United States District Court
EASTERN DISTRICT OF TEXAS
SHERMAN DIVISION

STATE OF NEVADA, ET AL.	§	
	§	
v.	§	Civil Action No. 4:16-CV-731
	§	Judge Mazzant
UNITED STATES DEPARTMENT OF LABOR, ET AL.	§	LEAD
	§	

MEMORANDUM OPINION AND ORDER

Pending before the Court is the Motion for Expedited Summary Judgment (Dkt. #35) filed by the Plano Chamber of Commerce and more than fifty-five Texas and national business groups (collectively, "Business Plaintiffs"). After considering the relevant pleadings, the Court grants Business Plaintiffs' motion.

BACKGROUND

Congress enacted the Fair Labor Standards Act ("FLSA") in 1938. The FLSA requires employees engaged in commerce to receive no less than the federal minimum wage (currently, $7.25 per hour) for all hours worked. Employees are also entitled to overtime pay at one and one-half times the employee's regular rate of pay for all hours worked above forty in a week. When enacted, the FLSA contained a number of exemptions to the overtime requirement. Section 213(a)(1) of the FLSA exempts from both minimum wage and overtime requirements "any employee employed in a bona fide executive, administrative, or professional capacity." 29 U.S.C. § 213(a)(1). This exemption is commonly referred to as the "EAP exemption." While the FLSA did not define the terms "bona fide executive, administrative, or professional capacity," Congress delegated to the Secretary of Labor the power to define and delimit these terms through regulations. The Secretary of Labor authorized the Department of Labor (the "Department") to issue regulations that interpret the EAP exemption.

The Department's initial regulations defined "executive," "administrative," and "professional capacity" employees based on the duties they performed in 1938. Two years later, the Department revised regulations to require executive, administrative, or professional capacity employees to be salaried.

In 1949, the Department again amended regulations. These regulations established the "long" test and the "short" test for assessing whether an employee qualified for the EAP exemption. The long test combined a low minimum salary level with a rigorous duties test, which restricted the amount of nonexempt work an employee could do to remain exempt. The short test combined a high minimum salary level with an easier duties test that did not restrict amounts of nonexempt work. After the Department implemented the long and short tests, Congress amended 29 U.S.C. § 213(a)(1) in 1961. This amendment permitted the Department to define and delimit the exemption "from time to time."

In 2004, the Department eliminated the long and short tests, replacing them with a "standard" duties test that did not restrict the amount of nonexempt work an exempt employee could perform. In addition, the Department set the salary level equivalent to the lower minimum salary level previously used for the long test. The 2004 regulations, which are currently in effect, require an employee to meet the following three criteria to be exempt from overtime pay. First, the employee must be paid on a salary basis (the "salary-basis test"). Second, an employee must be paid at least the minimum salary level established by regulations (the "salary-level test"). The current minimum salary level is $455 per week ($23,660 annually). Third, an employee must perform executive, administrative, or professional capacity duties as established by regulations (the "duties test").

On March 23, 2014, President Obama issued a memorandum directing the Secretary of Labor to "modernize and streamline the existing overtime regulations for executive, administrative, and professional employees." Presidential Memorandum of March 13, 2014; Updating and Modernizing Overtime Regulations, 79 Fed. Reg. 18,737, 18,737 (Mar. 13, 2014). Although the Department revised regulations in 2004, the President opined, "[R]egulations regarding . . . overtime requirements . . . for executive, administrative, and professional employees . . . have not kept up with our modern economy." *Id.* In response to the President's memorandum, the Department published a Notice of Proposed Rulemaking to revise 29 C.F.R. Part 541. The Department received more than 293,000 comments on the proposed rule, including comments from businesses and state governments, before publishing the final version of the rule (the "Final Rule") on May 23, 2016.

Under the Final Rule, the minimum salary level for exempt employees increased from $455 per week ($23,660 annually) to $913 per week ($47,476 annually). The Department bases the new salary level on the 40th percentile of weekly earnings of full-time salaried workers in the lowest wage region of the country, which is currently the South. The Final Rule also creates an automatic updating mechanism that adjusts the minimum salary level every three years. The first automatic increase is scheduled to occur on January 1, 2020.

The State of Nevada and twenty other states (collectively, "State Plaintiffs") filed suit against the Department, the Wage and Hour Division of the Department, and their agents (collectively, "Defendants") challenging the Final Rule (Dkt. #1). On October 12, 2016, State Plaintiffs moved for emergency injunctive relief (Dkt. #10).

Business Plaintiffs filed a similar action challenging the Final Rule in *Plano Chamber of Commerce et al. v. Perez et al.*, No. 4:16-CV-732 (E.D. Tex. Sept. 20, 2016). The Court

consolidated Business Plaintiffs' action with State Plaintiffs' action on the unopposed motion of Business Plaintiffs (No. 4:16-CV-732; Dkt. #11). On October 14, 2016, Business Plaintiffs moved for expedited summary judgment (No. 4:16-CV-732, Dkt. #7; No. 4:16-CV-731, Dkt. #35). On November 18, 2016, Defendants filed a response (Dkt. #56). On November 21, 2016, Business Plaintiffs filed a reply (Dkt. #58).

On November 22, 2016, the Court preliminarily enjoined the Final Rule, which prevented the rule from going into effect on December 1, 2016 (Dkt. #60).[1] The Court's injunction applied to both states and businesses on a nationwide basis.

On December 12, 2016, State Plaintiffs filed a motion to join Business Plaintiffs' motion for summary judgment (Dkt. #66). State Plaintiffs also requested the Court to consider their preliminary injunction briefing as part of the pending motion for summary judgment (Dkt. #66). On August 30, 2017, the Court granted State Plaintiffs' motion and thus will consider State Plaintiffs' preliminary injunction briefing as the States' briefs in support of summary judgment (Dkt. #97). The Court will likewise consider Defendants' preliminary injunction briefing as their opposition to State Plaintiffs' arguments (Dkt. #97).

STANDING

Before reaching the merits of Business Plaintiffs' motion, the Court must assess whether they have standing to sue in federal court. Article III of the Constitution limits federal jurisdiction to "Cases" and "Controversies." Standing addresses whether a plaintiff is the proper party to bring a matter before the court for adjudication. A plaintiff does not have Article III

[1] The Department appealed the Court's preliminary injunction order on December 1, 2016. In its appellate brief, the Department indicated the Court's reasoning would invalidate all versions of the salary-level test that the Department has used for the last seventy-five years. Although the Court stated it was not making a general statement on the lawfulness of a salary-level test, the Court acknowledges its injunction order might have been confusing. In the analysis set forth below, the Court clarifies any confusion regarding the general lawfulness of the salary-level test and the lawfulness of the salary-level test under the Final Rule.

standing if it cannot present a case or controversy. In *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560–61 (1992), the Supreme Court held Article III standing requires a plaintiff to show the following elements: (1) it has suffered an "injury in fact" that is concrete, particularized, and actual or imminent; (2) the injury is fairly traceable to the challenged action of the defendant; and (3) it is likely the injury will be redressed by a favorable decision. An association has standing to bring suit on behalf of its members when: "(a) its members would otherwise have standing to sue in their own right; (b) the interests at stake are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." *Hunt v. Wash. State Apple Advert. Comm'n*, 432 U.S. 333, 343 (1977).

The Court finds Business Plaintiffs have met their burden of establishing Article III standing. Business Plaintiffs are local, state, or national trade associations representing millions of employers in Texas and throughout the country. It is clear the Final Rule directly affects both Business Plaintiffs and the employers they represent. For example, Business Plaintiffs and their members would incur significant payroll, accounting, and legal costs to comply with the Final Rule, both before and after its effective date. In addition, the Final Rule would affect how Business Plaintiffs and their members manage executive, administrative, and professional capacity employees who now qualify for overtime pay. Millions of these types of employees would have to be reclassified from salaried to hourly workers, resulting in limited work hours, reduced pay, and fewer opportunities for career advancement. If the Court determines the Final Rule is unlawful, then Business Plaintiffs' alleged injuries would either be avoided entirely or be sufficiently redressed by preventing further injury.

RIPENESS[2]

Defendants argue any challenges to the Final Rule's automatic updating mechanism are not ripe for adjudication. The Court is unpersuaded by this argument. A challenge to administrative regulations is fit for review if "(1) the questions presented are 'purely legal one[s],' (2) the challenged regulations constitute 'final agency action,' and (3) further factual development would not 'significantly advance [the Court's] ability to deal with the legal issues presented.'" *Texas v. United States*, 497 F.3d 491, 498–99 (5th Cir. 2007) (citing *Nat'l Park Hosp. Ass'n v. Dep't of Interior*, 538 U.S. 803, 812 (2003)). Here, State Plaintiffs and Business Plaintiffs make only legal arguments. Both Plaintiff groups question whether the Final Rule is lawful, whether the Department has authority to promulgate the Final Rule, and whether the automatic updating mechanism complies with the Administrative Procedures Act ("APA"). After completing a robust notice-and-comment period, the Department published the final version of the Final Rule on May 23, 2016, and set the rule to go into effect on December 1, 2016. Further, the Final Rule creates new legal obligations for employers who must pay certain employees a higher minimum salary level to exempt such employees from overtime pay. Thus, all parts of the Final Rule constitute final agency action. *See Bennett v. Spear*, 520 U.S. 154, 177–78 (1997) (stating the two-part test for "final agency action" includes an action that marks the consummation of the agency's decision-making process and an action where "rights or obligations have been determined, or from which legal consequences will flow"). The facts of this case have sufficiently developed to address the legality of the Department's Final Rule at this stage in the litigation. Accordingly, the automatic updating mechanism is ripe for review.

[2] Defendants raised this argument in response to State Plaintiffs' preliminary injunction briefing.

LEGAL STANDARD

The purpose of summary judgment is to isolate and dispose of factually unsupported claims or defenses. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323–24 (1986). Summary judgment is proper under Rule 56(a) of the Federal Rules of Civil Procedure "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). A dispute about a material fact is genuine when "the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby Inc.*, 477 U.S. 242, 248 (1986). Substantive law identifies which facts are material. *Id.* The trial court "must resolve all reasonable doubts in favor of the party opposing the motion for summary judgment." *Casey Enters., Inc. v. Am. Hardware Mut. Ins. Co.*, 655 F.2d 598, 602 (5th Cir. 1981).

The party seeking summary judgment bears the initial burden of informing the court of its motion and identifying "depositions, documents, electronically stored information, affidavits or declarations, stipulations (including those made for purposes of the motion only), admissions, interrogatory answers, or other materials" that demonstrate the absence of a genuine issue of material fact. Fed. R. Civ. P. 56(c)(1)(A); *Celotex*, 477 U.S. at 323. If the movant bears the burden of proof on a claim or defense for which it is moving for summary judgment, it must come forward with evidence that establishes "beyond peradventure *all* of the essential elements of the claim or defense." *Fontenot v. Upjohn Co.*, 780 F.2d 1190, 1194 (5th Cir. 1986). Where the nonmovant bears the burden of proof, the movant may discharge the burden by showing there is an absence of evidence to support the nonmovant's case. *Celotex*, 477 U.S. at 325; *Byers v. Dall. Morning News, Inc.*, 209 F.3d 419, 424 (5th Cir. 2000). Once the movant has carried its burden, the nonmovant must "respond to the motion for summary judgment by setting forth

particular facts indicating there is a genuine issue for trial." *Byers*, 209 F.3d at 424 (citing *Anderson*, 477 U.S. at 248–49). A nonmovant must present affirmative evidence to defeat a properly supported motion for summary judgment. *Anderson*, 477 U.S. at 257. Mere denials of material facts, unsworn allegations, or arguments and assertions in briefs or legal memoranda will not suffice to carry this burden. Rather, the Court requires "significant probative evidence" from the nonmovant to dismiss a request for summary judgment. *In re Mun. Bond Reporting Antitrust Litig.*, 672 F.2d 436, 440 (5th Cir. 1982) (quoting *Ferguson v. Nat'l Broad. Co.*, 584 F.2d 111, 114 (5th Cir. 1978)). The Court must consider all of the evidence but "refrain from making any credibility determinations or weighing the evidence." *Turner v. Baylor Richardson Med. Ctr.*, 476 F.3d 337, 343 (5th Cir. 2007).

ANALYSIS

1. Application of the FLSA to the States[3]

State Plaintiffs argue the FLSA's overtime requirements violate the Constitution by regulating the States and coercing them to adopt wage policy choices that adversely affect state priorities, budgets, and services. State Plaintiffs rely on *National League of Cities v. Usery*, which held the Tenth Amendment limited Congress's power to apply the FLSA's minimum wage and overtime protections to the States. 426 U.S. 833, 851–52 (1976). The Supreme Court recognized:

> One undoubted attribute of state sovereignty is the States' power to determine the wages which shall be paid to those whom they employ in order to carry out their governmental functions, what hours those persons will work, and what compensation will be provided where these employees may be called upon to work overtime.

[3] State Plaintiffs asserted this argument in their preliminary injunction briefing.

Id. at 845. State Plaintiffs acknowledge the Supreme Court overruled *Usery* in *Garcia v. San Antonio Metropolitan Transit Authority*, 469 U.S. 528 (1985). However, they urge *Garcia* has been, or should be, overruled because subsequent decisions have called into question *Garcia*'s continuing validity. As such, State Plaintiffs claim the Department's Final Rule displaces their independence to set employee compensation, similar to the FLSA amendments at issue in *Usery*.

Garcia controls the disposition of this issue. The Supreme Court in *Garcia* established Congress has authority under the Commerce Clause to impose the FLSA's minimum wage and overtime requirements on state and local employees. 469 U.S. at 554. The Supreme Court overruled *Usery* because it found rules based on the subjective determination of "integral" or "traditional" governmental functions provide little or no guidance in determining the boundaries of federal and state power. *Id.* at 546–47. In the line of cases following *Garcia*, the Supreme Court imposed limits on the power of Congress to enact legislation affecting state and local governments. *See, e.g.*, *Printz v. United States*, 521 U.S. 898, 935 (1997) (holding Congress cannot compel the states to enact or administer a federal regulatory program). However, no Supreme Court case has specifically overruled *Garcia*. The Supreme Court has declared lower courts must follow precedent and allow the Supreme Court to overrule its decisions. *Agostini v. Felton*, 521 U.S. 203, 237 (1997) (quoting *Rodriguez de Quijas v. Shearson/Am. Express, Inc.*, 490 U.S. 477, 484 (1989)). Therefore, the Court will follow *Garcia* and apply the FLSA to the States.

2. Application of the Clear Statement Rule[4]

State Plaintiffs also argue the FLSA does not apply to the States based on the clear statement rule. This argument likewise does not succeed.

[4] State Plaintiffs asserted this argument in their preliminary injunction briefing.

The clear statement rule provides, "If Congress intended to alter the 'usual constitutional balance between the States and the Federal Government,' it must make its intention to do so 'unmistakably clear in the language of the statute.'" *Gregory v. Ashcroft*, 501 U.S. 452, 460–61 (1991) (quoting *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 242 (1985)). The FLSA requires employers to pay the federal minimum wage to their employees or those "employed in an enterprise engaged in commerce or in the production of goods for commerce." 29 U.S.C. § 206. "Enterprise engaged in commerce or in the production of goods for commerce" is defined to include the "activity of a public agency." *Id.* § 203(s)(1)(C). A "public agency" means "the government of a State or political subdivision thereof; any agency of . . . a State, or a political subdivision of a State." *Id.* § 203(x). Because Congress's intention for the FLSA to apply to the States is "unmistakably clear in the language of the statute," the clear statement rule does not apply. *Scanlon*, 473 U.S. at 242.

3. Application of *Chevron* to Section 213(a)(1)

Business Plaintiffs claim the Final Rule's revision to the minimum salary threshold exceeds the Department's authority under Section 213(a)(1). Business Plaintiffs argue the Final Rule increases the minimum salary threshold so high that it is no longer a plausible proxy for the job duties of an executive, administrative, or professional capacity employee. As a result, Business Plaintiffs assert the Final Rule is inconsistent with the FLSA and departs from both Department regulations and judicial decisions that Congress has accepted.

