LEGALCurrents®

EMPLOYEE BENEFITS AND EXECUTIVE COMPENSATION

NOVEMBER 2016

PRACTICE LEADER
Paul W. Holloway
pholloway@hselaw.com

PARTNERS
Thomas J. Hurley
thurley@hselaw.com
Samuel J. Palisano
spalisano@hselaw.com
Christopher M. Potash
cpotash@hselaw.com
Mark R. Wilson
mwilson@hselaw.com

COUNSEL
Cody R. Braithwaite
cbraithwaite@hselaw.com
Leslie E. DesMarteau
ldesmarteau@hselaw.com
Lisa G. Pelta
lpelta@hselaw.com
Joseph E. Simpson
jsimpson@hselaw.com
Lori J. Stone
lstone@hselaw.com

ASSOCIATES
Colleen M. Allen
callens@hselaw.com
Emily Ayers
eayers@hselaw.com
John W. Brill
jbrill@hselaw.com
Alexandra Lugo
alugo@hselaw.com
Jesse A. St.Cyr
jstcyr@hselaw.com

BENEFITS LITIGATION COUNSEL
John P. Bringewatt
jbringewatt@hselaw.com
Megan K. Dorritie
mdorritie@hselaw.com
Erika N. D. Stanat
estanat@hselaw.com

hselaw.com

Employee Benefits Year-End Checklist

2016 Employee Benefits Year in Review

Planning Ahead for 2017

With the end of the calendar year drawing near, this is a good time for employers to conduct a year-end review to make sure their benefit plans are up-to-date and operating in compliance with the law. In addition, the end of the year brings a number of important deadlines. To assist you with your year-end projects, this newsletter provides a summary of some important dates and new developments.

Important Reminders for 2016

- Some (but not all) of the benefit limits will increase for 2017, so your payroll and recordkeeping systems will need to be updated. A table setting forth the 2016 and 2017 IRS limits appears at the end of this newsletter.
- If you have participant-directed investments and utilize a "Qualified Default Investment Alternative" ("QDIA") for "default" investments, you should provide your default investment informational notice by December 1, 2016 if you have a calendar year plan year. Your plan recordkeeper generally will assist you in preparing the notice and coordinating its distribution.
- Participant-directed defined contribution plans must provide annual notices regarding plan expenses and investments. Plans should be sure they have met that obligation; the deadline will vary depending on the timing the plan has established. Disclosures must be provided no more than 14 months after the previous year's fee disclosure.
- If you have a "safe harbor" 401(k) or 403(b) plan or want to adopt a safe harbor structure for 2017, you must provide your annual notice by December 1, 2016 if you have a calendar year plan year. This applies regardless of whether you are using a traditional safe harbor or an automatic enrollment safe harbor. Make sure the notice includes a warning that the employer retains the right to reduce or eliminate safe harbor contributions, in order to preserve this ability for you if you need it.
- If you have an automatic enrollment 401(k) or 403(b) plan, regardless of whether it is a "safe harbor" plan, you must provide your automatic enrollment annual notice by December 1, 2016 if you have a calendar year plan year.
- Major medical plans are subject to the Transitional Reinsurance Fee, which, for 2016, is a fee of $27.00 per covered life under the plan. Insurance carriers are responsible for paying the fee for insured coverage, but sponsors of self-insured plans will need to meet the November 15, 2016 deadline to report the number of covered lives subject to the fee and to register at a government website to schedule the payment of the fee. Payment of the fee will not be due until January 17, 2017. See our newsletter at http://www.hselaw.com/files/Transitional_Reinsurance_Program_Data_October_2014.pdf for a detailed overview of the action items for self-insured plan sponsors. 2016 will be the last year for which the Transitional Reinsurance Fee will apply.
- If you want to make any amendments to your plan, you may need to adopt them before the end of the current plan year. Generally, an amendment to a qualified retirement plan that takes effect during a plan year must be adopted before the end of the plan year, unless Congress or the IRS has granted an extension.

HSE Harter Secrest & Emery LLP
ATTORNEYS AND COUNSELORS

- Some amendments must be in place before the desired effective date (for example, if you are changing your contribution structure, an advance amendment may be required).
- Changing a 401(k) or 403(b) plan to or from a "safe harbor" structure usually requires an amendment in advance of the start of the plan year, and certain changes to those plans cannot be made after the start of the year. If you have one of these plans, it is important to plan ahead.
- Adding an automatic enrollment feature to a 401(k) or 403(b) plan may also require an amendment before the start of the plan year.

- Benefit statements
  - Remember that you must provide benefit statements for your participant-directed plans within 45 days of the end of the quarter, and for non-participant-directed defined contribution plans by the filing date for Form 5500 for the plan year.
  - If you sponsor a defined benefit plan, you must either provide employed participants with an annual notice of the availability of a benefit statement on request, or with an actual benefit statement once every three years. (Bear in mind that the statute does not exempt frozen plans from these requirements.) Defined benefit plans sponsored by employers with intranet sites may also be required to make certain information available on the intranet site within 90 days of filing Form 5500.
- Make sure that you or your insurer have provided all notices required under your group health plan this year, which may include the Women's Health and Cancer Rights Act notice, the Children's Health Insurance Plan notice, notice of availability of the HIPAA privacy notice, and/or the Medicare Part D notice, and that you or your insurer provide required Summary of Benefits and Coverage documents during your open enrollment period.
- Most retirement plan participants are required to receive annual "required minimum distributions" after turning age 70½ and terminating employment with the plan sponsor (or after turning age 70½, in the case of a more-than-5% owner). Time limits also apply to payment to beneficiaries of deceased participants. Each year's payment must be made by December 31st, with the exception of a participant's first required minimum distribution (due April 1st of the following year). Make sure that your plan has arranged to make all required payments, and has up-to-date addresses for affected participants and beneficiaries.
  - As the population ages, more and more plan participants are affected by these deadlines. The IRS and the Department of Labor have increased the resources dedicated to enforcing these rules, and now require plans to indicate on Form 5500 whether they failed to make required payments (see "Increased Regulatory Focus on Retirement Plan Payment Deadlines" on page 7).
- If you expect to have assets remaining in your defined contribution plan's forfeiture account at the end of the year, you should review your options and obligations under the plan document to determine whether you can (and whether you must) make arrangements to use up your forfeiture account this year. The IRS has emphasized that plans generally should not be carrying forfeiture balances over from year to year.

