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BENEFIT PLAN DEVELOPMENTS AFFECTING PHYSICIAN PRACTICES

[This outline is not legal advice for any particular situation, but merely is a starting point for further discussion.]

I. Employer Medical Reimbursement Plans. IRS guidance prohibits: (1) an employer's reimbursement of individual health insurance premiums (on a pre-tax or after-tax basis); and (2) an employer's direct payment of individual health insurance premiums (on a pre-tax or after-tax basis). Note that there is an exception for a retiree-only Medicare premium reimbursement arrangement. Of course, an employer may provide taxable pay increases to employees that may be used by those employees to buy individual health insurance coverage, but the increases must be provided unconditionally and not in any way tied to the purchase of that coverage. In addition, the regulators have stated that "Health Reimbursement Arrangements" – programs under which employers reimburse employees for medical expenses they incur – violate the Affordable Care Act requirements that a group health plan have no annual limit on benefits and that it provide certain preventive care free of charge. However, under a regulatory exception, if the HRA is "integrated" with other health coverage meeting the ACA requirements, it is permissible. (Note that these rules do not apply to an HRA that reimburses only "excepted benefits" or that benefits "fewer than two active employees" (e.g. a retiree-only HRAs). Certain other exceptions existed that all expired by the end of 2015.

II. Relaxed Guidance for Opt-out Payments, SCA Cash-in-Lieu Payments, and the Like.

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

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

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

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

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

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

found themselves struggling to comply with the regulators' position.

C. Recommendations. Employers that currently utilize any of these features – or that are contemplating utilizing them – and that could face ACA affordability problems under the IRS world view should study the details of the temporary relief and monitor the expected future guidance.

III. The ACA Lookback Rules In General. (If you have questions on the infrequently used monthly measurement period rules, the special rules for educational organizations, or any other special rules please feel free to contact us.)

A. Plan Eligibility in General. A plan does not need to use either the monthly or lookback measurement period rules to define an eligible employee. A plan that does opt to use these rules for eligibility can either use them exclusively or add them to the plan's current provisions. Their use can be restricted to benefits subject to the ACA.

B. Identifying FTEs for IRS Reporting. Every plan subject to the ACA must use these measurement period rules for identifying "full-time employees" for IRS reporting purposes. An employer is not free to substitute its own definition(s) for that purpose.

C. Lookback Measurement Period/Ongoing Employees. A lookback measurement period is most commonly 12 months, ending prior to the first day of the associated stability period. In between, there can be an administrative period of at most 90 days.

D. Pay Periods. For employees paid on a weekly, biweekly or semi-monthly basis, if hours are tracked on a pay period basis, rather than a daily basis, hours during a measurement period can be counted from the start of the first payroll period that ends within the measurement period through the last day of the last payroll period that ends within the measurement period.

E. Classifications. IRS regulations limit an employer's flexibility with respect to determining which categories of employees can be treated differently. Acceptable classifications include salaried/hourly, employees whose principal places of employment are in different states, union/nonunion, and union/union.

F. Stability Period/Ongoing Employees. An employee who is determined to be a full-time employee based on the lookback measurement period must be offered coverage for the entire associated stability period. The stability period must be defined in terms of calendar months.

G. New Employees Expected to be Full-Time. A new employee who is reasonably expected to be full-time and is not a seasonal employee must be permitted to elect coverage. Because of the nondiscrimination rules, most plans will want to use the plan's existing entry date for these employees. With the exception of seasonal employees, the employer cannot take into account the fact that a given employee's termination date is predetermined so be cautious in excluding "temporary employees".

H. New Variable Hour Employees/Initial Measurement Period. The new employee initial measurement period can be up to one month shorter than the measurement period for ongoing employees and can start on the employee's start date or the first day of the following month (or any date in between) and can be followed by an administrative period. The administrative period can't exceed 90 days, the initial measurement period can't exceed 12 months, and the combined length of both cannot extend beyond the last day of the first calendar month beginning on or after the employee's first anniversary.

