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WEB's ***Benefits Insider*** is a bi-monthly member exclusive publication providing the latest developments from Washington, DC, on matters of interest to employee benefits professionals. The content of this newsletter is being provided through a partnership with the American Benefits Council, a premier benefits advocacy organization. To inquire about membership with the Council, contact Deanna Johnson at (202) 289-6700 or djohnson@abcstaff.org.

Articles in this Edition

RECENT LEGISLATIVE ACTIVITY

Nothing to report this issue.

Congress is currently in recess for the 2016 election season. Both the Senate and House of Representatives are scheduled to return for one week on November 14, then will recess again for the Thanksgiving holiday before returning for a lame-duck session to close out the calendar year.

RECENT REGULATORY ACTIVITY

Regulatory Agencies Announce Cost-of-Living Adjustments for 2017 Tax Year

This week, the Internal Revenue Service (IRS) issued **Notice 2016-62** and **Revenue Procedure 2016-55**, announcing certain inflation adjustments applicable to dollar limitations for Tax Year 2017.

In many cases, hikes in the cost-of-living index have triggered increased limits. An incomplete list of key adjustments is provided below:

Retirement Limits/Penalties	2016	2017
Maximum annual pension benefit: [415(b)] (The limit applied is actually the lesser of the dollar limit or 100 percent of the participant's average compensation (generally the high three consecutive years of service)) For a participant who separated from service before January 1, 2017, the participant's limitation under a defined benefit plan under § 415(b)(1)(B) is computed by multiplying the participant's compensation limitation, as adjusted through 2016, by 1.0112.	$210,000	$215,000
Defined contribution maximum deferral [415(c)]	$53,000	$54,000
Maximum elective deferral [401(k), 403(b), 457, Thrift Savings Plan]	$18,000	$18,000
Limit on Annual IRA Contributions [219(b)(5)(A)]	$5,500	5,500

Maximum Catch-up Contribution: for those age 50 and over, contributions to an applicable employer plan as described under Section 401(k)(11) or 408(p)) are limited to … [414(v)(2)(B)]	$3,000	$3,000
Maximum Catch-up Contribution: for those age 50 and over, contributions to an applicable employer plan other than those described under Section 401(k)(11) or 408(p)) are limited to … [414(v)(2)(B)]	$6,000	$6,000
Annual Compensation Limit [401(a)(17); 404(l); 408(k)(3)(C); 408(k)(6)(D)(ii)]	$265,000	$270,000
Annual Compensation Limit: For eligible participants in certain governmental plans, the compensation limitation to be taken into account [401(a)(17)]	$395,000	$400,000
Highly Compensated Threshold [414(q)]	$120,000	$120,000
Health Plan Limits/Penalties	**2016**	**2017**
Cafeteria Plans: Limitation on voluntary employee salary reductions for contributions to a health FSA [125]	$2,550	$2,600
Requirement to Maintain Minimum Essential Coverage: Individual penalty for not maintaining minimum essential health coverage – the higher of two calculation methods applies [5000A]	$695 (adults age 18 or over) and $347.50 per child to a maximum of $2,085 or 2.5 percent of household income to a maximum equivalent to al yearly premium for the national average price of a Bronze plan sold through the Marketplace	
Revenue procedure 2016-55 also provides sliding scale updates with respect to the ***Refundable Credit for Coverage Under a Qualified Health Plan*** [36B(f)(2)(B)] and ***Eligible Long-Term Care Premiums*** [213(d)(10)]		
Other Limits	**2016**	**2017**

Periodic Payments Received under Qualified Long-Term Care Insurance Contracts or under Certain Life Insurance Contracts: dollar amount of the per diem limitation regarding periodic payments received under a qualified long-term care insurance contract or periodic payments received under a life insurance contract that are treated as paid by reason of the death of a chronically ill individual [7702B(d)]	$340	$360
Monthly limitation for qualified transportation fringe benefit (transit/parking) [132(f)(2)]	$255	$255
Tax Responsibilities of Expatriation: the amount that would be includible in the gross income of a covered expatriate is reduced (but not below zero) by [877A(a)(1)]	$693,000	$699,000
Foreign Earned Income Exclusion: the foreign earned income exclusion amount [911(b)(2)(D)(i)]	$101,300	$102,100

In related news, the Social Security Administration announced a 0.3 percent Cost of Living Adjustment increase in 2017, triggering increases in certain tax, benefit and earning amounts, including the retirement earnings test exempt amounts. The maximum amount of earnings subject to the Social Security tax (taxable maximum) will increase to $127,200 from $118,500.