A Look Ahead at 2017

There are some important action items to bear in mind as 2017 gets underway:

- Under the Patient Protection and Affordable Care Act, larger employers can face a "shared responsibility" (a.k.a. "pay or play") penalty if they fail to offer full-time employees affordable medical coverage. Larger employers will also be subject to an information reporting requirement that will require them to track employees' hours of service as well as information about their offers of coverage to their full-time employees during the year. The IRS has finalized the instructions and forms for the 2016 filing, which are available here: https://www.irs.gov/pub/irs-pdf/i109495c.pdf, https://www.irs.gov/pub/irs-pdf/f1094c.pdf, https://www.irs.gov/pub/irs-pdf/f1095c.pdf. For the 2016

filing, copies of the 1095-Cs are due to individuals by February 1, 2017, and copies of the 1094-Cs and 1095-C forms are due to the IRS by February 28, 2017, or March 31, 2017, if filing electronically.

- The IRS issued proposed regulations regarding taxpayer identification number ("TIN") (i.e., a Social Security Number) solicitation for providers of minimum essential coverage. These regulations are relevant to employers who sponsor self-insured medical plans, as they must report all covered individuals (including spouses and dependents) on Form 1095-C, Part III. Employers are required to initially solicit TINs when an individual applies for coverage, or when an individual is added to existing coverage. If an employee does not provide a TIN of a covered spouse/dependent, the employer may instead use the date of birth on the 1095-C. However, if an employee fails to provide a TIN, employers are required to make at least two subsequent solicitations. The proposed regulations clarify employer's requirements with respect to the subsequent solicitations. For individuals enrolled in coverage prior to July 29, 2016, an employer will have satisfied the initial solicitation requirement if it requested the TIN prior to that date. The first subsequent solicitation must occur within 75 days after the date of the first solicitation. The second subsequent solicitation (the third solicitation in total) must occur by December 31 of the year following the year in which the individual applied for coverage or added an individual to existing coverage. If an employer makes the initial solicitation and the two subsequent solicitations as described above, the employer need not make any further solicitations and may continue to use the spouse's or dependent's date of birth in lieu of the TIN.
- If your plan uses an "individually designed" document and the plan sponsor EIN on your plan's Form 5500 ends in "1" or "6," your plan must be submitted to the IRS for re-approval by January 31, 2017. If you have an individually designed defined contribution plan, you can instead convert to an IRS pre-approved volume submitter or prototype document by April 30, 2017. (See "IRS Drastically Limits Determination Letter Program" on page 9.)
  - Special timing rules may apply if you are part of a group of companies that has opted to use the same cycle for all determination letter applications, or in certain other limited circumstances.
- The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act") requires group health plans to notify the Department of Health and Human Services ("HHS") of all breaches of unsecured protected health information. You must notify HHS within 60 days of discovering a breach affecting 500 or more individuals. For breaches involving fewer than 500 individuals, HITECH requires a group health plan to keep a log or other documentation of such breaches that occur within a calendar year and to notify HHS of such breaches within 60 days of the close of the calendar year. This means that you must notify HHS of all breaches affecting fewer than 500 individuals that occurred in 2016 by no later than March 1, 2017. Notifications must be submitted online at http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruction.html.
- Medicare Part D online disclosure to the Centers for Medicare & Medicaid Services ("CMS") for group health plans offering prescription drug coverage to individuals eligible for Medicare Part D is due by March 1, 2017.
- Some aspects of the Department of Labor's regulations re-defining "fiduciary" under ERISA become applicable April 10, 2017, though full compliance with the regulations and their accompanying exemption will not be required until January 1, 2018. (See "New Fiduciary Regulations" on page 7.)

Important Developments in 2016

A number of developments occurred in 2016 that affect employee benefit plans, including updated guidance from the IRS, Department of Labor and the PBGC along with some significant Supreme Court rulings. This segment of the newsletter summarizes the items we have found to be most relevant to our clients.

Supreme Court Employee Benefits Cases

The Court continued to display interest in employee benefits topics, issuing two full-length employee benefits decisions this term, as well as a brief decision further clarifying the handling of employer "stock drop" cases (discussed on page 6, under "Caselaw Continues to Develop Regarding Standards for Employer Stock Claims"). The Court also decided a case on an unrelated topic that may have implications for ERISA plaintiffs.

Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan

This case involved a participant who incurred medical expenses due to an automobile accident. His medical plan covered the expenses, and then sought to obtain a portion of his recovery from a lawsuit against the other driver (i.e., the health plan sought to exercise "subrogation" rights). The Supreme Court held that a plan cannot exercise subrogation rights against third-party payments that the participant has already spent, unless the participant has assets traceable to those funds. For example, a plan could seek to seize a car purchased with settlement proceeds, but would not be able to recover if a participant instead spent the proceeds on something impermanent or intangible, such as food or a vacation. The decision underlines the importance of timely pursuing subrogation rights and securing any claims the plan may have against settlement funds received, something the plan in this case notably failed to do.

Gobeille v. Liberty Mutual Insurance Company

This case addressed whether Vermont could require self-insured health plans to submit claims data to a state database. The Court ruled that such a requirement ran afoul of ERISA's preemption clause, which prevents states from regulating ERISA-covered benefit plans. Although states can regulate insurance, a self-insured plan is not subject to insurance regulation. Accordingly, the Court determined that Vermont could not enforce the reporting requirement against self-insured ERISA plans.

Spokeo, Inc. v. Robins

Although this case addressed liability for a website's provision of inaccurate information about an individual, its holding extends more broadly to the question of who has "standing" to sue. Under Article III of the U.S. Constitution, in order for a person to be entitled to sue in federal court, the person must have suffered an injury. The *Spokeo* case confirmed existing precedent that mere violation of statutory rights is not sufficient to create standing automatically, and went on to explain that a plaintiff must have suffered a "concrete" injury, although the injury does not necessarily need to be "tangible."

Spokeo is relevant to a widely accepted line of ERISA cases holding that participants in a defined benefit plan cannot bring a lawsuit merely because the plan suffers an investment loss, even if the loss occurred due to fiduciary imprudence in violation of ERISA. Instead, participants must show that their benefits were reduced or endangered. If the would-be plaintiff's plan remains financially healthy and/or is sponsored by a company expected to be able to meet the ongoing funding obligations, and especially when the plaintiff is fully protected by the PBGC benefit guarantee, courts historically have determined that the plaintiff has not in fact been harmed, and lacks standing to sue.

The Fifth Circuit, in *Lee v. Verizon Communications, Inc.,* became the first appellate court to apply the Supreme Court's "concrete injury" standard to an ERISA case. One of the plaintiffs in that case had objected to Verizon's decision to transfer roughly $7.4 billion in pension liabilities to Prudential Insurance Company, arguing that this decision was imprudent and left the plan underfunded. The Fifth Circuit held that the plaintiff's complaint failed to allege that his pension benefits were potentially at risk and hence failed to meet *Spokeo's* standard. The plan had not defaulted on pension payments, and the plaintiff had not provided any proof that it was likely to do so.

