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DOL Guidance on the ACA and Federal Wage Payment Statutes

The Wage and Hour Division (WHD) of the U.S. Department of Labor (DOL) has issued guidance (All Agency Memo, or AAM) to governmental agencies on the interaction of the Affordable Care Act and government contractors' responsibilities for payment of fringe benefits under the McNamara-O'Hara Service Contract Act (SCA), the Davis-Bacon Act (DBA), and the Davis-Bacon Related Acts (DBRA) (together DBA/DBRA). The SCA and DBA/DBRA require covered contractors to pay prevailing wages and fringe benefits to covered employees as part of the wage determinations issued by the DOL. The guidelines explain the issue of whether employers may receive credit for ACA-related premiums against prevailing wages/fringe benefits. The guidance from the DOL is "yes" for actual premium payments and "no" for excise tax payments made in lieu of offering an ACA-compliant plan.

The AAM underscores that the SCA, DBA/DBRA, and ACA are separate federal laws and government contractors that are applicable large employers (ALEs) should be mindful that each law is independent. Thus, for example, just because an ALE satisfies the SCA does not necessarily mean that it's compliant with the ACA. In general, the ACA's employer shared responsibility provisions require an employer with an average of at least 50 full-time employees (including full-time equivalents) to provide its full-time employees (and their dependents) affordable health care offering minimum value. If the ALE to whom this applies chooses not to offer such health care, then it may make a non-deductible payment (by way of an excise tax) to the Internal Revenue Service.

Under the SCA and DBA/DBRA, an employer may not take credit against the prevailing wage benefits for those benefits required by federal, state, or local law (such as the federal obligation for an employer to contribute to Social Security). The AAM confirms that, because an ALE may offer ACA-compliant health care or, alternatively, may simply pay an excise tax to the IRS, the ACA does not require an employer to provide health care.

The WHD permits ALEs to credit contributions to a health plan toward SCA or DBA/DBRA fringe obligations. The DOL treats the ACA the same way it has treated Massachusetts' medical care requirement – by permitting credit – and not like Hawaii's mandated health care coverage, for which the DOL does not allow credit toward fringes, although under the under SCA, does provide a separate and lower health and welfare benefit rate.

If an ALE decides to forego providing health care by paying the excise tax to the IRS, the employer cannot credit the payment of such tax toward SCA or DBA/DBRA fringe obligations. The AAM notes that such a payment does not confer benefits specifically on the workers and, therefore, is not a bona fide fringe benefit as that term is defined and interpreted under the SCA and DBA/DBRA.

Government contractors' employees often wrongly believe they should have the choice of receiving cash in lieu of benefits mandated by the SCA or DBA/DBRA. The AAM affirms that whether to provide employees with benefits or cash in lieu of benefits is the ALE's option, so long as it is not otherwise required under a collective bargaining agreement:

> …Thus, for example, if an [ALE] covered by the SCA or DBRAs chooses to provide all employees with fringe benefits in the form of health coverage, it may do so even if some or all of its employees might prefer to receive…cash…. [A] contractor need not obtain an employee's concurrence before contributing the [entire fringe to health care].

However, an employee's concurrence (and written authorization of deductions) is needed for any benefit the employer intends to provide which requires an employee payment or premium share to be deducted from wages. For example, if the employer pays 100 percent of a medical plan benefit for an employee, the employer may simply provide the benefit, and take credit under the SCA/DBA/DBRA. On the other hand, if the employer pays only 80 percent of the medical plan benefit, the employee must agree to the benefit and deduction of the employee portion of the benefit from wages.

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Common Compliance Issues for Health Savings Account Participants

A health savings account, or HSA, is an attractive means of offsetting heath care costs. HSAs are tax-exempt trusts or custodial accounts established to pay medical expenses or reimburse incurred expenses. Contributions made to an HSA on behalf of an eligible individual can be made by an eligible individual, an employer, or a family member. HSA contributions made by an eligible individual or family member are deductible for the eligible individual and distributions to pay qualified medical expenses from an HSA are not taxed. Employer contributions to an HSA may be excluded from an employee's gross income.

To enjoy tax-deductible or pre-tax HSA contribution benefits, participants must meet certain eligibility requirements. Overlooking the following will result in the taxpayer having to include in income all contributions made to the HSA, with the amount subject to a 10 percent additional excise tax.

An eligible individual will qualify for tax-exempt contributions if the individual:

- Is enrolled in a high deductible health plan (HDHP)
- Has no other health coverage under a plan which is not an HDHP (personally or through spouse coverage)
- Is not enrolled in Medicare
- Cannot be claimed as a dependent in the current tax year
- Is not participating in a medical flexible arrangement under a Code §125 plan unless the arrangement is a limited purpose flexible spending arrangement offering only vision, dental, or other non-health plan benefits

An individual is deemed as meeting these requirements even if the eligible individual's spouse is enrolled in non-HDHP family coverage, as long as the spouse's coverage does not cover the eligible individual. If each spouse in an eligible individual, each spouse wanting an HSA must open a separate HSA (as there is no "joint HSA").

