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CLIENTS & FRIENDS SEMINAR – MAY 11, 2017

(Note that this Outline is not intended as legal advice for any particular situation.)

HEALTH AND WELFARE PLANS

I. Continuing Guidance for Opt-out Payments, SCA Cash-in-Lieu Payments, and the Like.

A. The IRS Position. As discussed at prior seminars and in our e-Alerts, beginning in 2014 the regulators began to state that Section 125 Cafeteria Plan benefit dollars, payments to participants who opt-out of medical benefits, Service Contract Act and Davis-Bacon cash-in-lieu-of-fringe payments, cash options required under Union contracts, and similar types of payments create issues under the "affordability test" of the Affordable Care Act. The typical example provided by the regulators was as follows: An Applicable Large Employer charges $200 per month for its lowest cost self-only medical benefits coverage. The employer offers a $100 opt-out bonus if the employee waives coverage (or simply pays the employee $100 as cash-in-lieu of coverage). The employer is treated, for ACA affordability purposes, as "charging" the employee $300 for its lowest cost self-only coverage. (The regulators' rationale is that an employee wishing to enjoy coverage must pay $200 plus "forego $100" to have coverage, and therefore the coverage "costs" the employee $300.)

B. Response from the Commentators and the IRS Notice. As we also reported, numerous commentators challenged the regulators' logic on this point and requested that they withdraw this position. (We learned, for example, that the AFL-CIO held an in-person meeting with the regulators formally requesting that they withdraw this position.) In December 2015, the regulators issued Notice 2015-87 which, although it did not withdraw the position, provided additional time for employers to comply with it in some cases (and appeared to be, perhaps intended to provide additional time for the regulators to consider further modifying or withdrawing their position). The following are some of the most important points made in that extremely complex Notice:

-For plan years beginning before 2017 (as defined in the Notice), employer "benefit dollars" or "flex contributions" that can be used by Section 125 plan participants for health, other benefits or cash are not added to the stated cost of the employer's lowest cost self-only health coverage for ACA affordability test purposes.

-Until future guidance, opt-out payments under existing opt-out arrangements (as defined in the Notice) are not added to the stated cost of the employer's lowest cost self-only health coverage for ACA affordability test purposes.

-Until future guidance is issued, cash-in-lieu payments under the SCA or Davis-Bacon Act are not added to the stated cost of the employer's lowest cost self-only health coverage for ACA affordability test purposes.

The regulators hinted in the Notice that they would consider further relief for opt-out payments that are "conditioned on the employee meeting certain conditions such as demonstrating that the employee has other coverage," and hinted that they may consider further unspecified relief for SCA and Davis-Bacon employers. The retroactive, limited and highly technical relief of the Notice at least provided some breathing room to some employers who found themselves struggling to comply with the regulators' position.

C. The Subsequent Guidance. In December 2016, the IRS published additional guidance, which could be relied on beginning January 1, 2017, "clarifying" Notice 2015-87 to provide that opt-out payments are always added to actual employee contribution costs to determine ACA affordability, unless those opt-outs are offered under an "Eligible Opt-Out Arrangement." In general, this clarified guidance specifies that Applicable Large Employers are not required to treat opt-out payments as increasing employees' required contributions unless the opt-out arrangement was adopted after December 16, 2015 (a so-called "Non-Relief Eligible Opt-out Arrangement"). For opt-out

arrangements required under the terms of a collective bargaining agreement that was in effect before December 16, 2015, opt-out payments are not be treated as increasing employees' required contributions until the later of the first plan year beginning after expiration of that bargaining agreement (disregarding any extensions on or after December 16, 2015) or the applicability date of final IRS regulations regarding opt-out arrangements.

D. Recommendations. Employers that currently utilize any of these features – or that are contemplating utilizing them – and that could face ACA affordability problems under the IRS world view should study the details of this ever-evolving IRS position, consult with ERISA counsel, and monitor the expected future guidance.

II. Proposed Changes to Form 5500.

A. Background. Increasingly, the DOL and the IRS are using the information reported on the Form 5500 as a tool in their enforcement activities. In July 2016, DOL, IRS and PBGC jointly issued proposed revisions to the Form 5500 that would affect filings beginning with 2019. The proposed revisions are extensive.

B. Minor Changes for 2016. The 2016 form has only minor changes. Most likely the DOL is keeping changes to a minimum in anticipation of the significant modifications it intends to make beginning in 2019. Of course, the instructions do note that administrative penalties have increased for Form 5500 failures from $1,100 per day to $2,063 per day. This is certainly added incentive to make sure that no such failures occur. It may also be incentive for the DOL and IRS to increase their audit activity.

C. The Most Significant of the Proposed Changes. Currently, employer-sponsored group health plans with fewer than 100 participants that are fully-insured, unfunded or a combination of the two are generally not required to file a Form 5500. The proposed changes would eliminate this exception.

The proposed revisions would add a new Schedule J -- Group Health Plan Information. The newly-proposed Schedule J would require group health plans to report detailed information about plan compliance with ERISA and the ACA (among others). Some of the newly-required information will relate to (a) the number of individuals offered and taking COBRA, (b) whether the plan offers coverage for employees, spouses, children and/or retirees, (c) information regarding employer and participant contributions, (d) "grandfathered" status", (e) whether the plan offers an HSA, health FSA, HRA, (f) information regarding rebates, (g) more detailed stop-loss information, (h) detailed claims payment data, (i) questions about content requirements of SPDs and SBCs, (j) HIPAA, GINA, MHPAEA and ACA, and on and on and on.

D. Recommendations. Every plan sponsor should begin to evaluate these proposed requirements and conduct a self-audit to be sure that the plan's operations and documentation are in compliance before the new reporting obligations take effect. In addition, every plan sponsor should check with its 5500 provider to determine the impact that changes to the form may have on data collection. Finally, because of the potential that these forms could be used by the IRS and DOL to identify plans to audit, plan sponsors may want to consider having their forms reviewed by counsel before filing.

III. Retiree Coverage and Special Rules for Plans Covering One or Fewer Active Employees.

A. The Law. ERISA, the Code, and PHSA each contain an exemption from the HIPAA portability requirements for plans covering less than two active employees on the first day of the Plan year (often referred to as the "small plan exemption" although because it also covers retiree plans that name may be somewhat misleading). As part of health care reform, Congress added the ACA "market reforms" to the same sections of the law as HIPAA portability. Because of the technical way that Congress did that, there was initially some confusion as to whether the small plan exemption would apply to those market reforms. However, IRS, DOL and HHS each issued regulations stating that the exemption still exists and applies to all "small plans".

B. Market Reforms. Plans that qualify for the exemption are not subject to ACA's market reforms. Market reforms include no lifetime or annual limits, rules regarding rescissions, coverage of preventive health services, eligibility of children until at least age 26, SBC requirements, and internal claims and appeals and external review processes. So, for example, a retiree plan that qualifies for the exemption does not need to meet any of these requirements.

C. What is a Plan? Regulations proposed with respect to the HIPAA exemption presume that an employer's health benefits would constitute a single plan unless the instruments governing the arrangement (e.g. the Plan documents) make it clear that the Plans are separate, the arrangement(s) are in fact operated as separate plans, and avoiding a

legal requirement was not a principal purpose of establishing separate plans. Anyone relying on this exemption for a retiree or small plan will want to make sure everything properly indicates the number of plans including documents, SPDs, 5500 filings, insurance contracts, employee handbooks, etc.

D. Multiple Plans. Of course, someone almost immediately came up with the idea of establishing dozens of plans for an employer (one for each employee) in an attempt to avoid the market reforms. It would seem that such an arrangement would have difficulty arguing that avoiding a legal requirement was not a principal purpose. Further, in IRS Notice 2015-17, the IRS provides that if an employer has more than one reimbursement arrangement for different employees, they will all be treated as one plan. It is hard to imagine the IRS coming to a different result any time multiple single employee arrangements are established.

E. Partners and Self-Employed Individuals. IRS, DOL and HHS regulations specifically provide that partners are treated as employees for this purpose. What about self-employed individuals? IRS, DOL and HHS regulations do not mention self-employed individuals. In Notice 2015-17, the IRS states that, until additional guidance is issued, a "2% shareholder-employee health care arrangement" (defined as an arrangement under which reimbursement to the 2% sub S shareholder is included in his/her income but he/she may deduct the amount under Section 162(l)) will not be subject to an excise tax for failure to satisfy the market reforms. However, no non 2% sub S shareholder employee can be covered by the arrangement. Sole proprietors, not mentioned under any of this guidance, are presumably not employees for this purpose.

F. Rehired Retirees. An employer relying on the small plan exception for its retiree plan needs to be sure to avoid covering any rehired retirees on the Plan. That includes not just obvious rehired retirees but also retirees rehired by affiliates, retirees rehired as independent contractors or consultant agreements that might in fact create employer/employee relationships and employee leasing or outsourcing arrangement that might in fact create employer/employee relationships. If a retiree plan accidentally covers more than one employee on the first day of the Plan year, it loses the small plan exemption.

G. Employees as Covered Dependents. In Notice 2015-17 as well as in informal comments from agency officials we are told that a Plan covering an employee and his or her dependent who also happens to be an employee will be considered to cover only the one employee.

H. Plans Covering Both Retirees and Individuals on Long Term Disability. In an FAQ, the agencies said that until further guidance is issued, regulators will treat such plans as being within the exemption. The agencies also provided that any more restrictive guidance will be prospective only.

I. Form 8928. Employers are required to report failures to satisfy requirements for group health plans under chapter 100 of the Code, including the market reforms, on Form 8928. Just one of the many failures employers are expected to self-report on that form. Failures are subject to a $100 per day per individual excise tax if not corrected within 30 days. The Secretary of the Treasury can waive part or all of the tax to the extent the payment of the tax would be excessive relative to the failure involved. In the case of non-willful failures by an employer offering a single plan, the tax is capped at 10% of the aggregate amount paid or incurred by the employer during the preceding year for group health plans, or $500,000 whichever is less. No such cap exists if the failure is not due to reasonable causes.

J. Recommendations. Every sponsor of a plan that is relying on these exceptions should do a careful review to determine that the requirements for the exception are met.

IV. Spotting and Avoiding MEWAs.

As discussed at last year's seminar, a Multiple Employer Welfare Arrangement is an arrangement that provides ERISA Section 3(1) welfare benefits to employees of two or more employers that are not members of the same controlled group. Although ERISA generally preempts State laws that attempt to regulate ERISA-governed benefit plans, ERISA provides an exception that permits States to regulate MEWAs. States may require a fully-insured MEWA to maintain specific reserves, require contributions designed to ensure that the MEWA will be able to satisfy its benefit obligations, and comply with State licensing, registration, certification, financial reporting, examination, audit and other insurance laws necessary to ensure compliance with the State's insurance reserves, contributions and funding requirements. ERISA permits self-funded MEWAs to be subject to any State law "to the extent the law is not inconsistent with Title I of ERISA." Although MEWAs are permitted in a few States, many States apply significant portions of their onerous and costly insurance laws to MEWAs, and especially to those MEWAs that provide health benefits. Maryland imposes a fine of up to $50,000 for each violation of operating a

MEWA without a certificate of authority from the Maryland Insurance Administration. MEWAs are also subject to ERISA's reporting requirements and the DOL may impose a penalty of $1,527 per day for failure to file the appropriate documents, including the annual Form M-1 filing and filings upon origination.

Recommendations. In light of the above, it is important for employers to ensure that all employees covered by a particular welfare benefit plan are employed by employers within the same controlled group. Because entity ownership often is a dynamic thing, multi-entity employers should establish a procedure to review ownership facts on a regular basis to ensure that they know where the controlled groups are, and are not, within their benefit plan universe.

V. A Review of the Employer Mandate Rules Mid-Year Changes Provisions.

A. Mid-Year Changes under the Employer Mandate Rules. In general, the employer mandate lookback measurement period rules do not take changes in employment status into account. However, there are a few exceptions. For example, if a new part-time employee moves into a full-time position during the initial measurement period, the employer generally is required to offer the employee employer mandate-compliant coverage as of the first day of the fourth full calendar month following the change in status (rather than waiting until the end of the initial measurement period to determine if the employee is "full-time"). In addition, when an employee is hired in as full-time, the employee generally must be offered employer mandate-compliant coverage in each month that the employee averages at least 30 hours per week until the employee has completed one full standard measurement period (and his or her full-time employee status is determined under the ongoing employee lookback measurement rules). As a result, if a new employee averages less than 30 hours per week during a particular month (e.g., because the employee has moved from full-time to part-time status), the employee would not have to be offered employer mandate-compliant coverage for that month. Finally, the general rule is that, once an employee is an ongoing employee for purposes of the lookback measurement period rules, his or her status as a full-time employee is locked in during the stability period regardless of whether the employee has a change in status during that stability period. However, under an optional rule, an employer may cease offering employer mandate-compliant coverage to an employee who moves from full-time to part-time status during the stability period if certain requirements are satisfied.

B. Recommendations. Employers should evaluate and develop appropriate policies and procedures that are compliant with the employer mandate rules' mid-year change provisions, and confirm that the eligibility provisions contained in their plan documents are consistent with those rules. Please contact us if we can assist with your mid-year change in status compliance efforts.

VI. Formal Marriage, Common Law Marriage, Domestic Partners and Civil Union Partners. Most employers now have solid procedures in place under their employee benefit and executive compensation plans to identify properly their employees' spouses who have statutory, regulatory and contractual rights under those plans. Thanks to the Supreme Court, it is now very simple for an employer to determine if an individual is a spouse of one of the employer's employees; namely, if the pair are formally married (regardless of their respective genders, and regardless of the religious views of the court clerks and other bureaucrats where the pair live), or if the pair are recognized as married under an applicable State "common law marriage" statute, they are married for all legal purposes (including employee benefit/executive compensation law). Because of this evolved clarity about spousal status, very few employers still provide benefit plan coverage/rights to domestic partners or civil union partners (except where they are treated as "married" to the employee under applicable State law). One important point to remember: there is no obligation under the Affordable Care Act (or any other law) for an employer to provide spouse coverage in an employee health plan (as opposed to required coverage for qualifying dependent children for Applicable Large Employers under the employer mandate rules of the ACA).

Recommendation: All employers should review the census data for all of their plans to ensure that they are properly identifying all "spouses," and they should ensure that all of their forms, notices and procedures for complying with all applicable spousal rights rules are up-to-date.

VII. ACA Reporting Update.

Although the new leaders in several key federal agencies have suggested that they are reviewing the current ACA reporting rules, and although various provisions of proposed legislation like the AHCA could impact those rules, it currently is unclear whether there will be any changes for the 2017 reporting year. Employers therefore should proceed as if current law will apply in 2017, while watching for potential statutory and regulatory changes.