The Fifth Circuit's holding was based on the terms of the complaint at issue, so other courts may reach different conclusions if plaintiffs can allege plausible reasons for concern regarding a plan's ability to make future payments. In addition, other courts may view *Spokeo's* standard differently. The Department of Labor also has enforcement authority to address ERISA fiduciary breaches, and agency standing is

subject to a different analysis. Accordingly, defined benefit plan fiduciaries should conduct themselves in accordance with ERISA's prudence requirements, and should not view *Spokeo* and *Lee* as a guarantee against liability. However, *Spokeo* does offer some reassurance that plaintiffs will continue to find it difficult to challenge investment decisions that turned out poorly but did not endanger the plan's solvency.

Defined Contribution Litigation Continues

Investment and Fee Litigation

In contrast to the post-*Spokeo* cautious optimism for defined benefit plan fiduciaries, defined contribution plan fiduciaries continue to operate in a fraught environment. Plaintiffs continue to file lawsuits alleging use of investments that charge excessive fees, overly expensive recordkeeping compensation, and other inefficiencies or overpayments. While much of this litigation still centers on large plans, smaller ones are also receiving attention. Likewise, while much of the focus remains on the for-profit sector, a number of high-profile universities are now defendants in a group of lawsuits alleging that their retirement programs offered an excessive number of investments at an excessive cost.

There is no investment or operational safe harbor that will ensure a given plan cannot become a target. For example, some lawsuits claim that plans paid excessive fees to invest in stable value products, while other lawsuits object that a plan offered a money market fund rather than a stable value fund with a higher potential return. Fortunately, courts expect plan fiduciaries to maintain a prudent decision-making process, not to demonstrate infallibility in their selection of investments. Accordingly, the current litigation environment makes it more essential than ever that plan fiduciaries meet regularly, document their decisions in detail, and make appropriate use of professional advisors. Even if the fiduciaries have hired an investment professional to assume responsibility for investment decisions under Section 3(38) of ERISA, they remain responsible for overseeing that professional's performance, and should meet with the professional and review the plan's portfolio regularly.

Stable Value Fund Litigation

In other defined contribution litigation news, a number of insurance companies are facing lawsuits linked to their stable value products. The lawsuits allege that the insurers violated ERISA by controlling the interest crediting rates associated with the contracts, receiving excessive fees, and engaging in other problematic conduct. Plan fiduciaries whose plans use products offered by the targeted insurers should review their potential exposure, and plan fiduciaries whose plans use other products should see whether their own arrangements are vulnerable.

"White Label" Funds

Finally, some of the more complex investment structures used by large defined contribution plans have attracted unfavorable attention. While plaintiffs normally object to more expensive "retail" mutual funds rather than institutional fund share classes, collective investment trusts, or proprietary investment accounts, more esoteric investment models also carry risk. In late 2015, plaintiffs sued the Intel 401(k) plan fiduciaries, challenging the performance of hedge funds and private equity investments in the plan's customized target date funds. In that same year, Verizon was sued, with plaintiffs objecting to the performance and cost of its customized investments. Ultimately, plan fiduciaries must be sure they understand the risks, costs and special features of any investments they offer, and commit the time and resources necessary to provide effective oversight.

For those fiduciaries not comfortable with the burdens and complexities associated with customized investments, a recent case acknowledges that plan fiduciaries are not necessarily duty-bound to seek out alternatives to mutual funds. In *White v. Chevron Corp.,* the court noted that mutual funds have "unique regulatory and transparency features" and that plaintiffs could not simply allege that the mutual funds were imprudent because they were more expensive than collective investment trusts or separate investment accounts.

Caselaw Continues to Develop Regarding Standards for Employer Stock Claims

Caselaw in the wake of 2014's *Fifth Third Bancorp v. Dudenhoeffer* Supreme Court decision continues to favor defendant employers. In *Dudenhoeffer*, the Supreme Court observed that publicly traded stock bought at market price should be considered to have been bought for fair market value, absent "special circumstances" that interfered with the efficiency of the market. The Court further confirmed that plan fiduciaries with insider information were not required to violate federal securities laws in order to protect the plan, meaning that claims related to insider information must assert that there were actions that the fiduciaries legally could have taken that would have benefited the plan. In a subsequent brief decision, *Amgen, Inc. v. Harris,* the Supreme Court clarified that in order for a plaintiff to pursue a challenge to the prudence of a plan's investment in employer stock, the plaintiff's claim had to allege that there was a legally permissible action that could have been taken but was not, and that a prudent fiduciary "could not have concluded" that the proposed action "would do more harm than good."

Subsequent cases demonstrate that this is a high bar. For example, courts have generally accepted defendants' assertions that disclosing problematic information about an employer's prospects would accelerate the devaluation of stock already held by the plan, and concluded that a prudent fiduciary accordingly could conclude that disclosure "would do more harm than good." The Department of Labor's countervailing assertion, in an amicus brief in a lawsuit brought against BP, that "truth will out" and that prompt disclosure is therefore preferable to halt the impact of a fraud on the market did not gain traction. The court ruled for defendant BP in that case.

Overall, plan fiduciaries need to be sure they understand the *Dudenhoeffer* standard as it applies to their company's situation. Plan sponsors need to be thoughtful about whether continuing to allow plan fiduciaries to offer company stock as either an active or frozen investment makes sense from the perspective of potential litigation risk and expenses, even if the plan sponsor is confident that the stock remains a prudent investment over the long term.

In addition, it remains unclear to what extent *Dudenhoeffer's* market-price holding will apply to private companies. Two district courts had considered it relevant, but one of those holdings was overruled by the Seventh Circuit, in *Allen v. GreatBanc Trust Co.* As the Seventh Circuit observed, "the Court's holding [in *Dudenhoeffer*] was limited to publicly traded stock and relies on the integrity of the prices produced by liquid markets. Private stock has no "market price," for the obvious reason that it is not traded on any public market…There is no market price to explain away, and so no reason to apply any "special circumstances" rule. Additionally, another part of *Dudenhoeffer's* rationale—the need to protect fiduciaries from running up against insider trading law by relying on non-public information for stock valuation—has no application to the private stock context." In the wake of *Allen*, fiduciaries of plans with closely-held stock need to be particularly cautious.

Separately, on a positive note for ERISA plan investors in company stock, the Second Circuit recently ruled that AIG's ERISA retirement plans could share in the proceeds of a settlement of securities claims brought in connection with alleged fraud, stock price manipulation and other violations dating back to 2004. A district court had previously barred the plans from sharing in the settlement, asserting that they were "affiliates" of the company and hence ineligible to recover. The Second Circuit rejected that approach, noting that ERISA limited AIG's ability to control its plans and that those plans accordingly should not be treated as "affiliates" for purposes of the settlement. This holding is an important reminder that ERISA does not displace the obligation for a company and its employees to comply with securities laws, and that plaintiffs harmed by a company's loss of value may have avenues of recourse beyond ERISA.