Defendants contend the Final Rule is within their delegated authority because Section 213(a)(1) explicitly grants authority to the Department to "define[] and delimit[]" the terms "bona fide executive, administrative, or professional capacity." Thus, Defendants

encourage the Court to defer to the Department's interpretation of the statute as set forth in the Final Rule.

The Supreme Court established in *Chevron* a two-step standard for reviewing agency decisions. *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842–43 (1984). The first step of *Chevron* is to determine whether Congress has directly and unambiguously spoken to the precise question at issue. *Id.* at 842. To aid in this inquiry, a court should apply "traditional tools of statutory construction." *Id.* at 843 n.9. Statutory construction begins with the language of the statute, "the specific context in which that language is used, and the broader context of the statute as a whole." *Robinson v. Shell Oil Co.*, 519 U.S. 337, 341 (1997). A court may also reference the statute's legislative history and its purpose to ascertain Congress's intent. *Bellum v. PCE Constructors, Inc.*, 407 F.3d 734, 739 (5th Cir. 2005). "If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Chevron*, 467 U.S. at 842–43.

Second, if Congress has not directly addressed the precise question at issue, then "the question for the question for the court is whether the agency's interpretation is based on a permissible construction of the statute." *Id.* at 843. An agency's statutory interpretation is entitled to deference, as long as it is reasonable. *Id.* at 843–44.

Section 213(a)(1) provides, in relevant part, that "any employee employed in a bona fide executive, administrative, or professional capacity . . . as such terms are defined and delimited from time to time by regulations of the Secretary" shall be exempt from minimum wage and overtime requirements. 29 U.S.C. § 213(a)(1). Here, the precise question at issue is what constitutes an employee employed in a "bona fide executive, administrative, or professional capacity." Since the statute does not define the terms "executive," "administrative,"

"professional" or "capacity," the Court must examine the plain meaning of the terms at or near the time Congress enacted the statute. *Taniguchi v. Kan Pac. Saipan, Ltd.*, 132 S. Ct. 1997, 2002 (2012). "Beyond the law itself, dictionary definitions inform the plain meaning of a statute." *United States v. Radley*, 632 F.3d 177, 182–83 (5th Cir. 2011) (citing *United States v. Ferguson*, 369 F.3d 847, 851 (5th Cir. 2004)).

Generally, the plain meanings of executive, administrative, and professional capacity relate to a person's performance, conduct, or function. The Oxford English Dictionary defined "executive" as someone "[c]apable of performance; operative . . . [a]ctive in execution, energetic . . . [a]pt or skillful in execution." *Executive*, 8 *The Oxford English Dictionary* (1st ed. 1933). "Administrative" was defined as "[p]ertaining to, or dealing with, the conduct or management of affairs; executive." *Administrative*, 1 *The Oxford English Dictionary* (1st ed. 1933). The dictionary also defined "professional" as "[p]ertaining to, proper to, or connected with a or one's profession or calling . . . [e]ngaged in one of the learned or skilled professions . . . [t]hat follows an occupation as his (or her) profession, life-work, or means of livelihood." *Professional*, 8 *The Oxford English Dictionary* (1st ed. Supp. 1933). "Capacity" was understood to mean "position, condition, character, relation," or "to be in, put into . . . a position which enables or renders capable." *Capacity*, 2 *The Oxford English Dictionary* (1st ed. 1933).

After reading these plain meanings in conjunction with the statute, it is clear Congress defined the EAP exemption with regard to duties. In other words, Congress unambiguously intended the exemption to apply to employees who perform "bona fide executive, administrative, or professional capacity" duties. The statute's use of "bona fide" serves as further evidence of Congress's intent. For instance, the Oxford English Dictionary defined "bona fide" as "[i]n good

faith, with sincerity; genuinely." *Bona fide*, 1 *The Oxford English Dictionary* (1st ed. 1933). The fact that bona fide modifies the terms executive, administrative, and professional capacity suggests the exemption should apply to those employees who, in good faith, perform actual executive, administrative, or professional capacity duties. Therefore, the Court finds Section 213(a)(1) is unambiguous because the plain meanings of the words in the statute indicate Congress's intent for employees doing "bona fide executive, administrative, or professional capacity" duties to be exempt from overtime pay.

The Court next considers whether the Department has given effect to Congress's unambiguous intent. Section 213(a)(1) authorizes the Department to define and delimit the EAP exemption through regulations. The plain meaning of "define" is to "state explicitly; to limit; to determine the essential qualities of; to determine the precise signification of; to set forth the meaning or meanings of," and the plain meaning of "delimit" is "to fix or mark the limits of: to demarcate; bound." *Walling v. Yeakley*, 140 F.2d 830, 831 (10th Cir. 1944). Courts have recognized the EAP exemption gives the Department "broad authority to 'defin[e] and delimi[t]' the scope of the exemption for executive, administrative, and professional employees." *Auer v. Robbins*, 519 U.S. 452, 456 (1997); *see also Wirtz v. Miss. Publishers Corp.*, 364 F.2d 603, 608 (5th Cir. 1966) (asserting the EAP exemption "gives the Secretary broad latitude to 'define and delimit' the meaning of the term 'bona fide executive . . . capacity'").[5] However, the Department's authority is limited by the plain meaning of the words in the statute and Congress's intent. Specifically, the Department's authority is limited to determining the essential qualities

[5] The Court recognizes *Wirtz* is controlling and stands for the proposition that the Department has the authority to implement a salary-level test. This opinion is not making any assessments regarding the general lawfulness of the salary-level test or the Department's authority to implement such a test. Instead, the Court is evaluating only the salary-level test as amended by the Department's Final Rule, which is invalid under both steps of *Chevron*. *Wirtz* is distinguishable from this case because the Fifth Circuit did not evaluate the salary-level test under the Final Rule. As a result, *Wirtz* offers no guidance to the Court on the lawfulness of the Department's Final Rule salary-level test.

of, precise signification of, or marking the limits of those "bona fide executive, administrative, or professional capacity" employees who perform exempt duties and should be exempt from overtime pay. With this said, the Department does not have the authority to use a salary-level test that will effectively eliminate the duties test as prescribed by Section 213(a)(1). *See Michigan v. EPA*, 135 S. Ct. 2699, 2707–08 (2015) ("*Chevron* allows agencies to choose among competing reasonable interpretations of a statute; it does not license interpretive gerrymanders under which an agency keeps parts of statutory context it likes while throwing away parts it does not."). Nor does the Department have the authority to categorically exclude those who perform "bona fide executive, administrative, or professional capacity" duties based on salary level alone. In fact, the Department admits, "[T]he Secretary does not have the authority under the FLSA to adopt a 'salary only' test for exemption." 81 Fed. 32,446 (citing Defining and Delimiting the Exemptions for Executive, Administrative, Professional, Outside Sales and Computer Employees; Final Rule, 69 Fed. Reg. 22,122, 22,173 (Apr. 23, 2004) (codified at 29 C.F.R. pt. 541)).

The updated salary-level test under the Final Rule does not give effect to Congress's unambiguous intent. Since 2004, the Department has required an employee to meet the following criteria to be exempt from overtime pay: (1) the employee must be salaried; (2) the employee must be paid above a minimum salary level; and (3) the employee must perform executive, administrative, or professional capacity duties. While the plain meaning of Section 213(a)(1) does not provide for a salary requirement, the Department has used a permissible minimum salary level as a test for *identifying* categories of employees Congress intended to exempt. *See, e.g.*, *Wirtz*, 364 F.2d at 608 (upholding the Department's authority to use a minimum salary level). The Department sets the minimum salary level as a floor to "screen[] out

the obviously nonexempt employees, making an analysis of duties in such cases unnecessary." Harry Weiss, *Report and Recommendations on Proposed Revisions of Regulations, Part 541*, at 7–8 (1949). Further, the Department acknowledges that in using this method, "[a]ny new figure recommended should also be somewhere near the lower end of the range of prevailing salaries for these employees." *Id.* at 11–12. The use of a minimum salary level in this manner is consistent with Congress's intent because salary serves as a defining characteristic when determining who, in good faith, performs actual executive, administrative, or professional capacity duties.

The Final Rule more than doubles the Department's previous minimum salary level, increasing it from $455 per week ($23,660 annually) to $913 per week ($47,476 annually). This significant increase would essentially make an employee's duties, functions, or tasks irrelevant if the employee's salary falls below the new minimum salary level. As a result, entire categories of previously exempt employees who perform "bona fide executive, administrative, or professional capacity" duties would now qualify for the EAP exemption based on salary alone. The text of the Final Rule confirms this: "White collar employees subject to the salary level test earning less than $913 per week will not qualify for the EAP exemption, and therefore will be eligible for overtime, *irrespective of their job duties and responsibilities*." Defining and Delimiting the Exemptions for Executive, Administrative, Professional, Outside Sales and Computer Employees, 81 Fed. Reg. 32,391, 32,405 (May 23, 2016) (emphasis added).

This is not what Congress intended with the EAP exemption. Congress unambiguously directed the Department to exempt from overtime pay employees who perform "bona fide executive, administrative, or professional capacity" duties. However, the Department creates a Final Rule that makes overtime status depend predominately on a minimum salary level, thereby

supplanting an analysis of an employee's job duties. The Department estimates 4.2 million workers currently ineligible for overtime, and who fall below the minimum salary level, will automatically become eligible under the Final Rule without a change to their duties. 81 Fed. Reg. 32,405; *see also* 69 Fed. Reg. 22,173 (admitting "[t]he Department has always maintained that the use of the phrase 'bona fide executive, administrative or professional capacity' in the statute requires the performance of specific duties"). Because the Final Rule would exclude so many employees who perform exempt duties, the Department fails to carry out Congress's unambiguous intent. Thus, the Final Rule does not meet *Chevron* step one and is unlawful.

Even if the Court determines Section 213(a)(1) is ambiguous about what constitutes "any employee employed in a bona fide executive, administrative, or professional capacity," the Department's Final Rule does not pass muster under *Chevron* step two. The Supreme Court in *Chevron* explained, "If the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." 467 U.S. at 843. In such a case, a reviewing court must give deference to an agency's answer or interpretation of a statute if the agency's regulation is reasonable. *Id.* at 843–44. Although deference is given to agency interpretations of ambiguous statutes, "the judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear congressional intent." *Id.* at 843 n.9.

The Court finds the Department's Final Rule is not "based on a permissible construction" of Section 213(a)(1). The Final Rule more than doubles the previous minimum salary level.[6] By raising the salary level in this manner, the Department effectively eliminates a consideration of

[6] During questioning at the preliminary injunction hearing, the Court suggested it would be permissible if the Department adjusted the 2004 salary level for inflation. In fact, the Court stated in a question, "[I]f [the salary level] had been just adjusted for inflation, the 2004 figure, we wouldn't be here today . . . because [the salary level] would still be operating more the way it has . . . as more of a floor." (Dkt. #77, Nov. 16, 2016 Trial Tr. at 109:1–3, 6–8).

whether an employee performs "bona fide executive, administrative, or professional capacity" duties. As explored above, the plain meaning of the words in Section 213(a)(1) indicates Congress defined the EAP exemption with regard to duties. In other words, Congress intended for employees who perform "bona fide executive, administrative, or professional capacity" duties to be exempt from overtime pay. Congress delegated authority to the Department to not only define and delimit the EAP exemption but also to stay consistent with Congress's intent. However, with the Final Rule, the Department ignores Congress's intent. If Congress was ambiguous about what specifically constituted an employee subject to the EAP exemption, Congress was clear that the determination should involve at least a consideration of an employee's duties. Courts are "not obliged to stand aside and rubberstamp their affirmance of administrative decisions that they deem inconsistent with the statutory mandate or that frustrate the congressional policy underlying a statute." *Nat'l Pork Producers Council v. EPA*, 635 F.3d 738, 753 (5th Cir. 2011) (quoting *Tex. Power & Light Co. v. FCC*, 784 F.2d 1265, 1269 (5th Cir. 1986)). The Department has exceeded its authority and gone too far with the Final Rule. Nothing in Section 213(a)(1) allows the Department to make salary rather than an employee's duties determinative of whether a "bona fide executive, administrative, or professional capacity" employee should be exempt from overtime pay. *See* 81 Fed. 32,446 (indicating the Department admitted it could not create an evaluation for overtime exemption based on salary alone). Accordingly, the Final Rule is not a reasonable interpretation of Section 213(a)(1) and thus is not entitled to *Chevron* deference.

The Final Rule also creates an automatic updating mechanism that adjusts the minimum salary level every three years. Having determined the Final Rule is unlawful under *Chevron*, the Court similarly determines the automatic updating mechanism is unlawful.

Business Plaintiffs further claim the Final Rule is arbitrary, capricious, or otherwise contrary to law in violation of the APA. The Court concludes it is unnecessary to address this argument in light of the unlawfulness of the Final Rule under *Chevron*.

CONCLUSION

Accordingly, it is therefore **ORDERED** that Business Plaintiffs' Motion for Expedited Summary Judgment (Dkt. #35) is **GRANTED**. The Court hereby concludes the Department's Final Rule described in 81 Fed. Reg. 32,391 is invalid.

SIGNED this 31st day of August, 2017.

AMOS L. MAZZANT
UNITED STATES DISTRICT JUDGE

EXECUTIVE OFFICE OF THE PRESIDENT

OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

ADMINISTRATOR
OFFICE OF INFORMATION AND REGULATORY AFFAIRS

MEMORANDUM

TO: Acting Chair Victoria Lipnic, Equal Employment Opportunity Commission

FROM: Neomi Rao, Administrator, Office of Information and Regulatory Affairs

DATE: August 29, 2017

SUBJECT: EEO-1 Form; Review and Stay

After careful consideration and consultation with the Equal Employment Opportunity Commission (EEOC), and in accordance with the Paperwork Reduction Act (PRA) and its regulations at 5 CFR 1320.10(f) and (g), the Office of Management and Budget (OMB) is initiating a review and immediate stay of the effectiveness of those aspects of the EEO-1 form that were revised on September 29, 2016. These revisions include new requests for data on wages and hours worked from employers with 100 or more employees, and federal contractors with 50 or more employees. EEOC may continue to use the previously approved EEO-1 form to collect data on race/ethnicity and gender during the review and stay.

The PRA authorizes the Director of OMB to determine the length of approvals of collections of information and to determine whether collections of information initially meet and continue to meet the standards of the PRA. In this context, under 5 CFR 1320.10(f) and (g), OMB may review an approved collection of information if OMB determines that the relevant circumstances related to the collection have changed and/or that the burden estimates provided by EEOC at the time of initial submission were materially in error. OMB has determined that each of these conditions for review has been met. For example, since approving the revised EEO-1 form on September 29, 2016, OMB understands that EEOC has released data file specifications for employers to use in submitting EEO-1 data. These specifications were not contained in the Federal Register notices as part of the public comment process nor were they outlined in the supporting statement for the collection of information. As a result, the public did not receive an opportunity to provide comment on the method of data submission to EEOC. In addition, EEOC's burden estimates did not account for the use of these particular data file specifications, which may have changed the initial burden estimate.

OMB has also decided to stay immediately the effectiveness of the revised aspects of the EEO-1 form for good cause, as we believe that continued collection of this information is contrary to the standards of the PRA. Among other things, OMB is concerned that some aspects of the revised collection of information lack practical utility, are unnecessarily burdensome, and do not adequately address privacy and confidentiality issues.

In these circumstances, the regulations at 5 CFR 1320.10(f) and (g) require EEOC to submit a new information collection package for the EEO-1 form to OMB for review. In addition, the regulations require EEOC to publish a notice in the Federal Register announcing the immediate stay of effectiveness of the wages and hours worked reporting requirements contained in the EEO-1 form and confirming that businesses may use the previously approved EEO-1 form in order to comply with their reporting obligations for FY 2017.

