VOLUME 76 ◆ NUMBER 5

Employee Benefit Plan Review

JUNE 2022

Columns

Feature Articles

Wolters Kluwer

Employee Benefit Plan Review

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Employee Benefit Plan Review (USPS: 0910-000) ISSN 0013-6808 is published monthly, except bimonthly for March/April, July/August, and November/December by Wolters Kluwer, 28 Liberty Street, New York, NY 10005. For customer service, call 1-800-234-1660. Address editorial comments to Steven A. Meyerowitz and Victoria Prussen Spears, Co-Editors-in-Chief, smeyerowitz@meyerowitzcommunications.com and vpspears@meyerowitzcommunications.com, *Employee Benefit Plan Review,* 26910 Grand Central Parkway, Suite 18R, Floral Park, NY 11005.

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FEATURE ARTICLES

COLUMNS

From the Editor

By Victoria Prussen Spears

Welcome to *Employee Benefit Plan Review*!

This issue begins with a "Feature" article discussing the federal "Me Too" law and what it means for arbitration. We also have articles and columns on a host of other timely and important topics!

Arbitration

President Biden has signed into law the "Ending Forced Arbitration of Sexual Assault and Sexual Harassment Act," known informally as the "Me Too" law. It became effective immediately and amends the Federal Arbitration Act to ban the mandatory arbitration of sexual assault and harassment claims. The Me Too law will make harassment claims more expensive and more complicated to resolve. In our "Feature" article, "The End of Arbitration? What the 'Me Too' Law Means for the Future of Employment Arbitration," Barbara E. Hoey and Sebastian P. Clarkin, attorneys at Kelley Drye & Warren LLP, discuss the law and its implications for arbitration.

Pay Equity

With heightened scrutiny applied to compensation decisions, the advent of new pay equity legislation in several states and local jurisdictions, and an uptick in litigation, now is an ideal time to evaluate pay practices and correct any disparities to minimize potential risk for litigation. In our lead "Focus On" article, "Pay Equity: Five Things Employers Should Do When Considering Pay Adjustments," Kathleen McLeod Caminiti and Sarah Wieselthier, attorneys at Fisher Phillips, discuss five action items for employers evaluating pay equity and considering adjustments.

Paid Sick Leave

California Governor Gavin Newsom signed into law legislation reviving COVID-19 supplemental paid sick leave under a new California Labor Code Section 248.6. The law applies retroactively from January 1, 2022. In our next "Focus On" article, "COVID-19 Supplemental Paid Sick Leave Signed into California Law," Ben Gipson and Samantha Saltzman, attorneys at DLA Piper LLP, address common questions about the new law and what it means for employers.

Disability Lawsuit

A federal court has ruled that a nurse fired while isolating with a case of COVID-19 can proceed with disability discrimination lawsuit against her former employer, further developing a body of law permitting COVID sufferers to bring Americans with Disabilities Act claims against their employers. The case at issue is still in its infancy, and the Alabama healthcare facility facing the charge has barely had a chance to present its defense. In our next "Focus On" article, "Worker Fired During COVID-19 Isolation Can Proceed with Disability Lawsuit, Says Federal Court," Benjamin S. Morrell, an attorney at Fisher Phillips, discusses the decision and its implications.

And More...

In this issue, we have an "Ask the Experts" column by Damian A. Myers, Yelena F. Gray and Jean Y. Yu, attorneys at Nixon Peabody LLP, and a "Regulatory Update" column by Gary D. Blachman and Austin Anderson, attorneys at Ice Miller LLP. We also have an "FMLA – Back to Basics" column by Christy E. Phanthavong, counsel at Bryan Cave Leighton Paisner LLP.

This issue also contains a "Special Report," "Stretching Expectations: Planning with the New Life Expectancy Tables for Retirement Plans' Required Minimum Distributions," by Lisa S. Presser, Sarah F. Armstrong and Brian M. Balduzzi, attorneys at Faegre Drinker Biddle & Reath LLP.

* * *

We are pleased to announce that Ron M. Pierce, of counsel in Fisher Phillips' Denver office, has joined our Board of Editors. Mr. Pierce focuses his practice on all areas of employee benefits and executive compensation, regularly advising his clients on benefits-related compliance issues and controversies. Welcome, Ron!

Enjoy the issue!

Victoria Prussen Spears*
Co-Editor-in-Chief
June 2022

*Victoria Prussen Spears is a writer, editor and law firm marketing consultant for Meyerowitz Communications Inc. A graduate of Sarah Lawrence College and Brooklyn Law School, Ms. Spears was an attorney at a leading New York City law firm before joining Meyerowitz Communications. Ms. Spears is co-editor of *Employee Relations Law Journal*, *Employee Benefit Plan Review*, *The Computer & Internet Lawyer*, *Intellectual Property & Technology Law Journal* and *Benefits Law Journal*, all published by Wolters Kluwer. She can be reached at vpspears@meyerowitzcommunications.com.

Ask the Experts

By Damian A. Myers, Yelena F. Gray and Jean Y. Yu

Q Our employees want to invest in cryptocurrency through their 401(k) accounts. What are some of the issues that we should consider?

A As a plan sponsor, you are considered a fiduciary of your company's 401(k) plan. Under the Employee Retirement Income Security Act of 1974 ("ERISA"), a fiduciary is subject to certain standards of conduct and duties with respect to the plan, participants, and beneficiaries. One of the duties that a plan fiduciary has is a duty to prudently select and monitor plan investments. If your 401(k) plan allows for participants to choose their investments, chances are you are already familiar with the concept of vetting investments for your 401(k) plan's investment menu. However, if your 401(k) plan offers participants the ability to self-direct their investments through a brokerage window, you may be surprised that your duties may extend to monitoring the underlying investments that the participants pick.

The U.S. Department of Labor ("Department"), one of the governmental agencies that oversees the administration and enforcement of retirement plans, recently announced its intent to scrutinize 401(k) plans that allow investments in cryptocurrencies. In March, the agency issued Compliance Assistance Release No. 2022-01, 401(k) Plan Investments in Cryptocurrencies (the "Release") and made it clear that it is opposed to plan participants investing in cryptocurrencies or other forms of digital assets, such as tokens, coins and crypto assets.

Among the Department's key concerns are:

- The speculative nature of and extreme price volatility of cryptocurrencies, which tend to have a disproportionate impact on retirement age participants who may need retirement funds before they are able to recover from any negative price swings;
- The difficulties for plan participants to make an informed investment decision due to the complexity and, sometimes, sensationalized nature of information relating to cryptocurrency;
- The digital and nontangible aspect of the cryptocurrency medium make it susceptible to fraud, hacking, theft, and loss;
- Valuations relating to cryptocurrencies may be unreliable or inaccurate; and
- Evolving regulations relating to cryptocurrencies may ultimately result in the shut-down of or severe limitations on the ability to use or trade digital currencies.

Due to these concerns, the Department warns that plan fiduciaries must use "extreme care" when considering whether or not to make cryptocurrencies available as an option in their investment menu. The Department emphasizes that employers have an ongoing obligation to make sure that the investment choices they offer under their 401(k) plans are sound choices. Employers may not shift responsibility to the plan participants to understand and avoid bad investments.

Equally noteworthy from the recent guidance is that the Department's position on cryptocurrency also applies to participant investments made through brokerage windows.

Equally noteworthy from the recent guidance is that the Department's position on cryptocurrency also applies to participant investments made through brokerage windows. A brokerage window is an option offered by some employers under their 401(k) plans that provides participants the ability to buy and sell a broader range of investment securities on their own through a brokerage platform than those available through the plan's core fund menu. While employers have always been responsible for deciding whether or not to offer a brokerage window and choosing and monitoring the service providers for a brokerage window, the Department has traditionally not imposed fiduciary obligations on employers for investment choices made by participants through brokerage windows. The Release indicates that the Department is no longer taking that position and states that "plan fiduciaries responsible for overseeing such [cryptocurrency] investment options or allowing such investments through brokerage windows should expect to be questioned about how they can square their actions with their duties of prudence and loyalty in light of the risks described above."