HDHPs have a higher annual deductible than typical health plans (with the exception of plans for preventive care benefits only). HDHPs also have a maximum limit on the amount of annual deductible and out-of-pocket medical expenses that must be paid for covered expenses (such as copays).

Two types of HDHP coverage can be provided to an eligible individual enrolled in an HSA: "self-only" or "family." Self-only covers only an eligible individual. Family provides coverage to an eligible individual and at least one other individual. In order to be deemed an HDHP plan for 2016, an HDHP must have a minimum annual deductible of at least $1,300 for self-only coverage and at least $2,600 for family coverage, and the maximum annual deductible and out-of-pocket medical expenses must not exceed $6,550 for self-only coverage or $13,100 for family coverage.

If a family plan does not meet the HDHP rules for high deductible amounts, as long as the individual deductible is met for one family member, the higher annual deductible amount for the family does not need to be met. However, if neither the family nor individual family member deductible meets the minimum annual deductible for family coverage, the plan will not qualify as an HDHP and thus the individual will not be an eligible individual for purposes of attaining HSA qualified tax benefits.

HDHPs are subject to comparable contribution requirements, unless the participants make premium payments or contributions to the HDHP through a Code §125 plan. If contributions or premiums are made to the HDHP through an election under a Code §125 plan, the comparable contribution requirements do not apply, but the coverage and discrimination rules under Code §125 are applicable. Many employers disqualify their HDHPs because they do not know the rules applicable to contributions, coverage or discrimination.

Those employers who sponsor HDHPs and facilitate participant enrollment in HSAs should provide sufficient educational materials to participants to permit them to understand the basic eligibility requirements for HSA participation.

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How would you be sitting if a Department of Labor (DOL) investigator asked for your company's group

health plan documents? Would you be able to put your hands on an updated copy of the plan document, summary plan description, summary of benefits and coverage, all amendments and summaries of material modification since the last restatement of the plan? What kind of shape are those documents in? Do they comply with the changes imposed by the Affordable Care Act? Can you demonstrate that you actually distributed the summary plan description and other plan disclosure documents that are required to be distributed? Take a glance at the kind of documentation a DOL agent often requires in an audit on the DOL website.

Bear in mind that the DOL is not the only federal agency that might demand your company's plan documents. The Internal Revenue Service (IRS) enforces the federal tax code provisions that apply to employee benefit plans, including group health plans and cafeteria plans. To enjoy the tax benefits of offering and participating in such plans, the employer sponsoring the plan has to comply with a host of laws and regulations including documentation requirements. Also, you need to know that the agencies will share information with each other, so what's collected by the IRS in an audit will be shared with the DOL to the extent the IRS examiner sees fit. Take a closer look at an actual IRS document request for a retirement plan on the IRS website.

So, what are the significant consequences of plan document mistakes like failing to have a plan document, failing to update it, or failing to provide it to a plan participant? The IRS can require re-characterization of pre-tax amounts used to pay for group health coverage under a cafeteria plan if there's no cafeteria plan document and, under the Employee Retirement Income Security Act (ERISA), the company can be liable for civil penalties for failure to provide requested documents. Perhaps more significant is the litigation risk that arises when you fail to maintain or provide well-written plan documents to participants, especially summary plan descriptions (SPDs), which must be written so that they're understandable by the average participant. The bottom line is that plan document mistakes can cost an organization a lot of money and, as in everything else you do, an ounce of prevention is worth a pound of cure.

To prevent plan document mistakes, you first need to satisfy the content requirements of the applicable laws and regulations. For health and welfare plans (like those providing medical, dental, vision, life, or disability benefits), this generally means your company's SPDs must satisfy the content requirements specified under ERISA by the DOL in regulations, including the requirement that the content be understandable by the average participant. The SPD usually can double as the plan document for health and welfare plans, with a few important additional provisions. Not so for retirement plans! The content requirements specified by the IRS for retirement plan documents make the plan document too technical and confusing for the average participant to understand. For cafeteria plans, there is no SPD requirement, but the IRS requires specific content for the plan document as enumerated in proposed regulations.

Having the required content and ensuring it's well-written, of course, is not enough. You also have to make sure that plan documents are provided to participants within no more than 30 days of being requested and that SPDs (and certain other disclosures) are distributed even if they're not requested. SPDs need to be distributed to participants within 90 days after the person becomes a participant. If you're not mailing or hand-delivering the SPD and want to use email instead, make sure that using email is an integral part of your employees' jobs or get affirmative consent – there are specific rules about how you do that. ERISA requires that an updated summary plan description be distributed every five years unless there have been no amendments effecting the content of the summary plan description. In that case, the summary plan description just needs to be redistributed every 10 years.