I. New Variable Hour Employees/Initial Stability Period. The initial stability period begins the day after the initial administrative period ends. Typically the initial stability period is 12 months although the transition rules (from new employee to ongoing employee) may require that a new employee be treated as full-time (or not full-time) for a longer period.

J. Transitioning from New Employee to Ongoing Employee. Once a new variable hour employee (including a seasonal employee) has been employed for one full standard measurement period the employer must test him/her for full-time employee status, beginning with that standard measurement period.

K. Rehired Employees. A former employee who has not had an hour of service for at least 13 consecutive weeks can be treated as a new employee upon rehire.

L. Calculating FTE Status. An employee is an FTE if he or she averages 30 hours per week (or 130 hours per month) during the applicable measurement period. Certain leaves of absence are ignored. Employees for whom hours' records are not available generally must have hours calculated under one of the acceptable equivalency methods.

M. Recommendations. This summary is highly simplified. We recommend reviewing the plan's current documents and administration to make sure they are compliant and asking questions whenever a given situation arises for the first time.

IV. Changes in Employment Status and Special Employee Categories (e.g., Seasonal, On-Call, Leased, Etc.) Under the ACA Lookback Rules

A. Changes in Employment Status. In general, under the lookback measurement period rules, an employer is required to treat an employee who is determined to be a full-time employee (i.e., expected to work, on average, at least 30 hours per week) during a measurement period as a full-time employee during the entire following stability period. However, special rules may apply when an employee moves from full-time to part-time status or vice versa. If a new part-time employee moves into a full-time position during the initial measurement period, the employer generally is required to offer employer mandate-compliant coverage as of the first day of the fourth full calendar month following the change in status. If an employee is hired as full-time (i.e., expected to work, on average, at least 30 hours per week), then the employee generally must be offered employer mandate-compliant coverage by the 91st day of employment. For each month thereafter, the employee must be offered employer mandate-compliant coverage if the employee averages at least 30 hours per week during the particular month until the employee has completed one full standard measurement period. Once an employee is an ongoing employee for purposes of the lookback measurement period rules, his or her status as a full-time employee is locked in for the corresponding stability period regardless of whether the employee has a change in status during that stability period. However, under an optional rule, an employer may cease offering employer mandate-compliant coverage to an employee following his or her change to part-time status, provided certain requirements are satisfied.

B. Seasonal Employees. A seasonal employee is defined as an employee who is hired into a position for which the customary annual employment is six months or less. Employers can track seasonal employees' hours over an initial measurement period, even if the seasonal employee is expected to work full-time (but only for the season).

C. On-Call Hours. Until specific guidance is issued, employers of employees who have on-call hours are required to use a reasonable method for crediting hours of service.

D. Leased Employees. In determining who is a full-time employee of an employer under the ACA rules, the IRS has indicated that it intends to use a fact-based "common law" definition of employee. An employer who has authority over workers hired through a temporary staffing agency is at risk of having those workers characterized as the employer's employees for purposes of the employer mandate rules. However, there is an option under the ACA that allows employers to "take credit" for an offer of health insurance by a temporary staffing agency, provided certain requirements are satisfied.

E. Recommendations. Employers should evaluate and develop appropriate policies and procedures for handling changes in employment status, and confirm that the eligibility provisions contained in their plan documents correspond to the change in employment status rules. In addition, for those certain categories of employees whose hours of service are challenging to identify and track, employers should review their policies and procedures on counting and tracking those hours to evaluate whether those policies and procedures are reasonable under current guidance.

