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CLIENTS & FRIENDS SEMINAR – MAY 7, 2015

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

HEALTH AND WELFARE PLANS

I. Recent Case Law on SPDs v. Governing Plan Documents. In CIGNA v. Amara (2011), the Supreme Court muddied the on-going, and often perplexing, controversy concerning what controls when the terms of an ERISA plan document are different than statements contained in SPDs, employee communications, benefit statements, and the like. Although the language of the opinion in CIGNA v. Amara is often ambiguous, the case seems to stand for two, potentially conflicting concepts. First, the Court concluded that summary materials about a plan are not the legally binding plan itself, appearing to reinstate the longstanding, but occasionally recently ignored, rule that the formal plan document controls the SPD in the event of any conflict. However, the Court sent the case back to the lower courts for those courts to determine if some act or omission of the employer – presumably including faulty participant communications – caused harm to the plaintiff and therefore entitles the plaintiff to recover money damages from the employer.

A handful of post-Amara cases have held that the terms of a SPD are enforceable so long as they do not conflict with the governing plan documents. Recently, in Stiso v. Int'l Steel Group (6th Cir. 2015), a participant sued both his employer and the insurance company with respect to a long-term disability ("LTD") policy that had been purchased by the employer. The participant alleged an ERISA breach of fiduciary duty for the failure to increase LTD benefits in accordance with the terms of the summary plan description. The U.S. Court of Appeals for the Sixth Circuit ruled that the employer (1) functioned as an ERISA fiduciary when it prepared and distributed the SPD to participants, and (2) breached its fiduciary duty by furnishing the participant with a misleading SPD. The court remanded the case back to the district court with instructions to grant the increase in benefits to the participant. Naturally, employers must continue to be diligent in their efforts to ensure that all employer communications about an ERISA plan – plan documents, SPDs, employee communications, required notices and forms, benefit estimates and statements, etc. – are correct and consistent.

II. Annual Reporting Required by the ACA; Forms 1094 and 1095

1. Background. The ACA added two reporting requirements to the Internal Revenue Code which are designed to aid the IRS in its enforcement of the individual and employer mandate requirements under the ACA and to administer the premium tax subsidies for exchange coverage. The ACA added Section 6055 to the Code, which provides that every provider of minimum essential coverage (MEC) (including health insurance insurers and plan sponsors of self-insured plans) will report coverage information by filing an information return with the IRS and provide a statement to relevant individuals. This reporting is intended to aid the IRS in its enforcement of the ACA's individual coverage mandate. The ACA added Section 6055 to the Code, which requires applicable large employers (ALE) that are subject to the "play or pay" requirements, to file information returns with the IRS and provide statements to their full-time employees about the health insurance coverage the employer offered. This reporting is intended to aid the IRS in its enforcement of the ACA's employer mandate and to help the IRS administer the premium assistance tax credit. In February the IRS released final versions of the reporting forms and instructions.

2. Form 1095-B (Health Coverage) and Form 1094-B (Transmittal of Health Coverage Information). Form 1095-B is the return used for reporting MEC under Code Section 6055 to the IRS and for furnishing coverage information to covered individuals. Form 1094-B is the transmittal form filed with the IRS along with all of the Form 1095-Bs. The 1095-B and 1094-B forms are required to be filed by insurance companies to report individuals covered by insured employer-sponsored group health plans and by small employers with self-funded health plans. Form 1095-B reports the name, address and Social Security Number (or date of birth) of employees and their family members who have health coverage. Employees who are offered coverage, but decline the coverage, are not reported. The

form requires the insurer or the employer of a self-funded plan to report whether the individual had coverage for each month of the year. Coverage for one day of the month is reported as coverage for the entire month.

3. Form 1095-C (Employer-Provided Health Insurance Offer and Coverage) and Form 1094-C (Transmittal of Employer-Provided Health Insurance Offer and Coverage). Form 1095-C is the return used to report information required under Code Section 6056 to the IRS and for furnishing information about the employer's offer of health coverage to its full-time employees. Form 1094-C is the transmittal form filed with the IRS along with all of the Form 1095-Cs, and provides information to the IRS regarding potential employer mandate penalties. The Form 1095-C and 1094-C forms are required to be filed by applicable large employers (ALE) (i.e., employers having on average at least 50 full-time employees (including full-time employee equivalents) during the preceding calendar year). Small employers with fewer than 50 full-time employees (including full-time employee equivalents) will be required to file Forms 1095-C and 1094-C if they are members of a controlled group or affiliated service group that collectively has at least 50 full-time employees (including full-time employee equivalents). Applicable large-employer-group members must prepare a Form 1095-C for each full-time employee regardless of whether the employee is participating in an employer group health plan. In addition, a Form 1095-C must be completed for each non-full-time employee who is enrolled in the employer's self-insured health plan.

The information required to be reported on the Form 1095-C is extensive and includes the following: (1) identifying information for the ALE member and the employees (including Social Security number for employees); (2) month-by-month information as to whether the employee and family members were offered health coverage that met the minimum value standard and whether the employee; (3) whether the employee was a full-time employee each month; (4) the employee's share of the monthly premium for the lowest-cost minimum value health coverage offered; and (5) whether one of the three safe harbor affordability measures applied with respect to the coverage offered to the employee or whether the employer relied on one of the employer mandate transition rules. In addition to serving as the transmittal form for the submission of the Form 1095-Cs, the Form 1094-C includes the following information: (1) employer's name, address, EIN contact person and the names and EINs of other employers that are in the employer's controlled group or affiliated service group; (2) total number of Forms 1095-Cs filed with transmittal; (3) certification by month as to whether the employer offered its full-time employees and their dependents the opportunity to enroll in minimum essential coverage; (4) the number of full-time employees for each month; (5) the total number of employees for each month; and (6) whether transition relief applies to the employer.

4. Filing Deadline. The due date for filing the form with the IRS and providing information to employees track the Form W-2 rules. The information must be filed with the IRS by February 28 (March 31, if filed electronically), and the individual statement must be provided to employees by January 31 of the year following the year in which coverage is provided. Reporting will be required in early 2016 with respect to calendar year 2015. Note that employers with non-calendar year plans who qualify for delayed implementation of the employer mandate rules until the start of their 2015 plan year must still report for the entire 2015 calendar year. Also, reporting for 2015 is required for ALEs who qualify for the one-year delay in the employer mandate rules because they have more than 50, but fewer than 100 full-time employees.

III. Controlled Group/ASG/Predecessor Employer Determinations

A. Statutes and regulations provide numerous ways in which regulators can aggregate employers for purposes of various legal requirements. As they pertain to health and welfare benefits, a few of these legal requirements include:

1. In order to perform annual nondiscrimination testing for a Section 125 plan or for a welfare benefit plan, the Plan sponsor must know whether it is part of a "controlled group" or "affiliated service group" with any other entities. If it is, then all entities must be included in the testing.

2. In order to be sure they are not a MEWA (multiple employer welfare association) entities that share a common health plan must know whether they are part of a "controlled group" of entities. If they are not, then they may not be able to share a common health plan (depending on what state they are in). In addition, MEWAs have special reporting requirements.

3. In order to determine whether an entity qualifies for a Maryland "small group" insurance product, the entity must know whether it is part of a "controlled group" of entities. All members of the controlled group have to be included in determining the employee count for this purpose.

4. In order to count employees for purposes of the health care reform 50 FTE test, a Plan sponsor must know whether it is part of a "controlled group" or "affiliated service group". If it is, then all members of the controlled

group or affiliated service group have to be included in determining the employee count. Health care reform also requires aggregation of a "predecessor employer" for that purpose (see E, below).

5. In order to count employees of purposes of COBRA, a Plan sponsor must know whether it is part of a "controlled group" or "affiliated service group". If it is, then all members of the controlled group or affiliated service group have to be included in determining the employee count.

6. In order to count employee for purposes of the Medicare Secondary Payer rules, a Plan sponsor must know whether it is part of a "controlled group" or "affiliated service group". If it is, then all members of the controlled group or affiliated service group have to be included in determining the employee count.

7. In order to determine eligibility for the small employer health insurance credit, a Plan sponsor must know whether it is part of a "controlled group" or "affiliated service group". If it is, then all members of the controlled group or affiliated service group have to be included in determining the employee count.

8. For purposes of determining eligibility for a SIMPLE, cafeteria plan, a Plan sponsor must know whether it is part of a "controlled group". In addition, those rules also aggregate a predecessor employer.

9. For purposes of applying FMLA, a Plan sponsor must know whether it is part of a "joint employer" or "integrated" employer.

10. For purposes of answering the questions on its Form 5500 filing, a Plan sponsor must know whether it is part of a "controlled group" or "affiliated service group".

B. Determining its controlled group, affiliated service group or predecessor employer status is the Plan sponsor's responsibility. In an IRS or DOL audit, the auditor will expect that the Plan sponsor knows whether it and any related entities are a "controlled group" or "affiliated service group". Sometimes this determination has already been done for retirement plan purposes. If not, with health care reform mandates and DOL/IRS audits of welfare plans looming now is the time.

C. A controlled group of entities includes the following (note: this is a generalized description of extremely complex rules):

1. A parent/subsidiary controlled group exists if an entity owns (directly or indirectly) 80% or more of another entity (or entities).

2. A brother /sister controlled group exists if the same 5 or fewer persons own (directly or indirectly) 80% or more of two or more entities and, taking into account only identical ownership, those persons own more than 50% of the entities.

D. An affiliated service group of entities includes the following (again note: this is a generalized description of even more complex rules):

1. An A-Org affiliated service group consists of a service organization (the FSO) and any other service organization (the A-Org) which is a shareholder or partner in the FSO and which either regularly performs services for the FSO or is regularly associated with the FSO in performing services for third parties.

2. A B-Org affiliated service group consists of a service organization (the FSO) and any other organization (the B-Org) if a significant portion of the B-Org's business is the performance of services for the FSO of a type historically performed by employees and 10% or more of the B-Org is owned by highly compensated employees of the FSO.

3. A management service organization consists of an organization the principal business of which is performing management functions for another organization (or group or related organizations) (or group of related organizations).

E. Health care reform picked up "predecessor employers" in the rules for counting employees. The current IRS regulations do not define "predecessor employer". The regulations do suggest that eventual regulations will adopt rules similar to the rules for identifying successor employers in the employment tax context. Until further guidance is issued, employers may rely on a reasonable, good faith determination of the statutory provision on predecessor employers for purposes of determining whether there are 50 FTEs.

IV. Legal issues for Wellness Programs. Wellness programs may be required to comply with ERISA, HIPAA, COBRA, the ACA, the Americans with Disabilities Act and other laws that apply to group health plans.

A. HIPAA Nondiscrimination and Wellness Program Regulations. The HIPAA nondiscrimination rules generally prohibit health plans from discriminating based on health status factors, such as medical condition, claims history or disability. Most wellness programs that provide an incentive for participating would violate this requirement, unless an exception applies. Fortunately, there is an exception if the wellness program satisfies five safe harbor requirements in the regulations. Those rules include the requirement to offer a reasonable alternative method for qualifying for the financial incentive, and a limit on the total amount of that incentive. The limit on the incentive was increased by the Affordable Care Act, so that it may be as high as 30% of the total cost of coverage or, for wellness programs that involve tobacco use, as much as 50% of the total cost of coverage.

B. Americans with Disabilities Act. Of course, wellness programs, like other employee benefits generally are subject to the ADA and cannot discriminate against employees based on disabilities. That normally is not an issue for typical wellness programs. However, one ADA requirement has caused issues for many types of wellness programs. That provision generally prohibits employers from "requiring" employees to submit to medical exams or to answer disability-related questions. There is an exception for voluntary wellness programs but until recently, the EEOC's position was that a wellness program offered under an employer's health plan might not be considered voluntary if it provided a financial incentive, such as a premium discount, for participation. Fortunately, the EEOC recently issued proposed regulations that clarified its position on this issue. These regulations generally permit wellness programs that comply with the HIPAA wellness program rules, although they do add some additional requirements such as a new notice requirement.

C. ERISA and COBRA. For employers that are subject to ERISA, a wellness program would be subject to ERISA (and COBRA) if it provides any medical benefits. In many cases, this is not a significant issue because the wellness program is simply a part of the employer's medical plan, which is also subject to those laws. As long as the medical plan complies, there generally is nothing additional to do with regard to the wellness program. However, if a wellness program is offered to employees who are not enrolled in the medical plan, the employer should make sure it is reviewed to determine if it should be treated as subject to ERISA and COBRA.

V. Form 8928 Obligations of Employers

A. Background. The Internal Revenue Code imposes excise taxes for failures to comply with various health plan-related Code requirements. Persons liable for an excise tax under one of these Code provisions (e.g., employers, third party administrators or the plan itself) are required to self-report the failures using IRS Form 8928.

