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Employee Benefit Plan Review

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Columns

Feature Articles

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All feature articles and columns are bylined and are written by experts in various companies, compensation and/or benefits specialists and practitioners, lawyers and legal advisers, or staff experts.

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Approximate word counts:

- For features, 2,500 to 4,000 words
- For columns, 1,000 to 1,500 words

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Text should be submitted electronically, preferably in Microsoft Word format, either as an e-mail attachment or on a disk.

Type subheads flush left, with a one-line space above and below.

Articles should be written in neutral, third-person voice. "You," "I," "We," and similar terms will be changed. "This article" is discouraged.

Articles must appear as continuous prose, with full sentences. Outline format must be converted to ordinary paragraphs with transitional sentences. An author's internal headings should not be relied on as the sole means of making points or transitions.

First reference to any persons should include full names. Authors are responsible for verifying correct spelling and titles. First references to entities should include the entity's full title, followed by the acronym (if any) that will be used throughout the rest of the article, in parentheses.

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Authors should attach the following on separate pages:

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2. An abstract of 50–75 words; and
3. For each author or co-author, a biographical statement of no more than 50 words, written in the third person.

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Submit one copy of the manuscript to the Editor-in-Chief at the address indicated below (submission of articles via e-mail to the address indicated below is preferred).

If the use of e-mail is not an available option, submit one high-quality copy of the article to the Editor-in-Chief at the address indicated below. Once an article has been accepted, submit to the Editor-in-Chief (1) a high-quality manuscript copy, and (2) a 3.5" diskette formatted for IBM PC. Label disks with software programs and version, file name, author name, article title, and "EBPR." Macintosh or Quark disks and files are not acceptable.

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Thanks for your interest!

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FEATURE ARTICLES

COLUMNS

Health care benefits—and their costs—continue to be of interest, of course, and the articles in the "Focus" section of this issue of Employee Benefit Plan Review explore a variety of health care issues.

Health Care

First, David J. Laurent, John R. Washlick, and John H. Wilson, shareholders of Buchanan Ingersoll & Rooney PC, analyze recent government health care reform guidance defining full-time employees. The issue arises in the context of new obligations—the "employer shared responsibility" rules—that were imposed on "applicable large employers" by health care reform.

Our second Focus article, "The New Era of Health Care Benefits: Engaging Employees to Become Better Health Care Consumers," is by Douglas Ghertner, president and chief executive officer of Change Healthcare. Mr. Ghertner explains that, to realize the significant opportunity to reduce health care costs through greater cost transparency, consumers must be engaged in their care now more than ever, and he offers suggestions to reach that goal.

The third health care-related Focus article is by Peter C. Savage, the Senior Executive Vice President of the Health Plan Management Group of Cook & Company, Inc. Marshfield, Massachusetts. In his article, "Achieving a Physically Healthy Workforce and a Fiscally Healthy Workplace," Mr. Savage discusses several considerations that employers should keep in mind when examining the coverage and the cost of the health care insurance plans that they provide.

And More...

This issue also includes the second part of a two-part "Special Report" on "The Changing Landscape of Wage and Hour Laws," by Alan D. Berkowitz, Jennifer L. Burdick, and Jane Patullo of Dechert LLP, as well as our "Ask the Experts," "From the Courts," and "Regulatory Update" columns.

We also are pleased to introduce a new column in this issue: "Strategy." This month, the Strategy column is by Michael Klachefsky, national practice leader of The Standard's Workplace Possibilities program, and is entitled "Encouraging Enrollment for Voluntary Products Among the Millennial Generation."

Enjoy the issue!

Steven A. Meyerowitz
Editor-in-Chief
March 2013

Direct questions to Employee Benefit Plan Review *via e-mail to* smeyerow@optonline.net. *Answers by the columnists, Marjorie M. Glover and David Gallai, may appear in an upcoming issue.*

"Play or Pay" Mandate and Affiliated Entities

Q I have a small company (20 full-time employees) that is a member of a controlled group of corporations. I understand that under the new health care reform law, "large employers" (those with 50 or more full-time employees) will face penalties beginning in 2014 if one or more of their full-time employees obtains a premium credit for coverage through a health insurance exchange. I also understand that the proposed regulations on employer shared responsibility provide guidance on how the determination of "large employer" will apply to controlled groups. What do the proposed regulations say about how to determine whether a small company that is part of a controlled group is a "large employer" for purposes of the employer shared responsibility rules?