If your company is considering adding cryptocurrency to your 401(k) investment

lineup or as an option available through a brokerage window, you should consider the implications of the Department's stance on cryptocurrency as a plan investment. The Department appears to have made the assumption that crypto assets are imprudent as a 401(k) investment choice and is putting employers on the defensive to justify why offering such an investment option is not imprudent. The Department is also forming an "investigative program aimed at plans that offer participant investments in cryptocurrencies and related products, and to take appropriate action to protect the interests of plan participants and beneficiaries with respect to these investments."

While the Department's posture may face legal challenges down the road, its current focus on digital currency means that your 401(k) plan may potentially face unwelcomed scrutiny and additional costs associated with responding to such scrutiny if your 401(k) plan allows participants to invest in crypto assets. Such scrutiny and cost are likely to raise questions about whether it is prudent to allow the investment in the first place. If you are an employer who already permits digital investments through brokerage windows in your 401(k) plan, you may want to consider setting restrictions on such investments, at least for the time being.

Q My organization has a retirement plan committee responsible for fiduciary oversight of investment performance and service providers. Is there any need to have a similar committee for health and welfare plans?

A Years and years of litigation alleging fiduciary violations in connection with employer stock, investment performance, and investment/service provider fees has essentially required retirement plan sponsors and administrators to form fiduciary committees to monitor performance. Although fiduciary responsibilities are important on the health and welfare side of things, the lack of widespread litigation with respect to health and welfare fiduciary matters has not necessitated formal committee monitoring of plan and service provider performance. However, things are changing and plan sponsors and administrators should strongly consider establishing health and welfare fiduciary committees.

ERISA fiduciary responsibilities have been around since ERISA was enacted, so what has happened that would make it prudent to establish a health and welfare fiduciary committee?

As with retirement plans, ERISA fiduciaries must adhere to certain standards of conduct when administering ERISA-covered health and welfare plans. Among these standards of conduct are a duty of loyalty, duty of care, duty to follow plan documents, and a duty to avoid prohibited transactions and self-dealing. Under the duty of loyalty, fiduciaries must act solely in the interests of participants and beneficiaries for the exclusive purpose of providing benefits and defraying reasonable administrative costs. It is that "reasonable" requirement that has driven several class action lawsuits against retirement plan administrators based on allegations of excessive fees. As noted above, recent legislative developments requiring greater price and fee transparency in health plans may trigger heightened scrutiny of health and welfare plan fiduciary practice.

The duty of care requires ERISA fiduciaries to act with the care, skill, prudence, and diligence then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in similar circumstances. Plan administrators of health and welfare plans often delegate their ERISA fiduciary responsibilities to third-party administrators, which is perfectly fine as long as the delegation is properly documented. However, the delegating ERISA fiduciaries are still responsible under the duty of care for monitoring the performance of third-party delegates. The other primary standards of conduct are self-explanatory – plans must be administered in accordance with their terms and fiduciaries cannot enter into transactions that benefit themselves or other parties in interests (such as third-party administrators) unless an exception exists.

Now, ERISA fiduciary responsibilities have been around since ERISA was enacted, so what has happened that would make it prudent to establish a health and welfare fiduciary committee? Several things, actually.

First, the Consolidated Appropriations Act, 2021 ("CAA") introduces a new disclosure requirement for health and welfare plan brokers and consultants to disclose direct and indirect compensation they expect to receive for services provided to the plan. As noted above, fiduciaries must ensure that the compensation paid to service providers is reasonable and must ensure that parties in interest (such as brokers, consultants, and third-party administrators) have not entered into prohibited transactions.

Second, increasing scrutiny of third-party health plan administrators and pharmacy benefit managers ("PBMs") may have a downstream impact on ERISA fiduciaries. To the extent that third-party administrators and PBMs are retaining funds that should otherwise be returned to plan participants, it is possible that the Department or a court will hold the ERISA fiduciaries accountable for failing to adequately monitor the administrators and PBMs. For example, if a PBM is retaining

a share of rebates in addition to receiving a per employee per month administrative fee, the Department or a court might consider that excessive compensation.

Third, the CAA includes several other new requirements that are intended to make the cost of health and pharmacy benefit delivery more transparent. The specific requirements are beyond the scope of this column, but ERISA fiduciaries should monitor service providers to make sure the new requirements are implemented.

Finally, the Department is heavily focused on mental health parity compliance, and the CAA requires plan administrators to prepare and keep up-to-date comparative analyses showing compliance with certain mental health parity requirements. Failure to comply with the CAA and mental health parity requirements could result in fiduciary liability.

At a minimum, bi-annual meetings should be conducted to review performance guarantee achievement auditor reports, and PBM pricing guarantee compliance.

Based on all of this, plan administrators should strongly consider establishing a health and welfare fiduciary committee to monitor plan administration and service provider performance. Note that to the extent that a plan administrator is charged with managing plan benefits that are fully insured, fiduciary responsibility may be limited to obtaining broker/consultant fee disclosures, making assessments regarding fee reasonableness, and conducting periodic market checks and requests for proposals for brokers and insurance providers. For self-insured health and pharmacy benefit plans, the responsibilities of the committee would be more significant and might include, for example, the following:

- **Collecting fee disclosures from brokers and consultants.** Committees should scrutinize the fee disclosures closely and make sure that all direct and indirect compensation is disclosed. This may require specific follow-up questions regarding collection of commissions or referral fees often received by brokers and consultants from health plan administrators and PBMs.
- **Health plan service provider monitoring.** Many administrative service agreements have performance guarantees that require service providers to satisfy certain performance thresholds. Oftentimes, the service provider self-reports the results of the performance guarantees, but prudent fiduciaries should consider retaining independent auditors to review performance guarantee compliance. Further, as permitted under most administrative service agreements, fiduciaries should have the auditor review claims administration to ensure claims are being adjudicated in accordance with the plan terms. Once the auditor issues its report, fiduciaries should review the report and work with the service provider to take any appropriate corrective action.
- **PBM monitoring.** Similar to health plan service provider monitoring, fiduciaries should retain an independent auditor to review performance guarantees and claims administration compliance. Further, fiduciaries should audit compliance with contractual pricing discount guarantees and minimum rebate guarantees. More specific audit targets may also be warranted in the PBM context. For example, fiduciaries might consider auditing prior authorization protocol compliance, "dispense as written" exceptions, or formulary tier compliance. Note that PBM monitoring requires retaining consultants and auditors with specialized knowledge of the PBM industry, and care should be taken to ensure independence.
- **Requests for proposals/market checks.** To ensure that health and welfare plan fees and other costs remain reasonable, fiduciaries should conduct periodic requests for proposals ("RFPs") or market checks. In the health and welfare plan context, the cost of administering a plan can vary significantly by service provider. This variation is driven by several factors, including network provider discounts, total cost of care, care management programs, and general market/competitive conditions. All this is to say that a service provider with the lowest fees in one year, may actually have the highest fees just three to five years later. By performing RFPs, fiduciaries can compare the overall fees and costs for the selected service providers and decide if a change is warranted. Fiduciaries should work with benefit consultants to conduct these RFPs, with legal counsel assistance to ensure the RFP questionnaires are comprehensive and the administrative services agreements accurately reflect the deal agreed to between the plan and the service provider.
- **Miscellaneous administrative matters.** From time to time, participant complaints or claims will need to be escalated to the committee for review. Although it is generally important to defer to claims administrators to make claims decisions, situations may arise that warrant committee consideration. Additionally, the committee should review all material participant

communications and monitor implementation of legislative or regulatory changes impacting the plans.

The frequency in which a health and welfare fiduciary committee should meet will vary depending on the nature of the benefit plans. At a minimum, bi-annual meetings should be conducted to review performance guarantee achievement auditor reports, and PBM pricing guarantee compliance. If a PBM agreement provides for quarterly reconciliation of rebates, quarterly committee meetings may be appropriate. More frequent meetings may also be needed while an active RFP is being conducted. However often the committee meets, it is essential that the committee take adequate minutes of the committee's deliberations and actions. Written documentation of the committee's exercise of prudence is the best line of defense against allegations of fiduciary misconduct.

