



Changes to Employer Reporting Obligations Under the Affordable Care Act

By: John Collier

On December 23, 2024, President Biden signed into law H.R. 3797 (the "Paperwork Burden Reduction Act") and H.R. 3801 (the "Employer Reporting Improvement Act") (together, the "Acts"). Among other updates, these Acts streamline the reporting obligations under the Affordable Care Act ("ACA") for entities filing Forms 1095-B and 1095-C for reporting periods beginning after December 31, 2024. As the Acts are now in effect, it is essential for employers to understand their implications and implement proactive measures to ensure compliance and avoid potential penalties.

Key Updates to ACA Reporting Obligations

1. Paperwork Reduction Act

The Paperwork Reduction Act simplifies ACA health coverage reporting by reducing the paperwork required from reporting entities. Previously, reporting entities were obligated to provide annual statements to all full-time employees ("FTEs") and individuals receiving minimum essential coverage using Forms 1095-C. While IRS regulations allowed entities to provide Forms 1095-B only upon request from an individual, this flexibility was not available for Forms 1095-C.

The Paperwork Reduction Act codifies this

flexibility for Forms 1094-B and extends it to Forms 1095-C, allowing reporting entities to provide Forms 1095-B and 1095-C only to those individuals who request such forms.

It is important to note, however, that utilization of this flexible method requires reporting entities to:

- (1) Provide a "clear, conspicuous, and accessible notice" informing individuals of their right to request a copy of the form, and
- (2) Furnish the requested form by January 31 or within 30 days of receiving the request, whichever is later.

2. Employer Reporting Improvement Act

In addition to the changes introduced by the Paperwork Reduction Act, the Employer Reporting Improvement Act implements several important refinements to ACA reporting requirements:

i. TIN Flexibility

Previously, reporting entities had only 30 days to respond to IRS Letters 226-J. The Employer Reporting Improvement Act extends this response time to 90 days providing additional time for entities to review and address these notices.

ii. 6-Year Statute of Limitations

Under the previous ACA reporting rules, there was no statute of limitations for the IRS to assess ESRPs for ACA reporting failures. This created uncertainty for



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employers, as penalties could be imposed indefinitely for past non-compliance.

The Employer Reporting Improvement Act introduces a six-year statute of limitations, restricting the IRS from imposing ESRPs for reporting failures that occurred more than six years prior.

Employer Considerations

As discussed above, the changes introduced by the Paperwork Reduction Act and the Employer Reporting Improvement Act significantly impact ACA reporting obligations. While these changes do present opportunities for streamlined compliance, they also introduce new requirements for compliance. To effectively adapt to these changes, employers should consider the following:

1. Review and Update Reporting Procedures:

Employers should update their reporting processes to align with the new flexibility for providing Forms 1095-B and 1095-C. Importantly, however, this must include implementation of a reliable system to ensure that requested forms are furnished by the applicable deadline. Additionally, employers must prepare and prominently post a "clear, conspicuous, and accessible notice" on their website or benefits portal explaining the process for individuals to request these forms.

2. Ensure TIN Flexibility Compliance:

The Employer Reporting Improvement Act eliminates the need to demonstrate reasonable cause when substituting a date of birth for a missing TIN. Employers should review their internal systems and forms to confirm they are equipped to accommodate this flexibility and avoid delays in meeting reporting requirements.

3. Stay Ahead of Deadlines:

With the response window for IRS Letters 226-J now extended to 90 days, employers have more time to review and address proposed ESRPs. However, employers should maintain robust mail handling and tracking procedures to ensure timely responses, particularly given that response periods are calculated from the date the letter is mailed, not received.

4. Conduct Regular Audits:

The introduction of a six-year statute of limitations for ESRPs underscores the importance of maintaining accurate and complete records. Employers should conduct regular audits of their ACA compliance to identify and address potential issues within this timeframe, reducing the risk of penalties.

