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Employers are continually challenged to keep apprised of, and in compliance with, the myriad changes in employee benefit rules and regulations. In this issue of the *Employee Benefit Plan Review*, we cover a few of the important rules, and much more.

CORPORATE HEALTH AND WELLNESS

We begin with our feature article, “Health Care Reform Creates Opportunities for Corporate Health and Wellness Strategies,” by Joseph Berardo, Jr., of MagnaCare. The author explains the Patient Protection and Affordable Care Act’s new reimbursement models and behavior incentives for both patients and physicians—making wellness and prevention the default mechanism for cost control. Workforce health data will be the roadmap for companies developing effective, long term wellness strategies for healthier members, lower claims costs, and increased productivity. Therefore, the author believes that partnering with a health plan management partner that relies on powerful data analytics can make all the difference on a company’s bottom line and overall health and productivity.

POST-TERMINATION FORFEITURES

Rebecca E. Ivey and Rebecca Williams Shanlever of Troutman Sanders LLP, provide a snapshot of some state rules applicable to post-termination forfeitures of bonuses and commissions in their article, “Easy Come, Easy Go: State Rules on Post-Termination Forfeitures of Bonuses and Commissions.” The authors also suggest certain steps an employer can take to increase the likelihood that forfeiture provisions in its compensation plans will be enforced.

WAGE AND HOUR LITIGATION

State and federal wage and hour class actions have exploded over the last 10 or so years, becoming the largest and fastest growing area of employment litigation. Thomas M. Wilde, Jonathan A. Wexler, and Joseph K. Mulherin of Vedder Price P.C., in their article,

“Can Anything Be Done to Stop the Avalanche of Wage and Hour Litigation? A Few Class Action Avoidance Options,” advise employers not to sit idle, but rather proactively audit wage and hour practices and implement policies and procedures to prepare for and prevent wage and hour claims (including class actions) before those claims are filed.

SPECIAL REPORT ON THE CORPORATE EQUALITY INDEX

The Human Rights Campaign Foundation’s Corporate Equality Index (the Index) is a nationally recognized ranking of major employers throughout the United States on issues involving workplace equality for lesbian, gay, bisexual, and transgender (LGBT) individuals. This month’s Special Report, by Todd A. Solomon and Brian J. Tiemann of McDermott Will & Emery, describes the changes coming to the Index, and recommends that employers wanting to achieve or retain high rankings on the 2012 Index take action now to ensure that their employee benefit plans and employment practices and policies are updated in accordance with the new criteria.

AND MORE...

As usual, we have much more, including an article by Nick Stonnington and Aaron Werner who explain recently proposed Department of Labor rules that will affect the manner by which participants receive investment advice. We also have another important “Regulatory Update” from Julie K. Stapel of Winston & Strawn LLP, who reports on provisions of the Patient Protection and Affordable Care Act of 2010 that may require the attention of health plan sponsors now and in the near term. Norman L. Tolle of Rivkin Radler LLP, in his “From the Courts” column, brings us timely and informative analysis of cases impacting the benefits arena today.

Enjoy the issue!

Steven A. Meyerowitz
Editor-in-Chief
July 2010

Questions may be directed to Employee Benefit Plan Review, 10 Crinkle Court, Northport, NY 11768, or via e-mail to smeyerow@optonline.net. Answers by the benefits experts at Spencer's Benefits Reports will be included in an upcoming issue.

CAN EMPLOYEES DROP DEPENDENT COVERAGE?

Q We understand that with the first renewal after September 23, 2010, under the new federal health reform legislation, employees in a group plan will be able to cover adult dependent children to age 26.

We have received inquiries from employers asking if employees must carry dependents to age 26. These employees, as we understand it, wish to terminate dependents who are currently on the plan and are still within the eligible age for the coverage and also meet all other eligibility requirements. Please advise us if the employee's privilege to add or terminate dependents at will (within the eligibility requirements) is still in effect under the federal legislation.

A Yes. While the employer plan is required to provide coverage up to age 26, there is no existing rule that requires employees to elect that coverage for dependents. Whether employees can drop coverage for a specific dependent will depend on how the plan eligibility is written. For example, if a plan offers employee, employee plus one, and family coverage, an employee with a spouse and one older child could elect employee plus one; an employee in the same plan with a spouse and two children would get no advantage from dropping one child.

Note, however, that under the health reform legislation, in 2014 there will be a fee imposed on individuals who fail to cover their dependents.

SECTION 125 REIMBURSEMENTS FOR OVER-THE-COUNTER MEDICINE

Q Do you have any information on what over-the-counter items are still going to be covered under a Section 125 cafeteria plan after health reform takes effect?

A The Patient Protection and Affordable Care Act restricts reimbursement for medicines under a Section 125 plan beginning in 2011.

Specifically, expenses incurred in tax years beginning after December 31, 2010, the cost of all over-the-counter medicines may not be reimbursed through a Section 125 plan. Reimbursement is allowed under a Section 125 plan only if the medicine or drug is

a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

SPOUSAL RIGHTS TO CONTINUE COBRA

Q An employee terminates employment and elects family COBRA continuation coverage for himself and his spouse. Several months later, the former employee decides to receive health care services through the Veteran's Administration and wants to drop coverage for himself. Our plan does not allow an active employee's spouse to be covered unless the employee is enrolled. If the former employee decides to terminate his COBRA coverage can his spouse continue coverage as a single participant by exercising her individual COBRA right for continuation?

A Yes, the spouse is a qualified COBRA beneficiary, and she may elect to continue COBRA coverage independently from her husband.

REIMBURSEMENT FOR SPECIAL NEEDS SUMMER CAMP

Q We have an employee with a special needs child who will be attending a summer camp for special needs children. Can the employee put the cost of the camp through the dependent care flexible spending account (FSA), or can she pay for it through the medical spending piece of the FSA?

A Day camp expenses are excludable under a dependent care program, but overnight camp expenses are not. Whether or not the expenses can be paid for through a health care FSA depends on whether the camp meets the test for medical care in Internal Revenue Code (IRC) Section 213. Internal Revenue Service (IRS) Publication 502 notes the following:

Special Education

You can include in medical expenses fees you pay on a doctor's recommendation for a child's tutoring by a teacher who is specially trained and qualified to work with children who have learning disabilities caused by mental or physical impairments, including nervous system

■ Ask the Expert

disorders. You can include in medical expenses the cost (tuition, meals, and lodging) of attending a school that furnishes special education to help a child to overcome learning disabilities. A doctor must recommend that the child attend the school. Overcoming the learning disabilities must be a principal reason for attending the school, and any ordinary education received must be incidental to the special education provided. Special education includes:

- Teaching Braille to a visually impaired person,
- Teaching lip reading to a hearing-impaired person, or
- Giving remedial language training to correct a condition caused by a birth defect.

401(K) ROLLOVER

Q This question pertains to a rollover to our 401(k) plan. An employee's previous company went out of business, the entire 401(k) plan was terminated, and the company automatically rolled over these funds into a preapproved Safe Harbor IRA. Now our employee wants to rollover these funds into our 401(k) plan, but we need evidence that the money is coming from a Qualified Plan. This institution does not have a letter of Qualification/Determination from the previous 401(k) plan, because they are simply "holding" these funds. Is there anything else that can support that these funds came from a Qualified Plan? Also, do the rules state that a plan needs a Letter of Determination/Qualification for a 401(k) plan rollover? Or is that a plan level requirement?

A The plan administrator of the receiving plan has to seek assurances that the other plan is or was qualified. This may be a letter of explanation from the administrator of the prior plan. An actual

determination letter is not required. It may be sufficient to get such a letter from the administrator of the Safe Harbor IRA because presumably the Safe Harbor IRA received some kind of qualification notice before it accepted the money from the original plan. The important thing is for the plan administrator of the recipient plan to have documentation that they sought assurances that the prior plan was qualified.

Internal Revenue Code Regulation Section 1.401(a)(31)-1, A-14 notes that if the receiving plan later discovers that the distribution came from a nonqualified plan, the recipient plan is not disqualified if it took the money in good faith and, upon discovery that it was not from a qualified plan, backed out of the transaction.

HEALTH PLAN NONDISCRIMINATION RULES

Q An employer has four physical locations in Michigan and three physical locations in Texas. The employer provides employees at the three physical locations in Michigan with a HMO plan option with high benefits and low contributions. The employer provides employees at the other physical location in Michigan with a PPO plan option with higher out of pocket exposure and higher contributions. The employer provides employees at the three physical locations in Texas with a PPO plan option with higher out of pocket exposure but lower contributions. Is this considered discriminatory?

A Probably not, but the explanation is a bit complicated:

- Fully insured plans: Until health reform passed, there were no federal discrimination rules for insured plans. Under the health reform law, new plans (established on or after March 23, 2010) will be subject to the non-discrimination rules of self-insured plans (see below).
- Self-funded plans and new insured plans:

These plans must follow the non-discrimination rules of Internal Revenue Code Section 105(h). The eligibility rules in 105(h) allow plans to be established for a "reasonable classification" of employees, and geographic location is typically considered a reasonable classification.

MEDICARE PART B PREMIUM

Q I know that Medicare Part B increased for 2010. If you are 68 and have had qualified group coverage, what rate must you pay if you go on Medicare: the rate it currently is in 2010 or the rate from when you turned 65? Also, if you were paying the \$96.50 last year for Part B, do you have to pay the increased Part B premium for 2010 or are you grandfathered in at the lower rate?

A The Medicare Part B premiums and deductibles generally rise every year (there is no grandfathering) and every person enrolled in Medicare pays the same rate in that year. A person who retires in 2010 at age 68 and enrolls in Medicare Part B after her employer provided group health coverage ends pays the same Part B premium as all other Medicare enrollees with the same coverage during 2010. There are exceptions to this: Medicare beneficiaries with income above a certain level pay a higher premium. In addition, individuals who delay for one or more years beyond age 65 enrolling in Part B and who have not had coverage through an employer sponsored group health plan, pay a premium penalty for each year they delay enrollment.

IMPLEMENTING NEW RETIREE HEALTH PLAN

Q May an employer properly institute a retiree program now (or in the near future) and be eligible for the new retiree reinsurance program under health reform? In other words, may an employer start a retiree program after the June 2010 effective date of the retiree reinsurance program and be eligible for the program?

A Yes, an employer may implement a group health plan for early retirees after the June 2010 effective date of the early retiree reinsurance provision in the Patient Protection and Affordable Care Act. However, note that in order to qualify for the early retiree medical program, an “employer-based plan” must meet other requirements, including having programs and procedures in place to generate savings for covered individuals with chronic and high cost medical conditions. The reinsurance program will reimburse plans for certain claims between \$15,000 and \$90,000 for a covered individual. And the reinsurance program will end when the program has paid out its \$5 billion allocation (no later than January 1, 2014).

EMPLOYER FEES FOR HEALTH RESEARCH

Q I have read that under the health reform law, for plan years ending after September 30, 2012, a tax of \$2 times the average number of lives covered will be applied to insured and self-insured group health plans. (This amount will decrease to \$1 times the average number of lives covered for plan years ending in 2013.) My question is how will this apply to employers with self-funded plans?

A You are referring to a provision in the Patient Protection and Affordable Care Act under which fees will be charged in the form of a tax to pay for the new Patient-Centered Outcomes Research Trust Fund (Section 1181 of the Social Security Act).

