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Legal Update for Employers

As a service to our clients, Holifield Janich & Associates, PLLC periodically issues a newsletter to keep you informed of developments in statutes, regulations and case law that may impact you. If you would like assistance or further information about any of the matters described in this update, please contact us and we will be happy to discuss these issues with you further.

THE FLSA FINAL RULE IS HERE... ARE YOU READY?

The United States Department of Labor ("DOL") released the Final Rule amending the executive, administrative, professional, and computer employee exemptions under the Fair Labor Standards Act ("FLSA"). The new rule updates the salary level required for exemption that many "white collar" workers must meet to qualify as exempt from federal overtime rules.

<u>What do you need to know?</u>

- Effective Date: December 1, 2016
- Minimum salary necessary to qualify as an exempt executive, administrative, professional or computer employee is $913 per week or $47,476 annually (more than double the prior threshold of $455 per week)
- Minimum compensation necessary to qualify for the "highly compensated employee" exemption is $134,004 per year (an increase of $34,004 per year when compared to the prior threshold of $100,000 per year)
    - New salary thresholds for highly compensated employees will be set at the 90th percentile of earnings of full-time salaried workers nationally
- Special salary level for employees in American Samoa increased to $767 per week
- Special "base rate" for employees in the motion picture industry increased to $1,397 per week

- The salary threshold will be updated every three years, beginning on January 1, 2020, and the revised salary requirements will be announced 150 days prior to the date they are scheduled to go into effect
    - New salary thresholds will be set at the 40th percentile of earnings of full-time salaried workers in the lowest-wage Census Region (currently the South), as measured at the end of the second quarter of the previous year.
- The "duties test" does not change

<u>The Final Rule Is Not All Bad News for Employers</u>

As an offset to the drastic increase in salary levels, the DOL is granting employers the ability to use nondiscretionary bonuses and incentive payments (including commissions) to satisfy up to 10 percent of the standard salary level. This means that up to $91.30 in nondiscretionary bonus and incentive payments per week, or $4,747.60 in nondiscretionary bonus and incentive payments per year paid no less frequently than on a quarterly basis, can count toward meeting the $47,476 threshold. This also means that even if the employer can make use of the full 10 percent, the employee still will need to receive a salary of at least $821.70 per week, or $42,728.40 per year. To qualify, the bonuses, commissions or incentives must be paid on a quarterly or more frequent basis, and the payments must be tied to productivity and profitability. Employees who fail to earn sufficient bonus or commission income during the quarter to meet the new salary threshold must receive a "true-up" payment in the first pay period after the quarter ends to bring their total compensation to the required amount. As an example, by the last pay period of the quarter, the sum of the employee's actual weekly salary, plus received nondiscretionary bonus, incentive, and commission payments, does not equal $11,869 (i.e., 13 times the weekly minimum of $913), an employer may make one final payment to reach the $11,869 level no later than the next pay period after the end of the quarter.

On the other hand, the Final Rule does not allow employers to include any bonuses in the calculation of highly compensated employees ("HCEs") reaching the salary threshold. HCEs must receive at least the full standard salary amount each pay period on a salary or fee basis without regard to the payment of nondiscretionary bonuses and incentive payments. The DOL concludes that permitting employers to use nondiscretionary bonuses and incentive payments to satisfy the standard salary amount for HCEs is not appropriate because employers are already permitted to fulfill almost two-thirds of the total annual compensation requirement with commissions, nondiscretionary bonuses, and other forms of nondiscretionary deferred compensation.

<u>What Should You Do to Comply?</u>

- Adopt protocols to ensure that nonexempt salaried employees are paid overtime at the proper rate
    - Revise Employee Handbooks and policies relating to overtime and time keeping
    - Implement time clock system

    - Travel time incurred by newly reclassified employees should be analyzed to assess whether and to what extent that time should be considered compensable time and if adjustments to travel schedules should be implemented
- Evaluate telecommuting and other alternative work arrangements to determine whether compensable time can be realistically managed and tracked from remote locations
- Remind employees about when they are permitted and not permitted to engage in work-related activities outside of scheduled work hours
    - i.e. employees checking and responding to work-related emails and texts outside of their normal work hours.
- Be prepared for the reclassifications to occur every three years
    - Exempt status may be lost as a result of the automatic update if the weekly guaranteed salary is close to the threshold without an appropriate update
- Analyze whether nonexempt salaried employees should be converted to an hourly pay basis
    - Pros: tracking and paying overtime will be easily facilitated
    - Cons: may be viewed by the affected employees as a demotion
- Analyze whether the fluctuating workweek approach is beneficial, which can result in a substantial reduction in overtime pay costs
- Analyze whether the size of the payroll should be reduced
- Analyze whether the compensation of employees should be reduced
- Analyze whether bonuses should be reduced or future compensation increases should be eliminated or reduced