A Proposed regulations on the employer shared responsibility rules (often referred to as the "play or pay" mandate) were published in the Federal Register on January 2, 2013. 78 Fed. Reg. 219 *et. seq*. These proposed regulations provide that, for purposes of counting the number of full-time employees and full-time equivalent employees to determine whether an employer is subject to the "play or pay" mandate, all employees of a controlled group under Internal Revenue Code Sections 414(b) or (c), or an affiliated service group under Internal Revenue Code Section 414(m), are taken into account to determine whether the members of the controlled group or affiliated service group together constitute a "large employer" subject to the "play or pay" mandate. This means that related companies are combined together for purposes of determining whether they employ at least 50 full-time employees (or an equivalent combination of full-time and part-time employees). If, between the related entities, the combined total number of full-time employees (or full-time employees and full-time equivalent employees) is at least 50, then each separate entity will be subject to the "play or pay" mandate beginning in 2014. This is the case notwithstanding that the related companies, individually, may not have enough employees to be covered by the "play or pay" mandate.

However, the proposed regulations state that while these aggregation rules apply for purposes of determining whether an employer is sufficiently large to be covered by the "play or pay" mandate, these aggregation rules do not apply for purposes of determining liability for penalties and the amount of any penalties. Rather, the determination of whether an employer is subject to penalties and the amount of any such penalty will be determined on an entity-by-entity basis. Each entity in the controlled group will be liable for the penalty assessed with respect to it, but will not be liable for any penalty imposed on any other entity in the controlled group that comprises the "large employer." Employers may rely on the proposed regulations for guidance, pending the issuance of final regulations or other guidance.

Assessment of "Play or Pay" Penalties

Q I understand that there has been a lack of guidance under the new health reform care law about how an employer will know if it is subject to an employer shared responsibility penalty, how any penalty amount should be paid to the IRS, and what reporting obligations will apply to the employer with respect to the penalty. Is there any recent guidance that sheds some light on these questions?

A While the proposed regulations do not address these administrative questions, the preamble to the proposed regulations states that any assessed penalty under the "play or pay" mandate will be payable upon notice and demand and that, pursuant to regulations to be issued by the Department of Health and Human Services, the Internal Revenue Service (IRS) will follow procedures that ensure employers receive a certification that one or more of its employees has received premium tax credits or cost-sharing reductions, and that the employer will be provided with an opportunity to respond before the IRS issues any notice and demand for payment of the penalty. 78 Fed. Reg. 235.

The IRS published questions and answers about the "play or pay" mandate on its Web site on December 28, 2012, which clarify that the IRS will contact employers to inform them

of any potential penalty assessment, and after the employer has responded to the initial IRS contact, if the IRS determines that the employer is liable for a penalty, then the IRS will send a notice and demand for payment. "Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act," Q&A-17, Internal Revenue Service, 12/28/12. This IRS guidance states that the notice will instruct the employer on how to make the payment, and the employer will not be required to include the penalty on any tax return that it files. *Id.* While there are still many open questions about the administration of the "play or pay" penalty provisions, the recent guidance would seem to make clear that employers will not be required to self-report potential penalty amounts related to the "play or pay" rules.

Self-Correction vs. DOL's VFCP

Q My company sponsors a 401(k) plan. We were recently late in forwarding to the plan trust the employee deferral contributions that were withheld from our employees' paychecks. We understand that this late deposit was a prohibited transaction and a breach of fiduciary duty. We corrected the breach by depositing the withheld amounts into the plan trust. We also deposited an additional amount representing interest for each affected employee. We calculated the interest amounts using the Department of Labor's online calculator. Finally, we filed the necessary Form 5330 with the Internal Revenue Service reporting the prohibited transaction and paid the corresponding excise tax. Does my company need to proceed through the Department of Labor's Voluntary Fiduciary Correction Program (VFCP) or can we treat this matter as fully-corrected (and self-corrected)?

A At this time, the Department of Labor does not recognize self-correction of this breach of fiduciary duty. In order to receive the Department of Labor's "blessing" with respect to your company's correction of the breach of fiduciary duty (in the form of a "no action" letter from the Department), your company must proceed via the Department's VFCP. Should your company not proceed via the VFCP and the Department of Labor later discovers this breach, the Department may still seek to pursue an enforcement action and/or collect civil monetary penalties notwithstanding your company's self-correction.