The Pension Benefit Guaranty Corporation (PBGC) also announced the 2017 insurance premium amounts for both flat-rate and variable-rate payers.

The per-participant flat premium rate for plan years beginning in 2017 is $69 for single-employer plans (up from a 2016 rate of $64) and $28 for multiemployer plans (up from a 2016 rate of $27). The increase in the single-employer rate was provided in The Bipartisan Budget Act of 2015. The increase in the multiemployer rate is the result of indexing.

For plan years beginning in 2017, the variable-rate premium (VRP) for single-employer plans is $34 per $1,000 of unfunded vested benefits (UVBs), up from a 2016 rate of $30. This $4 increase reflects a $3 increase provided in The Bipartisan Budget Act of 2015 plus a $1 increase due to indexing. For 2017, the VRP is capped at $517 times the number of participants (up from a 2016 cap of $500). Plans sponsored by small employers (generally fewer than 25 employees) may be subject to a lower cap. Multiemployer plans do not pay a VRP.

Anticipated rates for 2018 and 2019 are available on the PBGC website.

IRS Finalizes 2016 ACA Employer Reporting Forms, Instructions

The Internal Revenue Service (IRS) has released final forms and instructions for employers to use to fulfill the calendar-year employer reporting requirements of the Affordable Care Act (ACA) as specified under Internal Revenue Code sections 6055 and 6056.

Under Code Section 6055, employer providers of "minimum essential coverage" (MEC), including employers with self-insured plans, must file a return with the IRS and furnish a statement to covered individuals that reports the months that they were provided coverage. Under Code Section 6056, every "applicable large employer member" (generally, an employer that, together with other employers in its controlled group, employed on average at least 50 full-time employees and/or equivalents) must file a return with the IRS and furnish a statement to full-time employees that reports certain information about terms and conditions of the health care coverage offered to the employer's full-time employees during the year. Employers that sponsor self-insured plans report information under both Code Sections 6055 and 6056 on the Forms 1094-C and 1095-C.

- Form 1095-C: Employer-Provided Health Insurance Offer and Coverage is to be used to fulfill the requirement under Code Section 6055, under which providers of MEC, including employers with self-insured plans, must file a return with the IRS and furnish a statement to covered individuals that reports the months of coverage.

- Form 1094-C: Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns is to be used for transmitting Form 1095-C.

- Form 1095-B: Health Coverage is used to fulfill the requirement under Code Section 6056 that every health insurance issuer, sponsor of a self-insured health plan, government agency that administers government-sponsored health insurance programs and other entities that provide minimum essential coverage (MEC) to file annual returns reporting certain information for each individual for whom minimum essential coverage is provided and to provide a copy of the return to the individual.

- Form 1094-B: Transmittal of Health Coverage Information Returns is to be used to transmit Form 1095-B.

- Instructions for completing Forms 1094-B and 1095-B and instructions for Forms 1094-C and 1095-C

Filers must submit these forms to IRS by February 28 if filing on paper (or March 31 if filing electronically) of the year following the calendar year to which the return relates. Employers must furnish a Form 1095-C to full-time employees by January 31.

IRS Advisory Panel Recommends Additional Guidance on ACA Reporting

The Information Reporting Program Advisory Committee (IRPAC) of the Internal Revenue Service (IRS) issued its 2016 report to IRS Commissioner John Koskinen on October 26. The report includes a number of recommendations to improve compliance with the Affordable Care Act (ACA) employer reporting requirements under Internal Revenue Code sections 6055 and 6056.

