees.

As a result of the creation of the Task Force, however, Wisconsin employers should expect increased scrutiny from the DWD and Department of Revenue regarding independent contractor relationships.

The Employment Law team of O'Neil, Cannon, Hollman, DeJong & Laing recently presented client seminars in Pewaukee and Green Bay on the many aspects of worker classification and are well-positioned to assist Wisconsin employers in reviewing current arrangements or discussing how the law applies under various circumstances.

Employment LawScene Alert:
IRS Issues a Second Set of April 2019 Changes to Retirement Plan Correction Program

The IRS Employee Plans division on Friday, April 19, released an updated version of its comprehensive retirement plan correction protocol. Although touted as a "limited update" to the Employee Plan Compliance Resolution System, or EPCRS, the changes contained in this new Revenue Procedure 2019-19 nonetheless offer substantial savings opportunities for certain employer sponsors of 401(k), 403(b), and profit-sharing plans, and employee stock ownership plans (ESOPs).

The update is effective immediately, and is notable for being the second change in the EPCRS rules to take effect in April 2019. Under a previously-issued update to the program, a new online-only submission requirement took effect on April 1, 2019. As of that date, plan sponsors are no longer permitted to submit EPCRS correction applications or payments by mail.

Bottom Line

The effect of the April 19 update is to expand the circumstances under which a plan sponsor is permitted to correct a self-identified error under the self-correction program (SCP), rather than having to submit a formal application, and accompanying fee, to the IRS.

This expansion of the opportunities for self-correction is a welcome opportunity for plan sponsors who become aware of certain plan compliance failures involving the language of the plan document as well as particular types of errors in the operation of participant loan programs. Correction of the specified errors may now be made on a less formal basis. Provided that the proper correction protocol is followed and documented, a correction can now be completed without having to pay the usual IRS submission fee, which ranges from $1,500 to $3,500.

EPCRS Background

The purpose of the IRS EPCRS program, generally, is to provide a system of correction programs and procedures for sponsors of tax-qualified retirement plans that have fallen outside of the qualification requirements either because of errors in the language of the plan document or because of mistakes in how the plan is operated. The EPCRS correction program permits plan sponsors to correct these errors and thereby to continue to offer retirement benefits to their employees on a tax-favored basis.

Depending on the nature and severity of a retirement plan compliance error, three different

EPCRS programs exist, each with slightly different rules:

- SCP. For the least significant errors, the Self Correction Program (SCP) permits a plan sponsor to self-correct the error without paying any fee or sanction and without submitting any documentation to the IRS. Even though no documents are submitted to the IRS under the SCP program, it is important that the proper self-correction protocols described by the IRS are followed. An improper or undocumented self-correction provides no future IRS audit protection. A proper retirement plan self-correction, however, will protect a plan sponsor from future fees or penalties related to the properly-corrected error.

- VCP. For more significant compliance failures, or for failures not corrected within a specified time period, the only way to receive approval of a correction is to participate in the Voluntary Compliance Program (VCP). This program requires that a description of the error, and of its correction, be submitted to the IRS for formal approval. To use this program, a plan sponsor must pay a fee to the IRS. Under the recently-amended fee structure, the amount of the fee depends solely on the amount of plan assets and ranges from $1,500 (for plans with less than $500,000 in assets) to $3,500 (for plans with more than $10,000,000 in assets).

- Audit CAP. If it is the IRS, rather than the plan sponsor, who identifies a compliance error, then the only permitted correction program is the more expensive Audit CAP program. Errors can be corrected under Audit CAP if the IRS identifies an error during an audit. Under Audit CAP, the penalties imposed in order to retain the retirement plan's tax-qualification will be larger than under the VCP program, and will vary, based upon the nature and extent of the compliance error, the severity of the error.

Potential Opportunity to Make Key Corrections at a Lower Cost

The Treasury Department and IRS expect to continue to update the EPCRS program, in whole or in part, from time to time. Given the ever-changing and highly fact-specific nature of the IRS correction program, the severely adverse threat of plan tax-disqualification, and the need to determine the most effective correction strategy, plan sponsors who suspect or know that a retirement plan has a compliance error are advised to work confidentially with legal counsel specifically experienced in this area of practice. Because an error cannot be corrected under either the SCP or VCP programs after an IRS audit has begun, it is always best to respond to a compliance error quickly and proactively.