Employer Stock Registration Requirements

Employers that do choose to offer employer stock under a defined contribution plan need to understand the registration and filing requirements applicable to this investment. For example, a participant-directed 401(k) plan that allows participants to choose to invest in employer stock typically will need to register its shares on an S-8, file an 11-K and comply with SEC prospectus requirements. The SEC recently warned

that at least in some cases, registration may be required even if the stock is made available under a brokerage account offering a range of investments, rather than as a specified core investment option.

Department of Labor News

New Fiduciary Regulations

Likely the biggest employee benefits story of the year has been the issuance of the Department of Labor's new regulations expanding the definition of "fiduciary" under ERISA. Under the new regulations, a wider range of activities will come under ERISA's fiduciary standards and the "prohibited transaction" conflict of interest rules imposed by the Internal Revenue Code on qualified retirement plans, IRAs and health savings accounts. The changes are intended to protect participants and plans by reducing opportunities for conflicts of interest when individuals and their plan fiduciaries seek advice about plan assets. Financial professionals who are fiduciaries are subject to ERISA's and/or the Code's "prohibited transaction" rules that restrict potential conflicts of interest, and must adhere to ERISA's requirement that they act prudently and in the best interests of plan participants and beneficiaries when they provide advice to or in connection with an ERISA plan.

While the financial industry will bear the bulk of the responsibility for complying with the new regulations, the sponsors and fiduciaries of ERISA-governed plans should consider the impact of the new definition on their existing vendor relationships and make any necessary changes to bring new and existing fiduciary relationships in line with ERISA. Sponsors and fiduciaries should also review their own communication materials to make sure that they themselves are not providing individualized investment advice to plan participants and beneficiaries. Furthermore, plan sponsors and fiduciaries should discuss participant outreach protocols with their recordkeepers, especially if the recordkeeper offers rollover IRAs for distributions from the plan. Finally, sponsors and fiduciaries should review their contracts to be sure that their agreements contain appropriate representations and indemnities in connection with a vendor's fiduciary status (or lack thereof).

Ultimately, the new regulations offer advantages for plan sponsors and fiduciaries. Employees will be at less risk of receiving conflicted advice, and investment professionals serving the plan and/or individual participants will generally need to provide clear disclosure about their fiduciary status, compensation, and potential conflicts of interest. However, plan sponsors and employee-fiduciaries still need to bear in mind that not all plan vendors will owe a fiduciary duty to the plan.

More information about the new regulations and the next steps for plan sponsors and their fiduciary committees is available at http://www.hselaw.com/news-and-information/legalcurrents/962-new-fiduciary-standards-for-erisa-plans.

Increased Regulatory Focus on Retirement Plan Payment Deadlines

Tax-qualified retirement plans, 403(b) plans and 457(b) plans must begin paying participants no later than the April 1st after the year in which the participant turns 70½ or the year in which the participant's employment terminates, whichever is later. In the case of individuals owning more than five percent of the plan sponsor, and all IRA owners, the deadline is always April 1st after the year in which the individual attains age 70½. Some plans (particularly defined benefit pension plans) require payment to commence earlier, when the participant reaches normal retirement age. Beneficiaries of deceased participants are also subject to payment deadlines, with the actual deadline varying depending on a number of factors.

As the baby boomer generation grows older, the number of participants reaching the age at which payments must commence is growing steadily. With that growth in numbers has come increased regulatory concern that plans are not tracking their payment obligations. A plan has an obligation to contact participants sufficiently in advance of the payment deadline to arrange for timely payment, and to search for participants who no longer have valid addresses on file. However, a number of plans have instead simply waited for participants to contact them.

The Department of Labor has announced a focused investigation of large defined benefit plans to examine whether these plans have adequate procedures to arrange for timely payment of benefits. In addition, the instructions to Form 5500 for the 2016 plan year included new details confirming that a plan that missed a required payment must report a failure to pay benefits due. The IRS subsequently clarified that a plan did not need to report a failure to pay if it had searched for but failed to find (or was still searching for) a participant, making it important for plans to be proactive in their efforts to find missing payees.

According to the Department of Labor, plan fiduciaries should maintain written procedures for enforcing payment deadlines and locating missing participants. If you are creating or updating your plan's procedures, consider addressing the following points:

- Identification of the party responsible for tracking and initiating required distributions. If you expect the recordkeeper to perform this function, the recordkeeping contract should expressly impose this obligation.
- A process for searching for participants and beneficiaries as soon as the plan learns of a bad address. For example, if a routine benefit statement comes back as undeliverable, an address search should be conducted at that time. Waiting until the payment deadline approaches increases the odds that you will not be able to find the person, or that you will not have timely notice of a death and associated payment requirements. In addition, the plan has an ongoing obligation to provide required communications to the participant or beneficiary; it cannot simply ignore a bad address.
  - Revisit the "bad address" list periodically, to conduct updated searches for individuals who could not be located through your original efforts.
- A process for conducting death searches. A participant's death may accelerate the time at which payments must begin, or mean that payments need to stop, be reduced, or be redirected. Beneficiaries may not know of a participant's retirement benefits, particularly if the participant had not yet commenced payment, so the plan should not assume it will receive timely notification from the next of kin. Note that enhanced requirements now apply to qualify for access to the Social Security death master file.
- The timing for initial and follow-up outreach to initiate payment, and rules for how to handle non-responsive participants and beneficiaries.

In addition, be sure to communicate payment deadlines in your summary plan description, exit packages and other appropriate plan communications.

Department of Labor Penalty Inflation Adjustments

ERISA authorizes a court (or, in some case, an agency) to impose monetary penalties for certain ERISA violations, and these penalties can be adjusted for inflation. The last adjustment was in 2003, but annual adjustments are required under new federal legislation. On June 30, 2016, the DOL issued the 2016 updates (https://www.dol.gov/ebsa/pdf/fs-interim-final-rule-adjusting-erisa-civil-monetary-penalties-for-inflation.pdf). Not all penalties are affected (for example, the penalty for failure to respond to a participant document request remains at $110/day), but many are.

As was previously the case, the penalties represent a maximum. The enforcing court or agency typically can waive or reduce the actual penalty imposed if circumstances warrant. For example, a court will be less likely to enforce the maximum penalty if an employer failed to meet a compliance requirement for reasons beyond its control, despite having appropriate processes in place, or if the employer discovered and corrected the compliance failure on its own. The enhanced penalties underline the importance of robust compliance monitoring and prompt action when an error is discovered.