V. COBRA and the ACA; Administering COBRA Under the Lookback Rules and Reporting COBRA.

A. COBRA and Lookback Measurement Periods. The ACA did not modify COBRA requirements, but it has a number of indirect effects on COBRA administration. For employers that use the lookback measurement periods to satisfy the employer mandate, one issue raised by the measurement period rules is whether COBRA must be offered when an employee ceases to be eligible for health coverage at the end of a stability period. Generally, that would be a loss of coverage because of a reduction in hours, which would trigger the obligation to offer COBRA at the end of the current stability period. Also, before the employer mandate rules became effective, if a full-time employee who is eligible for health coverage, moves to part-time status working 20 hours per week, and was no longer eligible for coverage (or was required to pay more for coverage than as a full-time employee), that employee previously would

have been offered COBRA based on a loss of eligibility due to a reduction in hours. For employers that use the lookback measurement period rules, the COBRA analysis is now a bit more complicated because that employee may still be eligible for coverage for the remainder of the current stability period (and maybe the next one), but if the employee continues to work 20 hours per week, the employee will eventually cease to be eligible under those rules as well, so a reduction in hours likely will still lead to a loss of eligibility for coverage at some point, which may be many months later. There is no detailed guidance from the regulators about when the COBRA event occurs in such cases, so more than one approach may be acceptable for now. Of course, employers should have uniform policies for offering COBRA in such cases and should make sure their plan documents and COBRA administration is consistent with those policies (and any applicable guidance).

B. Reporting COBRA Coverage. There are special rules for reporting COBRA coverage for purposes of IRS Forms 1095 and 1094. Generally, if a current employee is offered COBRA coverage (e.g., because of a reduction in hours), that is considered an offer of coverage for reporting purposes. Of course, if the coverage is offered at full COBRA rates, it may not be affordable. For former employees, an offer of COBRA is not considered an offer of coverage for reporting purposes. For the year in which the employee terminates employment, Code 1H generally should be entered on Line 14 of the 1095-C for any month when the former employee was offered COBRA. For any later year when the employee was not employed and was not enrolled in COBRA, there would be no need to complete a 1095-C.

VI. Cadillac Tax Delay Update. The ACA imposes on a "Cadillac plan" an excise tax in the amount of 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). The non-deductible tax that was originally to be effective in 2018 has been delayed by two years and the tax is now scheduled to be deductible for certain employers subject to the tax. The delay will also impact the dollar limits noted above as the dollar limits are designed to be indexed for years after 2018. While rumblings remain about the potential repeal of the Cadillac tax, at this point, it seems likely that the tax will be further modified before it is effective. Despite the delay in the effective date, employers should continue to monitor the guidance and be mindful of the potential impact of the Cadillac Tax on their health insurance plans and whether design and/or benefit changes might be needed in the future to avoid/minimize the tax.

VII. Recent DOL Audit Activity. The DOL has increased substantially the number and scope of compliance audits of health and welfare plans, focusing on issues ranging from ERISA, HIPAA, COBRA, ACA, etc.. The DOL's initial audit requests often contain pages and pages of detailed questions about the plan's document and operational compliance with various statutory and regulatory requirements. (In some cases, the DOL skips the document/information "requests" and instead issues a "subpoena" for the relevant documents and information.) Common causes of DOL audits include, but are not limited to, (i) participant complaints, (ii) Form 5500 Annual Report filing errors and failures, (iii) referrals from other agencies, and (iv) the DOL's review of industry publications. Naturally, if the DOL finds a violation of applicable law, an employer could not only face penalties imposed by the DOL, but the employer could also potentially be subject to an enforcement action by another agency (because of the regulators' policy of referring violations to other agencies). As a result, it is very important that employers review their plan documents, SPDs, administrative forms, etc. to ensure compliance (and to avoid potential penalties). In addition, employers should review their operational compliance with the applicable rules of ERISA and the like. Employers should conduct an internal self-diagnostic to determine the compliance of their health and welfare plans before the DOL comes calling.

VIII. ACA Reporting Obligations for Employers. Under the ACA, the following new reporting obligations are imposed on employers with group health plans under Code Sections 6055 and 6056:

A. "Small" Employers. If an employer did not employ at least 50 full-time employees, counting its full-time employee equivalents, during the preceding calendar year, the employer does not have any ACA reporting obligations unless the employer has a self-funded health plan. If a "small" employer has a self-funded health plan, the employer must issue a Form 1095-B to each covered employee and to certain covered non-employees (e.g., retirees). In addition, "small" employers with self-funded health plans must file the Forms 1095-B, along with a transmittal Form – Form 1094-B – with the IRS.