VIII. Updates on Transgender Benefits Coverage.

A. State Law. A number of states, including Maryland, Delaware, Pennsylvania and DC prohibit insurance policies from having a blanket exclusion for transgender benefits (i.e., gender transition surgery or other treatments of gender dysphoria or gender identity disorder). Some state insurance laws may also mandate coverage of specific transgender benefits. Of course, because of ERISA preemption, those state insurance rules would apply only to insured health plans. Similar laws may also apply in some states to self-funded plans sponsored by plans that are not subject to ERISA. Most of those states, as well as some others also have anti-discrimination laws that prohibit employment discrimination based on gender identity and those laws might also be interpreted to require coverage for some transgender benefits. Those laws also would be preempted by ERISA to the extent they would otherwise apply to an ERISA plan.

B. Federal Law. There is no express requirement under federal law that health plans cover any specific transgender benefits. However, two federal laws may potentially limit restrictions on such benefits. First, guidance relating to the preventive services mandate under the ACA requires that non-grandfathered plans cover all mandated preventive services for a transgendered person to the extent they are appropriate based on the person's anatomy without regard to whether the service would otherwise be appropriate based on the person's sex assigned at birth, gender identity, or recorded gender.

Second, there are special nondiscrimination rules that apply to plans that are subject to Section 1557 of the ACA. Section 1557 generally applies only to health care providers or health insurance carriers that receive any type of payments from the federal government (including Medicare or Medicaid payments or exchange subsidies). For plans sponsored by most other employers, Section 1557 does not apply unless the employer's health plan itself actually receives funding from HHS (which is unusual but may be true for plans that accept the Retiree Drug Subsidy). For those plans that are subject to Section 1557, regulations issued by HHS last year would have prohibited plans, starting in 2017, from having a categorical exclusion of all services related to gender transition. This would not mean that plans must cover all services related to gender transition but simply that plans cannot rely on a broad categorical exclusion to exclude all such services. For example, if a plan generally provides benefits for a hysterectomy as a treatment for uterine fibroids or cancer or other conditions, it generally would be required to offer benefits for a hysterectomy as part of gender transition, if recommended as a medically necessary treatment for gender dysphoria by the patient's treating physician. However, in December 2016, a federal district court issued a nationwide preliminary injunction in December of 2016 that prohibits HHS from enforcing this part of the Section 1557 regulations. That order is still in effect for now.

Third, Title VII of the Civil Rights Act generally prohibits most employers (and therefore virtually all employer-sponsored health plans) from discriminating against employees based on their sex. The Act itself does not include any specific reference to gender identity or to transgendered persons. However, the EEOC and courts are increasingly treating discrimination based on a person's gender identity as discrimination based on sex. Under that interpretation, a broad exclusion of transgender benefits would likely be considered discriminatory. Again, this would not mean that a plan is required to provide coverage for all types of treatments, but if benefits are available under the plan for a service as a treatment for another condition, then excluding coverage for the same benefit as a treatment for gender dysphoria or gender identity disorder would raise this potential issue, making the employer potentially liable to a complaint from the EEOC or to a federal court action.

C. Recommendations. Employers with self-funded health plans should review their health plan documents and determine if they include broad exclusions of benefits of treatments for gender transition surgery or other exclusions or restrictions that focus on transgender status. For plans that currently include such provisions, employers may want to consider changing those provisions to minimize potential liability and should continue to monitor developments in this area if such exclusions remain in the plan.

IX. HFSA Debit Cards.

To streamline administration, many Health Flexible Spending Accounts permit their participants to use debit cards that automatically pay applicable health expenses. The IRS provided guidance for these cards in proposed regulations that were effective January 1, 2009. Participants are required to agree, prior to receiving a debit card, that they (i) will only use the card to pay for eligible medical expenses; (ii) will not use the card for expenses that have already been reimbursed; (iii) will not seek reimbursement for the same expenses under any other health plan; and (iv) will acquire and keep sufficient documentation.

The balances available on each debit card must be limited to the amount of the participant's health HFSA coverage, and the card must be automatically canceled when the employer ceases to participate in the HFSA. Debit card usage also is limited to certain types of merchants (e.g., physicians/hospitals/dentists, 90% pharmacies, and stores with certain information systems installed). Every claim paid with an electronic card must be reviewed and substantiated, although "sampling" is prohibited. Employers must maintain specified correction procedures to recapture improperly paid funds. Finally, employers must keep auditable records of all card transactions.

Recommendation. Employers using debit cards should check all materials used in connection with their HFSAs and their HFSA procedures to ensure that they comply with the above, and should educate employees on these rules.

X. Eligibility Exclusions for Individual Employees.

In an attempt to contain health plan costs, some employers have considered excluding one or more high claim employees from the employer's health plan and instead providing the employee with cash that the employee may use to obtain individual health coverage. As a reminder, the DOL, the IRS, and the HHS released guidance a few years ago stating that this type of "high claims employee opt out provision" violates several laws, and can trigger large penalties. In essence, the regulators' position is that these large claimants have to "effectively pay more" to participate in the plan than low cost claimants not offered the opt out bonus opportunity, because the large claimants have to make the same contribution as the low claimants in order to participate in the plan, plus "forego" their bonus amount, which the regulators characterize as an "additional contribution" imposed only on them. Thus, this type of arrangement violates, for example, the HIPAA health status factor discrimination rules, affects the employer mandate "affordability" calculation, and has a number of other legal implications.

Recommendations. Employers should be mindful of the significant penalties associated with "high claims employee opt out provisions". For that reason, to the extent that an employer is considering such an arrangement and/or has utilized this type of arrangement in the past, we strongly recommend that the employer contact us to discuss.

XI. Pitfalls of Plan Vendor Agreements.

Arguably, the agreements an employer enters into with vendors for services to its employee benefit plans (e.g., recordkeepers, TPAs, investment managers, etc.) are the most important and often most overlooked aspect of administering an employee benefits program. Among other things, these agreements govern who is responsible for what so liability can be apportioned properly when something goes wrong. The following are some problematic provisions often found in draft vendor service agreements presented to employers for review:

Indemnification: Vendors often include extremely one-sided language (in their favor, of course) in their agreements requiring employers to indemnify them for losses incurred by the vendor in the performance of its duties, as if the employer was not a customer but rather was a professional liability insurance company. Some of these draft indemnification provisions even seek to extract coverage from the employer when the vendor's losses result from the vendor's own negligence or breach of the agreement.

Liability Limitations: Many vendors also try to limit their liability to the employer for the vendor's errors, omissions or willful acts that harm the employer or the plan to some amount less than the actual harm (such as the fees paid to the vendor under the agreement over some specified period of time).

Bonding and Insurance: If the Vendor that "handles funds" as defined in the ERISA fidelity bonding rules, the vendor's service agreement should confirm that the vendor is properly bonded. In addition, the agreement should specify the amount of liability insurance that must be maintained by the vendor (and, if practical, should require the vendor to name the employer as an additional insured) under the vendor's liability insurance policy).

Dispute Resolution: Although agreement provisions requiring arbitration and/or mediation of disputes between the vendor and the employer can effectively avoid the expense and delays associated with litigating a dispute, employers should be careful not to waive their right to judicial review of the arbitrator or mediator's decision and should avoid agreeing to arbitrate or mediate in a distant location convenient only for the vendor.

Fees, Services and Disclosures: Agreements often fail to set forth clearly all fees and services to be performed which can not only lead to disputes but also may result in both the vendor and the employer being penalized for engaging in a prohibited transaction under ERISA and/or the Code.

Recommendation. Employers should have all vendor agreements reviewed by ERISA counsel prior to signing them to ensure the agreements comply with all applicable laws and to ensure that the provisions of the agreements protect the employer from the pitfalls described above and other unnecessary exposure.

XII. Independent Contractors, Leased and Seasonal Employees and Other Special Categories.

A. Background. The employer mandate provisions under the ACA generally provide that Applicable Large Employers (employers with at least 50 full-time employees and full-time employee equivalents) must offer health insurance that is affordable and provides minimum value to 95% of their full-time employees and their dependent children, or be subject to penalties. The employer mandate penalties are imposed on these in relation to the number of their full-time employees. Therefore, it is important that employers correctly determine exactly which of their employees are full-time for purposes of applicability of the employer mandate rules so they can anticipate and avoid any potential penalties. In general, for these purposes, a full-time employee is defined as an employee who is reasonably expected to work an average of at least 30 hours per week. The final ACA regulations define an employee as an individual who is a common law employee, and also provides some clarification regarding whether certain types of employees are considered "full-time."

B. Independent Contractors. Under the ACA, independent contractors do not count as employees when determining whether an employer meets the minimum threshold as a large employer, and they do not count as full-time employees who could trigger a potential employer mandate penalty or count as full-time in the penalty calculation. The determination as to whether an individual is a common law employee or an independent contractor is not a bright-line test, but rather based on facts and circumstances; and the fact that an employer pays an individual through a Form 1099 rather than a Form W-2 is not determinative. On audit, the IRS is likely to require that the employer prove that the individual is actually not a common law employee. The determination as to whether an individual is an "employee" or an independent contractor is based on whether the employer has the right to control and direct the worker in the way, when, where, how and what work is performed. The IRS has identified 20 factors that may indicate whether the employer exercised enough control to establish an employer-employee relationship.

C. Leased Employees. An employer who has authority over workers hired through a staffing agency or PEO is at risk of having those workers characterized as the employer's employees for purposes of the employer mandate rules. (The IRS will use the same 20 factor common law employee test described above). However, there is an option under the ACA that allows employers to "take credit" for an offer of health insurance by a staffing agency/PEO, provided certain requirements are satisfied.

D. Seasonal Employees. A seasonal employee is defined as an employee who is hired into a position for which the customary annual employment is six months or less. Employers can track seasonal employees' hours over an initial measurement period, even if the seasonal employee is expected to work full-time (but only for the season). The likely result is that the employee will not ever qualify as a full-time employee, so he or she will not need to be offered coverage.

E. Adjunct Faculty. The determination as to whether adjunct faculty are full-time employees presents challenges since compensation is often not directly tied to the number of hours they work. That is, compensation does not take into account time spent on non-classroom activities such as preparing lessons, grading papers and counseling students. Until further guidance is issued, the IRS has provided a safe harbor which credits 2.25 hours of service for each hour of classroom time. In addition, adjunct faculty should be credited with an hour of service for each hour spent performing other duties for the school, such as attending meetings or holding office hours.

F. Educational Institution Student Employees. Hours worked under a federal or state work-study program, or hours worked in an unpaid internship do not count as hours of service for ACA purposes. However, all other hours for which an educational institution compensates students as employees are hours of service for ACA purposes.

G. Temporary Employees. Under the employer mandate rules, any individual who is reasonably expected to work 30 or more hours per week must be treated as a full-time employee, even if the employer anticipates or knows that he or she will not be a long term employee (unless the employee meets the definition of a seasonal employee, described above). Under the ACA waiting period rules, a temporary employee can be excluded for up to 90 days without triggering a penalty. However, all applicable discrimination rules will have to be considered in determining whether some employees can be excluded for 90 days if other employees have a shorter waiting period.

H. Recommendations. Employers should review any independent contractor relationships to confirm that the independent contractor is not a common law employee under IRS guidance, review any staffing company contracts

to confirm that health coverage provided to any leased employee by the staffing company satisfies ACA employer mandate regulations, and for any special categories of employees whose hours are challenging to identify and track, review policies and procedures on counting and tracking those hours and evaluate whether those policies and procedures are reasonable under current guidance.

XIII. Update on Wellness Rules.

A. EEOC ADA Regulations. In May of 2016, the EEOC issued new regulations under the ADA and the Genetic Information Nondiscrimination Act (GINA) that apply to some, but not all, wellness programs that offer incentives for participating. These regulations generally are applicable starting with 2017 plan years. The ADA regulations apply to wellness programs that offer an incentive for participating if the program requires employees to submit to any type of medical test or to answer any disability related questions as a condition for the incentive. The regulations include a limit on the amount of the incentive which is generally equal to 30% of the total cost of self-only coverage under the employer's lowest cost medical plan. This is similar but not always identical to the incentive limit under the HIPAA wellness program rules. Note that the ADA rules apply only to the extent that the program asks employees to respond to disability-related questions or submit to medical tests. They do not apply with respect to such questions or tests directed to other covered family members, so incentives based on participation of other family members in the wellness program would not be subject to the ADA limits.

The ADA regulations also included a new notice requirement. Employees who are offered an incentive for participating in a wellness program that is subject to the ADA rules must first receive a notice describing the incentive, the purpose of the program and limits on the use of any information received by the plan as part of the program. The EEOC has provided model language for such a notice, but the regulations also provide that a HIPAA privacy notice or other existing notice that is used to describe the wellness program may be used instead of a separate notice as long as the alternative notice includes all required content.

B. EEOC GINA Regulations. The EEOC's position is that GINA strictly prohibits basing any incentive on an employee providing his or her own genetic information, including family medical history, so no incentive may be offered under an employer's wellness program for an employee (or a child of an employee) to provide such information. To avoid GINA issues, if a wellness program, such as a health risk assessment, includes questions about the employee's family medical history or otherwise requests genetic information about the employee, no incentive may be offered for completing that program unless the employee is clearly informed that answering such questions is optional and is not a condition for receiving the incentive.

Information about a spouse's medical history technically would fall under GINA's definition of "family medical history" for this purpose, but because spouses generally are not actually related to each other, a spouse's information normally would not really be genetic information about the employee, so the regulations create an exception to the general rule against conditioning an incentive on anyone providing family medical history. Under the regulations, plans therefore may offer an incentive for a spouse to provide information (e.g., as part of a health risk assessment or biometric screening) about the spouse's own current and past medical history. The maximum incentive permitted by GINA is determined in the same manner as under the ADA regulations, but the regulations allow the maximum incentive to be offered based on both the employee's and spouse's participation, so the total incentive generally could be as much as 60% of the cost of self-only coverage under the employer's lowest cost plan, if the program requires participation by both the employee and the covered spouse. As under the EEOC's ADA regulations, there are notice and confidentiality requirements under the GINA regulations as well.

C. HIPAA Wellness Program Regulations. There have been no major recent changes in law regarding the HIPAA wellness program regulations. Of course, those regulations continue to apply, in addition to the ADA and GINA rules, if applicable. Some wellness programs with incentives are subject to all three sets of rules while others may be subject only one or two of them or to none of them. It is important to consider the requirements of each of these laws because efforts made to comply with one of them will not necessarily be enough to comply with the others.

D. Tax Issues. Benefits or incentives provided under a wellness program generally are not taxable if they qualify as medical expenses under the Internal Revenue Code or if they function to directly reduce the amount an employee pays for coverage (e.g., a premium discount) or cost-sharing (e.g., a reduction in deductibles or copays). However, other types of incentives, such as gift cards or payments for fitness center membership, generally would qualify as taxable compensation and should be treated as such for W-2 and other purposes.

XIV. The Updated Claims Procedures Rules.

A. Background. ERISA requires employee benefits plans to follow certain notice and appeals procedures when adjudicating/denying a claim for benefits under a plan. The ACA amended the claims/appeals procedures for group health plans to provide greater protection for participants; thereby imposing an increased burden on plan sponsors. (Note that the ACA's new-ish internal procedure requirements apply in addition to claims procedure regulations issued in 2004 by the DOL. In addition, these new requirements and the earlier DOL regulations now apply even for certain non-grandfathered church and governmental plans that are exempt from ERISA.) The ACA requirements did not apply to disability plans. The DOL has now published final regulations revising the claims/appeal procedures for disability plans in a similar fashion to those changes made by the ACA for group health plans. The new rules apply to claims beginning January 1, 2018.