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Employee Terminated upon Return to Work After Alcohol Treatment Could Proceed with Claims against Employer

An employee terminated immediately upon his return from medical leave for alcohol rehabilitation presented sufficient evidence of discrimination under the Family and Medical Leave Act (FMLA), Americans with Disabilities Act (ADA), and Ohio state law to present his case to a jury, according to a federal court in Ohio. The employer claimed that the

employee had been terminated for misappropriating company goods, but email exchanges between several supervisors discussing the plaintiff's alcoholism, as well as the timing of his termination, could show pretext. *Lankford v. Reladyne, LLC*, 32 AD Cases 959 (S.D. Ohio Nov. 19, 2015)

The plaintiff was a sales representative for the defendants, who provide motor supplies to car dealerships. On January 28, 2014, the plaintiff requested FMLA leave to attend an alcohol rehabilitation program. Shortly before the plaintiff requested leave, one of the defendants' employees informed them that the plaintiff had given free supplies to a customer in exchange for a free oil change given to the plaintiff's mother. On February 4, 2014, seven days after the plaintiff requested leave, the defendants investigated the incident and it was determined that a meeting with the plaintiff was necessary upon his return to work. At the meeting, the plaintiff denied any knowledge of how his mother came into possession of the coupons used for her free oil exchange. The defendants nevertheless terminated the plaintiff, who subsequently brought suit for disability discrimination, unlawful FMLA interference and unlawful retaliation.

The defendants moved for summary judgment on each of the plaintiff's claims, arguing they legitimately and non-discriminatorily terminated the plaintiff due to his misappropriation of company supplies. The Court rejected the defendants' arguments, holding that the plaintiff produced sufficient circumstantial evidence for a reasonable jury to conclude the defendants' offered justification for the plaintiff's termination was merely pretext. Among other things, the Court pointed to an email in which the defendants' Vice President of Sales and Marketing, stated "we have too many signs to ignore and not proactively address," after learning of the plaintiff's request for leave. In another statement, this VP also said "[the oil change] was not the only reason [Plaintiff] was fired." The plaintiff had received overwhelmingly positive reviews just six weeks earlier. Relying on these facts as well as the temporal proximity between the plaintiff's medical leave and his termination, the Court denied the defendants' motion for summary judgment.

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Death and Taxes for Qualified Plans

An IRS plan audit uniquely focuses an employer's mind on the core identity of its qualified retirement plan, which is that of a tax exempt organization, but one whose exemption (or "qualification") requirements are far pickier than those applicable to one's favorite charity. Any single material operational violation or non-conforming written plan provision risks disqualification and loss of the related special tax benefits.

And disqualification was in fact the Tax Court's ruling in *Family Chiropractic Sports Injury & Rehab Clinic, Inc. v. Commissioner*, decided January 19, 2016. The plan victim was an Employee Stock Ownership Plan (ESOP), a type of qualified plan primarily designed to invest in the stock of the employer and whose sole participants were a divorced chiropractor and his ex-wife. Without acknowledging the ESOP's ownership of virtually all of the stock of the company sponsor, the couple's divorce decree awarded each one-half of the plan sponsor's outstanding stock. By later documents the ex-wife transferred all of her ESOP share account to her former husband's ESOP account. Plan disqualification was held effective as of the date of that transfer principally because: (1) it was not pursuant to a properly approved qualified domestic relations order (QDRO) and, therefore, violated the anti-alienation rules of the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code – which generally prohibit assignment of a participant's plan benefit before it is properly distributed under the plan, and, independently, (2) the transfer violated the terms of the ESOP plan document regarding the distribution rights of participants.

In addition to ERISA fiduciary liability, the consequences of disqualification include, for open tax assessment years (generally three years back), taxes on the income of the plan's trust, taxation of participants on vested undistributed benefits, taxation of otherwise tax-free rollovers from the plan, and disallowance or deferral of the plan sponsor's deductions for contributions to the plan. In an IRS plan audit, a plan sponsor can avoid disqualification by not only fixing the mistake financially, but also paying as a sanction a negotiated percentage of the income tax amounts described above – potentially quite expensive, but normally far preferable to actual disqualification, which occurs only rarely.

Fortunately, the IRS's Voluntary Correction Program (VCP) and other IRS Employee Plans Compliance Resolution System (EPCRS) correction procedures can reduce exposure resulting from the inevitable plan failures. But these procedures are most attractive when the employer discovers the failures and can voluntarily propose correction before the IRS announces an audit. Also, no standard IRS correction procedure exists to remedy a transfer of a plan benefit by a participant outside of the QDRO rules. In Family Chiropractic, undoing the illegal assignment of the ex-wife's ESOP account may have simply been unacceptable to the IRS and the parties under the circumstances.