SUPREME COURT UPDATE

The United States Supreme Court recently had an opportunity to address two cases that will impact employers and employee benefits plans. *Zubik v. Burwell*was decided on May 16, 2016. In *Zubik*, the Supreme Court had the opportunity to address the Affordable Care Act’s birth control mandate for employees and students at non-profit religious hospitals, charities, and colleges. *Zubik* was a collection of cases from various U.S. Circuit Courts of Appeal. The Supreme Court remanded the cases back to the respective U.S. Courts of Appeal for those courts to find a solution which accommodates the challenger's religious exercise, and also ensures women covered by the challenger's health plans receive health coverage that includes contraceptive coverage. In the U.S. Court of Appeals, five courts had ruled in favor of the contraceptive mandate and one had ruled against. In essence, the Supreme Court has ordered all of those courts to rethink those outcomes based upon the positions the two parties had taken on the controversies in the pleadings before the Supreme Court.

One potential reason for this ruling is that the Supreme Court is only functioning with eight Supreme Court Justices given the recent demise of Justice Scallia. By sending the decision back to the lower courts to revisit this issue, essentially, the government is allowed to go forward and provide contraceptive benefits to the employees and non-profits are free from any risk of penalties by not providing the contraceptives. We will keep you informed of any future cases regarding this matter.

The other case that the Supreme Court addressed was *Spokeo, Inc. v. Robbins*. *Spokeo* is a Supreme Court case that dealt with the Federal Fair Credit Reporting Act. One would consider a case on the Fair Credit Reporting Act as not having an impact on any employee benefit plans. However, the Supreme Court was specifically addressing allegations of a “concrete” injury, which is a common issue in breach of fiduciary duty cases. The Supreme Court held that claims created by Congress can only be litigated in federal courts if the Plaintiff can allege a "concrete" injury that (1) affects a plaintiff in a personal or individual way, (2) whose actions are traceable to a defendant and (3) that is repressible to the federal judge. *Spokeo* will impact plaintiff lawsuits because now they must be more specific about the “concrete” injury that must be alleged in the Complaint. Simple, general allegations will no longer suffice. This is a win for defendants.

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Employers, why should you care about the Defense Trade Secrets Act?

The United States Congress passed the Federal Trade Secrets Act legislation on April 20, 2016. Generally speaking, this law means that an employer can now pursue claims against an employee for trade secret misappropriations in Federal Court like other claims it may have regarding its intellectual property, such as patents, copyrights, trademarks, etc. The key provision of this act, though, is there is now an obligation of an employer to give notice of immunity rights to its employees. One of the provisions of the Defense Trade Secrets Act requires employers to include in "any contract or agreement with an employee that governs the use of a trade secret or other confidential information" a notice that individuals can be protected from criminal or civil liability for disclosing trade secrets if such disclosure is made in confidence to a government official, directly or indirectly, or to an attorney, and it is for the purpose of reporting a violation of law. For purposes of the Defense Trade Secrets Act, an employee also includes a contractor or consultant if the work is done by an individual for an employer. Therefore, all employer agreements need to be modified to add this provision if it desires to comply with the Defense Trade Secrets Act and it desires to protect its trade secrets. If an employer does not include this provision in its employment agreement, the employer will not be able to recover any exemplary damages or attorney's fees in an action brought under the Defense Trade Secrets Act against the employee since the employer failed to provide the required notice.

EEOC FINAL RULES ON WELLNESS PROGRAMS: WHAT DO YOU NEED TO KNOW?