5. Monitor State-Specific Mandates:

While the Acts provide federal relief, employers should also be aware of state-specific mandates, as some jurisdictions impose their own reporting obligations. This requires careful monitoring to ensure compliance across all applicable states.

By proactively adjusting ACA reporting processes to align with the Acts, employers can reduce administrative burdens and enhance the efficiency and accuracy of their reporting obligations while also mitigating the risks of penalties.



The 2025 Proposed HIPAA Cybersecurity Rule and its Impact on Employers

By: Kate Belyayeva

On December 27, 2024, the Office for Civil Rights ("OCR") at the U.S. Department of Health and Human Services ("HHS") introduced a proposed rule aimed at strengthening cybersecurity protections under the Health Insurance Portability and Accountability Act ("HIPAA"). The proposed rule was published on January 6, 2025. Comments to the proposed rule are due on March 7, 2025. This article explores the key components of the proposed rule and how it may impact employers.

The Proposed Rule

The already-existing HIPAA rules provide certain requirements, and the proposed rule enhances such requirements by incorporating advanced cybersecurity practices. The proposed rule is part of one of the actions taken by HHS during the Biden Administration to improve the cybersecurity protections, which includes the release of the National Cybersecurity Strategy in 2023 and the corresponding plan to implement the strategy.

- **General Clarifications:** The proposed rule revises and clarifies certain definitions (e.g., the terms "deploy" and "implement"). It also removes the distinction between "required" and "addressable" in terms of implementation specifications. HHS also adds specific compliance periods and requires written documentation of all related policies, procedures, plans, and analyses.
- **Minimum Security Standards:** The proposed rule establishes certain baseline security measures. Multi-factor authentication, endpoint detection and response, and encryption standards are a few to mention. Employers are also required to monitor employee access to electronic protected health information ("ePHI") to prevent unauthorized access.
- **Risk Assessment Requirements:** Employers must conduct comprehensive cybersecurity risk assessments, including for

threats such as ransomware and advanced persistent threats. As such, periodic risk assessments and updates thereto are recommended to address current vulnerabilities and implement advancements. For example, the development and revision of a technology asset inventory and a network map of the ePHI movement should be documented on an ongoing basis and at least once every 12 months whereas vulnerability testing must be conducted at least every six months.

- **Mandatory Cybersecurity Training:** Employers must provide annual cybersecurity trainings to employees who handle ePHI on topics such as phishing detection, incident reporting procedures, communication protocols, etc.
- **Supply Chain:** Business associates and subcontractors must demonstrate compliance with cybersecurity standards (i.e., compliance audits at least once every 12 months).
- **Incident Response:** The proposed rule mandates written incident response plans in addition to the requirement for covered entities and business associates to report significant cybersecurity incidents to HHS within 72 hours. Similarly, certain entities must be notified when a workforce member's access to ePHI is changed or terminated.
- **Encryption:** Certain ePHI must be encrypted at rest and in transit, with limited exceptions.
- **Application to Group Health Plans:** The proposed rule requires group health plan documents to include the requirements for plan sponsors to: (1) generally comply with safeguards under HIPAA; (2) ensure that any agent to whom ePHI is provided implements such safeguards; and (2) notify the group health plans upon activation of contingency plans without unreasonable delay (but not later than 24 hours after activation).

Employer Impact

The proposed rule is expected to have far-reaching implications for employers, particularly those who function as covered entities or business associates under HIPAA. Employers, especially those who handle ePHI or work closely with healthcare providers, must evaluate how the proposed rule will affect their operations and, if the proposed rule becomes final, revise existing policies and procedures accordingly. Monitoring obligations and addressing cybersecurity concerns are likely to necessitate dedication of resources and significant efforts. As such, updating cybersecurity measures may require investments in technology, training, and personnel in order to avoid penalties and potential lawsuits. These financial demands could be challenging for smaller businesses. Just in the first year, HHS estimates the cost of the proposed rule to total around \$9 billion (with annual costs to total \$6 billion for the next four years); however, HHS anticipates that the proposed rule is likely to reduce the number of breaches, thus, justifying the cost.