Thank you for your attention to these matters. Please feel free to contact me with any questions.

LABOR, IMMIGRATION &
EMPLOYEE BENEFITS DIVISION

U.S. CHAMBER OF COMMERCE

2017 HEALTH CARE POLICY RECOMMENDATIONS

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The Chamber has long championed the invaluable benefits that the employer-sponsored health care system provides to both employees and employers alike. More than 177 million Americans currently rely on the health coverage and benefits offered by employers. The employer-sponsored system must be permitted to allow employers to customize the benefits offered to best serve the needs of their workforce and appropriately manage cost growth in health care. The Chamber will educate stakeholders, the administration and Hill staff about the innovative developments that are occurring in the private sector. Our focus will remain on promoting and advancing thoughtful legislative and regulatory changes to permit greater flexibility in benefit design and coverage that will improve health, reduce unnecessary costs, and reward high-value care.

I. CORRECTING THE HEALTH POLICY MISTAKES OF THE PAST EIGHT YEARS: AFFORDABLE CARE ACT (ACA) REFORMS

This section outlines different health policy mistakes that have been made in the past eight years and suggests opportunities and ways to correct these mistakes.[1]

[1] As when Bush succeeded Clinton, the Trump win opens the door to rolling back many of Obama's regulations. The press is very focused on these possibilities but keep in mind that this effort will vary depending on the underlying regulation in question, a fact lost on the press. Many were issued under executive orders and thus can be eliminated swiftly through repeal of the relevant executive order by the new president, which provided the underlying authority for the regulations, followed by procedural repeal of the regulations themselves. But others will have to be repealed and/or modified through notice and comment rulemaking. This can be done relatively quickly, but the courts have made clear that this must be a reasoned and deliberative process and not based simply on a change in the presidency. Another option is repeal through the Congressional Review Act (CRA) depending on when the underlying regulation was issued and when this Congress adjourns. In sum, we have huge opportunities here, which we are already working, but each has their own nuances. Ongoing court cases must also be calculated into the strategy.

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REPEAL THE CADILLAC TAX

Issue: The Affordable Care Act (ACA) includes a 40 percent tax on group health coverage that exceeds $10,200 for self-only coverage and $27,500 for other than self-only coverage. The purpose of the tax on "high cost employer-sponsored health coverage" was to discourage employers from offering exceedingly generous health plans that would insulate consumers from the cost of services and drive up unnecessary utilization. However, because of the way this so-called "Cadillac Tax" provision was drafted, the tax will eventually affect all plans and essentially fine employers for offering health coverage to their employees – which is particularly ironic given that the law also fines employers for failing to offer health coverage to their employees. The Chamber filed comments in response to Notice 2015-16 issued in February 2015, as well as comments in response to Notice 2015-52 issued in July 2015.

Current Status: As part of the 2015 year-end budget deal, a combined tax extenders and omnibus appropriation package (H.R. 2090) was signed into law on December18, 2015, delaying the effective date of the 40 percent excise tax and making the tax deductible. Instead of applying to employer-sponsored coverage with plan years beginning on or after January 1, 2018, the tax will now apply to employer-sponsored coverage with plan years beginning on or after January 1, 2020. Applicable rulemaking is underway.

Steps Requested:

- The tax must be repealed as soon as possible. A myriad of bills have been introduced to repeal the tax – H.R. 879; H.R. 2050; S. 2045 and S. 2075. These bills are similar but reflect the political divide on whether repealing this provision is messaged as repealing part of the ACA or as fixing the ACA. Despite the delayed effective date, businesses are already modifying health coverage offerings.
- Additionally, rulemaking efforts should consider the desired purpose of the tax – mitigating overutilization of unnecessary services – and any rules promulgate should encourage employers to offer and employees to leverage benefits that will reduce unnecessary costs.
- Further, the rules must recognize the conflicting requirements in the law and create a safe-harbor that exempts employers merely offering the minimum coverage required under the employer mandate from the Cadillac Tax.

Rationale: Over 177 million Americans enjoy health care coverage through their employer and this tax will force businesses to first reduce that coverage and then potentially stop offering coverage. The "Cadillac Tax" is not indexed to inflation and will therefore, impact an increasing number of health plans over a long period of time. Contrary to economic theory, employers will, in all likelihood, not increase wages as a result of this tax or to off-set benefit reductions. Instead, in order to avoid the tax, employers may either cut benefits or shift more of the costs onto the worker in the form of higher deductibles, or co-pays.

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REPEAL THE EMPLOYER SHARED RESPONSIBILITY PROVISION

Issue: Under the ACA, employers with more than 50 "full-time equivalent" employees that do not provide "affordable" health care coverage that meets the "minimum value" threshold to "all full-time employees" "(and their dependents)" may be assessed a penalty, if at least one full-time employee qualifies for a premium tax credit and purchases coverage in the health insurance exchange. In order for employer-sponsored coverage to be deemed "affordable," the employee's portion of the premium for self-only coverage cannot exceed 9.5 percent of the employee's household income.

This statutory obligation includes several different terms that were further fleshed out in regulation. Regulations were promulgated before the provision's effective date (originally January 1, 2014) to detail how to determine: 1.) if an employer has 50 or more "full-time equivalent" employees; if coverage is "affordable;" 2.) if coverage meets the "minimum value" requirement; 3.) if an employee is a "full-time employee;" and 4.) what is intended by the parenthetical "(and dependents)."

- The Treasury Department (Treasury) and the Internal Revenue Service (IRS) issued a notice and request for comments to initiate and inform the process of developing regulations regarding the shared responsibility provision of 4980H as added by the ACA. The Chamber filed comments on June 17, 2011.
- The Treasury Department and the IRS issued a notice of proposed rulemaking regarding the health insurance premium tax credit and the Chamber filed comments on October 31, 2011.
- The Treasury Department and the IRS issued a request for comments on health coverage affordability safe harbor for employers under the employer shared responsibility and the Chamber filed comments on December 13, 2011.
- The Treasury Department and the IRS issued Notice 2012-31 regarding the minimum value of an employer-sponsored health plan and the Chamber filed comments on June 11, 2012.
- The Treasury Department and the IRS issued a final rule on the Health Insurance Premiums Tax Credit and the Chamber filed comments on August 21, 2012.
- The Treasury and the IRS issued Notice 2012-58 to provide temporary guidance on how employers may determine which employees are treated as full-time employees for purposes of the shared responsibility provision. The Chamber filed comments on September 30, 2012.
- The Treasury and the IRS issued a notice of proposed rulemaking on the shared responsibility for employers regarding health coverage and the Chamber filed comments on March 18, 2013.
- The Treasury and the IRS issued a notice of proposed rulemaking on the determination of whether health coverage under an eligible employer-sponsored plan provides minimum value. The Chamber filed comments on July 2, 2013.
- The Treasury and the IRS issued a notice of proposed rulemaking on the minimum essential coverage requirements and other rules regarding shared responsibility payments. The Chamber filed comments on April 28, 2014.

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- The Tri-Agencies issued an FAQ on May 26, 2015, reiterating and clarifying their interpretation that an individual with non-self-only coverage (i.e. family coverage) must only be subjected to the individual out-of pocket (OOP) limit which statutorily applies to self-only coverage. This interpretation had been included in the preamble of the proposed rule on the notice of benefit and payment parameter for 2016, where the Chamber also identified the interpretation as problematic and disputed in our comments on December 22, 2014. The Chamber coordinated a letter from the National Coalition on Benefits to strongly dispute the Agencies authority and decision to interpret that the statute required embedded deductibles for individuals covered under a non-individual plan. Instead, we reaffirm that the statute provides one OOP limit for ***self-only*** coverage, and one OOP limit for ***family*** coverage.
- The Treasury and the IRS issued a supplemental notice of proposed rulemaking on minimum value of eligible employer-sponsored health plans and the Chamber filed comments on November 2, 2015.

Current Status: Originally, the shared responsibility provision was to go into effect for months beginning after December 31, 2013.

However, on July 2, 2013, a Treasury blog post announced the delay of the employer mandate requirements for the 2014 calendar year – including the requirement to offer affordable minimum value coverage under 4980H as well as the information reporting requirements for insurers, self-insuring employers and other providers of minimum essential coverage under §6055, and the information reporting requirements imposed on applicable large employers under §6056. This delay was formalized several days later with the issuance of Notice 2013-45.

In the final rule published on February 12, 2014, Treasury delayed the application of the shared responsibility requirement to the smallest of the applicable large employers that had not previously offered coverage or had not previously offer affordable minimum value coverage. Those "applicable large" businesses with fewer than 100 full-time equivalents were granted another transition year for 2015, meaning that application of the employer mandate to these employers did not go into effect until 2016. The final rule also allows applicable large employers with more than 100 full-time equivalents to have satisfied the requirement to offer minimum essential coverage if coverage was offered to "substantially all" of their full-time employees, defined as 70 percent in 2015. In the years following, all applicable large employers are deemed to satisfy the requirement to offer minimum essential coverage if it is offered to substantially all full-time employees, defined as 95 percent for 2016 and beyond.

Step Requested:

- Congress should pass legislation to repeal the employer shared responsibility requirement. Several bills have been introduced over the past six years to repeal (or modify) the shared responsibility requirement – including H.R. 1744 and S. 20; S. 1049.

Rationale: Complying with the requirement to offer affordable minimum value coverage to substantially all full-time employees is difficult. However, the reporting requirements have proven far more challenging.

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The offer and take-up rates of employer-sponsored insurance coverage have remained unchanged among nonelderly workers from June 2013 through March 2015. These rates remained stable for workers in both small and large firms, as well as for workers with higher and lower incomes.

If the employer mandate were to be repealed, the Urban Institute has estimated that only about 200,000 fewer people would get health coverage, a relatively small decrease compared to the millions expected to get insurance under the ACA. The Urban Institute noted that most big businesses already cover workers – and they have done so voluntarily, with no mandate. And the Institute has said that's unlikely to change.

Further, eliminating the employer mandate could allow employers to provide a wider range of offerings including more affordable plans for part-time employees or in industries with high turnover.

REPEAL THE HEALTH INSURANCE TAX

Issue: Starting in January 2014, the ACA began imposing a fixed dollar tax on health insurance providers in the fully-insured market based on net premiums written. Because small businesses generally offer fully-insured coverage to their employees, this tax disproportionately harms small businesses.

The Chamber commented on the proposed rule in June 2013 and a final rule was issued in November 2013 to implement this tax, after which the tax was collected for plan years 2014, 2015 and 2016 in the amounts of $8 billion, $11.3 billion and $11.3 billion respectively as prescribed by statute.

Current Status: As part of the 2015 year-end budget deal, a combined tax extenders and omnibus appropriation package (H.R. 2090) was signed into law on December18, 2015, which suspended the health insurance tax for the plan year beginning January 1, 2017. The tax will resume for the plan year beginning on or after January 1, 2018.

Step Requested:

- Congress should pass legislation (S. 183 and H.R. 928) to repeal this health insurance tax.

Rationale: The impact of the health insurance tax is expected to raise premiums as the amount of the tax will be subsequently passed on to policyholders. This new tax falls solely on the fully insured market, the market from which 88 percent of small business owners purchase health insurance for their employees and themselves.

Additionally, because of the way the regulations have been promulgated to implement this provision, the health insurance tax will cost employers offering these plans between $45 billion and $70 billion more over the next decade than the amounts statutorily prescribed to be collected. The regulations subject all premiums collected by the health insurers to federal income tax, including the amount that is collected to be passed onto the IRS to pay the tax. Therefore, in order to pay the IRS the statutorily dictated amount, even more must be collected in premiums before the insurers pay income tax on that amount.

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According to an analysis by Quantria, in order to cover federal income taxes due under the statute, taxable health insurers will need to collect $1.54 from customers for each $1 of premiums attributable to the health insurer fee. The health insurer tax contained in the ACA will increase costs of taxable health insurers by $175-200 billion over the 2014 -2023 period, assuming current market shares. This includes $130 billion attributable to the statutory fees plus $45 billion to $70 billion from the federal income tax treatment of the health insurer tax.

REPEAL THE MEDICAL DEVICE TAX

Issue: Beginning in January 2013, the ACA imposes a 2.3 percent tax on the sale of medical devices.

Current Status: As part of the 2015 year-end budget deal, a combined tax extenders and omnibus appropriation package (H.R. 2090) was signed into law on December18, 2015, which suspended the medical device tax for 2016 and 2017. This tax will resume in 2018.

Steps Requested:

- Congress should enact legislation (S. 149 and H.R. 160) to repeal the medical device tax or, in the interim, extend the suspension of this tax.

Rationale: The Chamber has argued that the ACA's new 2.3 percent medical device tax, which is imposed on medical device manufacturers whether or not they make a profit, will lead to increased health care costs, undercutting one of the primary goals of health care reform. Furthermore, by driving up the cost of medical technology, this tax undermines America's global leadership position in product innovation, clinical research, and patient care. The tax weakens the medical device industry's ability to create and maintain well-paying jobs in the United States and hinders the development of breakthrough treatments.

According to a survey by the Advanced Medical Technology Association (AdvaMed), two-thirds of the companies surveyed reported that they have had to "slow or halt U.S. job creation as a result of the tax." This survey found that 53 percent of respondents have reduced research and development as a result of the tax. Additionally, 75 percent of respondents said they have deferred or cancelled capital investments and plans to open new facilities, reduced investment in start-up companies, found it more difficult to raise capital, and reduced or deferred increases in employee compensation.

Similarly, a survey by the Medical Device Manufacturers Association (MDMA) of 100 industry executives found that 72 percent "slowed or halted job creation" to pay for the tax, and 85 percent would hire more workers if the tax were repealed. If not repealed, this tax will continue to weaken the industry's ability to create and maintain well-paying jobs in the United States and hinder the development of breakthrough treatments.

PERMIT STAND-ALONE HEALTH REIMBURSEMENT ARRANGEMENTS (HRAS)

Issue: The administration has issued multiple guidance documents articulating their interpretation that stand-alone Health Reimbursement Arrangements (HRAs) violate the insurance market reform rules and that therefore employers offering these stand-alone HRAs for

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their workers will be fined $100 per day, per employee. As a result, employers will face significant fines should they provide tax-preferred dollars in these tax-preferred accounts to help their employees pay for either premiums or other qualified medical expenses. Transition relief was provided for small employers until July 1, 2015, which essentially deferred the imposition of the fine.

- On January 24, 2013, the Departments of Labor (DOL), Health and Human Services (HHS) and Treasury (collectively the Tri-Agencies) issued Frequently Asked Questions (FAQs) Part XI, indicating that the administration interprets the ACA's §2711 prohibition on imposing annual or lifetime limits on the dollar value of essential health benefits as prohibiting an employer from the offering tax-preferred funds to employees through a stand-alone HRA.
- The Chamber filed comments on May 20, 2013, and met with officials in an effort to encourage Treasury to revise this interpretation and to permit employers to offer HRAs.
- On September 13, 2013, the DOL's Technical Release No. 2013-03 and the IRS's Notice 2013-54 were issued, both of which were reiterated by HHS's September 16, 2013 guidance.
- Over a year later, on November 6, 2014, the DOL issued FAQs Part XXII to further clarify the administration's position on HRAs.
- On February 18, 2015, the IRS's Notice 2015-17 provided transition relief for failure to satisfy the market reforms in certain circumstances. As a result, Notice 2015-17 provided temporary relief for failure to satisfy the Affordable Care Act market reforms. Under the notice, small employers get relief for 2014 and up to July 1, 2015. Small employers are employers that are not "applicable large employers" under §4980H (generally defined as employing less than 50 full-time equivalent employees per month).
- On March 4, 2016, the IRS's FAQs specifically said that if an employer does not establish a health insurance plan for its own employees, but reimburses those employees for premiums they pay for health insurance, that arrangement fails to satisfy the market reforms and may be subject to a $100 per day excise tax, per applicable employee (which is $36,500 per year, per employee) under section 4980D of the Internal Revenue Code.