As a technical matter, the Department of Labor states that its online calculator may be used to determine the applicable interest that must be contributed to participant accounts as a part of a correction under the VFCP; the Department does not expressly state that the online calculator can be used for a correction outside of the VFCP. One would hope, however, that, in deciding what action to take, and what penalties, if any, to levy, the Department of Labor would take into consideration your company's self-correction. As a result, even if your company elects not to proceed via the VFCP, your company is in a better position than if it had not self-corrected the breach of fiduciary duty. Your predicament does serve as a good reminder to all companies to ensure that they have proper administrative procedures in place to forward employee deferral contributions to their plan trusts on a timely and regular basis.

Expanded Availability of "In-Plan" Roth Conversions

Q My company's 401(k) plan currently offers "in-plan" Roth conversions for amounts that are otherwise eligible for distribution under the plan, such as amounts held in the accounts of participants who are age 59½ or older. As a result, there are only a few 401(k) plan participants who have amounts eligible for the "in-plan" Roth conversion. I understand that the recent "fiscal cliff" legislation changed this rule. Can my company now amend its 401(k) plan to expand the availability of "in-plan" Roth conversions to a wider group of plan participants?

A Yes. The recent "fiscal cliff" legislation included a special rule that expands the eligibility for "in-plan" Roth conversions. An "in-plan" Roth conversion is a feature that can be adopted by a qualified retirement plan, which allows participants to convert pre-tax contributions held in the plan to after-tax Roth contributions held in the plan. In order to do this, the plan must allow for Roth contributions. If a participant converts pre-tax amounts held under the plan to after-tax Roth amounts, the converted amounts will be taxable in the year they are converted, but any future qualified distributions of the converted amounts, and earnings thereon, will be tax-free to the participant.

Before the "fiscal cliff" legislation was enacted, this "in-plan" Roth conversion feature was only available for amounts that a participant could otherwise withdraw from the plan. *See* IRS Notice 2010-84. Many plan sponsors previously declined to adopt this optional feature due to the limited number of participants that it might benefit. However, the "fiscal cliff" legislation expands "in-plan" Roth conversions to allow participants to convert any pre-tax vested amounts held in the plan to after-tax Roth amounts, regardless of whether or not the participants are eligible to withdraw such amounts. This means that pre-tax amounts held under the plan that were previously ineligible for "in plan" Roth conversion may now be converted to after-tax Roth amounts under the plan under this new rule. Adopting this expanded rule for "in-plan" Roth conversions is optional. Plan sponsors that wish to adopt this new

rule must amend their retirement plans to allow for such "in-plan" Roth conversions.

It is expected that this new rule will operate the same way as existing "in-plan" Roth conversions under IRS Notice 2010-84, but as of the date of this writing, the Internal Revenue Service has not yet confirmed this, nor have they issued any other guidance on this expanded conversion right.

Marjorie M. Glover, a partner in the New York City office of Chadbourne & Parke LLP, is the partner in charge of the firm's executive compensation and employee benefits practice, and is co-chair of the firm's employment law department. David Gallai, who also is a partner in the firm's New York City office, practices in the areas of employment counseling, executive compensation, and employee benefits. The columnists can be reached at *mglover@chadbourne.com* and *dgallai@chadbourne.com*, respectively. Associate Rachel M. Santangelo assisted in writing this column.

Seven Steps to Effective Stewardship in Workers' Compensation Programs

Rudolph L. Rose and Shannon Gardner

Stewardship is defined as the careful and responsible administration and management of something entrusted to one's care.

In the workers' compensation context a successful stewardship program must include a comprehensive and on point stewardship strategic report and meeting as well as a collaboration of a community of stakeholders, including the client, insurer, third party administrator (TPA), consultants, broker, attorneys, and other key partners that may influence the claim management process. The stewardship report and meeting serve as the foundation for evaluating existing programs and identifying positive and negative outcomes of the client's workers' compensation claims management processes and procedures. Without a robust stewardship initiative, the client's program cannot be continuously and consistently guided toward optimal results.

The stewardship process provides a structure for these stakeholders to apply an analytical approach to workers' compensation claims management that will culminate in improved outcomes. The stewardship report and meeting provide to the stakeholders a basis for implementing future analysis, goal setting, and program improvements.