- Effective Date: First day of the first plan year that begins on or after January 1, 2017
    - Employers should begin tweaking wellness plans now to ensure compliance in the new year
- ADA final rule – the wellness program must be reasonably designed to promote health or prevent disease and must be voluntary
    - The program must have "a reasonable chance of improving the health of, or preventing disease in, participating employees, and must not be overly burdensome, a subterfuge for violating the ADA or other laws prohibiting employment discrimination, or highly suspect in the method chosen to promote health or prevent disease."
    - The program must be voluntary:
        - Employer cannot require employee participation in the program

    - Employer cannot deny coverage under any of its group health plans (or in a particular benefits package within its plan) for an employee not participating in the wellness program
    - Employer cannot take an adverse employment action or retaliate against, interfere with, coerce, intimidate or threaten employees who do not participate in the wellness program
  - Employers are only permitted to receive medical information as part of the wellness program in the aggregate form that does not disclose, and is not reasonably likely to disclose, the identity of specific individuals
    - Exception: information may be obtained as necessary to administer the plan or as permitted by regulations
  - Employers must provide participants with a confidentiality notice containing the following information:
    - A clear explanation of what medical information will be obtained
    - How the obtained medical information will be used
    - Who will receive the medical information
    - Restrictions on disclosure of the obtained medical information
    - Methods the employer will use to prevent improper disclosure of the medical information
  - Limits on financial incentives that a wellness program can offer under the ADA final rule, if the program involves a medical examination:
    - If the employer offers only one group health plan and participation in a wellness program is offered only to employees that are enrolled in the plan, 30% of the total cost of self-only coverage (including both the employee's and employer's contribution) of the group health plan;
    - If the employer offers only one group health plan and participation in a wellness program is offered to all employees regardless of whether they are enrolled in the plan, 30% of the total cost of self-only coverage under the covered entity's group health plan;
    - If the employer offers more than one group health plan and participation in a wellness program is offered to all employees regardless of whether they are enrolled in a particular plan, 30% of the total cost of the lowest cost self-only coverage under a major medical group health plan; and
    - If the covered entity does not offer a group health plan or group health insurance coverage, 30% of the cost of self-only coverage under the second lowest cost Silver Plan for a 40-year-old nonsmoker on the state or federal health care Exchange in the location that the covered entity identifies as its principal place of business
    - When analyzed with the HIPAA regulations, a program that is designed to prevent or reduce tobacco use that <u>does not include a medical examination</u> may offer an incentive up to 50% of the cost of coverage for participation in the program
  - ADA "Safe Harbor" Provision does not apply to wellness programs
    - Provision that allows insurers and plan sponsors to use information about risks posed by certain health conditions to make decisions about insurability and the cost of insurance does not apply to wellness plans

- GINA final rule – Incentives cannot be offered in exchange for health information about employees' spouses or children
    - Exception: employers may seek health information from a family member who is receiving health or genetic services offered by the employee
    - Employers may offer health or genetic services (i.e. participation in a wellness program) to an employee's children on a voluntary basis, but <u>cannot offer any inducement in exchange for information</u> about a disease or disorder in the child
    - Limits on financial incentives that a wellness program can offer for a spouse to provide information about his or her health status:
        - If a wellness program is open to only employees and family members in a particular group health plan, 30% of the total cost of self-only coverage under such group health plan;
        - If the employer provides more than one group health plan and enrollment in a particular plan is not required to participate in the wellness program, 30% of the lowest cost major medical cost of self-only plan the employer offers; and
        - If the employer does not offer a group health plan, 30% of the total cost to a 40-year-old non-smoker purchasing coverage under the second lowest cost Silver Plan available through the state or federal exchange in the location the employer has identified as its principal place of business.
- What should employers do?
    - Review existing wellness programs to determine if changes need to be made to bring such programs into compliance with the new rules
        - Specifically, ensure that information requested or medical testing involved does not exceed what is permitted by the rules
    - Confirm the wellness program satisfies the criteria for voluntariness under the new rules
    - Confirm that proper confidentiality notices are provided to employees
    - Ensure that health information that is collected and used is properly kept confidential
    - Ensure that any incentives offered in connection with the plans are in line with the requirements under the new rules

DOL FINAL FIDUCIARY RULES AND HEALTH SAVINGS ACCOUNTS

In April, 2016, the Department of Labor issued its long-awaited final fiduciary rules. The details of these rules are discussed elsewhere in this newsletter (See, "The Department of Labor New Fiduciary Rule - How it Affects Plan Sponsors"). At first glance, many assume that these rules apply only in the retirement plan context. However, the final rules extend beyond the conventional retirement plan world and directly apply to health savings accounts (HSAs), Coverdell education savings accounts, and Archer Medical Savings Accounts. This article will focus on the application of the final fiduciary rules to entities and individuals that provide services relating to HSAs.