Now that the opportunities for self-correction have been expanded, there is no time like the present for plan sponsors to review their tax-qualified plan documentation and operations. Because more types of compliance errors can now be self-corrected, the cost of bringing an employer-sponsored retirement plan back into good standing may now be reduced.

Employment LawScene Alert:
Remember March 1 Deadline for Reporting a "Small" HIPAA Breach

Employers who are classified as covered entities under HIPAA are required to report any 2018 breach of protected health information that affected fewer than 500 individuals (also known as a small breach) by March 1, 2019. This current breach notification requirement arises from amendments made to HIPAA under the Health Information Technology for Economic and Clinical Health (HITECH) Act, as finalized in 2013. HIPAA defines a covered entity as either (1) a group health plan, (2) a health care clearinghouse, or (3) a health care provider who electronically transmits any protected health information. A covered entity may be an individual, an institution, or an organization.

Background

Under applicable rules, a breach is defined as an impermissible use or disclosure under the HIPAA Privacy Rule that compromises the security or privacy of the protected health information. Some exceptions apply, so that not all incidents will rise to the level of a breach. Still, an impermissible use or disclosure of protected health information is generally presumed to be a breach unless the covered entity demonstrates that there is a low probability that the protected health information has been compromised based on a risk assessment of several specified factors.

Notification Requirement

Upon the occurrence of a confirmed (or in some cases, suspected) breach, the affected individuals must be provided with detailed notification letters without unreasonable delay and no later than 60 days after the discovery of the breach. While the covered entity, most often, provides the required notifications, the final rules permit the delegation of reporting duties to a business associate.

A HIPAA breach also triggers an obligation to notify the Office of Civil Rights (OCR) of the U.S. Department of Health and Human Services (HHS).

- When a breach affects 500 or more individuals, the reporting entity must notify OCR contemporaneously with the notification to individuals (and must also notify local media outlets).
- Where a breach affects fewer than 500 individuals (also known as a small breach), however, a reporting entity must maintain a log or other documentation of all breaches occurring during the year, and annually report all such breaches no later than 60 days after the end of that calendar year.

For a small breach occurring any time in 2018, the deadline to report that breach to OCR is

March 1, 2019.

Small Breach Reporting Details

A reporting entity is not required to wait until the March 1 deadline to report a small breach. Small breaches may be reported as early as contemporaneously with the occurrence of the breach. Regardless of timing, all small breaches must be reported to OCR in the same manner. Specifically a reporting entity must report the breaches online through the OCR's "Breach Portal."

Note that even when a covered entity delegates the reporting function to a business associate, the covered entity retains ultimate legal responsibility for proper reporting. Accordingly, covered entities who delegate reporting may want to require proof of timely reporting.

Be aware that, while the reporting entity may report all small breaches on a single date, each separate breach incident will require a separate submission. Instead of simply uploading a log of breach incidents occurring in the prior year, the reporting entity must complete a six-section questionnaire to provide: (1) general information; (2) identification of the covered entity, business associate, and relevant contact information; (3) the nature of the breach; (4) a summary of related notices provided and actions taken; (5) an attestation, and; (6) a summary. Multiple fields must be completed within each of these six sections. The HIPAA status of a reporting party (as either a HIPAA covered entity or a business associate) must be indicated on the "Contact" tab of the online filing form.

The online reporting form also requires the reporting entity to indicate the level of pre-breach HIPAA compliance status, including whether or not HIPAA Privacy Rule safeguards and HIPAA Security Rule safeguards were in place.

Because filing the breach notice can be time-consuming, parties tasked with reporting 2018 small HIPAA breaches of unsecured protected health information are advised to gather and prepare the content to be reported before actually logging on to the OCR Breach Portal. Because any changes or updates to the submitted information must be entered as a separate entry, it is preferable to ensure that each submission is fully accurate. Moreover, because the content of Breach Notifications to OCR can form the basis for a future OCR investigation and enforcement action, it is advisable to have legal counsel review content prior to submission.

In addition to ensuring that 2018 breaches affecting fewer than 500 individuals are reported by March 1, covered entities and business associates should continue to ensure that HIPAA Policies and Procedures, as well as the applicable administrative, physical and technical safeguards are up to date and periodically reviewed.