Numerous subsequent sub-regulatory guidance documents, as detailed above, specifically stated that any business offering HRAs on a stand-alone basis to their employees would be fined at a rate of $100 a day per employee beginning July 1, 2015.

Current Status: Bipartisan legislative language was included and enacted with the December 2016 passage of the 21st Century Cures Act which would create an exception to qualified small employers to offer stand-alone HRAs, on a limited basis. The bipartisan compromise included in the Cures Act allows businesses that are not applicable large employers to offer stand-alone HRAs. However, the contribution made to the HRA by the employer cannot exceed $4,950 (or $10,000 if the HRA also provides for reimbursements for an employee's family members), indexed for inflation. While this exception will be helpful for small businesses once enacted, it is likely that additional flexibility may be achievable through regulatory changes in the next administration.

Steps Requested:

- Revise regulatory guidance documents to reinterpret the application of the insurance market reform rules for HRAs or pass broader legislation that permits all employers to offer a stand-alone HRA, regardless of size or coverage obtained.

Rationale: Prior to enactment of the ACA, employers were able to provide their workers with tax-free money to help their employees purchase health care coverage, subsidize premiums, or pay for qualifying medical expenses. Employers of all sizes should have the flexibility to offer a variety of different benefits to their employees.

STREAMLINE EMPLOYER REPORTING REQUIREMENTS

Issue: In order to determine coverage offerings and enrollment as required by the employer mandate and individual mandate, the ACA requires employers and insurers to gather a tremendous number of data points on a monthly basis and submit them to the IRS and individuals. The challenge of collecting this information and submitting it successfully has been costly and burdensome to employers and insurers alike.

The Chamber has responded to numerous regulatory materials published to implement these requirements.

- On July 11, 2012, the Chamber filed:
  - Comments on (Notice 2012-32 on §6055).
  - Comments on (Notice 2012-33 on §6056).
  - Comments on Notice 2012-31on minimum essential coverage.
- On July 2, 2013, a Treasury blog post announced the delay of the employer mandate requirements for 2014. Several days later, the issuance of Notice 2013-45 formalized the delay.
- On November 8, 2013, the Chamber filed:
  - Comments on the proposed rule to implement §6055, which requires health coverage providers to report information on individuals enrolled in minimum essential coverage.
  - Comments on the proposed rule to implement §6056, which requires applicable large employers to report information on health insurance coverage offered, and the individuals to whom it is offered, under employer-sponsored plans.
- On March 10, 2014, a final rule was issued to implement §6055, which requires health coverage providers to report information on individuals enrolled in minimum essential coverage.
- On March 10, 2014, a final rule was issued to implement §6056, which requires applicable large employers to report information on health insurance coverage offered, and the individuals to whom it is offered, under employer-sponsored plans.
- On December 28, 2015, Notice 2016-04 extended the deadlines for the 2015 reporting requirements, employers and insurers submitted forms in the spring of 2016 to comply with these requirements to report on coverage offered and elected in 2015. Employers and insurers were required to send paper forms to individuals by March 31, 2016, and to the IRS by May 31, 2016. Employers and insurers were required to send forms electronically to the IRS by June 30, 2016.

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Current Status: Bipartisan legislation has been introduced in the House (H.R. 2712) and Senate (S.1996). While not identical, Hill staff is working to create a redline version that would synchronize the bills and incorporate technical assistance from the IRS. While it is unlikely that this legislation will move in the short term, it may be reexamined when republicans pursue a replace proposal which is expected to also offer premium tax credits to individuals without an offering of employer sponsored coverage.

Step Requested:

- Enact legislation or issue regulations that would simplify the reporting requirements and permit employers to report on a prospective basis to mitigate the cost and complexity that results from retrospectively reporting on coverage offered over a year earlier.

Rationale: There are a host of problems that are expected to occur with the 2017 income tax deadline due to retrospective reporting on the part of employers and insurers, as well as the prospective application for Advanced Premium Tax Credits (APTCs) by individuals. The information required to be reported in these forms will be used by the IRS to determine which employers satisfied their obligation under the employer mandate to offer affordable minimum value coverage to their full-time employees (and dependents). The IRS will similarly determine which employers: 1.) failed to offer affordable minimum value coverage to their full-time employees; 2.) had an employee who received an APTC to purchase coverage in the exchange; and 3.) therefore, must be fined a tax.

The IRS will also use the information reported on these forms to assess which individuals satisfied their obligation under the individual mandate to have minimum essential coverage.

Finally, the IRS will also use this information to reconcile the APTCs that were given to help individuals purchase coverage on the exchange and ensure that those individuals provided with APTCs were in fact eligible for the amounts that were given. (Recall – to be eligible to receive an APTC, an employee has to fall within a certain income bracket and must not be offered affordable minimum value coverage from an employer.)

Because the administration requires employers to send notices to all employees informing them of the ability to purchase coverage on the exchanges and the availability of APTCs, it is expected that many full-time employees who were offered employer-sponsored coverage elected instead to go to the exchange and apply for an APTC. Since documentation from the employer as to which employees received an offer of minimum value affordable coverage is provided to IRS roughly a year and a half later, it is likely that thousands of individuals received these APTCs in error. In April 2017, it is expected that many individuals will receive notification from the IRS that they must repay the APTC they received in error to purchase coverage on the exchange in 2015.

When employees receive these tax notices, they are likely to complain to their employer – inquiring as to why the employer gave them a notice about the availability of the APTC to purchase coverage on the exchange when the employer's offer of affordable minimum value coverage would have rendered the employee ineligible for an APTC. It is also unlikely that the IRS will be able to recoup the improperly awarded APTCs since these funds were sent directly to the insurers through whom individuals enrolled in coverage on the exchange. Beyond this future

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problem, employers already received multiple error messages in response to large batch submissions of thousands of forms that they submitted in advance of the 2016 filing deadlines. The IRS is currently unable to tell employers which form, much less which line item, contains the error. Finally, for employers with transient workers or high-turnover, ensuring that these forms are mailed to the employee's current address for work rendered a year and a half ago is highly problematic.

Employers provide information to the IRS regarding the number of workers and dependents enrolled in any of their health plans on a monthly basis, which is then matched against files provided by the exchanges. The IRS has been informing businesses that the information they are receiving is incomplete or the exchange has provided them with information that contradicts the information on the employer's forms. The IRS should continue to work with the business community while the agency improves system processing capabilities by providing businesses with a safe harbor until the underlying problems have been resolved.

MITIGATE THE ADMINISTRATIVE BURDEN OF §1557 NON-DISCRIMINATION COMPLIANCE

Issue: The ACA includes a provision that prohibits "covered entities" from discriminating on the basis of sex, race, color, national origin, age, and disability in any health program or activity. These discrimination prohibitions generally apply to "covered entities" that offer health care programs receiving federal funds and include covered entities' operations as health insurance issuers in Federally Facilitated Marketplaces or Exchanges ("FFMs") and State-Based Marketplaces or Exchanges ("SBMs"), health care providers, managed care providers, and even health insurance issuers acting in their capacity as third-party administrators for self-insured group health plans.

The Chamber filed comments on the proposed rule issued in November 2015, and a final rule was published by the HHS's Office of Civil Rights (OCR) on May 18, 2016.

Current Status: Concerns remain regarding the frequency and circumstances under which notice of these protections must be provided, as well as the requirement to have taglines on these notices provided in 15 different languages to indicate that language assistance is available. Outstanding questions remain as to how the OCR will assist with compliance efforts or pursue enforcement.

Steps Requested:

- The Chamber is working with a number of different stakeholders to recommend ways to streamline notice requirements and simplify the administrative requirements necessary for compliance.
- Several recommendations include allowing notices to include an icon indicating that language assistance is available, which would limit the need to translate the tagline informing consumers of this assistance into 15 different languages.
- Additionally, the notices of this protection should be only required on an annual basis – as part of open-enrollment (or special enrollment periods) or in conjunction with the documentation provided to satisfy the summary of benefit and coverage requirements.

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Rationale: The expense of having to provide translations into 15 different languages and to provide multiple notices of these protections is significant and outweighs the benefit to consumers. It is expected that by providing these notices with such frequency, consumers will disregard the information rather than realize the protections afforded.

STABILIZE THE INDIVIDUAL INSURANCE MARKET

Issue: The ACA imposed significant new insurance market rules on carriers offering plans in the individual and small group insurance markets. Under these rules, all plans offered in these markets must cover newly mandated benefits and also be priced based on new rating rules. Beginning in 2014, carriers were challenged with pricing insurance products in the individual market on and off the health insurance exchanges with very little information as to the cost of covering new enrollees.

There were several different provisions included in the law designed to mitigate negative financial risk for carriers. Three separate premium stabilization provisions (transitional reinsurance, risk adjustment and risk corridors) were incorporated to provide some financial protections to carriers. Several other provisions were intended to help sure up the viability of the individual market – including provisions around open enrollment and limitations as to when individuals could enroll in coverage at other times. The goal of these provisions was to discourage or even prevent individuals from improperly waiting to obtain insurance and only enrolling when, and for as long as, health care services were needed.

Many regulations have been issued by HHS on a litany of issues regarding the health insurance exchanges. On an annual basis, HHS issues a proposed notice of benefit and payment parameters which provides details and parameters related to "Risk adjustment, reinsurance, and risk corridor programs; cost sharing reductions; the advance payments of premium tax credit; and the medical loss ratio program." The Chamber has filed comments each year in response to these largely exchange focused proposed rules:

- On December 24, 2012, the Chamber filed comments in response to the proposed rule on the notice of benefit and payment parameters for 2014.
- On March 11, 2013, HHS issued the final rule for 2014.

- On December 26, 2013, the Chamber filed comments in response to the proposed rule on the notice of benefit and payment parameters for 2015.
- On March 11, 2014, HHS issued the final rule for 2015.

- On December 22, 2014, the Chamber filed comments in response to the proposed rule on the notice of benefit and payment parameters for 2016.
- On February 27, 2015, HHS issued the final rule for 2016.

- On December 21, 2015, the Chamber filed comments in response to the proposed rule on the notice of benefit and payment parameters for 2017.
- On March 8, 2016, HHS issued the final rule for 2017.

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- On October 6, 2016, the Chamber filed comments in response to the proposed rule on the notice of benefit and payment parameters for 2018.
- The final rule on the notice of benefit and payment parameters for 2018 is expected to be released before the end of 2016.

Other improper action is destabilizing the individual market and the Chamber continues to weigh in with regulators to ensure that protections intended to be provided are in fact afforded to carriers. On such an issue, the Chamber has filed comments in response to a request for information about inappropriate steering of individuals eligible for Medicare and Medicaid benefits into the individual insurance market plans.

Current Status:
Amounts collected to help pay for the transitional reinsurance program have not been paid as promised to carriers:

- In 2014, a $63 per member, per year assessment was assessed to collect $12 billion ($10 billion for reinsurance payments to issuers and $2 billion for Treasury repayments). However, for 2014, the Centers for Medicare and Medicaid Services (CMS) collected only $9.7 billion of the statutorily required $12 billion.
- In 2015, a $44 per member, per year assessment was assessed to collect $8 billion ($6 billion for reinsurance payments to issuers and $2 billion for Treasury repayments). However, for 2015, CMS collected only $6.5 billion of the required $8 billion.
- In 2016, a $27 per member, per year assessment was assessed to collect $5 billion ($4 billion for reinsurance payments to issuers and $1 billion for Treasury repayments). We will know at the end of June 2017 how much will be collected for 2016.

With regard to the risk corridor payments, carriers have also not received the amounts promised:

- In 2014, carriers only received 12.6 percent of what was promised.
- In 2015, budget neutrality legislation was enacted for all three years of the risk corridor program to require that carriers that experience losses only receive an amount equal to what other carriers that experience profits pay in. Therefore, the amount of money promised will not be paid to insurers to cover their losses since more issuers lost money than received a profit.
- For 2015, CMS will owe health plans operating in the individual market $5.2 billion and those in the small group market $588 million, according to an announcement issued on November 18, 2016. But insurers won't see any of that money yet as the government still has to pay down its balance from 2014. Since CMS paid insurers only $362 million for 2014 when they were owed $2.87 billion, there is still a $2.5 billion balance on the government's 2014 obligation. Therefore, all 2015 benefit year risk corridor collections will be used to pay a portion of the balance on 2014 benefit year risk corridor payments. In total, the program will pay just $95 million toward the calculated 2014 benefit year payments.
- In 2016, it is again unlikely that any money will be paid to insurers to help cover their losses. Whatever is collected for 2016 will go towards the outstanding balances for 2014 and 2015.

The Chamber will continue to respond to regulatory inquiries and proposals on premium stabilization programs and improper manipulation of special enrollment periods. The Chamber

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will oppose legislative efforts to defund or stop payments promised to carriers under these programs.

Step Requested:
- Oppose any efforts to reduce the payment of funds promised under these programs.

Rationale: Carriers priced premiums based on assurances that unexpected and unforeseen high risk claims and challenges estimating costs for a new population would be off-set by premium stabilization programs. As with any contractual arrangement, the government must uphold its side of the agreement.

ENCOURAGE WORKPLACE WELLNESS PROGRAMS

Issue: Despite a provision in the ACA that would strengthen incentives for employees participating in workplace wellness programs, a myriad of conflicting and confusing regulations issued by a variety of agencies over a four year period has limited the ability to leverage these programs.

The Chamber filed four comments letters to four different agencies:
- Comments on the Tri-Agencies' proposed rule issued in November 26, 2012.
- Comments for the record following an Equal Employment Opportunity Commission (EEOC) public meeting and request for comment held on May 8, 2013.
- Comments on the EEOC's proposed rule regarding restrictions on wellness program incentives under the Americans with Disabilities Act (ADA) issued in April of 2015.
- Comments on the EEOC's proposed rule regarding restrictions on wellness program incentives under the Genetic Information Nondiscrimination Act (GINA) issued in October 30, 2015.

On May 17, 2016, the EEOC's final GINA rule and the EEOC's final ADA rule were published nearly three years after the Tri-Agencies' final ACA rule which had been published June 3, 2013. There were significant areas of discrepancy between the EEOC's final rules and the earlier Tri-Agencies' final rule leading to tremendous confusion and uncertainty about how employers could vary premiums for employer-sponsored health coverage in response to employee (and employee family members) participation and engagement in workplace wellness programs.

Current Status: The EEOC's final rules further limit the application of these incentives and create different standards for compliance.

Steps Requested:
- Oppose additional regulations that would make the administration of workplace wellness programs more challenging and burdensome.
- Smooth inconsistencies among the EEOC's final ADA rule, the EEOC's final GINA rule and the Tri-Agencies' final ACA rule.

Rationale: Although there is no silver bullet for controlling health care costs, well-designed workplace wellness programs reduce costs while improving the quality of lives. Legislation should further encourage adoption of these types of programs. Confusion with conflicting

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regulations will reduce the use of financial incentives that are known to be critical in encouraging participation and improving health.

II. Promote Private Sector Innovation

This section details positive policy proposals that go beyond correcting the record of the last eight years. Note that this list will evolve as circumstances dictate and additional proposals are vetted by Chamber members. Obviously, there will be opportunity to explore more far-reaching proposals, as we get a better grasp on what is actually doable.

Protect the Employer-Sponsored Coverage: Preserve the Current Tax-Treatment and Employee Retirement Income Security Act (ERISA) Pre-emption of Employer-Sponsored Coverage

Issue: Over 177 million Americans receive health care coverage through their employer based on the framework of the Employee Retirement Income Security Act (ERISA). Employers operating in and/or employing individuals in multiple states rely on ERISA pre-emption protection in order to offer and administer uniform benefits. Several potential efforts at the federal and state level could disrupt this highly-valued source of coverage either by changing the current tax-treatment of the benefit, or by piercing the ERISA pre-emption veil.

