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

SPRING 2018

New Excise Tax on Excess Compensation Paid by Tax-Exempt Employers

By Brian Belisle, Esq.

The 2017 Tax Cut and Jobs Act, signed into law on December 22, 2017, added Internal Revenue Code section 4960, which imposes a 21% excise tax on annual compensation in excess of $1 million paid by an "applicable tax-exempt organization" to a "covered employee." In addition, the excise tax applies to "excess parachute payments." The excise tax is payable by the tax-exempt organization.

Effective Date. The new excise tax is effective for tax years beginning after 2017. There is no grandfather or transition rule for existing arrangements, such as Section 457(f) retirement arrangements.

Applicable Tax-Exempt Organization. An "applicable tax-exempt organization" includes any entity that is exempt under Code section 501(a), a farmers' cooperative under Code section 521(b)(1), and a governmental entity whose income is exempt under Code section 115(l). It is not clear that a public university would be included, because its exemption relies on the doctrine of intergovernmental immunity, not Code section 115(l).

Covered Employee. Under this new excise tax provision, a "covered employee" is each of the five highest paid employees for the year, and any person (including a former employee) who was a covered employee for any tax year after December 31, 2016. Thus, a tax-exempt employer must determine its covered employees for their 2017 tax year, which is one year prior to the effective date of the new excise tax. Once an employee is a covered employee, that person is a covered in employee in all subsequent tax years.

Compensation Counted Towards the Limit. Compensation subject to the excise tax generally includes all taxable wages subject to tax withholding, other than Roth contributions to a qualified plan. This includes any amounts that become taxable under a Code section 457(f) retirement arrangement. In addition, a tax-exempt employer must include compensation paid to the covered employee by any "related entity." A person or government entity is considered to be related to the tax-exempt organization if the person or entity:

- controls, or is controlled by, the applicable tax-exempt organization;
- is controlled by a person, or persons, that control the organization;
- is a supported organization under Code section 509(f)(3);
- is a supporting organization under Code section 509(a)(3); or
- if the organization is a VEBA under Code section 509(c)(9), establishes, maintains, or makes contributions to that VEBA.

Compensation subject to the excise tax does not include wages paid to a licensed medical professional (including a veterinarian) for medical or veterinary services performed by the professional.

Excess Parachute Payments. The new 21% excise tax is also imposed on "excess parachute payments." An excess parachute payment arises if an employee's severance payments exceed *three times* the employee's "base amount." An employee's base amount is the average annual taxable compensation from the employer for the employee's prior five calendar years (or shorter period of employment). If the severance payments exceed three times the base amount, then everything

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in excess of *one times* the base amount is an excess parachute payment subject to the 21% excise tax.

IRS' Anti-Abuse Authority. New Code section 4960(d) gives the IRS authority to issue regulations "as may be necessary to prevent avoidance of the tax under this section, including regulations to prevent avoidance of such tax through the performance of services other than as an employee or by providing compensation through a pass-through or other entity to avoid such tax."

Next Steps. While we anticipate further guidance from the IRS in the coming months, and will update you accordingly, tax-exempt employers with employees who may receive more than $1 million of compensation during a tax year, including upon the vesting of any 457(f) arrangement, or who have a robust severance package, should determine whether they might be subject to the excise tax. One key consideration for tax-exempt employers is the impact of significant accumulated savings under a section 457(f) retirement arrangement. A modestly paid executive, who was one of the top five paid employees in any year after 2016, could easily accumulate over $1 million in a section 457(f) arrangement, and subsequently trigger the excise tax when the right to those benefits vest.

Impacted tax-exempt employers will need to identify and maintain a list of their "covered employees," and identify the compensation that might be subject to the excise tax. A tax-exempt employer should review, and if necessary, restructure its compensation and retirement programs to minimize the potential impact of the excise tax. As with any compensation and retirement plan changes, a tax-exempt employer must consider the requirements imposed by Code sections 457(f) and 409A.

Author

Brian G. Belisle
612.607.7271
bbelisle@foxrothschild.com

The Unintended Consequence of Rising Interest Rates: Overfunded Defined Benefit Plans

By Harvey M. Katz, Esq.