The application of the final fiduciary rules to HSAs results from the definition of “individual retirement account.” The definition contained in the rules references Internal Revenue Code Section 4975, which includes HSAs. The DOL explained in the preamble to the final rules that because HSAs receive tax preference as an IRA and some have associated investment accounts that can be used as long-term savings accounts for health expenses incurred after retirement, HSAs owners are entitled to the same protections as IRA owners.

The requirements of the final rules are triggered by certain types of client communication and investment education. These events will cause the individual or business providing the communication or education to become fiduciaries, subjecting them to the compliance responsibilities contained in the final rules. Agents and brokers that advise group benefit plans regarding HSAs may trigger the fiduciary requirements of the final rules depending on whether the advice they give falls within the definition of “investment advice” in the final rules. The important distinction is whether a “recommendation” is given. The final rules define a “recommendation” as a communication that “would be reasonably viewed as a suggestion” to take a particular course of action or refrain from taking an action. Generally, the provision of general investment education materials, including certain plan information, asset allocation models, interactive investment materials and general financial, investment, and retirement information, does not constitute “investment advice” as long as the materials do not identify specific investment alternatives or distribution options. In addition, general communications such as newsletters, marketing materials, presentations, and investment reports do not fall within the definition of “investment advice.”

Most of the provisions of the final rules are effective April 8, 2017. Brokers and agents that provide HSA services should assess their level of services against the new standards to determine whether such services fall within the parameters of the final rules. If it is determined that the services provided constitute “investment advice”, new operating procedures should be adopted to either scale back such services to avoid application of the final rules, or establish compliance with the requirements of the final rules prior to the effective date.

HHS ISSUES ASA NONDISCRIMINATION FINAL RULES

On May 13, 2016, the Office of Civil Rights (OCR) at the Department of Health and Human Services (HHS) issued its final rule implementing the nondiscrimination provisions of Section 1557 of the Affordable Care Act. This rule prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. The final rule applies only to "covered entities" that operate a health program or activity, any part of which receives federal funding or assistance, or under any program or activity that is administered by an executive agency or an entity established by Title I of the Affordable Care Act. Therefore, the final rule will apply mostly to health insurance issuers, health care providers (including pharmacies and health clinics) and some group health plans.

The final rule provides that an individual cannot be excluded from participation in or denied benefits or otherwise be subject to discrimination under any health program or activity based on the individual's race, color, national origin, sex, age, or disability. The final rule does not include specific examples of discriminatory benefit design. Instead, the determination of whether a benefit design is discriminatory will be made on a fact-specific, case-by-case basis. The rule does not specifically prohibit discrimination on the basis of religion. However, the rule does state that if application of the final rule would violate applicable federal statutory protections for religious freedom, application of the rule will not be required.

The prohibition against discrimination based on sex includes discrimination related to a person's sexual orientation where evidence establishes that the discrimination is based on gender stereotypes. The rule further prohibits discrimination based on sex in the following forms:

1. denial of health care or health coverage based on individual's sex, including gender identity;

2. treatment inconsistent with an individual's gender identity, including access to facilities;

3. denial or limitation of sex-specific health care based only on the fact that the person seeking such services identifies as belonging to another gender; and

4. explicit categorical exclusion in coverage for all health services related to gender transition. (The rule does not require coverage of particular services to treat gender dysphoria, gender identity disorder, or of individuals transitioning genders. Health plans are allowed to deny non-medically necessary services, however such denials will be subject to careful scrutiny.)

The final rule is generally effective July 18, 2016; however, if changes are necessary to health insurance or group health plan benefit design as a result of the application of the final rule, the rule will be effective on the first day of the first plan year beginning on or after January 1, 2017. The notice requirements contained in the final rule must be implemented within ninety (90) days of the effective date.

For employers sponsoring group health plans, the determination of whether they are a "covered entity" (and, therefore, the final rule applies to them) depends on whether the employer receives federal financial assistance from HHS for any purpose.