Disqualification exposure is reduced through regular administrative and legal review of plan operations in order to discover and deal with failures before the IRS does. IRS officials have stated that an employer's probability of plan audit is reduced if the annual Form 5500 does not contain blank fields, internal inconsistencies, large unvested benefits for terminated participants (a partial termination risk), or substantial amounts of hard-to-value "other" assets.

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Controlled Groups, Affiliated Groups and Management Companies: The Heavy Price of Ignorance

It is not unusual for an entrepreneurial family, a group of physicians, or a fast-growing corporation to spin off pieces of a certain segment of a business or to open a completely new business with profits earned from an existing one. When a business is thriving, tax planning is often undertaken, and efficiencies in operations are examined, to evaluate a proposed new corporate structure. The last thing that anyone thinks about in these circumstances is whether a controlled or affiliated service group is being created (or currently exists) and what impact such a group will have on the existing or new employee benefit plans. Yet, the potential financial impact of overlooking related corporate entity issues in these situations may be severe.

Properly Counting Employees under the Affordable Care Act (ACA)

Treasury Regulations promulgated under the employer shared responsibility rules under the ACA provide that controlled groups and affiliated service groups of employers, including management groups, must be aggregated for purposes of deciding how many full-time equivalent employees (FTEs) exist. The number of FTEs dictates whether an employer, or a group of related employers, are an "applicable large employer" (ALE) under the ACA.

Failure to recognize that an employer is an ALE under the ACA has two, potentially expensive, consequences. First, if the employer is not offering minimum essential coverage to full-time employees, the employer may be subject to a penalty equal to $180 per month (in 2016) for each full-time employee (minus the first 30 employees) under Section 4980H(a) of the Internal Revenue Code (the Code).

Failure to properly count FTEs may also cause an employer to miss reporting offers of coverage to those employees by disseminating and submitting Form 1095-C and 1094-C. The penalty for this omission (assuming the omission is not willful) is $250 per form per year. The $250 penalty is assessed for each missing Form 1095-C for each full-time employee, each year.

The number of FTEs also dictates whether an employer or group of employers is a "small employer" that is permitted to participate in the Small Business Health Options Programs (SHOP) and may offer health insurance coverage under SHOP. The determination that an employer is "small" also dictates whether that employer is qualified for a tax credit for offering group health insurance coverage to its employees.

Failing to properly count FTEs may result in a referral by the Department of Health and Human Services to the Centers for Medicaid and Medicare Services or the Internal Revenue Service that the employer is wrongfully participating in SHOP or receiving a tax credit. Tax penalties may result as a consequence of such referrals.

Tax Qualification of Retirement Plans

The failure to recognize the existence of controlled groups, affiliated service groups, and management groups has the potential to wreak havoc with an employer's tax qualified retirement plan. This is because the Code's statutory provisions governing a plan's tax-qualified status (e.g., Code sections 401(a), 410, 411, 415, 416) treat related entities as

single employer for purposes of the important inquiries into minimum participation, discrimination, vesting, maximum contribution and top-heavy status.

This means, to highlight only one example, that one employer's 401(k) plan must be aggregated with all other related employers' 401(k) plans for purposes of testing the tax qualified status of the plans under Code section 410's coverage rules. The aggregation rules work similarly for all the other Code provisions that govern whether a retirement plan constitutes a Code section 401(k) plan.

What makes this most concerning is that the operational failure of one or more of the related employer's plans to satisfy the mandates of the Code in any given year will likely cause all the related entity plans to also be disqualified. Further, there is no statute of limitations that applies to the tax consequences that arise when one or more of the retirement plans fail to satisfy the Code's requirements for tax-qualified status.

Consequently, if the 401(k) plans of related employers, taken in the aggregate, fail to pass coverage tests, and certain employees should have been offered an opportunity to participate in the right to make elective deferrals, but were not offered such opportunity, the plans must be corrected. This may mean going back many years and giving each of the omitted employees 50 percent of their missed elective deferral amounts, plus 100 percent of the missed employer matching contributions, plus earnings calculated from the date the employees were first eligible to participate in the plans. The cost of such a correction has the potential to put an employer literally out of business.

Conclusion

The potential monetary exposure associated with missing the existence of related entity issues warrants that such issues be a material consideration when any business is considering changing its corporate structure or engaging in an acquisition or divestiture of a portion of its business interests. Not only tax, but civil liability exposure associated with potential breaches of fiduciary duties may arise when related entity issues are not recognized and properly addressed in the environment of employee benefit plans. Employers engaging in corporate transactions should consult with knowledgeable tax professionals regarding related entity issues early in the due diligence process to avoid these potential areas of monetary loss.

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