IRS News

IRS Drastically Limits Determination Letter Program

In 2015, the IRS announced that the February 1, 2016 - January 31, 2017 "Cycle A" determination letter submission cycle (for individually designed plans whose sponsor's EIN ends in "1" or "6" and certain electing controlled group employers) will be the last opportunity for existing individually designed plans to obtain determination letters, except in cases of plan termination and certain other circumstances to be identified. The IRS has extended the deadline for sponsors of individually designed defined contribution plans to adopt IRS-preapproved documents (*i.e.,* prototype and volume submitter plans) until April 30, 2017. The IRS has also expanded the types of plan designs for which it will pre-approve plan documents to include employee stock ownership plans and cash balance defined benefit plans. However, the IRS has yet to offer a pre-approved solution for multiemployer plans.

Alternatively, the IRS confirmed in Revenue Procedure 2016-37 that plan sponsors with current determination letters can continue to rely on those letters for any plan provisions that remain unchanged and unaffected by legal or regulatory changes. This is true regardless of whether the letter contains an expiration date, since the IRS has stated that the expiration dates are no longer applicable. The IRS has also indicated that it will expand its efforts to provide model language and other tools to update plan documents in the event of future legislative or regulatory changes, and has revamped its approach to plan document problems discovered on audit to take into account the lack of ongoing determination letter review.

Revenue Procedure 2016-37 also announced that, as part of the promised expansion of plan compliance tools, the IRS will issue an annual list of required plan amendments reflecting legal changes. The list will be issued after October 1st of each year, and plan sponsors will then be required to adopt amendments to reflect any relevant items on that year's list by the end of the second calendar year. As under the previous system, a plan sponsor must adopt amendments reflecting any changes it chooses to make (as opposed to legally required changes) by the end of the plan year in which it makes the change. In addition, consistent with existing rules, changes involving changes to benefits or vesting and certain other types of changes must be made in advance, and some amendments may need to be adopted before the beginning of the relevant plan year.

At this point, it remains to be seen how well the new system will work. For an employer whose plan contribution or benefit formula fits comfortably into a pre-approved document and who does not need specialized administrative provisions or other unique features, converting to a pre-approved document at the next convenient opportunity offers a number of advantages. This will be true in particular for employers seeking to make significant changes to important plan design features for which they will not be able to obtain an updated determination letter. However, some employers, particularly those with complex plan designs, will find it difficult to use a preapproved document efficiently. Employers will need to make this important decision based on their particular situations and after discussion with their plan recordkeepers and counsel.

IRS Issues Updated EPCRS Procedure

In September, the IRS issued Revenue Procedure 2016-51, a new set of instructions for the Employee Plans Compliance Resolution System ("EPCRS"). EPCRS provides guidance on the correction of qualified plan errors, and offers three different programs: the Self-Correction Program (SCP) for operational errors that meet certain parameters, the Voluntary Correction Program (VCP) allowing plan sponsors to seek IRS approval for correction of operational or document problems, and the Audit Closing Agreement Program (Audit CAP) for problems identified during an IRS examination.

The new Procedure does not make any significant changes to SCP or VCP, although it incorporates updated procedures that had been previously announced, and deletes the section establishing VCP user

fees in favor of including these fees in an annual Revenue Procedure. The Procedure sets more detailed parameters for negotiation of sanctions on Audit CAP, and adapts EPCRS' requirements to reflect the changes to the IRS determination letter program (see "IRS Drastically Limits Determination Letter Program" on page 9).

New Rules for Safe Harbor Plan Mid-Year Amendments

In Notice 2016-16, the IRS liberalized the restrictions it had previously imposed on mid-year amendments to 401(k) and 403(b) plans designed to automatically satisfy certain nondiscrimination tests ("safe harbor" plans). Previous guidance had indicated that employers had little, if any, ability to amend these plans during the plan year, so that amendments generally needed to be in place before the plan year began. Under the new guidance, only a few amendments are outright prohibited during the plan year:

- Plan sponsors cannot reduce or suspend safe harbor contributions unless they included a warning of that possibility in the annual safe harbor notice provided before the beginning of the year, or meet certain standards of financial distress. Thirty (30) days' advance notice is required.
- Plan sponsors cannot increase the vesting requirements applicable to safe harbor contributions under a Qualified Automatic Contribution Arrangement ("QACA") safe harbor plan.
- Plan sponsors cannot reduce or narrow the group of employees eligible for safe harbor contributions, although service crediting or entry date rules can be changed for employees not yet eligible for the plan.
- A non-QACA safe harbor plan cannot be changed to a QACA design, and vice versa.
- Plan sponsors generally cannot change the matching contribution formula or associated definition of compensation. An exception to this prohibition is available if the changed formula is effective retroactive to the beginning of the year, is more generous, and is adopted and announced at least three months before the end of the year.

Other amendments generally are permissible, although amendments that affect plan provisions required to be described in the annual safe harbor notice must be accompanied by 30 days' advance notice.

The IRS indicated that it is considering additional guidance, and requested comments in particular on the special issues associated with business acquisitions and divestitures.

IRS Clarification Regarding Tax Treatment of Certain Wellness Plan Rewards and Premium Reimbursements May Affect Retirement Plan Compensation Definitions

Earlier this year, the IRS released a Chief Counsel Advice Memorandum regarding the inclusion in taxable income of cash rewards and reimbursements of premiums for participating in a wellness program. A Chief Counsel Advice Memorandum does not have the authority of the Code or the Treasury Regulations, but it gives an indication as to how the IRS might approach these issues.

The IRS attorney concluded that an employer must include in an employee's taxable income payments of cash rewards for participating in a wellness program. The IRS attorney also noted that if an employee receives some other reward, such as payment of gym membership fees, the fair market value of that reward generally must be included in the employee's taxable income as well. While the IRS memorandum focused upon the tax implications of these rewards, their inclusion in taxable income could have retirement plan implications as well. If you offer a health plan that includes these types of awards, you should review your retirement plan documents to determine whether the rewards must be treated as plan compensation. You also may wish to consider whether you would like to amend your retirement plan document to exclude these rewards from eligible compensation (note that an end of the plan year deadline may apply for this amendment, and in many cases the addition of this exclusion may only be prospective; also, as with any change to a plan's definition of compensation, consideration should be given to any impact on the plan's compliance testing).

The IRS attorney also concluded that a reimbursement of premiums for participating in a wellness program is includible in taxable income if those premiums were originally paid by salary reduction through a Section 125 cafeteria plan. The benefit plan implications of this situation are less clear. Unless specifically excluded, it would appear that the reimbursement would constitute eligible plan compensation under most common definitions of compensation used for retirement plans. However, many retirement plans also include contributions to a Section 125 plan in eligible compensation, in which case the amount of the reimbursement would have already been included in plan compensation. If your health plan offers premium reimbursements and you would like to discuss clarifying their treatment as compensation under your retirement plan, please contact us.

IRS Extends Nondiscrimination Relief for Frozen Defined Benefit Plans

Through the last plan year beginning before 2018, the IRS will continue to allow additional nondiscrimination testing flexibility for defined benefit plans that permit existing participants to continue earning benefits but are closed to new hires, if the plans satisfy specified requirements. Congress is also considering legislation that would provide for more generous protections.