B. Form 8928 Compliance Failures. The compliance failures subject to Form 8928 reporting include the following:

1. COBRA administration errors. (Special rules are provided concerning how to report multiple COBRA notice and other operational failures occurring in a single year.)
2. Failures to provide required pediatric vaccine coverage.
3. Failures relating to HIPAA portability and nondiscrimination requirements.
4. Failures relating to minimum hospital stays for mothers and newborns under the Mothers and Newborns Health Protection Act.
5. Failures relating to required benefits under the mental health/substance abuse parity rules.
6. Failures under the HSA comparability rules.
7. Failures under the Genetic Information Nondiscrimination Act (GINA)
8. Failures under Michelle's Law.
9. Failures relating to various Affordable Care Act group health plan reforms, including, but not limited to: no waiting periods in excess of 90 days, rules on access to primary care providers and emergency room, coverage of preventative care without cost-sharing, uniform SBC requirements, improved claims and appeal rules, including external review requirements, and removal of annual dollar limits and removal of pre-existing condition limits.

The excise tax amounts vary depending upon the violation. Generally, the excise tax for noncompliance with rules related to COBRA, ACA's group health plan reforms, HIPAA, GINA, Mother and Newborns Health Protection Act and Michelle's Law is $100 per day per affected individual. There are some exceptions to the excise taxes. Excise taxes may not apply if the employer can demonstrate that it did not know (and in exercising reasonable diligence, would not have known) that there was a compliance failure, or if the compliance failure was due to reasonable cause and was corrected within 30 days after the employer know (or in exercising reasonable diligence, should have

known) that the failure existed. A compliance failure is "corrected" if it is retroactively undone to the extent possible and the affected individual is placed in a financial position as good as he or she would have been in had the failure not occurred.

C. Filing Obligations. In general Form 8928 must be filed on or before the filer's due date for filing its federal income tax return (without extensions). However, if the Form 8928 relates to the failure to comply with the comparable HSA contributions requirement, the deadline for filing the Form 8928 is the 15th day of the fourth month following the calendar year in which the noncomparable contributions were made. An automatic 6-month extension is available by filing IRS Form 7004 on or before the deadline for the IRS Form 8929. However, obtaining the extension to file the Form 8928 does not extend the time to pay any excise taxes due. Note that compliance failures which meet the requirements for exemption from excise taxes (e.g., failures attributable to reasonable cause and corrected within 30 days) still must be reported on Form 8929. Failure to timely file the Form 8928 results in a penalty of 5% of the unpaid excise tax per month late, up to 25%. Failure to timely pay any excise taxes due results in a penalty of .5% of the unpaid excise tax amount per month late, up to 25%. Both of these penalties may be waived for reasonable cause. Late excise tax payments are also subject to interest at the variable underpayment rate set by the IRS.

D. Next Steps. The Form 8928 self-reporting obligation makes compliance with group health plan requirements more important than ever. Because the IRS and CPAs that audit plans and employers have "discovered" the Form 8928 requirement, and because the excise taxes paid with the filing of the Form and the late penalties for not filing the Form are so onerous, employers have no practical alternative other than ensuring that their health plans satisfy all of the compliance requirements the failure of which could be reported on the Form. The compliance obligations which are the subject of the Form create a useful "self-diagnostic checklist" for employers that sponsor employee health plans. This "checklist" should be used to implement procedures and processes that are designed to reasonably ensure compliance. Of course, if a compliance failure occurs nonetheless, the employer and other responsible parties must take prompt action to correct the failure within 30 days.

VI. Independent Contractors, "Contingent Workers," Temporary Employees: Issues for Employers

A. Independent contractors, individuals that perform services for an entity but who are not treated by that entity as common law employees, have long been an issue of serious interest to the IRS. In an audit, an IRS agent often asks to see all 1099 forms that the business wrote to individuals, rather than entities.

1. The business has to prove to the agent's satisfaction that each individual who was paid through a Form 1099 is NOT a common law employee.

2. If the entity loses the argument with respect to any individuals, those individuals are retroactively treated as employees with sometimes serious ramifications, not just for payroll taxes but also for retirement and welfare plans.

3. Most welfare plans are written to exclude such individuals prior to the date the IRS determines that they are employees. As long as the Plan isn't just barely passing the applicable nondiscrimination tests, such exclusion is not typically problematic.

4. However, with the advent of the employer mandate penalty, the stakes have changed. Now the potential exists that such reclassifications could trigger a penalty retroactively. Therefore, proper classification of individuals performing services for any entity is even more critical.

B. Contingent Workers. Many welfare plans have long contained an exclusion for "leased employees".

1. The first issue that arises with any contingent worker is "who is the (common law) employer"?

a. The final pay or play regulations suggest that temporary staffing agencies, those who send individuals out to temporary or short term positions with clients, will generally be considered to be the common law employer of those individuals.

b. Those same regulations caused a fair amount of confusion by suggesting that "other" staffing firms including PEOs will typically NOT be the common law employer. E.g. assume that Company X has 125 employees. Company X and PEO Y sign a contract that makes PEO Y the employer (or co-employer) of the 125 employees. PEO Y takes over various functions such as payroll but otherwise life for the 125 employees goes on as before. Company X managers and executives who were their bosses before are still their bosses. The IRS has always had an

issue viewing PEO Y as the common law employer of those individuals and these regulations reflect that.

2. The final pay or play regulations do NOT provide a safe harbor if an employer misclassifies a worker as a common law employer of another entity. In other words, if the IRS reclassifies a worker the employer will potentially be retroactively liable for penalties for prior years.

3. In the "other" staffing firm/PEO scenario, where the client is the common law employer, the regulations provide a safe harbor method by which the staffing firm/PEO can provide health benefits to workers on behalf of their clients.

a. That safe harbor requires that the client pay a higher fee to the staffing agency or PEO for an employee enrolled in health coverage than for the same employee not enrolled in health coverage.

b. Of course if the parties are uncertain whether they are a "temporary" staffing agency or an "other" staffing agency/PEO, there is nothing to prevent them from making an agreement that meets the requirements of the safe harbor, just in case.

4. With respect to whether leased employees are full-time, part-time or variable hour employees, the regulations provide factors to be considered in making the determination and also include examples.

C. Temporary Employees. Many welfare plans have long excluded "temporary employees". As a result, many employers are used to having flexibility to label an individual as "temporary" and exclude him/her from coverage.

1. Final pay or play regulations provide that 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 knows or anticipates that he or she will not be a long term employee. In other words, the fact that the employee has a fixed termination date is ignored.

2. Under the waiting period rules, such a temporary employee can be excluded for up to 90 days without triggering a penalty. However, all applicable nondiscrimination rules have to be considered in deciding whether some employees can be excluded for 90 days if other employees have a shorter waiting period.

3. An exception to this general rule is that "seasonal employees" can be treated as variable hour employees, which means most of them will never have to be offered coverage.

a. Of course, all applicable nondiscrimination rules have to be met.

b. Seasonal employees are defined as employees who customarily work six months or less in a year. In addition, the nature of the position should be such that an employee typically works during a period that begins at the same time every year. The regulations also provide that an employee can still be considered seasonal even if the season is extended in a particular year beyond its customary duration.

c. Final regulations describe rules for a seasonal employee who changes employment status.

VII. <u>ACA 30 Hour Employee Definition; "Change in Employee Status" Rules</u>. Employers often have employees who move from full-time to part-time status during the employee's period of employment. This presents a challenge for employers who are subject to the employer mandate because of the general rule that requires that the employer treat an employee who is determined to be a full-time employee during a measurement period as a full-time employee during the entire following stability period - even if the employee's hours are reduced significantly during the stability period. However, there is an optional change in status rule that employers may choose to utilize for employer mandate purposes. This optional rule permits an employer to cease offering employer mandate-compliant coverage to an employee following his or her change to part-time status as long as (i) the employer has offered a full-time employee health plan coverage that provides minimum value by the first day of the fourth calendar month following the employee's date of hire through the calendar month in which the employee has a change to part-time status and (ii) the employee actually averages less than 30 hours of service per week during the three full calendar months following the change from full-time to part-time employment.

Assuming the above two requirements are satisfied, the employer may apply the monthly measurement period rules to the employee as of the first day of the fourth full calendar month following the change in status through the end of the first full measurement period (plus administrative period) following the change in status. In other words, once the employee is subject to the monthly measurement period rules, the employer does not need to offer the employee employer mandate-compliant coverage to the employee for any month as long as the employee does not average 30

or more hours a week during that month.

VIII. Definitions of Spouse/Domestic Partner/Civil Union Partner/Common Law Spouse/Child/Stepchild/Foster Child/Adopted Child/Child Placed for Adoption/Etc. – FMLA Rules Updated

A. Spouse. The Supreme Court's DOMA decision, which generally required the federal government to recognize same-sex marriages that are recognized under state law, was issued in June 2013, did not require any plans (other than federal governmental plans) to recognize same-sex marriages, but it simplified plan administration for plans that do recognize same-sex marriage, because coverage for same-sex spouses is treated exactly like coverage for opposite-sex spouses. That also applies to state income tax law in most states.

1. Gender Discrimination Issues. There is an argument that recognizing only opposite-sex spouses is actually discrimination based on gender and therefore violates Title VII of the Civil Rights Act. So far, no reported court decisions have found that to be true in any case involving coverage under a health plan, but that may change in the future.

2. FMLA Update. Shortly after the DOMA decision was issued by the Supreme Court, the Department of Labor issued some guidance applying that decision to its FMLA regulations. Applying the spouse definition already included in its FMLA regulations, the Department of Labor announced that it would recognize same-sex marriages for FMLA purposes only if the marriage was recognized in the state in which the employee resides. By contrast, other guidance issued by the IRS and the Department of Labor indicated that marriages would be recognized if the marriage was valid under state law in the state where the marriage ceremony occurred. In February of 2015, the DOL issued a final regulation revising the definition of spouse to use the state of ceremony rule.

B. Common Law Marriage. A common-law marriage is a relationship that is considered a marriage for state law purposes based on common law principles rather than based on an actual marriage ceremony or marriage certificate issued by a state. Only eight states currently recognize common law marriage and at least five others formerly recognized them (and still recognize marriages that were recognized before a specified date). If a state recognizes the marriage, it generally would also be recognized for federal purposes as well and would also be treated as a marriage in many other states that do not recognize common law marriages arising within their own borders. The requirements for common law marriage vary from state to state but it is never as simple as a couple living together for any particular period of time. It can very difficult to prove that a common law marriage exists. For that reason, many health plans simply decline to recognize any common law marriages. For plans that do recognize such marriage, it is best to require clear evidence that the relationship has been recognized as a marriage under applicable state law.

C. Civil Union Partner. A civil union is a relationship that is generally treated, at least under state law in states that recognize them, as equivalent to a marriage for most purposes. In most, if not all, states that recognize civil unions, same-sex marriage is now permitted, and in many of those states, civil unions were automatically converted to marriages sometime after the state began recognizing same-sex marriages. For that reason, this term is becoming increasingly irrelevant. However, there are still some couples who are in civil unions that are not recognized as marriages under state law. That means they are not recognized as marriages for purposes of federal law. Federal law generally does not recognize civil unions as a separate legal status. This was not affected by the Supreme Court's DOMA decision. Health coverage for civil union partners is taxable unless the partner is a dependent of the employee for tax purposes.

D. Domestic Partners. This term is used in two different ways. Most commonly, it simply refers to two people who are in a relationship that is similar to a marriage but is not recognized as a marriage but that meets certain requirements specified by the employer. Employers who offer coverage for domestic partners are generally free to define the requirements for the relationship any way they wish. More often than not, employers who offered domestic partner coverage offered it only to same-sex partners because opposite-sex couples had the option to marry while same-sex couples did not. That is no longer the case in most states and, for that reason, some employers are starting to phase out domestic partner coverage. However, some employers offer coverage to opposite-sex domestic partners as well. Nothing in the DOMA decision requires or prevents employers from offering coverage to domestic partners. Of course, coverage provided to a domestic partner generally is a taxable benefit for the employee unless the partner happens to qualify as a tax dependent of the employee.

In some states and some foreign jurisdictions, there is (or was) a state-recognized relationship status known as a registered domestic partnership. The requirements for being a registered domestic partner varied from state-to-state, as did the legal consequences. In some cases, a registered domestic partnership provided only very limited legal

rights, while in others, a registered domestic partnership was essentially the same as a civil union, i.e., it was treated as a marriage for most purposes but was not called a marriage. As with civil unions, there is no federal recognition of registered domestic partnerships.

E. Child Definition Issues. For health plan purposes, child is usually defined to include biological, adopted or step-children, as well as eligible foster children. Although employers have some flexibility in determining which children are eligible for coverage, there are a few legal requirements to consider.

1. Affordable Care Act Age 26 Mandate. The ACA does not require that plans offer coverage to children, but if a plan does offer coverage to any children, it must offer coverage until they reach age 26. This applies to biological and adopted children and to stepchildren, as well as eligible foster children. However, a plan could exclude all children in one or more of those categories. For example, a plan could exclude all stepchildren, but it could not offer coverage to stepchildren who live with the employee and exclude those that do not live with the employee.

2. ACA Employer Mandate Rules. For employers that are subject to the employer mandate rules, to avoid penalties, the employer must offer coverage to full-time employees and their dependents. Dependents for this purposes has been interpreted by the regulators to mean, at a minimum, biological and adopted children.