Below is how the Committee Report to the health reform law explains the fees, including those for self-insured plans. Note that “average

number of lives” is not defined in the law and presumably will have to be addressed in regulations.

In the case of an applicable self-insured health plan, new [Internal Revenue] Code section 4376 imposes a fee equal to two dollars (one dollar in the case of policy years ending during fiscal year 2013) multiplied by the average number of lives covered under the plan. For any policy year beginning after September 30, 2014, the dollar amount is equal to the sum of: (1) the dollar amount for policy years ending in the preceding fiscal year, plus (2) an amount equal to the product of (A) the dollar amount for policy years ending in the preceding fiscal year, multiplied by (B) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year. The plan sponsor is liable for payment of the fee. For purposes of the provision, the plan sponsor is: the employer in the case of a plan established or maintained by a single employer or the employee organization in the case of a plan established or maintained by an employee organization. In the case of: (1) a plan established or maintained by two or more employers or jointly by one of more employers and one or more employee organizations, (2) a multiple employer welfare arrangement, or

(3) a voluntary employees’ beneficiary association described in Code section 501(c)(9) (“VEBA”), the plan sponsor is the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan. In the case of a rural electric cooperative or a rural telephone cooperative, the plan sponsor is the cooperative or association.

Under the provision, an applicable self-insured health plan is any plan providing accident or health coverage if any portion of such coverage is provided other than through an insurance policy and such plan is established or maintained: (1) by one or more employers for the benefit of their employees or former employees, (2) by one or more employee organizations for the benefit of their members or former members, (3) jointly by one or more employers and one or more employee organizations for the benefit of employees or former employees, (4) by a VEBA, (5) by any organization described in section 501(c)(6) of the Code, or (6) in the case of a plan not previously described, by a multiple employer welfare arrangement (as defined in section 3(40) of ERISA, a rural electric cooperative (as defined in section 3(40)(B)(iv) of ERISA)), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of ERISA). ❁

Health Care Reform Creates Opportunities for Corporate Health and Wellness Strategies

JOSEPH BERARDO, JR.

It is time to cut costs, improve productivity, and lower claim costs. The health care reform act gives small companies an opportunity to create wellness and prevention programs as part of cost cutting initiatives, but they must also put efforts into controlling chronic illness and adopting data analytics technology to ensure long term success.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

While the Patient Protection and Affordable Care Act (PPACA) failed to directly address health care costs, it did provide new reimbursement models and behavior incentives for both patients and physicians—making wellness and prevention the default mechanism for cost control. This is potentially good news because, according to the California Healthcare Foundation, roughly half the conditions treated in the American health care system are avoidable. But it also means that effective alternatives for controlling chronic illnesses have become that much more critical—as is continued investment in technology.

The PPACA's Prevention and Public Health Fund expands and sustains funding for prevention and public health programs. For small employers, it will:

- Provide grants for up to five years to help them establish wellness programs;
- Provide technical assistance and other resources to evaluate employer-based wellness programs; and
- Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost sharing requirements, or benefits that would otherwise not be provided—of up to 30 percent of the cost of coverage for participating in a wellness program and meeting certain health related standards.

This grant program supports the delivery of evidence-based and community-based prevention and wellness services aimed at

strengthening prevention activities, reducing chronic disease rates, and addressing health disparities.

This will trigger companies to adopt wellness and prevention programs as part of their cost cutting initiatives; but to improve individual health and financial sustainability, companies must also focus on controlling chronic illness and adopting health information technology that generates important data for tracking individual health costs and prompting appropriate interventions or behavioral changes.

CONFRONTING CHRONIC ILLNESS

The key to creating an environment of better health management for more people lies in creating incentives. For example, consider these two patients with diabetes. The first one manages his diabetes well. He gets his hemoglobin A1c levels tested; he exercises; he watches what he eats. As a result, his monthly costs are roughly \$147 for the plan. The second diabetic patient is a different story. He does not watch his diet, exercise, or take any other steps to manage his illness. He has had admissions to the hospital and other co-morbidities as a result. His price tag is closer to \$1,800 a month.

Two people with the same disease exhibit different behaviors, and it results in a huge cost differential. Health care administrators need to find the tools and the resources and the ability to work with the plan sponsors and employers to reach out to individuals with poor health management.

TECHNOLOGY

The second part of the equation is technology. A strong technological infrastructure provides health data that is easy for plan sponsors to assess. Real change depends on useful, actionable information. This information must also be shared across stakeholders in order to incent behavior change and help members make better choices, from a quality perspective as well as a cost perspective.

As a powerful tool, data analytics gives employers a comprehensive set of utilization

data to support decisions related to streamlining inefficiencies and designing strategies to improve population health, both overall and on a personal level.

Take for example an employee with diabetes who is noncompliant with taking prescribed medications and not adhering to the standards of care, such as making good lifestyle choices (diet and exercise) for maintaining low HgA1c results. Inevitably, other co-morbidities will surface. Cardiac, circulatory, and vascular problems, in particular, can emerge and ultimately lead to catastrophic costs. But this is not the only type of cost at stake: When health is compromised, employees become less productive, both personally and professionally.

DATA ANALYTICS: TECHNOLOGY IMPROVING PERSONAL HEALTH

A physician's ability to closely monitor a patient, including an individual's progress over time, can improve an individual's care and the overall health of a population. With the right data, health managers can proactively address significant medical issues, determine gaps in care, and intervene when necessary by, for example, prescribing appropriate medication, recommending a diet, or outlining an exercise program.

Pairing the latest, most powerful data analytics technology with health management programs will help self-insured companies achieve fiscal sustainability over the long run. Health

information can be quickly sifted and sorted by age, medical, conditions, chronic illnesses, risk factors, lab results, and drug interactions. On a large scale, this allows employers to take action and provide optimal prevention and wellness programs.

The point of data analytics—and health management based on data analytics—is to ensure that every communication about employee health is personal, relevant, and effective. Success often stems from finding the right partner that can provide the best health plan management along with the best possible data analytics—one that provides comprehensive data, a complete analysis of the data, and potential individual and organizational solutions.

The ability to personalize medical care allows patients and physicians alike to make better health care decisions and tailor preventive, wellness, and treatment methods. Data analytics also provides decision support tools, remote monitoring tools, and real-time care when it is needed, based upon the idea that effective care continues even after the patient leaves the doctor's office.

As workforce health begins to improve, companies will be able to use data analytics to reassess individuals and the key health issues of the company, be it diabetes, obesity, or chronic heart conditions. Company-wide performance can be reported on a monthly or quarterly basis for optimal effectiveness. New at-risk employees can also be identified and

monitored. Ideally, employees previously enrolled should be reclassified into lower risk categories as their health improves. In this way, the severity of at-risk health categories and health care costs diminishes overtime.

CONCLUSION

Given the increased economic pressures and the provisions laid down by PPACA, companies are more motivated than ever to implement wellness and prevention programs for their workforce. Partnering with a health plan management partner that relies on powerful data analytics can make all the difference on a company's bottom line and overall health and productivity.

It is about making an investment in workforce health and wellness, and not simply focusing on the cost of health care. Workforce health data that can be consistently refreshed and reanalyzed—combined with predictive modeling—gives companies the ability to identify health issues and cost drivers. It is the roadmap for developing an effective, long term wellness strategy for healthier members, lower claims costs, and increased productivity. 🌟

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Easy Come, Easy Go: State Rules on Post-Termination Forfeitures of Bonuses and Commissions

REBECCA E. IVEY AND REBECCA WILLIAMS SHANLEVER

Many employers have a compensation plan in which an employee may qualify for commissions or a bonus as of December 31 to be paid in the following year. These plans often provide that if the employee is no longer employed by the date on which the bonus is scheduled to be paid, the bonus is not earned, and consequently the employer need not pay it. Are there any problems with this?

The answer is: yes and no. In many states, an employer may legally require an employee to forfeit a bonus or commission if the employee is no longer employed on the date the bonus or commission is to be paid. In other states, these types of forfeiture provisions are expressly prohibited. Whether a forfeiture provision is legally permissible will vary based upon many factors, including:

- The state in which the employee is employed;
- Whether the compensation being forfeited is a commission (based on sales made) or a bonus (based upon company or individual performance);
- How and when the commission or bonus is calculated, earned, and paid; and
- When, why, and how the employee's employment terminates.

This article addresses just some of these factors, but not all state laws regarding bonus or commission forfeiture provisions. Because the rules vary widely from state to state, one-size-fits-all plans may not be enforceable everywhere an employer has employees. Employers should consult with counsel to confirm that a specific forfeiture provision is lawful in a particular state. Below is a snapshot of some state rules applicable to post-termination forfeitures of bonuses and commissions.

GEORGIA

Generally, absent a contract that provides otherwise, at-will employees in Georgia are

entitled to bonuses and commissions "earned" while they were employed. Forfeiture provisions are disfavored in Georgia, but they are not unlawful. Where a bonus or commission plan in unmistakable terms provides that the compensation will not be paid if the employee is no longer employed on a certain date (and has no other legal problems), Georgia courts will uphold the forfeiture provision. Georgia law does not distinguish between bonuses and commissions in the forfeiture context, and have enforced forfeiture of both.

Forfeiture provisions must be carefully worded, because any confusion in the language will be resolved in favor of paying the bonus or commission. Employers also should be careful to comply with all other terms in the bonus or commission plan. A carefully worded forfeiture provision that is clear and unmistakable in its terms is likely to be enforceable in Georgia.

VIRGINIA

In Virginia, courts treat forfeiture provisions in much the same way as they are treated in Georgia: They are disfavored but not unlawful. Virginia treats a provision stating that an employee must be employed when the bonus or commission is to be paid as a requirement for vesting of the bonus or commission and generally essential to the right to compensation. Virginia, like Georgia, requires clear, unambiguous language setting forth the terms of the compensation plan.

NEW YORK

New York courts treat bonuses, incentive plans, and commissions differently in the forfeiture context. Bonuses or incentive payments may be forfeited under the terms of the compensation plan, but commissions are considered earned wages, which cannot be forfeited. Thus, the key determination is whether the compensation to be forfeited is properly characterized as a bonus, incentive payment, or commission.

Under New York law, earned wages—which are defined to include commissions—are not subject to forfeiture. Bonuses, however, may be forfeited because they are paid at the discretion of the employer. New York law states that an employee's entitlement to a bonus is governed by the terms of the employer's bonus plan, and courts in New York have regularly upheld forfeiture where employees left or were discharged from their jobs before a bonus became payable under the employer's bonus plan. Similarly, compensation owed under incentive compensation plans may be forfeited. Compensation is part of an incentive compensation plan where it is supplemental income based on the employee's individual achievement as well as overall business performance or other factors outside of the employee's control.

Whether a particular type of compensation is an earned commission or a forfeitable bonus or incentive compensation turns on various factors. A bonus or incentive compensation must supplement the employee's base salary. If the compensation plan has ambiguous or contradictory language, or there is conflicting evidence as to the nature of the payments, a question of fact may arise regarding whether the compensation is a bonus or a commission, potentially rendering the forfeiture clause unenforceable.