The IRPAC is a federal advisory committee that provides an organized public forum for discussion of information reporting issues. The committee is comprised of individuals drawn from the tax professional community, financial institutions, small and large businesses, universities and colleges, as well as securities and payroll firms. The report covers existing employer information reporting burdens, emerging compliance issues and international reporting and withholding matters.

Generally, the panel observes that "there are barriers preventing the information reporting process from working as simply and effectively as it should" and notes that "an ongoing wave of new information reports shifts new and substantial burdens to payors and financial intermediaries."
To address challenges presented by the ACA employer reporting requirements, IRPAC specifically recommends that IRS:

- Continue to work with filers to provide education about problems with the new ACA Information Returns (AIR) system, namely through webinars that focus on the most common errors.

- Address confusion about certain aspects of the new Form 1095-B and Forms 1095-C, particularly as regards date of birth reporting and truncated Social Security numbers.

- Extend "good faith efforts" penalty relief for incorrect or incomplete 2016 Forms 1095-B and Forms 1095-C filed in 2017.

- Permit an Applicable Large Employer (ALE) group member that undergoes a corporate transaction in a calendar year to provide separate reporting to employees based on a change in group membership during the year. Or, if the IRS will not provide a special exception to the current reporting rules requiring a single Form 1095-C, it should provide clear guidance to large employers that such reporting is unacceptable through specific guidance in the instructions to Forms 1094-C and 1095-C.

- Consider guidance specific to what constitutes "inconsequential" errors with respect to reporting under tax code sections 6055 and 6056.

IRS Advises Form 5500, 5500-SF Filers to Continue Skipping New Compliance Questions

The Internal Revenue Service (IRS) is once again advising filers of the Form 5500 annual return/report to skip the new compliance questions recently added to the form, this time for Form 5500 filings related to the 2016 plan year.

The Form 5500 series is used to satisfy annual reporting requirements under ERISA and the Internal Revenue Code. The new questions, originally added to the form for 2015 plan year filings, included a series of additional compliance questions for filers, but in February the IRS instructed filers not to complete them.

According to guidance newly posted on the IRS website, the agency is once again advising filers not to complete the new compliance questions for forms related to the 2015 and 2016 plan years.

As a reminder, the U.S. Department of Labor (along with the IRS and the Pension Benefit Guaranty Corporation (PBGC) recently issued proposed revisions to the Form 5500 that would take effect for plan year 2019.Comments on those proposed changes are due on December 5.

EEOC Hosts Wellness Rules Compliance Webinar

On October 19, the Equal Employment Opportunity Commission (EEOC) hosted the webinar “The ADA, GINA, and Employer Wellness Programs” to help employers and wellness programs comply with the new wellness rules. The Department of Labor (DOL) also participated in the webinar.

The U.S. Equal Employment Opportunity Commission (EEOC) has issued final wellness plan regulations under Title I of the Americans with Disabilities Act (ADA) and under Title II of the Genetic Information Nondiscrimination Act (GINA). The regulations' new notice requirements and rules regarding the use of financial inducements will apply to plan years beginning on or after January 1, 2017.

EEOC representatives participating on the October 19 webinar were Christopher J. Kuczynski (Assistant Legal Counsel and Director of the ADA/GINA Policy Division), Kerry Leibig (Senior Attorney Advisor) and Joyce Walker-Jones (Senior Attorney Advisor). The DOL representative participating on the webinar was Elena Lynett (Senior Specialist in the Office of Health Plan Standards and Compliance Assistance).

The major takeaways from the webinar are described below:

Interaction with HIPAA and the Affordable Care Act (ACA): The DOL representative noted that, although participatory wellness programs are not subject to the stringent rules under HIPAA and the ACA, they may be subject to the new final EEOC regulations. She stressed that there are program designs that can be used that comply with all applicable rules.