The IRS has issued proposed regulations that are intended to modify the nondiscrimination testing rules and provide a longer-term approach to the problem of these "soft-frozen" defined benefit plans, within the limits of current legislative requirements.

QSERP Regulations

In its proposed revisions to the nondiscrimination testing regulations intended to assist soft-frozen defined benefit plans, the IRS had originally included provisions that would have limited or prohibited "qualified supplemental executive retirement plans," or "QSERPs." QSERPs offer enhanced benefits (typically for senior management) within the limits allowed for qualified defined benefit plans. When it withdrew this segment of the proposal, the IRS indicated that it wants more time to consider the issues associated with QSERPs.

Late Rollover Safe Harbors

The IRS has provided new relief for individuals who miss the 60-day deadline to deposit a rollover distribution in the intended recipient plan or IRA. If the deadline is missed due to one of 11 pre-approved reasons (including financial institution errors, severe illness of the individual or a family member, or the death of a family member), the individual makes the contribution as soon as possible, and the individual meets certain other requirements, the individual can certify that the delay is due to one of the pre-approved reasons and can complete the rollover without needing to apply to the IRS for a formal waiver of the deadline. Plan administrators may rely on an individual's certification for purposes of accepting and reporting a rollover contribution, unless the plan administrator has knowledge that contradicts the certification. IRS Revenue Procedure 2016-47 is available at https://www.irs.gov/pub/irs-drop/rp-16-47.pdf.

Bifurcated Forms of Payment

The IRS issued regulations intended to make it easier for a participant to elect payment of a portion of his or her retirement benefit as a lump sum while receiving the remainder as an annuity. Of course, the participant's plan will need to permit a bifurcated payment, something most plans currently do not allow under normal circumstances.

PBGC News

Reduction in PBGC Premium Penalties

The PBGC has issued final regulations reducing penalties for late payment of PBGC insurance premiums. Late payment penalties were cut in half, and sponsors with good payment histories who make payment promptly upon receiving an underpayment notice can qualify for additional reductions. Plan sponsors should bear in mind, however, that interest continues to accrue on unpaid premiums.

Final PBGC Reportable Event Regulations

In 2015, the PBGC issued long-awaited final regulations addressing reporting obligations applicable to a variety of events affecting defined benefit plan sponsors under Section 4043 of ERISA (known as "reportable events"). The final regulations revised the applicable reporting waivers and the definition of several of the reportable events, and took effect January 1, 2016. More information about the reportable event rules, as well as Section 4062(e)'s funding requirements in the event of facility closures, is available at http://www.hselaw.com/files/Single-Employer_Defined_Benefit_Plans_Oct_2015.pdf. In addition, a more detailed look at some aspects of the final regulations is available at http://www.hselaw.com/news-and-information/legalcurents/994-single-employer-defined-benefit-plans-the-expansion-of-the-loan-default-pbgc-reportable-event and http://www.hselaw.com/news-and-information/legalcurrents/936-single-employer-defi-ned-bene-fit-plans-the-public-company-waiver-for-certain-pbgc-reportable-events.

PBGC Missing Participant Program

The PBGC has issued proposed regulations to expand its missing participant program for terminated defined benefit plan participants. A PBGC database will enhance participants' ability to find their benefits. The PBGC also has proposed modest changes to the way missing participants' benefits are transferred to the PBGC, and would offer access to the program for participants in terminated defined contribution plans and certain defined benefit plans (such as multiemployer plans) not currently covered by the program. The PBGC anticipates the expanded program will be implemented in 2018.

Other News

Cybersecurity

2016 saw heightened concern regarding the security of plan records, with high-profile data breaches bringing more and more calls for plan sponsors and fiduciaries to make sure their own systems and those of their vendors offer appropriate safeguards. While ERISA does not impose any special requirements for data security, all plan fiduciaries need to be aware of the issue when working with their internal IT resources and when hiring or monitoring vendors who have access to employees' personal information. Plan fiduciaries need to make sure that they are in compliance with generally applicable federal, state and local laws, as well as organizational data security policies, and should be sure appropriate clauses are included in their contracts. Plan fiduciaries of group health plans also have to comply with HIPAA (although in the case of an insured group health plan, the bulk of HIPAA privacy and security compliance falls upon the insurance carrier).

Plan Record Retention

Aside from cybersecurity concerns, plan fiduciaries should also be reviewing their systems and data retention policies to be certain that they are keeping all required records for the required periods of time. Especially in the case of retirement plans, this may mean keeping plan documents and participant records indefinitely. In *Estate of Barton v. ADT Security Services Pension Plan,* the Ninth Circuit recently held that despite the normal requirement that a plaintiff prove his own claim, an employer instead could be required to produce records *disproving* the plaintiff's claim, if the employer had control of the necessary records and the plaintiff had articulated a plausible basis for his claim. In *Barton,* the plaintiff had demonstrated that he was employed by members of the plan sponsor's corporate group and that he had received compensation steadily for the requisite 10-year period. The court held that the company therefore must show why the employee was not entitled to a pension.

Revisions to Form 5500

The IRS, Department of Labor and PBGC intend to make a number of changes to Form 5500. The revised Form 5500 will require more detailed financial disclosures and better accommodate the wide range of investment products used by modern benefit plans. The new form will also obtain more information from group health plan filers. In addition, the new form will ask more questions regarding plan administration and compliance. Service provider disclosure requirements will be aligned with other

regulatory disclosure requirements. Overall, as well, the new form is expected to facilitate data mining. The agencies have extended the comment period on the proposed revisions to December 5, 2016. More information about the proposed revisions is available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/fs-proposal-to-modernize-and-improve-the-form-5500-filed-by-employee-benefit-plans.pdf.

In the meantime, additional compliance questions were added to Form 5500 for 2015, which the IRS subsequently instructed employers not to complete. The IRS has confirmed that these questions should not be answered for 2016, either. See https://www.irs.gov/retirement-plans/irs-compliance-questions-on-the-2015-and-2016-form-5500-series-returns.

Form 5500 Deadline

The Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 directed the IRS to increase the available extension for filing Form 5500 (currently limited to 2½ months) to 3½ months, starting with the form due for the 2016 plan year. However, this provision was repealed on December 4, 2015. This means that for calendar year plans, the Form 5500 deadline remains July 31, with an available extension to October 15th (October 16th, in 2017, since October 15th is a Sunday).

Multiemployer Pension Reform Act of 2014

The Multiemployer Pension Reform Act of 2014 allows multiemployer plans facing insolvency to seek IRS permission to reduce pensions to current retirees. So far, plans seeking this permission have not been successful, with the Central States, Southeast and Southwest Areas Pension Plan losing a high-profile, bitterly contested effort to cut retirees' pensions. The law remains controversial, and Congress may consider another multiemployer pension reform bill after the November election.