CALIFORNIA

California also draws a critical distinction between a bonus and a commission, and different rules apply depending on the nature of the payment. Forfeiture of a bonus generally is permissible where the employee resigns or is terminated with good cause. Where an employer terminates an employee without good cause, however, forfeiture is unlawful, and the employer must pay the bonus. The forfeiture clause should carefully define what grounds will constitute good cause, such as poor performance or misconduct. Commissions are seen as earned, vested wages and generally may not be forfeited.

WHAT SHOULD EMPLOYERS DO?

There are certain steps an employer can take to increase the likelihood that forfeiture provisions in its compensation plans will be enforced:

- The language providing for forfeiture must be completely clear and unambiguous.
- The provision should state not only that the employee will not receive the compensation if he or she is not employed on a certain date, but also whether the employee will receive compensation if he or she resigns, is terminated for cause, or is terminated without good cause.
- For commission payments, the employer should state that the

commission is not earned or vested until certain specific conditions are met, including that the employer has received payment from the customer and that the employee must be employed on the date of payout (specifying what the date is).

- All employees should sign an acknowledgment that they have read the compensation plan and agree to its terms. Consider having employees initial the forfeiture provision.
- Where a compensation plan includes both bonuses and commissions, distinguish between the bonus portion of the compensation and the commission portion of the compensation, with different forfeiture rules for each.

Taking the steps listed above will increase the likelihood that post-termination forfeiture provisions will be enforced, but even with these precautions, some states will not permit the forfeiture of earned commissions. As an employer grows and expands its ranks to new states, it is crucial to review compensation plans with counsel for compliance. 🌐

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Can Anything Be Done to Stop the Avalanche of Wage and Hour Litigation?

A Few Class Action Avoidance Options

THOMAS M. WILDE, JONATHAN A. WEXLER, AND JOSEPH K. MULHERIN

It is no secret that state and federal wage and hour class actions have exploded over the last 10 or so years, becoming the largest and fastest growing area of employment litigation. Unfortunately, the plaintiffs' bar is showing no signs of letting up as plaintiffs continue to garner multimillion dollar settlements and jury awards. In 2009, the top 10 private wage and hour settlements under the Fair Labor Standards Act totaled \$363.6 million, a 44 percent increase from 2008.

Wage and hour lawsuits can challenge a variety of policies and practices including the classification of employees as exempt, meal and rest breaks, off-the-clock work such as donning and doffing and travel time, expense reimbursements, and tip pools. With the increased focus by plaintiffs' attorneys on these claims, odds are that most employers have been or will be drawn into some type of wage and hour litigation or dispute. Smart employers are not sitting idle. Rather, they are proactively auditing wage and hour practices and implementing policies and procedures to prepare for and prevent wage and hour claims (including class actions) before those claims are filed.

WHAT CAN EMPLOYERS DO TO COMBAT THIS EPIDEMIC?

Wage and Hour Compliance Initiative

The most effective way to avoid wage and hour lawsuits is to enact and enforce policies that comply with state and federal wage and hour law. This sounds simple enough. Nevertheless, employers should strive to reach a level of compliance with state and federal law that reduces the likelihood of litigation. At a minimum, it is recommended that employers undertake the following preventive measures:

Ensure compliance with state and federal law: Employers should, with the help of

counsel, periodically examine their policies and practices, including, but not limited to:

- Whether employees are correctly classified as exempt or nonexempt for minimum wage and overtime purposes;
- Whether the employer has adopted a valid "safe harbor" policy to prevent improper deductions from ruining a perfectly good exemption;
- Whether nonexempt employees are being paid for all compensable work time, including time spent working at home, traveling, training, on-call, waiting, etc.;
- Whether overtime for nonexempt employees is being calculated correctly, including whether bonuses and commissions are being included in the employees' regular rate of pay;
- Whether the employer is in compliance with all applicable state and federal meal and rest break laws;
- Whether the employer is in compliance with all applicable state wage payment statutes regarding the payment of earned vacation and wages at termination, and whether wages are being improperly withheld from employees' paychecks; and
- Whether the employer has properly classified individuals as independent contractors.

Audit and update record keeping practices: The successful defense of any class action wage and hour lawsuit is contingent on accurate and detailed record keeping. An audit of an employer's record keeping practices is necessary to ensure that records are being maintained correctly and for the appropriate period of time.

Provide wage and hour training for human resources, supervisors, and employees: Supervisors in particular should be trained regularly on employer wage and hour policies. Many wage and hour lawsuits arise after supervisors interpret and apply employer policies in an individualized and inconsistent manner.

Implement an effective “open door” wage and hour complaint reporting system: Frequently, the most cost effective way to resolve wage and hour issues is to address the employee’s concerns directly. Employers should consider implementing a complaint reporting system that invites discussion about these issues and provides for a timely and fair resolution of employee concerns.

MANDATORY ARBITRATION

A more aggressive approach to avoiding class action litigation is to implement a mandatory arbitration system, under which all employees are required to sign an arbitration agreement that explicitly waives their right to bring or participate in any collective or class action. Under such programs, any wage and hour claims must be arbitrated as individual claims in arbitration instead of court, where individual actions can morph into class actions. Arbitration can also provide other benefits such as:

- Maintaining confidentiality of the proceedings, thus shielding the company from bad publicity;
- Providing input into which arbitrators will resolve the dispute;
- Eliminating sympathetic juries and unsupported damage awards;
- Reducing litigation costs;
- Assuring that disputes are resolved using a nationally uniform set of procedures; and

- Providing savings on cost of appeals.

Mandatory arbitration programs are not advisable for all employers. Mandatory arbitration programs can be costly and time consuming to design. Such programs may not make sense for a small organization where class action litigation is unlikely due to the number of employees and the disparate responsibilities of those employees. In contrast, mandatory arbitration programs may be worth serious consideration by large employers that are more often targeted with class action litigation.

Also, the extent to which an employer may enforce a mandatory arbitration provision and compel arbitration depends on the jurisdiction. For example, federal district courts in the Southern District of New York and Connecticut recently affirmed arbitration provisions where wage and hour class litigation was precluded. However, some state legislatures and courts, including the California Supreme Court, have found arbitration clauses that preclude the right of employees to participate in any collective or class actions to be unconscionable and therefore unenforceable. So, consideration must be given to whether an employer may implement a mandatory arbitration system companywide or whether certain locations must be excluded. Employers must also

determine whether certain types of claims must be excluded from the mandatory arbitration provision due to statutory provisions or case law. In light of this, counsel must be involved in designing and implementing a mandatory arbitration program.

Complicating matters further, a bill, the Arbitration Fairness Act, has been reintroduced in Congress that would bar all mandatory arbitration provisions that require employees to arbitrate employment related claims. Congress recently passed legislation known as the “Franken Amendment” (after Minnesota Senator Al Franken) that bars defense contractors with government contracts exceeding \$1 million from implementing new or enforcing current mandatory arbitration agreements for employees or independent contractors. This was a significant win for the plaintiffs’ bar, which has long sought to ban mandatory arbitration provisions. 🌟

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Toward Conflict-Free Advice

NICK STONNINGTON AND AARON WERNER

The Department of Labor (DOL) recently proposed new rules that will affect the manner by which participants receive investment advice. The purpose of these rules is to clarify how advisors can remain exempt from the prohibited transaction rule, which prevents them from giving investment advice that unfairly benefits him/her (or an affiliate) financially. The rules will outline specific steps potentially conflicted advisors can follow that will contain safeguards against providing conflicted advice. The result will be that the advice arrangement is exempted from ERISA's prohibited transaction rule.¹ This article will discuss how the DOL proposes to define these steps, how plan sponsors will be affected, and why this definition may give a competitive advantage to registered investment advisors (RIAs) over potentially conflicted stockbrokers.

WHERE IS THE CONFLICT, WHAT IS THE EXEMPTION, AND HOW DOES IT RELATE TO ME AS A PLAN SPONSOR?

If a broker, in rendering investment advice to a plan and/or plan participants receives additional fees or higher commissions from recommending certain investments over others, the broker is engaging in a prohibited transaction unless an exemption applies. An example of this would be if a broker benefits financially from recommending a mutual fund that is owned by the broker-dealer, as the management fees charged by proprietary investments will provide additional compensation to the firm. Another example would be if a broker recommends an investment or provider that has higher commissions and/or 12b-1 fees that are paid to the broker and/or his/her firm. A broker in this situation is not always conflicted, however, but could be at risk of giving potentially conflicted advice to a plan participant simply because there are a number of ways brokers choose to be compensated. There are some brokers who choose to be compensated on a level fee based on asset size, but there are also many who choose commission-based compensation where there is a potential for conflict. Hence the term "potentially

conflicted" broker. On the other hand, a traditional, stand alone RIA typically is compensated on a pure level fee, which is explained in more detail below.

In discussing the exemption to the prohibited transaction rule, it should be stated at the outset that an advisor can avoid being subject to the new DOL rules and the prohibited transaction rule itself if his/her fee (and any compensation received by affiliates, or other parties in which the advisor has an interest) is a "pure" level fee, meaning it does not vary based on the advice given to the plan sponsor and/or participants. An advisor who charges a pure level fee has the easiest time complying with the new rules proposed by the DOL because he/she can avoid them entirely; and the DOL has expressly stated that plan sponsors who prudently select and monitor an unconflicted advice provider will be afforded the same protections as that offered to those operating under the exemption—the plan sponsor will have no liability for the advice provided and, thus, no responsibility for investment related losses in those accounts that are being advised.² This fact should be very appealing to plan sponsors, as they can avoid the time and expense associated with verifying the potentially conflicted advisor's compliance with the exemption.

The problem, however, is that many plan sponsors do not know if their advisor is charging a pure level fee or whether they are somehow being compensated beyond the terms of his/her fee agreement. As a result of this confusion, plan sponsors often throw their hands up in the air and decide not to offer investment advice to participants at all because they are afraid they might one day be liable for an advisor's poor or conflicted advice. This fear by plan sponsors has led to less investment advice being offered to plan participants—even after the issuance of the Pension Protection Act of 2006 (PPA)—a goal of which was to increase access to professional investment advice. At the same time, most studies show that participants benefit significantly from receiving ongoing, individualized investment advice.

The drafters of the PPA wisely predicted concerns over liability on the part of plan

sponsors hiring potentially conflicted advisors, so they wrote statutory exemptions into the law that would provide plan sponsors with express relief for certain kinds of investment advice from potentially conflicted advisors. These exemptions are what the DOL is now proposing to implement through its new regulation. The DOL is hoping these clarifications will encourage plan sponsors to offer investment advice in their plans and, in doing so, help them understand why the advice arrangement can mitigate their risk for investment related losses in participant accounts.

For an advisor to qualify for the statutory exemption (i.e., offer potentially conflicted advice and be exempt from the prohibited transaction rules), he or she must adhere to one of the following:

- “Limited” Level Fee Exemption—Ensure that any fees received (by the individual advisor and the adviser’s firm) in connection with the provision of investment advice will not vary based on any investment options recommended by the adviser and selected by the participant; or
- Computer Model Exemption—Utilize an objective computer model that is independently certified not to inappropriately favor investment options offered by the fiduciary advisor or those that generate greater income for the fiduciary advisor or its affiliates.