B. Changes. Some of the more significant enhancements are: (a) claims and appeals must be decided in a way that ensure independence, (b) increased detail in benefit denial notices for the reason of denial, including an explanation of scientific and clinical judgment in certain cases, and explanation of internal rules, guidelines, etc. relied on in denying the claim), (c) a requirement to notify claimants of rights to access the claims file, (d) a requirement to provide claimants with an opportunity to review and respond to new evidence relied up on in connection with the claim, (e) allowing claimants to seek court review of a matter if the plan fails to comply, (f) coverage rescissions are treated as adverse benefit determinations, (g) culturally and linguistically appropriate notices, etc.

C. Recommendations. Remember, it is the nature of the claim (rather than the type of plan) that determines whether the disability provisions apply. As a result, the special rules that apply to disability claims may apply to any plan providing benefits based on a finding of disability. Employers will want to review disability insurance contracts and plan documents, etc. to ensure that they are compliant with the final regulation.

XV. Qualified Small Employer HRAs or "QSEHRAs."

Since the effective date of the ACA, employer plans that reimburse employees for individual health policy premiums and/or for medical expenses (or that pay those premiums and/or expenses directly) are unlawful, unless those reimbursement/payment arrangements are "bundled" with an underlying health plan that meets all of the relevant ACA requirements (or that cover "no more than one" active non-highly compensated employee). On December 13, 2016, the 21st Century Cures Act was enacted into law. Under the law, small employers (generally, those with less than 50 full time employees) that do not maintain a "group health plan" for any employees may reimburse employees for premiums paid for individual major medical coverage on a tax-free basis through a Qualified Small Employer Health Reimbursement Arrangement.

QSEHRAs are required to cover "any employee of the employer," except employees who (i) have 90 days or less of service, (ii) under age 25, (iii) are part-time or seasonal, (iv) are union employees, and (v) are non-resident aliens. QSEHRAs must be funded by employer contributions only; that is, no salary reduction contributions are permitted. Annual QSEHRA benefits are limited to $4,950 for individuals and $10,000 for families, and reimbursements are permitted only "after the employee provides proof of coverage" (phrase that has still not been defined).

Note that QSEHRAs are subject to ERISA because they constitute welfare benefit plans. However, because the Act expressly excludes QSEHRAs from being "group health plans," they are not subject to certain ACA requirements (including 1095 reporting) or COBRA. The Act does require employers to provide informational reporting about their QSEHRAs on employees' W-2s. In addition, employers must provide a notice to eligible employees on initial eligibility and at least 90 days prior to the beginning of each calendar year, and the notice must explain: (i) the amount available for reimbursement for the upcoming calendar year; (ii) reimbursements may affect ACA tax credits; and (iii) reimbursements that may be taxable if the employee is not covered under "minimum essential coverage" (as defined in the ACA). Currently, there is no due date for this notice for the 2017 Plan Year.

Recommendation. Employers that establish or that are considering establishing a QSEHRA should be on the lookout for guidance from the regulators. Unfortunately, pending this guidance there is significant uncertainty about what a QSEHRA is and what it may or may not do.

XVI. Church Plan Developments.

A. Grandfathered Plans. Grandfathered Plans are exempt from the preventive care mandates, including the coverage of contraceptives. Therefore, as long as a plan maintains its grandfathered status, the plan is not required to provide contraceptive coverage.

B. Regulations. Under regulations issued in 2011, group health plans of "churches" (churches, their integrated auxiliaries, conventions or associations of churches, or the exclusively religious activities of any religious order) are exempt from the requirement to provide contraceptive services. However, this exemption does not apply to the group health plans covering employees of certain affiliates of religious employers (e.g., schools, charities, etc.) ("church affiliates").

Under regulations issued in 2013, the government provided special accommodation rules for non-grandfathered plans of "eligible employers" that objected to the provision of contraceptives coverage on religious grounds, but that were not eligible for the exemption for churches. In addition, the regulations provided a delayed effective date for certain church affiliates (as defined) for the provision of contraceptives coverage. The accommodation rules and the application of those rules to church affiliates and other eligible employers has been the subject of protracted and ongoing litigation in the federal courts.

C. Litigation. A stay from the imposition of penalties for failure to provide the required documents under the accommodation rules was granted by the Courts to the parties in the litigation. The most recent decision of the U.S. Supreme Court in Zubik v. Burwell, 136 S. Ct. 1557 (2016), concludes that the "petitioners" have provide the required "notice" to the government by participating in the litigation, and concludes that the government may not impose any taxes or penalties on the "petitioners" for failure to provide any notice required under the accommodation regulations. The most recent pronouncement of the regulators came in the form of FAQs issued on January 9, 2017. In footnote 13 of the FAQs, the regulators conclude that the "Supreme Court specified that, while the RFRA litigation remains pending," the stay from the imposition of taxes or penalties remains in place. It could be argued that the prohibition against the imposition of taxes or penalties is permanent, regardless of any ongoing litigation, because the prior litigation provided to the government the required notice to be entitled to the exemption from the contraceptives coverage requirement.

D. Recommendations and Developments. Based upon the above, it is likely that any action taken by a church that causes its plans to lose their grandfathered status will have no effect on the stay from the imposition of taxes and penalties provided by the U.S. Supreme Court in its most recent decision. However, grandfathered status provides an exemption from the mandated coverages for as long as the plans remain grandfathered. The stay may not remain in place forever.

The recent development of the appointment of Judge Neil Gorsuch to the U.S. Supreme Court is a very positive one for churches. Judge Gorsuch joined in the Dissent in the Little Sisters of the Poor v. Burwell 2015 decision of the 10th Circuit Court of Appeals. The Dissent argued that a rehearing should be granted, because any action (including self certification) required under the accommodation rules would be a violation of the plaintiffs' free exercise of religion. Judge Gorsuch also wrote the concurring opinion in the Hobby Lobby v. Sibelius 2013 decision of the 10th Circuit Court of Appeals. The Concurring opinion argued that Hobby Lobby was entitled to an injunction against the enforcement of the contraceptives coverage mandate, but also was entitled to relief from the mandate under the Religious Freedom Restoration Act.

May 4, 2017 EO signed to "protect and promote religious liberty". One provision promises regulatory relief to religious groups that have a moral objection to the contraceptive mandate under ACA.

XVII. State Escheat Laws Impact on ERISA Plans.

Most states have laws requiring property that remains unclaimed for certain number of years to be transferred to the state's custody. These are either escheat laws, where the state becomes the owner of the property, or unclaimed property laws, where the state becomes the custodian but not the owner of the property. The scope of these laws generally includes employee benefit plans. If benefits are unclaimed (a benefits check remains uncashed or a plan is unable to locate a participant or beneficiary), the plan will be required to turn the unclaimed benefits over to the state unless the state law is preempted. ERISA preempts any and all state laws that relate to any employee benefit plan. There are limited exceptions to ERISA preemption allowing states to enforce insurance, banking and securities laws of general application. For example, a state may not be able to regulate an ERISA benefit plan directly, but may be able to regulate an insurance company which insures plan benefits.

The DOL has confirmed that this broad preemption applies to state escheat and unclaimed property laws, taking the position that the application of state escheat and unclaimed property statutes to an ongoing ERISA benefit plan would "affect the core functions of the plan" by reducing the amount of plan assets held for the benefit of all participants and beneficiaries of the plan. Although ERISA preemption can apply to any type of ERISA plan (both

pension and welfare plans), the DOL also has taken the position that preemption of state law won't occur where the assets are not actually plan assets, which might be the case for fully insured welfare plans. In other words, escheat and unclaimed property statutes may apply to third-party insured welfare plans, both because the assets may be insurance company assets and because a state is generally allowed to enforce insurance statutes of broad application. Courts considering whether state escheat and unclaimed property laws are preempted by ERISA have come to varying conclusions, although most are consistent with the DOL's interpretation.

Recommendations. When faced with the question as to whether certain unclaimed benefits are subject to a state's escheat or unclaimed property laws, it is important to evaluate all of the surrounding facts and circumstances – whether the underlying arrangement is a plan which is subject to ERISA, the particular state and state escheat or unclaimed property statute, the circumstances surrounding the unclaimed benefit, and any plan provisions applicable to unclaimed benefits. Given the DOL's opinion, it appears that state laws requiring transfer to the state of unclaimed benefits that are not plan assets and will not revert to the plan if unclaimed (that is, certain insured benefits), may not be preempted by ERISA. However, ERISA preemption is more likely to apply to unclaimed benefits that are plan assets (such as self-insured welfare benefits or pension benefits).

XVIII. Update on the Status of the Affordable Care Act. Although an earlier version of the American Health Care Act was not brought to a vote in the House because of a lack of support, on May 4 the House passed a modified version of the Act. It is (way) too early to tell what (if anything) will become of this piece of proposed legislation in the Senate, and in any Conference Committee that might ultimately be needed to reconcile any differences in the House-passed bill and any version that ultimately might be passed in the Senate. Our clients and friends likely will recall that wise students of employee benefits law refused to read any advance drafts of the Affordable Care Act in 2009 and 2010 (and even refused to read the version that was passed by both Houses of Congress on March 23, 2010, with their wisdom being rewarded when that version was changed radically by a second version passed on March 30, 2010 and signed into law by the President). Because the House-passed version of the AHCA eliminates many of the patient protections and low-income individual assistance provisions of the ACA (along with eliminating the ACA's employer and individual mandates), while providing a very significant tax cut to the top one percent, it is difficult to see how it would garner significant public support to propel it through the Senate. In addition, as of May 4 there was no CBO scoring of the bill, so only time will tell what will become of this utterance.

Recommendation: Our clients and friends should ensure that our e-Alerts are getting through to them and not getting spam-filtered (and that they're at least skimming them!) so if legislation ultimately is passed they receive a prompt heads-up about it and how it will affect employer-sponsored health plans.

QUALIFIED RETIREMENT PLANS

I. The New DOL Fiduciary Rule.

A. Background. As previously reported, on April 8, 2016, the DOL issued final regulations re-defining "fiduciary" for retirement plan and IRA purposes and creating a new Best Interest Contract exemption that, if complied with, permits these fiduciaries to continue to be paid. The Rule was scheduled to become "applicable" April 10, 2017, which would have commenced a phase-in period until January 1, 2018, at which time all aspects of the Rule would have been applicable. On February 3, 2017, the President directed the Department of Labor to examine the Fiduciary Rule against certain standards, and to prepare an updated economic and legal analysis of the Rule. The DOL subsequently delayed the Applicability Date of the Rule until June 9, 2017 and significantly simplified the phase-in period requirements that apply from June 9 to December 31, 2017. The Rule is still scheduled to be fully applicable on January 1, 2018, although the DOL has reserved the right to make further changes to comply with the President's Executive Order.

B. Primary Impact. The Fiduciary Rule has and is expected to continue to have a significant real world impact on the financial services industry by, among other things, defining a "fiduciary" as anyone who, for direct or indirect compensation, advises on retirement plan, IRA, HSA or ESA investments, policies or procedures, rollovers, transfers, distributions and the like (including the investment of property distributed from a retirement plan or an IRA). As a practical matter, the new fiduciary definition will result in almost any investment recommendation, even if only made one time, to a retirement plan or IRA or to a participant or beneficiary of a retirement plan or IRA owner, constituting a fiduciary act and the new fiduciaries being held to the fiduciary and prohibited transaction rules with which ERISA plan fiduciaries are familiar (e.g., no self-dealing, no conflicts of interest, no third party compensation or compensation based on investments selected without qualifying for a specific exemption, and the like).

C. The "BIC" Exemption. New fiduciaries can avoid a prohibit transaction and may continue to receive compensation based on investments selected and may continue to receive third party compensation (e.g., commissions, 12b-1 fees, etc.) by complying with the new Best Interest Contract Exemption, which among other things, requires financial firms and advisors to disclosure material conflicts of interest to customers, adhere to the Impartial Conduct Standards, and provide a written contract under which the customer can sue the advisor and/or financial institution for breach of contract.

D. Recommendations. Before June 9, 2017, all investment and advisory professionals who work with retirement plans, IRAs, HSA and ESAs, or their participants and owners, will need to review the Fiduciary Rule and the DOL's final rule delaying the Applicability Date in detail with their attorneys and determine what steps they need to take to continue to operate lawfully. Employers likely will receive new service agreements, amendments and disclosures from their service providers that should be reviewed carefully by ERISA counsel because the Rule has caused significant confusion with respect to service provider responsibilities.

II. EPCRS – New Fees and Options for Correcting Missed 401(k) Deferrals.

A. New Fees. The IRS has issued new user fees for a submission under the Voluntary Correction Program (VCP), offered as part of the Employee Plans Compliance Resolution System (EPCRS). The fee is based on the number of plan participants and is detailed in a chart in the new rules. For user fee determination purposes, the number of participants is generally based the plan's most recent Form 5500 (line 6(f)) or the last day of the prior plan year (if the plan does not file a Form 5500). Special lower user fees are specified for corrections involving only the late adoption of IRS interim amendments, other non-amender failures filed within a year after the amendment deadline, certain loan failures, RMD failures, and corrections to SEPs and SIMPLE IRAs. Special fees are specified for certain union multiemployer plans, multiple employer plans, and group submissions.

The IRS recently announced that it has noticed an increase in VCP submissions filed with incorrect user fees and offered tips for avoiding errors regarding the VCP user fee, including: 1. use the current version of Form 8951 (revised September 2016) for listing the user fee included with the VCP submission; 2. determine the correct number of plan participants (as described above); and 3. correctly reference the user fee chart and confirm whether any reduced user fees apply.

B. Correcting Missed 401(k) Deferrals. A common error in 401(k) plans is missed 401(k) deferrals for a plan participant due to: (1) an error in automatic enrollment for deferrals; (2) a failure to withhold elective deferrals; (3) withholding an incorrect amount of deferrals; and (4) excluding an eligible employee, who enters the plan late and does not have an opportunity to make deferrals. The available correction methods are now set forth by the IRS. In the past, corrective contributions for fixing missed employee 401(k) deferrals required plan sponsors to contribute 50% of the participant's missed deferral amount. To promote prompt correction of any missed deferral errors, the IRS reduced the corrective contribution amount and the time period for when the correction is required if certain requirements are met (with special rules for plans with an automatic deferral feature).

A corrective contribution is not required for missed deferrals if the correct deferrals begin by the first payment of compensation made on or after the earlier of: (1) three months after the failure first began; or (2) if the employee notified the plan sponsor of the error, the last day of the month after the month the affected employee first notified the plan sponsor. Implementing the correct deferrals within this timeframe avoids corrective contributions for missed deferrals; however, the plan sponsor is required to contribute any missed matching contributions (plus earnings). If deferrals are not correctly implemented and the missed deferral issue exceeds three months, but correct deferrals begin by the first payment of compensation made on or after the earlier of: (1) the last day of the second plan year after the plan year in which the failure first began for the affected employee; or (2) if the employee notified the plan sponsor of the error, the last day of the month after the month the affected eligible employee first notified the plan sponsor, then a reduced corrective contribution is required. That is, a 25% corrective contribution based on the employee's missed deferral is required to fix the error and any missed matching contributions, plus applicable earnings. Any corrections made outside of the above timeframes are subject to the standard correction method requiring a plan sponsor contribution equal to 50% of the participant's missed deferral (plus earnings).