Also, note that employers generally are not treated as offering coverage to an employee's dependents unless coverage is offered through the end of the month in which the child reaches age 26. So, if coverage terminates on the child's birthday, the employer would not be considered to be offering coverage to the employee for that month and the employee would be potentially subject to a penalty with respect to that employee for that month. In practice, a penalty would rarely apply except in unusual cases, but this would also raise some issues regarding the reporting of offers of coverage on the 1095-C for the month in which an employee's child reaches age 26.

3. Children of Same-Sex Spouses or Civil Union Partners. As noted above, plans are not required to offer coverage to same-sex spouses or civil union partners. However, children of an employee's same-sex spouse are stepchildren of the employee for purposes of federal law. Also, children of an employee's civil union partner (or even a registered domestic partner) would be considered stepchildren of the employee for purposes of federal law if they are considered stepchildren of the employee in the state in which the employee resides. Therefore, even if a plan does not offer coverage to same-sex spouses or civil union partners, it may be required to offer coverage to their children, if the plan otherwise covers stepchildren.

IX. The Value of Spouse/Dependent Audits

A spouse/dependent audit is a type of voluntary compliance review that compares a plan's eligibility rules to the individuals actually enrolled in the plan as dependents for the purpose of identifying individuals that should no longer be covered as dependents (such as children that have met the maximum age limit or who have been impacted by a divorce/custody arrangement and divorced spouses). The benefits of performing a dependent audit include reducing plan costs by eliminating claims paid for ineligible individuals and complying with ERISA rules related to operating a benefit plan in accordance with its terms. (In addition, you can use any spouse verification as part of a retirement plan beneficiary audit.) There are two types of audits that can be performed. The first is more intensive, and more beneficial, and requires participants to (i) confirm that their enrolled dependents meet the definition of dependent set forth in the plan, and (ii) substantiate that confirmation with appropriate documentation (such as a marriage certificate, tax return, birth certificate, adoption papers or custody papers). The second is less intensive, and simply requires employees to certify, by signing an affidavit, that any covered individuals meet the definition of dependent set forth in the Plan.

As an incentive for employees to respond truthfully, you can offer employees the chance to voluntarily drop coverage for those who don't meet the dependent eligibility requirements within a designated "grace period" without penalty (e.g., without repayment of claims paid for ineligible individuals). However, for any employee whom you "penalize" by rescinding coverage retroactively, you must take care to avoid violating the ACA prohibitions against rescissions. In all cases, ineligible individuals should be immediately dropped from coverage, and generally you should offer affected employees an appeals process.

X. HFSAs and Grace Periods, Run-Out Periods, Carryovers, Etc.

A. Run-Out Periods. The run-out period is the period of time after the Plan year ends during which expenses incurred during the previous Plan year (or during the grace period for that Plan year, see below) can be submitted for reimbursement.

1. Run-out periods are typically 30-90 days, but can be of any desired length.

2. Run-out periods can, if desired, begin on the earlier of the last day of the Plan year OR the date of termination of employment. E.g. an employee who terminates June 10 can be required to submit expenses for reimbursement within 30/60/90 days after June 10.

B. Grace Periods. The 2007 cafeteria plan proposed regulations restated the rules set forth in Notice 2005-42, permitting a grace period of up to two and one-half months after the end of the Plan year in which a participant can continue to incur FSA-qualified expenses against the prior year's salary reduction contribution amount. Shorter grace periods are permissible.

1. Grace periods are available for both Health Care and Dependent Care FSAs. They can be adopted for either or both.

2. Plan documents must be amended before the last day of the Plan year to adopt a grace period for that Plan year.

3. May require an adjustment to the Plan's run-out period.

C. Carryovers. In Notice 2013-71, the IRS announced a new carryover rule that may be adopted by employers that sponsor Health Care FSAs. Under this new rule, employers may amend their Health Care FSAs to permit employees to carryover up to $500 of unused Health Care FSA dollars from a Plan year to the following Plan year to be used to reimburse qualifying expenses incurred in that following year.

1. Not available for Dependent Care FSAs.

2. Cannot be combined with the grace period so that in order to adopt the carry-over a Plan that previously utilized a grace period will need to remove it.

3. Employers must amend their HFSA documents and announce the change to employees by dates specified in IRS guidance. Generally, an amendment to implement the $500 carryover option must be adopted by the end of the plan year and can be retroactively effective to the first day of that plan year.

4. Care must be taken not to carryover funds into a general purpose Health Care FSA for any year in which the employee wants to utilize an HSA. This can be accomplished automatically by providing a default under the Plan documents. Alternatively, the participant can be asked to make an election.

XI. Electronic Distribution Rules Update

A. General DOL and IRS Requirements. Federal law imposes a number of participant notification and communication requirements on sponsors of employee benefit plans (including welfare benefit and retirement 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.

B. 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.

C. 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.

XII. Voluntary Benefits v. ERISA-Governed Benefits

Benefits which are offered to employees on a voluntary basis, with employees paying the entire premium, have increased in popularity in recent years. If the voluntary benefits program does not fall within the DOL safe-harbor voluntary benefits exception, it will be subject to ERISA requirements, which include the requirement to file a Form 5500, provide an SPD to plan participants and comply with ERISA's claims procedures. In addition, if the voluntary plan involves health benefits, the arrangement may be considered to be a group health plan for purposes of COBRA and HIPAA.

A. DOL Safe-Harbor Voluntary Benefits Exception. DOL regulations provide a safe harbor under which ERISA does not apply to certain voluntary group, or group type insurance programs. To fall within the safe-harbor the program must meet the following requirements: 1) no contributions are made by the employer; 2) participation in the program is completely voluntary for employees; 3) the sole function of the employer with respect to the program are, without endorsing the program, to permit the insurer to publicize the arrangement to employees and to collect premiums from employees through payroll deductions and remit them to the insurer; and 4) the employer receives no consideration in connection with the program except reasonable expenses.

B. Employer Involvement. The absence of employer involvement or "endorsement" is arguably the most difficult part of complying with the safe harbor. DOL guidance states that endorsement occurs if the employer urges or encourages participation in the program or engages in activities that would lead employees to reasonably conclude that the program is part of a benefit arrangement established or maintained by the employer. The employer may facilitate the marketing of a program, but only to the extent short of endorsing the program. Actions that courts and/or the DOL have determined to indicate "endorsement" or employer involvement exceeding the bounds of the group insurance exception are:

1. Taking some position or action on behalf or in coordination with the insurer, such as making suggestions or negotiating with the insurer as to plan design and structure of the program.
2. Representing the plan to employees as part of its benefit package, such as incorporating the terms of the insurance program into a SPD or characterizing the program as an employer program in a brochure.
3. Providing help to employees in understanding their rights in filing claims under the plan.

4. Deciding key contract terms (such as amount of coverage), or deciding issues of employee eligibility.
5. Creating a contract with the insurance company and designating employees who were to be eligible to purchase coverage.
6. Permitting pre-tax premium payments through the employer's cafeteria plan.

XIII. <u>Avoiding a Promise of Lifetime Retiree Health Benefits.</u>

General Rules. Although ERISA governs pension and welfare benefit plans, including union plans, and imposes minimum funding and vesting standards for pension plans, welfare benefit plans are exempt from those rules. Therefore, courts apply the principles of contract law to determine whether an employer's promise to provide welfare benefits can be amended or terminated or was a promise of lifetime benefits. These principles apply to both ERISA-governed and ERISA-exempt welfare benefit plans. Since 1986, plans have been written to include the right to amend or terminate an employer's promise to provide health benefits, including retiree health benefits. As long as this right is clearly and unambiguously stated in the governing plan documents, and is not contradicted by other legally enforceable documents or communications, the employer will be able to amend or terminate retiree health benefits.

CBA rules. Since 1984, when US Supreme Court denied cert. for the 6th Cir. decision in "Yard-Man", these principles of contract law have been applied to collective bargaining agreements, to require a specific limitation in the CBA on the duration of retiree health benefits to avoid a promise of lifetime retiree health benefits. In Yard-Man, the key provision of the collective bargaining agreement, Article XVII, Section 4, states: "When the former employee has attained the age of 65 years then: (1) The Company will provide insurance benefits equal to the active group benefits ... for the former employee and his spouse." Article XIX, for example, provides that "savings and pension plan programs" continue only for the duration of the collective bargaining agreement. No such specific limitation was provided to similarly restrict payment of retiree insurance benefits to the life of the collective bargaining agreement. Therefore, the Court concluded that the retiree health benefits continued after the expiration of the CBA.

Recent Sup Ct. M&G Polymers USA, LLC v. Tackett (01/26/2015), completely abrogates the Yard-Man interpretation and concludes that the Yard-Man decision and its progeny have misapplied the applicable contract principles and "failed even to consider other traditional contract principles, including the rule that courts should not construe ambiguous writings to create lifetime promises and the rule that 'contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement,'". "The Court of Appeals also failed even to consider the traditional principle that courts should not construe ambiguous writings to create lifetime promises." "Similarly, the Court of Appeals failed to consider the traditional principle that 'contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement.' . . . 'a collective-bargaining agreement [may] provid[e] in explicit terms that certain benefits continue after the agreement's expiration.' . . . But when a contract is silent as to the duration of retiree benefits, a court may not infer that the parties intended those benefits to vest for life."

Executive Agreements. A district court's summary judgment dismissing a participant's claim under a top hat plan intended to provide lifetime health insurance benefits for her and her husband, was reversed and remanded by the Third Circuit. (Campbell, Paula v. Sussex County Federal Credit Union (2015). Campbell's claim for lifetime health benefits survived all arguments for summary judgment and was remanded for review of all of the evidence, including extrinsic evidence, to resolve the claim.

Employers should review their current plan documents, CBA's and executive agreements to confirm the language of those documents provide the intended duration of, and right to amend or terminate, retiree health benefits.

XIV. <u>Recent Cadillac Tax Guidance</u>. The IRS recently issued guidance on the ACA's "Cadillac plan' excise tax that becomes effective in 2018. (One survey estimated that 17% of U.S. employers will be affected if they do not-re-design their plans before 2018.) This ACA provision imposes a non-deductible excise tax on these Cadillac plans equal to 40% of the excess of the "value" of the plan over the ACA's Cadillac plan limit of $27,500 family/$10,200 self-only (as adjusted). For current planning purposes, this guidance makes clear that employers may use the COBRA rate (less the 2% administrative charge) as the "value" for Cadillac tax purposes, but employers should monitor future guidance which could change this. The most disappointing provision of the guidance states that "employer contributions to Health Savings Accounts, including salary reduction contributions" are included in amounts that need to be valued for Cadillac tax purposes.

XV. New Summary of Benefits and Coverage Guidance. Since late 2012, the ACA has required employers to provide health plan participants a new overview document -- the so-called "Summary of Benefits and Coverage". The SBC was designed to allow for an "apples to apples" comparison of the key features of health coverage. The regulators recently issued proposed rules to make the SBC more "user-friendly". For example, while the new SBC template has been streamlined to remove outdated references such as to annual limits and pre-existing condition exclusions (reducing the sample, completed SBC from 4 double-sided pages to 2.5 double-sided pages), it also adds a new coverage example regarding a broken foot to show how the plan might operate when the participant has an emergency. (This example is in addition to the two current examples of having a baby and managing diabetes.) Importantly, the proposed regulations (among other things) would end the enforcement safe harbor for information regarding MEC and MV and allow for electronic delivery of the SBC in certain circumstances.

The proposed rules also clarify the rules surrounding when a plan must provide the SBC again if the plan already provided the SBC prior to application (e.g., if a plan provides the SBC prior to application for coverage, the plan is not required to provide another copy automatically unless there is a change in the information). The regulators recently stated that if finalized (as expected this year), the rules would require new SBCs meeting the updated requirements to be available with respect to plan years beginning on or after January 1, 2016 (including for the related 2015 open enrollment period), although the use of the template would be delayed by an additional year.

XVI. Update on Opt-out Credit Guidance. Last year, the regulators published their thoughts on the practice -- then being by some employers -- of providing opt-out bonuses to high claim health plan participants. In very general terms, these employers were approaching high claim participants in their health plan and providing them with an additional benefit not available to low claim participants; namely, an unrestricted, taxable cash opt-out bonus if they decide not to participate in the employer's health plan. In the guidance, the DOL, the IRS and the HHS announced their view that this large claimant variation on the opt-out concept violates several laws. In essence, the regulators concluded that offering this additional option to large claimants actually "discriminates" against them (rather than in favor of them) by "increasing" their required contribution for plan participation. The regulators supported their position by arguing that these large claimants have to "effectively pay more" to participate in the plan than low claimants not offered the bonus, 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.