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The End of Arbitration? What the "Me Too" Law Means for the Future of Employment Arbitration

By Barbara E. Hoey and Sebastian P. Clarkin

President Biden has signed into law the "Ending Forced Arbitration of Sexual Assault and Sexual Harassment Act of 2021," known informally as the "Me Too" law. It became effective immediately, and amends the Federal Arbitration Act ("FAA") to ban the mandatory arbitration of sexual assault and harassment claims.

What does the new law mean for the future of employment arbitration? Can employers still have any type of a mandatory arbitration program? The answers to these questions are not immediately obvious, but rest assured that the Me Too law will make harassment claims more expensive and more complicated to resolve. It is also not a surety that the end of arbitration will be good for victims or potential plaintiffs.

What the law will mean for your business will depend on a number of factors, including where you are doing business (as mandatory arbitration is already prohibited in some states) and whether your company had a mandatory arbitration program in place for customers or employees. However, all businesses may see an uptick in harassment claims, as often happens whenever there is a very public legal development in this area.

What Does The Me Too Law Say?

The main provision of the law is short enough to reproduce here:

> [A]t the election of the person alleging conduct constituting a sexual harassment dispute or sexual assault dispute, or the named representative of a class or in a collective action alleging such conduct, no predispose arbitration agreement or predispose joint-action waiver shall be valid or enforceable with respect to a case which is filed under Federal, Tribal, or State law and relates to the sexual assault dispute or the sexual harassment dispute.

The terms "sexual assault dispute" and "sexual harassment dispute" are not confined to federal claims, but any such claim as defined according to "applicable Federal, Tribal, or State law."

What are the Key Elements of the Law?

1. Employers may no longer be able to mandate the arbitration of claims of sexual assault or sexual harassment, whether those claims are brought under federal or state law.

   The new law does not redefine assault and harassment, and instead defines those terms as any instance where such claims may be brought under applicable federal or state law.

   Now more than ever, it is important to understand how the state you are doing business in defines sexual harassment or sexual assault. For example, in New York, sexual harassment is defined far more broadly than it is in Title VII, and constitutes instances where "an individual is subjected to inferior terms, conditions or privileges of employment" on the basis of their sex. Perhaps even more importantly, while Title VII applies only to employers with 15 or more employees, the New York State Human Rights Law applies to employers of any size. Even if you are a small employer to whom Title VII does not apply, if your state has laws similar to New York, the Me Too law may apply.
2. Plaintiffs also cannot waive their right to bring claims of sexual assault or harassment collectively through a class action.
3. Importantly, the law applies to both claims of sexual harassment and assault, and does not just apply to employment disputes. It extends to any person who might sign a mandatory arbitration agreement or a mandatory waiver of their right to bring a class action for a claim of sexual misconduct.

For instance, a "services" company may have previously mandated, through its terms of service, the arbitration of any claims brought by a customer that they were sexually assaulted by an employee. These types of mandatory arbitration clauses will no longer be enforceable.

4. The law provides that it "shall apply with respect to any dispute or claim that arises or accrues on or after the date of enactment of this Act."

   Therefore, it will apply to current arbitration agreements, even those signed before the law went into effect.

   There may be an argument that a claim of sexual harassment or assault that is now in arbitration can be completed, but companies will certainly not be able to enforce an arbitration mandate going forward.
5. Finally, the law states that it must be a federal judge, not an arbitrator, who decides whether a claim is subject to arbitration.

What Should Be Done Now?

According to a 2018 study, 53.9 percent of nonunion private sector employers have mandatory arbitration procedures, so the new law will have a far-reaching effect. But depending on where you do business, the law may change very little.

New York, Maryland, Vermont, New Jersey and Washington have all passed similar laws effectively banning mandatory arbitration for employee claims of sexual harassment in the workplace. In fact, New Jersey's law is the most expansive of these, and bans the mandatory arbitration of all claims of discrimination, not just sexual harassment. Meanwhile, California has taken things further than any other state and effectively banned all mandatory arbitration agreements in the employment context. Those doing business in any of those states should have already addressed these limitations in their arbitration policies.

Nonetheless, this new law provides a ripe opportunity for every business to review their sexual harassment and arbitration policies. If your policy covers harassment claims, consider changing it for the future. It does not make sense to have employees who have already signed an agreement re-sign, as this will create administrative headaches.

But you should revise all future mandatory arbitration agreements to affirmatively state that notwithstanding anything else in the agreement, the signatory has the choice to bring their claims of sexual harassment or assault in court, collectively or individually, and that they are not required to individually arbitrate those claims.

For existing employees, create a policy statement that makes clear that they are no longer required to arbitrate harassment or assault claims, even if those are covered in an agreement they may have signed in the past. As long as this carve-out is clear, the old agreements should still be enforceable.

Can You Still Arbitrate Other Claims?

Yes. Subject to applicable state laws, companies remain free to mandate arbitration or a waiver of class action rights for all other claims, including salary or wage/hour claims, other types of discrimination, retaliation or any other kind of liability.

Can You Still Arbitrate Harassment or Assault Claims?

That now depends on the claimant. Employees may opt to arbitrate even assault or harassment claims. It will just have to be clear that this is their choice, so forms will have to be developed to give them that choice.

This type of a choice will be easier to enforce if the employee has an attorney, and it may be advisable to suggest that they consult with counsel before choosing to arbitrate a harassment claim.

What About Claims That Combine Sexual Harassment or Assault with Other Allegations?

Employees are smart, as are lawyers. You may well see them add on harassment to every claim, just to get out of mandatory arbitration. What are your options then?

Nonetheless, this new law provides a ripe opportunity for every business to review their sexual harassment and arbitration policies.

While the new law is not clear and will have to be fleshed out in the courts, it does appear that if an employee combines a harassment claim with other claims, you may still be able to require that they arbitrate the non-harassment aspects of their case. Strategically, this will depend on whether harassment or assault is the "main" claim or just tacked on. If harassment is not the primary claim, it may make sense to push the other claims to arbitration, but be ready for a fight. That is a decision best left to you and your counsel.

What About Prevention?

There is no hiding this change in the law from plaintiff's attorneys and employees, and it may well cause an uptick in claims. You may also be facing juries, not arbitrators, in the future. Thus, all employers should take stock of your current training and prevention policies and redouble

efforts to prevent sexual harassment or assault from occurring in the first place.

Ask some key questions:

- Is training reaching everyone?
- Is it time to offer a live (not online) training to key executives?
- Is there a region or business unit where harassment is a problem? Do they need some extra guidance?

The best way to prepare for the law is not to merely change a few sentences in a contract. Businesses should be trying to do more than the bare minimum in this respect, both because of ethics and, thanks to the Me Too law, optics.

Implementing and enforcing zero-tolerance policies can be one of your most powerful tools. Empower your Human Resources department to conduct thorough investigations and act independently to root out misconduct. Put systems in place that ensure that employee complaints are solicited and kept as confidential as possible.

The end goal is to stop sexual harassment before it starts, and well before you face a verdict in the court of public opinion.

Barbara E. Hoey (*bhoey@kelleydrye.com*), a partner at Kelley Drye & Warren LLP and a member of the firm's Executive Committee, counsels clients in all areas of employment law, and defends single-plaintiff, multi-plaintiff and class action litigation. Sebastian P. Clarkin (*sclarkin@kelleydrye.com*) is an associate at the firm focusing his practice in all areas of labor and employment law.

Pay Equity: Five Things Employers Should Do When Considering Pay Adjustments

BY KATHLEEN MCLEOD CAMINITI AND SARAH WIESELTHIER

By this time of year, most companies have long ago wrapped up their 2021 performance review process and have handed out year-end bonuses and raises for 2022. However, how can employers know their pay plans and compensation decisions are really in compliance with pay equity principles?

With heightened scrutiny applied to compensation decisions, the advent of new pay equity legislation in several states and local jurisdictions, and an uptick in litigation, now is an ideal time to evaluate pay practices and correct any disparities to minimize potential risk for litigation. This article discusses five action items for employers evaluating pay equity and considering adjustments.