Recent Decisions Heighten Controversy Surrounding "Church Plan" Status

ERISA requires most employers' retirement plans to comply with strict rules regarding, among other things, vesting, eligibility and funding. However, plans sponsored by churches are exempt from these rules. Recent decisions by the federal courts of the Third, Seventh and Ninth Circuits have added fresh fuel to a growing legal controversy about which retirement plans can qualify as exempt "church plans." For example, a number of religiously affiliated hospitals and schools claim "church plan" status for their plans. The proper interpretation is far from settled, with similar cases still pending and decades of contrary authority on the books. However, all three appellate courts to address the issue have decided for the plaintiffs, holding that the plans in question are not church plans and must comply with ERISA. The Supreme Court has been asked to review the issue; Justice Kennedy's decision to delay implementation of the appellate court's ruling in one recent case may hint at good odds that the Court will take the case. In the meantime, caution is essential for anyone operating or considering the acquisition of a religiously affiliated entity that is not itself a house of worship but which sponsors a defined benefit plan claiming "church plan" status. See our newsletter at http://www.hselaw.com/news-and-information/legalcurrents/1011-victories-for-plaintiffs-in-erisa-church-plan-cases-cause-concern-for-church-af-filiated-pension-plan-sponsors for details.

State IRA Programs

State efforts to facilitate or mandate the availability of retirement savings programs continue to gain steam. The Department of Labor issued guidance intended to assist these programs, establishing a safe harbor that would allow states and certain municipalities to design automatic enrollment IRA programs that would qualify for exemption from ERISA. Several states have enacted laws that will require employers doing business in those states who do not offer retirement plans to automatically enroll their employees to contribute to state IRA programs, and approximately 20 states are currently considering similar legislation. These programs generally require employers to deduct specified amounts from their employees' paychecks and remit them to a state-run IRA while allowing employees to opt out at any time. At present, none of these state programs is up and running, so the practical impact remains to be seen.

However, employers and benefits practitioners are concerned about the risks associated with overlapping and potentially conflicting state mandates and with the need for employers to facilitate different retirement programs in different states.

New SEC Money Market Fund Rules Take Effect

The SEC's new rules regarding money market fund liquidity took effect October 14, 2016. The regulations classify funds into three separate categories: government, retail prime, or institutional prime money market funds. Government money market funds must invest at least 99.5 percent (up from the previous minimum of 80 percent) of their assets in cash, government securities, or repurchase agreements that are collateralized by cash or government securities. Retail money market funds must limit all beneficial owners of the fund to "natural persons." Defined benefit plans would not qualify, but individual retirement accounts and participant-directed retirement plans (such as most 401(k) plans) qualify as "natural persons" for this purpose. Money market funds not in the government or retail categories will be classified as institutional prime funds.

Historically, money market funds have maintained a stable $1.00 Net Asset Value ("NAV"). Government and retail funds can continue to do so, but institutional prime funds will be required to maintain a "floating" NAV based on the value of the fund's investments. In addition, both retail and institutional funds (but not government funds) will be required to provide for the imposition of "gates" (*i.e.,* restrictions on liquidity) and/or redemption fees if the fund's liquid assets fall below certain benchmarks. Fund types that are not subject to these new rules can choose to adopt some or all of them, so when selecting a fund, review its prospectus or other offering materials to be sure it has the liquidity features you want.

If you have a money market fund in your plan and have not considered the impact of these new rules, take the opportunity to assess whether your current fund is still the right fund for your plan. Since different rules apply to different types of money market funds and different plans use money market funds for different purposes, fiduciaries' reactions to the new rules will depend on a plan's specific circumstances. You should discuss the impact of the new rules with your investment professional.

New EEOC Wellness Program Regulations

In May 2016, the U.S. Equal Employment Opportunity Commission ("EEOC") issued final regulations addressing employer-sponsored wellness programs pursuant to two different federal laws: the Americans with Disabilities Act ("ADA") and Title II of the Genetic Information Nondiscrimination Act ("GINA"). These final regulations clarify and amend earlier-released proposed regulations on each of these laws issued by the EEOC in April 2015 and October 2015.

ADA

The ADA generally prohibits employers from making disability-related inquiries of employees or requiring employees to take medical examinations. One exception is for "voluntary" medical examinations or medical history questionnaires that are part of an employee health program. The final ADA regulations clarify the proposed regulations on when wellness programs that involve disability-related inquiries or medical examinations will be considered "voluntary" and thus compliant with the ADA, and the extent to which employers may use incentives to encourage employees to participate in these types of wellness programs.

The regulations require disability-related inquiries and medical exams to be reasonably designed to promote health or prevent disease. For example, a medical examination would not be considered "reasonably designed" if it simply resulted in the collection of health-related information without providing the employee the results or follow-up information or advice. Employers may not require employees to participate in the wellness program, and they cannot deny coverage under any group health plan to employees for not participating in the wellness program. The results of any medical examinations or questionnaires must be kept confidential and generally may not be disclosed to the employer except in aggregate terms. The regulations also require a written notice worded so that an employee is reasonably likely to understand it, explaining the type of medical information that will be collected, the specific

purposes for which it will be used, and restrictions on how that information will be disclosed and shared. Lastly, the regulations impose a limit on the incentive an employer can offer to promote an employee's voluntary participation in a wellness program that includes disability-related inquiries and/or medical examinations. Calculation of the incentive limitation can be complicated and it depends on a number of factors, but the limit is generally 30% of the cost of self-only coverage in the employer's group health plan.* Employers should be aware, however, that compliance with the incentive limitations contained in the longstanding HIPAA wellness programs rules (which apply to wellness programs offered in connection with a group health plan) will not necessarily ensure compliance with the ADA regulations. In particular, employers that offer a reward for not using tobacco products and who test for the presence of nicotine or tobacco should review their programs carefully. While the HIPAA regulations allow for an incentive of up to 50% of the cost of coverage in which the employee is enrolled, the ADA regulations would cap the rewards at 30% of self-only coverage. (Note that the ADA rules do not apply to tobacco cessation programs that only ask employees whether or not they use tobacco, and do not actually test for the presence of nicotine or tobacco.)