In November, the regulators issued additional guidance generally interpreted to provide that amounts paid by employers to employees who opt-out of the employer's health plan must be treated as additional employee contributions for purposes of the affordability component of the ACA's employer mandate rules. This position is a radical departure from conventional notions of "employee cost," and therefore it is unlikely that employers with these arrangements have considered the cash-out amount available to employees who waive coverage as part of the cost calculation for employees who do not waive coverage. (These rules are also applicable to many arrangements where the employer makes available consideration (e.g., "benefits credits") other than cash to employees who waive health plan coverage.) The unfortunately convoluted text of the regs is best illustrated by the following example:

-An employee's required contribution for individual coverage under the employer's health plan is $90 per month. The employer offers a cash opt-out payment of $50 per month to the employee if health plan coverage is declined. The "cost" to the employee for purposes of determining ACA affordability is $140 (not $90).

Employers that offer payments (or credits) for opting-out of health coverage should determine – sufficiently in advance of the effective date for their plan of the ACA affordability rules – the steps they should take to respond to these regulations and avoid ACA employer mandate penalties. Employers that maintain a "no benefits" employment category also need to pay immediate attention to this development. (A "no benefits" practice is one where the primary distinction between an employee in one class of employee (a "benefits" category) and another (the employer's standard employment category) is that the latter gets more salary and no benefits and the former gets less salary but also receives benefits, all other aspects of employment being equal.) These arrangements – and arrangements where government contractor employees are paid their "fringe rate" in cash -- are particularly impacted by the new regulations.

XVII. Rules Regarding Health Expense Reimbursement Plans. The IRS has issued a series of pronouncements (starting with IRS Notice 2013-54) concluding that employer payment plans (i.e., generally the reimbursement by employers of employee-paid health premiums, or the direct payment by employers of premiums for individual health policies for employees), violate the ACA and subject the employer to significant penalties. In late February, the IRS released Notice 2015-17 reaffirming its prior position and providing some "limited transitional relief" from this rule for small employers. (For this purpose a small employer is an employer with fewer than 50 "full-time

employees" as measured under the complex employer mandate rules.) The new relief provides that small employers with plans reimbursing or paying individual health policy premiums or Medicare Part B or Part D premiums will not incur ACA penalties for 2014 and for the period January 1-June 30, 2015. This relief does not extend to stand-alone HRAs. While the IRS also created a special exception for plans that reimburse or pay premiums for 2% or greater S corporation shareholders, exempting them for the applicable ACA penalties through December 31, 2015, the IRS indicated that it is considering publishing additional guidance on this issue, as well as the federal tax treatment of such arrangements.

XVIII. Responding to Health Information Security Breaches. Recent security breaches by Anthem and Premera Blue Cross involving millions of health plan participants demonstrate the importance of complying with the HIPAA privacy and security regulations, including rules for responding to security breaches and other improper uses and disclosures of health plan protected health information. The Anthem breach involved close to 80 million individuals and the similar Premara breach involved about 11 million. In those cases, as in most cases involving insurance carriers and third party administrators, most of the required response is handled by the carrier or TPA, but employers should be aware of the requirements that apply to health plans. For insured plans, the insurance carrier normally is responsible for responding to any improper uses or disclosures of protected health information. Unless information maintained by the employer is directly involved, the employer's response generally would be limited to cooperating with the insurance carriers efforts to respond to the incident and monitoring the carrier's response to make sure that no further action by the employer is required. For sponsors of self-funded plans, the employer's response to such incidents should include the following (with these functions either performed by the employer or performed by a TPA or other business associate, with the employer monitoring the response):

1. Investigate the incident.

2. Mitigate any risk of harm or damages.

3. Review any plan procedures that may have caused the breach and determine if additional safeguards are needed.

4. Maintain records for at least six years. This includes records of the incident itself and any response to the incident.

5. Accounting for disclosures. Records must be maintained for a period of six years in a manner that would allow the plan to respond to any request from a covered individual for an accounting of certain disclosures of PHI.

6. If the incident qualifies as a "breach" for purposes of the HIPAA security rule, the following notice requirements apply:

a. If the breach is discovered by a business associate, the business associate must provide notice to affected plan sponsor.

b. Notices to affected individuals must be provided.

c. Notices to media outlets should be provided if a breach affects more than 500 people.

d. Notice to HHS must be provided.

QUALIFIED RETIREMENT PLANS

I. **Final and Proposed Regulations on Cash Balance and Other Hybrid Plans.** On September 19, 2014 the IRS released final regulations and proposed regulations regarding hybrid plans. The final regulations update proposed regulations which were issued in 2010 and generally apply to plan years that begin on or after January 1, 2016. The proposed regulations offer guidance on how certain noncompliant hybrid plans can transition from a noncompliant interest crediting rate to one permitted under the final regulations (and qualify for anti-cutback relief).

A. Final Regulations Qualified retirement plans, including hybrid plans (such as cash balance plans) may not be designed to discriminate on the basis of age. Code Section 411(b)(5)(B) provides that statutory hybrid plans satisfy the Code requirement prohibiting age discrimination only if the plan does not credit interest at greater than a market rate of return. The final regulations detail which interest crediting rates meet the market rate of return requirement. While the list has been broadened from the proposed regulations list, the final regulations make clear that a plan must use an interest crediting rate detailed in the regulations. The list of permissible interest crediting

rates includes permissible fixed rates, a fixed floor rate in connection with permissible bond-based interest crediting rates and circumstances under which the rate of return on plan assets, or a subset of plan assets, may be used.

The regulations provide guidance on when and how a plan can provide early retirement and certain optional form subsidies. The regulations clarify that, even though a hybrid plan treats the account balance or a pension equity plan accumulation as the present value of the accrued benefit, a hybrid plan must either provide actuarial increases to participants who commence their benefits after normal retirement age or satisfy the suspension of benefits requirements which generally apply to defined benefit plans. The regulations contain special rules for determining interest crediting rates and plan factors following the termination of a hybrid plan and plan documents must include these rules.

While the regulations do not provide extensive guidance on pension equity plans, they do clarify that a pension equity plan formula may use a participant's highest average compensation within a permitted period (such as the five highest years during the last ten year period) instead of final average compensation.

B. Proposed Regulations The proposed regulations provide guidance on how a plan's interest crediting rate may be amended, with respect to future interest credits, to bring the plan into compliance with an accepted market rate of return. Only the specific feature(s) that cause the interest crediting rate to be noncompliant can be amended. To qualify for anti-cutback relief [Code Section 411(d)(6) relief], the amendment must be adopted prior to and be effective no later than the first day of the first plan year that begins on or after January 1, 2016.

II. Fiduciary Best Practices Issues. Under ERISA, fiduciaries may be held individually and personally liable for failing to satisfy their fiduciary duties. Much of this liability may be limited, however, by demonstrating that the fiduciaries exercised proper due diligence in the decision-making process. This can be shown, for example, by:

A. Having good policies, procedures and forms. In addition to making certain that the plan document and the Summary Plan Description are accurate and up-to-date, make certain that there are policies, procedures and forms in place for the plan that are specific to the plan and that adequately document the steps that will be taken with respect to various plan administration issues. Examples of such policies, procedures and forms include, but are not limited to: QDRO procedures, a loan policy, a rollover acceptance policy, a salary deferral declination form, and hardship procedures and forms.

B. Documenting the basis for plan committee decisions. To the extent that the employer has an administrative and/or investment committee for the plan, make certain that there is a charter that describes the committee's roles and responsibilities. In addition, make certain that the committee's decision-making process is fully documented in the minutes for each committee meeting.

C. Complying with ERISA Sections 404(a)(5) and 404(c). If the plan has participant-directed investments, make certain that the requirements of ERISA Sections 404(a)(5) and 404(c) are followed so as to limit the fiduciaries' responsibility for investment-related losses.

D. Monitoring the plan's service providers and costs. When a service provider is hired, or its contract is extended or renewed, make certain that the service provider's contract and related disclosures comply with ERISA Section 408(b)(2). On a related note, make certain that the compensation paid to the plan's service providers is "reasonable" within the meaning of ERISA.

E. Monitoring legal developments. Stay abreast of legal developments that affect the plan. For example, on April 14th, the DOL released proposed regulations that would expand the definition of "fiduciary" under ERISA. If finalized in their current form, some brokers, for example, may be considered ERISA fiduciaries. This may require changes to the plan's compensation arrangements with such brokers, as well as revisions to the disclosures that the broker must provide to the plan (and that the employer must ask the broker to provide in the event that the broker does not volunteer such disclosures).

III. Hardship Substantiation Rules. On April 1, 2015 the IRS published a newsletter article that requires plan sponsors to maintain all records relating to hardship distributions. This guidance caught many by surprise, as it is contrary to previous statements issued by IRS representatives and adds a requirement that is not contained in the hardship distribution regulations. Further, it is the first time that the IRS has provided that the failure maintain such documentation is a qualification failure to be corrected using the Employee Plans Compliance Resolution System (EPCRS).

In particular, the newsletter article notes that it is not sufficient for participants to maintain substantiating documents, nor it is sufficient for participants to self-certify the nature of the hardship. Rather, it now appears that the IRS will require plan sponsors to themselves request and maintain such documents, together with other hardship distribution records. In light of this article, plan sponsors should be cautious if they choose to approve a hardship distribution without obtaining all substantiating records. This is especially important now that the IRS has indicated that the failure to do so can lead to a plan qualification failure, and may be indicative of its position when reviewing plan procedures.

IV. <u>De-Risking Defined Benefit Pension Plans</u>. Defined benefit plan costs are volatile. Funding varies based on factors such as investment performance, interest rates and participant mortality and are further impacted by when participants choose to take their benefits and the optional form chosen. These factors are all, to some extent at least, outside the plan sponsor's control. Uncertainties continue even with respect to terminated participants and retirees. Once payments begin, unless an annuity is purchased, plan sponsors still face fluctuating funding requirements for benefits as well as PBGC premiums. Participants who take a lump sum remove that ongoing, fluctuating liability but including lump sums options in a defined benefit plan has its own issues. The cost of lump sums is typically less than the cost of purchasing annuities so it is a less expensive way of achieving these goals.

Defined benefit plans can offer lump sums as an option but cannot require terminated participants to take a lump sum distribution unless the dollar amount is low (currently $5,000). Because lump sums are a "protected benefit" once that option is added to a plan it generally cannot be removed except for future benefit accruals. Because lump sums are a cash drain and their value is subject to interest rate fluctuations plan sponsors are often reluctant to add lump sums as an ongoing option. Offering lump sums for a limited time – often known as a "window benefit" – avoids creating a protected right to a lump sum (if done correctly), may increase the number of participants who choose a lump sum (after all the message is take it now or the option's gone), and permit the plan sponsor to define the group eligible for the lump sum option (subject to all applicable legal requirements and nondiscrimination rules).

Prior to 2012, lump sums had to be calculated using Treasury bond rates as well as corporate bond rates. That created the possibility of increased costs. However, corporations still used lump sum windows as a strategy to de-risk their pension plan. For example in April 2012, Ford offered a lump sum window to 90,000 retirees and former employees. Shortly after, General Motors announced a similar program. Beginning with the 2012 plan year lump sums are calculated based solely on corporate bond rates. Because these rates were low, which means lump sums based on them were high, it might seem like it wouldn't make sense to offer lump sum windows. However, plan sponsors continued to compare the risk of continuing to maintain the liabilities and the cost of doing so (including PBGC premiums) against the advantages of offering a lump sum window and sometimes concluded that a window would reduce volatility in two ways (1) investment, interest rate and mortality risks are transferred to the former employee and (2) because the plan shrinks in size overall, the plan's remaining investment, interest rate and mortality risks are moderated.

The strategy is often referred to as "de-risking". Two plan sponsors (widely believed to be Ford and General Motors) requested and received IRS private letter rulings on their proposed de-risking programs. Private letter rulings cannot be used as precedent by other employers but they do indicate the IRS willingness to consider such programs and provide some guidelines for plan sponsors to follow. Employers considering a de-risking strategy need to carefully consider and compare the advantages and disadvantages. Advantages include everything discussed above. Disadvantages include the increased cost of lump sums while interest rates are so low, the chance of adverse selection among former employees and the possibility of violating one of the (many) legal requirements governing such a program. Some employers may also be concerned that participants will make unwise choices when offered a limited period of time to take what looks like a large lump of money. To address that issue, some plan sponsors may offer counseling to former employees eligible for the window.

Employers considering a window benefit need to make sure that all legal issues are addressed. The legal issues include the duration of the window, which former employees will be included in the window, nondiscrimination requirements, employee notice and consent requirements, the spousal consent requirements, the minimum required distribution requirements, mortality tables and interest rates to be used in calculating lump sums, reporting and withholding requirements and others. Some plans may also have to be concerned about the funding based payment limitations found in Code Section 436. A de-risking strategy is typically a joint effort by – among others - the plan sponsor, the plan's actuary and the plan's legal counsel and requires sufficient lead time to make sure that the likely advantages outweigh the disadvantages and that all issues have been properly addressed.

In addition to lump sum windows, defined benefit plan sponsors can incorporate other elements into a de-risking plan including: (1) making changes to the Plan's investment strategy to better match the risks of the Plan's

investments with the risks associated with benefit liabilities; (2) an "annuity buy-in" approach with the Plan purchasing, as a Plan asset, a group annuity contract to fund future benefits payments; and (3) an "annuity buy-out" approach with the Plan purchasing group annuity contract and issuing certificates to participant/retirees with the result that participant rights are then enforceable against the insurer.