Conclusion

Evidently, the OCR has noted a substantial increase in large breach reports over the last five years and thus views the

cybersecurity efforts in the health care sector as one of its priorities. The proposed rule represents a significant step forward in addressing the growing cybersecurity threats in the employee benefits space and underscores the importance of proactive measures. With the Trump Administration taking over soon, the proposed rule may face challenges, and the final rule may be modified, postponed, or never promulgated at all. Stakeholders should nevertheless get acquainted with the proposed rule and its potential impact on their operations as the existing HIPAA rules remain in effect regardless of the fate of the proposed rule. We will monitor the developments and provide updates as HHS comments further on the status of these rules.



Fixed Indemnity Regulations Vacated by Court

By: Abby Blankenship

On December 4, 2024, the U.S. District Court for the Eastern District of Texas issued a ruling in *ManhattanLife Insurance and Annuity Co. et al. v. U.S. Department of Health and Human Services et al.*, vacating a new notice requirement for fixed indemnity insurance in the group market. This requirement, which was set to take effect for plan years beginning on or after January 1, 2025, would have required fixed indemnity insurance providers to include a notice on their marketing and application materials stating that the policy is "NOT health insurance."

Background

Fixed indemnity coverage provides income replacement benefits consisting of a fixed cash amount after a hospitalization, illness, or similar event, subject to the governing contractual terms. Generally, fixed indemnity insurance is exempt from numerous regulatory requirements that apply to comprehensive health insurance products sold in the United States, as long as the fixed indemnity policy satisfies certain statutory criteria. Specifically, fixed indemnity insurance is exempt from the Affordable Care Act's requirements for comprehensive health insurance when all of the following conditions are met:

1. The benefits are provided under a separate policy, certificate, or contract of insurance;
2. There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and

3. Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer.

In summary, fixed indemnity insurance is exempt from otherwise applicable federal requirements for health insurance if the benefits it provides are separate from, not coordinated with, and independent of other health insurance.

Final Rule

On March 28, 2024, the Department of Health and Human Services ("HHS"), together with the Department of Labor ("DOL") and the Department of the Treasury (collectively, the "Departments"), released the final regulations (the "Final Rule"), which added a new requirement for fixed indemnity policies. Under the Final Rule, fixed indemnity insurance is not exempt from federal insurance requirements unless, in addition to meeting the three statutory criteria mentioned above, the policy's marketing, application, and enrollment materials include a conspicuous notice stating that the product is "NOT health insurance." Specifically, the Final Rule mandates that the notice be provided "in at least 14-point font" on "the first page (in either paper or electronic form, including on a website) of any marketing, application, and enrollment materials" at the time of enrollment or reenrollment.

The rationale behind this Final Rule was to ensure that consumers can differentiate fixed indemnity benefits from traditional health coverage. The Departments also provided a template notice that plans were required to use without modification or customization. As a result, beginning January 1, 2025, any fixed indemnity policy that failed to provide this notice would be subject to the same requirements as comprehensive health insurance.

The Court's Ruling

After the Final Rule was issued, fixed indemnity insurers challenged the notice requirement in the Eastern District of Texas (the "Court") under the Administrative Procedures Act. The insurers argued that the new notice requirement exceeded the Departments' statutory authority and was issued without adequate notice and comment. The lawsuit alleged that upholding the Final Rule would result in harm to insurers through reduced sales, wasted business time spent explaining the notice, and compelled speech. The insurers then filed for summary judgment, asking the court to vacate the portion of the final regulations imposing the consumer notice. On December 4, 2024, the Court vacated the Final Rule's notice requirement for fixed indemnity coverage, agreeing with the insurers. The Court ruled that:

1. The Final Rule's notice requirement exceeded the statutory authority of the Departments; and
2. The Final Rule's notice language "was not a logical outgrowth" of the notice requirement in the proposed regulations.