Reasonable Design: The ADA and GINA reasonable design requirements are satisfied if, in connection with a Health Risk Assessment (HRA) and/or biometric screening, the employee is provided with information about his/her health which could be then used to improve one's health.

Gatekeeping: Tiered/gateway programs that limit entry in the higher tier to employees who participate in a wellness program are not permitted under the ADA.

ADA Notice: If an employee has to complete multiple requirements at different times, the employer may need to provide the notice multiple times. In some cases, the passage of time may require that an employer distribute a notice again. If enough time has passed that the employee might not remember what the notice said, the EEOC suggested that it would be a good idea to provide the notice again.

Calculation of ADA and GINA Incentive Limits: In determining the "lowest-cost" coverage for purposes of calculating the 30 percent limit, look to the lowest-cost plan the employer offers, regardless of whether all employees are eligible for that plan. Also, where an employer has more than one health plan and requires participation in any of those plans in order to participate in a wellness program, look to the lowest-cost plan.

ADA Confidentiality Requirement: Compliance with HIPAA will generally result in compliance with the ADA's confidentiality requirements.

GINA Authorization Requirement: The EEOC confirmed that the GINA authorization requirements described in the final rule are not new requirements.

Applicability Date: Where an incentive is earned with respect to the 2016 plan year but not paid until 2017, the final rules limiting incentives do not apply. If an incentive is available for a wellness program that is part of a 2017 plan year, but the condition for receiving the incentive is fulfilled in late 2016, then notice must be provided in late 2016.

Fact Patterns Addressed by EEOC: The EEOC discussed whether certain fact patterns would trigger one or both rules:

- Requiring a spouse to participate in a weight loss program or to exercise weekly does not trigger GINA because it does not involve genetic information of an employee.

- Requiring certification that a child or a spouse has undergone a physical exam does not trigger GINA if the results of the exam are not required to be provided. However, requiring certification that an employee has undergone a physical exam would trigger the ADA because it is a medical exam.

- The incentive limits do not apply to a smoking cessation program available to a child because whether the child smokes is not the genetic information of the employee.

- If a wellness program has multiple ways to earn the incentive, some of which are disability-related inquiries/medical exams and some of which are not. If the employee has to complete the disability-related inquiries/medical exams (such as an HRA) to earn the incentive or to gain access to other incentives, then the ADA incentive limit applies. If the employee can earn the entire incentive without undertaking the disability-related inquiries or medical exams, then the ADA incentive limit does not apply. However, the employee must have a meaningful choice and the other items must not be overly burdensome or time consuming.

The EEOC has released an informal discussion letter on these points.

A recording of the webinar and the associated slide deck should be available on the EEOC website by the end of October. In addition, the EEOC also encouraged webinar participants to email questions regarding the regulations to FinalWellnessRules@eeoc.gov. The email address will remain active for at least six weeks, and the EEOC will consider questions it receives as it puts together a resource document, potentially in the form of "frequently asked questions."

Agencies Finalize Regulations for Short-term and Travel Insurance; Will Address Fixed Indemnity and Expatriate Coverage in Future Rulemaking

The U.S. departments of Labor, Treasury and Health and Human Services have issued final regulations regarding short-term, limited duration insurance, travel insurance, similar supplemental coverage, and lifetime and annual limits. Taking into account public comments received on the proposed regulations, the departments did not finalize proposed rules for on hospital indemnity or other fixed indemnity insurance and expatriate health plans, indicating an intent to address them in future rulemaking. This result avoids any disruption for plans sponsors who offer fixed indemnity coverage that might have been impacted had the rules been finalized.

The earlier proposed regulations implemented the Expatriate Health Coverage Clarification Act of 2014 (EHCCA). Congress enacted EHCCA in 2014 to provide relief from specific ACA requirements, fees and taxes for multi-national employers, globally mobile individuals and U.S. providers of expatriate insurance coverage. The proposed regulations also addressed certain "excepted benefits" (benefits that are not subject to certain requirements of group health plans and health insurance plans) under the Affordable Care Act (ACA), including hospital indemnity and other fixed indemnity insurance, specified disease coverage and travel insurance.