Model stewardship programs give the workers' compensation stakeholders the ability to establish baselines for comparative analysis. This analysis will assist these stakeholders in identifying strengths and weaknesses in part and whole which will allow for implementation of policies and procedures to leverage their strengths and minimize or eradicate their weaknesses. Stewardship offers the stakeholders the ability to define and address organizational goals, benchmarks, best practices, and deliverables.

Step One: Commit to the Truth

Stewardship, by design, involves identification of the positive and negative attributes of the system being examined. Step one is committing to reporting the truth.

The purpose of a stewardship report and meeting is not to inform the stakeholders of what is working well while ignoring the areas that need improvement. A useful stewardship report and meeting will inform the stakeholders what they are doing well, where they could be reaping the benefits of improvement, and quite simply highlight what is going wrong.

A disingenuous or overly optimistic stewardship report is not a useful tool in moving the stakeholder's position forward.

Step Two: Identify Content, Format, Deadlines and Attendees

Step two is the time to have frank conversations concerning expectations of the group.

To create a useful stewardship report, one that goes beyond simple benchmarks, the stakeholders must identify the data that is most useful to their inquiry, and thus, should be included within the report.

Preliminary data sets, perhaps provided by your insurance carrier or TPA, is an appropriate method to get the group focused on what information is readily available and needed. That data is a useful tool in the stakeholders' toolbox because it gives the group an easy jumping off point but can be customized as the information needs of the community are recognized.

However, preliminary data should not be the exclusive source of data that the stakeholders rely upon. To make data more meaningful, consider utilizing client specific data such as payroll and revenue. Client specific data can often prevent skewed trending reports that do not reflect what is taking place in the stakeholders' organization.

The format of the Stewardship Report should be determined by the stakeholders at this stage. The Stewardship report format should be tailored based upon the attendees of the meeting. If members of management are invited to the meeting, consider a high-level executive summary with charts and graphs that will speak succinctly to your targeted audience. The focus should not be on the length of the

report but rather the quality of the information you hope to present. Failing to plan the content, format, and tailor-it to the actual attendees will enhance the stewardship process.

It is imperative that the relevant stakeholders come together to define what information is going to be included in the report, the format of the report, and the list of attendees and locale of the meeting. Setting deadlines early on allows the collaborative partners to monitor their own progress and plan their work flow.

Step Three: Identify the Necessary Data and Ask for It

Step three is crucial: identify who has the necessary data and ask for it.

Once the content, format, and attendee list are established, the stakeholders must work together to provide the required data sets to satisfy the content requirements. Collecting the requisite data can often times extend beyond the data acquired by the carrier/TPA and will encompass other members of the community. Safety consultants, insurance brokers/agents, medical advisers, data analyst, and legal counsel may all be vital providers of critically important data.

Keep in mind, you can become paralyzed by data. This is an instance when more is not necessarily better! Aim for the right data to ensure meaning and avoid data overload paralysis. Be sure you understand what the data is trying to tell you. Understand the metric time-frames utilized (i.e., point-in-time, rolling, and year to date) as this can dramatically alter the results if not interpreted correctly. Anticipate the questions that may be raised on the data utilized to maintain credibility.

Step Four: Recommit to the Truth and Create Your Draft Report

Step four is the recommit to the truth of your report.

The aim of stewardship is to identify program strengths and areas for continuous improvement. The leakage identified during the process will often be more insightful than the savings presented. At this juncture, the data has been collected, the trends have been identified, and it is time to draft an accurate, comprehensive stewardship report. Be mindful that factors of influence such as jurisdictional and economic changes, merger and acquisition activities, etc. can dramatically change the appearance of the data year over year. If dramatic changes appear from one year to the next, take pause. Significant variances in the findings should dictate a deeper dive into the data before drawing broad- based conclusions.

For cohesiveness of the finished product, identify the party that will have primary responsibility for drafting the report. Often times, this will be your insurance carrier or TPA. While many stakeholders may be involved in the culmination of the data, too many view points during the writing of the report could lead to a less focused and inconsistent report.

Before finalizing the report, engage the key stakeholders in peer-review to identify and delineate trends. Any unexpected or unexplained trends should be vetted prior presenting the report. Surprises should not be revealed as late as the stewardship meeting.