1. Examine Your Compensation Process

Now that most employers have implemented their year-end compensation decisions, it is time to ask whether you critically examined your compensation policies and practices to ensure that, moving forward, pay inequality does not persist among individuals with substantially equal job duties. Questions that should be considered include:

- Are compensation decisions based on objective or subjective criteria?
- Is there documentation to justify the pay decisions?
- If pay differentials are based upon performance, do the performance appraisals and documentation substantiate the pay treatment?
- Are there legitimate factors other than gender (or another protected category, depending on the state) that justify a pay disparity between employees performing substantially similar work?

Based on your answers to these questions, steps may be warranted to ensure that compensation decisions are based upon objective, well-documented criteria, and that any disparities among employees who perform substantially similar work are due to legitimate reasons identified under applicable federal and state law. Where disparities are identified, adjustments in pay may be required. Caution: in some locations across the country, it is not permitted to justify a wage differential because of salary history – and a blisteringly hot job market makes compensation review even more challenging.

2. Know Your Legal Obligations

While the federal Equal Pay Act ("EPA") has long required that men and women in the same workplace be compensated with equal pay for equal work, many state and local laws are more stringent. For example, many states have laws requiring equal pay for "substantially similar work," which extends the scope of the equal pay laws beyond the federal mandate. Many states have enacted legislation greatly expanding employers' obligations and broadening the protected classes from those under the EPA. Of course, the advent of remote work makes multistate compliance even more challenging. Pay equity is a growing claim du jour for plaintiffs' attorneys both on an individual and collective basis, so now is the time to evaluate the pay practices in light of the relevant law applicable to your organization.

Transparency is the latest trend in pay equity. Certain states and localities, including Colorado, Connecticut and New York City, now or will soon require employers to establish a salary range for each position. Other states will likely amend their pay equity laws to include similar transparency provisions. It is important for all employers, especially multistate employers, to stay on top of these legal developments and begin considering appropriate salary ranges for all positions.

3. Conduct A Pay Equity Audit

There are significant financial consequences of pay equity claims, so employers should consider conducting pay audits to determine which

employees perform "comparable" work, ensure employees are being paid fairly and determine whether they are complying with new laws. The fundamental starting point for reviewing compensation and adjustments is to collect and analyze the relevant data. This ordinarily includes the following data for each employee included in the analysis: job title, department, job grade or level, hire date, gender (and, depending on the scope of the audit, other protected class identifiers such as race, age, etc.), job location, hours worked over the past 52 weeks, base wage or salary, overtime pay and bonuses or other forms of compensation.

Depending upon the quality and accessibility of data, this process can be time consuming. Therefore, many companies use the lull after the annual performance process – such as the first few months of the new year – to conduct an audit. Before embarking on this analysis, it is recommended you work with counsel so that the results of the audit are protected by the attorney-client privilege.

4. Analyze the Data

The goal of the analysis is to determine whether men and women (and other classes of protected employees) within the group are paid equally. The methodology can vary, depending upon the size of group and the complexity of the compensation scheme. Whether you have been conducting pay equity analyses for years or are new to the process, there are critical questions to address, such as:

- What are the challenges and practical issues that arise in collecting data for a pay equity audit?
- How does an employer use pay audit results to conduct remediation, and what are the challenges inherent in that process?
- How does pay equity fit into employers' other Diversity, Equity and Inclusion ("DEI") initiatives?

5. Level the Playing Field

In the context of compensation reviews, there are a few red flags. Where compensation for employees performing the same job could not be explained by bona fide business-related factors like experience, education, seniority or responsibility, it is important to develop a plan to address pay disparities.

One strategy you may consider employing would be to award bonuses to bridge the gap between disparate compensation for employees who perform substantially similar work.

One strategy you may consider employing would be to award bonuses to bridge the gap between disparate compensation for employees who perform substantially similar work. Additionally, you may plan to increase compensation of those disadvantaged to remedy any pay disparities going forward into 2022 and beyond. Through a bonus payment or salary increase, you may be able to take steps to equalize compensation without drawing attention to a potential pay disparity. Of course, it is important to evaluate both base pay and total compensation (including perks). Finally, many organizations use the audit process to identify their talent pipeline and identify candidates for promotion or changes in role.

Conclusion

Tackling pay equity is a critical element of building a diverse and inclusive workplace. The good news is that nearly three in five (58 percent) U.S. organizations voluntarily conduct pay equity reviews to identify possible pay differences between employees performing similar work. Of those organizations, 83 percent adjusted employees' pay following a pay equity review, according to new survey data from the Society for Human Resource Management ("SHRM"). Fair and competitive pay is essential for employers to attract and retain talent in a tight job market.

No matter what stage your business is in, now is an ideal time to review and update compensation policies and practices and make adjustments to alleviate potential pay equity concerns.

Kathleen McLeod Caminiti (*kcaminiti@fisherphillips.com*) is a partner in Fisher Phillips' New Jersey and New York offices, and a co-chair of both the Wage and Hour and Pay Equity practice groups. She handles all aspects of employment litigation, including individual plaintiff discrimination claims, restrictive covenant litigation and wage and hour class and collective actions. Sarah Wieselthier (*swieselthier@fisherphillips.com*) is of counsel in the firm's New Jersey office focusing her practice on employment litigation.

COVID-19 Supplemental Paid Sick Leave Signed into California Law

BY BEN GIPSON AND SAMANTHA SALTZMAN

California Governor Gavin Newsom has signed into law legislation reviving COVID-19 supplemental paid sick leave ("SPSL") under a new California Labor Code Section 248.6.[1] The new SPSL requirement took effect on February 19, 2022, and applies retroactively from January 1, 2022. The law's provisions are set to expire on September 30, 2022. This article addresses common questions about the new law and what it means for employers.

WHICH EMPLOYERS MUST COMPLY WITH THIS LAW?

The new SPSL obligations generally apply to California employers with more than 25 employees. Related FAQ guidance clarifies that the Labor Commissioner's Office interprets this headcount to even include out-of-state employees.[2]

While employers with 25 or fewer employees are not covered by this law, they may be covered by local supplemental paid sick leave ordinances.

HOW MUCH SPSL ARE COVERED EMPLOYERS REQUIRED TO PROVIDE AND WHEN?

Like its 2021 predecessor, the new law provides for up to 80 hours of SPSL for various COVID-19-related reasons. However, there are notable differences this time around. Instead of simply providing for up to 80 hours of SPSL, the new law splits the hours into two buckets:

1. Up to 40 Hours of SPSL for an Employee Who Is Unable to Work or Telework due to Any of the Following Qualifying Reasons:
    - The employee is subject to a quarantine or isolation period related to COVID-19 (as defined by an order or guidance of the State Department of Public Health, the federal Centers for Disease Control and Prevention or a local public health officer who has jurisdiction over the workplace);
    - The employee has been advised by a healthcare provider to isolate or quarantine due to COVID-19;
    - The employee is attending an appointment for themself or a family member to receive a vaccine or a vaccine booster for protection against COVID-19;
    - The employee is experiencing symptoms, or caring for a family member experiencing symptoms, related to a COVID-19 vaccine or vaccine booster that prevents the employee from being able to work or telework;
    - The employee is experiencing symptoms of COVID-19 and is seeking a medical diagnosis;
    - The employee is caring for a family member who is subject to an order or guidance described in the first bullet or who has been advised to isolate or quarantine as described in the second bullet; and
    - The employee is caring for a child whose school or place of care is closed or otherwise unavailable for reasons related to COVID-19 on the premises.
2. Up to 40 Hours of Additional SPSL for an Employee Who Is Unable to Work or Telework because the Employee Tested Positive for COVID-19 or Cares for a Family Member Who Tested Positive for COVID-19.

Related FAQ guidance clarifies that an employer may, at its discretion, provide one bank of up to 80 hours for any of the qualifying reasons rather than keeping track of the two separate banks of 40 hours each.