The Chamber filed comments on a proposed rule published on March 14, 2011, regarding the application, review and reporting process for waivers for state innovation. A final rule was issued by the Departments of Treasury and Health and Human Services on February 27, 2012, and FAQs as well as a fact sheet were issued on July 22, 2015. Finally, guidance was published on December 16, 2015, detailing the additional requirements that must be met for approval.

Current Status: States have started applying for §1332 state innovation waivers and several are exploring taxes on claims, a creation of the public option, and other proposals that may threaten the ability of employers to offer and administer uniform benefits across different states.

Steps Requested:

- Urge Congress not to dismantle the ERISA framework.
- Fight efforts to change the current tax-treatment of employer-sponsored health coverage.
- Oppose state and local efforts to circumvent ERISA pre-emption and interfere with self-insured plans.

Rationale: The employer-sponsored health care system is not only where the majority of Americans receive private health care coverage, but it is also where innovation in benefit and plan design are advancing, where chronic disease management and population health efforts are improving productivity and wellbeing, and where unnecessary health care costs are being reduced. Further, recent surveys show that this benefit remains paramount to employees. Millions of Americans like the plans they have through the employer-sponsored system. According to the Employee Benefit Research Institute 2015 Health and Voluntary Workplace Benefits Survey:

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- Eighty-eight percent of workers report that employment-based health insurance is extremely or very important, far more than for any other workplace benefit.
- More than one in five workers report accepting, quitting or changing jobs because of the benefits, other than salary or wage level, that an employer offered or failed to offer.
- Eighty-five percent of workers take the health insurance coverage they are offered through their employer.

Employers depend on the ERISA framework to ensure that they can offer plans nationwide, providing fairness to all employees regardless of where they live, work, or receive medical care. Any attempts to erode ERISA would make it more difficult for businesses to offer health plans as businesses would face additional reporting and paperwork requirements.

ADVANCE HEALTH INFORMATION TECHNOLOGY

Issue: For years now, efforts have been underway to encourage the adoption of health information technology both to facilitate the adoption and use of electronic medical records (EMRs) and to permit the use of technology in delivering treatment through telemedicine.

Current Status: While the use of EMRs continues to increase and become more widely adopted, the advent and wide use of telemedicine remains elusive. One main reason for this may be the challenge in reimbursing providers for services rendered through this modality.

Step Requested:

- Support legislation that would further accelerate the use of health information technology, such as permitting the use of telemedicine across state lines.

Rationale: Health information technology has the potential to lower costs, improve quality, reduce medical errors, and promote continuous care.

ENACT MEDICAL MALPRACTICE REFORM

Issue: The threat of lawsuits forces doctors to practice defensive medicine and order medically-unnecessary tests that needlessly drive up health care costs. Also, medical liability has forced doctors in high-risk fields like obstetrics and neurology to either quit or limit their practices, reducing the availability of their services and access to treatment. The ACA did very little to reform our medical liability system. With health care costs continuing to rise, we can't ignore this cost driver.

Current Status: Efforts to cap non-economic damages and impose a statute of limitations have been unsuccessful. Various proposals have been put forth over the years, including one supported by Dr. Tom Price (R-GA), chairman of the House Budget Committee in H.R. 2300, which would change the burden of proof based on compliance with clinical practice guidelines and provide a safe harbor for physicians following the recommended protocols of the professional specialty association.

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Steps Requested:

- Support reforming the medical tort system to reduce the perverse incentive for providers to perform unnecessary tests which increase costs needlessly.
- Medical malpractice cases could be tried in special administrative health courts, similar to bankruptcy courts, which may reduce the cost of litigation.

Rationale: The medical liability system costs the U.S. health care system over $50 billion annually. Defensive medicine coupled with additional care given by providers to protect against lawsuits diminishes provider accountability while adding to the total cost of care.

DRIVE PAY-FOR-PERFORMANCE & DELIVERY SYSTEM REFORM

Issue: Our health care system should reward providers for the health outcomes achieved. To do this, our payment systems should transition away from simply rewarding providers for each service rendered and move beyond the traditional fee-for-service construct.

Current Status: The ACA began to encourage this transition through the development of Accountable Care Organization (ACO) demonstrations, the Medicare Shared Savings Program (MSSP), and other alternative payment program demos. Additional work has been done by the Center for Medicare and Medicaid Innovation (CMMI) which has set the goal of tying 50 percent of Medicare fee-for-service payments to quality or value through alternative payment models (APMs) by 2018. While efforts to advance delivery system reform are laudable, questions remain about the precise payment methodologies and lack of progress made by CMMI.

Steps Requested:

- Support transition from fee-for-service to pay-for-performance. Provider-led ACO demonstrations have shown that when patients are actively cared for under a robust primary care provider network which is reimbursed under prospective payments, patients receive exceptional quality care at a lower cost and ultimately lower spending.
- Assess CMS and CMMI's efforts to shift providers to alternative payment models that: 1.) reimburse providers under prospective down-side risk; and 2.) reward providers based on transparent quality metrics that are scalable and transferable to the private sector.

Rationale: Transitioning to pay-for-performance reimbursement models reward quality over quantity, and promotes cross-collaboration between and among providers as well as health insurance issuers. Ultimately, reforming payment systems will drive delivery system reform and lead to better patient outcomes as well as reduced unnecessary procedures and health care costs.

EXPAND CONSUMER-DIRECTED ACCOUNTS/VALUE-BASED INSURANCE DESIGN SAFE HARBOR

Issue: There are a number of limitations and restrictions on the use of Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs) that are hindering their use and unnecessarily limiting benefit design innovation.

The Chamber filed comments in response to a request for information published on December 28, 2010, regarding value-based insurance design in connection with preventive care benefits.

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Current Status: Some of these restrictions have existed since HSAs were created by the Medicare Modernization Act of 2003 (MMA) and others are more recent. Two such issues that should be tackled are: 1.) the inability of employers or issuers to offer secondary preventive services to enrollees in high deductible health plans either before the deductible is met and/or on a zero dollar cost sharing basis; and 2.) the inability to use HSA/FSA funds to pay for over-the-counter items without a prescription.

Steps Requested:

- Support changes to HSAs that make the accounts more flexible and appealing to consumers and plan sponsors.
- Repeal limitations that require a prescription for individuals to use HSA and FSA funds to purchase over-the-counter (OTC) items.
- Encourage the IRS to expand the HSA preventive care safe harbor to permit for value-based insurance design.

Rationale: Consumerism depends on placing health care spending decisions back into the hands of individuals. To achieve this goal, employers and workers need health plan options that meet their needs and give them personal ownership of their health care dollars. An expansion of the HSA preventive care safe harbor would enable individuals to receive the right care at the appropriate time.

STOP DRUG IMPORTATION

Issue: Repeatedly, members of Congress have tried to change federal law to allow individuals to import price-controlled foreign prescription drugs into the United States. However, allowing individuals to import prescription drugs from foreign countries where they are available at a lower cost is dangerous in two ways: 1.) allowing personal importation of drugs into the U.S. could create a gateway for unsafe, substandard or counterfeit drugs to enter our prescription drug supply; and 2.) allowing individuals to purchase prescription drugs from countries where the cost is lower will cut off the research funding that drug laboratories need to develop the next generation of treatments.

Current Status: Senators and Congressmen frequently introduce amendments and legislation to permit individuals to import drugs from other countries. While there is nothing currently expected on this issue, we remain vigilant on any efforts to permit this legislative change.

Step Requested:

- Oppose proposals that permit importation of drugs.

Rationale: The Food and Drug Administration (FDA) cannot guarantee the efficiency or safety of drugs that re-enter the United States. Such drugs may be adulterated or counterfeit, and jeopardize patient safety.

One of the reasons countries like Canada can impose price controls on their drugs is that much of that multi-billion-dollar investment is made back in the American market. A wave of drug importation would make pharmaceutical investment far less attractive, choking off funding for

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researchers who work to develop the next generation of treatments for diseases like cancer and Alzheimer's.

PRESERVE THE NON-INTERFERENCE CLAUSE IN MEDICARE MODERNIZATION ACT (MMA)

Issue: When the Medicare Modernization Act (MMA) was enacted to create a Medicare prescription drug benefit (commonly referred to as Medicare Part D), it included a provision known as the non-interference clause, which prohibits the Secretary of Health and Human Services from interfering in the private price negotiations between Medicare Part D plans and drug manufacturers and pharmacies in the program. Despite numerous claims that repealing the non-interference provision will save money, the nonpartisan Congressional Budget Office (CBO) continues to say that: 1.) private Medicare Part D plans can effectively negotiate savings on Medicare drug costs; and 2.) striking the non-interference clause is not likely to achieve any significant savings unless the government also restricts beneficiary access to prescription drugs or fixes prices.

Current Status: Various members of Congress frequently offer amendments or legislation to repeal the non-interference clause. While nothing is currently expected in the next few weeks, we remain vigilant on any efforts to advance this change.

Step Requested:

- Oppose proposals that would attempt to remove the non-interference clause from Part D.

Rationale: The CBO has stated that even if the Secretary of Health and Human Services had the authority to negotiate drug prices, there would be no discernable savings. The Medicare Part D program is a success because the program relies on free market principles such as choice and competition, which has led to lower prices than originally projected.

DEFEND MEDICARE ADVANTAGE (MA)

Issue: Medicare Advantage (MA) reimbursement rates must be stabilized to preserve a program valued by seniors and employers alike. The Chamber opposes reimbursement cuts to the MA program. Every February, the administration issues an annual call letter and notice outlining possible changes in reimbursement or methodology to MA plans for the following plan year. After a public comment opportunity, the administration issues a final notice in April detailing MA changes for the upcoming calendar year.

The Chamber has filed multiple comments on an annual basis in response the Center for Medicare and Medicaid Services' proposed advance notice of methodological changes:

- In response to the annual notice of methodological changes for calendar year 2017:
  - The Chamber filed comments.
  - The Chamber spearheaded comments signed by employer organizations after the notice was issued.
  - The Chamber spearheaded comments signed by state and local Chambers.
  - The Chamber spearheaded comments signed by employer organizations before the advance notice was issued.

    - On April 4, 2016, the administration announced the annual rates and changes for Calendar Year 2017.
- In response to the annual notice of methodological changes for calendar year 2016:
    - The Chamber spearheaded comments signed by employer organizations.
    - The Chamber spearheaded comments signed by state and local Chambers.
    - On April 6, 2015, the administration announced the annual rates and changes for Calendar Year 2016.
- In response to the annual notice of methodological changes for calendar year 2015:
    - The Chamber filed comments.
    - On April 7, 2014, the administration announced the annual rates and changes for Calendar Year 2015.
- In response to the annual notice of methodological changes for calendar year 2014:
    - The Chamber filed comments.
    - On April 1, 2013, the administration announced the annual rates and changes for Calendar Year 2014.

Current Status: The Chamber expects to comment before and again following the February 2017 issuance of an advance notice of methodological changes for calendar year 2018. Our comments will focus on the importance of preserving the ability of MA plans to continue to offer highly valued coverage to Medicare beneficiaries.

Step Requested:

- Stop additional reimbursement cuts and changes to methodology that will undermine the ability of MA plans to continue to provide highly valued coverage.

Rationale: MA plans such as coordinated care plans (e.g., Health Maintenance Organizations, Preferred Provider Organizations), private fee-for-service plans, and/or special needs plans provide for an expanded set of option for beneficiaries. MA plans promote continuity of care and are highly valued by consumers and employers alike.

III. Reauthorize Laws

Several programs and amendments are up for reauthorization in 2017, which the Chamber expects to support generally. Our role in these reauthorizations has generally consisted of high level support and we expect that will be the case this year as well.

Reauthorize Children's Health Insurance Program (CHIP)

Issue: The Children's Health Insurance Program (CHIP) is a partnership between the federal government and states and territories to help provide low income children with the health insurance coverage they need. The program improves access to health care and the quality of life for millions of vulnerable children less than 19 years of age. In general, CHIP reaches children whose families have incomes too high to qualify for Medicaid, but too low to afford private health insurance.

Current Status: Originally created under the Balanced Budget Act of 1997, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended funding for the program through FY 2017.

Step Requested:

- Support reauthorization of the Children's Health Insurance Program.

Rationale: The Children's Health Insurance Program has reduced the number of children that are uninsured.

REAUTHORIZE PRESCRIPTION DRUG USER FEE ACT (PDUFA), MEDICAL DEVICE USER FEE AMENDMENTS (MDUFA), GENERIC DRUG USER FEE AMENDMENTS PROPOSALS

Issue: The Prescription Drug User Fee Act (PDUFA) was created by Congress in 1992 and authorizes the Federal Drug Administration (FDA) to collect fees from companies that produce certain human drug and biological products. Since the passage of PDUFA, user fees have played an important role in expediting the drug approval process.

PDUFA must be reauthorized every five years, and was renewed in 1997 (PDUFA II), 2002 (PDUFA III), 2007 (PDUFA IV), and 2012 (PDUFA V). On July 9, 2012, the president signed into law the Food and Drug Administration Safety and Innovation Act (FDASIA), which includes the reauthorization of PDUFA through September 2017. PDUFA V will provide for the continued timely review of new drug and biologic license applications.

Current Status: The current legislative authority for PDUFA expires in September 2017. At that time, new legislation will be required for the FDA to continue collecting prescription drug user fees in future fiscal years. Following discussions with the regulated industry and periodic consultations with public stakeholders, the Federal Food, Drug, and Cosmetic Act directs the FDA to publish the recommendations for the reauthorized program in the Federal Register, hold a meeting at which the public may present its views on such recommendations, and provide for a period of thirty days for the public to provide written comments on such recommendations. The FDA will then consider such public views and comments and revise such recommendations as necessary.

Step Requested:

- Respect the negotiated deals between pharmaceutical industry and the Food and Drug Administration.

Rationale: The FDA and the pharmaceutical industry have thoughtfully reached agreement on a set of principles spelled out in the Prescription Drug User Fee Act, Medical Device User Fee Amendment, and Generic User Fee Amendment frameworks. Any proposals to further reopen negotiations would jeopardize these agreements and lead to delays in drug market approval.

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IV. Reform Unsustainable Entitlement Programs

The Chamber has been campaigning for years to tell the truth to the American people about the unsustainability of our country's entitlement programs. Government agencies from the Social Security Trustees to the General Accountability Office have been sounding the alarm for many, many years. Think tanks and academic researchers have done so as well. Some members of Congress have occasionally and courageously added their voices to the chorus, much to the dismay of some of their colleagues.

The Chamber understands that the Social Security, Medicare, and Medicaid programs, all of which we strongly support, have complicated problems, both structurally and politically. We understand the problems with these programs go beyond setting them on a sound financial footing for future generations. We understand these problems have been allowed to build and fester over many years and so correcting them all in a single Congress is probably beyond a reasonable expectation. However, we expect to see real progress in the coming Congress.

Reform Medicare & Medicaid

Issue: The Congressional Budget Office in its regular updates to the economic and budget forecast and in its annual long-term budget update have told the tale of fiscal imprudence repeatedly and well for years. The federal government's fiscal policies are simply not sustainable, largely because the entitlement programs are not sustainable in their current form. Mandatory spending currently comprises about 70 percent of the federal budget. If overall spending levels hold, entitlement spending and interest on the debt will account for 98 percent of all federal revenue by 2026. This leaves only 2 percent for discretionary spending without running a deficit, according to Congressional Budget Office projections. Absent a change in policy, the CBO predicts a return to trillion-dollar deficits, almost entirely because of an aging population, rising health care costs, and projected interest rate hikes.

Current Status: According to the 2016 Centers for Medicare and Medicaid Services (CMS) Trustees' report, Medicare spent $647.6 billion on medical services for America's seniors but only collected $323.7 billion in payroll taxes and monthly premiums. Medicaid expenditures including additional items such as administrative costs, accounting adjustments, or the U.S. Territories, totals $552 billion in FY 2015.