As a result of the ruling, the notice requirements related to fixed indemnity insurance issued under the Final Rule will no longer apply.

Employer Takeaways

For group coverage, the notice requirement described in the Final Rule no longer applies. While the information contained in the notice may be useful to participants, it is no longer required. Additionally, while it is unlikely, it is possible that the Departments may appeal the Court's ruling, so employers should continue to monitor any further developments related to this decision.



Compliance Corner: Navigating ERISA's Fiduciary Duties: What Employers and Plan Administrators Need to Know

By: John Collier

ERISA imposes strict standards of conduct (i.e., fiduciary duties) on entities and individuals who fall within the definition of a fiduciary with respect to an employee benefit plan. The purpose of ERISA's fiduciary duty rules is to ensure that plans are operated in the best interests of plan participants and beneficiaries. A fiduciary's failure to comply with these rules may result in harsh consequences, including personal liability and enforcement actions by the Department of Labor ("DOL").

The fiduciary rules generally apply to retirement plans, health plans, and other welfare plans alike, provided those plans are subject to ERISA. Some health and welfare plans could be exempt from ERISA under the church or governmental plan exemptions or the regulatory safe harbors for "voluntary" plans or plans that constitute "payroll practices." Others may be exempt from ERISA because they are maintained outside of the United States or maintained solely for the purpose of complying with state workers' compensation, unemployment compensation, or disability insurance laws. However, unless a company's health and welfare plans fall under one of these exceptions, ERISA's fiduciary rules will broadly apply to any entity or individual deemed to be a fiduciary with respect to those plans. Accordingly, the first question to ask is who is a fiduciary with respect to the company's plans?

Who is a Fiduciary?

There are certain entities or individuals who, by virtue of their designated roles, will be "automatic" fiduciaries with respect to an ERISA plan. For example, every ERISA plan is required to have one or more "named fiduciaries" who jointly and severally "have authority to control and manage the operation and administration of the plan." In addition to the named fiduciary, every plan will have a "plan administrator" (though many times the named fiduciary and plan administrator will be the same

person or entity). In the case of employer-sponsored plans, the employer will typically serve as both the named fiduciary and plan administrator by default. Qualified retirement plans and “funded” health and welfare plans (i.e., health and welfare plans that are not exempt from ERISA’s trust requirement) will also have one or more trustees. The trustees, named fiduciaries, plan administrators are all automatic fiduciaries with respect to ERISA plans due to the nature of their positions.

In addition to these automatic fiduciaries, there may be other entities or individuals who are deemed to be fiduciaries with respect to an ERISA plan because of the plan functions they perform. Under ERISA § 3(21), an entity or individual is a “fiduciary” with respect to a plan to the extent the entity or individual does any of the following:

- Exercises any discretionary authority or control with respect to the management of the plan or exercises any authority or control with respect to the management or disposition of plan assets;
- Renders investment advice for a fee or for any other compensation, direct or indirect, or has any authority or any responsibility to do so; or
- Has discretionary authority or responsibility in the administration of the plan.

There are two important distinctions to keep in mind when analyzing whether a person’s decisions or actions with respect to an ERISA plan are fiduciary in nature. The first relates to when a person’s decisions or actions are deemed to be administrative functions (i.e., fiduciary) versus when they are deemed to be “settlor” functions (i.e., non-fiduciary). Settlor functions generally are decisions or actions that relate to the formation, design, or termination of ERISA plans. For example, the following kinds of decisions or actions are likely to fall within the category of settlor functions: deciding whether to sponsor one type of plan (or option within a plan) versus another; changing required levels of employee contributions or eligibility rules; amending a plan, including changing plan options; and terminating a plan or portion of a plan. Entities or individuals performing settlor functions will not be deemed to be fiduciaries, at least not with respect to those particular decisions or actions that are settlor functions. This distinction becomes particularly important when ensuring that the Exclusive Benefit Rule is being met (as discussed below under the section entitled “What are ERISA’s Fiduciary Duties?”).