B. "Large" Employers. If an employer employed at least 50 full-time employees, counting its full-time employee equivalents, during the preceding calendar year, the employer must issue a Form 1095-C to each "full-time" employee (as defined in the employer mandate guidance), regardless of whether (i) the employer has a fully insured or self-funded health plan and/or (ii) a full-time employee had coverage under the employer's group health plan. If the employer has a self-funded health plan, Part III of the Form 1095-C must be completed. In addition, the employer must file Forms 1095-C, along with a transmittal Form – Form 1094-C – with the IRS.

C. Deadlines. Generally, the Forms 1095-B and 1095-Cs must be provided to employees no later than January 31st of each year. In addition, the Forms must be filed with the IRS, along with the applicable transmittal Form, no later than February 28th unless the Forms are being filed electronically, in which case the Forms must be filed with the IRS no later than March 31st. If an employer fails to timely provide the Forms to employees or timely file the Forms with the IRS, penalties may apply. For Forms filed in 2016 (for the 2015 year) only, special extended deadlines apply. That is, the Forms 1095-B (for "small" self-funded employers) and 1095-Cs (for "large" employers with fully insured or self-funded plans) must have been provided to employees no later than March 31, 2016. The applicable Forms must generally be filed with the IRS by May 31, 2016 unless the employer is filing electronically, in which case the deadline is June 30, 2016.

D. Recommendations. Note that the codes used on the applicable Forms are not intuitive. To the extent that a material mistake is made, an employer should consider issuing and filing amended Forms. Employers should also be certain to provide the Forms to employees and file with the IRS by the applicable deadlines. If the Forms are provided and/or filed late, an employer should attempt to limit penalties by satisfying the reporting requirements as soon as possible. Finally, the determination of whether an employer is "small" or "large" for purposes of the ACA reporting requirements takes into account whether the employer is a member of a controlled group or affiliated service group so employers should make certain that they are aware of their controlled group and affiliated service group status.

IX. Same-Sex Spouses; Civil Unions; Domestic Partners; Etc. Health Benefits.

Notwithstanding the positions being taken by isolated public servants in the American South, all individuals in the United States may marry their loved ones regardless of the gender(s) of the spouses, and the employee benefit and executive compensation laws of the United States treat married individuals as married regardless of the spouses' gender(s). Now that significant time has passed since the Supreme Court's landmark decision, many employers have revisited benefit plan provisions that provide coverage to employees' civil union partners, domestic partners, and the like, simplifying their plans and communicating to their employees that only spouse coverage will be provided going forward. One caution: for employers that oppose same-sex marriage on some personal grounds and therefore do not offer benefit plan rights to same-sex spouses, the first Title VII plaintiffs' cases have been filed (as we predicted in our early advice on this development). Employers should consider their benefit plan provisions impacting the same-sex question and consult with counsel about any concerns.

X. DOL and IRS Electronic Delivery Rules. 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. Other agencies, such as the Department of Health and Human Services and the Centers for Medicare and Medicaid Services, impose a separate set of requirements that apply to certain employee benefit plans and the requirements for electronic delivery of notices required by those agencies may be different. Employers should review any electronic delivery processes being used by the employer or its vendors to confirm they comply with the most recent regulatory requirements.

XI. The New DOL Fiduciary Rule, Including Impact on HSAs, ESAs and IRAs.

A. Background. On April 8, the DOL issued long awaited/feared final regulations defining "fiduciary" for retirement plan, Health Savings Account, Education Savings Account and IRA purposes and creating a new Best Interest Contract exemption that, if complied with, permits these fiduciaries to continue to be paid. The regulations were the culmination of a years-long process and are expected to have a significant real world impact on the financial services industry.

B. The Fiduciary Definition. In very general terms, the regulations define a fiduciary as anyone who, for direct or indirect compensation, advises on retirement plan, HSA, ESA or IRA investments, policies or procedures, rollovers, transfers, distributions and the like (including the investment of property distributed from a plan, HSA, ESA or an IRA).