While many in the employee benefits community have sounded the death knell for defined benefit plans in recent years, there is some mounting evidence that their prediction has been premature. While corporate America has virtually abandoned defined benefit plans as a retirement benefit, these plans are alive and well among profitable, closely-held companies, particularly in the case of professional employers such as doctors and lawyers. To be sure, these plans present opportunities for larger tax deductions and, by virtue of their design, are more easily structured to favor owners and other key employees.

The larger deductions are a function of the nature of defined benefit plans -- which is to pay a fixed monthly pension to participants upon termination or retirement. It is the employer's responsibility to deposit sufficient funds into the plan so that enough dollars will be available to pay the pensions promised to participants. As a result, fluctuations in interest rates and investment returns affect the amount of the employer's obligation.

Notwithstanding the large deductions available under defined benefit plans, they are subject to limitations. These limitations are known as the Section 415 limitations and they restrict the level of benefits that can be paid to a single participant. Without going into the nuances of the applicable Treasury Regulations, the maximum annual pension that may be paid to a single participant

is $220,000. The approximate lump sum value of this pension under currently mandated conversion rates is $2,800,000.

Therein lies the rub. Current interest have not materially risen from historic lows in more than 20 years. Given recent moves by the Federal Reserve, this appears likely to change. While there will be many "winners" and "losers" as a result of a sustained rise in interest rates, sponsors of defined benefit plans will certainly be one of the affected parties.

The question is whether rising interest rates hurt or help the sponsor of a defined benefit plan. The answer is a simple one for many sponsors of "legacy" defined benefit plans who have struggled to fund them during many years of low interest rates and lean years during the recession of the previous decade. Rising interest rates lower the lump sum value of most pension benefits, and thereby increase their level of funding. However the answer is not so simple for employers of well-funded plans that are structured to favor owners and key employees. Higher interest rates only serves to decrease the value of the pensions promised to the individuals that the plan was designed to favor. To be sure, a rule of thumb estimate is that pension liabilities decrease by six to seven percent for every one-half percent increase in interest rates. Thus, a one percent increase in interest rates will like result in a $400,000 reduction in the maximum lump sum payable to each key employee receiving maximum permitted benefits.

As a result of the less valuable pensions for key participants, a plan that is already adequately funded will have a surplus of assets. Ostensibly, a surplus may appear to be a positive development. However, it results in lower plan deductions, as well as lower lump sum pension payments. More importantly, in certain situations the excess may be "locked up" inside the plan, because key employees are already receiving the maximum pensions permitted by law. If the excess cannot be eliminated, upon the termination of the plan, it must be returned to the employer as taxable income and, in addition, is subject to a 50% excise tax on that reversion. The net result is that 85% to 90% of the surplus could be consumed by income and excise taxes.

There is a silver lining to this cloud. Unless most of the key participants are close to retirement, excess assets can be a good thing. They serve as cushion against future investment losses, declines in interest rates and lean years in which the employer is unable to make all of the permitted or required contributions to the plan. The pension law recognizes inherent volatility of pension funding status by limiting deductible pension contributions to 150% of the current value of the plan's liabilities, enabling an employer to establish a reserve against future reversals.

In the event that the surplus is not otherwise eliminated, there are ways that it can be monetized. In some cases, the ancillary benefits such as life insurance can consume part of an existing surplus. In cases where the defined benefit plan is terminated, the excise tax can be reduced or eliminated by rolling the surplus into a defined contribution plan. In other cases, part of the employer's business, together with the overfunded plan, can be sold to a third parties with underfunded plans. The purchase price in the sale can be adjusted to compensate the employer for the value of the surplus.

In conclusion, employers who find themselves with an overfunded plan as a result of rising interest rates have many options available to them. However, it starts with an awareness that rising interest rates will likely create an overfunded situation. Armed with such knowledge, employers can be proactive and ready to make decisions to address any situation that arises.