To take advantage of the 25% reduced corrective contribution, the plan sponsor must distribute a written notice to affected individuals no later than 45 days after the date deferrals begin (specific content is required for the notice). If these notice and corrective contribution requirements are not satisfied, the plan sponsor can correct the missed deferrals using the older correction method equal to 50% of the participant's missed deferral (plus earnings).

C. Recommendations. Ideally, employers may avoid the expense, inconvenience and risk of a VCP filing by close monitoring of employee eligibility, entry dates, and accurate 401(k) deferral withholding. However, for employers requiring a VCP filing, this new guidance is welcome.

III. New Rules Permitting Funding Safe Harbor Contributions, QNECs and QMACs.

A. Overview. On January 18, 2017, the IRS released proposed regulations that permit the use of forfeitures to reduce an employer's safe harbor contribution, qualified nonelective contribution (QNEC), and/or qualified matching contribution (QMAC) obligation under the employer's qualified plan. Previously, the IRS's position was that, in order to be treated as a safe harbor contribution, QNEC, and/or QMAC, an amount must be fully vested and subject to certain distribution restrictions when contributed to the plan. Since forfeitures represent amounts that were not fully vested and/or subject to the applicable distribution restrictions when actually contributed to the plan, the IRS's view was that forfeitures could not be used to satisfy the safe harbor contribution, QNEC, or QMAC requirements. The new IRS regulations reverse this position, and provide that amounts, such as forfeitures, may be used to satisfy an employer's safe harbor contribution, QNEC, and/or QMAC obligation as long as those amounts satisfy the vesting and distribution requirements when allocated to participants' accounts under the plan. Although the regulations are in proposed form, employers may rely on them now.

B. Recommendations. Although this reversal of the IRS position is a welcome change for employers, employers will need to review their plan documents before using forfeitures to satisfy their safe harbor contribution, QNEC and/or QMAC obligations. To the extent that the plan language does not currently permit using forfeitures to reduce these contribution obligations, the plan will need to be amended to provide for this. Please contact us if we can assist in reviewing your plan's language and/or preparing or reviewing any necessary amendments.

IV. Form 5500 Audit Exception and Other Form 5500 Issues.

A. Small Plan Audit Exception. Plans with fewer than 100 participants at the beginning of the plan year must be audited each year by an independent qualified public accountant as part of the plan's annual report unless at least 95% of the plan's assets are invested in qualifying plan assets or the assets that are not qualifying assets are covered by an enhanced fidelity bond; an enhanced SAR is distributed (model language for the enhanced SAR is available from the DOL), and, in response to a request from a participant or beneficiary, the plan administrator furnishes without charge copies of asset statements for the plan's "qualifying plan assets" and evidence of any required fidelity bond. The enhanced SAR requirements do not apply to any assets over which the participant or beneficiary have investment control (assuming certain disclosures are made), qualifying employer securities or participant loans. (In determining whether a plan is eligible for this exception, the 80-120 participant rule is available, the Plan Administrator must disclose on the Form 5500 that it is claiming the waiver, and the 95% calculation is done as of the last day of the prior plan year.

For this purpose, qualifying assets include assets held by regulated financial institutions, shares issued by an investment company registered under the Investment Company Act of 1940, investment and annuity contracts issued by an insurance company, any assets over which the participant or beneficiary have investment control (assuming certain disclosures are made), qualifying employer securities and participant loans. Non-qualifying assets are defined as assets which do not have a readily determinable value or are not publicly traded on a registered exchange. Putting non-qualifying assets in a safe deposit box does not make them qualifying assets. If the plan has more than 5% of its assets in non-qualifying assets, persons that handle non-qualifying assets must be covered by a fidelity bond that meets the requirements of section 412 of ERISA except that the bond amount must be at least equal to 100% of the non-qualifying assets that the person handles. The plan can get the bond or the plan can have the persons handling the assets get their own bond. (Even if 95% of the plan's assets are qualifying, the SAR must still contain the enhanced language.)

B. 5500 Data Errors. Often a cursory comparison of plan documents and SPDs with the most recent form 5500 filing reveals basic errors such as a difference in the company name or EIN. A more thorough review often turns up more significant errors. Since for most plans the Form 5500 is the primary source of information about the plan available to the DOL and IRS, it is often the agencies' only way to identify specific plans to be audited. As a result, it is critical to fill out a plan's 5500 correctly.

C. Form 5500 Changes 2016. The 2016 form has only minor changes. Most likely the DOL is keeping changes to a minimum in anticipation of the significant modifications it intends to make beginning in 2019. First, administrative penalties have increased for Form 5500 failures from $1,100 per day to $2,063 per day. This is certainly added incentive to make sure that no such failures occur. It may also be incentive for the DOL and IRS to

increase their audit activity. Second, the Schedules H and I for defined benefit plans covered by PBGC must now enter the MY PAA generated confirmation number for the PBGC premium filing for the year. Third, the second page of the 2016 instructions contains a list of questions that Plan sponsors do NOT need to answer even though the questions were not removed from the form. Note: the proposed 2017 Form 5500 does NOT include these questions. Fourth, Schedule SB has been updated for guidance issued in the Cooperative and Small Employer Charity Pension Flexibility Act.

D. Proposed Form 5500 Changes 2019. In July 2016, DOL, IRS and PBGC jointly issued proposed revisions to the Form 5500 that would affect filings beginning in 2019. These revisions are extensive. According to the agencies the goals of these revisions are modernizing financial information, updating the reporting requirements for service provider fee and expense information, improving compliance through new compliance questions, and data mining. The proposal makes it clear that, due to resource and other constraints, the agencies are increasingly relying on the Form 5500 for their enforcement efforts. The new compliance questions cover a multitude of specific legal requirements under ERISA, the Code and other federal laws. These questions will likely add time and expense to preparing the 5500 and may lead to targeted audits and potentially even more plaintiff litigation. Examples of these questions include default investments, catch-up contributions, employer contributions, participants and uncashed checks. The Agencies want more information with regard to investments, expanding Schedule H to reflect new asset categories and sub-categories to require plan sponsors to disclose the variety of alternative and complex investments held by the plan. The rules regarding the reporting of "indirect compensation" earned by service providers have been simplified and made more consistent with information already required by DOL regulations, and more information would be requested concerning plan terminations and mergers.

In addition to the above, IRS only questions would be back (see, for example, the questions that are on the form but that do not need to be answered for 2016) as would a revised Schedule E providing ESOP information to both the DOL and IRS. Some of the IRS-only questions are being modified by the IRS and might become mandatory in 2017. Plans will need to disclose additional information about the trust, nondiscrimination and coverage testing, 401(k) testing, determination letters, distributions and the preparer. Also, information would be moved from attachments to the body of the 5500 or the schedules to make the data more accessible and mineable for government agencies and other related parties. This may increase the software difficulties preparers already encounter and reduce the flexibility of putting information into an attachment when the 5500 instructions are unclear or not relevant to the particular plan. Finally, additional questions about participant directed plans would include distributions to participants, designated investment alternatives and default investments, and Schedules SB and MB would require additional information about projected benefit payments and would move some information from PDF attachments to the schedules themselves.

E. Proposed Statement on Auditing Standards. The AICPA has released an exposure draft of a proposed statement on auditing standards. This is the result of the work of the AICPA's Employee Benefit Plan Task Force which was created in January 2015. The goal of the task force was to improve the quality of employee benefit plan audits through strengthening of the auditor's report. The DOL has expressed their support for an auditor's report that requires both reporting on noncompliance with laws, rules, and regulations, and also reporting on internal controls while also having more transparency. Once the AICPA has worked through this process, Plan sponsors may experience changes in their accountant's data requests and in the final product.

F. Recommendations. The sponsor of any plan relying on the small plan audit exception should review the rules to make sure it qualifies. And every plan sponsor should check with its 5500 preparer to determine the impact that changes to the form may have on data collection. Because of the potential that these forms could be used by the IRS and DOL to identify plans to audit, sponsors may want to consider having their forms reviewed by counsel before filing.

V. A Review of the Electronic Delivery Rules.

Federal law imposes a number of participant notification and communication requirements on sponsors of employee benefit plans. These requirements can be satisfied by providing documents in an electronic format if certain specific requirements are met. The requirements for electronic delivery vary depending on the source of the particular notice requirement. If the disclosure is required under ERISA, the DOL's electronic delivery rules apply. If the disclosure is required by a section of the Code that's not part of ERISA, then the IRS's electronic delivery rules apply.

Special Rules for Quarterly Statements. Pension benefit statements may be provided through a secure continuous access website in compliance with Field Assistance Bulletin 2006-03. Briefly, FAB 2006-03 requires that participants and beneficiaries receive a notification that explains the availability of the required pension benefit

statement information and how such information may be accessed, as well as inform participants and beneficiaries of their right to request and receive, free of charge, a paper version of the pension benefit statement. The notice must be written in plain English, and must be provided in advance of the date on which the plan is required to furnish the first pension benefit statement and annually thereafter. Alternatively, pension benefit statements may be distributed in accordance with the general DOL or IRS electronic delivery rules. In addition, if an employer's obligation to distribute the "plan related information" that must be included in participant fee disclosures (i.e., general plan information and administrative/individual expenses that may be charged to a participant's account) is being satisfied by including that information on the pension benefit statements, then the employer is deemed to satisfy its "plan related information" obligation even if the pension benefit statements are provided through a secure continuous access website.

Special Rules for "Investment Related Information" and "Plan Related Information" That is Not Included in Quarterly Statements. The participant fee disclosures that are not included in the quarterly pension benefit statements – which includes "investment related information" - may be furnished electronically, either in accordance with the DOL's electronic delivery requirements or by meeting the following conditions: 1. Initial notice. A notice must be provided to participants and beneficiaries entitled to receive the new disclosures, informing them that they may voluntarily provide their email address in order to receive the disclosures electronically. In addition, the initial notice must satisfy certain other requirements described in DOL Technical Release No. 2011-03R. 2. Voluntary provision of email address. In response to the initial notice, participants and beneficiaries must voluntarily provide their email address for the purpose of receiving the 404(a) disclosures. Note that, if the provision of the email address is a condition of employment or participation in the plan, the participant will not be considered to have provided his or her email address voluntarily. 3. Annual notice. The plan administrator must provide the participant with an annual notice that includes certain information described in DOL Technical Release No. 2011-03R and is delivered in the manner required by DOL Technical Release No. 2011-03R. 4. Delivery. The plan administrator must take appropriate and necessary measures reasonably calculated to ensure that the electronic delivery system results in actual receipt of the transmitted information (e.g., using return receipt or notice of undelivered electronic mail features, etc.) 5. Confidentiality. The plan administrator must take appropriate and necessary measures reasonably calculated to ensure that the electronic delivery system protects the confidentiality of personal information. 6. Plain English. The notices provided to participants and beneficiaries must be written in a manner designed to be understood by the average plan participant.

Recommendations: Employers should carefully review their electronic delivery practices (and their service providers' electronic delivery practices) to confirm they are following the applicable rules.

VI. Governmental Retirement Plans Update.

A. State Sponsored IRA Program for Non-Governmental Employees. November 2015, EBSA issued proposed regulations that detailed how a state established payroll deduction IRA program for non-governmental employees would be exempt from ERISA. September 2016, EBSA finalized the proposed rules, adding a provision that allowed the state savings program to restrict employee withdrawals to prevent "leakage" from the IRA accounts, adding a provision allowing tax incentives and credits to employers participating in the program and adding a provision clarifying that a board, committee, governmental agency or instrumentality of the state could design, implement and administer the program. An EBSA proposed rule in September 2016 (finalized in December 2016) also allowed a "qualified political subdivision" to establish an ERISA exempt program.

In 2016, Maryland implemented the Maryland Small Business Retirement Savings Program and Trust, effective July 1, 2016. The Maryland law established the Maryland Small Business Retirement Savings Program and Trust for private sector employees; established the Maryland Small Business Retirement Savings Board to implement, maintain, and administer the Program and the Trust; requiring the Board to take any action to ensure that the Program is not preempted by federal law, to establish procedures and disclosures to protect the interests of participants and employers, and to disseminate to employers and employees information about the Program prior to enrollment.

On April 13, 2017, the President signed into law H.J. Res 67, which nullified the December 2016 final EBSA regulations that had created an ERISA safe harbor exemption for payroll deduction IRAs for non-governmental employees established by local governments. The House and the Senate now have approved resolutions that rescind the September 2016 final EBSA regulations that had created an ERISA safe harbor exemption for state sponsored payroll deduction IRAs for non-governmental employees. The President is expected to sign the joint resolution into law.

B. Proposed Pick-Up Legislation. Except for certain "grandfathered" plans, a governmental entity cannot sponsor a 401(k) plan for its employees. However, under Code section 414(h)(2), a governmental employer can implement a "pick up" program that converts mandatory after-tax employee contributions to a defined benefit plan into pre-tax contributions. To qualify as a "pick up" contribution, the employee cannot be given a choice between receiving the picked up amounts directly as cash and having the amounts contributed to the plan. Over the past several years, in attempts to control costs, some governmental employers have offered new plan designs that allow employees to choose between a current benefit structure and a new benefit structure. If the choice between the two benefit structures will result in a change in the amount of the employee contributions that are picked up, the IRS has stated that this will violate the "no employee choice" requirement for a valid pick up program and could result in a non-qualified 401(k) program. A recent IRS private letter ruling confirms this IRS position.

Proposed legislation (H.R. 2187), introduced by Rep. Diane Black (R-TN), who is the Chair of the House Budget Committee and a member of the Ways and Means Committee, would modify Code section 414(h)(2) to allow an election by an employee to move from one plan or tier to another plan or tier, even if that results in a change in the employee contribution rate.

C. Recommendations. Employers should refrain (if possible) from participating in any state or local government sponsored IRA program for non-governmental employees. Governmental employers that provide choice between different plans or tiers with different employee contribution rates, or that are considering offering these options, should track the proposed pick up legislation.

VII. New Mortality Tables for Defined Benefit Plans.

A. Mortality Tables in General. Mortality tables are used by defined benefit pension plans for multiple purposes including calculating (a) the Plan's minimum required contribution and maximum deductible contribution, (b) the Plan's liabilities and funded status, (c) optional forms of benefit including lump sums, (d) relative value disclosures, (e) PBGC variable rate premiums, and (f) financial statement disclosures. Actuaries do not have complete discretion over the choice of mortality tables. For example, the IRS prescribes the mortality table to be used for lump sum calculations, the Pension Protection Act of 2006 gave the IRS the authority to prescribe mortality tables to be used in the calculation of funding liabilities, and the Plan's accountant has a lot of impact on the factors to be used in calculating financial statement disclosures.