The “limited” level fee exemption is similar to the “pure” level fee discussed earlier. In the “limited” instance above however, the level fee requirement does not extend to affiliates of the advisor as it does in the “pure” instance. If the level fee did extend to affiliates, the exemption would not be necessary at all because the advice would not constitute a prohibited transaction (i.e., conflicted advice). From this, one can see why a “pure” level fee

advisor (i.e., nonconflicted advisor) may be preferable to plan sponsors, as engaging a conflict-free advisor avoids the compliance costs associated with the exemption (i.e., annual audits, additional participant disclosures, etc.). In addition, it should be noted that broker-dealers will be less likely to allow their brokers to operate under this exemption option since the broker-dealer itself is likely going to have a difficult time complying with the “limited” level fee rules, as the requirements are very complex and difficult to institute operationally in a product and/or commission-based environment.

The computer model exemption does not affect the fee charged by the advisor. Instead, conflict is avoided by using a third party software program that cannot subjectively favor one fund over another because it generates greater income for an advisor. The system must be certified annually by an independent expert and the arrangement must be audited for compliance with the terms of the exemption.

Perhaps what is most important is that regardless of the type of statutory exemption chosen, it is required that the potentially conflicted broker acknowledge in writing that he/she is acting as a fiduciary and he/she must provide details of fees and compensation, affiliates (and their compensation), and services to be rendered. Additionally, the broker must be willing to submit to an annual audit that evaluates the conditions present for the exemption as well as policies and procedures. Again, due to concerns about prohibited transactions and the challenges associated with “levelizing” compensation across the firm, most broker-dealers will not permit their brokers to acknowledge fiduciary status under ERISA.

WHY THE RIA HAS AN ADVANTAGE

Considering the new regulation being proposed by the DOL, the

easiest scenario for a plan sponsor in the future will likely be one in which they do not have to worry about these exemptions at all and can simply work with an advisor who charges a pure level fee. Since most independent RIAs already do this, the prohibited transaction risk and the complicated DOL exemptions would not apply to them and their appeal would increase to the plan sponsor community, a community that craves clarity and the avoidance of “one more hassle.”

If the terms and conditions of the exemptions are clearly communicated to plan sponsors, many will see that, practically, it will be easier to receive advice from conflict-free RIAs and not potentially conflicted brokers who plan sponsors must not only take time to vet but must also make sure they follow the exemption rules.

Participants deserve conflict-free advice and plan sponsors deserve an easier way to manage their plans. Regulatory constraints promote this idea, as does the RIA model. This is why, under the DOL’s current proposal, the role of fiduciary advisor would be best filled by an RIA.

NEW CHOICES, NEW CHALLENGES

The DOL’s new rules highlight plan sponsors’ options on how they wish to provide participants with access to individualized investment advice. The DOL has made clear that a plan sponsor, which prudently selects and periodically monitors an advice provider, will not be liable for the advice rendered. In other words, plan sponsors can substantially lessen potential exposure for investment-related losses in participants’ accounts by engaging a fiduciary advisor. The easiest way for plan sponsors to ensure compliance with ERISA’s prohibited transaction rules is to engage an RIA that does not receive additional compensation and is, therefore, a “pure” level fee advisor. 🌐

■ Focus On...

NOTES

1. The exemption provides relief from the prohibited transaction rules set forth at Section 406(b) of ERISA. Similar relief is offered with respect to advice provided IRA account holders and beneficiaries, under Section 4975 of the Internal Revenue Code, but the IRA exemption is beyond the scope of this article.

2. *See, e.g.*, DOL Field Assistance Bulletin 2007-1.

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Although Plaintiff Prevailed in ERISA Action Seeking Disability Benefits, She Is Denied Attorney's Fees

The plaintiff in this case brought a lawsuit under ERISA against Liberty Life Assurance Company of Boston after the insurer denied her claim for partial disability benefits. The parties filed motions for summary judgment and the district court remanded the matter to the insurer for further administrative review of the plaintiff's claim. The district court instructed the insurer to consider evidence that the plaintiff had submitted with her summary judgment motion but that had not been included in the administrative record. The insurer again denied the plaintiff's claim, and both parties thereafter submitted supplements to their existing motions for summary judgment.

The district court granted summary judgment to the plaintiff after concluding that the insurer had abused its discretion by failing to evaluate the plaintiff's medical records "in their totality." The insurer appealed to the U.S. Court of Appeals for the Eighth Circuit, challenging both the merits of the district court's judgment and its decision to remand the case for further administrative review. The Eighth Circuit affirmed.

The plaintiff subsequently moved for attorney's fees and costs under an ERISA provision that provides that a district court may in its discretion "allow a reasonable attorney's fee and costs of action to either party." In deciding whether to award attorney's fees, the district court considered the following factors:

1. The degree of the opposing parties' culpability or bad faith;
2. The ability of the opposing parties to pay attorney's fees;
3. Whether an award of attorney's fees could deter other persons acting under similar circumstances;
4. Whether the parties requesting attorney's fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and
5. The relative merits of the parties' positions.

The district court determined that only one of the factors clearly weighed in favor of an attorney's fee award and that was the insurer's ability to pay. Moreover, the district court further concluded that although the final factor—the relative merits of the parties' positions—tipped slightly in favor of an award, the remaining factors weighed against one. The district court denied the plaintiff's motion, and she appealed to the Eighth Circuit, asserting that the district court had erred in its assessment of the relevant factors in its decision on her motion for attorney's fees and costs.

In its ruling on appeal, the Eighth Circuit explained that an appellate court should not overturn a district court's determination regarding an attorney's fee award absent an abuse of discretion. An abuse of discretion occurs "when the district court commits a clear error of judgment in weighing the relevant factors."

The appellate court noted that the plaintiff first contended that the district court erred in finding a lack of culpability or bad faith on the insurer's part. She asserted that the insurer's culpability was evident from the district court's conclusion that the administrator had abused its discretion by conducting a cursory review of her claim for benefits. The Eighth Circuit noted, however, that the district court had disagreed with that contention, reasoning that, even though the plaintiff had ultimately prevailed on her claim, the insurer's decision to deny benefits did not amount to culpable conduct, because substantial evidence existed in the record to support the insurer's conclusion that the plaintiff was not disabled. The appellate court observed that a plan administrator's decision to deny benefits was not culpable conduct if it was supported by substantial evidence, as it was in this case.

The circuit court also explained that the plaintiff claimed on appeal that the district court had made a clear error of judgment with respect to whether a fee award in this case would have a significant deterrent effect. As the circuit court noted, the plaintiff argued that an award would deter the insurer and other

insurers from conducting cursory claim reviews. The district court had acknowledged the plaintiff's argument, but also considered the effect the denial of fees could have in discouraging unnecessarily prolonged ERISA litigation. The district court determined that the deterrence factor weighed against a fee award, finding that plaintiff's counsel was seeking a "clearly excessive" amount of fees and had engaged in a "pattern of inflammatory and vitriolic arguments" and "did more to unreasonably multiply these proceedings than any litigating position Liberty Life took." Although the plaintiff placed blame on the insurer for the time and resources expended in this lawsuit, the Eighth Circuit found that the district court was in the best position to evaluate the relative roles of the parties in extending the litigation, and it gave "great deference to that decision."

Next, the plaintiff challenged the district court's finding on the fourth factor, common benefit to plan participants. She contended that her claim would in fact benefit all plan participants indirectly because it would motivate the insurer to conduct a more thorough evaluation of future claims for benefits. The Eighth Circuit explained, however, that the common benefit factor involved a "subjective element" in that a claimant must have "sought to benefit" all plan participants. The plaintiff did not contend that she "sought to benefit all participants and beneficiaries" by bringing her claim for benefits, according to the Eighth Circuit, and therefore it found that the district court had not abused its discretion by finding that this factor weighed against an attorney's fee award.

Finally, the plaintiff argued that the merits of the case were strongly on her side. The Eighth Circuit explained that although she ultimately prevailed, the insurer's position "nevertheless had merit." The appellate court concluded that the district court had not made a "clear

error of judgment" in weighing the relevant factors, and that the only factor the district court found to weigh clearly in favor of an award of attorney's fees was the insurer's ability to pay, which factor alone, the appellate court stated, did not justify an award where the other factors weighed against one. The Eighth Circuit then affirmed the district court order. [*Willcox v. Liberty Life Assurance Co. of Boston*, 2010 U.S. App. LEXIS 6248 (8th Cir. March 25, 2010).]

Court Rejects Claims by Plaintiff Who Was Terminated Before Company Executives Knew of Her FMLA Leave Request

In this case, the plaintiff, a sales associate selling homes in housing developments in Sarasota, Florida, for Pulte Home Corp., alleged that she fell and injured her foot in June 2007. The plaintiff did not initially request any Family and Medical Leave Act (FMLA) leave from work at Pulte as a result of this injury. In July, the plaintiff received two written warnings from her supervisor and was placed on a 30 day performance improvement plan. On August 17, the plaintiff contacted a Pulte human resources representative and requested FMLA leave for the period of time during which she was scheduled to have surgery on her foot. The plaintiff was sent the relevant forms and also was provided with contact information so that she could file a claim for short term disability benefits. The plaintiff alleged that she attempted to have her supervisor sign her leave form on the same day, but the supervisor was in her office with her door shut, and the plaintiff was never able to ask for approval.

Also on August 17, the plaintiff met with a disgruntled customer who had complained to Pulte's chief executive officer about a situation with a home she was purchasing. After meeting with the plaintiff, the customer spoke and complained to Pulte's vice president of sales and marketing. That executive called Pulte's director of sales in Sarasota to discuss the situation. On August 18, a Saturday, the Sarasota director of sales decided to terminate the plaintiff. When the plaintiff reported to work on August 20, the director of sales informed her of that decision.

The plaintiff filed a complaint in federal district court claiming that her termination was an act of retaliation and interfered with her rights under the FMLA and under ERISA. The director of sales testified in his pretrial deposition that he had decided to terminate the plaintiff based on her failure to address the issues in her performance improvement plan, including lack of communication with customers and infractions regarding attitude and teamwork, and also based on the situation with the disgruntled customer, and that he had not been aware of any request by her for FMLA leave at the time he had made the decision. Pulte's vice president of sales and marketing testified that she had first become aware of the plaintiff's request for leave in an e-mail dated August 20, and that the decision to terminate the plaintiff had been made on August 18.

The district court granted Pulte's motion for summary judgment as to the plaintiff's FMLA retaliation and ERISA interference claims on the ground that there was no evidence in the record that management at Pulte had been aware of the plaintiff's FMLA leave request at the time the decision had been made to terminate her and as to the FMLA interference claim based on a finding that the plaintiff would have been terminated regardless of any request for FMLA leave.

The plaintiff appealed to the U.S. Court of Appeals for the Eleventh Circuit, arguing that the close temporal proximity between her termination and her requests for FMLA and short term disability benefits, and the circumstances of the termination, could prove that the termination and requested benefits were not wholly unrelated.

In its decision, the appellate court found that no evidence in the record rebutted the affirmative evidence offered by Pulte that both its director of sales and its vice president of sales and marketing had been unaware of the plaintiff's FMLA request at the time the decision was made to terminate her employment. The Eleventh Circuit also found that there was no evidence to support a finding that either executive had known of any application for short term benefits by the plaintiff at the time the decision was made to terminate her employment. Because the plaintiff failed to present sufficient evidence to create a genuine issue of fact as to a causal connection for her alleged FMLA retaliation and ERISA interference claims, Pulte was entitled to summary judgment on those claims, the appellate court ruled.