C. Primary Impact. The new fiduciary definition applies in the ERISA retirement plan, HSA, ESA and IRA settings, so new fiduciaries of HSAs, ESAs and IRAs will be held to the fiduciary and prohibited transaction rules

with which ERISA plan fiduciaries are familiar (e.g., prudent expert, no self-dealing, no conflicts of interest, no third party compensation or compensation based on investments selected without qualifying for a specific exemption, best interest of client, and the like).

D. The "BIC" Exemption. To enable these new fiduciaries to continue to receive compensation based on investments selected and third party compensation, the DOL issued a new Best Interest Contract exemption from the fiduciary prohibit transaction rules. That's the good news. The bad news is that the requirements that must be met to enjoy the BIC exemption are many and arguably challenging.

E. Recommendations. Before April 10, 2017, all investment and advisory professionals who work with retirement plans, IRAs, HSAs, ESAs or their participants and owners will need to review these new rules in detail with their attorneys and determine what steps need to be taken to enable them to continue operate lawfully in these settings. Employers likely will receive new service agreements and disclosures from their financial advisors that they will want to review with ERISA counsel.

XII. Health and Welfare Plan Nondiscrimination Rules. Historically, only self-funded employer sponsored health coverage has been subject to nondiscrimination rules (although pre-tax contributions to any plan are subject to the nondiscrimination rules found in IRC Section 125). Congress' last attempt to apply nondiscrimination rules to insured medical coverage (the infamous "Section 89") went down in flames. The rules that apply to self-funded health plans are found in IRC Section 105(h). The regulations under that section are not well understood, somewhat dated (more than 20 years old), and unevenly enforced.

As part of the ACA, Congress instructed the IRS to write rules similar to 105(h) and apply them to non-grandfathered insured plans. Standalone retiree plans are also exempt as are limited scope dental and vision plans. The rules were to have been effective for plan years beginning on or after September 23, 2010. The penalties for insured plans that fail the new test is an excise tax equal to $100 multiplied by the number of employees discriminated against and the number of days the plan does not comply and the plan is subject to a civil action to compel it to provide nondiscriminatory benefits. The excise tax is capped at the lesser of $500,000 or 10% of the employer's health care expenses for the prior year. The employer must self-report and pay the excise tax using Form 8928. We await guidance on exactly how the excise tax will be calculated but it's obviously serious money.

The IRS has suspended enforcement of the new nondiscrimination rules until it releases regulations. They recently confirmed that the suspension is still in effect. There are many possibilities for those new rules. The IRS could do anything from simply saying the existing self-funded plan rules apply to insured plans to completely scrapping the existing rules and starting fresh.

What can you do while you wait for IRS regulations?

1. If you are relying on the grandfathering exception, make sure you protect your grandfather.
2. If you are relying on the standalone retiree medical plan exception, make sure you really have a standalone retiree medical plan.
3. If you are relying on dental or vision coverage being an "excepted benefit", make sure it really is.
4. Start to plan what to do about coverage that will almost certainly not survive such as executive only coverage and many salaried only plans. To start thinking about that, you may want to understand how the test for self-funded plans works.

The 105(h) nondiscrimination test for self-funded plans:

1. Like all nondiscrimination tests, this test looks at the entire controlled group/affiliated service group. So you need to know which entities have to be aggregated for testing purposes. Hopefully if you have a 401(k) plan this analysis has already been done. Of course you also need that information to determine which entities have to be aggregated for 125 nondiscrimination testing and determining which entities have to be aggregated for health care reform. If that analysis has never been done, now's the time!

2. Also like all nondiscrimination tests, certain employees are excludable. Excludable employees can just be ignored (whether they can be ignored if they are covered under the plan is one of those questions that we would hope the regulations would clarify). For example, under 105(h) employees who regularly work less than 25 hours per week are excludable. That means employees who work 26 hours are not excludable even if you label them "part-time."

3. After you remove excludable employees, you split the remaining employees into 2 groups. The first group is made up of "highly compensated individuals" which are the 5 highest paid officers, more than 10% shareholders and the top 25% of all employees ranked by pay. "Non-highly compensated individuals" are everyone else.