B. Society of Actuaries Updated Tables. In 2009, the Society of Actuaries (SOA) began a project to revisit US mortality assumptions for pension plans. In 2014 they published their report along with updated mortality tables and an updated mortality improvement scale. Projected mortality rates for younger workers are only slightly different. However, those for older workers and retirees increased significantly. People are living longer. That's good news. However, it provides a challenge to defined benefit pension plans, especially coupled with investment issues. The cost of lifetime benefits is dependent on how long the retiree lives. There is no way to avoid these increased costs. Adopting the new mortality tables will not change what a plan ultimately pays out to retirees and beneficiaries. The question is when plan sponsors will be required to begin recognizing those increased costs. After the SOA published its report, several things began to happen almost immediately: various parties began to question the validity of the new tables, commentators began to speculate as to when the IRS would require adoption of the new tables, and many plans were required by their auditors to adopt the new tables for financial statement purposes.

C. HAFTA. Also in 2014, Congress passed the Highway and Transportation Funding Act of 2014 (HAFTA) which contained provisions reducing cash contribution requirements to pension plans. Adoption of the new tables would have the opposite effect which was one of many factors for the IRS to consider in determining timing of adoption of the new tables.

D. Mortality Tables for 2016 and Later Years. In July 2015, the IRS issued Notice 2015-53 which provided the mortality tables to be used in 2016 for funding and calculating lump sums. These tables were NOT based on the SOA tables so Plan sponsors got at least a one-year delay at that point. In September 2016, the IRS issued Notice 2016-50 which provided the mortality tables to be used for 2017. Again, the tables were NOT based on the SOA tables. To the extent that a plan does not incorporate mortality tables by reference for lump sum calculations, a plan amendment is required to adopt the new mortality tables. Meanwhile, the SOA continues to issue its annual updates to its tables. The tables for 2016, based on additional years of mortality information from SSA, show the increases projected in 2014 to have been reduced. At the end of December 2016, the IRS issued proposed regulations that would (1) require the use of updated tables based on the SOA tables and (2) revise the requirements for a plan sponsor to obtain IRS approval for its own plan-specific mortality table (the current requirement that a plan have at least 1,000 participant deaths per gender within the period of the experience study (2-5 years) would be reduced to at

least 100 deaths per gender so there will still be a limited number of plans to which this will be available). The proposed effective date of these regulations is the first plan year beginning on or after January 1, 2018. The IRS accepted public comments through March 29 and had a public hearing April 13.

E. Recommendations. Every employer that sponsors a defined benefit plan should review the potential impact of these tables on their plan and whether anything can or should be done to mitigate the impact. In addition, pension plan sponsors should determine if a plan amendment is required to adopt the 2017 tables.

VIII. Document Correction Window for 403(b) Plans. 403(b) plan sponsors have until March 31, 2020 to correct document defects and/or adopt a pre-approved plan restatement, provided that an initial plan document was adopted timely under the 2007 final 403(b) plan regulations and subsequent guidance. It wasn't until the issuance of final regulations in 2007 that a written plan document was required for 403(b) plans. Under the final regulations, a sponsor of a 403(b) plan is required to maintain its plan pursuant to a written plan document that complies with the 403(b) regulations in both form and operation. Under the final regulations, and additional IRS guidance, existing 403(b) plans were required to adopt plan documents by the end of 2009. In 2013, the IRS issued Revenue Procedure 2013-22, which established the program and procedures for the IRS to issue opinion and advisory letters for pre-approved 403(b) plan documents. In addition, the Revenue Procedure also provided for a remedial amendment period that would allow a plan sponsor to retroactively correct defects in the form of its 403(b) plan document. For employers that have timely adopted a 403(b) plan document, the remedial amendment period begins on the later of January 1, 2010, or the plan's effective date. However, the Revenue Procedure did not state when the last day of the remedial amendment period would occur. Rather, the IRS reserved that it would provide the date of the last day of the remedial amendment period in subsequent guidance.

On January 13, 2017, the IRS issued Revenue Procedure 2017-18, announcing that the last day of the remedial amendment period will be March 31, 2020. 403(b) plan sponsors will have until March 31, 2020 to either adopt a 403(b) pre-approved plan or otherwise amend its 403(b) plan document to correct any document defects. The remedial amendment period is available only if an employer adopted a written plan document intended to satisfy the Code section 403(b) requirements on or before January 1, 2010, or the plan's effective date, if later. By the end of the remedial amendment period, all provisions of the plan that are required to satisfy Code section 403(b) must be adopted and made effective retroactive to the beginning of the plan's remedial amendment period.

Recommendations. 403(b) plan sponsors should review their documents sooner rather than later to confirm that the plan meets the 403(b) requirements both in form and operation. Plan documents should be updated to incorporate all amendments that have been made and to reflect the plan's operation from the first day of the remedial amendment period. If a retroactive change is needed to correct an impermissible feature, operations may require adjustments back to 2010 and may require IRS approval using VCP. Assessing the need for changes now will leave time for any document and operational adjustments before the end of the remedial amendment period.

IX. Review of Permissible Mid-Year Amendments to Safe Harbor Plans.

In early 2016, the IRS changed its prior position that safe harbor 401(k) and 403(b) plans may not be amended during the plan year unless the IRS specifically approved the particular amendment. Under the revised IRS view, generally, if the plan amendment does not impact content required to be included in the annual safe harbor notice, the amendment is permissible (even if the change impacts optional information that is included in the safe harbor notice). For example, the plan entry date for employees who meet the plan's eligibility conditions is not required to be included in the annual safe harbor notice. This is an optional detail that plan sponsors usually provide in the safe harbor notice, but if a plan sponsor prefers to change the entry date provision mid-year, an updated safe harbor notice is not required ahead of the amendment (provided the amendment is limited to employees who are not already eligible to receive safe harbor contributions).

In addition, many amendments that impact the content of the safe harbor notice are permissible, as long as: (1) the plan sponsor provides employees advance notice of the change; (2) employees are provided a reasonable opportunity before the effective date of the amendment to make changes to their deferral elections; and (3) the mid-year change is not prohibited. The updated safe harbor notice used to provide advance notice of a mid-year change must be provided to eligible employees within a reasonable period before the effective date of the change. Whether the timing is reasonable is based on the facts and circumstances. Similar to the annual safe harbor notice, distributing the updated notice 30-90 days before the effective date is deemed to be reasonable. Further, each employee must have a reasonable period of time to change their deferral election after receiving the notice and before the amendment is effective. A 30-day period is deemed reasonable to give employees an opportunity to make deferral election changes.

For both the updated safe harbor notice and the deferral election opportunity, there are special rules that apply if it is not practicable for the plan sponsor to provide notice or election opportunities in advance of the amendment effective date (e.g., when a mid-year amendment increases matching contributions retroactively for the entire plan year). In this circumstance, the notice may be provided no later than 30 days after the date the amendment is adopted, and the deferral opportunity is reasonable if it begins within 30 days after the amendment is adopted. The IRS provided specific examples of permissible mid-year amendments (provided the notice and deferral opportunity requirements are met): 1. Increase future safe harbor non-elective contributions from 3% to 4% for all eligible employees. 2. Add in-service distributions at age 59 ½. 3. Change the plan's default investment fund. 4. Change the plan entry date for employees who meet the plan's minimum age and service eligibility requirements from monthly to quarterly.

Certain types of amendments are still not permissible unless required by legal or regulatory guidance. For example, the IRS prohibits amending a safe harbor plan mid-year to narrow the group of employees who are eligible to receive the safe harbor contribution (however, employees who are not already eligible could be subject to new eligibility or entry date requirements adopted in a mid-year amendment). Further, a plan sponsor cannot amend the safe harbor plan mid-year to switch to a different type of safe harbor plan, such as changing from a safe harbor nonelective to a safe harbor matching plan. Certain other mid-year changes impacting the plan's regular matching contributions also are prohibited, depending on the timing of the change.

If an employer has a safe harbor 401(k) or 403(b) plan and wishes to amend the plan mid-year, the employer should first confirm that the amendment is permissible. Assuming that the particular mid-year amendment is not prohibited and the change impacts the safe harbor notice content, the employer should ensure that, prior to the amendment's effective date, the employer satisfies any advance notice and deferral election requirements associated with the amendment. Further, plan sponsors should note that certain changes, such as suspending safe harbor contributions, adding safe harbor contributions for the first time, or changing a plan year definition in a safe harbor plan are still governed by regulations separate from the mid-year amendment guidance.

X. Update on IRS Determination Letter Program.

A. Announcement 2015-19. Sponsors of individually designed qualified plans have for years submitted their plans for a determination letter to the IRS which allows the sponsor to rely on the qualification of the plan document in form. The determination letter gives the plan sponsor the comfort that the IRS will not question the qualified status of the plan provided that the plan is operated pursuant to the plan's terms. In Announcement 2015-19, the IRS announced that, effective January 1, 2017, the 5-year staggered determination letter cycles for individually designed plans were eliminated. Determination letters for individually designed plans are now limited to initial qualification, plan termination, and special exceptions announced by the IRS. In addition, effective July 21, 2015, the IRS no longer accepted off-cycle determination letter applications, except for determination letter applications for new plans and for terminating plans.

B. Revenue Procedure 2016-37. A Plan Sponsor may now only request a determination letter for the following: (1) a Plan that has never received a favorable determination letter, (2) a terminating Plan, and (3) IRS special exceptions. For 2017, there are no special exceptions.

C. Required Amendment List. Instead of submitting your plans every five years, there will now be a Required Amendment List encompassing all amendments needed for individually designed plans to keep their qualified status. This Required Amendment List will be published by the IRS after October 1 of each year. Plan Sponsors will have until the end of the second calendar year following the publishing of the Required Amendment List to amend their plans and stay compliant. Discretionary amendments will still be required by the plan year end for which the amendment is put into effect.

D. Recommendations. As always, employers should keep a well-documented paper trail for all amendments and administrative forms. The end of the IRS determination program is a "double whammy" for plan sponsors. One the documentation side, a useful governmental service for document reliance has been substantially eliminated. One the operational side, because the IRS ended the Remedial Amendment Cycle so as to have more staff power to devote to audits, the need for more careful attention to the rules in plan administration has increased. Plan sponsors of prototype or other "pre-approved" plans may want to convert to individually designed plans and/or strongly consider the "privatized" program discussed below. Employers also should look for the IRS's annual Required Amendment List, and contact us each October to make sure they are staying compliant.

XI. "Privatizing," Expanding and Improving the Former IRS Determination Letter Program.

A. Options Available for Determining Qualification Status. As noted above, effective January 1, 2017, the IRS ended its every five year determination letter program for individually designed tax-qualified retirement plans. Although some lawyers, CPAs and service providers are in distress over this development, we welcome this return to the more sensible prior rules that only called for IRS determination letters upon significant events, such as when the plan is first adopted, upon a plan termination and when legislation or regulations require significant changes to the plan.

Some law firms and commentators have suggested that the elimination of the five year program will mean plan sponsors, plan auditors and plan service providers will not be able to tell whether a plan should be treated as tax qualified unless the plan sponsor (1) adopts a pre-approved prototype plan, or (2) obtains from the law firm a formal, written opinion regarding the qualified status of the plan.

Although adopting a pre-approved prototype plan offers advantages in some cases, using an individually designed plan provides much greater flexibility for the design and features of the plan and much greater clarity of the provisions of the plan. Our experience is that most pre-approved prototype plans necessarily have become extremely confusing and cumbersome as they are required to continually add features and complexity to try to be "one plan fits all" documents. And this complexity often results in the resulting documents not correctly incorporating the desired plan design features and IRS and DOL auditors frequently finding that the operation of the plan does not match the written terms of the prototype.

Our bottom line conclusion: the IRS elimination of the five year program provides a great opportunity for a process that is dramatically better than the five year program. Prior process focus on document compliance that served as a self-audit was good, but it required IRS user fees and IRS interaction. Prior process also was only every five years and was not available to 403(b) Plans. The new process eliminates the bad (that is, the IRS user fee and IRS interaction). The new process allows an annual compliance focus that is efficient, certain and of minimal cost. The new process can apply to all plans, including 403(b) plans, and can result in a legal "comfort" letter for the Board, for plan auditors and for other qualification purposes.

B. Recommendations. Annual Checkup. We recommend that all qualified plan sponsors that formerly participated in the IRS determination letter program continue to do so, but on the "private program basis". This will retain the positive aspects of the former process and add new positives, at a lower total cost (due to the elimination of IRS user fees and legal fees associated with IRS interaction).

Automatic Updates Program. Alternatively, you can let us know if you would like us to prepare and send to you for adoption any required amendments in future years. This simple, inexpensive, straightforward, annual update check, and plan amendment adoption (if necessary) will ensure the terms of your tax-qualified plan remain in compliance with the qualification requirements. This also will allow us to confirm for any plan audit, plan service provider or other qualified plan (e.g., for rollover purposes) that the provisions of your retirement plan meet all qualification requirements.

Individually Designed Plan. This approach also enables plan sponsors that desire or need to have the flexibility and clarity of an individually designed plan to do so. Please contact us if you would like us to convert your pre-approved prototype plan to an individually designed plan or put your individually designed plan on our automatic annual plan amendment update program.

XII. Investment Policy Statement Best Practices and Related Issues.

One of the most overlooked documents from a compliance perspective is a retirement plan's Investment Policy Statement (IPS). An IPS is intended to assist Plan fiduciaries by establishing guidelines for making investment choice-related decisions concerning the Plan. A well-written IPS is both the core of an investment program under the Plan and can provide much-needed protection in the increasingly litigious environment where lawsuits -- class action and individual -- against employers have become an epidemic. An IPS forms the basis for demonstrating reasonableness and prudence in making investment-related decisions. Documenting compliance with a carefully-tailored IPS can make a plaintiff's case for breach of fiduciary duties that much harder to make. It is imperative that Plan fiduciaries show that they have a prudent process outlined in the IPS and that Plan fiduciaries document how they followed that prudent process. In the event that the Plan fiduciaries can demonstrate that they had a prudent process and followed that prudent process, the courts are much less likely to impose liability for investment results.

Plan fiduciaries should be careful about having an IPS that is too specific, thereby creating an impossible standard to meet and giving plaintiffs a "slam-dunk" in terms of arguing that some minor provision of the IPS was not followed, even if inadvertently. To over-generalize a bit, IPSs of participant-directed defined contribution plans typically should say little more than "we/our 3(38) advisor will follow the 404(c)/QDIA/fee disclosure rules."

Recommendation. Employers should have their IPSs reviewed by ERISA counsel on a regular basis, and should check regularly compliance with the terms of the IPS on a quarterly or other appropriately regular basis.

XIII. IRS's New Hardship Documentation Examination Guidelines.

Over the last several years, the IRS has offered conflicting advice on what documentation is adequate to substantiate a hardship distribution under a 401(k) or 403(b) retirement plan. In its most recent informal guidance, which appeared in two memos written to Employee Plan Examiners of 401(k) or 403(b) retirement plans, the IRS seemingly approved an alternative, and potentially less burdensome, substantiation method. This new method allows a plan sponsor to obtain a summary from an employee detailing the source documents describing the nature and amount of the hardship, rather than requiring the plan sponsor to collect copies of the source documents. While the memos are not legally binding, they do indicate what substantiation the IRS will look for in an audit.