Employment LawScene Alert:
Recent Legislation Impacts Qualified Retirement Plan Hardship Withdrawal and Plan Rollover Rules

The two-year budget agreement passed by Congress on Friday, February 9th, and signed by President Trump later that day, includes tax policy changes that affect qualified retirement plans. Specifically, qualified retirement plan hardship withdrawal operations will be impacted by the Bipartisan Budget Act of 2018 (the Budget Act) as follows:

- **Removal of the six-month prohibition on deferrals following a hardship withdrawal.** Section 41113 of the Budget Act directs the IRS to issue updated guidance to permit 401(k) and 403(b) plan participants who have taken a hardship distribution from a retirement plan to continue contributing to the plan, even immediately following the hardship distribution. Under current rules, once a participant elects to take a hardship distribution, no elective deferrals are permitted to be made until six months have passed from the date of the distribution. The revised rule will take effect on January 1, 2019 for plans that have a calendar-year plan year.
- **Inclusion of QNECs, QMACs, and profit-sharing contributions in hardship withdrawals.** Under current regulations, a plan sponsor may specify the sources of a participant's plan assets eligible for a hardship withdrawal, but such assets may in no event include certain employer contributions. Beginning on January 1, 2019 (for calendar-year plans), the Budget Act rules will permit a participant's 401(k) or 403(b) plan assets deriving from employer profit-sharing contributions, as well as from employer corrective contributions known as Qualified Nonelective Employer Contributions (QNECs) and Qualified Matching Contributions (QMACs), to be included in sources from which a hardship withdrawal may be taken. The earnings on such contributions will also be included among the assets available for withdrawal. Section 41114 of the Budget Act not only expands the potential sources of a hardship withdrawal, but also eliminates the requirement (previously elected by some employers) that a participant must have taken a plan loan before qualifying to take a hardship withdrawal.

The Tax Cuts and Jobs Act of 2017 (the Tax Act), signed into law by President Trump on December 22, 2017, affects certain plan loan distributions. Specifically, for all tax-qualified retirement plans that offer loans, including 401(k), 401(a), 403(b), and governmental 457(b) plans, the Tax Act provides for an:

- **Extended Deadline for Rolling Over Certain Plan Loan Offsets.**
  - Background and prior law: A plan loan "offset" occurs when an individual owes an outstanding loan to a qualified retirement plan, but then experiences a distribution event that is either (1) a termination of employment; or (2) the termination of the plan. If the plan, in such situation, permits a participant's account balance to be paid out in full, minus the loan amount, then a plan loan offset occurs. A Form 1099-R is issued, indicating that the offset amount is an actual distribution. If a participant receiving a loan offset takes no action, the offset loan amount is considered or "deemed" to be a distribution, and is subject to taxation. Under these facts,

taxation of the offset amount can be avoided if: (1) the distribution is otherwise eligible to be rolled over; and (2) the participant rolls the full amount of the distribution, including the amount of the offset, into an IRA. To include the offset amount in the rollover, the participant will need to contribute personal (or borrowed) funds to the rollover amount. Previously, offset loans could only avoid taxation if such a rollover occurred within the 60-day period beginning on the date offset distribution.

- New law, effective for plan years beginning on and after January 1, 2018: The Tax Act expressly extends the time period for avoid taxation by rolling over an offset loan until the participant's deadline for filing a federal income tax return (taking any extensions into account). This change means that in many cases, a participant will have more time in which to effect a tax-free rollover of a loan offset occurring following termination of employment.

Caution: No Change to Basic Tax Rules

Although recent legislation is trending toward easing the rules relating to hardship withdrawals and plan loans, it is important to remember that nothing about the fundamental tax treatment of these distributions have changed.

A common misconception (especially among participants) is that if a participant qualifies for a hardship distribution, then the distribution from the plan is tax-free. A hardship distribution is subject to the same taxation rules as other plan distributions. Satisfying the standards for a hardship distribution simply entitles the participant to receive an in-service distribution of elective deferrals (and other contributions) from the plan, but the hardship distribution is subject to income taxes applicable to plan distributions. A hardship distribution is also generally subject to a 10% early distribution penalty, unless the participant has reached age 59-1/2. A hardship distribution is never eligible to be rolled over into an IRA.