For each vaccination or vaccine booster, an employer may limit the total SPSL to three days or 24 hours, unless the employee provides verification from a healthcare provider that the employee or their family member is continuing to experience symptoms related to a COVID-19 vaccine or vaccine booster.

An employee does not need to exhaust the 40 base hours of SPSL before using the additional 40 hours of SPSL. For this second bucket of SPSL, covered employers may require documentation of test results. Specifically, covered employers may require the employee to submit to a diagnostic test on or after the fifth day following the initial positive COVID-19 test and provide documentation of the results. However, the employer must make the diagnostic test available at no cost to the employee.

Similarly, covered employers may require employees to provide documentation of the family member's test results. If the employee refuses to provide documentation of the COVID-19 test results, the employer is not obligated to provide the additional 40 hours of SPSL.

The amount of SPSL entitlement is prorated for workers who are not full-time, as the new law specifically provides different methods for calculating the amount of leave for employees who work part-time or who have variable schedules. Generally, such workers will be eligible for SPSL based on the number of hours they typically work in a week.

Are There Caps on the Amount of SPSL Pay?

Yes, the new law provides for the same caps on SPSL pay as in 2021. Specifically, covered employers are not required to pay more than $511 per day or $5,110 in aggregate to a qualifying employee, unless federal legislation is enacted that increases these amounts beyond what was previously included in the federal Families First Coronavirus Response Act.

What is the Retroactive SPSL Requirement?

The retroactive SPSL obligation is similar to that in the 2021 law. If an employee took leave between January 1 and February 19 for a qualifying reason that was either unpaid or not paid at the level required by this new law, the employee may make an oral or written request for retroactive payments. Employers are not required to make retroactive payments without such a request, but the law does not expressly prohibit them from doing so or address if such payments would satisfy obligations without a corresponding request from the employee.

Retroactive payments must be paid on or before the payday for the next full pay period after the request is made. However, an employer may require an employee to provide documentation of a positive test if the employee requests retroactive leave for a positive test or because they were caring for a family member with a positive test in relation to the second bucket of 40 SPSL hours. Related FAQ guidance clarifies that this documentation could include a medical record of the test result, an email or text from the testing company with the results, a picture of the test result, or a contemporaneous text or email from the employee to the employer stating the employee or a qualifying family member tested positive for COVID-19. An employer generally may not request similar documentation for other qualifying reasons.

How Does SPSL Interact With Related Leave Requirements?

The new law's SPSL requirement is in addition to rights under traditional state and local paid sick leave ordinances. However, local COVID-19 paid sick leave ordinances may satisfy the SPSL requirement depending on whether paid sick leave was provided for the same reasons and compensated at an amount equal to or greater than the SPSL pay requirements under this new California law.

In addition, the new law specifically prohibits employers from requiring an employee to use any other paid or unpaid leave, paid time off or vacation provided to the employee before or in lieu of using SPSL.

Similarly, it prohibits employers from mandating that an employee exhaust SPSL before satisfying any requirement to provide leave related to COVID-19 under any Cal/OSHA COVID-19 Emergency Temporary Standard ("ETS"), which includes Cal/OSHA exclusion pay requirements. This is a notable change from the 2021 predecessor law, which allowed employers to require an employee to use SPSL before being obligated to exclusion pay under Cal/OSHA's COVID-19 ETS. However, if an employer voluntarily pays another supplemental benefit for COVID-19 related sick leave, the employer may receive a credit toward these SPSL requirements in accordance with current FAQ guidance.

Are There Paystub and Notice Requirements?

Yes, covered employers must provide an employee with a written notice setting forth the amount of SPSL that the employee used on either the employee's itemized wage statement or a separate writing provided on the designated payday with the wage payment. The designated payday must be on the next regular payroll period after the sick leave was taken. The employer must list zero hours if the worker has not used any SPSL and must list SPSL hours separately from traditional paid sick leave, but the new law does not address whether the paystub must differentiate between the two SPSL buckets.

These paystub requirements become enforceable the next full pay period after the new law took effect on February 19. They also reflect a welcomed change from the 2021 predecessor, which required statements to list the available (rather than used) hours. The change should reduce the burden on employers as they are not required to make complicated calculations before employees even request leave.

In addition, covered employers must provide notice of entitlements under Labor Code Section 247, as they do for traditional California

paid sick leave. Covered employers generally are required to display a poster in a conspicuous place with information about the employee's rights to receive SPSL. The law contains a limited exception to satisfy this SPSL notice requirement through electronic means (e.g., email) if employees do not frequent the workplace. The Labor Commissioner is required to make available a model notice within seven days. The Labor Commissioner's model poster is currently available on California's Department of Industrial Relations website.

Are There Tax Credits to Offset the Related Costs For Employers?

This new law does not directly provide for tax credits specific to SPSL costs. However, Governor Newsom signed a separate bill providing for various tax credits, grants and reliefs for some businesses in California that may provide general relief depending on the circumstances.

Next Steps

Covered employers are encouraged to comply with the new SPSL requirement. Steps to consider include preparing an updated SPSL policy and process for handling related leave requests, planning for the paystub requirement, and evaluating the need for any retroactive payments.

Notes

1. *https://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=202120220AB84&showamends=false.*
2. *https://www.dir.ca.gov/dlse/COVID19Resources/2022-SPSL-FAQs.html.*

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Worker Fired During COVID-19 Isolation Can Proceed with Disability Lawsuit, Says Federal Court

By Benjamin S. Morrell

A federal court has ruled that a nurse fired while isolating with a case of COVID-19 can proceed with her disability discrimination lawsuit against her former employer, further developing a body of law permitting COVID-19 sufferers to bring Americans with Disabilities Act ("ADA") claims against their employers. The case at issue is still in its infancy, and the Alabama healthcare facility facing the charge has barely had a chance to present its defense. But what can employers learn from the decision?

Infection Leads to Isolation That Leads to Termination

Lucious Brown worked as a certified nursing assistant for Roanoke Rehabilitation & Healthcare Center in eastern Alabama from September 2019 until her eventual termination in the summer of 2020. In late June 2020, Brown began feeling severely weak with fatigue, brain fog, high blood pressure, cough, difficulty breathing, fever and swollen eyes. On July 1, her physician informed her that she had tested positive for COVID-19.

Her employer maintained a policy that required a 14-day isolation period for any employee who tested positive, which was in line with the Centers for Disease Control and Prevention ("CDC") guidelines at the time. Thus, she began to isolate at home and presumed she would not be required – or permitted – to return to work until at least July 14.

It is important to understand that the allegations as recounted in the court's decision are taken from Brown's side of the story only, and that the healthcare facility may dispute this version of events. But according to Brown, her supervisor contacted her on July 7 and instructed her to return to work to again be tested for the virus – in direct contradiction of both CDC guidance and company policy. Brown declined, indicating that she was still isolating and still experiencing severe COVID-19 symptoms. Three days later, Brown's supervisor again reached out to her and repeated the instruction that she was to report to work to take a COVID-19 test. Once again, Brown told the supervisor that she was still suffering from virus symptoms. The following day, the supervisor contacted Brown for a third time, informing her that if she did not return to work on July 13, they would consider her to have "voluntarily quit." Despite the third and final instruction to return to work, Brown did not return to work because she alleges she still suffered from severe COVID-19 symptoms.

Brown claims that the healthcare facility terminated her employment that day, the 13th day of her 14-day isolation period. The day after her termination, because she continued to suffer from the same symptoms, Brown retested for COVID-19 and once again tested positive.

Lawsuit and Crux of Claims

In September 2021, Brown filed a disability discrimination claim against her former employer in Alabama alleging that her discharge violated the ADA. As a gateway to proceed with any such claim, a plaintiff must allege that they have a "disability." They can do this in one of three separate ways, and Brown alleged that she satisfied two possible pathways. The arguments raised by Brown to satisfy this initial step are that she had an actual disability and that she was regarded by her employer as having an impairment that would qualify under the ADA.

- *Actual Disability*: A plaintiff must show they have a physical or mental impairment that substantially limits one or more of their major life activities. These include, but are not limited to, breathing, concentrating, thinking and working.