The memos provide instructions to examiners when reviewing hardship distributions substantiated by an employee's summary. First, an examiner should confirm whether, prior to distributing a hardship withdrawal, the plan sponsor provided certain required notices to the employee, as well as requested specific information describing the nature of the hardship (which information varies depending on the type of hardship involved). One of these notifications is that the employee agrees to maintain the source documents and provide at any time upon request. Second, an examiner should confirm that the summary substantiates the hardship and contains the required information. Third, an examiner may request copies of source documents if the examiner finds that the required notices or the employee's summary contain incorrect or inconsistent information, or that an employee has received more than two hardship distributions in a plan year without an adequate explanation. Fourth, if an employer uses a TPA, an examiner should determine whether the TPA provides an annual report to the employer summarizing the hardship distributions made during the plan year.

In response to this newest guidance, sponsors of 401(k) or 403(b) plans should consider whether to take advantage of this alternative substantiation method. The advantage is that it may streamline an already burdensome hardship distribution process. The risk, however, is that an employee may fail to maintain copies of the underlying documents or may not be employed at the time of an audit. This can be troublesome given an examiner's ability in certain situations to request copies of the source documents from the plan sponsor. A plan sponsor considering the alternative substantiation method should (i) review and, if necessary, update its plan and forms, and possibly participant communications (e.g., the summary plan description); (ii) ensure, before making a hardship distribution, that it provides the required notifications and receives a complete summary; (iii) appropriately limit the number of hardship distributions permitted during each plan year; and (iv) if the plan utilizes a TPA, ensure that the TPA provides an annual report describing each hardship distribution made during the plan year.

XIV. Update on Plaintiff's Litigation.

As we previously reported, the plaintiffs' bar has discovered ERISA. Most of the litigation to date alleges violations of the duties of prudence and loyalty under ERISA and much of it is being brought by "professional class action lawyers." The plaintiffs' claims generally are that the plan's investment options were not the best in the universe, the fees charged to participant accounts were not the best in the universe, and/or the services provided by various vendors were not of the highest quality in the universe. The plaintiffs' lawyers often attempt to enhance their claims by alleging that employers have acted in their own self-interest, rather than in the exclusive interest of plan participants and beneficiaries. The first wave of lawsuits were against elite universities, alleging the above and that the employers breached their duties by offering complex investment lineups with options that were duplicative, poor-performing and had high fees. Now, plaintiffs' lawyers are increasingly targeting smaller employers. In 2016, cases were brought against plans with 110 participants/$9 million in assets (LaMettry's Collision) and $25 million in assets (Checksmart Financial). In addition, over the past three years, at least 20 companies have been sued over the offering of "affiliated financial products" in their 401(k) plans. For example, on March 31, 2017, a class action was allowed to proceed against American Airlines where plaintiffs accused the company of offering expensive, poorly performing mutual funds from an affiliated company. Generally, courts have shown a tendency to have these cases proceed beyond the initial stages of litigation which puts increased pressure on settlement when employers are facing heightened defense costs.

Published studies concluding that actively managed mutual funds often fail to perform as well as index funds also are encouraging a wave of litigation against fiduciaries offering actively managed funds under their plans. For example, in a recent lawsuit against JPMorgan Chase (filed March 2, 2017) the plaintiffs appear to be advancing a theory that actively managed funds are de facto imprudent because of the higher associated fees and, citing the studies, their failure (as a group) to perform as well as passive funds over extended periods. These lawsuits are encouraging fiduciaries to take consult with their investment advisors and take a fresh look at their plans' active-versus-passive offerings.

Recommendations. The successful defendants in these lawsuits don't always prevail because they can combat the plaintiffs' claims on the merits, but rather because they can show a prudent process where they considered and deliberated with respect to the subject matter of each claim. Therefore, employers should consult with ERISA counsel to ensure that their processes are truly at a best practice level. On a related point, it is important for employers to protect their internal personnel (e.g. Board members, administrative committee members, HR staff, etc.) against personal liability for their part in this process, and that appropriate insurance and indemnification are in place for all personnel with ERISA plan responsibilities. In addition, in light of this litigation epidemic, more and more employers are moving to ERISA Section 3(38) investment advisors to remove much of the liability they face.

XV. Updates on Church Plan Rules.

A. Litigation. Retirement plans that meet the definition of a "church plans" under ERISA and the IRC, are exempt from ERISA and PBGC premiums, and, if they are non-electing plans, are exempt from some IRC requirements and subject to different, less stringent requirements under other Code sections. For almost four decades, the IRS and DOL have issued letters granting "church plan" status to plans established and maintained by churches and church related organizations (e.g., hospitals). In the last few years, a very active plaintiff's bar has filed and won several lawsuits in which the federal courts have determined that (even though the plan has an IRS private letter ruling) the plan is not a church plan and thus is subject to ERISA and the various Code provisions affecting qualified retirement plans. At the federal District Court level several courts have found that, to be a church plan, the plan must be established and maintained by a church (directly or through a pension board) and plans established by a church associated non-profit healthcare organization are not church plans. The Third and Seventh Circuit Court of Appeals have now concluded that, to be a church plan, a plan must be established by a church and not a church affiliated hospital.

Three Court of Appeals decisions have been granted review by the U.S. Supreme Court. On March 27, 2017 (prior to the seating of Judge Gorsuch), the Supreme Court heard the oral arguments in these three cases. Advocate Health Care Network v. Stapleton, U.S., No. 16-74; Saint Peter's Healthcare Sys. v. Kaplan, U.S., No. 16-86; and Dignity Health v. Rollins, U.S., No. 16-258. The decision of the Supreme Court is expected in June 2017. The primary question is "Must a benefit plan be initially established by a "church" to qualify as a "church plan"?". At stake are $66 billion in potential penalties, $4 billion in potential under funding of pension plans, and an impact on more than 300,000 hospital employees/plan participants.

B. Recommendations. Sponsors of plans that have claimed "church plan" status should review their plans to determine what effect a loss of church plan status would have on their plans. Depending on the analysis, sponsors may choose to make changes to the plans to ensure their "church plan" status continues or to bring the plans into compliance with ERISA and the Code as non-church plans (for example, should the plan be better funded, should vesting be changed and so forth).

C. Church Controlled Group Rules. On December 18, 2015, the PATH Act became law. One part of that Act added a new section 414(c)(2) to the Internal Revenue Code, which contains rules for applying the controlled group rules to church organizations. These rules apply retroactively. Generally, aggregation is required if an organization provides at least 80 percent of the operating funds and is directly involved in the day-to-day operations of the other organization. However, the new Code section adds a "permissive aggregation" rule and a "permissive disaggregation" rule, that can be elected to include or exclude organizations that would be excluded or included under the general rule. However, once the election is made, it can only be revoked in the future by notice to the Secretary of the Treasury in a manner to be prescribed in future guidance. While not a model of clarity, these provisions seem to suggest that a church is permitted to treat another organization as part of the church's controlled group for purposes of extending coverage under the plan, for example, to employees of another organization if (a) the other organization is "otherwise eligible to participate in a church plan" and (2) that organization "shares common religious bonds and convictions with" the church. In addition, in the case of a church plan, an employer may elect to treat churches (i.e., churches and QCCOs) separately from entities that are not churches (e.g.,

NQCCOs), without regard to whether such entities maintain separate church plans.

Definitions. "Church" means a church, a convention or association of churches, or an elementary or secondary school which is controlled, operated, or principally supported by a church or by a convention or association of churches. There also are definitions for: "QCCO" stands for a "qualified church-controlled organization"; "NQCCO" stands for a "nonqualified church-controlled organization"; "Church plan"; "employee of a church a convention or association of churches"; and "Associated With" means the organization shares common religious bonds and convictions with that church or a convention or association of churches.

D. Recommendations. Church organizations should review these new controlled group rules to determine the advantages and disadvantages to these new rules and modify the organization's benefit programs accordingly.

XVI. Accidental Multiple Employer Plans and MEP Compliance Issues. A multiple employer plan is a retirement plan adopted by two or more employers that are not members of the same controlled group or affiliated service group. MEPs present compliance and administration challenges because they are simultaneously considered, under ERISA and the Code, to be both an aggregate single employer plan and separate plans maintained by each participating employer. MEPs are considered to be single employer plans for the following purposes: eligibility, so minimum age and service requirements under Code Section 410(a) are applied as if all the participating employers are one employer; vesting, so service with all participating employers is counted for vesting purposes; elective deferral limits, so deferrals at all participating employers are counted as if from one employer; 415 testing, so compensation and contributions from all participating employers are counted for purposes of Code Section 415 (unless the plan specifies otherwise); plan disqualification, so a disqualifying violation by one participating employer can disqualify the entire MEP; and, the exclusive benefit rule, so contributions and forfeitures may be allocated across participating employers without violating the rule that an employer's contributions must be only for the benefit of its employees/former employees.

MEPs are considered to be separate employer plans for each participating employer for the following purposes: Highly Compensated Employees, so HCE status is based on the compensation the employee receives from the specific participating employer; Coverage, Nondiscrimination, Top Heavy, ADP and ACP testing, so participating employers performs these test as if they maintained separate plans; and, annual Reporting and disclosure, so "Open MEPs" must file Form 5500s on an employer-by-employer basis as if that employer sponsored its own plan (and perform individual plan audits, if necessary). ("Closed" MEPs may file one Form 5500 and perform one audit for the MEP, as necessary.)

MEPs often result inadvertently from business transactions (e.g., mergers, consolidations, spin-offs, sales, etc.) because the sponsoring employer continues to operate the retirement plan as it did prior to the transaction, including former or new employer employees in the plan, unaware that the transaction caused the plan to became a MEP. This results in costly errors such as Form 5500 errors, plan audit errors, coverage, non-discrimination and ADP/ACP testing errors, inaccurate plan documents, fiduciary liability issues, etc. These errors require retroactive corrections including retroactive audits, amending Form 5500 submissions, plan document amendments and IRS and DOL penalties.

Recommendations: Plan sponsors should keep up-to-date, and regularly revised, charts of their controlled groups and affiliated service groups, and should have ERISA counsel review all business transactions to ensure that the transactions do not create MEPs and if they do, to discuss alternative options and, if necessary, amend plan documents and procedures to comply with all laws and regulations applicable to MEPs.

EXECUTIVE COMPENSATION

I. Update on 457(f), 457(e)(11) and 457(b).

On June 21, 2016 the IRS issued proposed regulations to modify and clarify existing regulations under Section 457(f), Section 457(e)(11), and Section 457(b) of the Internal Revenue Code. Described below are some of the most substantial changes reflected in the proposed regulations.

A. 457(f).

1. Short-Term Deferral. The proposed 457 regulations generally adopt the short-term deferral exception that is included in the section 409A regulations. In other words, payments made by the applicable short term deferral deadline may be includible in the recipient's income when it is paid, rather than when it becomes vested.

2. Substantial Risk of Forfeiture. Although the IRS previously announced in IRS Notice 2007-62 its intention to follow the section 409A rules in defining a substantial risk of forfeiture, the proposed regulations depart from those rules in a number of ways, including the following:

(a) Initial Deferral of Current Compensation: The proposed 457(f) regulations permit the initial deferral of current compensation as being subject to a substantial risk of forfeiture if the present value of the amount to be paid upon the lapse of the risk of forfeiture is more than 125 percent of the amount deferred. In addition, the risk of forfeiture must be limited to the future performance of substantial services of at least two years or a qualifying agreement not to compete, and the deferral must be made in writing prior to the calendar year the services are performed.

(b) Rolling Risk of Forfeiture: The proposed 457(f) rules permit the extension of a risk of forfeiture if, at least 90 days prior to the lapse of the forfeiture, the compensation is made subject to the future performance of substantial services of at least two years or an agreement not to compete and the present value of the amount to be paid upon the lapse of the risk of forfeiture is more than 125 percent of the amount of compensation that is being put at risk.

(c) Noncompete Condition: A noncompete condition may constitute a substantial risk of forfeiture under the proposed 457(f) regulations, provided several requirements are satisfied. The agreement must be in writing and enforceable under applicable law, the employer must make reasonable efforts to monitor compliance with the noncompete agreement and, at the time the agreement becomes binding, the facts and circumstances must show that the employer has a substantial and bona fide interest in preventing the employee from competing and the employee must have a bona fide interest in performing the prohibited services.

3. Bona Fide Sick Leave and Vacation Leave Plans. The proposed 457 rules provide a list of factors that are to be considered in determining whether a vacation or sick leave plan is exempt from the definition of deferred compensation under section 457(f). The rules include limits on the ability to cash out any unused sick or vacation days. It is possible the IRS would look to these same factors when determining whether a vacation or sick leave plan is exempt from the definition of deferred compensation under section 409A.

B. 457(e)(11) Bona Fide Severance Pay Plan. The proposed 457 rules define a bona fide severance pay plan, which is eligible for "tax-on-distribution" treatment (rather than being subject to Section 457(f)'s taxation on vesting rules): (1) The severance must only be payable upon a participant's involuntary severance from employment or under a voluntary early retirement incentive plan or window program; (2) The amount of severance payable under the plan may not exceed two times the participant's annualized pay; and (3) The severance must be paid in full within two years after the year the participant terminates. As with the rules under section 409A, an involuntary severance from employment includes certain terminations by an executive for "good reason" pursuant to written, pre-specified circumstances relating to material adverse employment actions taken by the employer.

C. Recurring Part Year Compensation. The proposed regulations (and the 409A guidance discussed in the next item) revise the exemption applicable to "recurring part year compensation" (e.g., compensation earned over a ten-month school year but paid over 12 months). Such an arrangement will not be subject to 457(f) or 409A so long as it does not defer payment of the recurring part year compensation to a date beyond the last day of the 13th month following the first day of the service period for which the compensation is paid and the amount of the recurring part year compensation does not exceed the 401(a)(17) limit ($270,000 for 2017) for the calendar year in which the service period commences.

D. 457(b) Plans. The proposed regulations reflect statutory changes relating to eligible governmental plans since the publication of final regulations in 2003. These changes involve: (1) Roth contributions in a governmental 457(b) plan; (e) Death benefits under a governmental 457(b) plan for a participant who dies while performing qualified military service; and (3) Special rules for excluding from gross income amounts paid directly from an eligible governmental plan for accident, health, or long-term care insurance premiums, pursuant to an eligible retired public safety officer's election; and (4) Clarifying that a severance from employment for purposes of distribution restrictions applicable to eligible plans, whether governmental or not, includes an individual being treated as having a severance from employment during any period of services in the uniformed services.

Recommendations: Tax-exempt and governmental employer should carefully review all of their 457 executive compensation, executive employment agreement, and severance arrangements in light of the proposed regulations, to confirm whether amendments are required or enhancements can be made.