Author

Harvey M. Katz
212.878.7976
hkatz@foxrothschild.com

Beware: HIPAA Applies to the Health Plans You Never Knew You Had

By Jessica Forbes Olson, Esq. and Elizabeth R. Larkin, Esq.

You may be surprised to learn that those "extra" benefits your company offers to its employees such as your employee assistance program (EAP) and wellness program likely are subject to the HIPAA privacy, security and breach notification rules (collectively, HIPAA Rules). In both cases, EAPs and wellness programs must comply with the HIPAA Rules to the extent that they are "group health plans" that provide medical care.

As background, the HIPAA Rules apply to "covered entities" and their "business associates." Health plans and most healthcare providers are "covered entities." Employers, in their capacity as employers, are not subject to the HIPAA Rules. However, the HIPAA Rules do apply to any "protected health information" (PHI) an employer/plan administrator holds on a health plan's behalf when the employer designs or administers the plan.

Employee Assistance Programs

Plan administrators and some EAP vendors may not consider EAPs to be group health plans because they do not think of EAPs as providing medical care. Most EAPs, however, do provide medical care. They are staffed by health care providers, such as licensed counselors, and assist employees who are struggling with family or personal problems that rise to the level of a medical condition, including substance abuse and mental health issues. In contrast, an EAP that provides only referrals on the basis of generally available public information, and that is not staffed by health care providers, such as counselors, does not provide medical care and is not subject to the HIPAA Rules.

A self-insured EAP that provides medical care is subject to the HIPAA Rules, and the employer that sponsors and administers the EAP remains responsible for compliance with the HIPAA Rules because it acts on behalf of the plan. On the other hand, for an EAP that is fully-insured or embedded in a fully-insured policy, such as long-term disability coverage, the insurer will have the primary obligations for compliance with the HIPAA Rules for the EAP. The employer will not be responsible for overall compliance with the HIPAA Rules for an insured EAP even though it provides medical care, but only if the employer does not receive PHI from the insurer or only receives summary health information or enrollment/disenrollment information. Even then, the employer needs to ensure it doesn't retaliate against a participant for exercising their rights under the HIPAA Rules or require waiver of rights under the HIPAA Rules with respect to the EAP.

An EAP that qualifies as an "excepted benefit" for purposes of HIPAA portability and the Affordable Care Act – as is most often the case because the EAP is offered at no cost, eligibility is not conditioned on participation in another plan (such as a major medical plan), benefits aren't coordinated with another plan and the EAP does not provide "*significant* benefits in the nature of medical care" – can be subject to the HIPAA Rules. In other words, just because you've determined that your EAP is a HIPAA excepted benefit doesn't mean the EAP avoids the HIPAA Rules. Most EAPs are HIPAA excepted benefits, yet subject to full compliance with the HIPAA Rules.

Employers/plan administrators facing unexpected compliance obligations under the HIPAA Rules because of a self-insured EAP that provides medical care will need to enter into a HIPAA business associate agreement with the EAP vendor, amend the EAP plan document to include language required by the HIPAA Rules and develop and implement other compliance documents and policies and procedures under the HIPAA Rules. One option is to amend any existing compliance documents and policies and procedures under the HIPAA Rules for another self-insured group health plan to make them apply to the EAP as well. If the EAP is the plan administrator's only group health plan for which it has compliance responsibility under the HIPAA Rules, the plan administrator should consult with legal counsel to develop and implement all necessary documentation for compliance with the HIPAA Rules.

Wellness Programs

Although many employers do not think of their wellness programs as a group health plan, wellness programs may be considered a group health plan in at least two common ways. First, if an employer offers a wellness program as part of another group health plan (e.g., a major medical plan), any individually identifiable health information collected from participants in the wellness program is PHI under the HIPAA Rules. In other words, if the wellness program is part of another group health plan, such as a major medical plan—for example, by offering incentives like premium reductions or lower cost-sharing amounts for major medical coverage based on participation in the wellness program—the wellness program will be subject to the HIPAA Rules.