The final regulation adopts the proposed rules for limited duration insurance, similar supplemental coverage and annual and lifetime limits with minimal substantive changes. The departments did not finalize the proposed regulations related to fixed indemnity and

expatriate coverage, stating that “The Departments intend to address hospital indemnity or other fixed indemnity insurance and expatriate health plans in future rulemaking, taking into account comments received on these issues.” Existing sub-regulatory guidance allows the use of a reasonable good faith interpretation in applying the requirements of the EHCCA.

The final regulations are generally applicable for plan or policy years beginning on or after January 1, 2017. (With regard to the revised definition of short-term, limited-duration insurance, the Department of Health and Human Services (HHS) will not take enforcement action against an issuer with respect to the issuer’s sale of a short-term, limited-duration insurance product before April 1, 2017, on the grounds that the coverage period is three months or more, provided that the coverage ends on or before December 31, 2017 and otherwise complies with the definition of short-term, limited duration insurance in effect under the regulations).

Administration Issues New FAQ Guidance on ACA, Mental Health Parity; White House Parity Task Force Releases Report

Frequently asked questions (FAQ) , Part 34, guidance about Affordable Care Act (ACA) implementation was released on October 27 by the U.S. departments of Treasury, Labor and Health and Human Services. The guidance addresses coverage of preventive care related to tobacco cessation interventions and several issues related to mental health and substance use disorder (MH/SUD) parity implementation.

Coverage of Preventive Services
The guidance includes one question and answer related to the ACA requirement that non-grandfathered group health plans and health insurance cover certain preventive items and services without cost-sharing consistent with current recommendations of the U.S. Preventive Services Task Force’s (USPSTF).

The FAQ notes that the USPSTF updated its recommendation regarding tobacco cessation on September 22, 2015, clarifying that both pharmacotherapy and behavioral interventions are effective and recommended, that “combinations of interventions are most effective, and all should be offered.” The USPSTF Final Recommendation Statement provides additional detail on telephone behavioral interventions and describes a seven FDA-approved over-the-counter and several prescription medications now available for treating tobacco dependence.

The FAQ indicates that the departments have received stakeholder questions requesting clarification regarding what items and services must be provided without cost-sharing to comply with the updated recommendation (applicable to plan years or policy years beginning on or after September 22, 2016.

The FAQ requests public comment on whether all seven of the FDA-approved pharmacotherapy interventions must be covered without cost sharing when prescribed by a health care provider or whether plans and issuers may use reasonable medical

management techniques to determine which specific categories of FDA-approved pharmacotherapy interventions will be covered without cost sharing, and to limit or manage such interventions.
Comment is also requested on whether plans or issuers could limit the number of quit attempts per year, duration of intervention, or types of behavioral interventions. The FAQ further states that the request for comment will inform any future guidance on tobacco cessation coverage and "does not supplement or clarify the USPSTF recommendation and plans and issuers must offer coverage consistent with the specific recommendation made by the USPSTF.

Mental Health Parity
The FAQ also provides eight separate questions and answers addressing the application of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). These scenarios address parity analyses and documentation by insurers and issuers related to nonquantitative treatment limitations (NQTLs) (including medical necessity criteria or preauthorization requirements) and medication-assisted treatment (MAT) for opioid use disorder and court-ordered treatment.

Most notably, in Question No. 3, the FAQ clarifies Question No. 8 of the April 20, 2016, FAQ (Part 31), which had stated that plans and issuers, when conducting financial and quantitative limits parity testing, could not rely on an issuer's or third-party administrator's overall "book of business" data, and must use plan-specific data. The answer to Question No. 3 of the new FAQ makes clear that although plan-specific data must generally be used in conducting financial and quantitative limits parity testing, that requirement only applies on such data if that data "is credible to perform the required projections." FAQ No. 3 then goes on to state that if a qualified actuary finds that the plan "does not have sufficient data at the plan or product level for a reasonable projection of future claims costs," the plan may use other data sources, including "other similarly-structured products or plans with similar demographics," which term seems to be broad enough to allow testing on an aggregate basis across similar plans. However, FAQ No. 3 also reminds plans and issuers that they will need to document the assumptions they use.