With respect to the plaintiff's FMLA interference claim, the appellate court explained that the right to commence FMLA leave was not absolute, and that an employee could be dismissed, preventing the employee from exercising the right to commence FMLA leave, without thereby violating the FMLA, if the employee would have been dismissed regardless of any request for FMLA leave. In this case, the appellate court ruled, the un rebutted evidence that the decision maker was not aware, at the time of the decision to terminate the plaintiff, of her request to commence FMLA leave established as a matter of law that her termination was for reasons other than her requested leave. Pulte, therefore, was entitled to summary judgment on the FMLA interference claim, the Eleventh Circuit concluded. [Krutzig v.

Pulte Home Corp., 2010 U.S. App. LEXIS 7029 (11th Cir. Apr. 5, 2010).]

Circuit Court Decides That ADA Can Obligate Employer to Accommodate Employee's Disability-Related Difficulties in Getting to Work, If Reasonable

The plaintiff in this case, a cashier at the Rite Aid store in Old Forge, Pennsylvania, was diagnosed with "retinal vein occlusion and glaucoma in her left eye," and eventually became blind in that eye. Although able to see out of her right eye and to perform her duties at work, the plaintiff informed her supervisor that her partial blindness made it dangerous and difficult for her to drive to work at night. The plaintiff claimed, and Rite Aid did not dispute, that public transportation was not an option for the plaintiff because bus service ended at 6 p.m. and there were no taxis. Nonetheless, the plaintiff alleged that her supervisor told her that she would not be assigned only to day shifts because it "wouldn't be fair" to the other workers.

The plaintiff's doctor sent the plaintiff's supervisor a note that recommended that the plaintiff "not drive at night," but her supervisor again informed the plaintiff that she was unwilling to assign the plaintiff to exclusively day shifts, and she continued to schedule the plaintiff for a mixture of day and night shifts. The plaintiff relied on her family to shuttle her to and from work for night shifts.

After the second conversation with her supervisor, the plaintiff discussed her desire to change to

day shifts with her union representative. He contacted the plaintiff's supervisor to discuss the matter, but then told the plaintiff that he "got nowhere" with her. The union representative then scheduled a meeting with the plaintiff and her supervisor, but the union representative failed to appear. The plaintiff then resigned, submitting her resignation in a handwritten note that gave two weeks' notice and that stated, "I feel I have not been given fair treatment. There has been prejudice against me. I have been picked on and lies have been told about me. No one deserves that kind of treatment." The plaintiff subsequently filed suit against Rite Aid under the Americans with Disabilities Act for failure to accommodate her partial blindness, for constructive discharge, and for retaliation.

After the parties moved for summary judgment, the district court granted Rite Aid's motion. It held that the plaintiff's vision problem qualified her as disabled under the ADA, and it reasoned that a reasonable juror could so conclude from her testimony that she had "substantial difficulties with depth perception," making it difficult for her to drive at night.

The district court held, however, that the plaintiff had not suffered any adverse employment action cognizable under the ADA. In particular, the district court granted Rite Aid summary judgment on the plaintiff's failure to accommodate claim, noting that the parties had agreed that the plaintiff "did not need an accommodation to perform her job once she arrived at work." In light of that agreement, the district court stated that the accommodations that the plaintiff sought "had nothing to do with the work environment or the manner and circumstances under which she performed her work," and thus Rite Aid had no duty to accommodate the plaintiff in her commute to work. In so holding, the district court concluded that "the ADA is designed to cover barriers to an employee's ability to work that exist inside the workplace, not difficulties over which the

employer has no control,” and that imputing a duty to accommodate the plaintiff was tantamount to “mak[ing] an employer responsible for how an employee gets to work, a situation which expands the employer’s responsibility beyond the ADA’s intention.”

The plaintiff appealed, arguing that the district court had erred in holding that Rite Aid had no duty to accommodate her shift request. The appellate court agreed with the plaintiff, finding that the reach of the ADA was not so limited. It held that under certain circumstances the ADA can obligate an employer to accommodate an employee’s disability-related difficulties in getting to work, if reasonable. One such circumstance was when the requested accommodation was a change to a workplace condition that was entirely within an employer’s control and that would allow the employee to get to work and perform the employee’s job, the appellate court declared. It then stated that a change in shifts “could be that kind of accommodation.”

Accordingly, the appellate court remanded the case to the district court for a jury to decide whether a shift change was a reasonable accommodation under the circumstances. [*Colwell v. Rite Aid Corp.*, 2010 U.S. App. LEXIS 7249 (3d Cir. Apr. 8, 2010).]

Comment: In a footnote, the appellate court expressly noted that it was not holding that Rite Aid was required to provide the shift change that plaintiff desired, but rather that it was for the jury to decide.

Time Former Employee Was On Leave Does Not Assist Her FMLA Claims

The defendant in this case, Pregis Innovative Packaging, Inc., fired the plaintiff because she had

received more than eight “points” for absenteeism during a 12 month period—a firing offense under Pregis’ “no-fault attendance policy.” The plaintiff argued, however, that she would not have received so many points had she not taken two absences in July 2006—and she contended that these absences were leaves to which the Family and Medical Leave Act entitled her.

The plaintiff brought suit and the district court granted the defendant’s motion for summary judgment. In affirming the district court’s decision, the U.S. Court of Appeals for the Seventh Circuit explained that the plaintiff was correct that Pregis could not lawfully penalize her for taking the two July 2006 leaves if she had been entitled to take them. However, the court continued, to be entitled to take leaves protected by the Act in July 2006, the plaintiff had to have been employed for at least 1,250 hours of service with Pregis during the previous 12 month period. The court pointed out that the plaintiff did not meet this test unless, as she argued, she was entitled to “toll” the 12 month period for the 56 days during that period in which she *was* on FMLA leave—that is, unless she was entitled to add, to the time she worked during those 12 months, the time she worked during the 56 days that preceded the 12 months.

The court ruled that she was not permitted to do that. As the court explained, tolling ordinarily adds time to the end of a limitations period, as in this example: Suppose a two year statute of limitations began to run on January 1, 2008, but was tolled for six months beginning on July 1, 2008, because the defendant had agreed to waive any defense based on the statute of limitations for that period while the parties tried to work out a settlement. In that example, the court stated, the statute of limitations would expire not on December 31, 2009, but on June 30, 2010.

As the court observed, the problem for the plaintiff in this case was that the 1,250 hour qualifying

minimum “must be satisfied before she can take any further FMLA leave.” That was why the plaintiff wanted to be credited with hours worked for a period before the 12 months that was equal to the FMLA leave she took during the 12 months that preceded the two July 2006 leaves that caused her to be fired. The court rejected that argument, finding “no hint in the statute or elsewhere that Congress envisaged and approved such a circumvention of the requirement that an applicant for FMLA leave have *worked* 1,250 hours in the preceding 12 months.”

The plaintiff also argued that Pregis had retaliated against her for taking FMLA leave. She reasoned that under Pregis’ policies, a “point” was removed 12 months after it was imposed, but if Pregis did not count time on leave, including FMLA leave, toward the 12 months, it would take someone such as the plaintiff, who had taken FMLA leave in the preceding 12 months, longer to have points removed than it would take an employee who had not taken such FMLA leave. The plaintiff relied for her argument on the provision of the FMLA that provides that taking FMLA leave “shall not result in the loss of any employment benefit accrued prior to the date on which the leave commenced.”

The court agreed that a removal of absenteeism points was an “employment benefit,” but found that the plaintiff had no claim under this section of the FMLA because the benefit accrued after the plaintiff’s leave commenced. As the court explained, if removal of absenteeism points was an employment benefit, it was one that accrued 12 months after an absence. Until then, the employee had no right to have an absenteeism point removed. An employee who worked for 11 months and was on leave the other month (for example, the employee began work on January 1 and was still employed on December 31, but was on leave during the month of July) could not add the month that the

employee was on leave to obtain a benefit available to an employee who worked for 12 months rather than 11, because the employee was not entitled to “the accrual of any . . . employment benefits during any period of leave.”

The court explained that an employee must not be penalized by being deprived, just by being on family leave, of a benefit that the employee had earned (i.e., that had accrued to the employee) by working. But, by the same token, the employee could not, when on family leave, accrue benefits that accrued only by working. Accordingly, the appellate court ruled that the plaintiff’s FMLA claims had been properly dismissed. [Bailey v. Pregis Innovative Packaging, Inc., 2010 U.S. App. LEXIS 6909 (7th Cir. April 2, 2010).]

Sales Representative Not Entitled to Overtime Under FLSA, Circuit Court Decides

The plaintiff in this case had been hired as a sales representative by Eagle Waste & Recycling, Inc. After her employment with Eagle ended, she brought suit against Eagle under the Fair Labor Standards Act (FLSA), alleging that she had not been paid the overtime due to her under the Act. Eagle moved for summary judgment, arguing that the plaintiff was exempt from the FLSA because she was either an “outside salesperson” or a combination of an “outside salesperson” and an “administrative employee.” The district court granted summary judgment to Eagle, and the plaintiff appealed to the U.S. Court of Appeals for the Seventh Circuit.

The circuit court affirmed the decision in favor of Eagle. In its view, the undisputed facts showed that the plaintiff’s primary duty was “outside sales.” On average, the Seventh Circuit noted, the plaintiff spent four to eight hours a day outside the office making in-person sales calls, and she visited the office on only about half of her workdays. At the office, much of her work furthered her efforts to make sales, which related “directly to her outside sales work” and thus was exempt, the appellate court ruled.

As the appellate court also noted, the plaintiff spent about 10 hours a week developing marketing plans and doing other promotional work inside the office, and five to six hours a week promoting Eagle outside of the office. Other than Eagle’s president, who made some sales directly, there did not appear to have been any other Eagle employees directly involved in sales work, according to the appellate court. Most of the fruits of the plaintiff’s promotional work were therefore realized through her own sales. Thus, the appellate court ruled, this promotional work also counted as “exempt outside sales work.”

Importantly, the circuit court also agreed with the district court that even if the plaintiff did not qualify for the outside salesperson exemption on its own, she fell within the “combination exemption” to the FLSA for employees “who perform a combination of exempt duties as set forth in the regulations in this part for . . . administrative [and] outside sales . . . employees may qualify for exemption.” It found that to the extent that the plaintiff’s work was not related to outside sales, it was primarily exempt administrative work. With the exception of her first few months of employment, the plaintiff’s base salary exceeded the \$455 per week minimum required

to meet this exemption. In addition, the circuit court stated, when the plaintiff was not actively pursuing sales, she developed advertising and marketing plans, managed customer complaints, administered the customer database, and dealt with issues that would have been handled by the company’s president had he been in the office, such as approving an order of parts for broken machinery. This office work was “directly related to the management and general business operations” of Eagle, the appellate court found. The appellate court rejected the plaintiff’s argument that the company’s president had “micro-managed” her work, finding that the facts showed that she negotiated with customers over price and service credits, created marketing campaigns, placed advertisements, collected from accounts, and set her own schedule. Thus, it concluded, the district court had not erred by holding that even if the plaintiff’s primary duty was not outside sales, the combination of her outside sales and administrative work exempted her from the FLSA’s overtime requirements. [Schmidt v. Eagle Waste & Recycling, Inc., 599 F.3d 626 (7th Cir. March 22, 2010).]