II. Update on 409A.

On June 21, 2016 the IRS issued proposed regulations to modify and clarify existing regulations under Section 409A of the Internal Revenue Code. Most of the changes are clarifications (and in some cases highly technical) or apply to limited circumstances (stock-related awards). Two of the most broad-based are the following: (1) The proposed regulations allow death benefit payments to be made until the December 31 of the first year following the year of the employee's death without violating Section 409A; and (2) The proposed regulations now provide employers the flexibility to make accelerated payments of a participant's account balance remaining after death to a beneficiary on account of the beneficiary's death, disability or unforeseeable emergency, whether or not the deferred amounts are in pay status.

Recommendations: Employers should carefully review the new 409A guidance to confirm whether the clarifications impact their nonqualified deferred compensation plans and administration of them and consider whether amendments to reflect the new flexibility provided under the proposed regulations is desired.

III. 501(c) Employers – Compliance with the Intermediate Sanctions and Form 990 Rules. As previously reported, the furor about alleged "excessive compensation" to 501(c) executives in the popular press, in various trade presses, among certain interest groups, and among certain members of Congress (thank you , Senator Grassley) continues. This furor does not seem to be justified by the relevant data (except in rare cases). Fortunately, and perhaps surprisingly, the agency with the responsibility for enforcement of the relevant rules (the IRS) seems to be data-driven, rather than furor-driven. However, this makes it as critical as ever that 501(c)(3) (and 501(c)(4)) employers determine the compensation packages of their executives in the precise manner specified in the IRS intermediate sanctions rules, and that they memorialize their efforts in this regard in great detail and again in the manner specified in those rules. (The IRS still routinely imposes the $20,000 Board member penalty and 225% executive excise tax penalties in cases in which it discovers that the intermediate sanctions rules have not been followed, to the letter.) It also remains critical that tax-exempt employers prepare the executive compensation sections of their annual Form 990s not only accurately, but just as importantly with sensitivity to the manner in which their Form 990 answers will be perceived by those who view them – especially by those with a particular ox to gore. Fortunately, the current version of the Form 990 permits employers to include detailed explanation of their executive compensation programs, and this opportunity should be utilized carefully by employers and employers should have their Form 990 executive compensation disclosures reviewed by ERISA counsel before they are filed with the IRS.

Recommendations: 501(c)(3) (and 501(c)(4)) employers should perform a regular self-diagnostic to ensure that their executive compensation-setting procedures comply with the finest details of the intermediate sanctions rules, that this compliance is carefully and permanently documented, and that their Form 990 executive compensation disclosures are reviewed by ERISA counsel – before filing the 990 -- to ensure that they are accurate and present the best "optics."

IV. Traps for the Unwary – Health and Welfare Severance Violations,;Post-Employment Health and Welfare Coverage, Pre-tax Contributions from Severance Pay, COBRA Reimbursements, Etc..

For the most part, post-employment medical benefits are exempt from Code section 409A (at least for the duration of the COBRA period), or can easily be drafted to comply with 409A, and are exempt from Code section 457(f)'s taxation-on-vesting rules pursuant to the proposed 457 regulations. However, post-employment health coverage raises numerous issues under other areas of law.

1. Plan Documents/Insurance and Stop Loss Coverage. The employer's health and welfare plan/cafeteria plan document will dictate whether employees can continue participating in the health and welfare plan after termination and, if so, whether the employee can pay his/her share of the cost of that coverage with pre-tax contributions deducted from severance payments (subject to nondiscrimination rules, described below). A few plans permit such payments from severance pay, but most do not. So, it is important to confirm whether your plan allows continued participation (absent a COBRA election) and whether the employee can pay for the coverage with pre-tax contributions. Similarly, most group health insurers and stop loss carriers do not cover former employees. Therefore, employers will want to confirm when coverage ceases under their group health insurance or stop loss coverage and align their severance practice with such coverage to avoid large losses.

2. Nondiscrimination Issues. Even if the employer's plan, and insurance/stop loss coverage would allow former employees to participate, there are nondiscrimination issues to consider. Covering highly compensated employees

after termination may raise nondiscrimination issues under Code section 105(h) (if the employer's plan is self-insured) and Code section 125 (if employees make pre-tax contributions for coverage) if an employer does not provide non-highly compensated employees the same coverage. Similarly, for employers who sponsor self-funded group health plans, it is possible that the IRS could argue that reimbursing a former highly compensated employee's COBRA premiums is, in effect, a discriminatory health plan benefit under 105(h). (While the future of the ACA is questionable, if the nondiscrimination rules included in the ACA are finalized and implemented, the reimbursement of COBRA premiums for former highly compensated employees could potentially result in an excise tax, civil money penalty or civil action against an employer.) There is some argument that the nondiscrimination issues can be avoided by requiring the highly compensated employee to pay for coverage with after-tax dollars, and by including the value of any employer contribution/reimbursement towards coverage in the highly compensated employee's income. But, there is no guarantee that these approaches will avoid all nondiscrimination problems.

Recommendations: Employers should carefully review all severance agreements to confirm they comply with, or are exempt from, section 409A (and 457(f)/(e)(11) if applicable), and to confirm they do not raise these other issues.

LABOR AND EMPLOYMENT LAW

I. Employment Law in the New Administration: What to Expect. It's going to be huge . . . But, then again, the arrival of a new President usually is! Moreover, the transition from a Republican-to-Democrat or Democrat-to-Republican administration has historically meant significant changes with respect to labor and employment legislation and enforcement. The Obama-to-Trump transition has the potential for being particularly volatile. President Obama was aggressive in expanding workplace rights for employees, including the overhaul of overtime regulations and the introduction of new regulations for government contractors (e.g., the Fair Pay and Safe Workplaces executive order; the executive order increasing minimum wage to $10.20 per hour; the executive order requiring federal contractors to provide paid sick leave to employees working on government contracts). Although President Trump has indicated that his administration will continue to enforce President Obama's executive order barring discrimination against LGBT employees working for federal contractors, it is expected that the new administration will try to scale back many of President Obama's efforts to expand employee rights in the workplace. Of particular interest is the President's proposed budget which calls for a nearly 21 percent decrease in funding for the Department of Labor. It seems inevitable that such a reduction would impact the DOL's enforcement capacity, which, in turn, could reduce the amount of enforcement activities against employers.

II. Employer-Provided Leave and the ADA. In May, 2016, the EEOC issued long-anticipated guidance with respect to leave as a form of reasonable accommodation. The EEOC enforces Title I of the ADA, which prohibits discrimination on the basis of disability in employment and requires that covered employers (employers with 15 or more employees) provide reasonable accommodations to applicants and employees with disabilities that require such accommodations due to their disabilities. A reasonable accommodation is, generally, "any change in the work environment or in the way things are customarily done that enables an individual with a disability to enjoy equal employment opportunities." That can include making modifications to existing leave policies and providing leave when needed for a disability, even where an employer does not offer leave to other employees. As with any other accommodation, the goal of providing leave as an accommodation is to afford employees with disabilities equal employment opportunities.

The EEOC noted that some employers appeared unaware that they are required to modify policies that limit the amount of leave employees can take when an employee needs additional leave as a reasonable accommodation. By way of example, employer policies that require employees on extended leave to be 100 percent healed or able to work without restrictions may deny some employees reasonable accommodations that would enable them to return to work. Perhaps the greatest challenge to employers with respect to leave accommodation is the transition from FMLA compliance to ADA compliance. The FMLA, which is enforced by the DOL, requires up to 12 weeks of leave for an employee's serious medical condition. Unfortunately, full compliance with FMLA does not equate to full compliance with the ADA, and employers are often surprised to discover that once an employee exhaust her FMLA leave, then a brand new obligation arises under the ADA, where the employer is obligated to engage in an interactive dialogue with the employee seeking additional leave as a form of accommodation. Absent an undue hardship, such requests must be granted.

III. Expansion of Age Discrimination Claims and "Subgroup" Theories. On the surface, the ADEA is a relative simple law, prohibiting employers from using age as a reason for depriving employment opportunities to applicants and employees over the age of 40. However, since its enactment in 1967, courts and Congress have added nuances that make ADEA compliance increasingly challenging to even the most sophisticated employers. The most recent development reveals the complexity of the ADEA. In *Karlo v. Pittsburgh Glass*, the 3rd Circuit

Court of Appeals held that the ADEA permits disparate impact claims by subgroups of older workers even when younger ADEA-protected employees are not negatively impacted. *Karlo* involved a reduction in force that resulted in a disparate impact to employees over the age of 50, but with no such impact upon employees over the age of 40. The 3rd Circuit found that the ADEA is designed to protect the rights of individual employees rather than the rights of a class. Accordingly, even though the class of *Karlo* employees over the age of 40 (i.e., the class protected by the ADEA) suffered no disparate impact, the negative experiences of employees over the age of 50 was enough to allow these over-50 employees to assert their rights under the ADEA. Other federal circuit courts have reached a different conclusion, and it is likely that the Supreme Court will eventually issue a definitive ruling on this issue.

IV. Status Update on the Changes to the FLSA Regulations. We noted last year that the Department of Labor had released proposed regulations to the FLSA that would have nearly doubled the "salary threshold" for white collar exemptions from $455 per week ($23,660 per year) to $913 per week ($47,476 per year). Following our annual seminar, the DOL released the long-anticipated final rules. Just ten days before the new final rules were to go into effect, a federal judge in Texas granted a nationwide preliminary injunction. The government appealed that injunction, and on April 21, 2017, the Fifth Circuit granted the government's request for an extension of time to file a final brief. The government's final brief is now due on June 30, 2017, and oral argument will likely take place in the summer. The new Secretary of Labor, Alexander Acosta, will determine whether the Trump Administration wishes to pursue the case. During his March 22nd confirmation hearing, Mr. Acosta questioned the effectiveness of the salary level as a tool for determining overtime eligibility, suggesting that the DOL should instead focus on the duties performed by workers. Nevertheless, Mr. Acosta indicated that he may support a less burdensome increase to the salary basis threshold, and suggested that a straight inflation adjustment to $33,000 per year may be appropriate.

While employers across the country wait for action on the FLSA regulations, employers in New York are already facing a higher salary threshold. The New York State Department of Labor adopted regulations, effective December 31, 2016, that adjusted the salary basis threshold for exemption from overtime under state wage and hour laws. The new thresholds vary by region and employer size, and will rise annually over the next few years.

V. Defend Trade Secrets Act of 2016. Last year we reported that Congress had passed the Defend Trade Secrets Act of 2016, which would provide greater trade secrets protections if signed into law. President Obama subsequently signed the law and it is now in effect. To take advantage of key protections in the law, employers must include specific language in their employee handbooks, employment agreements, separation agreements, and other documents dealing with trade secrets, notifying employees that they will not be held criminally or civilly liable for disclosing trade secrets in confidence to the government or an attorney for whistleblowing purposes; or in court papers filed under seal. The employer-provided notice must be substantially identical to language set forth under the law. Employers are encouraged to consult with legal counsel to ensure that all relevant documents and agreements contain language that complies with the Defend Trade Secrets Act.

VI. OSHA Updates. At the end of the Obama administration, OSHA enacted a number of aggressive rules relating to workplace safety issues. While it is possible that some of these rules will not survive the new administration, employers should carefully monitor the status of these rules and confirm that they are in full compliance.

A. Post-Accident Drug Testing Rules. On December 1, 2016, OSHA's new post-accident drug testing rules went into effect. Under the new rules, automatic blanket post-accident drug testing is prohibited. In other words, an employer is not allowed to have a policy that requires every employee involved in a work-related accident to be drug tested. Rather, the employer's policies and procedures must take into consideration the context surrounding a workplace accident in deciding whether a drug test is warranted. Accordingly, even a serious accident, standing alone, is not sufficient cause to require a drug test. To order a post-accident drug test, an employer must: (1) have an objective reason to believe that the accident was "likely" caused by drug or alcohol impairment; and (2) the drug test must be used to determine whether the employee was in fact under the influence of drugs or alcohol at the time of the accident.

B. Injury Reporting Rules. Also effective December 1, 2016, OSHA rules require employers to allow employees "sufficient" time to report workplace injuries, and prohibit employers from requiring employees to report workplace injuries "immediately."

C. Limits on Employee Incentive Programs. Also effective December 1, 2016, OSHA rules prohibit employers from tying employee incentive awards to low injury/illness reporting rates. OSHA has stated that such incentive programs deter employees from making valid injury and illness reports.

D. Electronic Reporting Rule. OSHA previously announced that certain employers would be required to electronically submit report injury and illness data effective January 1, 2017. This rule would effectively serve to shame employers by making their injury and illness records public. Despite the January 1st effective date, OSHA has not yet implemented a means for employers to begin electronic posting, and there is speculation that the new Secretary of Labor, Alexander Acosta, may rescind this rule.

E. OSHA Inspections. In April 2017, OSHA provided notice that it is rescinding its prior position that employers must allow certain non-employees (such as community organizers and officials of unions that did not represent the employer's workers) to accompany OSHA during the walk around portion of a safety inspection. This notice is welcome news to employers, who had expressed serious concerns about allowing such unrelated parties to be involved in the inspection process.

VII. Updates to Independent Contractor Issues. In January of 2017, the U.S. Court of Appeals for the Fourth Circuit (which has jurisdiction over Maryland, Virginia, West Virginia, North Carolina, and South Carolina), applied a new and expansive standard for determining joint employer status in a case involving independent contractors. In *Hall v. DIRECTV*, satellite TV technicians who were employed by various service providers claimed that DIRECTV "jointly employed" them. The Fourth Circuit articulated the following test for determining whether there is a joint employment relationship: (1) first, determine whether the defendant and one or more additional companies shared, agreed to allocate responsibility for, or otherwise jointly determined the key terms and conditions of the plaintiff employees' work; and (2) second, determine whether the worker is an employee or independent contractor by determining whether the employee is "economically dependent" upon the defendant. Applying the test, the Fourth Circuit determined that DIRECTV and subcontracting companies shared authority to hire, fire, and compensate the plaintiffs. Accordingly, plaintiffs alleged sufficient facts to satisfy the first test. The court also held that the plaintiffs had alleged sufficient facts to show that they were employees of DIRECTV because DIRECTV exercised significant control over their hiring, firing, compensation, training, schedule, manner of job performance, and uniform. As a result of this case, employers in the Fourth Circuit are much more likely to be found to be joint employers in situations where they bring subcontractors, temporary employees hired through contracting agencies, and other such workers into the workplace. Employers should consult with legal counsel and take steps to minimize the likelihood that they will be deemed to be in an employment relationship with their independent contractors.