Steps Required:

- Advance advocacy efforts that reflect our general health policy priorities such as broader choice and competition, greater quality and efficiency in care delivery and financial sustainability.
- Push for broader entitlement reform more generally, in order to preserve the system's long-term viability, and supporting a new reimbursement model that rewards quality and efficiency.

Rationale: As the Chamber has historically done, we recommend that our focus with regard to entitlement reform remain on advancing general goals to: preserve choice and competition for beneficiaries, reduce unnecessary costs, and improve quality of care and outcomes. Efforts at the highest levels of the Chamber to address entitlement reform have focused and should continue to focus on the need for a holistic conversation *after* consensus is reached that the programs are not sustainable. Any efforts to advance reform priorities before this consensus will be futile.

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LABOR, IMMIGRATION & EMPLOYEE BENEFITS DIVISION

U.S. CHAMBER OF COMMERCE

2017 LABOR POLICY RECOMMENDATIONS

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I. RIGHTING THE SHIP: CORRECTING THE LABOR POLICY MISTAKES OF THE PAST EIGHT YEARS

This section sets forth the major labor/employment policy mistakes that have been made in the past eight years. These policies should be corrected, repealed or overturned.[1]

[1] As when Bush succeeded Clinton, the Trump win opens the door to rolling back many of Obama's employment regulations. The press is much focused on these possibilities, but keep in mind that this effort will vary depending on the underlying regulation in question, a fact lost on the press. Many were issued under executive orders (such as "blacklisting") and thus can be swiftly eliminated through repeal of the relevant executive order by the new president which provided the underlying authority for the regulations, followed by procedural repeal of the regulations themselves. But others, such as the DOL overtime regulations will have to be repealed/modified through notice and comment rulemaking. This can be done relatively quickly, but the courts have made clear that this must be a reasoned and deliberative process and not based simply on a change in the presidency. Another option is repeal through the Congressional Review Act (CRA) depending on when the underlying regulation was issued and when this Congress adjourns. So for example, under Bush, we achieved repeal of the Clinton ergonomics regulation under the CRA, but repealed the Clinton blacklisting regulations through notice and comment rulemaking. Reversing the problems at the NLRB present a much different situation as it is an independent agency and is driven by caselaw. The Board will have to be reconstituted through new appointees and a new general counsel, which will obviously take some time. In sum, we have huge opportunities here, which we are already working, but each has their own nuances. Ongoing court cases must also be calculated into the strategy.

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EXECUTIVE ORDERS (EO)/PRESIDENTIAL MEMORANDA

When Congress rejected the administration's policy objectives, the president exercised his executive authority in order to establish new policies in the labor and employment law areas. Relying on the president's procurement power, these executive orders and their implementing regulations apply to federal contractors, but have little to do with encouraging economy and efficiency in the federal procurement process – as required by the Federal Property and Administrative Services Act – and everything to do with the president usurping Congress' role to make labor and employment policy. Indeed, while the Procurement Act provides the president with significant discretion with regard to federal procurement, it does not provide a "blank check for the President to fill in at his will."[2] Unless otherwise noted, the following executive orders should be rescinded, along with the corresponding implementing regulations.[3]

- Nonreimbursement for Labor Relations Costs (EO 13494). The EO prohibits federal contractors from seeking reimbursement for certain labor relations costs for activities that are undertaken to persuade employees to exercise or not exercise their right to join a union or engage in collective bargaining, such as preparing and distributing materials, hiring or consulting legal counsel or consultants, and holding meetings. The Chamber's comments are here.
    - Status: On November 2, 2011, the Federal Acquisition Regulatory (FAR) Council published a final implementing regulation (48 CFR Part 31) to implement the EO. The regulation took effect on December 2, 2011.
    - Steps Requested: The EO should be rescinded, along with its implementing regulations.
- Non-displacement of Qualified Workers Under Service Contracts (EO 13495). The EO requires federal contractors under the Service Contract Act to offer the employees of a contractor that they displace the right of first refusal for employment. The Chamber's comments are here.
    - Status: The FAR Council and the Department of Labor's (DOL) implementing regulations (48 CFR Parts 1, 2, 22, and 52) went into effect on January 18, 2013.
    - Steps Requested: The EO should be rescinded, along with its implementing regulations.
- Notice of Employee Rights Under Labor Laws (EO 13496). The EO requires federal contractors to post a notice of employee rights to unionize and participate in concerted protected activity under federal labor law. While some improvements were made in the

[2] *Chamber of Commerce of U.S. v. Reich,* 74 F.3d 1322, 1330-31 (D.C. Cir. 1996) *quoting AFL-CIO v. Kahn,* 618 F.2d 784, 793 (D.C. Cir.).
[3] These EOs are listed in order of issuance, not impact or priority.

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language of the final posters, it still has a very "pro union" slant, in that it does not explain to employees their right to decertify an unwanted union. The Chamber's comments are here.

  - Status: A final implementing rule (29 CFR Part 471) was published on May 20, 2010, and it became effective on June 21, 2010.

  - Steps Requested: The EO should be rescinded, along with its implementing regulations.

- Use of Project Labor Agreements for Federal Construction Projects (EO 13502). The EO encourages agencies to "to consider requiring the use of project labor agreements in connection with large-scale construction projects in order to promote economy and efficiency in Federal procurement." This really means that jobs are only available to bidders who are unionized. As the *Wall Street Journal* noted, the EO and implementing regulations "put an end to open, competitive federal bidding, which means higher project costs. They also mean taxpayers must finance the benefits and work rules of union members."[4] The Chamber's comments are here.

  - Status: The FAR Council issued final implementing regulations (48 CFR Parts 2, 7, 17, 22, and 52) on April 13, 2010, and they took effect 30 days thereafter.

  - Steps Requested: The EO should be rescinded, along with its implementing regulations.

- FAR Human Trafficking (EO 13627). On January 29, 2015, the U.S. Government finalized a rule (48 CFR Parts 1, 2, 9, 12, 22, 42, and 5) which amends the Federal Acquisition Regulation ("FAR") to combat human trafficking by placing new reporting and compliance burdens on federal contractors.[5] The Chamber's coalition comments are here.

  - Status: The regulation went into effect on March 2, 2015. A separate notice of proposed rulemaking (NPRM) was issued to define "recruitment fees."[6]

  - *Note*: Given political sensitivities surrounding this issue, it is recommended that any changes to regulations largely leave intact the new requirements that apply to

[4] WALL STREET JOURNAL. "Crony Contracts: Want federal business? Better be a union shop." April 14, 2010, available at http://www.wsj.com/articles/SB10001424052702303695604575182333308913608?alg=y

[5] The final rule implements Executive Order 13627 ("Strengthening Protections Against Trafficking in Persons in Federal Contracts")(September 25, 2012) and Title XVII of the National Defense Authorization Act for Fiscal Year 2013 ("Ending Trafficking in Government Contracting").

[6] As of this writing, that definition has not been finalized. The new administration should ensure that any final definition of "recruitment fees" is not overly broad or ambiguous, but is instead consistent with current U.S. law and lawful business practices.

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contracts performed domestically, which are not as controversial (e.g., prohibition confiscation of worker passports), but instead focus on technical changes to the onerous requirements that apply to contracts performed abroad.

- Compensation Data Collection. Pursuant to a memorandum issued by President Obama, on August 8, 2014, the Office of Federal Contract Compliance Programs (OFCCP) issued a proposed rule which would require federal contractors and subcontractors to submit to the Department of Labor summary data on the compensation paid their employees, including data broken down by race and sex. The Chamber submitted comments on January 5, 2015, which are here.

  - Status: As of the date of this document, the OFCCP has not issued a final rule.[7]

- Establishing a Minimum Wage for Federal Contractors (EO 13658).
  On February 12, 2014, President Obama, citing his authority under the Procurement Act to impose changes that increase economy and efficiency in federal contracting, issued an EO that set the minimum wage for federal contracts at $10.10 per hour with an annual increase based on inflation. Tipped wages are also addressed. Final regulations implementing the new wage were issued October 7, 2014. The executive order applies to "new contracts" resulting from a solicitation issued on or after January 1, 2015, or a contract that is awarded outside the solicitation process on or after January 1, 2015. The Chamber submitted strongly critical comments.

  The EO applies to all Service Contract Act and Davis Bacon Act contracts if the prevailing wages are not as high as the new specified minimum wage. In addition, the EO applies to employers who merely lease space from the federal government such as fast food franchises in federal office buildings or on military bases, as well as concessionaires at national parks.

  - Status: The EO driven minimum wage is in effect and the second increase will set it at $10.20 per hour beginning January 1, 2017. Also, the required minimum cash wage that generally must be paid to tipped employees performing work on or in connection with covered contracts will increase to $6.80 per hour.

  - Steps Requested: The EO should be rescinded, along with its implementing regulations.

  - Basic Rationale: This EO overrides wage setting mechanisms set by the Service Contract Act and Davis Bacon Act. It also forces employers who are not normally considered federal contractors, e.g. those merely leasing space from the

[7] This rulemaking has been eclipsed by the Equal Employment Opportunity Commission's (EEOC) finalization of changes to the EEO-1 form which will require employers to report employee compensation and hours worked information. A detailed discussion of EEOC's compensation collection effort is set forth below.

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federal government, to have to raise their wages, often putting them at a competitive disadvantage with nearby competitors not tied to federal leases.

- Anti-Retaliation Regarding Compensation (EO 13665). This EO amends Executive Order 11246 to provide that federal contractors shall not discriminate against employees or applicants that share, inquire about, or disclose compensation data. Characterizing this protection as "anti-discrimination" rather than "anti-retaliation," allows aggrieved employees to only have to demonstrate that their discussions relating to compensation disclosure were a "motivating factor" of the adverse action taken against them. This runs counter to a recent Supreme Court ruling which states that the "motivating factor" analysis does not apply to retaliation claims. The Chamber's comments are here.

    - Status: On September 11, 2015, the DOL promulgated final regulations (41 CFR Part 60-1) that went into effect January 11, 2016.

    - Steps Requested: The EO should be rescinded, along with its implementing regulations.

- Executive Order 13673, Fair Pay and Safe Workplaces (a.k.a., Blacklisting). On July 30, 2014, President Obama signed Executive Order 13673, "Fair Pay and Safe Workplaces." The EO will govern new federal procurement contracts and subcontracts valued at more than $500,000, and mandate that companies provide information to the federal government if there "has been any administrative merits determination; arbitral awards or decision or civil judgment, as defined in guidance issued by the Department of Labor" with respect to labor law violations under 14 different laws and executive orders (and equivalent state laws) that have occurred within the previous three years. If these violations are determined to be severe, repeated, willful, or pervasive, they are to be factored into the determination of whether the contractor or bidder is responsible. In addition to submitting this information during the bidding process, contractors will be required to submit information every six months during the life of the contract and may have their responsibility determination reexamined accordingly. Final regulations and guidance were published on August 24, 2016. However, no guidance on what constitutes "equivalent state laws" has been proposed or issued. The Department of Labor indicates that will be handled in a forthcoming notice and comment process.

  Violations include "any administrative merits determination; arbitral awards or decision or civil judgment." The Department of Labor has defined, in guidance, administrative merits determinations to mean low level enforcement actions such as Occupational Safety and Health Administration (OSHA) citations, National Labor Relations Board (NLRB or "Board") complaints, Equal Employment Opportunity Commission (EEOC) reasonable cause letters, and Wage and Hour's Form WH-56 inquiries. This means companies would have to submit reports on mere citations and other first level enforcement actions, before they have had a chance to contest them or have their day in court.

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The Chamber submitted comprehensive comments found here.

Final FAR regulations and DOL guidance were issued on August 25, 2016. Dates for compliance with different provisions were staggered as follows:

- October 25, 2016: The FAR rule takes effect. Mandatory disclosure of labor compliance history begins for all prime contractors (only) under consideration for contracts with a total value greater than or equal to $50 million.

    - The 3-year disclosure period will be phased in so that no contractor or subcontractor need disclose any decisions regarding labor violations that were rendered against them before October 25, 2015. The reporting disclosure period is initially limited to one year and will gradually increase to three years by October 25, 2018.

- October 25, 2016: Companies with federal contracts of $1 million or more are prohibited from requiring their workers to enter into pre-dispute arbitration agreements for disputes arising out of Title VII of the Civil Rights Act, or from torts related to sexual assault or harassment, except where valid contracts already exist and remain unmodified.

- January 1, 2017: The paycheck transparency clause takes effect, requiring contractors to provide wage statements and notice of any independent contractor relationship to their covered workers.

- April 25, 2017: The total contract value above which prime contractors must make disclosures is reduced to $500,000.

- October 25, 2017: Mandatory disclosure begins for all subcontractors under consideration for covered subcontracts with a total contract value greater than or equal to $500,000.

- Steps Requested:

    - The Chamber has been leading the effort to get riders into appropriations bills to block this rulemaking or to keep the regulations from taking effect as well as spearheading an effort to get language into the National Defense Authorization Act that would limit the impact this EO will have on Defense Department contracting.

    - The Chamber has made clear from the outset that if final regulations and guidance were issued to implement the EO a legal challenge would be

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necessary. Such a challenge has been filed in federal court in Texas and has resulted in a preliminary injunction blocking all but the "paycheck transparency" provisions from taking effect.

    - Based on the results of the election, a Congressional Review Act (CRA) resolution is possible. In addition, the new administration should suspend any further implementation of the regulations, including the paycheck transparency provision not blocked by the preliminary injunction, and pursue rescinding the EO and its regulations and guidance.

  - Basic Rationale: To preserve their ability to remain federal contractors, companies will be under strong pressure to resolve unadjudicated enforcement actions by accepting "Labor Compliance Agreements" largely on agency-favorable terms as the preferred way to demonstrate that they have come into compliance. The EO exceeds the president's authority to make changes to government contracting and procurement based on improving "economy and efficiency" under the Procurement Act.

- Executive Order 13706, Establishing Paid Sick Leave for Federal Contractors. The executive order provides for earning up to 7 days of paid sick leave per year, and applies to "contracts," "contract-like instruments," and "solicitations" that result from solicitations issued on or after January 1, 2017. The leave could be used for a wide array of conditions, including relief from domestic violence, by the employee or to assist any relative or person who is in the same relationship to the employee as a relative. The executive order applies to contractors and all subcontractors covered by the Davis-Bacon Act, the Service Contract Act, or whose employees are covered by the Fair Labor Standards Act, and any companies that lease space from the federal government or have concession agreements with the federal government such as those selling souvenirs at national parks. The final rule was issued September 30, 2016.

  The Chamber submitted extensive comments on the proposed regulations and the executive order, in conjunction with the International Franchise Association, to Department of Labor. We also submitted comments, on the proposed Information Collection Request under the Paperwork Reduction Act.

  Final regulations were issued on September 30, 2016, and go into effect for new solicitations issued on or after January 1, 2017.

  - Steps Requested: Revoke the EO and with it the implementing regulations.

  - Basic Rationale: This new requirement for providing paid sick leave will create serious problems for many employers, including small businesses and franchise operators who lease space from the federal government. It will also be disruptive to employers who already have generous leave benefits in place who will have to conform those benefits to these requirements.

NATIONAL LABOR RELATIONS BOARD

- Joint Employer. In *Browning-Ferris Industries (BFI)*, 362 NLRB No. 186, the Board overturned its clear bright-line test for determining whether an entity is the joint employer of another company's employees. The old test looked to see which business entity retained direct and immediate control of the workers (e.g., ability to hire, fire, discipline, etc.). The new test will find joint employment even where one company only has the right to exert indirect or potential control over the terms and conditions of another company's employees. This means, for example, that a company which has a contract with a security vendor to provide guards in its lobby could be considered the employer of those guards, even though the company does not hire, fire, discipline, pay or supervise those guards.

  - Status: The Board issued *Browning-Ferris* in August 2015 and the decision became Board policy upon its issuance. The case is currently on appeal at the D.C. Circuit Court of Appeals. The Chamber filed an amicus brief both with the Board, and with the Court of Appeals.