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Health Care Reform: What Plan Sponsors Need to Know Now

Few issues in recent memory have garnered as much attention, or controversy, as health care reform. The bill that was passed in March is sprawling and complex with many important provisions applicable to individuals and health insurance companies as well as employers. While a comprehensive review of the Patient Protection and Affordable Care Act of 2010¹ (PPACA) is beyond the scope of this column, the following is a high level overview of provisions that may require the attention of health plan sponsors now and in the near term.

While many notable provisions are not due to take effect until 2014 or later, such as the creation of state sponsored health exchanges (effective in 2014), mandated employer sponsored health care coverage (effective in 2014), and the implementation of a 40 percent excise tax on high cost health insurance plans (effective in 2018), there are other provisions, such as “grandfathering” of certain plans, the expansion of covered individuals and the early retiree reimbursement program, that may require plan sponsor consideration and action sooner.

GRANDFATHERED PLANS

Under PPACA, certain plans are “grandfathered” with respect to some of the health care reforms. Plan sponsors may wish to evaluate the extent to which their existing health plans may be able to take advantage of these exemptions.

PPACA defines a grandfathered plan as a group health plan or health insurance coverage in which an individual was enrolled on the date of PPACA’s enactment (March 23, 2010). Unfortunately, it is not clear what aspects of a plan, if any, a plan sponsor may amend and still maintain the plan’s grandfathered status. However, PPACA does provide that an individual covered by a grandfathered plan may add his or her dependents to the plan after enactment as long as the grandfathered plan allowed for dependent coverage on or before the date of enactment. Further, a grandfathered plan may permit individuals to reenroll in the plan and new individuals to enroll in the plan after

enactment without compromising its grandfathered status.

While PPACA does not exempt a grandfathered plan from all reforms, it does exempt them from certain key provisions, including, among others:

- The requirement that preventive care must be provided without requiring the participant to share the cost.
- Application of nondiscrimination requirements under Internal Revenue Code Section 105(h) rules (currently these requirements apply only to self-insured plans).
- Compliance with certain annual reporting requirements regarding plan coverage and health care reimbursement structures.
- The requirement that avenues for external review of benefit claim appeals must be provided.
- The requirement that any participating provider must be designated as a primary care provider.
- The prohibition on rules for plan eligibility based on health related factors of the individual.

The Department of Labor (DOL) and the Internal Revenue Service (IRS) have indicated that regulations related to grandfathered plans will be published in the near future. In the meantime, plan sponsors may wish to review contemplated plan changes in light of any potential effect on grandfathered status.

EXPANSION OF COVERED INDIVIDUALS

A number of provisions of PPACA expand who must be covered by a health plan and these provisions have different effective dates. Section 1511 of PPACA provides that if an employer has 200 or more employees and offers coverage under a health plan, the employer must automatically enroll all full time new hires and ensure continued enrollment for current full time employees (30 hours per week or more). Employers required to automatically enroll employees must provide notice to those employees and an opportunity to select another option or opt out of coverage

altogether. The statute contains no effective date for this provision and, as of this writing, no guidance had been provided on the effective date. As a result, the safer course is to assume this provision was effective upon enactment and seek to comply.

There are two other coverage provisions with a near-term effective date—coverage of preexisting conditions and coverage of adult children up to age 26. While PPACA contains several preexisting condition provisions, plans must cover children under 19 with preexisting conditions by the beginning of the first plan year beginning after September 23, 2010 (which, for calendar year plans, would be January 1, 2011).

In addition, any plan that provides dependant coverage must cover adult children up to age 26 for plan years beginning after September 23, 2010 (i.e., January 1, 2011, for a calendar year plan). Recent guidance in IRS Notice 2010-38 sets forth a definition of a qualifying adult child for purposes of the coverage requirement under PPACA. The age limit, residency, and support tests found in Section 152 of the Internal Revenue Code do not apply in determining whether an individual will be considered a qualifying adult child. For nongrandfathered plans, adult children need only be under age 27 for the taxable year to qualify for such coverage, provided that the individual is a legal child, stepchild, or eligible foster child of the employee. Grandfathered plans are permitted to exclude otherwise eligible adult children who have coverage from their own employers. The coverage extension applies generally to individual or group health coverage, though it does not apply to HIPAA-accepted benefits such as Medicare supplemental insurance and onsite medical clinic coverage. Coverage of adult children under PPACA will have the same tax benefits to employer as coverage of younger children, but employers may *not* charge such adult children any more than is charged for younger eligible children.

Plan sponsors may wish to evaluate their plans and coordinate with any providers to ensure that newly required coverage is in place when required.

EARLY RETIREE REIMBURSEMENT PROGRAM

Although many predict that PPACA is likely to result in increased health care costs to employers, one provision may instead offer some relief. Section 1102 of PPACA seeks to defray the cost of early retiree health coverage for plan sponsors by reimbursing plan sponsors for 80 percent of the net cost of an early retiree's health claims. This provision applies only to claims that total between \$15,000 and \$90,000 in any one plan year. Claim amounts are determined before copayments, coinsurance, and deductibles.

Eligible plans under this program include all self-insured and fully insured employer sponsored health plans that cover "early retirees." In providing guidance on this program, the U.S. Department of Health & Human Services (HHS) issued an Interim Final Rule (IFR) on May 3, 2010.² According to the IFR, "early retirees" include all former employees of the sponsor who are 55 or older, but not yet Medicare eligible, as well as all covered family members of such former employees.

Importantly, this is a temporary program that will end at the earlier of January 1, 2014, or the time when the budget for the program (\$5 billion) is exhausted. Because applications will be processed in the order in which they are received, this is essentially a first-come, first-served program. As a result, plan sponsors wishing to take advantage of this program have an incentive to file claims as soon as possible. Additionally, if there is a defect in an application, the applicant will be required to remedy the defect and resubmit a new application, thereby losing its original place in the queue. Thus, applications will need to be both timely and accurate to take full

advantage of this program. There has been no indication as to how long it will take a claim to be processed, when reimbursement payments will be made, or how long the \$5 billion budget is expected to last.

To receive benefits under this program, an employer is required to:

- Timely file an application with HHS;
- Be certified by the Secretary of HHS (which requires a net claim amount of at least \$15,000);
- Ensure it has certain HIPAA-related agreements with the plan or the insurer;
- Implement programs and procedures to (a) generate cost savings for participants with chronic and high cost conditions and to (b) fight fraud and abuse; and
- Provide documentation of actual medical claim costs.

As of this writing, it was projected that application forms would be released in mid-to-late June 2010. HHS has indicated that these forms will be similar to the Medicare Part D subsidy application. Based on the guidance in the IFR, the forms are expected to require, among other things:

- Identifying information about the employer (TIN, name, address, contact information);
- The participant's name;
- Information regarding the benefits provided (the nature of the benefits, the names of the health care providers, dates, applicable plan option);
- A summary of how the reimbursement will be used to meet the requirements of the program (PPACA requires that the funds received under this program may not be used as general revenue of the employer but instead must be used to lower the costs of the retiree health plan);
- A summary of the applicant's plans to implement programs and procedures to generate savings for plan

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participants with chronic and high cost conditions;

- A projection of the applicant's reimbursement amounts for the first two plan year cycles (so that HHS may monitor the funding limit); and
- An attestation by the sponsor that there are fraud, waste, and abuse policies and procedures in place.

ACTION

This discussion has covered only a very narrow slice of the myriad issues raised by PPACA for health plan sponsors. While plan sponsors will be addressing these issues

for years to come, this discussion is intended to identify certain issues that may require plan sponsor actions sooner than others.

As a high priority matter, plan sponsors may wish to (1) consult with their advisors to review contemplated plan changes or other plan related actions in light of the grandfathering provisions; (2) evaluate the effect of the expanded coverage rules (preexisting conditions and adult children) that become effective on January 1, 2011, for calendar year plans; and (3) if eligible, prepare to file claims under the early retiree reimbursement program. ☼

NOTES

1. P.L. 111-148, PPACA, as amended by the Health Care and Education Act of 2010, P.L. 111-152.
2. 45 C.F.R. 149.1 *et seq.*

Julie K. Stapel, an Employee Benefits and Executive Compensation partner in the Chicago office of Winston & Strawn LLP, is the "Regulatory Update" columnist for *Employee Benefit Plan Review*. The author would like to thank her partner, Linda Lemel Hoseman, and her colleagues, Alexis Backs, Steve Flores, and Matt Wright, for assistance in preparation of this month's Regulatory Update. Ms. Stapel can be reached at jstapel@winston.com.

Changes Coming to the Human Rights Campaign Foundation's Corporate Equality Index

The Human Rights Campaign (HRC) Foundation's Corporate Equality Index (the Index) is a nationally recognized ranking of major employers throughout the United States on issues involving workplace equality for lesbian, gay, bisexual, and transgender (LGBT) individuals. The annual Index evaluates employers on a series of evolving criteria that demonstrate the employer's commitment to equal treatment of all people regardless of their sexual orientation and gender identity or expression.

Employers listed in *Fortune* magazine's 1,000 largest publicly-traded businesses, *American Lawyer* magazine's top 200 revenue-grossing law firms, and *Forbes* magazine's 200 largest private businesses are invited to participate in the survey. In addition, any private sector, for-profit employer with 500 or more full time U.S. employees can request to participate. Employers generally are ranked on the Index based on a survey that the employer submits to the HRC. In 2010, 305 of the 590 employers evaluated received a perfect 100 percent ranking on the Index.

Since the Index was introduced in 2002, the HRC has updated the criteria on which employers are evaluated several times to continue raising the bar on the comprehensive benefits and inclusive employment practices and policies that employers must implement in order to ensure that LGBT individuals are treated equally. The newest version of the criteria will take effect with the 2012 Index. As detailed below, the new criteria stress comprehensive employee benefits for same-sex spouses and partners, transgender-inclusive medical and short term disability benefits, organizational competency on LGBT issues, and public engagement with the LGBT community.

Surveys for the 2012 Index will be distributed to employers in March 2011. Employers must demonstrate that all new criteria other than those impacting employee benefits will be in place by July 29, 2011. All changes to an employer's benefit plans must be effective no later than January 1, 2012. In addition, the HRC requires employers to announce to employees any changes that will be made to the employer's benefit plans to satisfy the criteria

for the Index prior to the publication of the 2012 Index on September 1, 2011.

EQUAL BENEFITS FOR SAME-SEX PARTNERS

Employers must now ensure that benefits extended to same-sex partners of employees (including state registered domestic partner, civil union partners, and same-sex spouses) are equivalent to the benefits that the employer offers to opposite-sex spouses to the extent permitted by law. This criterion requires employers to make all benefits currently available to opposite-sex spouses also available to same-sex spouses, including retirement benefits, medical, and dependent coverage, COBRA-equivalent coverage, FMLA-equivalent leave, and any fringe benefits. In addition, employers must ensure that these benefits are offered under the same terms to same-sex spouses or partners of employees.