Similarly, once a plan loan has been deemed distributed (either due to a plan loan repayment default, because a plan does not provide for an offset option upon distribution, or because an offset is not timely rolled into an IRA), the deemed distribution of a plan loan is taxed in the same manner as a regular plan distribution for purposes of determining the tax, including any early distribution penalty. A deemed distribution may never be rolled over into an IRA.

Plan Sponsor Action Items:

With respect to plan hardship distributions, employer sponsors of 401(k) and 403(b) plans should prepare for the 2019 plan year by:

- Considering whether it is desirable to add a hardship distribution option to the plan (if not already permitted). If hardship distributions will be added, amend the plan and communicate the availability of the option to participants by preparation and distribution of a Summary of Material Modification (SMM) (or other appropriate form of communication in the event of a non-ERISA plan).
- Plan documents that already provide for hardship distributions should be amended, effective for

the first day of the 2019 plan year, to eliminate the 6-month restriction on elective deferrals following a hardship distribution and to expand the permitted accounts from which hardship distributions may be taken. These details should be communicated to participants in the form of an SMM.

With respect to plan loans, plan sponsors of plans that permit loans should:

- Review the plan loan policy and plan loan provisions to determine if either should be updated to reflect this rule, or consider whether to modify the loan policy to take advantage of this rule. For example, if the plan currently permits continued loan repayments following termination of employment consider whether this option should be continued or eliminated. Consider also whether a loan note should be allowed to be rolled over to a successor plan upon plan termination or if the new extended rollover period provides sufficient flexibility to participants absent a rolled over loan note.
- Consider whether plan participant communications should be revised to alert participants to the greater flexibility now allowable for rollover of loan offset amounts.
- As applicable, confer with any third-party administrator for the plan to avoid inadvertently deeming a participant's loan a deemed (taxable) distribution.

Employment LawScene Alert: Internal Revenue Code Section 409A Survives Repeal-and-Replace Attempt

Employer sponsors of nonqualified deferred compensation (NQDC) plans, as well as the executives and other service providers, who benefit from them, can breathe a sigh of relief. The ability to reward and retain key employees with incentive and compensation plans that provide a current opportunity to earn a payment to be provided (and taxed) in the future, will continue to be available, as it has been under American tax law for more than 80 years. Since late 2004, NQDC agreements have been regulated primarily by Internal Revenue Code (Code) Section 409A.

The House Tax Bill

The ongoing viability of NQDC came under direct threat in the initial draft of the Tax Cuts and Jobs Creation Act (TCJA) as proposed by the U.S. House of Representatives Ways and Means Committee on November 2, 2017 (the House Tax Bill). Section 3801 of the House Tax Bill, which was proposed in substantially similar form to the Section 409A repeal-and-replace proposal introduced in a proposed Tax Reform Act of 2014, would have drastically reduced the ability of employers to reward key employees with deferred compensation arrangements.

As drafted, the House Tax Bill would have eliminated Section 409A and supplanted it with a

new Section 409B. These changes, intended to be effective for services performed on and after January 1, 2018, would have meant, as of the New Year, that all NQDC arrangements would become fully taxable upon vesting, with only very limited opportunity to defer taxation until a future year. The proposed law would have applied not only to the common elective, nonelective, incentive payment, and phantom stock forms of NQDC, but would have also expressly *included* the (currently) sometimes-exempt equity-based compensation forms such as stock options, restricted stock units, and stock and stock appreciation rights.

The Joint Tax Committee had estimated that the proposed change would increase revenues by $16.2 billion between 2018 and 2027.

2017 Senate Tax Bill

The language that would repeal section 409A and replace it with a new Section 409B was removed from the final version of the House Ways & Means Committee's Tax House Bill, as issued on November 9, 2017. The Chairman's Mark of the Senate tax reform proposal issued on the same day, however, resurrected the proposals. As unveiled on November 9, 2017 by Senator Orrin Hatch, Chairman of the Senate Finance Committee, the initial Senate version of the TCJA (the Senate Tax Bill) contained the identical Section 409A repeal-and-replace provisions.

Senate Finance Committee Mark Up

Finally, upon the successful amendment offered by Senator Rob Portman, the Section 409A repeal-and-replace proposal was stricken in its entirety from the legislation. This action preserves the current, well-established system, which would have been rendered virtually extinct by the repeal-and-replace proposal. The proposal's demise became known concurrent with the Joint Committee on Taxation's issuance of the Chairman's Modification to the Chairman's Mark of the TCJA late in the day on November 14, 2017.