- *Regarded As*: A plaintiff is "regarded as" disabled when they are perceived as having a physical or mental impairment by their employer, regardless of whether the impairment actually exists or is perceived to limit a major life activity. An individual cannot be regarded as having such an impairment, however, if the impairment is "transitory and minor."

Another important point: courts have been instructed by Congress to interpret the ADA in "favor of broad coverage of individuals" to the "maximum extent permitted" by the statute's terms. Accordingly, courts have noted that the bar to be considered "disabled" under the ADA is not a high one. Despite these hurdles, the employer filed a Motion to Dismiss at the outset of the case to argue that Brown could not even muster a legal argument that would permit her claim to proceed.

Actual Disability

The court rather easily concluded that Brown advanced sufficient arguments to satisfy the legal standards and allow her claim to get to the next stage of litigation.

- Recent guidance by the Department of Health and Human Services and Department of Justice indicates that certain forms of COVID-19 may be considered a disability under the ADA, and the Equal Employment Opportunity Commission ("EEOC") also recently issued guidance as to whether COVID-19 can qualify as an actual disability. The upshot from these guidance documents: COVID-19 can be a disability, so long as the condition is sufficiently severe to impair major life activities.
- In this case, Brown gave specifics as to how her particular COVID-19 condition at the time of her termination impaired her ability to breath, concentrate and work – all of which are statutorily recognized as major life activities.
- Therefore, the court denied the employer's Motion to Dismiss as to this argument.

Another important point: courts have been instructed by Congress to interpret the ADA in "favor of broad coverage of individuals" to the "maximum extent permitted" by the statute's terms.

Regard as Disabled

- The employer's primary argument was that COVID-19 is a "transitory and minor" impairment as defined by the statute, so it could not have perceived Brown as disabled within the meaning of the ADA.
- While the court acknowledged that Brown's virus may have been "transitory" – with an actual or expected duration of six months or less – it noted that the employer essentially ignored the "minor" component of the legal standard. Because Brown alleged that she told her supervisor that she was suffering from a severe and symptom-laden case of COVID-19, the court concluded that she raised sufficient allegations to demonstrate that her impairments were not minor.
- Therefore, the court also denied the Motion to Dismiss this claim.

Lessons Learned For Employers

The federal guidance cited by the court means that many more decisions along these lines are likely to be seen, permitting workers to advance ADA claims for virus-related conditions. Accordingly, employers should take proactive measures to address potential COVID-19 claims, including the following:

- Train managers and supervisors to consider COVID-19-related illnesses just as they would any other illness. This holds true as it applies to your sick leave policies, any federal or local leave obligations and disability practices at your workplace.
- Where this issue is most likely to arise from an ADA perspective – and lead to litigation – is in the area related to accommodation requests and the interactive process.
  - Thoroughly analyze company, department and employee production/performance levels before, during and after the pandemic to determine the feasibility of alternative schedules, remote work and other "accommodations" likely to be requested by employees suffering from COVID-related disabilities;
  - Review your company's ADA request-for-accommodation processes and procedures to ensure compliance with the latest guidance pertaining to COVID-19;
  - Update medical inquiry forms (e.g., ADA Interactive Process forms) and develop COVID-specific forms to be completed by the employee's healthcare provider; and
  - Continue to train managers and supervisors on the importance of avoiding inappropriate and potentially disability-related inquiries regarding COVID-19, along with protecting confidentiality of employee medical information.

CONCLUSION

Although employees with COVID-related impairments may not always be able to establish that they are disabled or entitled to a reasonable accommodation under the ADA, proactive steps should be taken to prepare for what is likely to be an onslaught of such claims following the federal guidance – and decisions such as these. Developments related to COVID-19 will continue to be monitored.

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By Gary D. Blachman and
Austin Anderson

IRS Releases Proposed Required Minimum Distributions Rule

The Internal Revenue Services ("IRS") has issued the long-awaited proposed regulations ("Proposed Rule") that addressed, in large part, the changes to required minimum distribution ("RMD") rules made by the Setting Every Community Up for Retirement Enhancement Act of 2019 ("SECURE Act").

The Proposed Rule affects qualified 401(a) plans, 403(b) plans, governmental 457(b) plans, and Individual Retirement Accounts ("IRAs"). It updates regulations under Sections 401(a)(9), 402(c), 403(b), 457, 408, and 4974 of the Internal Revenue Code ("Code"), to replace the existing question-and-answer format and, in addition to changes made by the SECURE Act, to reflect other statutory amendments made since the RMD regulations were last issued in 2002.

The Proposed Rule applied beginning January 1, 2022. The existing regulations applied to the 2021 calendar year, but in applying them taxpayers must take into account a reasonable, good faith interpretation of the SECURE Act's changes. Compliance with the Proposed Rule for 2021 will satisfy the reasonable, good faith standard. Since RMDs were suspended for 2020, relief is not required for that year.

Background

The SECURE Act became law on December 20, 2019, and made two major changes to the RMD rules:

- For any employee born on or after July 1, 1949, the required beginning date ("RBD") for RMDs was increased from age 70 1/2 to age 72. This change was effective for all retirement plans and IRAs on January 1, 2020.
- Effective for employees who die after December 31, 2019 (or after December 31, 2021, for governmental plans and collectively bargained plans), if the employee dies before distribution of their entire interest in the plan and has designated beneficiaries who are not "eligible designated beneficiaries," then full distribution must be made within 10 years (not five years) of the employee's death and the life expectancy rules are no longer available. This change was effective for most retirement plans and IRAs on January 1, 2020, and for governmental plans and collectively bargained plans on January 1, 2022.

10-Year Rule for Designated Beneficiaries in a DC Plan/IRA

The Proposed Rule keeps the rule that allows an employee's interest to be distributed over the designated beneficiary's life or life expectancy. However, in the case of a defined contribution ("DC") plan, that rule is available only if the designated beneficiary is an "eligible designated beneficiary."

The SECURE Act defined both terms, and the Proposed Rule adopts those definitions.

A "designated beneficiary" means any individual designated as a beneficiary by the employee.

An "eligible designated beneficiary" means a designated beneficiary of an employee that, on the date of the employee's death, is:

- Their surviving spouse;
- Their child who has not reached the age of majority;
- Disabled;
- Chronically ill; or
- Not more than 10 years younger than the employee.

The Proposed Rule provides that an eligible designated beneficiary also includes a beneficiary of an employee who dies before January 1, 2020. However, if an eligible designated beneficiary dies on or after January 1, 2020, the successor beneficiary will be treated as a designated beneficiary.

The Proposed Regulations set forth rules for identifying designated beneficiaries and eligible designated beneficiaries, including:

- A beneficiary does not need to be specified by name to be the designated beneficiary, as long as they are identifiable from the designation (e.g., children in equal shares).

- Rights under a will or state law do not make a person a designated beneficiary.
- The "age of majority" is generally age 21, with a special rule for defined benefit plans.
- Default designations in a plan can create a designated beneficiary.
- A designated beneficiary must be an individual (e.g., not an estate). Generally, if a non-individual is designated, there is no designated beneficiary, even if individuals are also designated (except for see-through trusts). The RMD rules have not changed for non-individual beneficiaries.
- If there are multiple designated beneficiaries and at least one of them is not an eligible designated beneficiary, the employee is treated as having no eligible designated beneficiary (unless any designated beneficiary is an eligible designated beneficiary due to being a child or in certain cases for disabled or chronically ill eligible designated beneficiaries).
- An individual who has not attained age 18 is disabled if, as of the date of the employee's death, the individual has a medically determinable physical or mental impairment that results in marked and severe functional limitations and that can be expected to result in death or to be of long-continued and indefinite duration.
- An individual determined by the Social Security Administration to be disabled is deemed to be disabled for purposes of the Proposed Rule.

It is important to note that the separate account rules for beneficiaries under the existing regulations still apply. If these rules are met, each beneficiary is treated as the sole beneficiary of the employee's account and the rules relating to the treatment of multiple beneficiaries outlined above will not apply.