The FAQs also add two questions on nonquantitative treatment limitations, one of which (Question No. 5) notably appears to implicate provider/service network adequacy issues by stating that a plan that requires fail-first treatments for certain MH/SUD instances and medical/surgical (M/S) conditions, but which does not offer such MH/SUD fail-first treatments in the geographic area of the participant, has in place an NQTL that is, in operation, impermissible.

Specifically, FAQ No. 5 states that if an NQTL applies to an MH/SUD benefit and the participant "cannot reasonably satisfy" the NQTL (in this case because no programs are available in the participant's geographic area), this creates an impermissible NQTL. However, because the departments were concerned about prior guidance being interpreted in a manner different than this specific clarifying guidance, FAQ No. 5 makes

clear that this clarifying guidance will apply only for plan or policy years beginning on or after March 1, 2017.

Finally, the FAQs contain several questions regarding Medication Assisted Treatment (MAT) for Opioid Use Disorder. Of these, Question No. 8 is most notable. It states that, if a plan states that it follows "nationally-recognized guidelines," and/or if it deviates from such guidelines, the following of such guidelines or the degree of deviations from such guidelines must be in parity as between M/S and MH/SUD benefits.

FAQ No. 8 goes on to note that many plans and issuers use committees to decide how to cover prescription drugs and to evaluate whether to follow or deviate from nationally recognized standards. The FAQ states that the processes of such a committee must themselves comply with the NQTL requirements (i.e., the committee must use the same processes and evidentiary standards in evaluating both M/S and MH/SUD medications). Interestingly, FAQ No. 8 also states that if a plan imposes a restriction on a MH/SUD medication that deviates from nationally recognized guidelines, and does not impose "comparable restrictions on medications for medical/surgical conditions," the restriction on MS/SUD medications "is a 'red flag' or 'warning sign' that the plan may be imposing an impermissible NQTL" (and there would, per the FAQ, be an impermissible NQTL in the absence of specific evidence supporting the use of this NQTL.

The departments are also seeking feedback on the potential utility of model forms and other resources to "help facilitate uniform implementation and enforcement of MHPAEA, and relieve some complexity that MHPAEA compliance poses for health insurance issuers operating in multiple States." Notably, however, the model forms discussed by the departments appear to relate only to model disclosure request forms, intended to assist "participants and their representatives" in requesting information relating to NQTLs. There is only passing mention of potential model forms that plans could use to respond to disclosure requests (although the FAQ notes that this issue was raised to the departments by various stakeholders), and none of the requests for comment specifically address or seek comment on that issue.

It is also worth noting that none of these new FAQ sections mention or discuss any changes to the broad categories of disclosure documents mentioned in Question No. 9 of the April 16 FAQ. Indeed, the "breadth of disclosure required" under that FAQ is cited favorably, which seems to indicate that there have been no changes to those broad disclosure categories.

Comments are due on both the preventive questions and the mental health parity questions by January 3, 2017.

In related news, the Mental Health and Substance Use Disorder Parity Task Force, established by a presidential memorandum earlier this year, issued **its final report** on October 27. The Task Force is charged with securing parity protections and expanding coverage to further realize the intended benefits of the MHPAEA.

The report provides background on key developments in parity and enforcement and describes stakeholder and public input. The report offers a range of recommendations to advance parity in MH/SUD, including creating a one-stop consumer portal to help consumer navigate parity, providing simplified disclosure tools, increasing agencies' capacity to audit health plans for parity compliance and congressional action to allow the DOL to assess civil monetary penalties for parity violations.

Society of Actuaries Revises Mortality Table Improvement Scale

The Society of Actuaries (SOA), a professional organization representing 27,000 members, released a modified mortality improvement scale, the MP-2016 Mortality Improvement Scale, on October 20. This new improvement scale can be used to update the RP-2014 base mortality table.