Common changes that employers may need to make to their employee benefit plans and policies include the following:

- Certain hardship distribution options from qualified defined contribution plans must take same-sex spouses or partners into consideration to the same degree as an employee's opposite-sex spouse in determining the employee's eligibility for the distribution. This change is legally optional under the Pension Protection Act of 2006, but will be required in order to retain a perfect score on the Index.
- Qualified joint and preretirement survivor annuities from the employer's defined benefit pension plans must be extended to same-sex spouses and partners in the same manner as opposite-sex spouses. Most pension plans permit an employee's benefits to be paid over the employee's life or the joint lives of the employee and his or her opposite-sex spouse, as well as providing a preretirement survivor annuity if the employee dies before his pension benefit commences. Employers with pension plans with joint spousal annuity options will need to amend their plans to permit employees to elect an annuity that is payable over the joint lives of the employee

and his or her same-sex spouse or partner. In addition, employers will need to allow same-sex spouses and partners to be eligible to receive a preretirement survivor annuity. To avoid the added administrative complexity of limiting this payment options to same-sex spouses and partners, many employers have opted to offer a joint annuity and preretirement survivor annuity for any non-spouse beneficiary designated by the employee. However, extending a survivor benefit under a pension plan to all nonspousal beneficiaries can be more costly for an employer to offer than limiting this benefit to only same-sex spouses and partners.

- Same-sex spouses and partners must be included in any default beneficiary provisions of an employer's retirement plans. Many employers offer defined contribution plans which state that an employee's benefit will be paid to his or her spouse in the event that the employee dies without having designated a beneficiary. Plans with such default beneficiary language now must be amended to include an employee's same-sex spouse or partner as the default beneficiary in the event that the employee dies without a designated beneficiary.
- The definition of "spouse" in any insurance contracts must be revised to include same-sex spouses in those states where same-sex marriage is legal or recognized. Same-sex marriage is currently legal in Connecticut, Iowa, Massachusetts, New Hampshire, Vermont, and the District of Columbia. New York will also recognize same-sex marriages formed in any of these jurisdictions even though same-sex couples cannot legally marry in New York.
- Any required evidence of "proof" of a same-sex couple's relationship must be the same as the evidence required from opposite-sex spouses.

INCLUSIVE HEALTH BENEFITS FOR TRANSGENDER EMPLOYEES AND DEPENDENTS

Employer sponsored medical and short term disability benefits must now include comprehensive coverage of transgender-specific treatments. Previously, employers only had to offer benefits that covered one of the following categories of treatment for transitioning individuals: counseling by a mental health professional, pharmacy benefits covering hormone therapy, medical visits to monitor the effects of hormone therapy, and other associated lab procedures, medically necessary surgical procedures such as hysterectomy, or short term disability leave for surgical procedures.

Many employers' medical and short term disability benefit plans currently exclude transgender-specific treatments by classifying them as "cosmetic." The new criteria will require employers to work with their insurance carriers and administrators to remove such exclusions and affirmatively extend coverage to any medically necessary treatments and procedures. Guidance on the transgender-specific treatments and procedures that should be covered because they are medically necessary is available under the standards of care defined by the World Professional Association for Transgender Health (WPATH). To complete the survey for the 2012 Index, employers will be required to submit documentation to verify that medical and short term disability benefits will in fact provide coverage for transgender-specific treatments beginning no later than January 1, 2012.

ORGANIZATIONAL COMPETENCY OF LGBT ISSUES

Employers must demonstrate a "firm-wide sustained and accountable commitment to diversity and cultural competency" through at least two of the following:

- Training for new employees that informs them of the employer's nondiscrimination policy which includes gender identity and sexual orientation and provides them with definitions or scenarios illustrating how the policy applies to each;
- Training for supervisors that includes gender identity and sexual orientation as discrete topics and provides definitions or scenarios illustrating how the policy applies to each;
- Integration of gender identity and sexual orientation in professional development, skills-based, or other leadership training that includes elements of diversity and/or cultural competency;
- Development of gender transition guidelines with supportive restroom, dress code, and documentation guidance;
- Implementation of senior management and executive performance measures that include LGBT diversity metrics.

PUBLIC COMMITMENT TO THE LGBT COMMUNITY

Employers must demonstrate an "ongoing LGBT-specific engagement that extends across the firm" through at least three of the following:

- Demonstrated efforts to reach LGBT applicants and recruit LGBT employees;
- Supplier diversity program with demonstrated effort to include certified LGBT suppliers;
- Marketing or advertising to LGBT consumers (e.g., advertising with LGBT content, advertising in LGBT media, or sponsoring LGBT organizations and events);
- Philanthropic support of at least one LGBT organization (e.g., financial, in kind or pro bono support);
- Demonstrated public support for LGBT equality under the law through local, state, or federal legislation or initiatives.

Employers that want to achieve or retain high rankings on the 2012

Index will need to take action now to ensure that their employee benefit plans and employment practices and policies are updated in accordance with the new criteria. 🌟

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■ News

HealthEdge Introduces Healthcare Payor Application

■ Through its HealthRules® Portal, HealthEdge has updated a platform that enables a health payor to effectively serve its members, providers, and employers. The enhanced product can function either as a comprehensive and customized end-to-end solution or be implemented into a payor's existing technology, enhancing operations.

The HealthRules product furnishes customers with an immediately accessible and protected array of detailed information about coverage, claims, and billings that eliminates time consuming telephone calls and other drawn out communications efforts while assuring that data is transparent and accurate.

For more information, visit www.healthedge.com.

Grant Thornton Survey Indicates That Employee Benefits Is Top Pricing Pressure

■ In a recently conducted survey by Grant Thornton about how U.S. companies are

preparing for future economic challenges, maintaining cost effective and quality employee benefits was cited as the chief pricing concern. The survey, conducted between March 22 and April 9, 2009, gathered responses from 496 chief financial officers and comptrollers about how to address their workers' financial packages in the face of an anticipated market downturn.

Little change was planned about salaries over the next six months, with a slight majority (53 percent) of executives planning no change, 32 percent planning to decrease salary, and 15 percent planning to increase salary. A similar trend prevailed for bonuses, with 47 percent of executives planning no change in bonus offerings, 44 percent planning to decrease bonuses, and eight percent planning to increase bonuses.

Concern over maintaining quality and cost effective employee benefits was by far the leading price pressure cited by executives (68 percent), followed distantly by concerns over procuring raw materials (29 percent) and energy (26 percent).

The following data represents the survey's findings:

IS YOUR COMPANY REDUCING AVERAGE COSTS PER EMPLOYEE IN ANY OF THESE EMPLOYEE BENEFIT AND COMPENSATION AREAS? (CHECK ALL THAT APPLY.)

	Increasing	Reducing	Same
401(k) match	5%	21%	74%
Bonuses	8%	44%	47%
Disability benefits	1%	10%	88%
Health care benefits	6%	29%	66%
Life insurance benefits	2%	11%	86%
Salary raises	15%	32%	53%
Stock options and other forms of equity-based compensation	5%	29%	66%

ARE YOU HAVING DIFFICULTY IN ACCESSING CREDIT IN GENERAL?

Yes	23%
No	77%

ABOUT WHICH TYPE(S) OF PRICING PRESSURE ARE YOU MOST CONCERNED? (CHECK ALL THAT APPLY.)

Employee benefits (e.g., health care, pensions)	68%
Raw materials (e.g., food, metals)	29%
Energy	26%
Insurance	19%
Other	17%

COMPARED TO THIS TIME LAST YEAR, ARE YOU MORE OR LESS WORRIED ABOUT YOUR ORGANIZATION'S ABILITY TO CONTINUE AS A GOING CONCERN?

More worried	12%
About the same	44%
Less worried	44%

CIGNA and Humana Form Health Care Partnership

■ To advance employers' efforts at delivering quality health care benefits for their employees and retirees, CIGNA Corporation and Humana Inc. pooled their expertise. The alliance pairs CIGNA's consulting focus and single point of contact for clients with Humana's well-established group Medicare Advantage support features. Under this agreement, the health and wellness programs of CIGNA will be combined with Humana's Medicare offerings so that employees who are about to retiree will receive quality assistance delivered by their employer.

Sam Srivastava, CIGNA's president of government segments, observed that the partnership enables CIGNA to expand its portfolio "while Humana is able to expand its distribution to a larger base of employer customers for its Medicare Advantage plans, creating broad-based, affordable coverage from two companies widely recognized for their services excellence."

Mr. Srivastava's enthusiasm was echoed by Humana senior vice president of senior products, Thomas Liston, who observed "CIGNA will be exclusively supplementing its retirement offerings with Humana's Medicare Advantage plans, enabling CIGNA to offer a cost-effective, one-stop solution."

For more information about the partnership between CIGNA and Humana, contact either www.cigna.com or www.humana.com.

Wolters Kluwer Law & Business Acquires ftwilliam.com

■ To upgrade a key area in its effort to deliver the foremost in customer support, Wolters Kluwer, a tax, human resources, and business information services provider, has acquired ftwilliam.com, a software as services (SaaS) company. Ftwilliam.com provides third party administrators and other retirement plan professionals with integrated

workflow solutions to automate administrative functions as well as securely comply with 5500 filing requirements.

Operating since 2005, ftwilliam.com has more than 2,000 customers throughout the U.S. The company's Web-based integrated workflow solutions simplify and enhance the reliability and accuracy of such pension plan operations as document creation and management, annual compliance filings, and plan administration. Ftwilliam.com was the first vendor to be approved by the U.S. Department of Labor for Form EFAST2 electronic filing.

For more information about Wolters Kluwer Law & Business' acquisition of ftwilliam.com, visit www.cch.com/pensions.

Hartford Creates Leave Management Product to Track Employee Absences

■ Responding to employer surveys indicating grave problems with managing their workers' absences, Hartford Financial Services Group has created a product that effectively manages and controls this problem. Entitled Hartford Productivity Advantage, the product monitors both occupational and non-occupational leave, integrating the insurer's short term and long term disability and workers' compensation insurance with its leave management administration services. This approach helps employers minimize lost time while enhancing productivity.

Citing research estimating lost productivity due to disability-related leave of absence to be \$23,000 per individual, Juan Andrade, Hartford Property and Casualty Operations president and chief operating officer, emphasized how this customizable solution can save a company hundreds of thousands of dollars through careful implementation.

Hartford Productivity Advantage is being used in a modular fashion, with workers' compensation, disability insurance, and leave management features available for employee's

design based on their objectives and timelines.

For more information about Hartford Financial Services Group's Hartford Productivity Advantage leave management product, contact www.thehartford.com.

HighRoads and Corporate Executive Board Partner on Employee Health Project

■ To help employers most effectively implement and take advantage of the new health care reform law, two companies have pooled their expertise to provide a benchmarking repository measuring the connection between health care benefit data and consequent benefit plan design changes. HighRoads, a provider of employer health care database and benefit management support, and Corporate Executive Board, a provider of research and technology assistance to Fortune 500 companies, will combine real-time health care benefit data to analyze and recommend procedures resulting from the new health care requirements.

Under the agreement, HighRoads will apply its database of benefits plan design metrics into the Corporate Executive Board's benchmarking repository, The Lab®. This project should be ready to study employer benefit plan structure and effects on employees as the 2011 procurement season takes place. The compiled information should offer employers a clear understanding of the plans being offered by other firms in the industry and allow for cost comparisons to support more competitive bidding.

For more information about the HighRoads and Corporate Executive Board health care benefit data benchmarking partnership, visit either www.highroads.com or www.exbd.com.