Special Rules for Trusts

The Proposed Rule provides significant additional guidance on trusts as beneficiaries. It keeps the see-through trust concepts from the existing regulations under which certain beneficiaries of a see-through trust are treated as beneficiaries of the employee. The Proposed Rule also adds guidance for determining which beneficiaries of a see-through trust are treated as beneficiaries of the employee, including many more sample fact patterns than under existing regulations. The IRS' stated intention in providing this guidance is to minimize the need for taxpayers to request private letter rulings.

Distributions After the Employee's Death

For defined contribution plans and IRAs, the RMD rules that apply at the death of an employee will depend on whether the employee has reached the employee's RBD and whether the employee's beneficiary is a designated beneficiary, eligible designated beneficiary, or non-individual beneficiary.

If an employee dies before the employee's RBD:

- An eligible designated beneficiary will receive distributions over their lifetime. A plan can instead provide that distributions will be made under the 10-year rule. Alternatively, a plan can permit an eligible designated beneficiary to elect to receive distributions either over their lifetime or under the 10-year rule, and specify a default rule if a timely election is not made.
- A designated beneficiary must receive a full distribution under the 10-year rule.
- A non-individual beneficiary must still receive a full distribution under the five-year rule.

If an employee dies after the employee's RBD, then:

- An eligible designated beneficiary must receive benefits at least as rapidly as they were being paid to the employee.
- A designated beneficiary must receive a full distribution under the 10-year rule. In an unexpected twist, however, the designated beneficiary must also take annual distributions under the life expectancy rule until the account is fully distributed under the 10-year rule.
- A non-individual beneficiary must still receive a full distribution under the life expectancy rule.

The Proposed Rule additionally provides that a full distribution from the plan must be made by the earliest of the following dates:

- The end of the 10th calendar year following the calendar year in which an eligible designated beneficiary dies. If the eligible designated beneficiary is receiving benefits over their life expectancy at death, their beneficiary must also take distributions under the life expectancy rule until the account is fully distributed under the 10-year rule.
- If the eligible designated beneficiary is the child of the employee who has not yet reached the age of majority as of the employee's death, the end of the 10th calendar year following the calendar year in which the child reaches the age of majority.
- The end of the calendar year in which the applicable denominator would have been less than or equal to one if it were determined using the eligible designated beneficiary's remaining life expectancy, if the appliable denominator is determined using the employee's remaining life expectancy.

The Proposed Rule also adds a modified version of the general rule that applies if an employee has multiple designated beneficiaries. Rather than determining the applicable

denominator using the designated beneficiary with the shortest life expectancy, the Proposed Rule uses the life expectancy of the oldest designated beneficiary.

RMDs From Defined Benefit Plans

The Proposed Rule did not make significant changes to defined benefit plan RMD requirements.

For employees who retire after reaching the age of 70 1/2, the SECURE Act did not change the requirement that benefits be actuarially increased to take into account the period after age 70 1/2 in which the employee was not receiving any benefits under the plan. In other words, the SECURE Act did not change the age of this actuarial adjustment from age 70 1/2 to age 72. In addition, the Proposed Rule confirms that the required actuarial adjustment does not apply to a five-percent owner, and, as under the existing regulations, does not apply to governmental and church plans.

Other changes under the Proposed Rule that apply to defined benefit plans include:

- An exception to the five-year rule was added so that a plan will not fail to comply merely because payments by the plan are restricted by Section 436(d) (which requires limitations on accelerated benefit distributions).
- Additional circumstances under which annuity payments under a defined benefit plan may increase were added by the Proposed Rule, including as a result of benefits suspended for a retiree on account of reemployment, and for an insolvent plan or for a participant or beneficiary of a plan in critical and declining status whose benefits have been suspended in some circumstances.
- While the age of majority under the Proposed Rule is generally age 21, a defined benefit plan may have a different age of age of majority definition if adopted prior to February 24, 2022.

Rollovers

The Proposed Rule makes clear that if an employee dies before their RBD, any distribution made during the year of the employee's death is an eligible rollover distribution. Moreover, if the five- or 10-year rule applies, any distribution made prior to the fifth or 10th year is an eligible rollover distribution. Any amount distributed in the fifth or 10th year, however, is considered a RMD.

Plan sponsors should consider how these changes will impact their plan administration, procedures and processes, documentation, and employee communications.

If the participant dies after their RBD or the life expectancy rules apply, then the distributions made under the life expectancy rule are not eligible for rollover. This includes distributions made during the year that an employee dies, if the RMD was not made prior to the employee's death.

403(b) and 457(b) Plan Changes

The Proposed Rule amends the regulations for 403(b) plans and 457(b) plans to generally conform to the SECURE Act changes that apply to qualified plans. One exception is recognition that the SECURE Act's exception from the 10-year rule for existing qualified annuity contracts applies in the case of a 403(b)(9) retirement income account even if a commercial annuity is not used.

Importantly, the preamble to the Proposed Rule states that the IRS is considering additional changes to the RMD rules for Section 403(b) plans so the rules more closely follow those for qualified plans. For example, the IRS has invited comments on a potential change that would require each 403(b) plan to force a required minimum distribution as is currently required for qualified plans and 457(b) plans. This would be a significant change and may pose significant practical challenges for many 403(b) plan sponsors.

Next Steps

The Proposed Rule introduces significant complexity to the already complex RMD rules. Plan sponsors should consider how these changes will impact their plan administration, procedures and processes, documentation, and employee communications. While plan documents, summary plan documents and administrative practice will generally need to be reviewed and amended to address the changes by December 31, 2022 (December 31, 2024 for governmental plans), plans must be administered in accordance with the Proposed Rule now (and for 2021 must be administered in good faith compliance with the SECURE Act and existing regulations).

A public hearing on the Proposed Rule is scheduled for June 15, 2022.

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By Christy E. Phanthavong

Covered Family Members, and the 12-Month Period

Employees who are eligible for leave under the Family and Medical Leave Act ("FMLA") may use their FMLA entitlement for a number of qualifying reasons. One such reason is to provide physical and/or psychological care for a covered family member – specifically, a "spouse, son, daughter or parent" – with a serious health condition. So, who is included within those family relationship terms?

Eligible Family Members

Spouse

- The employee's husband or wife as defined in the state where the individual was married (or, if the marriage was entered into outside of any state, if the marriage is valid in that place and could have been entered into in at least one state).
- Spouse includes a spouse through same-sex and common law marriages.

Son or Daughter

- The employee's biological, adopted, or foster child, stepchild, or legal ward who is either:
  - Under age 18; or
  - Over age 18 and is incapable of self-care because of a physical or mental disability.
- Also includes a child with respect to whom the employee stands "in loco parentis" (in the place of a parent):
  - The employee must have assumed the day-to-day responsibilities of a parent for the care and financial support of the child. Factors to consider include the child's age and degree of dependence, the extent to which the employee exercises the general duties of parenthood, and the amount of financial support provided to the child.
  - No biological or legal relationship is necessary.
  - Examples provided by the U.S. Department of Labor: Employee raising child with a same-sex partner; grandparent who cares for grandchild whose parents are incapable of doing so; aunt who assumes responsibility for a child after the child's parents pass away.

Parent

- The employee's biological, adoptive, step or foster father or mother;
- Also includes any other individual who stood in loco parentis to the employee when the employee was a son or daughter (see discussion of "in loco parentis" above);
- Does not include parents "in law."

Employees may be required to provide reasonable documentation confirming the family relationship. This may include a simple statement from the employee, or other documentation such as a birth certificate (which should be returned to the employee), court document, etc.

Recommended Next Steps

Employers should ensure they are sensitive to family relationships that may implicate FMLA rights even though such relationships may fall outside relationships that have traditionally been considered the "norm."

What is the "12-Month Period"?

Eligible employees of employers covered by the Family and Medical Leave Act are entitled to take up to 12 weeks of FMLA leave during the applicable 12-month period for family and medical reasons, and up to 26 weeks of FMLA leave during the applicable 12-month period for military caregiver reasons. So, what is the applicable "12-month period?"