The federal government typically considers SOA's calculations in formulating mortality assumptions with respect to pension funding, benefit restrictions, Pension Benefit Guaranty Corporation (PBGC) premiums and lump sum valuations. Many plan sponsors believe that recent SOA reports overstate mortality improvement, and would thus inflate funding liabilities, lump sums, and PBGC premiums.

In Notice 2016-50, released on September 2, the U.S. Treasury Department and Internal Revenue Service (IRS) updated the static mortality tables to be used for defined benefit pension plans for 2017. The agencies also announced that the next update will not be applicable until 2018 and indicated that they would soon propose revisions to the base mortality rates and projection factors.

OSHA Finalizes Rule Governing Whistleblower Protections under ACA

Finalizing regulations first issued as an interim final rule in 2013, the Occupational Safety and Health Administration (OSHA) of the U.S. Department of Labor (DOL) has formally issued a final rule establishing protections for employees who file complaints against their employer for certain violations under the Patient Protection and Affordable Care Act (ACA).

Section 1558 of the ACA added section 18C to the Fair Labor Standards Act (FLSA) to protect employees against retaliation by an employer for:

- receiving a tax credit or cost-sharing reduction as a result of participating in a Health Insurance Exchange or Marketplace; or

- reporting alleged violations of Title I of the statute, which includes a range of health insurance reforms, such as prohibition of annual or lifetime dollar limits on essential health benefits and exclusions due to pre-existing conditions.

If an employee reports a violation of one of these policies or requirements, the law's whistleblower provision prohibits employers from retaliating against the employee. If an

employee is subject to retaliation in violation of the whistleblower provision, he or she may file a complaint with, and ultimately receive relief from, OSHA or the courts.

The new final rule, published on October 13, establishes procedures and time frames for the handling of retaliation complaints, including procedures and time frames for employee complaints to OSHA, subsequent investigations, appeals of OSHA determinations to an administrative law judge (ALJ), hearings by ALJs, review of ALJ decisions by the Administrative Review Board (ARB) (acting on behalf of the Secretary of Labor), and judicial review of the Secretary's final decision. A fact sheet linked by OSHA in an October 12 news release summarizes and provides examples of protected activities and prohibited retaliatory actions, along with procedures and deadlines for filing a complaint.

The final rule makes only very minor changes from the interim final rule. The regulation makes clear that the whistleblower protections under FLSA Section 18C do not replace any protections that a whistleblower may have under ERISA. According to the preamble of the final rule, "Whistleblowers may bring claims under either or both statutes if their whistleblowing is protected under both. However, in order to pursue a claim under Section 18C either in district court or before the [DOL], the complainant must file a complaint with OSHA within 180 days of the alleged adverse action."

The final rule is effective immediately.

IRS Permits Hardship Distributions, Verification Relief for Hurricane Matthew Victims

In an October 21 announcement, the Internal Revenue Service (IRS) formally allowed certain victims of Hurricane Matthew to collect hardship distributions from qualified employer plans.

The prevailing laws relating to qualified employer plans impose various limitations on the permissibility of loans and distributions from those plans. Hardship distributions – the distribution of money from a qualified plan prior to retirement to cover a pressing financial need – are generally only available for a narrow set of medical or personal expenses. Hardship distributions are taxable as an early distribution and subject to a 10 percent penalty.

IRS Announcement 2016-39 permits hardship distributions to employees and certain members of their families who live or work in disaster area localities that have been affected by Hurricane Matthew and are designated for individual assistance by the Federal Emergency Management Agency (FEMA).

The announcement also provides relief from certain verification procedures that may be required under retirement plans with respect to loans and hardship distributions. The relief provided under this announcement is in addition to the relief previously provided

by the IRS pursuant to News Release IR-2016-135. More information about other relief related to Hurricane Matthew can be found on the IRS disaster relief page.

RECENT JUDICIAL ACTIVITY

Nothing to report this issue.