  - Steps Requested:

    - *Protecting Local Business Opportunity Act* (S. 2015; H.R. 3459)– this bill would codify the "direct and immediate" control standard that existed for over 30 years prior to *BFI*.

    - A Republican-majority NLRB could overturn *BFI* and return to the prior standard.

    - Appropriations Rider – a prohibition on the NLRB's (and other agencies') continuation of its expanded "joint employer" standard would be an effective – but perhaps temporary – solution.

  - Basic Rationale: According to the dissent, "the number of contractual relationships now potentially encompassed within the majority's new standard appears to be virtually unlimited." By changing its joint employer standard, the Board has opened up a "Pandora's box" of problems that may now potentially befall almost any employer who enters into a contract for services with another business. If left uncorrected, the NLRB's new joint employer standard will hold employers responsible for, and require them to bargain over, workers whom they do not control. Indeed, this new standard is really about expanding the universe of potential employers who can be targeted by the NLRB, unions, and plaintiffs' bar.

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- Ambush Elections. Through various changes to the union election process, the NLRB's ambush election regulation shortens the timeframe between when the employer receives an election petition and when the election actually occurs.[8] Additionally, the rule requires employers to turn over to the unions personal information about workers such as home addresses, home phone numbers, personal e-mail addresses, shift schedules and work locations. Chamber comments are here.

    - Status: Originally proposed in 2011, the regulation was struck down by the District Court for the District of Columbia in 2012. The NLRB re-proposed the regulation in 2014 and it went into effect in April 2015. To date, the regulation has survived legal challenges.

    - Steps Requested:

        - *Workforce Democracy and Fairness Act* (S. 933 and H.R. 1768)
            - Provides for a fair hearing process by allowing employers at least 14 days to prepare their case for the Board and allows employers to raise issues during the hearing.
            - Prohibits ambush elections by requiring a campaign period of at least 35 days prior to an election. This will guarantee that workers have an opportunity to hear both sides of the unionization debate.
            - Allows employees to choose how they may be contacted by union organizers.

        - A Republican-majority NLRB could rescind the ambush election regulations and return to the prior standard.

        - *Employee Privacy Protection Act* (H.R. 1767) – an incomplete solution, as it addresses employee Excelsior list privacy concerns only, by allowing employees to choose means by which they may be contacted by a union.

    - Basic Rationale: By dramatically reducing the campaign period, the ambush election rule limits employers' abilities to communicate with their employees about the pros and cons of unionization and employees will hear only one side of the story. Thus, the rule is intended to boost sagging union membership rolls, while depriving employees of information needed to make a rational decision as to whether or not they wish to be represented by a union.

- Union Manipulation of Bargaining Units – *Specialty Healthcare*. In *Specialty Healthcare*, the Board announced a new standard for determining the composition of bargaining units, making it easier for unions to gerrymander the workforce and force their way in to an employer's business. The Board and its regional directors have

[8] In practice, the regulation has shortened the average "campaign period" from about 38 days to 28 days.

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applied the *Specialty Healthcare* rationale in a variety of workplace settings, including department stores, manufacturing facilities and even a winery.

- Status: *Specialty Healthcare* was decided in 2011 and became effective immediately. To date, the case has survived several challenges before federal courts of appeal. The Chamber filed an amicus brief both with the Board, and with the Court of Appeals.

- Steps Requested:

  - *The Representation Fairness Restoration Act* (S. 801) – codifies the pre-*Specialty Healthcare* community of interest standard for bargaining unit determinations.

  - A Republican-majority NLRB could overturn *Specialty Healthcare* and return to the prior standard.

- Basic Rationale: As noted above, by allowing unions to choose which employees make up the bargaining unit, unions will increase their chances of establishing a beachhead at employers' places of business. Additionally, the fractured and multiple units that will result will place employers in a perpetual state of bargaining and constant threat of labor disruption. They will also greatly limit an employer's ability to cross train and meet customer demands via flexible staffing.

- Other NLRB Decisions. Set forth below is a sample of other NLRB cases that negatively impact the employer community. (The Chamber will soon release an additional comprehensive document of NLRB cases which should be reversed). They should be reversed with legislation of appointment of new Board members who prioritize fealty to the National Labor Relations Act (NLRA) over union handouts.

  - *D.R. Horton/Murphy Oil* – To help try to avoid the costs of class and collective actions, many employers have adopted arbitration agreements that include class action waivers. Under these agreements, employees agree that any dispute with their employer will be resolved through arbitration, rather than in court, and they also agree that their claims will be heard only on an individual basis and not in a class or collective action. The Supreme Court of the United States and the federal courts of appeals have issued numerous decisions endorsing the use of arbitration agreements and class action waivers. In *D.R. Horton* and *Murphy Oil* the Board ruled that such waivers violate Section 7 of the NLRA (see Chamber amicus brief). The Fifth Circuit Court of Appeals has overruled the Board in these two cases, and the Board has appealed the *Murphy Oil* case to the Supreme Court. Two other cases – *E&Y* and *Epic Systems* – have recently endorsed the Board's view and are waiting for a decision on certiorari.

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- *Purple Communications* – permits employee use of employer-owned email systems for purposes of organizing and participating in concerted activity. The Chamber's amicus brief is here.

- *KYC/Lincoln Lutheran* – NLRB overturned over 50 years of precedential history under *Bethlehem Steel, Co.,* 136 NLRB 1500 (1962), holding that employers could not unilaterally end dues check-off at the expiration or termination of a collective bargaining agreement.

- *American Baptist Homes of the West/Piedmont Gardens* – restricts employers' abilities to permanently replace striking workers, providing unions with greater leverage during labor disputes.

- *Miller & Anderson* – reversed *Oakwood Care Center*, 343 NLRB 659 (2004), to permit mixed units of solely employed employees and jointly employed employees absent consent of all employers. The Chamber's amicus brief is here.

- *Babcock & Wilcox* – overhauled longstanding rules governing when the Board will defer unfair labor practice charges to arbitration. As a result, unions can relitigate arbitrated or settled grievances as unfair labor practices before the Board, effectively getting two bites at the apple. This deprives the employer of the prompt and efficient resolution that such procedures are intended to achieve. The Chamber's amicus brief is here.

- *Nexeo Solutions* – further muddies NLRB successor law, meaning that buyers of unionized operations must take extra precautions if they wish to retain the right to set initial terms and conditions of employment unilaterally.

DOL - Office of Labor Management Standards

- Persuader. DOL's "persuader" rule narrows the scope of the "advice" exemption so that virtually all interactions with labor lawyers and consultants will be subject to the disclosure requirements. The Chamber filed comments in September of 2011.

  - Status: Proposed in 2011, the "persuader" regulation was finalized in 2016. On November 16, 2016, the U.S. District Court for the Northern District of Texas permanently enjoined the regulation, preventing the rule from going into effect. Challenges to the rule are also pending in Minnesota and Arkansas.

  - Steps Requested:
    - Repeal using the DOL's rulemaking authority
    - Enact legislation which would codify the previous bright-line standard so that as long as the consultant does not speak directly with the employees

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and as long as the employer is free to accept or reject the advice, then the advice is not reportable.

- Basic Rationale: By limiting access to counsel and making disclosure more complicated and detailed, employers will be less likely to exercise their federally protected free speech rights. The new interpretation is designed to limit, particularly in "Ambush" discussed above, employers' ability to communicate with their employees regarding the pros and cons of unionization.

DOL - OFFICE OF FEDERAL CONTRACTOR COMPLIANCE PROGRAMS.

- Commentary on OFCCP Regulations. During this administration, OFCCP has finalized regulations concerning discrimination and affirmative action requirements for individuals with disabilities, veterans and prohibiting federal contractors from discriminating on the basis of sexual orientation and gender identity. OFCCP also finalized a rule which prohibits federal contractors from retaliating against employees who discuss compensation matters in the workplace. While these final regulations could likely use some improvements on the edges, given the sensitive nature of these issues and the fact that many contractors already had similar policies in place, wholesale revisions or repeal of these regulations is not recommended.

- Issue: The current "Scheduling Letter and Itemized Listing" set forth the documents and information that contractors must supply to OFCCP during the first phase of an audit. The "Scheduling Letter and Itemized Listing" was amended in 2014 to require numerous new reporting requirements, including disclosure of individualized – rather than aggregate – employee compensation data. These new requirements dramatically increase employer compliance burdens.

    - Steps Requested: Amend the current Scheduling Letter and Itemized Listing to reduce employer reporting requirements.

- Issue: Federal contractor affirmative action obligations are triggered for employers with 50 or more employees and a direct federal contract (or certain subcontracts) of at least $50,000. This low dollar threshold requires small employers – sometimes with an attenuated attachment to the government procurement process – to engage in expensive and time-consuming compliance requirements, such as detailed recordkeeping and adoption of an affirmative action plan.

    - Steps Requested: increase the OFCCP affirmative action and reporting requirement threshold through rulemaking process in order to ease the compliance burden on small business.

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- Enforcement Against TRICARE Subcontractors. Despite language in Section 715 of the 2011 National Defense Authorization Act (NDAA), which states that a TRICARE managed care contract shouldn't be deemed "a contract for the performance of health care services or supplies" for determining whether network providers are "subcontractors" under the Federal Acquisition Regulation or any other federal law, OFCCP continued to assert jurisdiction over medical providers that are TRICARE subcontractors.

    - Steps Requested:
        - *Protecting Health Care Providers from Increased Administrative Burdens Act* (H.R. 3633) – would prevent medical providers that receive funds from federal health care programs from being classified as subcontractors subject to the OFCCP's jurisdiction.
        - Alternatively, the five-year enforcement moratorium for TRICARE subcontractors, which is scheduled to expire in 2019 and can be "revoked" at any time, should be made permanent (to the extent possible).

    - Basic Rationale: If OFCCP begins enforcement anew against TRICARE subcontractors, such actions would: (1) ignore clear intent of Congress; (2) expand jurisdiction of the agency; and (3) create great uncertainty for healthcare providers.

DOL – WAGE AND HOUR DIVISION (WHD)

- New Overtime Regulation Defining and Delimiting the Exemptions for Executive, Administrative, Professional Employees. On May 23, 2016, the Department of Labor published its final overtime regulation increasing the minimum salary threshold for exemption from $23,660 per year, to $47,476 per year ($913 per week). The salary threshold will be automatically increased every three years by pegging it to the 40th percentile of the lowest income region of the country (currently the South which includes MD, VA, and DC). Similarly, the compensation requirement needed to exempt highly compensated employees will increase to $134,004 per year, up from $100,000 per year and will be indexed to the annualized value of the 90th percentile of weekly earnings of full-time salaried employees in the lowest income region. The new regulation is scheduled to take effect on December 1, 2016.

  The Chamber's comments can be found here.

  A Chamber led legal challenge, joined by over 50 other business groups, has been filed in the Eastern District of Texas challenging the excessively high salary threshold as undermining Congressional intent to maintain these exemptions, and the automatic escalator as not being authorized by the Fair Labor Standards Act. At the same time, a coalition of 21 states filed a similar challenge and the two cases have been consolidated. On November 11, 2016, a nation-wide preliminary injunction blocking implementation of the rule was granted.

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- <u>Steps Requested.</u> Since the court has blocked the regulation from taking effect, revoking and revising the salary threshold increase will be more practical. This will also make a CRA resolution more politically acceptable. Even if the court does not eventually rule against the regulation on the merits, the entire regulation should be revised through new rulemaking and the automatic escalator eliminated.

- <u>Basic Rationale.</u> The new salary threshold doubles the current threshold, and as such is highly disruptive to many employers. The new threshold was set so high as to frustrate Congressional intent to have these exemptions available, and was a clear departure from past DOL methodology. Employees will also be disadvantaged as putting them on the clock will mean that work done outside the workplace will need to be tracked and captured against the 40 hours a week to determine if they qualify for overtime. This will also mean that use of smart phones and travel will have to be tracked or curtailed. Furthermore, the automatic update provision is not authorized by statute and will result in the salary threshold continuously increasing without input from affected parties, or any consideration for whether it makes sense in the current economic conditions.

- <u>Administrator's Interpretation (AI) on Misclassification of Employees.</u> On July 15, 2015, Wage and Hour Administrator David Weil issued an interpretation detailing how workers are to be classified between employees and independent contractors for purposes of coverage under the Fair Labor Standards Act. Traditionally, the level of control over the workers' action exerted by the employer was the key issue, with more control resulting in an employee designation. The AI replaces that test with a multi-factor "economic realities" test that includes the control issue but not as the primary concern. As a result, employers will have much less clarity and certainty about whether they have properly classified their workers and the WHD will have more latitude to find misclassification. Indeed, the AI makes clear that the definition of an employee under the FLSA is intended to be very broad and that "most workers are employees under the FLSA."

    - <u>Steps Requested:</u> Revoke the AI.

    - <u>Basic Rationale:</u> The AI makes a substantive change in the classification process. There was no input taken from affected parties, or notice that this was coming. Employers will be at a disadvantage to have their classifications upheld, and will often be unable to know whether their classifications are valid until the WHD decides whether they are.

- <u>Administrator's Interpretation on Finding Joint Employment Under the FLSA.</u> Similar to the AI on misclassification, WHD Administrator Weil on January 20, 2016, issued an interpretation detailing when a joint employment relationship would exist under the FLSA such that both employers would be liable for violations. The AI describes two versions of joint employment—horizontal and vertical. Horizontal joint employment exists where there is a connection between the two employers, such as common corporate

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ownership. Vertical joint employment would be found where the employee for one employer works under the direction of a second employer, such as with staffing agencies or other outside contractors for workers. The vertical joint employment analysis relies on the "economic realities" concept embodied in the AI on misclassification.

- Step Requested: Revoke the AI.

- Basic Rationale: Like the AI on misclassification, the AI on joint employment was issued with no input from affected parties, or any indication it was coming. It also makes substantive changes to how the FLSA is enforced, most notably in the creation of vertical joint employment relationships. The vertical joint employment relationship will mean that many companies will be vulnerable to being held liable for FLSA violations of smaller contractors they may have employed for specific functions that they no longer wish to handle. The reliance on the economic realities test will also mean great uncertainty about whether such a relationship exists.

DOL - OSHA

- Injury and Illness Reporting Regulation with Anti-Retaliation Provision.
  On May 11, 2016, OSHA released its final regulation requiring employers to submit to OSHA electronically their injury and illness records so that OSHA can post these to the Internet. Employers with more than 20 employees who have to keep records will have to submit summary records by July 1, 2017. Employers with 250 employees or more will be required to submit more detailed records annually, beginning July 1, 2018. Others must continue to submit summaries.

  In addition, the final regulation included a provision requiring employers to have "reasonable" polices for employees to come forward with their injuries or safety hazards, and not to retaliate against employees who report injuries or safety violations. In preamble commentary to the final regulation, OSHA grants itself the authority to issue citations under the whistleblower protection provision of the statute to enforce this new prohibition. Among the employer policies OSHA will target as being unreasonable are safety incentive programs and certain uses of drug testing that OSHA believes deter employee reporting of injuries. The Chamber's comments on the original proposed regulation are here, and the comments on the supplemental proposed regulation are here.

  - Steps Requested: This rulemaking should be revoked through a subsequent rulemaking.

  - Basic Rationale: The statute does not give OSHA the authority to publicize these records. Doing so will expose employers to being mischaracterized as having unsafe workplaces for reporting injuries that had to recorded but which having nothing to do with their approach to workplace safety. These postings are expected to be used by unions in their organizing and negotiation efforts, which is

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why they requested this rulemaking. The "anti-retaliation" provision should be revoked because: 1) The text for this was never actually proposed, instead a series of questions was asked and employers were unable to learn what would be expected of them; and 2) It is so vague as to be meaningless—how is an employer to know when their policy is "reasonable" or whether "a reasonable employee" would be deterred? The only way to understand what is expected is to rely on the preamble commentary which results in backdoor rulemaking; OSHA does not have the authority under the statute to enforce whistleblower protections through citations. The statute is explicit that any whistleblower claims must originate with an employee filing a complaint. OSHA's approach would result in a whistleblower action without a whistleblower.