4. The next step is to test eligibility. The eligibility test looks at whether the plan covers enough non-highly compensated individuals to justify the number of highly compensated individuals that are covered. You never have to cover everyone to pass the nondiscrimination test.

5. If the plan passes the eligibility test, then you need to do the benefits test. The benefits test is passed if all benefits provided to highly compensated individuals are provided to all participants. Again, we need guidance as to exactly what this means but it's a very strict test. The plan must also not discriminate in favor of HCIs in operation.

The IRS notice delaying enforcement of the rules acknowledged that applying rules similar to Section 105(h) is a near impossible task when it's uncertain what the current rules even are. In that notice, the agencies asked for comments in several areas including:

1. Is the rate of employer contribution a "benefit" that must be provided on a nondiscriminatory basis? What about the duration of an eligibility waiting period?
2. Should any sort of safe harbor plan design be available?
3. What is the proper definition of "highly compensated employee"?
4. Can employers aggregate different but substantially similar coverage options in determining nondiscrimination compliance?

Finally, employers need to be mindful of the existing nondiscrimination rules for group term life insurance, pre-tax Section 125 contributions, self-funded health plans, Health Flexible Spending Accounts, Dependent Care Flexible Spending Accounts, Health Savings Accounts, and so on.

XIII. <u>The "Menu" of Benefit Planning Options for Physician Practices</u>.

A. Standard health and welfare benefit plans – medical/dental/vision/Rx, group life, group LTD, HFSA, DFSA, etc.

B. "Carve-out" executive/owner life, and especially LTD, Qualified Long Term Care Insurance

C. Severance protection/Change of control protection

D. Equity compensation (stock grants, restricted stock, options) and equity-like compensation (phantom stock, SARs)

E. Carefully designed (as to eligibility, vesting, contribution formula, Roth feature, etc.) qualified defined contribution plans – Note $53,000 plus $6,000 catch-up limit for 2016

F. Carefully designed (as to eligibility, vesting, benefit formula, etc.) qualified defined benefit plans – Note $210,000 limit for 2016

G. Voluntary deferral nonqualified plan (note pass-through entity deduction issues)

H. Employer funded SERP (note pass-through entity deduction issues)

I. Health Savings Account (note HDHP requirement) – Note $3350/$6750 plus $1,000 catch-up limit for 2016

J. Guaranteed retirement income product investment options in defined contribution plans

To: Clients and Friends
From: Smith & Downey
Date: September 6, 2016
Re: Montgomery County, MD Paid Sick and Safe Leave – Effective October 1, 2016

Montgomery County, MD's new "Earned Sick and Safe Leave Law," which goes into effect October 1, 2016, requires employers to provide paid sick and safe leave to most employees who perform work in Montgomery County. (The law includes exceptions for employees who work eight or fewer hours per week and those who "do not maintain a regular work schedule" with the employer.)

Employees are entitled to earn one hour of "Sick and Safe Leave" for every 30 hours worked in the county, up to 56 hours of leave per year. Employers with fewer than five employees are only required to pay for the first 32 hours of earned leave, and the remaining 24 hours may be unpaid. Employers with five or more employees must pay for all earned leave.

Employees may elect to use Sick and Safe Leave:

1. To care for the employee's own or a family member's mental or physical condition, illness or injury;
2. To obtain preventive care for the employee or a family member;
3. For various public health emergencies outlined in the law; and
4. For reasons related to domestic violence, sexual assault, or stalking committed against the employee or a family member of the employee.

Employers may not ask employees to provide documentation of the need for leave unless the employee has used more than three consecutive days of leave.

Employers are required to provide specific notice to employees regarding their legal entitlement to Sick and Safe Leave, and to provide individualized notices to employees each pay period regarding the amount of Sick and Safe Leave available.

Finally, employers are required to maintain records regarding each employee's accrual and use of Sick and Safe Leave for three years.

Before October 1, employers with employees working in Montgomery County must put in place procedures to comply with this new county law.

