Employee Benefits Report

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Navigating DOL 401(k) Audit Red Flags

Think there's no way your retirement plan might be audited? Think again.

The Department of Labor (DOL) can select any size retirement plan for a random 401(k) audit. Your plan also could face an audit if it matches an Internal Revenue Service (IRS) dataset targeting certain types of plans or if the plan raises a "red flag."

What are the red flags? Here are a few things you can do to avoid or lessen your chances of being audited and increase your chances of surviving an audit.

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Changes to the Disability Benefit Landscape

Employee disability benefit plans now must comply with new requirements designed to strengthen the claims and appeals process.

The Department of Labor's (DOL) requirements, effective April 1, 2018, apply to plans governed by the Employee Retirement Income Security Act (ERISA).

Section 503 of ERISA requires employee benefit plans to:

- **Provide claimants adequate notice, in writing, if their benefit request is denied.**
- **Give claimants whose request was denied a reasonable opportunity to have their case reviewed.**

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Unhappy Employees

Most DOL 401(k) audits are triggered by complaints from current and former employees. One way to head off formal complaints is to respond to employees' inquiries in a timely fashion. Keep copies of all correspondence.

If an employee makes a formal claim of benefits, follow the Employee Retirement Income Security Act (ERISA) regulations. Check with your ERISA attorney any time you issue a claim denial to ensure it is consistent with the written plan terms. Also, make sure that you clearly explain the participant's appeal rights and the reason for the denial.

It's not unusual for employees to become frustrated because they don't understand the benefit plan. Regular training sessions can reduce these misunderstandings.

Problems with Form 5500

The second most frequent trigger for a DOL 401(k) audit is mistakes made when filing Form 5500 each year. Frequent errors include:

- Forgetting to file.
- Failing to file on time.
- Not including all required schedules.
- Failing to answer multiple-part questions.
- Answering "no" to whether the plan is protected by an ERISA bond. If you don't have a bond, you may be able to obtain retroactive coverage.
- Having a bond that is less than 10 percent of the plan assets at the beginning of the year (plans with certain types of investments need higher than 10 percent coverage).
- Your asset values at the end of the prior year don't match your opening year balance for the succeeding year.
- Having several alternative investments such as hedge funds or holding large amounts of cash not invested.
- Not submitting participants' 401(k) contributions to the trustee within a reasonable time. Although reasonable is not defined, most large companies deposit the money within a couple of business days. At the very least you should make the deposit no later than the 15th business day of the month following the day you withhold funds from the employee's wages. Participants will notice if it takes a long time for their payroll deductions to be deposited in the fund, and this is one reason they might report you to the DOL. If you are late with the deposit or forgot to make it at all, there are procedures you can to follow. Call your benefits attorney for advice.
- Forgetting to make a distribution to retirees. A minimum distribution of the account balance must be made to those who retire or who reach age 70½. Depending on your plan, you might have to make a distribution a year after an employee turns 70½ – even if that person hasn't retired. However, it's OK if you've made a reasonable effort to find the employee but couldn't.

Experts recommend you pay a reliable third-party administrator, such as an accountant, to file your plan's Form 5500 to make sure the compliance questions are answered correctly.

The DOL's final rule includes details about what the reports should include, such as a discussion of reasons for the denial and what actions claimants must take to request a decision review. Plan administrators must also take steps to avoid conflicts of interest.

In related news, fewer Americans are seeking Social Security disability benefits. The federal government previously was concerned the program would run out of money by 2023. Because claims have decreased so much, the government now believes there will be enough money until 2032.

Observers attribute the decrease in claims to a strong economy and more lower-skilled jobs available that don't require manual labor.

- Using a Plan Document That is Out of Date – A plan document is a formal document detailing the type of plan and investment tools you're offering employees, as well as participation requirements and guidelines. In short, it serves as the operating manual for the plan. Follow the plan closely, and don't forget to update it if you change any rules or requirements.
- Improperly Maintained or Inaccurate Records – The plan document spells out employees' rights to retirement benefits and the formulas for determining them based on service or age requirements. If these are incorrect, an employee's benefit calculation might be incorrect.

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- Making Improper Loans or Withdrawals – Plan documents list the specific reasons employees can take out hardship distributions. Anything not listed in the plan document is not allowed. Check to confirm the distributions reflect what is allowed.
- Failing to Perform Nondiscrimination Testing – ERISA requires plan sponsors to perform discrimination testing to prevent favoritism for highly compensated employees. If you find errors, you must correct them. The record keeper or the third party administrator usually performs the test.