Second, a wellness program will be a group health plan subject to the HIPAA Rules if it provides medical care to employees. Some benefits commonly provided by wellness programs are not medical benefits—a health risk assessment (HRA), for example, is typically a questionnaire intended to identify an employee's possible health risks and to motivate the employee to make positive behavior changes to reduce those risks. HRAs are not medical care if they are not administered by medical professionals and are not intended to diagnose illness or prescribe treatment. Other non-medical benefits offered by wellness programs include exercise, nutrition, or weight loss programs, as long as they are not connected with or recommended in response to a medical practitioner's diagnosis. A wellness program may also provide general health-related information, or referrals (if made by people without any special medical training), without providing medical care (and without triggering compliance obligations under the HIPAA Rules).

Other common wellness program benefits, however, may provide medical care. A biometric screening (often conducted in conjunction with an HRA) is typically medical care because it often involves a blood draw, labs and a clinical assessment of an employee's health and is intended to diagnose, or indicate an increased risk of, certain health conditions (heart disease, diabetes, etc.). Wellness programs also often include disease management and smoking cessation services, which are considered medical care because they are designed to assist with specific health conditions. Even something as simple as an employee flu shot is medical care, whether or not it is part of another group health plan. Individualized health coaching by trained nurses or counseling provided by trained counselors also would be considered medical care. Providing any of this medical care through a wellness program may lead to unexpected compliance obligations under the HIPAA Rules.

Employers/plan administrators facing unexpected compliance obligations under the HIPAA Rules because of a self-insured wellness program that provides medical care will need to enter into a the HIPAA Rules business associate agreement with the wellness program vendor, amend the plan document for the wellness program to include language required by the HIPAA Rules and develop and implement other compliance documents and policies and procedures under the HIPAA Rules. One option is to amend any existing compliance documents and policies and procedures in place under the HIPAA Rules for another self-insured group health plan (such as a major medical plan) to make them apply to the wellness program as well. If the wellness program is the plan administrator's only group health plan for which it has compliance responsibility under the HIPAA Rules, the plan administrator should consult with legal counsel to develop and implement all necessary documentation for compliance under the HIPAA Rules.

Authors

Jessica Forbes Olson
612.607.7478
jforbesolson@foxrothschild.com

Elizabeth R. Larkin
612.607.7468
elarkin@foxrothschild.com

(Another) Change to the Annual HSA Limit

By Seth I. Corbin, Esq.

On April 26, 2018, the IRS released welcomed guidance in the form of Revenue Procedure 2018-27. Rev. Proc. 2018-27 reverses a recent change made to the annual limitation on health savings account (HSA) contributions for individuals electing family coverage under their high deductible health plan. This is much needed relief for individuals with such coverage, as well as many employers who were scrambling to accommodate a downward adjustment to the annual limitation based on retroactive IRS guidance issued earlier this year.

Specifically, the IRS had previously adjusted the annual limitations for individuals enrolled in family coverage from $6,900 per year to $6,850 per year; the inflation adjustment was made earlier in 2018, via Rev. Proc. 2018-18, and applied retroactively to all of 2018 without any transition relief. As a result, employers were left trying to reconcile this new, lesser maximum amount with elections already made by employees, such as annual salary reduction elections made through cafeteria plans. As one might imagine, the administrative issues and financial burdens created some unrest as to how to account for this $50 reduction without exposing employees to the penalties associated with excess contributions.

Fortunately, this new guidance allows those $6,900 contribution elections to remain in place without triggering excise taxes for excess contributions. Further, Rev. Proc. 2018-27 includes guidance for those who already received a $50 distribution based on the change. Those individuals may repay that distribution to their HSA and treat the distribution as the result of a mistake of fact due to reasonable cause, and it will not be included in that individual's gross income. Alternatively, individuals can retain the $50 distribution and it will not be subject to the 20% additional tax or included in gross income so long as the distribution is received on or before the taxpayer's 2018 tax return filing due date.

Author

Seth I. Corbin
412.394.5530
scorbin@foxrothschild.com

Fox Rothschild LLP
ATTORNEYS AT LAW

For Your Benefit is available online at

www.foxrothschild.com.