V. Defined Benefit Plan Final Funding Notice.

The Department of Labor recently released its Final Rule on the Annual Funding Notice (AFN) for Defined Benefit Plans. The Final Rule, which is substantially similar to the proposed rule, implements the annual funding notice requirements under Section 101(f) of ERISA and is effective for plan years beginning on or after January 1, 2015. The Final Rule requires that all defined benefit plans subject to Title IV of ERISA must provide the AFN to participants, beneficiaries receiving benefits, labor organizations representing participants or beneficiaries, each employer required to make contributions to the plan, and the Pension Benefit Guaranty Corporation (PBGC). The AFN must generally be provided by the 120th day following the end of the Plan Year to which it relates (the Notice Year), or, for small plans (generally with 100 or fewer participants), on the earlier of the date the date the Form 5500 is, or is required to be, filed.

The AFN is required to include certain information, including (1) the plan's funding percentage for the Notice Year and the previous two plan years, (2) a statement of the value of the plan's assets and liabilities and a description of how the plan's assets are invested, (3) demographic information on participants, (4) a summary of the funding and investment policies, (5) the asset allocation of investments, (6) a summary of material effect events, such as plan amendments, scheduled benefit increases/reductions, and other known events, (7) a description of the benefits eligible to be guaranteed by the PBGC and any limitations, and (8) a summary of the rules governing the termination or insolvency of the plan. The Final Rule also contained two Model Notices, including one Model Notice for single employer plans, and one Model Notice for multiemployer plans.

VI. Definition of Governmental Plan - New Developments. On November 8, 2011, the Treasury/IRS announced proposed rules regarding the definition of governmental plan. Those proposed rules merely indicate the current thinking at Treasury/IRS and list "major factors" and "minor factors" for determining whether or not a plan meets the definition of a governmental plan under IRC 414(d). On January 23, 2015, the Treasury/IRS announced their intention to issue proposed regulations under 414(d) to define the term "governmental plan" to allow participation by certain charter school employees, if certain conditions are met. The Notice lists the following expected conditions: (a) the entity is a nonsectarian independent public school that serves a governmental purpose by providing tuition-free elementary or secondary education, or both; (b) the entity is established and operated in accordance with a specific State statute; (c) participation in the State or local retirement system by the entity's employees is expressly required or permitted under applicable law; (d) either (1) the entity's governing board or body is controlled by a State, political subdivision of a State, or agency or instrumentality of a State or of a political subdivision of a State, or (2) the entity satisfies one of three other requirements regarding funding, rights to accrued benefits or being part of a local educational agency, and (e) all financial interests of ownership in the entity are held by a State, political subdivision of a State, or agency or instrumentality of a State or of a political subdivision of a State. The 2011 and the 2015 announcements request comments and state that the agencies anticipate that the final regulations will apply prospectively and will include a delayed effective date and transition relief. Governmental employers should monitor closely the developments in this area and consider providing comments to the IRS if the provisions in these announcements would create any problems if included in proposed or final regulations.

VII. Definition of "Church Plan"- New Developments. Retirement plans which are "church plans", as defined in ERISA and the Internal Revenue Code, are exempt from ERISA and, if they are non-electing plans, are exempt from some Internal Revenue Code requirements and subject to different, less stringent requirements under other Code sections. Plans may request a private letter ruling from the Internal Revenue Service, or a letter from the Department of Labor, ruling that they are church plans. In the last few years several cases have been brought by plan participants seeking to have the courts determine that (even though the plan has an IRS private letter ruling) their plan is not a church plan and thus is subject to ERISA and the various IRC provisions affecting qualified retirement plans (see, for example, Rollins v. Dignity Health, Kaplan v. St. Peter's Healthcare System and Overall v. Ascension Health). 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. Thus far one federal District Court has come to the opposite conclusion finding that a church associated non-profit healthcare organization can sponsor a church plan. The cases in question have been appealed (or could be appealed) and it is still too early to know how the issue will finally be resolved. However, since, especially for defined benefit plans, the loss of church plan status could be costly, plans

may want to monitor the situation and analyze the effect any loss of church plan status could have on their plans.

VIII. Non-ERISA Plan 5500 Relief Program Expiring June 2. The DOL's Delinquent Filer Voluntary Compliance Program (which generally allows ERISA-governed retirement plan sponsors to file overdue 5500s along with payment of a reduced penalty) does not apply to certain retirement plans covering only self-employed sole owners (and their spouses) or partners (and their spouses), leaving such plan sponsors without an available amnesty program to correct failures to file the annual report. Effective June 2, 2014, the IRS established a "pilot program" that provided amnesty relief for certain retirement plans not covered by Title I of ERISA with respect to late/unfiled 5500-EZs or Form 5500s (if the employer was required to file this return because the plan did not meet the filing requirements for the Form 5500-EZ for years prior to 2009). The "pilot program" allows the plan sponsor to file the 5500-EZ/5500 without payment of any fee and without penalty. The program closes June 2, 2015.

IX. 3(16), 3(21) and 3(38) Fiduciaries Overview. Every ERISA-governed employee benefit plan is required to identify its "named fiduciaries" who operate the plan and who are held to the highest standard of care, loyalty and expertise possible under American law. Historically, the employer-sponsor itself served as the named fiduciary of its ERISA plans for most purposes, a very uncomfortable position for many employers. Fortunately, there is now a marketplace of "contract fiduciaries" that offer their "professional fiduciary services" to ERISA plan sponsors. First, some firms agree to be "ERISA Section 3(21) co-fiduciaries" with the employer-sponsor of an ERISA plan, often with respect to the selection and monitoring of investments offered under a defined contribution retirement plan. Although hiring such a co-fiduciary does not relieve the employer of any fiduciary liability, it at least adds to the employer's fiduciary "team" an expert in the applicable field. Second, more and more investment firms are agreeing to be "ERISA Section 3(38) sole investment advisors" that take all of the investment-related liability from the employer-sponsor. Note that only certain professional investment advisors qualify as 3(38) advisors, and only after they provide a specific "3(38) letter" to the employer. Finally, the latest offering in this area is firms agreeing to be the employer's professional "ERISA Section 3(16) Plan Administrator," relieving the employer of liability concerning a number of ERISA fiduciary responsibilities. Employers considering hiring a 3(21), 3(38) or 3(16) "professional fiduciary" should appreciate that the selection, monitoring and retention of the professional remains an ERISA fiduciary obligation of the employer.

X. Recent Guidance on Lost Participants. Locating lost participants is a common problem facing many plan fiduciaries. Depending on whether the plan is terminating or ongoing, there are certain steps that can diminish liability with respect to the account balances of lost participants. For terminating plans, the Department of Labor recently updated its guidance on locating and distributing benefits to lost participants. First, when it becomes apparent a participant may be lost, the plan fiduciary must engage in certain low-cost-high-potential search steps to locate the participant (including certified mail, checking related plan and employer records, checking with a designated plan beneficiary, and using free electronic search tools). The DOL notes that the failure to take these search steps will result in a violation of the fiduciary's duties. If the participant remains lost, the plan fiduciary must then determine if additional search steps are appropriate considering the size of the participant's account balance and the cost of additional search steps. (Please note that the DOL eliminated the requirement to use the IRS and/or SSA letter forwarding services, which have been discontinued.)

Second, if the participant remains lost after all appropriate search steps have been conducted, the participant's account balance should be distributed into an individual retirement plan. Under a DOL safe harbor, plan fiduciaries can distribute the accounts of lost participants into an individual retirement plan while satisfying fiduciary responsibilities under ERISA Section 404(a). While alternative distribution options may be available, they are strongly cautioned against by the DOL. For ongoing plans, there is no DOL guidance for handling lost participants similar to the DOL guidance for terminating plans. Nevertheless, there are steps the plan sponsor and fiduciary can take to minimize liability. First, when it becomes apparent a participant may be lost, the plan fiduciary should engage in the same low-cost-high-potential search steps to locate the participant as it does in a terminating plan setting (including certified mail, checking related plan and employer records, checking with a designated plan beneficiary, and using free electronic search tools).

A plan document can include a quasi-forfeiture provision that provides for the forfeiture of the lost participant's account, with a restoration provision if the participant is later found. This type of provision can help the plan avoid a missed required minimum distribution. Alternatively, the plan fiduciary may use a distribution approach similar to the method permitted by the DOL for terminating plans, but without the protection of a fiduciary safe harbor. With the DOL's guidance in a terminated plan context, plan fiduciaries have a useful guide for dealing with lost participants. This guidance can also be useful in an ongoing plan context, even though the DOL has not specifically addressed how to handle the account balances of lost participants and does not provide fiduciary safe harbors. We would be happy to discuss how your plan can prepare for and deal with potential lost participants.

XI. DOL Audit Activity Re Late Remittance of Salary Reduction Contributions. The timeliness of the deposit of voluntary deferral amounts is examined in every DOL audit and plan sponsors should perform a self-diagnostic to ensure that all voluntary deferral amounts are being deposited timely. Applicable regulations require that voluntary deferral amounts be deposited into a qualified plan's trust "as soon as they can be reasonably segregated" from the Employer's general assets. This means that typically these deposits should occur "instantaneously," or in all events in a matter of a few days after amounts are withheld from employees' paychecks. Under a DOL safe harbor for "small" retirement plans (i.e., those plans with fewer than 100 participants), if participant contributions are deposited into the Plan within seven business days of receipt (e.g., a participant loan payment given to the employer) or withholding (i.e., the date on which the amounts would have been payable to the participant in cash), the Plan will be deemed to have satisfied the timing requirements.

XII. DOL Position on ERISA Spending Accounts.

A. Background. Some participant-directed plans enter into arrangements where a mutual fund or investment managers will "share" or transfer compensation to the plan or its recordkeeper so the plan may use the compensation to pay for plan administrative expenses (as opposed to having the expenses paid directly from participant accounts under the plan or billed to the plan sponsor) and/or allocated to participants' accounts under the plan. This revenue sharing compensation is often described as being held in an ERISA spending, recapture, or budget account.

B. Fiduciary Concerns. Deciding how to handle revenue sharing is a fiduciary decision. The Department of Labor discussed fiduciary issues surrounding revenue sharing in Opinion Letter 2013-03A. Fiduciaries must consider the following:

1. The negotiated fees and compensation paid to the service provider must be reasonable.

2. The plan fiduciaries must understand and act in the plan's interest in negotiating the formula and methodology under which the revenue sharing will be credited to the plan and paid to the plan or plan service providers.

3. The plan fiduciaries must be able to periodically monitor the service provider to ensure that the terms of the arrangement are correctly calculated and the proper revenue sharing is provided to the plan or plan service providers.

4. The plan fiduciaries must understand the relationship between service providers to ensure that any service providers paid directly with revenue sharing are receiving reasonable compensation for the service provided.

5. The plan fiduciaries must ensure that any plan fee disclosures requirements are met.

XIII. Revisions to EPCRS. The Internal Revenue Service recently issued two Revenue Procedures (Rev Proc 2015-16 and Rev Proc 2015-28) updating (and effectively amending) certain guidance in the Employee Plans Compliance Resolution System (EPCRS). Some of the more significant changes include:

A. Correcting Overpayments. EPCRS has been modified to clarify that, in addition to seeking the return of overpayments from participants and beneficiaries, there are other methods which may be used to correct overpayments such as having the employer or another person contribute the amount of the overpayment (with appropriate interest) to the plan.

B. Fees The compliance fees for Voluntary Correction Program (VCP) submissions relating solely to participant loans that do not satisfy IRC Section 72(p) (and affect no more than 25% of participants) have been significantly reduced and are now based on the number of participants with loan failures rather than the number of participants in the plan. For required minimum distribution failures (if this is the only failure) the $500 fee will now cover up to 150 participants. If the failure involves 151-300 participants the fee will be $1500.

C. Elective Deferrals Rev Proc 2015-28 modifies EPCRS by adding new safe harbor correction methods for automatic contribution features (including automatic enrollment and automatic escalation of elective deferrals) in 401(k) and 403(b) plans and by providing special safe harbor correction methods for plans (including plans with automatic contribution features) that have failures that are of limited duration and involve elective deferrals.

XIV. Alternatives and Requirements for the Frozen Defined Benefit Pension Plan Extended Relief. A "frozen" or "closed" defined benefit ("DB") pension plan (i.e., a plan that provides ongoing accruals only for employees

who participated in the plan on a specified date) must continue to comply with applicable minimum coverage and nondiscrimination requirements under the Code. IRS Notice 2014-5 provides temporary relief for meeting these requirements and requests comments on this temporary, and possible future (several examples are proposed in the Notice), relief. The notice permits certain employers that sponsor a closed DB plan and a defined contribution ("DC") plan to demonstrate that the aggregated plans comply with the nondiscrimination requirements on the basis of equivalent benefits, even if the aggregated plans do not satisfy the current conditions for testing on that basis. Notice 2015-28 (03/19/2015) extends this temporary nondiscrimination relief for an additional year by applying that relief to plan years beginning before 2017, if the conditions in that notice are satisfied. Notice 2015-28 states that the IRS expects to issue regulations that will apply after the relief under Notice 2014-5 and Notice 2015-28 expires.