Additional Precautions

In addition to avoiding mistakes, make sure you have all of the documents needed to provide to the IRS or DOL. These documents include executed plan documents, participant notices and fiduciary policies.

Anticipate any problems by performing a self-audit and correct any issues before the IRS or DOL come calling.

For help or additional advice about your firm's 401(k) program, please contact us. ■

Enforcement of the Employer Shared Responsibility Provisions Now in Full Force

The Internal Revenue Service (IRS) now is enforcing the Affordable Care Act's Employer Shared Responsibility provisions (ESRP) for health care benefits for 2015 and 2016. The IRS also has announced the affordability percentage for tax year 2019.

The ESRP applies to Applicable Large Employers (ALEs). The provisions require ALEs to offer health benefits that provide at least minimum essential coverage and value and are "affordable" (as defined by the IRS) for full-time employees and their dependents. Employers who fail to comply must pay a penalty to the IRS.

If your company is an ALE and you received Letter 226-J from the IRS requiring more information about your health benefit plan in 2015, you soon will receive Letter 227 informing you if you must pay a penalty.

And, if you're breathing a sigh of relief because you did not receive a notice for 2015, be aware that the IRS will soon be sending its 2016 notices.

Definition of an ALE

The ACA defines an ALE as an employer who, during the prior year, had on average at least 50 full-time employees, including full-time equivalent employees.

Full-time denotes an employee who works at least 30 hours each week or 130 hours per month. A full-time equivalent employee is a combination of all your part-time employees. To determine your number of full-time-equivalent employees for a month, you must:

- Combine the number of hours of service of all non-full-time employees for the month but do not include more than 120 hours of service per employee, and
- Divide the total by 120.

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Letter 227

Letter 227 is not a bill. It is the IRS response to information an ALE filed after receiving Letter 226-J. It explains the outcome of the review and the next steps you will take to fully resolve the ESRP.

There are five types of Letter 227. The responses range from notification that an ESRP penalty will be assessed to the IRS's decision on an appeal.

The IRS has set up a new web page at www.irs.gov/individuals/understanding-your-letter-227 for businesses that have already been assessed a penalty and have written to the IRS to either dispute their proposed assessment or to pay it. The web page explains each type of Letter 227 and outlines the next steps for affected employers in the IRS's penalty assessment, appeals and resolution processes.

Employers who are required to pay a penalty should review the letter and attachments and complete and return the Letter 227-L or 227-M by the date provided. They then will receive a CP220J (a bill).

New Affordability Percentage

The IRS recently set the "affordability" percentage for employer-sponsored coverage for the tax year 2019. All employers, who are ALE's, who offer health insurance, must ensure that the health benefit coverage offered to employees costs no more than 9.86 percent of an employee's household income in 2019 (previously 9.56% in 2018).

Your employees need to know whether the insurance you offer is considered affordable, because they will qualify for a premium tax credit subsidy from a health insurance exchange if their share of the employer-group coverage offered to them is unaffordable.

If you are unsure whether you need to be — or are — in compliance with the employer mandate, please contact your broker.

The Nonprofit Dilemma – How to Provide Good Health Care Benefits

Health care benefits are a good way to attract and keep top talent. Here's what you can and cannot do when offering benefits.

Small employers — including charitable nonprofits — technically don't have to provide health insurance to employees. The Affordable Care Act (ACA) does not penalize businesses with 50 or fewer full-time employees who choose not to offer group health care benefits. Although some Republicans are talking about removing the penalty, the employer mandate to provide coverage remains in effect for large employers with 50 or more employees.

Yet, like any business wanting to attract top talent, nonprofits should consider offering health insurance as a way to attract and retain talented employees.

Cost obviously is a concern. It can be even more of a concern for charitable nonprofits, which often have limited access to capital. PPI Benefit Solutions conducted a Nonprofit Employee Benefits Survey in 2015 and discovered that the number one objective when selecting benefit plans was to control costs. Since 1999, the national average cost to cover employees with group health insurance has increased nearly 14 percent per year, according to the Kaiser Family Foundation.

Fortunately, nonprofts have a num-

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ber of economical options when seeking ways to offer health care benefits that will be both affordable and valuable.

Before looking at what you can do, let's start with what you can't do. Under the ACA, small employers no longer could reimburse employees for medical costs or individual health plan premiums. This law went into effect July 1, 2015, and employers who continued to offer employer-funded individual health insurance could be fined.