Please contact Doug Desmarais at ddesmarais@smithdowney.com or Kerstin Miller at kmiller@smithdowney.com if we can be of any assistance with your paid sick leave compliance.

To: Clients and Friends
From: Smith & Downey
Date: August 30, 2016
Re: Retirement Plan Fee and Investments Lawsuits Against Employers

We imagine that all of our clients have seen the rather extensive press about the growing series of lawsuits being brought – often by "professional class action lawyers" -- against employers and various retirement plan decision makers (e.g., Board investment committees, etc.) alleging that they have permitted their retirement plans to pay "excessive" administrative and investment-related fees and/or permitted poorly performing investments to remain in their plans.

In addition to this new entry into the fray by the plaintiffs' bar, the Department of Labor also has aggressively focused on this issue in plan audits in the last year or two.

Most of the press has centered on a series of coordinated class action lawsuits being brought against decision makers of retirement plans in the higher education space, but a number of additional lawsuits have been brought in other industries and on a non-class action/single employer basis. (The tax-exempt employer environment is a particularly fertile area of attention for the plaintiffs' bar, in light of its perception that volunteer board members do not have the time to focus on these fine details in addition to their core commitment with regard to mission.) Although there are some unique historical aspects of some of the retirement plans of some higher education employers, the allegations

by the plaintiffs in these cases easily could be cloned for any other employer that sponsors a retirement or welfare benefit plan.

Over the last decade, prudent advisors have urged employers to engage in steps to help protect themselves from these lawsuits. However, the diligence called for by the rules often wanes with the absence of meaningful enforcement.

For example, although employers commonly adopt investment policy statements ("IPSs") and other procedural documents that are intended to be "blueprints" for compliance with the rules, we often find that a decision maker's actual practice operates on instinct, rather than agreeing with the controlling documents, and this is a recipe for liability.

In light of the recent litigation and DOL activity, it is now more critical than ever that every employer that sponsors a retirement plan (whether ERISA-governed or not) regularly and vigorously benchmark the plan's administrative and investment-related fees, select the plan's administrative and investment service providers in a professional and prudent manner, and keep an extensive, permanent file memorializing its efforts in these regards. Employers must take this same approach to the selection and monitoring of investment options for their participant-directed retirement plans and to their related 404(c), QDIA and fee disclosure compliance efforts.

In addition to this diligence, it is important for employers to ensure that their internal personnel (e.g. Board members, administrative committee members, etc.) are not personally liable for their representative decision-making, and that appropriate insurance and indemnification are in place for all employer personnel with ERISA plan responsibilities.

We believe it is critical for employers to take the following steps at this time:

-Conduct Legal Review of Documentation and Processes. Engage ERISA counsel to examine documents and processes concerning vendor selection and monitoring, fee review, and investment selection and monitoring.

-Ensure Operational Compliance. Ensure that actual decision making behavior conforms to the controlling documentation.

-Continuing Education. Schedule regular, legally-oriented presentations to decision makers regarding the new risk environment and the steps they should take to best position the employer and the decision makers against these threats.

Please contact us if we can assist you with these efforts.

To: Clients and Friends
From: Smith & Downey
Date: June 9, 2016
Re: Employee Health Plans - HHS Begins Nationwide HIPAA Audit Programs

The Office for Civil Rights of the Department of Health and Human Services has begun its previously-announced nationwide HIPAA audit programs of employers and their HIPAA Business Associates. The audits, which will be both by mail and on-site, reportedly will focus on:

-the Notice of Privacy Practices required to be distributed by employers;

-issues concerning plan participants' right to access their Protected Health Information;

-risk management and risk analysis under the HIPAA security rules; and

-procedures for dealing with HIPAA privacy breaches.

Naturally, now would be a good time for employers that maintain employee health plans, and their health plan service providers, to perform internal HIPAA privacy and security self-diagnostics to ensure that they are in full compliance with the various HIPAA rules before an OCR auditor shows-up.

Please contact us if we can be of any assistance with your HIPAA compliance.