IRS Notices 2014-5 and 2015-28 provide a temporary additional alternative that permits a DB/DC plan to demonstrate satisfaction of the nondiscrimination in amount requirement of Section 401(a)(4) on the basis of equivalent benefits even if the DB/DC plan does not meet any of the existing three alternative eligibility conditions for testing on that basis. Under this additional alternative, the DB/DC plan may comply with the nondiscrimination requirement on the basis of equivalent benefits for a plan year that begins before January 1, 2017, if the DB/DC plan includes a DB plan providing ongoing accruals that was amended, by an amendment adopted before December 13, 2013, to provide that only employees who participated in the DB plan on a specified date continue to accrue benefits under the plan, and if each of the DB plans in the DB/DC plan satisfies one of the following conditions: (1) For the plan year beginning in 2013, the DB plan was part of a DB/DC plan that either was primarily defined benefit in character or consisted of broadly available separate plans, or (2) In the case of a DB plan that was amended, by an amendment adopted before December 13, 2013, to provide that only employees who participated in the DB plan on a specified date continue to accrue benefits under the plan, the DB plan was not part of a DB/DC plan for the plan year beginning in 2013 because the DB plan satisfied the coverage and nondiscrimination requirements without aggregation with any DC plan. Employers whose "closed" DB plan is subject to the minimum coverage and nondiscrimination requirements should confirm that the closed DB plan continues to meet these requirements without aggregation, or meets these requirements through permitted aggregation with a DC plan sponsored by the employer.

XV. Uncashed Checks/Float. The DOL, in both Advisory Opinion 93-24A and in Field Assistance Bulletin 2002-3, has advised that a trustee's use of float income for its own benefit constitutes a prohibited transaction unless the trustee (1) disclosed the float to the independent plan fiduciary at the time the trustee was retained, (2) openly negotiated with the independent plan fiduciary to retain float income as part of its overall compensation, and (3) was not in a position to affect the amount of its float compensation, as it would, for example, if it had "broad discretion over the duration of the float." Fidelity was recently (2015) sued by a group of participants who claimed interest on benefit payments equal to the "float" earned by Fidelity during the time the payment checks remained uncashed. The participants claimed that Fidelity violated ERISA with respect to: (1) its practice of appropriating float earned on plan assets to pay banking fees that Fidelity was required to pay, and (2) its practice of misappropriating float income for the use of clients other than the participants in the plans. The Massachusetts District Court considered the DOL advice, but found that the participants had failed to establish that the float was a plan asset subject to ERISA protections. Plan sponsors should review their contracts with any vendor who holds funds used for the payment plan benefits to be sure the determination and use of float income is addressed appropriately.

EXECUTIVE COMPENSATION

I. FICA Tax – Case Law Developments. Under the Code, benefits accrued under any nonqualified plan of deferred compensation (including 457(b), 457(f) and 451) become subject to FICA/Medicare tax withholding and reporting on the date the benefit becomes vested (or, the case of certain nonqualified defined benefit plans, when the benefit is vested and its value becomes "reasonably ascertainable"). The IRS's regulations are clear that if an amount was not taken into account when vested (or, if applicable, "reasonably ascertainable"), and was not corrected during the applicable statute of limitations period, then such amount – including the post-vesting date earnings attributable thereto - must be reported for FICA/Medicare tax purposes upon distribution. The result of this later FICA/Medicare withholding is that it typically subjects the executive to increased FICA/Medicare taxation because (i) post vesting date earnings are subject to FICA/Medicare (when they otherwise would have escaped taxation under a "non-duplication rule"), and (ii) taxation often occurs in a year in which a formerly high-paid executive is no longer earning wages, which often subjects all or a portion of nonqualified deferred compensation benefits to the 6.2% Social Security portion of FICA (which may have otherwise been avoided if withholding had occurred at the time of vesting, when executives' wages typically exceed the Social Security wage base).

Unfortunately, many employers do not understand or follow these rules. As a matter of good will, employers often will make whole an executive who is negatively impacted by the failure to properly withhold. But, as a result of

recent case law, there is a risk that employers may actually be liable for the failure. In Davidson v. Henkel Corporation, a federal district court in Michigan concluded that the employer's failure to properly withhold FICA/Medicare violated the design and purpose of the nonqualified plan at issue, therefore resulting in the plaintiff and the other participants receiving lower benefits than they were entitled under the plan. Therefore, it is vitally important that employers understand, and administer, the FICA/Medicare withholding rules correctly in nonqualified deferred compensation plans.

II. "Separation from Service" Issues. Under Code Section 409A, a determination of whether an employee has experienced a separation from service is based on a determination of whether the service provider is anticipated to continue providing significant services to the service recipient. The determination of whether an independent contractor has experienced a separation from service is more black and white (i.e., whether there has been a "good faith and complete termination of the contractual relationship"). If a service provider is providing services as both an employee and an independent contractor, the service provider will not be treated as having a separation from service unless the service provider separates from service both as an employee and as an independent contractor. (Special rules apply if an employee is providing services as an employee and as a non-employee director.)

Complications arise when employers try to side-step these rules by converting employees to independent contractor "consultants" in an effort to delay a distribution that is due from a nonqualified deferred compensation plan upon separation from service. However, in that instance, the general separation from service rules applicable to employees will still apply, and the employee is presumed to have separated from service if it is anticipated that his or her level of bona fide services (as either an employee or an independent contractor) is going to be permanently reduced to 20 percent or less of the average level of services performed over the immediately preceding 36 months (unless the deferred compensation plan in question defines "separation from service" by reference to some other level of reduction in services).

The Code Section 409A regulations provide guidance for determining when a separation from service occurs for employees and for independent contractors, which should be relied on only for purposes of Code Section 409A, and not for purposes of any other Code Section (e.g., for distributions from qualified plans). That is, whether or not the employee has a separation from service under 409A, a separate analysis must be made to determine the impact of a change in the employee's employment status (either from full time to part time, or from employee to independent contractor) under the employer's qualified plan. Also, careful attention also must be paid to whether an individual can be properly identified as an independent contractor (exempt form tax withholding) based on the factors outlined by the IRS. Otherwise, employers may be held liable for failing to withhold employment taxes for that worker.

III. Self-Correction Alternatives for 457(b) Plans

IRC 457(b)(6) provides: A plan which is established and maintained by [governmental employer] and which is administered in a manner which is inconsistent with the requirements of [457(b)] shall be treated as not meeting the requirements of such paragraph as of the 1st plan year beginning more than 180 days after the date of notification by the Secretary of the inconsistency unless the employer corrects the inconsistency before the 1st day of such plan year. EPCRS, Rev Proc 2013-12, sec. 4.09, allows some plan sponsors of 457(b) governmental plans, under limited circumstances, to submit requests for voluntary correction (VC) to IRS. Generally, self-correction under EPCRS is not available for a 457(b) plan of a non-governmental tax-exempt entity (although IRS may consider a submission for a non-governmental plan incorrectly covering NHCEs and operated as a qualified plan). On its website, IRS has clarified some details regarding the governmental 457(b) plan submissions. IRS has complete discretion to accept or reject correction requests. IRS will not process submissions for VC that involve the form of a written 457(b) plan document. Plan sponsors who want IRS to review their 457(b) plan document, or consider any other document form issue, may request a private letter ruling. A governmental 457(b) plan sponsor may submit a VC request for a non-plan document failure, but must acknowledge that it is aware of the self-correction rule in IRC 457(b)(6). Governmental plan sponsors should not make a submission to VC to voluntarily fix problems with their 457(b) plans, because of the self-correction permitted under IRC 457(b)(6). However, employers that sponsor 457(b) plans should review those plans' documents and compliance procedures carefully because the IRS has recently begun a nationwide field compliance review of these plans.

LABOR AND EMPLOYMENT LAW

I. EEO Update. Although the law surrounding equal employment opportunity in the workplace is fairly settled (for now), the cultural dynamics that could give rise to an EEO claim seem more turbulent in 2015 than in any year since the enactment of Title VII of the Civil Rights Act of 1964. The rapid expansion of marriage rights and employment laws protecting the LGBT community sometimes results in a clash with religious expression rights

available to employees under Title VII. In addition, the recent unrest in Baltimore revealed racial tensions that may spill over to the workplace and, if not addressed properly, could result in costly and potentially high-risk litigation. Thorough training remains a vital weapon when combatting EEO litigation.

II. Wage and Hour Updates.

A. Expansion of Maryland Wage Payment and Collection Law: On August 13, 2014, the Maryland Court of Appeals held in *Peters v. Early Healthcare Giver, Inc.*, that employees have a private right of action under the Maryland Wage Payment and Collection Law (MWPCL) for all overtime violations (including claims that an employee was misclassified as exempt). Prior to this ruling, Maryland federal courts and the Maryland intermediate appellate court had held that overtime claims could not be brought under the MWPCL, but rather, had to be brought under the Fair Labor Standards Act (FLSA) or the Maryland Wage and Hour Law (MW&HL). Because the MWPCL allows an award of up to treble damages (in contrast to the FLSA and MW&HL, which only allow for liquidated (double) damages), employers now face increased potential liability for overtime claims.

B. FLSA Classification of Loan Officers: As many employers in the banking industry are aware, the question of whether loan officers are exempt under the FLSA has been a volatile issue in the past several years. The DOL's historic interpretation was that loan officers generally *do* qualify for the administrative exemption. In 2010, the U.S. Department of Labor (DOL) reversed its position and issued an interpretation stating that mortgage loan officers generally *do not* qualify for the administrative exemption. The reversal was subsequently challenged because it was issued without notice and without providing the public the opportunity to comment. On March 9, 2015, the U.S. Supreme Court held that the DOL did not violate the Administrative Procedure Act by issuing the interpretation without public notice or comment. Now that the FLSA classification of loan officers is settled (at least until the DOL changes its mind again!) employers should review their job classifications to ensure that loan officers are properly classified.

C. Validity of Forum Selection Clauses in Wage Payment Disputes: Forum selection clauses allow the parties to an employment agreement to choose which state court and law will govern the agreement in the event of a future dispute. For example, a D.C.-based employer might enter into an employment agreement with a Maryland-domiciled employee stating that D.C. law will apply to the employment relationship. While Maryland courts have historically approved of forum selection clauses in employment agreements, it appears that the courts will take a less favorable approach in the future. In January of 2015, the Maryland Court of Appeals issued an opinion stating, in dicta, that Maryland's wage payment laws reflect a "strong public policy" of Maryland. Based on this reasoning, the Court urged Maryland courts to reject out-of-state forum selection clauses in future wage claims. *See Cunningham v. Feinberg*. Employers should be aware that their out-of-state forum selection clauses may not hold up against an employee with Maryland connections. Accordingly, there is an increased likelihood that out-of-state employers could be subject to treble damages for wage claims under Maryland's employee-friendly wage laws.

III. Pregnancy Discrimination.

A. EEOC Guidance on Pregnancy Discrimination. Last summer, the EEOC released long-awaited enforcement guidance regarding pregnancy discrimination and accommodation issues. While the EEOC's guidance is not the law, it does provide insight into how the EEOC (and, possibly, the courts) will enforce laws governing pregnancy discrimination. Three issues discussed in the EEOC's Guidance are of particular note:

1. "Future Pregnancy" Discrimination. According to the EEOC, an employee may place herself in a protected class based on pregnancy simply by declaring her intent to have children or to undergo infertility treatments. Employers must ensure that personnel decisions are not based on an employee's future availability or perceived commitment to work based on her intent to have children.

2. Light Duty Requirements. The EEOC took the position that pregnant employees with physical restrictions must be eligible for an accommodation (including light duty assignment) that is available to any other employee similar in his or her ability or inability to work. For example, if an employer provides light duty work as an accommodation to employees who suffered on-the-job injuries, the employer must also provide light duty work as an accommodation to a pregnant employee with physical restrictions. In *Young v. UPS*, the Supreme Court rejected this approach as overbroad, and held that an employer *may* deny an accommodation to a pregnant employee, even if it provides the same accommodation to another class of workers, *if* the employer has a legitimate, non-discriminatory reason for the distinction. The EEOC is currently revising this portion of its Guidance to come into line with the Supreme Court's ruling.

3. Reasonable Accommodation. Finally, the EEOC Guidance states that pregnant employees with physical restrictions must be provided the same types of reasonable accommodations offered to disabled non-pregnant employees. From a practical perspective, this guidance simply reinforces an employer's obligations under the Americans with Disabilities Act Amendments Act (ADAAA). That law greatly expanded the type of physical impairments that are considered a "disability" to include nearly all pregnancy-related physical impairments (including, for example, gestational diabetes and morning sickness).