Impact

The retention of the existing system of taxation for NQDC arrangements is great news for employers and key employees, who can now continue to offer (and benefit from) compensation packages as appropriate to reward and retain top talent. It is also good policy, in that it does not impose limitations on the ability to earn and save for retirement at a time when the general retirement savings rates of Americans across nearly all income levels are widely reported to be insufficient.

Employment LawScene Alert:
ACA Employer Payment Notices Arriving Soon

Buried in IRS guidance issued on November 2 is news that the IRS will soon be issuing notices to employers of potential ACA taxes. While the ACA employer payments are widely referred to as “penalties,” they are actually “assessable payments” in the form an excise tax.

Specifically, the IRS has announced that applicable large employers (ALEs) will begin receiving notices of potential liability “in late 2017” if the information reported for 2015 on Forms 1094-C and 1095-C indicates that the employer may owe an employer shared responsibility payment. ALEs are employers with 50 or more full-time (including full-time equivalent) employees for a calendar year. Internal Revenue Code Section 4980H, generally, provides for two circumstances under which an employer may owe an employer shared responsibility payment.

First, under Section 4980H(a), an ALE in 2015 may be penalized if it did not offer health coverage to at least 70% of full-time (30 hour-per-week) employees (and their dependents). The Section 4980H(a) penalty, for 2015, was $177.33 per month (or $2,080 per year, if applicable in all months), multiplied by all full-time employees, and reduced by the first 80 full-time employees. This assessed payment would be triggered if at least one employee (of an ALE not offering coverage) enrolled in subsidized coverage through the Exchange.

Second, under Section 4980H(b), an ALE in 2015 may be penalized if although it offered coverage to at least 70 percent of its full-time employees (and their dependents), at least one full-time employee received a premium tax credit to help pay for coverage through the Exchange, which may occur because the ALE did not offer coverage to that particular employee or because the coverage the employer offered that employee was either unaffordable or did not provide minimum value. The Section 4980H(b) penalty, for 2015, was $260 per month (or $3,120 per year, if applicable in all months) per full-time employee who was not offered coverage (or was offered coverage that was either unaffordable, or did not provide minimum value), and who enrolled in subsidized coverage through the Exchange.

Any potential employer shared responsibility payment that might be assessed would relate to coverage offered (or not offered) to the employer’s full-time employees during the 2015 calendar year.

What Information Will the IRS Letter Contain?

The proposed payment notice will be in the form of IRS Letter 226J, which will include:

- a brief explanation of Code Section 4980H;
- an employer shared responsibility payment summary table itemizing the proposed payment by month and indicating for each month if the liability is under Code Section 4980H(a), Code Section 4980H(b), or neither;

- an employer shared responsibility response form, Form 14764, “ESRP Response”; and
- an employee PTC list, Form 14765, “Employee Premium Tax Credit (PTC) List” which lists, by month, the ALE’s assessable full-time employees (individuals who for at least one month in the year were full-time employees allowed a premium tax credit and for whom the ALE did not qualify for an affordability safe harbor or other relief (see instructions for Forms 1094-C and 1095-C, Line 16), and the indicator codes, if any, the ALE reported on lines 14 and 16 of each assessable full-time employee’s Form 1095-C.

The response to Letter 226J will be due by a specified date, which will generally be 30 days from the date of Letter 226J.

Letter 226J will contain the name and contact information of a specific IRS employee that the ALE should contact if the ALE has questions about the letter.

What Do I Need to Do?

If your business receives a Letter 226J from the IRS, you should carefully review all information and determine whether you believe the proposed payment amount is correct. You may want to consider whether your company was eligible for any transition relief in 2015.

If the Letter is Correct

If you agree with the payment amount determination, you should complete, and return to the IRS the enclosed Form 14764. You should also provide full payment for the amount, either by check, or electronically, using the Electronic Federal Tax Payment System EFTPS system.

If the Letter is Incorrect

If you disagree with the payment amount determination, you will be required to complete and return the “ESRP Response” section of the enclosed Form 14764 to substantiate the basis for your disagreement. Your response may include supporting documentation, such as proof that health insurance was offered, or relevant coverage records. Your response must also specify, on the “Employee PTC List,” which changes are requested in order to correct the Forms 1094-C and 1095-C filed for 2015. The Letter 226J will include instructions on how to complete the required forms.