While the final rule does not apply to employers who do not receive federal funding, it is possible that employers of self-funded group health plans may be affected. The final rule provides that health insurance issuers acting as third-party administrators for self-funded group health plans must comply with the rule. Commenters to the proposed rule expressed concern that such TPAs could be held responsible for administering an allegedly discriminatory benefit design of a self-insured plan even when the plan or the employer sponsoring the plan was responsible for the benefit design decisions. The final rule addresses these concerns. If a complaint is brought against a TPA under the rule, OCR will determine whether responsibility for the alleged discrimination rests with the employer or with the TPA. If it is found that alleged discriminatory conduct relates to the administration of the plan (i.e., timing of claims processing), OCR will process the complaint against the TPA. If, however, the discriminatory conduct relates to a decision or conduct by the employer, OCR will determine whether it has jurisdiction over the employer (i.e., whether it is a "covered entity"). If jurisdiction exists, OCR will process the complaint against the employer. If, however, OCR does not have jurisdiction over the employer, it may refer the matter to another federal agency with jurisdiction (for example, the Equal Employment Opportunity Commission).

In addition to the prohibition against discrimination, the final rule requires covered entities to provide language assistance services, through oral interpreters or written translators to individuals with limited English proficiency. In addition, notices must be provided alerting such individuals that language assistance services are available.

Please contact us if you think you may be subject to the final rule or if you have questions regarding its application.

THE DEPARTMENT OF LABOR NEW FIDUCIARY RULE – HOW IT AFFECTS PLAN SPONSORS

In April 2016, the Department of Labor (DOL) issued its final rule addressing conflicts of interest and fiduciary standards in the provision of investment advice to participants in 401(k)-type retirement plans and individual retirement accounts (IRAs). The purpose of the final rule, according to the DOL, is to "protect investors by requiring all who provide retirement investment advice to plans and IRAs to abide by a "fiduciary" standard – putting their clients' best interest before their own profits." Going forward, advisers must either avoid payments that create conflicts of interest or comply with the requirements of a new prohibited transaction exemption. The rule is generally effective as of April 10, 2017; however, certain provisions related to the exemption from the prohibited transaction rules will be phased in between April 10, 2017 and January 1, 2018.

The final rule defines who is a fiduciary investment adviser and contains prohibited transaction exemptions to allow those that act as investment advice fiduciaries to continue to receive certain common types of compensation if they adhere to the requirements of the exemptions, all to ensure the investment advice given is impartial and in the best interests of their customers.

The DOL limited the application of the final rule only to "covered investment advice" that amounts to a "recommendation." "Covered investment advice" is defined as a recommendation to a plan, plan fiduciary, plan participant/beneficiary, or IRA owner for a fee or other compensation, direct or indirect, regarding the advisability of buying, holding, selling or exchanging securities or other investment property. A "recommendation" is defined as a "communication that, based on its content, context, and presentation, would reasonably be viewed as a suggestion that the advice recipient engage in or refrain from taking a particular course of action." The "fee or other compensation" referenced in the final rule includes any explicit fee or compensation paid for advice received, including commissions, loads, finder's fees and revenue sharing payments.

The rule does not apply to all communications with financial advisers. For example, education about retirement savings and general financial and investment information that does not equate to a "recommendation" is not covered. Similarly, general communications such as newsletters, general marketing materials, and general market data are not covered.

The DOL also provided a prohibited transaction exemption (known as the "Best Interest Contract Exemption" or "BICE") in the final rule to allow advisers to receive otherwise prohibited commission-based compensation if certain requirements are met, including acknowledgment of their fiduciary status, adherence to basic standards of impartial conduct, institution of policies and procedures designed to mitigate the harmful impact of conflicts of interest, and disclosure of the conflict of interest and the cost of advisory services.

While the final rule is aimed at financial advisors, it will impact plan sponsors as well. Under the final rule, nearly all types of advisors on which a plan would rely for investment advice, not only to the plan sponsor but also to plan participants, will now be held to a fiduciary standard. This will require those providing investment advice to retirement plan sponsors and participants to evaluate their operations, including contracts with plan sponsors, to ensure they are in compliance with the requirements of the final rule. This may require changes to the way these entities do business, changes in contract terms with plan sponsors, additional disclosures and possible increases in fees for services. This will all affect plan sponsors who utilize investment advice services.

We recommend that plan sponsors communicate with their advisers to determine what steps the adviser is taking to comply with the new rule. Specifically, plan sponsors should determine whether the adviser considers itself a fiduciary under the new rule and, if not, why not. Failure to make and document these inquiries could be deemed a breach of the plan sponsor's fiduciary duty to select and monitor plan service providers. Plan sponsors should also be prepared for contracts with their advisers to contain new language addressing the final rule. Such language should be carefully reviewed to determine whether the adviser considers itself covered by the rule or if it meets the requirements of the prohibited transaction exemption.

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