The second distinction relates to when a person is performing administrative functions that are truly fiduciary in nature versus when a person is performing administrative functions that are purely ministerial (i.e., clerical functions that, arguably, do not require the exercise of discretion) within a framework of established policies and procedures. In situations involving the latter, the entity or individual will not be a fiduciary with respect to the plan. The following are examples of ministerial functions that have been cited by the DOL or courts as falling outside of the fiduciary definition (when performed within a framework of established plan policies and procedures): applying rules to determine eligibility for participation or benefits; processing claims; calculating benefits; orienting new participants and advising participants of their rights and options under the plan;

preparing employee notices and government filings; and making recommendations to others for decisions about plan administration.

In many cases, third party administrators (“TPAs”) of ERISA plans (as well as individuals who are directors, officers, or employees of the plan sponsor) may escape fiduciary status by only performing ministerial functions within an established framework of policies and procedures. However, if an administrative function involves final authority to approve or deny benefits in cases where coverage is disputed over the interpretation of plan provisions, then a person performing that function will not be performing purely ministerial functions. Thus, a TPA that provides claims processing services will be a fiduciary if it has final discretionary authority over administering claims. Many TPAs attempt to avoid fiduciary status with respect to claims processing by including language in their service agreements stating that, although the TPA has the power to make claims decisions, final authority to approve or deny disputed claims remains with the plan sponsor.

What are ERISA’s Fiduciary Duties?

For those entities and individuals who are deemed to be fiduciaries with respect to an ERISA plan, it is important to understand the fiduciary duties that ERISA imposes, particularly since fiduciaries may be held personally liable for any breach of those duties, even if the breach was unintentional. The following are the main fiduciary duties imposed under ERISA:

- (1) The duty to act solely in the interests of plan participants and beneficiaries (aka, the “Duty of Loyalty”), and to use plan assets for the exclusive purpose of providing plan benefits, or for defraying the reasonable expenses of plan administration (aka, the “Exclusive Benefit Rule”);
- (2) The duty to act with the care, skill, prudence, and diligence that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims (aka, the “Prudent Expert Rule”);
- (3) The duty to diversify the investments of the plan; and
- (4) The duty to administer the plan in accordance with the plan documents.

Duty of Loyalty / Exclusive Benefit Rule. A fiduciary must act solely in the interests of plan participants and beneficiaries, which includes ensuring that plan assets are used solely for the benefit of those participants and beneficiaries, and/or solely to pay for the reasonable costs of plan administration. When plan assets are used to pay for administrative expenses, it is vital that the plan’s fiduciaries ensure that those administrative expenses are reasonable, which entails exercising regular oversight over a plan’s service providers, including the service agreements under which they operate, and over the plan’s operations in general. This may include ensuring that vendors provide any required fee disclosures and that the fiduciaries (either themselves or by retaining separate advisors to do so) regularly benchmark those fees against a cross-section of comparable fees charged by other vendors in the same market.

It is also vital that fiduciaries be able to recognize when funds represent plan assets versus non-plan assets and when decisions/actions they take represent administrative functions versus settlor functions. This is because, among other things, plan assets cannot be used to pay for expenses related to settlor functions. For

example, legal or other advisory fees incurred in connection with establishing a plan or making discretionary plan design changes are expenses related to settlor functions, for which should not be paid for with plan assets.

Prudent Expert Rule. A fiduciary also must act with the care, skill, prudence, and diligence of a prudent person acting in a similar situation and in a like capacity. For purposes of the Prudent Expert Rule, prudence is measured according to an objective standard, and a fiduciary's subjective intent or good faith do not matter, except to the extent such intent or good faith may be relevant to the comparison of the fiduciary's actions with what a hypothetical prudent expert would have done in a similar situation. In assessing a plan fiduciary's prudence in a particular situation, the DOL, court, or other reviewing entity will adjudge the prudence of how a fiduciary went about reaching a decision, as opposed to the result of the decision.