VIII. Sexual Orientation Discrimination Under Title VII. It may be hard to believe in a post-*Obergefell* world that sexual orientation discrimination in the workplace may be lawful, but, depending on the jurisdiction, that may still be the case. As of the date of this seminar, there is no universal federal law prohibiting discrimination on the basis of sexual orientation. For many employers this is a moot point, since there are a substantial number of state and local laws prohibiting such discrimination (e.g., Maryland prohibits workplace discrimination on the basis of sexual orientation and gender identity and expression), as well as an executive order prohibiting such discrimination amongst government contractors. However, many key states, including Pennsylvania and Virginia, still do not prohibit private sector workplace discrimination on the basis of sexual orientation. A recent development in the 11th Circuit Court of Appeals may signal a universal expansion of workplace prohibitions against workplace discrimination. In *Hively v. Ivy Tech Comm. College,* the 7th Circuit became the first federal appellate court to hold that discrimination on the basis of sexual orientation is a form of discrimination on the basis of "sex," and, therefore a violation of Title VII. For employers located in Indiana, Illinois and Wisconsin, the 7th Circuit's ruling is binding precedent. For those outside of these three (3) states, the *Hively* ruling may be a bellwether of things to come. Given the trends, many employers are choosing to extend anti-discrimination protections to LGBT employees even when not required to do so.

IX. New EEOC Guidance. Under the Obama administration, the EEOC has sought to expand workplace rights for employees.

A. Workplace Harassment. The EEOC has issued proposed guidance on unlawful workplace harassment, which includes a directive that "[u]sing a name or pronoun inconsistent with the individual's gender identity in a persistent or offensive manner" ca constitute sex-based harassment.

B. Mental Health Disorders. On December 12, 2016, the EEOC issued a publication entitled "Depression, PTSD & Other Mental Health Conditions in the Workplace: Your Legal Rights." Although this publication consists primarily of a summary of existing law, it signals that the Commission is focused on ensuring that employees with mental health conditions are fully informed of their rights under the ADA.

C. National Origin Discrimination. The EEOC updated its guidance on national origin discrimination, emphasizing that national origin discrimination can appear in many forms, including ethnic slurs, ridicule, intimidation,

workplace graffiti, physical violence or other offensive conduct directed towards an applicant or employee because of his/her birthplace, ethnicity, culture, language, dress or accent. The EEOC also addressed language proficiency challenges, and distinguished between (i) accent discrimination; (ii) fluency requirements; and (3) English only rules. With respect to this latter issue, the EEOC emphasized its presumption that policies requiring employees only to speak English in the workplace are violative of Title VII. There are some limited exceptions to this rule, and those exceptions are to be interpreted narrowly.

X. Arbitration Agreements – Should You Ask Your Employees to Sign One? Arbitration agreements are increasingly popular for good reason. Arbitration is often quicker and less expensive than litigation, and can keep inflammatory allegations out of the public eye. However, arbitrators are known to be less likely to resolve cases prior to trial; they may be less likely to accept procedural defenses; and they may be more likely to allow hearsay and irrelevant witnesses. Moreover, some arbitrators have a reputation for "splitting the baby" and are less likely to award a full victory to either party. Employers considering mandatory arbitration agreements should consult with legal counsel to determine whether mandatory arbitration is the best choice for your workplace, and to confirm that your arbitration agreement is enforceable. To be enforceable under Maryland law, an arbitration agreement must meet two requirements. First, it must contain an explicit mutual agreement by both parties to submit disputes to arbitration. In other words, the employer cannot retain the unilateral right to decide whether it wants to submit a dispute to arbitration; nor can it retain the right to change the arbitration agreement at any time. Second, the agreement must provide for a neutral forum to resolve disputes. In other words, the employer cannot unilaterally decide which arbitrators will be acceptable. Part of the value of arbitration is that it places workplace disputes out of the public eye. To that end, many employers include provisions in their arbitration agreements that prohibit employees from discussing arbitration proceedings with their colleagues. On April 13, 2017, the NLRB struck down an arbitration agreement on the basis of its confidentiality provision, holding that employees have the right to discuss the terms and conditions of employment with each other—including details of work-related arbitration. *See Dish Network, LLC,* 365 N.L.R.B. No. 47.

Arbitration agreements must make clear that employees have the right to file claims with federal agencies such as the NLRB or the EEOC, regardless of the requirement to otherwise arbitrate their claims. If employees' rights are not made clear, the arbitration agreement is likely to be held invalid. For example, in the case discussed above, the NLRB held that Dish Network's arbitration agreement was invalid because employees would likely believe that the agreement prohibited them from filing charges with the NLRB. Arbitration agreements may be particularly valuable to employers when they require employees to arbitrate claims on an individual basis and waive the right to arbitrate as a class action. Under the Obama administration, the National Labor Relations Board (NLRB) took the position that requiring employees to waive the right to file and/or arbitrate class and collective action lawsuits as a condition of employment violated employees' rights under the National Labor Relations Act. The Fifth, Second, and Eighth Circuit Courts of Appeals disagreed with the NLRB, while the Seventh Circuit Court of Appeals agreed with the NLRB that such a waiver is a violation of employees' rights. In January of 2017, the Supreme Court agreed to hear a case to resolve the issue. The case will likely be heard by the Supreme Court in the Fall. Arbitration agreements are strongly disfavored in some states. For example, California has long held that mandatory arbitration agreements violate public policy. In September of 2016, Governor Brown signed a law prohibiting employers from requiring California employees to arbitrate disputes in other states using another state's laws. Multijurisdictional employers should be careful to understand how state laws impact their arbitration agreements.

XI. New Form I-9. Effective January 22, 2017, all employers must use the new Form I-9 released by the Citizenship and Immigration Services to verify employment eligibility. The revised Form I-9 contains expanded instructions and includes several substantive changes to the form itself, such as: (1) employees are only required to enter other "last names" they have used, if any, as opposed to the previous requirement to enter "all other names used", a change meant to protect transgender employees and others who are concerned about confidentiality; (2) the ability to include multiple preparers or translators; and (3) an area to provide additional relevant information. The list of acceptable documents that employees may present in order to establish identity and employment authorization has not been changed. The revisions also include changes to make the form easier to complete on a computer. In the event the employer wishes to complete on a computer, the form must still be signed physically.

XII. MD, VA and DC Updates - New Credit Inquiry Laws and More.

A. New Credit Inquiry Laws. The District of Columbia has joined Maryland in placing significant limits on employers' ability to use background checks involving employee credit information. The District of Columbia's "Fair Credit in Employment Amendment Act" was signed on February 15, 2017 and went into effect on April 1, 2017. With limited exceptions, the new law prohibits employers from asking job applicants or employees about their credit information or from using, accepting, referring to, or inquiring about credit information of job applicants or

employees. Exceptions include: (1) employees in law enforcement positions; (2) employees in positions where a security clearance is required; (3) employees of financial institutions in positions that involve access to personal financial information; (4) when an employer is otherwise required by D.C. law to request or use credit information; and (5) information received in response to a lawful subpoena, court order, or law enforcement investigation.

B. New Pay Equity Laws. Maryland has joined California, New York, and Massachusetts in implementing laws that are designed to give greater transparency to employees' wages, with the goal of helping women to recognize if they are being underpaid. Pursuant to Maryland's Equal Pay for Equal Work law, effective October 1, 2016, employers may not prohibit employees from asking about, disclosing, or discussing wages. Foreseeing that employers might try to find loopholes, the law explicitly prohibits employers from requiring employees to sign a waiver or any other document that denies the employee the right to disclose or discuss wages.

C. Predictive Scheduling Laws – The Next Fight for Retail and Restaurant Employers. Labor proponents are pushing states to consider "predictive scheduling" or "fair workweek" bills, which would require retail stores and restaurants to provide employees with significant advance notice of their work schedules, and to pay extra for last-minute schedule changes. Currently San Francisco, Seattle, and Emeryville, CA have passed predictive scheduling laws. Both Maryland and Washington, D.C. are expected to face a push for predictive scheduling legislation.

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A 2017 COMPLIANCE CHECKLIST FOR HEALTH AND WELFARE PLANS

The following are some important 2017 compliance tasks for sponsors of health and welfare benefit plans. (Naturally, this Checklist is not meant to provide a comprehensive list of all compliance requirements.)

___1. Consider impact, and monitor developments concerning, IRS transition relief for opt-out payments, cash-in-lieu payments, and the like.

___2. . Review and respond accordingly to the new Form 5500 rules, monitor 2019 developments, and consider legal review of completed Form 5500 prior to filing.

___3. Confirm compliance with special rules for any retiree-only or one or fewer actives health plans.

___4. Keep an up-to-date list of all controlled group members to avoid MEWA issues.

___5. Confirm compliance with ACA reporting, 30-hour employee determination rules, lookback rules, change in employment status rules, rules for special employee categories and impact on COBRA compliance efforts.

___6. Review and develop position on recent developments affecting wellness programs.

___7. Confirm that spouses are properly identified, and plan provisions concerning spouses are properly operated.

___8. Consider impact on health plans of recent transgender benefits developments.

___9. If applicable, confirm compliance with HFSA debit card rules.

___10. Monitor ongoing compliance with health and welfare plan nondiscrimination rules (e.g., HIPAA, ACA, Section 125, Section 105(h), Section 79, Section 129, etc.).

___11. Have ERISA counsel review all vendor service agreements.

___12. Ensure compliance with DOL and IRS electronic distribution rules.

___13. Ensure that any "independent contractors" actually qualify as such, and consider impact on plans of other special categories of workers.

___14. Ensure compliance with updated claims procedures rules.

___15. Eliminate non-compliant health reimbursement plans and consider whether QSEHRA is a fit.

___16. If applicable, consider church plan developments.

___17. Consider impact of State escheat/unclaimed property laws (if any).

___18. Monitor developments affecting the ACA, and ensure receipt (and reading!) of S&D e-Alerts.

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A 2017 COMPLIANCE CHECKLIST FOR QUALIFIED RETIREMENT PLANS

The following are some important 2017 compliance tasks for sponsors of qualified retirement plans. (Naturally, this Checklist is not meant to provide a comprehensive list of all compliance requirements.)

___1. Consider impact of June 9, 2017 fiduciary rules, and have ERISA counsel review related agreement documents.

___2. Utilize new VCP rules/fees to correct errors, if indicated.

___3. Plan around the new IRS determination letter program by considering an improved "privatized" approach.

___4. For defined benefit plans, consider the impact of the new mortality tables.

___5. If a church plan or a governmental plan, review recent litigation and other developments to determine if steps should be taken.

___6. For advisors, consider potentially substantial impact of new DOL fiduciary rules.

___7. For 403(b) plans, determine if document correction window applies and act accordingly.

___8. For safe harbor 401(k) and 403(b) plans, review guidance on new IRS position on mid-year amendments.

___9. Have ERISA counsel review investment policy statements, and investment selection and monitoring processes.

___10. Prepare for new compliance questions on Form 5500. Have ERISA counsel review Form 5500 before it is filed with the IRS/DOL.

___11. If applicable, determine compliance with new hardship documentation guidelines.

___12. Ensure compliance with electronic distribution rules.

___13. Consider plan amendment to allow expanded use of forfeitures for funding certain 401(k) contributions.

___14. Keep an up-to-date list of all controlled group members to avoid MEP issues.

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A 2017 COMPLIANCE CHECKLIST FOR EXECUTIVE COMPENSATION PLANS

The following are some important 2017 compliance tasks for sponsors of executive compensation plans. (Naturally, this Checklist is not meant to provide a comprehensive list of all compliance requirements.)

___ 1. Review Section 409A document and operational compliance. Pay particular attention to separation from service issues, executive employment agreements, split-dollar life insurance, severance arrangements, the 2-1/2 month bonus exemption, post-employment reimbursements and in-kind benefits, "disability" deferred compensation, and the like.

___ 2. If Section 409A non-compliance is discovered, utilize (if applicable) the IRS self-correction program.

___ 3. If employer-sponsor is in financial "distress," ensure that nonqualified plans are not funded in violation of PPA distressed employer rules.

___ 4. If a tax-exempt or government employer, consider requirements and opportunities provided by the June 21, 2016 IRS proposed regulations.

___ 5. Where applicable, ensure that nonqualified plans are properly coordinated with 401(k) plans.

___ 6. If a 501(c)(3) or 501(c)(4) employer, perform self-diagnostic to ensure that intermediate sanctions rules are being complied with – including the reporting of taxable fringe benefits and the inclusion of benefits in market comparability testing -- and that the compliance is well-documented, and ensure that extensive new executive compensation questions on the annual Form 990 are answered completely in the manner that best portrays the "optics" of the nature of, and care taken with respect to, the employer's executive compensation programs. Have ERISA counsel review Form 990 disclosures before they are filed with the IRS.

___ 7. Review participants in executive deferred compensation plans to ensure that they are limited to members of your top-hat group.

___ 8. Ensure that all nonqualified plans – whether 451 plans, 457(b) plans, 457(f) plans, etc. -- have up-to-date administrative forms, and that comprehensive and correct procedures are in place for their use.

___ 9. Review documentary and operational compliance of any 457(b) plan in light of nationwide IRS field review. Governmental 457(b) plan sponsors should consider whether EPCRS provisions are applicable.

___ 10. Review Domestic Relations Order procedures of nonqualified plans.

___ 11. Review compliance with tax reporting rules applicable to nonqualified plans, with special attention to FICA/Medicare issues.

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A 2017 LABOR AND EMPLOYMENT LAW COMPLIANCE CHECKLIST

The following are some important 2017 compliance tasks concerning labor and employment laws. (Naturally, this checklist is not meant to provide a comprehensive list of all compliance requirements.)

____1. Watch for our e-Alerts to learn of new developments under the new administration.

____2. Review workplace leave policies to identify provisions that may indicate a lack of commitment to the rigorous ADA accommodation requirements.

____3. Conduct a self-audit of policies/practices that may have a negative impact on employees over 40.

____4. Conduct an FLSA self-audit and work with legal counsel to confirm that employees meet the current FLSA exemption test. Stay updated on any changes to the salary-basis threshold and be prepared to make changes to exempt status and/or employees' wages accordingly.

____5. New York Employers – Immediately conduct a self-audit to confirm that exempt employees meet the new salary basis threshold for exempt status under NY law. Work with legal counsel to determine how to transition formerly exempt employees into non-exempt status without incurring significant increase in labor and overtime costs and/or legal claims.

____6. Review employee handbooks, employment agreements, and other documents to confirm that they contain required Defend Trade Secrets Act language.

____7. Revise drug testing, injury reporting, and employee incentive policies and work with legal counsel to confirm compliance with OSHA rules. Stay up-to-date on any changes to mandatory electronic posting of injury reports.

____8. Review status of independent contractors, and especially those hired in connection with subcontractors, temporary employee contracting agencies, and the like. Consult with legal counsel and take steps to minimize the likelihood that these independent contractors may be deemed to be employees.

____9. Examine EEO policies to assess compliance with protected classifications, including national origin, sexual orientation and gender identity and expression. Provide harassment training to supervisors and to the general workforce to ensure that your workforce is committed to a discrimination-free and harassment-free workplace.

____10. Consider whether mandatory arbitration agreements are beneficial for your company and, if so, work with legal counsel to prepare a legally compliant arbitration agreement.

____11. If you have not yet done so, immediately begin to use the new Form I-9 and become familiar with the new set of instructions.

____12. Confirm compliance with new D.C. Fair Credit in Employment Amendment Act.

____13. Confirm compliance with Maryland Equal Pay for Equal Work Act.

____14. Stay up-to-date on the push for predictive scheduling laws and review workplace impact.