- Letter of Interpretation Granting Union Representatives Walk Around Rights. OSHA issued a letter of interpretation, in response to a request from the United Steelworkers, which upended longstanding regulations on whether outside third parties could accompany an OSHA inspector during walk around inspections. The regulations made clear that only employees of the company can accompany OSHA inspectors unless special circumstances (such as unique expertise or language issues) suggest otherwise. OSHA's letter uses these exceptions to grant union representatives the right to enter non-union workplaces when requested by an employee.

    - Steps Requested: This letter of interpretation should be rescinded.

    - Basic Rationale: This letter was done as a favor to the agency's union patrons. It disturbs well settled regulations and as such, if this is to be the new policy, it should have been done through a rulemaking so the affected parties could participate, and there would be a way to hold the agency accountable. Instead this letter waits to be invoked, and only if the employer resists will a challenge result.

- OSHA Joint Employer Enforcement Memo. Following the NLRB's decision in *Browning Ferris,* a memo from OSHA detailing how inspectors could establish joint employment relationships in the franchise setting leaked. It relies on the "economic realities" concepts used by the WHD and seeks to hold the brand name company liable for the OSHA violations of its franchise operators.

    - Steps Requested. The status of this memo is unclear as it was leaked in a draft form and never made public or formalized. It should be rescinded.

    - Basic Rationale. This memo was done in secret, and if this is to be new policy it must be done in a participatory process. More importantly, it would make franchise relationships almost impossible, thus destroying a vibrant sector of the economy. The criteria are so vague that employers will never be able to tell with certainty, but whether or not they are in compliance until an OSHA inspector decides.

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<u>Equal Employment Opportunity Commission</u>

- <u>Compensation and Hours-Worked Reporting (EEO-1)</u>. Beginning in 2018, the EEOC will require employers with 100 or more employees (both private industry and federal contractors) to submit data on their employee's W-2 earnings and hours worked broken down by ethnicity, race, and sex, and sorted into 10 job categories. The Chamber filed comments with the EEOC and the White House's Office of Management and Budget.

    - <u>Status</u>: Proposed in February 2016, the changes to the EEO-1 form were approved on September 29, 2016. The 2016 report deadline has passed and employers complied by filing the old form. Employers will be required to file their 2017 report – which will include compensation and hours worked data – by March 2018.

    - <u>Steps Requested</u>:

        - With a Republican-majority commission, rollback using the Paperwork Reduction Act (PRA).

        - Appropriations rider prohibiting EEOC from proceeding with the changes to the EEO-1 form.

        - *EEOC Reform Act* (S. 2693) – would require EEOC to take three reasonable steps before it continues with the proposal: 1) EEOC would have to collect and compile the same employment data information from the executive branch departments and agencies and report this information to Congress, along with the number of staff and staff hours it took to complete; 2) EEOC would be required to develop software and a comprehensive plan regarding how the data will be used; and 3) EEOC would be required to reduce its current backlog of discrimination complaints (which include over 1,000 cases alleging compensation discrimination) by a specified number.

    - <u>Basic Rationale</u>: Time spent by employers reporting on this new form and costs associated with developing information systems to accurately do so will rise dramatically, despite claims by EEOC. Further, because non-discriminatory variables are not accounted for and the job groups and pay bands are arbitrary, this data will provide EEOC with no insight as to whether an employer's pay practices are discriminatory. Finally, the EEOC fails to set forth appropriate safeguards to ensure that this sensitive information remains confidential, and it is anticipated that unions and other interest groups will use this information out of context to publicly promote unfounded allegations against employers.

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- Wellness Regulations. On May 17, 2016, EEOC issued final rules under the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act relating to workplace wellness programs.

    - Steps Requested: Amend EEOC wellness regulations to smooth out inconsistencies with Affordable Care Act and Health Insurance Portability and Accountability Act (e.g., smoking cessation incentives).

    - Rationale: Inconsistencies between EEOC's wellness regulations and the Tri-Agency wellness regulations increase compliance costs and discourage employers from offering wellness benefits to employees.

    - The AARP has filed a challenge to the incentives provided in the regulations. The Chamber has filed a brief countering these arguments.

- Criminal Background Check Guidance. In 2012, EEOC issued guidance relating to employers' use of criminal background check information when making employment decisions. There are still concerns in the business community about what is required for "individualized assessments" and what employers should do when faced with state laws which require background checks be performed for certain jobs.

    - Steps Requested:

        - EEOC could issue revised guidance.
        - *Certainty in Enforcement Act of 2015* (H.R. 548) - provides a safe harbor for employers who perform criminal background checks as mandated by federal, state, or local law.

NATIONAL MEDIATION BOARD (NMB)

- NMB Representation Rule Change. The National Mediation Board oversees labor-management relations in the railroad and airline industries. Because of the unique nature of these industries, a union could only be certified as a bargaining representative of a group of employees if a majority of all eligible voters cast ballots in favor of unionization. However, in order to make it easier for unions to organize, in 2010 the NMB changed this rule to allow unions to be certified as the bargaining representative if they secure a majority of the votes cast (see Chamber comments here). For example, under the traditional rule, if a union sought to represent 10,000 airline employees, 5,001 votes would be needed in the election. Under the new rule, a bare majority of votes cast would make the determination regardless of how many employees voted. If only one person voted, and she voted for the union, she and the remaining 9,999 employees would become unionized. In other words, an employer could be required to bargain with a union with no evidence that the union ever enjoyed the support of a majority of employees in the craft or class.

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- Step Requested:
    - Enter into rulemaking to reconsider these new voting procedures.

II. Charting a New Course and Priming the Pump: Advancing Positive Reforms To Encourage Economic Growth

This section details positive policy proposals that go beyond correcting the record of the last eight years. Note that this list will evolve as circumstances dictate and more proposals are vetted by Chamber members. Obviously there will be opportunity to explore more far-reaching proposals, such as preemption of state and local employment laws, as we get a better grasp on what is actually doable. Many of the initiatives discussed below have been acted upon in the past, including through hearings and proposed legislation.

NLRA Reform

1. Union Access – Ensure that an employer has the right to control access to private property and can draw reasonable distinctions between the nature of a union's organizing efforts and the efforts of charitable organizations.

2. Clearer NLRA Preemption – With nothing explicit now in the statute, make something broad and sweeping, also doing away with the market participant exception.

3. D.R. Horton – Protect employers' use of arbitration agreements; language that the Act does not conflict with the Federal Arbitration Act.

4. Employee bill of rights, including issues like:
    a. Requiring a secret ballot strike vote.
    b. Prohibiting union fines for activity protected by Section 7.
    c. Strengthened Beck rights for dues or fees used for political purposes. (There have been several legislative initiatives and extensive hearings in the past, documenting the need for strengthened Beck rights)

5. Establish a decertification process with no blocking charges. Right now the law provides an easy in, but a hard out.

6. Racketeer Influenced and Corrupt Organizations (RICO) Act - Expand RICO statutes to include coercion by unions and corporate campaigns.

7. Secret Ballot Protection Act or codify *Dana.*

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8. <u>Buyers' Remorse / Return of Authorization Cards</u> – Guarantee the right of an employee to have an authorization card returned upon request.

9. <u>Do Not Contact List</u> – Create a national "do not call" list like the one for telephone solicitation that would bar a union (its officers, union organizers and even coworkers) from contacting that individual -- either directly, via telephone or otherwise -- to solicit an authorization card. Make it a unfair labor practice with financial penalties for a union to contact an employee on the "do not contact" list.

10. <u>Strengthen Decertification Rights</u> – Permit the use of authorization cards for decertification and abolish the recognition and contract bars.

EEOC Reform Bills

- <u>EEOC Transparency and Accountability Act (H.R. 4959)</u>
    - Would require the EEOC to post on its website and in its annual report an array of information to promote transparency, including any case in which EEOC was required to pay fees or costs, or where a sanction was imposed against it by a court; the total number of charges filed by an EEOC member or as a result of a directed investigation; and each systemic discrimination lawsuit brought by the EEOC.
    - Would require the EEOC to conduct conciliation endeavors in good faith and such endeavors would be subject to judicial review.
    - Would require the EEOC's Inspector General (IG) to notify Congress within 14 days when a court has ordered sanctions against EEOC. The IG must also conduct a thorough investigation of why the agency brought the case, and submit a report to Congress within 90 days of the court's decision explaining why sanctions were imposed.
    - Would require the EEOC to submit a report to Congress within 60 days of the court's decision detailing steps EEOC is taking to reduce instances in which it is subject to court-ordered sanctions; further, the EEOC would have to post this report to its website within 30 days of submitting to Congress.

- <u>Litigation Oversight Act of 2014 (H.R. 5422)</u>
    - Would require the EEOC to approve or disapprove by majority vote whether the EEOC shall commence or intervene in litigation involving: 1) multiple plaintiffs, or 2) an allegation of systemic discrimination or a pattern or practice of discrimination.
    - Provides EEOC members with the power to require the Commission to approve or disapprove by majority vote whether the EEOC commences or intervenes in any litigation.
    - Requires the EEOC, within 30 days after commencing or intervening in litigation pursuant to such an approval, to post on its public website: 1) information

regarding the case, including the allegations and causes of action; and 2) each Commissioner's vote on commencing or intervening in the litigation.

- Chamber testimony in support of these bills can be found here.

Labor Management Reporting and Disclosure Act (LMRDA)

- Prior Rep. Sam Johnson bills on LMRDA reform (108th Congress)
    - Union Members Right to Know – H.R. 992
    - Labor Management Accountability Act – H.R .993 (civil penalties)
    - Union Member Information Enforcement Act – H.R. 994

Paperwork Reduction Act Reform

Despite the fact that the EEO-1 proposal clearly violated the PRA, it was ultimately approved by Office of Information and Regulatory Affairs (OIRA). It was no accident that the administration abandoned a similar OFCCP Administrative Procedure Act (APA) rulemaking and instead chose the PRA process to extract this information from employers: unlike the APA, the PRA does not provide for a private cause of action. The administration knows the PRA is ineffective and will continue to use this as a vehicle for driving policy.

- Steps Requested:
    - The PRA should be amended to allow for a private cause of action in certain circumstances.
    - The PRA should be amended to require OIRA to issue a regulatory impact statement (i.e. how it analyzed the PRA criteria, how it calculated burden, etc.) and make this statement reviewable by federal courts.

Procurement Act Reform

To guard against future presidents using the Procurement Act's broad delegation of authority to implement non-procurement related policy, the Act could be amended to define or limit the key term of "economy and efficiency."

Pay Equity

The issue of pay equity was prominent in the November 2016 elections. Though both the Equal Pay Act and Title VII prohibit compensation discrimination based on sex, Democrats favor passage of the Paycheck Fairness Act to combat what they ostensibly see as lingering inequality in wages between men and women. There may be opportunity for Republicans to offer their

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own alternatives to address this issue, focusing on anti-retaliation and clarification of employers' defenses.[9]

Pregnancy Accommodation

Many law makers on Capitol Hill remain unsatisfied with the Pregnancy Discrimination Act's (PDA) multi-step balancing test announced by the Supreme Court in *Young v. UPS*. Consequently, here has been a push on both sides of the political aisle to provide clarity regarding employer obligations to accommodate pregnant workers. Republicans may choose to consider language to clarify the PDA.

Fair Labor Standards Act Reform

The FLSA was passed in 1938 to fit the industrial workplace where jobs and duties had much clearer distinctions. The contemporary workplace bears very little resemblance to that of 1938, since with the advent of technology, work is done in many locations instead of one central workplace. The FLSA needs to be updated to make its protections relevant to today's workers and allow employers to implement more options for flexible work arrangements. Among the updates that are needed are the following:

- Modernize the Computer Employee Exemption by including a 21st Century list of current and future duties, and allow for the option to pay an employee on a salary basis.
- Allow inside salespeople to be exempt, like outside sales, by removing the 'fixed office location' requirement. The distinction should be eliminated since in many cases salespeople work from both a fixed location and a non-fixed location through technology.
- Specify that normal commute time is not compensable, even if work is performed before or after the commute.
- Exclude specific de minimis activity from "paid time" and clarify that non-exempts' de minimis activity does not trigger the start of the work day or signify the end of the work day.

Family and Medical Leave Act Reform

The FMLA provides for 12 weeks of job protected unpaid leave for various reasons. It was enacted in 1993, and while employers have learned how to comply, there are some provisions that continue to create problems and opportunities for misuse. The following concepts give employers the most problems and should be clarified or updated:

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[9] The Lilly Ledbetter Fair Pay Act of 2009 reset the statute of limitations for filing a compensation discrimination claim each time an employee receives a paycheck, benefits, or "other compensation," that resulted from a discriminatory decision or practice. Given the highly-charged political atmosphere surrounding equal pay issues and the limited negative impact of the law, it is probably not worth expending the political capital trying to overturn this law.

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- Serious health condition – clarify that the definition of "serious health condition" does not include minor ailments.
- Intermittent leave – permit employers to use larger time blocks in offering intermittent leave rather than the current requirement that could require tracking even a few minutes of time.

Pro-Employer Paid Leave Incentive

Mandates requiring employers to provide various types of paid leave (sick, parental, family based) are proliferating throughout the country on both the state and local levels. Many companies and employers with operations in different locations are struggling to comply with the varied requirements. A federal program that gave employers the incentive of voluntarily implementing a paid leave program in exchange for being exempt from state and local mandates would likely achieve two goals: 1) increase the number of employers providing paid leave benefits for their employees; and 2) give employers with locations throughout the nation relief from the patchwork of requirements that currently exists and are likely to get worse.

Modest Minimum Wage Increase

Similar to the proliferation of paid leave mandates, many states and localities are implementing minimum wages significantly higher than the current federal minimum wage ($7.25/hour), with $15/hour being a popular level. Even President-elect Trump signaled during the campaign that he thought the federal minimum wage should be $10/hour. The last increase in the federal minimum wage was implemented in 2009. Employers could possibly support a modest increase in the minimum wage, if it is coupled with significant beneficial reforms.

OSHA Reforms

Over the years there have been various efforts to update how the OSH Act operates. These are still needed reforms.

- Attorneys' Fees – The FAIR Act (H.R. 742, passed by the House in the 109th Congress) allows small employers to recover attorneys' fees when they successfully defend against an OSHA citation by closing the loophole in the Equal Access to Justice Act that requires the employer to prove OSHA acted with "substantial justification." In addition to being almost impossible to meet, this also requires a second hearing, thus adding cost and burden which further impedes small businesses recovering their fees. This relief is limited to small businesses with less than 100 employees and a net worth of not more than $7 million.

- Restore Congressional intent that the Review Commission's legal interpretations of OSHA's actions be given deference, thus restoring it as the independent authority on whether OSHA has acted properly. Current case law gives deference to OSHA's legal interpretations of its own actions, thus ensuring that OSHA's actions will be upheld upon

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appeal and blocking any chance a small business would have to prevail. (H.R. 741, passed by the House in the 109th Congress.)

- Provide the Occupational Safety and Health Review Commission some flexibility in the application of the 15-day period employers have to contest citations/proposed penalties. The exceptions are based on those available to judges in federal courts, and are intended to preserve an employer's opportunity to make their case on the merits if they can show "mistake, inadvertence, surprise or excusable neglect." (H.R. 739, passed by the House in the 109th Congress.)

- Create incentive for employers to use certified safety consultants to analyze their workplaces to identify areas needing improvement thus bringing workplace safety expertise and assistance to more employers than they will ever be able to get from OSHA alone. Such a bill might also give employers credit for implementing industry-specific safety programs such as those produced by associations. Also, it would have to provide protection for the audit reports, similar to the privilege granted materials generated in an attorney-client relationship. (Previously introduced as S. 2065, "The Occupational Safety Partnership Act", 109th Congress.)

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