The IRS will respond to an ALE’s formal disagreement by sending Letter 227, acknowledging the ALE’s response and describing any further actions required. If the ALE disagrees with the IRS conclusions in the Letter 227, the ALE may request, within 30 days, a “pre-conference assessment” with the IRS Office of Appeals.

If, after any additional correspondence or discussions, the IRS ultimately determines that the payment is owed, the ALE will be provide the ALE with Notice CP 220J, which is a notice and demand for payment.

In light of the imminent arrival of the ACA potential payment notices, employers should be prepared to review and respond to Letter 226J quickly. Now is a good time to revisit the coverage offered in 2015, and to ensure easy access to applicable records.

It is important to note that, while scammers might see an opportunity to contact employers to demand payments, the IRS will initially contact ALEs about ACA payments only by letter (and not by email or phone).

Employment LawScene Alert:
IRS Announces 2018 FSA, Transportation, and Employee Benefit Plan Limits

The Internal Revenue Service has released the cost-of-living adjustments to the dollar limits under various employer-sponsored benefit plans for 2018. Several key limits (indicated in bold, below) have been increased for 2018.

Employer-sponsors of benefit plans should update payroll and plan administration systems for the 2018 limits and ensure that any new limits are incorporated into relevant participant communications, enrollment materials and summary plan descriptions, as applicable.

Health FSA Employee Contribution and Transportation Plan Limits

- For 2018, the maximum dollar limit on employee contribution to health flexible spending arrangements (FSAs) will increase to **$2,650** from the prior limit of $2,600. An Employer is not required to adopt the new Health Care FSA increase, but may do so as long as the Health FSA Plan document is expressly amended for this purpose.
- The maximum pre-tax value of a qualified transportation plan for employee parking or transit passes will increase by $5 to **$260** per employee, per month in 2018.

2018 Qualified Retirement Plan Limits

For retirement plans beginning on and after January 1, 2018, the following dollar limitations apply for tax-qualified retirement plans:

- The elective deferral limit under Section 402(g) or the Internal Revenue Code (Code) will increase from $18,000 to $**18,500** for employees who participate in:
  - Code Section 401(k) plans;
  - Code Section 403(b) plans; and
  - Most Code Section 457 plans.
- The catch-up contribution limit for those age 50 and over under will remain unchanged at $6,000 for all plans other than SIMPLE 401(k) and SIMPLE IRAs. (For these SIMPLE plans, the catch-up

contribution limit for those age 50 and over under will remain unchanged at $3,000).

- The limitation on the annual benefit for a defined benefit plan will increase from $215,000 to **$220,000**.
- The limitation on annual additions (meaning total employee plus employer contributions) to a participant's defined contribution plan will increase from $54,000 to **$55,000**.
- The limit on the amount of annual compensation taken into account under a tax-qualified retirement plan will increase from $270,000 to **$275,000**.
- The limitation used in the definition of a highly compensated employee (HCE) under Code Section 414(q) will remain unchanged at $120,000.
- The limitation used in the definition of a key employee in a top-heavy plan under Code Section 416 will remain unchanged at $175,000.
- The dollar amount under Code Section 409(o) for determining the maximum account balance in an employee stock ownership plan (ESOP) subject to a five-year distribution period will increase from $1,080,000 to **$1,105,000**.
- The dollar amount used to determine the lengthening of the five-year distribution period will increase from $215,000 to **$220,000**.

Prior Guidance on Additional 2018 Limits

Social Security Taxable Wage Base

As announced in mid-October (and adjusted in November), the Social Security Administration announced that the Social Security wage base for 2018 will increase slightly (from $127,000) to **$128,400**. This is the maximum wage base subject to the FICA tax and is also the maximum "integration level" for retirement plans using "permitted disparity." (The 2018 increase is about 1% higher than the 2017 wage base. In contrast, the 2017 wage base increase was more than 7% higher than the 2016 amount).

2018 Health Savings Account Limits

In May of this year, the IRS announced that combined annual contributions to a Health Savings Account (HSA) in 2018 must not exceed the maximum annual deductible HSA contribution, which will be **$3,450** for single coverage and **$6,900** for family coverage. These limits reflect a $50 and $150 increase over the 2017 maximums, respectively. The catch-up contribution for eligible individuals who will attain age 55 or older by year end remains at $1,000.