One of the key points to consider is whether fiduciaries are being prudent in their selection and monitoring of a plan's service providers. In many instances, selecting a plan's service providers is a fiduciary function. In addition, plan fiduciaries have an ongoing fiduciary duty to monitor the performance of the service providers that are selected. Given all of the new transparency reporting and disclosure requirements that have been implemented over the past few years, the duty to monitor service providers has become increasingly important, as newly available public information has led to a rise in fiduciary breach lawsuits. Although such lawsuits are typically based on the actions of TPAs, they often include claims against the plan sponsor as the primary named fiduciary and plan administrator (and potentially against other individuals who may have been acting as fiduciaries) with respect to the plan.

Takeaways

Fiduciaries who breach their fiduciary duties may be liable for legal and equitable remedies to participants and beneficiaries as well as civil penalties in lawsuits or enforcement actions brought by the DOL. Among the legal remedies, fiduciaries may be held personally liable for restoring any losses to the plan resulting from the breach and disgorging any profits made from a transaction resulting in a breach. A civil penalty may be assessed on fiduciaries for breaches of their fiduciary duties, which is equal to 20% of the amount that the plan recovers from the fiduciary as the result of a court order or settlement with the DOL.

It is generally recommended that plan sponsors obtain sufficient fiduciary liability insurance to help mitigate the impacts of the aforementioned liabilities with respect to any potential fiduciary breach actions and, as necessary, that plan sponsors ensure the appropriate individuals are added to such policies (or portions of such policies) as covered persons thereunder. Additionally, plan sponsors (and individual directors, officers, and employees who may be fiduciaries with respect to a plan) should carefully review plan documents and contracts to confirm how responsibilities may be allocated among fiduciaries and to determine whether any indemnification or limitation of liability provisions are present that may be legally enforceable. Beyond purchasing insurance and reviewing plan documents and contracts, however, it is

important that plan sponsors put in place appropriate policies and procedures establishing how fiduciary functions are to be allocated and what protocols are to be followed by fiduciaries on a regular basis. Fiduciaries are also advised to engage in periodic, formal fiduciary training.



STAY IN THE KNOW...

- On December 27, 2024, the US Department of Health and Human Services ("HHS") Office for Civil Rights ("OCR") proposed significant updates to the HIPAA Security Rule, marking the first changes since 2013 (the "Proposed Rule"). Among other changes, the Proposed Rule would require HIPAA-regulated entities to maintain a written technology asset inventory, obtain annual verifications from business associates on HIPAA safeguards, and elevate encryption and risk management implementation standards. While HHS maintains these updates will enhance security and mitigate breaches, the Proposed Rule is expected to face opposition under the incoming administration. HIPAA-regulated entities are advised to monitor developments and prepare to comply with additional requirements if the Proposed Rule proceeds.
- Last month, the Treasury Department, Department of Labor, and the Department of Health and Human Services (the "Departments") withdrew proposed regulations that would have addressed religious exemptions to certain contraceptive services required to be offered by health insurance plans. Current regulations include exemptions and optional accommodations for entities and individuals with religious objections or non-religious moral objections to coverage of contraceptive services. On February 2, 2023, the Departments proposed rules that sought to resolve ongoing litigation regarding religious objections to providing contraceptive coverage, by respecting the objecting entities' religious objections while also ensuring that women enrolled in plans or coverage offered by objecting entities had the ability obtain contraceptive services at no cost. On December 23, 2024, however, the proposed rule was withdrawn. The Departments stated that the withdrawal was to focus time and resources on other matters.
- Recent comments from incoming Trump Administration nominees and surrogates suggest that the new Trump Administration may introduce international reference-based pricing for certain drugs given its prior proposal of such pricing in the Medicare program during President Trump's first term.

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