B. Supreme Court Ruling Further Extends Employees' Rights. On March 26, 2015, the Supreme Court issued a decision in the case of *Young v. UPS*, extending the rights of pregnant employees in the workplace. In *Young*, the Supreme Court was asked to interpret a provision of the Pregnancy Discrimination Act ("PDA") requiring employers to treat women affected by pregnancy, childbirth or related medical conditions "the same for all employment-related purposes . . . as other persons not so affected but similar in their ability or inability to work." Young's employer, UPS, denied her request for a light-duty accommodation during her pregnancy. UPS explained that it denied the request because, in accordance with its collective bargaining agreement, it only provided light duty work assignments to drivers who: (1) were injured on the job; (2) suffered an ADA-qualified disability; or (3) lost their Department of Transportation certification. At the time, pregnancy-related impairments were not considered an ADA-qualified disability, and Young did not fall within any of these three categories. (As a result of the later-enacted Americans with Disabilities Amendments Act ("ADAAA"), pregnancy may be considered an ADA-qualified disability). Young sued her employer, arguing that UPS violated the PDA because it failed to provide the same accommodations to pregnant employees as it provided to non-pregnant employees similar in their inability to work.

The Court held that a pregnant employee may prove pregnancy discrimination by pointing to other non-pregnant employees who were similar in their ability and inability to work and were granted an accommodation. The Court adopted a balancing test under which the employee must do more than simply show that other employees received an accommodation. Under the test, if the employer has a legitimate, non-discriminatory reason for denying pregnant employees the accommodation, the employee must demonstrate that the employer's reason is simply a pretext for discrimination. The employee can show pretext by demonstrating that the employer's policies impose a significant burden on pregnant workers or that the reason for not accommodating pregnant employees is weak. In light of this decision, employers should evaluate their accommodation policies and how those policies are applied to pregnant employees.

IV. FMLA Update.

A. Extended FMLA Rights for Same-Sex Couples. On March 27, 2015, new regulations went into effect extending FMLA leave rights to same-sex couples based on the state of celebration. Previously, the FMLA regulations extended leave rights to same-sex spouses based on their state of residence. Employers must now recognize same-sex spouses for the purposes of the FMLA if the employee entered into the marriage in a state (or foreign country) where the same-sex marriage was legal. A federal court has issued a temporary injunction prohibiting the DOL from implementing these final regulations in Texas, Arkansas, Louisiana, and Nebraska. Despite this challenge to the regulations, the DOL has indicated that it intends to enforce the regulations in all other states. Employers should review their FMLA policies to ensure that they are in compliance with the new regulations.

B. Delivery of FMLA Notices. The FMLA requires employers to provide numerous notices to employees, but does not prescribe a delivery method. This past year, several courts addressed the issue of whether FMLA notices sent by first-class mail and e-mail were properly delivered. Under common law, there is a legal presumption called the "mailing rule" in which courts assume that a document addressed to the proper address and mailed by first-class mail will reach its destination within three mailing days. In August of 2014, the Third Circuit Court of Appeals (which has jurisdiction over Delaware, New Jersey, and Pennsylvania) held that the mailing rule does not apply in the FMLA context. The Court ruled that the presumption of delivery is merely rebuttable if the employer has no receipt or proof of delivery. In other words, if an employee says that she never received the FMLA paperwork (despite the fact that the employer has proof it was mailed to her), then the employee will get the chance to take her claim before a jury and have the jury decide who is telling the truth. Several months after the Third Circuit's decision, another federal court addressed a case where an FMLA notice had been e-mailed to an employee. The employee claimed that she had never received the notice. The employer produced the email, but the court refused to dismiss the claim, reasoning that "[t]he transmitting of an email, in the absence of any proof that the email had been opened and actually received, can only amount to proof of constructive notice."

In light of the trend by courts to allow employees to deny receipt of FMLA notices, employers should consider providing required FMLA notices and certification to employees in person and have employees sign a confirmation

of receipt. If in-person delivery is not feasible, send notices in a manner that allows for proof of receipt, such as courier delivery (e.g., Fed Ex) or by an email with return receipt voting buttons. If sending FMLA notices by emails, first ask employees to confirm that email communications are an acceptable means of communication.

V. New NLRB Developments.

A. "Quickie" Election Rule. Effective April 14, 2015, the NLRB's new "Quickie Election Rule" may dramatically reduce the time between the filing of a representation petition and an election to as little as 13 days. This decidedly pro-union rule also provides that (a) unions may file petitions electronically with the NLRB; (b) employers must post a Notice of Petition within two business days after the service of the Petition upon the Employer; and (c) if an employer wishes to challenge the appropriateness of a petitioned-for unit, the employer must file a Statement of Position within seven days after service of the Petition. Additionally, the information required in an *Excelsior* List has been expanded to include the employee's name, address, available personal cell and home telephone numbers and personal email addresses, work location, shift and job classification.

B. Employee Use of Employer Email System for Union Organizing. In the matter of *Purple Communications, Inc. and Communications Workers of America, AFL-CIO*, the NLRB ruled that employees who have been given access to an employer email system can use the system for union organizing during nonworking time, unless the employer can demonstrate (among other things) that all non-work use is prohibited.

C. Guidance Regarding Employee Handbooks. The NLRB continues to tighten its restrictions on employer policies that it perceives to in any way "chill" an employee's protected Section 7 activity (which includes any activity by an employee which seeks to improve pay and/or working conditions). Handbooks that reference behavior standards (e.g., rudeness, disrespect, courtesy, etc.) will be required to provide examples that make clear that those standards do not apply to an employee's Section 7 activity, nor do they prohibit an employee from expressing dissatisfaction regarding a supervisor. Similarly, guidelines pertaining to "confidential" information must also include examples that make it clear that such information does not include information pertaining to wages, hours of work, etc. It is imperative that employers recognize that the NLRB guidance on handbooks is not limited to unionized workforces, and that the Board has shown an increasing willingness to bring charges against employers when unions are not even on the distant horizon.

VI. New OSHA Reporting and Recordkeeping Rules.

A. Updates to OSHA's Reporting and Recordkeeping Rule. New OSHA regulations went into effect on January 1, 2015. The new regulations make changes to reporting and recordkeeping requirements. First, the regulations update the list of industries that are exempt from the requirement to routinely keep OSHA injury and illness records due to relatively low occupational injury and illness rates (although they retain the exemption for any establishment with ten or fewer employees, regardless of their industry classification). Second, the regulations expand the list of work-related injuries and illnesses that employers must report to OSHA.

1. Reporting requirements. The new rule requires all employers to report the following to OSHA (or the state equivalent): (1) all work-related fatalities must be reported within eight (8) hours of when the employer learns of the fatality; and (2) all work-related inpatient hospitalizations, all amputations, and all losses of an eye must be reported within twenty-four (24) hours of when the employer learns of the hospitalization, amputation, or loss of the eye. An inpatient hospitalization, amputation, or loss of an eye must only be reported to OSHA if it occurs within 24 hours of a work-related incident, and a fatality must only be reported if it occurs within 30 days of a work-related incident.

2. Recordkeeping requirements. The new rule provides an updated list of low-hazard industries that are exempt from routinely keeping OSHA injury and illness records. As a result of the update, about 200,000 employers that had been previously partially exempt will be newly required to keep OSHA injury records using the OSHA 300 log. Those industries include automobile dealers, liquor stores, bakeries, performing arts companies, museums, historical sites, and emergency and other relief services.

VII. Critical Government Contractor Updates.

A. Minimum Wage for Federal Contractors. On February 12, 2014, President Obama signed Executive Order 13658, authorizing an increase in the minimum wage to $10.10 for all workers on federal construction and service contracts. The U.S. Department of Labor (DOL) published the final rule on October 7, 2014. The final rule sets forth the standards for employee coverage; recordkeeping requirements; and the required rate of pay.

B. Equal Pay Report. On August 6, 2014, the DOL's Office of Federal Contract Compliance Programs (OFCCP) issued a Notice of Proposed Rulemaking (NPR). Under the NPR, each covered contractor would be required to submit a supplement to the EEO-1 form, called an "Equal Pay Report," containing wage and hour data for employees by race, sex, and ethnicity. The comment period ended on January 1, 2015, and the OFCCP is currently drafting a final rule.

C. VETS-4212 Form. In September of 2014, the DOL issued amendments to its reporting regulations, in which it eliminated the VETS-100 form and amended the VETS-100A form (now called the VETS-4212 form) to require reporting of veterans in the aggregate, rather than by the previously-required categories. Contractors must begin using the VETS-4212 form in the 2015 reporting cycle, which runs from August 1 – September 30, 2015.

D. Affirmative Action Plan Updates. There have been numerous recent changes to regulations that govern affirmative action plans (AAPs), which most federal contractors are required to adopt. The most important recent changes include:

1. Changes to Section 503 AAP Requirements (Women and Minorities). Effective March 24, 2014, the new regulations require contractors, to, among other things: (a) set a 7% utilization goal for individuals with disabilities; and (b) give applicants the opportunity to self-identify as an individual with a disability at both the pre- and post-offer stage of hiring.

2. Changes to VEVRAA AAP Requirements (Protected Veterans). Effective March 24, 2014, the new regulations require contractors to, among other things: (a) establish annual hiring benchmarks for protected veterans; and (b) list their job openings with a state employment service agency.

3. Sexual Orientation and Gender Identity Discrimination. All federal contracts newly entered into or modified after April 8, 2015 must include language prohibiting discrimination on the basis of sexual orientation and gender identity. Contractors will not be required to collect data from applicants or employees regarding sexual orientation or gender identity, and will not be required to engage in outreach activities targeting those groups. However, contractors are required to update their job ads and solicitations to add sexual orientation and gender identity to the list of bases on which discrimination is prohibited. Furthermore, contractors that choose to provide benefits to spouses must now provide the same benefits to employees in same-sex marriages as those in opposite-sex marriages. The regulations provide for only a narrow religious exemption.

E. Sex Discrimination Guidelines. On January 28, 2015, the OFCCP announced a Notice of Proposed Rulemaking to replace the current Sex Discrimination Guidelines for government contractors with updated regulations. According to the OFCCP, the revised regulations would include:

1. Clarification regarding discrimination based on gender-stereotypes about family caretaking responsibilities.

2. Clarification that leave for childcare must be provided to men on the same terms as to women.

3. Clarification regarding workplace accommodations that must be provided to women affected by pregnancy, childbirth, and related medical conditions.

4. Clarification that unlawful compensation discrimination can result from job segregation or classification on the basis of gender, not just unequal pay for equal work.

5. Confirmation that contractors must provide equal benefits and equal contributions for male and female employees participating in fringe-benefit plans.

6. Expanded discussion of sexual harassment that includes both quid pro quo and hostile work environment harassment and discussion of best practices to eliminate sexual harassment.

7. Clarification that unlawful sex discrimination includes adverse treatment because an employee does not conform to gender norms and expectation about his or her appearance, attire, and/or behavior.

8. Clarification that unlawful sex discrimination includes discrimination against an individual because of his or her gender identity.

VIII. Marijuana in the Workplace. It is hard to imagine a more difficult workplace challenge than dealing with an applicant's or employee's alcohol or drug abuse. Substance abuse by employees results in higher health care expenses for injuries and illnesses, higher rates of absenteeism, higher turnover, reductions in job productivity and performance, more workers' compensation and disability claims; and safety and other risks for employers. Thus, it is critical that employers know how to assess and address possible substance abuse, in order to both maintain productivity and keep the workplace safe. In 2012, Colorado and Washington were the first two states in the nation to legalize recreational marijuana. On April 14, 2014, Governor O'Malley signed a bill de-criminalizing the possession of small amounts of marijuana in Maryland. To date, twenty-three states (including Maryland) and the District of Columbia allow for medical marijuana. The changes in the law regarding the legality of marijuana have led to confusion among employers, who are unsure how the new laws interact with employers' general obligations under the ADA, FMLA, and other laws. Workplace substance abuse raises complex legal issues concerning background checks, privacy rights, disability discrimination, and workplace safety. These issues have become more complicated with recent decriminalization/legalization laws concerning marijuana, as well as the controversies associated with medical marijuana.

A. Status of Marijuana Laws in Maryland. Governor O'Malley signed legislation to de-criminalize small amounts of marijuana on April 14, 2014. The "de-criminalization" means that the possession of small amounts of marijuana is ***not legal***, but neither will it be treated as a criminal offense (i.e., it will be treated similar to traffic violations). Effective October 1, 2014, the law imposes civil fines – not criminal penalties or possible jail time – on individuals possessing less than 10 grams of marijuana. Fines are up to $100 for the first offense, up to $250 for the second offense, and up to $500 for a third offense. Individuals under the age of 21 and individuals with a third offense or more may be referred by the court to substance abuse education, assessment for a substance abuse disorder and, if necessary, treatment.