All Types of Leave Except Military Caregiver Leave

For all types of FMLA leave other than military caregiver leave (covered in greater detail below) – so, for leave needed due to the employee's own or employee's family member's serious health condition, or for birth/placement of a child and to care for the child, or for qualifying exigency leave – employers are

able to choose the definition of the "12-month period" from among the following options:

- The calendar year;
- Any fixed 12-month leave year, such as a fiscal year, a year required by state law, or a year starting on an employee's anniversary date;
- The 12-month period measured forward from the date any employee's first FMLA leave begins; or,
- A "rolling" 12-month period measured backward from the date an employee uses any FMLA leave.

There are pros and cons to each definition. For example, the calendar year or fixed leave year are likely easier to administer than the rolling backward leave year, but the calendar and fixed leave year definitions would permit "stacking" (where an employee could use 12 weeks of FMLA leave towards the end of the defined year and continue with an additional 12 weeks of FMLA leave at the beginning of the next year, for 24 weeks of leave in a row).

Once the employer selects which definition will be used, that definition should be stated in the employer's FMLA policy (including any such policy included in a broader handbook or employee manual), communicated accurately to employees in connection with leave requests (such as in the space indicated on the Notice of Rights and Responsibilities Form (WH-381[1])), and applied consistently and uniformly to all employees.

An employer may choose to change to one of the other "12-month period" definitions, but in making this change must: (a) give at least 60 days' notice to all employees, and (b) ensure the transition occurs in such a way that employees retain the full benefits of 12 weeks of leave under whichever method would give them the greatest benefit.

Military Caregiver Leave

Military caregiver leave is available when an eligible employee needs to provide care to a covered servicemember who has a serious injury or illness. There is only one option for the 12-month period applicable to military caregiver leave: the 12-month period is measured forward from the date an employee's first FMLA leave to care for the covered servicemember begins.

Employers should make sure that this distinction in the definition of the 12-month period is recognized by leave administrators, communicated to employees, and applied correctly.

Recommendations

- Ensure your FMLA policy: (a) states the selected definition of the 12-month period applicable to all types of leave other than military caregiver leave, and (b) states the accurate definition of the 12-month period for military caregiver leave.
- Ensure your FMLA leave administrator (including any third-party administrator) is familiar with the applicable definitions of the 12-month period as stated in the FMLA policy.
- Evaluate whether your chosen definition remains the best option for your company. If not, follow appropriate steps to change the definition with notice and transition time.
- Ensure the correct 12-month period is identified in communications to the employee, including in the Notice of Rights and Responsibilities (Form WH-381).
- Ensure the correct 12-month period is applied to employees' leave requests and usage. Correct tracking of leave usage is imperative so that employees are given accurate information as to whether they have FMLA leave available and when their leave will be exhausted.

Note

1. *https://www.dol.gov/sites/dolgov/files/WHD/legacy/files/WH-381.pdf.*

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By Lisa S. Presser, Sarah F. Armstrong and Brian M. Balduzzi

Stretching Expectations: Planning with the New Life Expectancy Tables for Retirement Plans' Required Minimum Distributions

For the first time in nearly 20 years, the Internal Revenue Service ("IRS") has updated its actuarial tables for determining required minimum distributions ("RMDs") from retirement plans. These new tables affect plan participants and Individual Retirement Account ("IRA") owners, "Eligible Designated Beneficiaries" and more. All individuals in pay status and their advisors should review the new tables to ensure that the proper RMD is paid from retirement accounts for 2022 and beyond.

Required Minimum Distributions Explained

Under an IRA or defined contribution plan, such as a 401k, you must start taking annual withdrawals when you reach age 72 (or 70 1/2 if you reached that age before January 1, 2020). The Internal Revenue Service ("IRS") mandates the minimum amount of these annual withdrawals, commonly referred to as the RMD. The annual RMD is calculated using a formula that is equal to the account's value as of the beginning of the year divided by the "Applicable Divisor." This Applicable Divisor is determined by most plan participants using the "Uniform Lifetime Table." A plan participant whose sole beneficiary is his or her spouse may instead use the "Joint and Last Survivor Table" if the spouse is more than 10 years younger than the participant. Beneficiaries of inherited retirement plans determine their RMD using the "Single Life Table." These tables are published in the Treasury Regulations and can also be found in IRS Publication 590-B.

How Your RMD Might Change

A 75-year-old IRA owner who applied the Uniform Lifetime Table under formerly applicable Section 1.401(a)(9)-9 to calculate her RMDs used a life expectancy of 22.9 years. However, applying the updated Uniform Lifetime Table, the same 75-year-old would use a life expectancy of 24.6 years. Assume that this same IRA owner had an IRA with an account balance of $1 million at the beginning of 2022. Under the old table, this $1 million account balance would be divided by the 22.9 years to get an RMD for 2022 of approximately $43,668; under the new tables, however, this same account would be divided by 24.6, resulting in a lower RMD of approximately $40,650, leaving $3,018 to grow tax-deferred in the retirement plan.

Tables and Calculations for Beneficiaries

The surviving spouse of an account owner who is the sole IRA or plan beneficiary will use the new Single Life Table and will continue to recalculate his or her life expectancy annually based upon the new table.

A beneficiary of an account owner who died in 2020 or later who is a minor child, chronically ill or disabled (an Eligible Designated Beneficiary) and beneficiaries of account owners who died prior to 2020 will also be able to take advantage of the new tables. The distribution period for these beneficiaries is determined by finding the life expectancy on the Single Life Table based upon the beneficiary's age in the year following the year of the account owner's death. For each subsequent year, the RMD is calculated by taking that life expectancy number and subtracting one. For example, assume that a grandfather died in 2018, leaving his IRA to his granddaughter, who turned 40 in 2019. Under the old tables, the granddaughter would have used an Applicable Divisor of 43.6, which would then be reduced by one to calculate the RMD for each year after 2019.

Using the new tables, in 2022 the granddaughter will need to go back and determine the new life expectancy for a 40-year-old, which is now 45.7 years, and reduce it by one for each year that has elapsed since 2019. Applying this method, the granddaughter's Applicable Divisor, which would have been 40.6 in 2022 under the old table, is now 42.7. For a $1 million inherited IRA, the granddaughter would have a 2022 RMD of only $23,419 under the new tables, compared with $24,631 under the old tables.

Most beneficiaries of deceased account owners who died in 2020 or later will not be

affected by the new tables, as the SECURE Act limited the payout period for people who are not Eligible Designated Beneficiaries to no more than 10 years. Similarly, if there is no Designated Beneficiary, and the IRA owner died prior to his Required Beginning Date, the five-year rule may apply, requiring distribution over that period instead of using the LIFE expectancy tables.

Why This Change Matters

The new tables apply for RMDs in 2022 and future calendar years, even if the owner started taking RMDs in prior years. The longer life expectancies in the new tables mean longer distribution periods and smaller RMDs each year. The owner will, therefore, be able to further stretch the distribution of the retirement assets over his or her lifetime, deferring the income tax for a longer period and, potentially, leaving more assets in the plan for his or her beneficiaries upon his or her death.

Returning to the 75-year-old owner previously discussed, under the prior tables, she would have an annual RMD equal to 4.37 percent of her total retirement account, whereas under the new tables, she would have an annual RMD equal to only 4.07 percent of her account. The 0.30 percent net difference can be retained in the retirement account to grow free of income taxes. This comparison becomes even starker when looking at the RMDs for owners in their 80s and 90s. These lower RMDs may help keep owner's adjusted gross income ("AGI") low, reducing the possible effects of the net investment income or Medicare taxes, or the possibility of reaching the threshold or phase-outs for certain deductions and credits.

What to Do Next

Although many people's annual retirement plan withdrawals may be based upon cash flow needs, for those who are able to limit their withdrawals to the minimum required by law it will be important to understand the new life expectancy tables in order to take advantage of their potential benefits. For IRA owners or plan participants with substantial retirement assets, or advisors looking to help clients plan for inherited retirement assets, contact an attorney to discuss appropriate strategies to maximize the use of retirement assets and the tax advantages associated with these assets.

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Employee Benefit Plan Review
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June 10041545-0500