Here are some options that are still legal.

QSEHRA: a new healthcare reimbursement plan – Beginning Jan. 1, 2017, small employers (less than 50 employees) were allowed to establish a Qualified Small Employer Health Reimbursement Arrangement to contribute to their employees' healthcare cost. If a small employer does not offer a group health plan to any of its employees, then they can offer a pre-tax contribution for insurance premiums and healthcare expenses. It is not a group health plan and so is not subject to the ACA coverage rules and no employment or income taxes are due. The QSEHRA is solely funded by the employer.

The employer can contribute any amount up to $4,950 for individuals or $10,000 for family contribution, prorated for those not working a full year. There are some other rules, but the funds can be used for individual health insurance premiums, and/or medical expenses, as allowed by the way the employer establishes the plan.

Employer Sponsored Health Plan – An employer sponsored health plan is one of the most popular options for health care coverage. Almost 60 percent of Americans get their coverage through their employer, according to Healthinsurance.org.

If you choose to offer a group health plan, work with a broker to determine which plan and which insurance company will provide the coverage levels and costs that meet most of your employees' needs and pocketbooks.

One challenge for a small nonprofit is meeting the company's minimum contribution level toward employee premiums. The nonprofit also must guarantee minimum participation requirements and should be prepared to handle hefty annual cost increases. According to the Kaiser Employer Survey, annual premiums rose three percent between 2015 and 2017. This type of plan can be the most expensive, but monthly premiums may be lowered by choosing a higher deductible.

SHOP Marketplace Group Plan – If you qualify, your nonprofit can purchase a plan on the state- or federally-run SHOP (ACA's Small Business Health Options Program) Marketplaces. SHOP plans are similar to employer-sponsored group health insurance. The difference is that SHOPs offer access to small business tax credits and may have more flexible participation or contribution requirements.

To purchase group coverage from a SHOP, your organization must have 50 or fewer employees and meet other requirements, depending on your state. For example, if you operate a nonprofit in Massachusetts, you must contribute at least 50 percent of the premium amount. And, if you have fewer than five employees, you must have 100 percent participation.

Small Business Health Care Tax Credit – Eligible small nonprofits purchasing coverage from a SHOP can receive a Small Business Health Care Tax Credit. The credit is 50 percent of employer-paid premiums; for tax-exempt employers, the percentage is 35 percent.

To be eligible, you must meet these requirements:

- Have fewer than 25 full-time equivalent employees
- Pay an average wage of less than $51,600 a year
- Pay at least half of employee health insurance premiums

To take advantage of these savings, work with a licensed broker who is authorized to sell SHOP insurance. You will find plan options; evaluate eligibility for a tax credit; and purchase a benefit plan. Keep in mind that you can only claim this tax credit for two consecutive years. Some states provide additional premium assistance (AL, AZ, GA, IN, KS, and OK).

Co-Op – Nonprofts can join a co-op or other association to buy health insurance. Cooperatives can be formed at the national, state, or local level. The more members in the association, the more buying power the co-op will have and the better their ability to spread the risk among a large group.

Please contact and we will help you explore your best options. ■

Wave of the Future: Value-Based Care

The practice of insurers paying fee for services to physicians and hospitals is going the way of the dinosaurs. Look for value-based care to replace the current payment model.

With the fee for service approach, insurers pay medical providers based on the amount of health care services they deliver. With value-based care, insurers pay providers to improve patients' health. Physicians work with patients on an ongoing basis which reduces the effects and incidence of chronic disease and keeps them healthy.

Most major insurance carriers and government health agencies are moving toward a value-based care system. Aetna expects that 75 percent of their medical payments will be for value-based care by 2020. The U.S. Department of Health and Human Services also is dedicated to the concept and has plans to move 50 percent of traditional Medicare payments to value based payment models between now and 2019.

The goal of value-based care is to improve the quality of care and reduce health care costs across the board by coordinating efforts between different health providers. According to the United Nations World Health Organization, life expectancy in the United States is lower than 30 other countries. Insurers and providers hope that the value-based care approach will improve that situation.

The benefit of value-based care is that these models focus on helping patients recover from illnesses and injuries more quickly and help

clients avoid chronic disease. As a result, patients have fewer doctor's visits, medical tests and procedures.

There also are challenges with this concept. It's been more difficult for providers to transition to this model than was expected because providers still must focus on patient care while continuing to focus on improving patient care. Also, the volume of electronic health records and other information that must be shared requires coordination and more time.

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