B. Status of Marijuana Laws in D.C. In November of 2014, D.C. voters approved Initiative 71, which legalized the limited possession and cultivation of small amounts of marijuana by adults age 21 and older. The law went into effect on February 26, 2015. In December of 2014, D.C. enacted the Pre-Employment Marijuana Testing Temporary and Emergency Acts of 2014. The law prohibited employers from testing a job applicant for marijuana use until the employer has first extended a conditional offer of employment (unless otherwise required by law). The emergency version of the law went into effect immediately but expired when additional required action was not taken. The D.C. Council has since advanced new legislation that would prohibit employers from pre-employment marijuana testing. The D.C. Chamber of Commerce has stated that it will not oppose the legislation as long as employers could continue to require drug testing after making a conditional offer of employment.

C. Status of Marijuana Laws in Virginia. Virginia law currently provides for a very narrow affirmative defense to patients who, in limited circumstances, use a marijuana extract for medicinal purposes. There are currently no state laws that legalize or de-criminalize marijuana or prevent employers from continuing their drug-testing practices. However, public opinion polls show that there may be public support for de-criminalizing small amounts of marijuana, and employers should continue to follow this volatile legislative topic.

IX. Maryland Update.

A. Ban-the-Box Laws. Effective January 1, 2015, employers that conduct business in Prince George's and Montgomery County, Maryland are barred by county law from asking about the criminal history of applicants on employment applications.

B. Law Prohibiting Discrimination Based on Gender Identity. In March of 2014, Governor O'Malley signed the "Fairness for All Marylanders Act," which protects transgender individuals from discrimination in employment. The law went into effect on October 1, 2014.

C. Parental Leave Law. The Maryland Parental Leave Act went into effect on October 1, 2014. The law requires employers who employ between 15 and 49 employees in Maryland to provide up to six weeks of unpaid leave to eligible employees during any 12-month period for the birth of the employee's child or the placement of a child for adoption or foster care. Eligible employees are those who have been employed by the employer for at least 12 months and have worked 1,250 hours prior to the start of the leave. Additionally, the employee must be employed at a work location in Maryland at which at least 15 employees work within a 75-mile radius in Maryland. An employer may deny requested leave only if the denial is necessary to prevent "substantial and grievous economic injury" to its operations, provided that the employer notifies the employee of the denial before the leave begins.

X. D.C. Update.

A. D.C. Wage Theft Prevention Act. Effective February 26, 2015, D.C. employers are required to comply with the D.C. Wage Theft Prevention Act. The law requires detailed disclosure of pay information to employees and imposes penalties on employers that fail to comply.

1. Among other requirements, employers must

a. Issue a Pay Notice. D.C. employers must distribute a written "pay notice" to each employee containing the terms of employment. The pay notice must be signed and dated by both the employer and employee. For current employees first employed prior to February 26, 2015, the notice must be provided by May 27, 2015; for all new employees, the notice must be provided at the time of hire. The pay notice must be updated whenever required information (such as the applicable wage) changes. The notice must contain information including: the name of the employer; any "doing business as" names used by the employer; the employer's contact information; the employee's pay information (including the rate of pay and basis for the rate); and the regular pay day. Employers are required to provide the notice in the same form as the sample template made available by the Mayor's Office.

b. Post a Notice. Covered employers must post a government notice summarizing the law.

c. Keep Detailed Records. Covered employers must keep records for three years of the "precise time worked for employees covered by the D.C. Wage Payment and Wage Collection Law who are not exempt from minimum wage and overtime requirements. The law does not define "precise time worked," but commentators believe that it will be interpreted to mean that, for example, instead of recording "8 hours worked," the employer would be required to record the employee's exact start time, the beginning and end time of any unpaid break, and the employee's exact end time.

2. The law creates an administrative complaint and hearing process, but also allows employees to forego the administrative process and bring a civil action. The law increases the civil and criminal penalties available for violations of the law. "Willful" violators may be barred from obtaining a D.C. business license for a 3-year period.

3. Class Claims. The law also contains a provision that lowers the bar to class claims. Generally, class action rules require the proposed class to demonstrate the typicality and commonality of their claims. The law reduces these requirements and allows an employee to pursue an "opt out" class claim as opposed to an "opt in" claim.

B. D.C. Wage Transparency Act. Effective March 11, 2015, the D.C. Wage Transparency Act makes it unlawful for employers to prohibit employees from discussing their wages with each other and also prohibits employer retaliation against employees who choose to discuss their wages or who file a complaint, testify, or participate in an investigation related to a violation of the Act. The Act does not create a private cause of action, but does provide for fines up to $20,000, depending on whether the employer is a repeat offender.

C. D.C. Pregnancy Accommodation Law. Effective March 3, 2015, the Protecting Pregnant Workers Fairness Act requires D.C. employers to provide reasonable accommodations to employees and job applicants whose ability to perform their job is affected by pregnancy, childbirth, breastfeeding, or related medical conditions. The law also prohibits employers from discriminating or retaliating against a pregnant employee or job applicant who requires accommodations; forcing a pregnant employee to accept an unneeded accommodation; or requiring the employee to use leave if other accommodations are available. An employer may, however, refuse to provide an accommodation if it would create an undue hardship. The employer must post a notice of rights under this law; provide written notice to current and new employees; and provide an additional written notice to any employee who notifies the employer of her pregnancy or related medical condition, within ten days of the notification.

XI. A Look into the Future.

A. Legislative Push for Paid Sick Leave. Both federal and state governments have recently pushed for mandated paid sick leave for employees. In January, President Obama urged Congress to pass the Healthy Families Act, which would require all employers to provide some level of paid sick leave benefits to their employees. While it appears unlikely that the law would pass in the current congressional environment, employers should be aware of the potential impact. In the absence of a federal law, individual states have begun to fill the gap. In Maryland, legislators have proposed a paid sick leave law, SB40, which would apply to employers with nine or more employees and would allow employees to earn up to seven (7) days of paid sick leave each year. While paid sick leave laws are

expected to have the most financial impact on small employers, large employers are also impacted by this trend. For example, multi-state employers must now ensure that their sick leave and paid time off (PTO) policies comply with a number of conflicting state law requirements.

B. DOL Plans to Issue Proposed Revisions to FLSA White Collar Exemptions. As we reported in last year's Clients & Friends Seminar, on March 13, 2014 the President directed the Secretary of Labor, Thomas Perez, to "modernize and streamline" the DOL's "white collar" overtime exemption regulations. Secretary Perez has indicated that he expects the regulations to be released sometime this spring. Although it is hard to predict what the final changes to the current regulations will be, the focus appears to be on the following three issues.

1. Minimum salary level: The proposed regulations will increase the minimum salary level for white collar exempt employees. It is likely that the DOL will tie any increase to inflation indexes. Additionally, the highly compensated test for employees earning over $100,000 per year may be increased or eliminated altogether.

2. Duties test. The DOL will most likely remove or significantly revise the "concurrent duties" section under the executive exemption test, which provides an exemption to managers even if they are simultaneously performing the same duties as their subordinates. The DOL may replace the "primary duty" test under all of the exemptions with a quantitative test that requires an exempt manager to spend more than 50% of his time supervising employees.

3. Computer professional exemption. It is likely the DOL will further clarify the duties and positions that do – and do not – qualify for the computer professional exemption under the FLSA. However, the DOL could face a legal challenge if it attempts to narrow the computer employee exemption because the duties test for this exemption is set forth in the statutory provisions of the FLSA. In 2004, the DOL opined that it does not have authority to depart from the statutory definition of an exempt computer employee.

All revisions to the regulations must go through notice and comment rulemaking. Once proposed regulations are prepared, the DOL will publish a notice of proposed rulemaking, giving the public between 30 and 90 days to file comments. After the close of the comment period, the DOL reviews and responds to comments before publishing final regulations.

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A 2015 COMPLIANCE CHECKLIST FOR HEALTH AND WELFARE PLANS

The following are some important 2015 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. Review plan documents, SPDs and other communications to be sure there are no conflicts among these documents, in light of CIGNA v. Amara and its progeny.

___2. Confirm procedures in place for required Forms 1094/1095 reporting.

___3. Identify any controlled group/ASG/leased employee/predecessor employee situations, and independent contractor/contingent worker/temporary employee issues.

___4. Confirm wellness program compliance with latest guidance/EEOC developments.

___5. Confirm compliance with all applicable ACA obligations to date, and prepare for future changes. (Note the numerous, and often onerous, penalties for non-compliance.)

___6. Confirm especially compliance with 30-hour employee determination rules/change of status rules.

___7. Ensure compliance with any Form 8928 reporting obligations.

___8. Consider document and operational compliance with same-sex marriage and related rules, and related issues.

___9. Determine HFSA grace period, run-out period and carryover rule positions.

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

___11. Ensure amendment/termination rights reserved in retiree health plans.

___12. Ensure compliance with electronic distribution rules.

___13. Ensure that any "voluntary benefits" are truly ERISA-exempt.

___14. Begin planning for ACA Cadillac tax.

___15. Ensure compliance with new SBC rules.

___16. Consider recent guidance on opt-outs, benefit dollars, no-benefit employees, contractor cash-in-lieu, etc.

___17. Eliminate non-compliant health reimbursement plans.

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A 2015 COMPLIANCE CHECKLIST FOR QUALIFIED RETIREMENT PLANS

The following are some important 2015 compliance tasks for sponsors of qualified retirement plans. (Naturally, this Checklist is not meant to provide a comprehensive list of all compliance requirements.)

___1. Ensure compliance of cash balance/hybrid plans with most current regulations.

___2. Ensure ongoing compliance of frozen or closed defined benefit pension plans.

___3. Review procedures against fiduciary best practices standard.

___4. Review plan documents, SPDs and other communications to be sure there are no conflicts among these documents, in light of CIGNA v. Amara and its progeny.

___5. Review the plan's hardship documents and procedures (if applicable).

___6. Review and document, on a regular basis, all participant-directed retirement plans' compliance with the 404(c), QDIA and fee disclosure requirements.

___7. Consider de-risking strategies for defined benefit pension plans.

___8. If 401(k) ADP and/or ACP challenges, or 403(b) ACP challenges, consider an auto-enrollment feature.

___9. If appropriate, consider whether a defined benefit pension plan is desired, either in lieu of or in addition to a defined contribution plan.

___10. Consider plan design features that focus employer retirement plan budgets on key performers.

___11. Consider a self-diagnostic to determine if qualified retirement and 403(b) plans are in full compliance with all applicable requirements. If any operational or document failures are discovered, consider correction programs (IRS and DOL) for bringing the plan back into full compliance, especially the expanded EPCRS program and the options for employers that remit employee contributions late. Use this process to anticipate increased likelihood of DOL and IRS qualified retirement and 403(b) plan audits.

___12. Defined benefit plans should ensure compliance with final funding notice rules.

___13. If applicable, consider developments in "governmental plan" and "church plan" definitions.

___14. Confirm compliance with DOL position on revenue sharing proceeds/ERISA spending accounts.

___15. Review guidance and procedures on lost participants, plan floats, uncashed checks.

___16. Ensure compliance with electronic distribution rules.

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A 2015 COMPLIANCE CHECKLIST FOR EXECUTIVE COMPENSATION PLANS

The following are some important 2015 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 "amnesty" program.

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

___ 4. Consider offering executives voluntary deferred compensation and/or phantom stock/stock appreciation plans.

___ 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 2015 LABOR AND EMPLOYMENT LAW COMPLIANCE CHECKLIST

The following are some important 2015 compliance tasks concerning labor and employment laws. (Naturally, this checklist is not meant to provide a comprehensive list of all compliance requirements.)

____1. Ensure that appropriate jurisdiction-specific protections relating to gender identity and expression and other protected classifications are in place.

____2. Provide training to supervisors regarding EEO and related laws.

____3. Audit FLSA classifications of all exempt employees.

____4. Audit pregnancy-related leave and accommodation practices and procedures.

____5. Update FMLA policy to include same-sex married couples.

____6. Audit FMLA paperwork procedures to ensure that deliveries are verifiable.

____7. Have a union election plan/campaign in place.

____8. Audit handbooks to ensure compliance with new NLRB Guidance on handbooks.

____9. Update OSHA reporting and recordkeeping practices and procedures.

____10. Federal Contractors: Audit compliance with new minimum wage and recordkeeping requirements.

____11. Federal Contractors: Audit policies to ensure compliance with the new VETS-4212 Form.

____12. Federal Contractors: Update Affirmative Action Plans to ensure compliance with new requirements.

____13. Federal Contractors: Update ads to include sexual orientation, gender identification as protected classes and provide benefits to employees in same-sex marriages on the same basis as to employees in heterosexual marriages.

____14. Federal Contractors: Stay current on status of rules re: Equal Pay Report, Sex Discrimination Guidelines.

____15. Update employment applications to ensure compliance with local Maryland ban-the-box laws.

____16. Update policies and procedures to ensure compliance with the Maryland Parental Leave Law.

____17. Ensure compliance with the D.C. Wage Theft Prevention Act, including issuing pay notices to each employee by May 27, 2015 and posting notices.

____18. Update policies and procedures to ensure compliance with the D.C. Wage Transparency Act.

____19. Update policies and procedures re: accommodations to ensure compliance with D.C. PAL.

____20. Stay current on status of anticipated changes involving sick leave laws, revisions to FLSA exemptions.