GINA

Although GINA generally prohibits employers from requesting genetic information of employees, longstanding GINA regulations allow an employer to request genetic information as part of a voluntary wellness program if certain requirements are met. One of those requirements is that if an employer offered a reward in connection with the wellness program, the full reward would need to be made available to the employee regardless of whether the employee actually provided the genetic information†. Prior to the issuance of the proposed regulations in October 2015, it appeared that, based on the wording of the GINA law itself,‡ employers could not offer an incentive for an employee's spouse to undergo a medical examination or provide information about his/her current medical status. The GINA regulations clarify that employers may in fact offer incentives to an employee whose spouse undergoes a medical examination or provides current or past health status information. (Incentives may not be offered, however, in return for the spouse providing his or her own genetic information, such as results of his or her genetic tests.) Unfortunately, the EEOC has created an administrative burden on employers in that employers will be required to obtain prior, knowing, voluntary, and written authorization from the spouse when the employee or spouse is given a reward for the spouse undergoing a medical examination or providing information about his/her current medical status. Thankfully, the EEOC has informally confirmed that a wellness program that provides a reward for a spouse completing an annual physical with his or her personal physician, with no reporting of results by the physician, is NOT considered a request by the employer for genetic information and is therefore not subject to the GINA rules. The final GINA rules also include limitations on incentives that may be offered, which now mirror the ADA regulations' incentive limits.

---

*An incentive of up to 30% of the total cost of self-only coverage of the group health plan in which the employee is enrolled is allowed when participation in the wellness program is limited to employees enrolled in a particular plan;

An incentive of up to 30% of the total cost of self-only coverage of the employer's group health plan is allowed where 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;

An incentive of up to 30% of the total cost of the lowest cost self-only coverage under a major medical group health plan is allowed where an employer offers more than one group health plan, but participation in the wellness program is offered to employees whether or not they are enrolled in a particular plan; and

An incentive of up to 30% of the cost of self-only coverage under the second lowest cost Silver Plan for a 40-year-old non-smoker on the state or federal health care exchange in the location that the employer identifies as its principal place of business is allowed if the employer does not offer a group health plan or group health insurance coverage.

†For example, if an employer offered a reward for completion of a medical questionnaire containing 100 questions, and 20 of those questions asked questions about the employee's family medical history (which is considered genetic information), the full reward would need to be given to the employee if he/she answered the 80 questions that did not pertain to family medical history.

‡For some reason, Congress drafted the law to define "genetic information" to treat information about an employee's spouse's current medical status as genetic information of the employee (Don't ask us why!).

The EEOC has released Q&As in conjunction with these final regulations, addressing the ADA final rule https://www.eeoc.gov/laws/regulations/qanda-ada-wellness-final-rule.cfm and the GINA final rule https://www.eeoc.gov/laws/regulations/qanda-gina-wellness-final-rule.cfm. The EEOC has also released a sample notice https://www.eeoc.gov/laws/regulations/ada-wellness-notice.cfm for employer-sponsored wellness programs to be used to comply with the final ADA regulations. As noted above, it is important to remember that compliance with the final ADA and GINA regulations does not guarantee compliance with other federal laws, including HIPAA.

Executive Compensation

New Proposed 409A Regulations

The IRS issued new guidance under Section 409A of the Internal Revenue Code, which governs nonqualified deferred compensation. For the most part, the new regulations are not applicable yet, pending finalization by the IRS. However, the IRS did include some clarifications to existing guidance, which take effect immediately. The new regulations expand some 409A exemptions, provide more flexibility for post-death payments, and make a number of helpful revisions and clarifications. More details are available at http://www.hselaw.com/files/IRS_Issues_New_Proposed_Regulations_Under_Section_409A_August_2016.pdf.

New 457 Regulations

The IRS issued long-awaited proposed regulations governing deferred compensation for tax-exempt organizations and state and local governments. Under Section 457 of the Internal Revenue Code, generally, an employee of a tax-exempt organization or state or local government must pay tax when he or she becomes vested in the right to receive compensation, even if the compensation is not yet payable. Certain exceptions apply, such as for tax-qualified retirement plans, 403(b) plans, eligible 457(b) plans, bona fide death benefit plans, and bona fide severance plans, but Section 457 otherwise has a very broad sweep.

The proposed regulations address the standard for determining when compensation is vested (i.e., no longer subject to a "substantial risk of forfeiture") and address the availability and scope of exemptions. More information is available at http://www.hselaw.com/news-and-information/legalcurrents/1010-irs-issues-new-proposed-regulations-on-deferred-compensation-arrangements-of-tax-exempt-organizations.

Confidentiality and Severance Agreements

When drafting a severance agreement, severance plan or associated release, be aware that the SEC in recent enforcement actions has taken a very restrictive view of the permissible scope of confidentiality clauses. The SEC has targeted documents that it considered inadequate to protect the right to report violations of law, asserting that agreements should carve out reporting rights from confidentiality obligations and objecting to clauses requiring advance notice to the company. More information is available at http://www.hselaw.com/news-and-information/legalcurrents/1019-sec-takes-a-hard-line-on-confidentiality-and-severance-agreements.

For More Information

As always, please feel free to contact a member of the Employee Benefits & Executive Compensation group for more information about the items discussed in this newsletter, or for assistance in other matters. ■

HSE Harter Secrest & Emery LLP
ATTORNEYS AND COUNSELORS

ROCHESTER
1600 Bausch & Lomb Place
Rochester, NY 14604-2711
585.232.6500

BUFFALO
50 Fountain Plaza, Suite 1000
Buffalo, NY 14202-2293
716.853.1616

ALBANY
111 Washington Ave., Suite 303
Albany, NY 12210-2209
518.434.4377

CORNING
8 Denison Parkway East, Suite 403
Corning, NY 14830-2638
607.936.1042

NEW YORK
733 Third Avenue
New York, NY 10017
646.790.5884

This publication is provided as a service to clients and friends of Harter Secrest & Emery LLP. It is intended for general information purposes only and should not be considered as legal advice. The contents are neither an exhaustive discussion nor do they purport to cover all developments in the area. The reader should consult with legal counsel to determine how applicable laws relate to specific situations. © 2016 Harter Secrest & Emery LLP

Updated Internal Revenue Code Limits

	2017	2016
IRAs		
IRA Contribution Limit	5,500	5,500
IRA Catch-Up Contributions	1,000	1,000
IRA AGI Deduction Phase-out Starting at		
Joint Return	99,000	98,000
Single or Head of Household	62,000	61,000
SEP		
SEP Minimum Compensation	600	600
SEP Maximum Contribution	54,000	53,000
SEP Maximum Compensation	**270,000**	**265,000**
SIMPLE Plans		
SIMPLE Maximum Contributions	12,500	12,500
Catch-up Contributions	3,000	3,000
401(k), 403(b), Profit-Sharing Plans, etc.		
Annual Compensation	270,000	265,000
Elective Deferrals	18,000	18,000
Catch-up Contributions	6,000	6,000
Defined Contribution Limits	54,000	53,000
ESOP Limits	1,080,000 215,000	1,070,000 210,000
Other		
HCE Threshold	120,000	120,000
Defined Benefit Limits	215,000	210,000
Key Employee	175,000	170,000
457 Elective Deferrals	18,000	18,000
Control Employee (board member or officer)	105,000	105,000
Control Employee (compensation-based)	215,000	215,000
Taxable Wage Base	127,200	118,500