U.S. DOL Introduces New Product to Help Firms Comply with Disability Rules

■ The U.S. Department of Labor has created Disability Nondiscrimination

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Law Advisor, a product designed to help employers determine which laws apply and what steps to follow in adhering to disability nondiscrimination regulations. To assure that employers fulfill their obligations, the products asks users to answer a

few relevant questions and then it generates a customized list of federal disability nondiscrimination laws that likely apply, along with easy to understand information about employers' responsibilities under each of them.

This product is the latest in a series of elaws (Employment Laws Assistance for Workers and Small Businesses) Advisors created to assure employer compliance. It can be accessed at the elaws Web site: www.dol.gov/elaws/.

■ Transitions

Arizona State University

■ This educational institution has named **Kevin Salcido** associate vice president and chief human resources officer. Mr. Salcido had served as interim chief human resources officer since August of 2009 and for more than 20 years has held executive and senior management positions in the retail, consumer products, newspaper, and utility industries.

Brown & Brown

■ This diversified provider of insurance and health care services has named **Linda S. Downs** senior executive vice president, overseeing operations in offices and at subsidiaries located in the South, East Coast, and Midwest. Having been with the company since 1980, while taking on positions of increasing responsibility, Ms. Downs will continue to oversee corporate matters relating to the corporate benefits department and the company's leadership schools.

CBCA Administrators, Inc.

■ This leading employee service organization has named **Tim Reed** vice president of human resources, heading the human resources division's product offerings. Most recently, Mr. Reed had been vice president at Sequent HR Outsourcing, and he earlier held human resources positions with Acloche and Frigidaire.

The Children's Place Retail Stores, Inc.

■ **Larry McClure** has been named senior vice president of human resources at this children's specialty apparel retailer. Most recently, Mr. McClure had been senior vice president of human resources for Liz Claiborne. He earlier held human resources positions with The Dexter Corporation, Aetna, and United Technologies.

Clark Consulting

■ This Dallas-based firm, providing solutions for executive benefits, and corporate and bank owned life insurance, has promoted **Anthony Laudato** to senior vice president of product & services and chief product officer, and **Brian Katz** to senior vice president of market strategy and development and chief marketing officer.

EPIC (Edgewood Partners Insurance Center)

■ In the employee benefits consulting practice of this diversified services insurance brokerage, **Dana Liedel** has been assigned executive leadership responsibilities. Ms. Liedel, a veteran professional in insurance and human resources operations, joined the firm in November of 2009 as principal and corporate development officer.

U.S. Equal Employment Opportunity Commission

■ Former U.S. Assistant Secretary of Labor **Victoria A. Lipnic** has been appointed as a Commissioner for this federal agency enforcing employment law, restoring the organization to its full complement of five commissioners. Ms. Lipnic was nominated last November and received a recess appointment by President Barack Obama on March 27, 2010. Ms. Lipnic served as Assistant Secretary of Labor to Employment Standards from 2002 to 2009. Most recently, Ms. Lipnic had been of counsel with Seyfarth Shaw LLP in Washington, D.C., providing guidance on compliance issues relating to labor and employment laws.

Lockton Companies

■ As part of expansion efforts in the retirement practice of the Dallas office, **Glenn Able** has joined as vice president, and **Scott Andricks** has joined as account executive. Mr. Able, who will provide guidance on design, administration, and investment management issues, had most recently been executive director of business development with GuideStone Financial Resources. Mr. Andricks was most recently with Fidelity Investments where he handled a variety of assignments in marketing and investments. In the Denver office, **Leo Tokar** has joined on as senior vice president and client services executive in the benefits department, in charge of implementing strategic solutions relating to employee benefits. Most recently, Mr. Tokar had been an executive with Kaiser Permanente and served as vice president of marketing, sales, and business development.

Longfellow Benefits

■ This Boston-based employee benefits consultant and broker has added **Colleen Grady** and **Robin Blue** to its professional staff. Ms. Grady, who joins as a benefits consultant, has 10 years of human resources experience working for

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companies in a variety of industries. Ms. Blue has worked in the insurance industry for 30 years and has held positions with some of the largest insurance companies, including UNUM, Pacific Life, National Life of Vermont, and Travelers.

Marathon Oil Corporation

■ Joining this major energy resources organization is **Robert L. Slovine**, who has been named vice president of human resources, in charge of all related policies, programs, and practices for the company's worldwide workforce of nearly 30,000 employees. Most recently, Mr. Slovine had been manager of Marathon's Upstream organization.

Merck & Co.

■ This leading pharmaceutical and health products provider has named **Adam H. Schechter** to serve as president of global human resources. Mr. Schechter has been with the organization since 1988 and most recently had served as head of its pharmaceutical business in the United States.

Monster Worldwide, Inc.

■ Veteran human resources professional **Cynthia McCague** has been named a member of this online employment services provider's board of directors, entrusted with imparting advice on global recruitment challenges and strategies. Ms. McCague has been involved

in human resources operations for 35 years, including serving as head of the global human resources activities for Coca-Cola Company.

St. Bernard Software

■ This leading provider of Web security appliances has named **Brian Nugent** chief operating officer, which will entail handling all human resources operations. Mr. Nugent has had 15 years experience as an executive, having held posts with Applied Identity and Citrix.

Stemler, McTigue & Lewis

■ This newly established firm, comprising three well-known names in the California insurance industry, has named **Craig W. Lewis** as its chief executive officer. The organization is dedicated to providing the foremost in insurance brokerage services.

TASC, Inc.

■ To strengthen its ability to operate independently, this security systems developer and provider, which recently spun off from Northrop Grumman, has named **Jim Lawler** chief human resources officer. Mr. Lawler most recently had served as managing director of professional services at Preston Reffert.

Transamerica Retirement Services

■ This special services marketing unit of Transamerica Financial Life Insurance Company has named

Michael Hammerschmidt regional vice president of the Northeast Region, based in Marcellus, NY, comprising an area from Buffalo to Syracuse. Mr. Hammerschmidt joins the company after a 12 year career with ING Financial Advisors, where he handled a variety of assignments dealing with retirement issues.

Unum

■ This leading provider of employee benefits products has made the following three appointments in offices around the country. In Chattanooga, TN, **Tim Arnold** has been named senior vice president of integrated underwriting and will focus on underwriting group disability, life, long term care, and voluntary benefit products. Mr. Arnold joined the Unum organization in 1985 and most recently had been vice president of integrated underwriting for Unum subsidiary, Unum US. In the Portland, ME, office, **Don Boutin** has been named senior vice president of national client group, and **Diane Garofalo** has been named senior vice president of long term disability and individual disability benefits. Mr. Boutin, with the firm since 1985, will continue to oversee the company's efforts to attract, support, and retain employers with 2,000 or more employees. Ms. Garofalo, with the firm since 1980, will continue to oversee claims management and adjudication for long term care, individual disability, and long term care product offerings. 🌐

■ Publications, Etc.

2010 Social Security Explained, written by Avram Sacks, J.D., published by Wolters Kluwer Law & Business in conjunction with CCH, 564 pages

This work provides a concise explanation of the federal old age, survivors, and disability insurance (OASDI) program under Title II of the Social Security Act, commonly referred to as “Social Security.” This information comes amid recent discussions on the solvency and wisdom of retaining the program, with the overwhelming conclusion being that the key elements of the program, regulations extending coverage, conditions of entitlement, liability for the tax, and other conditions, are likely to remain intact. The book also provides extensive data on the benefits computation process for individual calculations. Tables, charts, graphs, and sample benefits guide the reader through the many requirements.

For more information, contact www.hr.cch.org.

CCH’s Law, Explanation and Analysis, published by CCH, \$149

This analysis of the Patient Protection and Affordable Care Act of 2010 provides the most comprehensive and practical guidance available to professionals needing to understand and implement the requirements of this historic legislation. CCH editorial staff, supported by leading health care experts, provides clear and practical guidance on the vast tangle of new provisions established by the law, so professionals can quickly fulfill their responsibilities, be in compliance, and plan for the future.

For more information or to order, call (800) 248-3248 or visit <http://hr.cch.com/Products/ProductID-7127.asp>. Discounts are available for multiple copies.

Leaves of Absence and Time Off from Work Manual, 9th Edition, written by Richard J. Simmons, published by Castle Publications, 180 pages

In recent years, the development of leave of absence rights has been strongly reinforced by state and federal laws and has impacted how employers might handle worker requests for time off. In some instances, related

laws may provide employees with overlapping protections as a result of multiple rules. In addressing the legal obligations and requirements governing leaves of absence, attorney Richard J. Simmons details the specific statutory references and provides clear explanations, covering issues such as Family and Medical Leave, Military Leave, Pregnancy Leave, Qualifying Events, and much more.

For more information, visit www.castlepublications.com/absence.html.

An Employer’s Guide to Child and Adolescent Mental Health, published by the National Business Group on Health, copies accessible online from the NBGH Web site

This recently released work imparts guidance to help employers improve the delivery of child and adolescent behavioral services, and provide services for family caregivers. The work is divided into two parts, with the first reviewing the most prevalent behavioral health disorders experienced by children and adolescents, the impact of the workplace, and treatment and cost trends of these disorders. The second part assesses the current state of treatment and challenges facing providers, and offers recommendations for health plans, employer oversight, and the workplace. By following the recommendations in the guide, employers should be fortified with the most prudent strategies for securing health benefits.

For more information (including accessing a copy), visit www.businessgrouphealth.org.

Profit at the Bottom of the Ladder: Creating Value by Investing in Your Workplace, written by Jody Heymann with Magda Barrera, published by Harvard Business Press, 288 pages, \$29.95

The author tells the stories of companies around the world that are linking successes at the top of the corporate ladder to those on all other rungs and shows how businesses have profited more by improving working conditions. Featuring cases from companies around the globe, the author shows what works—from stock options for bakers to flexibility for factory workers to career tracks in call centers.

For more information, visit www.hbr.org.

■ Calendar

August

August 2 & 3

Benefit Communication and Technology Institute. The Fairmont Copley Plaza, Boston, MA. Sponsored by the International Foundation of Employee Benefit Plans. For more information, contact IFEBP, (888) 334-3327, www.ifebp.org.

August 9–12

HR & EEO in the Federal Workplace Conference. Atlanta Marriott Marquis, Atlanta, GA. For more information, visit www.fedconferences.com.

August 9–13

Certificate in Employee Relations Law Seminar. Sheraton Seattle, Seattle, WA. The seminar is also being held August 16 to 20 in Boston. Sponsored by the

Institute for Applied Management. For more information, contact IAML, (949) 760-1700, www.iaml.com.

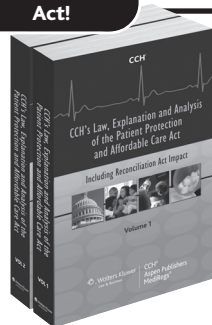
August 10–12

Vermont Captive Insurance Association Annual Conference. Sheraton Hotel and Conference Center, and UVM Davis Center, Burlington, VT. Sponsored by Towers Watson. For more information, contact Towers Watson, (212) 309-3400, fax (212) 309-0975, www.towerswatson.com.

August 30–September 2

HR Florida Annual Conference & Exposition. Rosen Shingle Creek, Orlando, FL. Sponsored by HR Florida. For more information, visit [HR Florida](http://www.hrflorida.org), www.hrflorida.org.

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