Step Five: Present the Findings

Step five determines who is best equipped to present the stewardship report.

Often this will include representatives from the insurance carrier/TPA with other possible key stakeholders. Circulate your stewardship report and hold a meeting to review the findings. Evaluate the results of the report and discuss the rationale behind the emerging trends. Pro-actively identify services, initiatives, and program enhancements that may impact the trends recognized in the data sets. The stewardship meeting should be collaborative in nature in order for the participants to reap the maximum benefit from the stewardship process.

The workers' compensation industry is not static. Rather, it is a dynamic industry and without collaborative efforts from the stakeholders, claims, and costs can spin out of control. The stewardship report and meeting are the beginning of an ongoing conversation, and topics addressed in the meeting will be and should be revisited often.

Step Six: Set Goals

Step six is to be realistic in the goals set.

After a thorough review of the stewardship report, set program goals and metrics to measure success of strategies implemented. Create a detailed action plan for follow-up based on the stakeholders involved and set target dates for completion. Don't try to redesign your entire program at one time. Pick those items which will result in the greatest impact on your program. Reassess your information needs to ensure all stakeholders are collecting relevant data for any required follow-up.

Step Seven: Begin Again

Step seven begins the change process.

After presenting your stewardship report and conducting your stewardship meeting, do not rest. Your work has just begun. Instead, implement changes, move toward goal, and think ahead to your next stewardship endeavors.

Conclusion

Stewardship is a collaborative endeavor from start to finish. A comprehensive and complete Stewardship Report and the Stewardship Meeting will build confidence and keep your client on the path toward success in the management of its Workers' Compensation Program.

Timeline

100 days before due date

- Determine final report delivery date
- Review prior reports (or TPA/insurer canned report if this is your first time) for baseline
- Formulate preliminary concept
- Confirm process and establish expectations

90 days out

- Engage resources
- Conduct preliminary data review
- Discuss initial observations
- Reach preliminary conclusions and identify additional data needs
- Predraft report

60 days out

- Peer-review report
- Make needed revisions

30 days out

- Forward draft report to all partners

15 days out

- Finalize report for deliver (incorporating any requested changes)

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Defining Full-Time Employees: More Government Health Care Reform Guidance

David J. Laurent, John R. Washlick, and John H. Wilson

The Internal Revenue Service (IRS) and the Departments of Labor (DOL) and Health and Human Services (HHS), simultaneously, but separately, issued long awaited guidance to employers under the Patient Protection and Affordable Care Act (ACA) regarding when part-time or seasonal employees must be treated as "full-time" employees and the 90-day waiting period.

The ACA imposes new obligations on "applicable large employers." The new obligations, referred to as "employer shared responsibility" rules, have been codified under I.R.C. Section 4980H.

On August 31, 2012, the IRS released IRS Notice 2012-58, which provides safe harbors that employers may use to determine which employees to treat as full-time for purposes of the employer shared responsibility rules. On the same day, the agencies released IRS Notice 2012-59, Department of Labor Technical Release 2012-02, and HHS Bulletin, "Guidance on 90-Day Waiting Period Limitation under Public Health Service Act § 2708," each of which provided the same temporary guidance regarding the 90-day waiting period limitation under the employer shared responsibility rules.

Background

Beginning January 1, 2014, new I.R.C. Section 4980H provides that an "applicable large employer" that does not provide its "full-time employees" with affordable minimum health care insurance coverage will face significant tax penalties. An "applicable large employer" is defined generally as any employer (taking into account all related businesses) that employed at least 50 full-time / full-time equivalent employees on business days during the preceding calendar year. For purposes of I.R.C. Section 4980H, the term "full-time employee" generally means an employee who is employed on average at least 30 hours per week.

I.R.C. Section 4980H also provides that an applicable large employer is subject to a potential tax penalty if (a) the employer fails to offer its full-time employees (and their dependents) the opportunity to enroll in any minimum essential health care coverage under the employer's sponsored health plan, or (b) the employer offers its full-time employees (and their dependents) the opportunity to enroll in health coverage, but the coverage is either not affordable for the employee or does not provide minimum value or coverage and, as a result of such deficiency, one or more full-time employees is certified to receive a premium tax-credit or cost-sharing reduction. Coverage is considered "affordable" to a particular employee if the employee's required contribution to the plan does not exceed 9.5 percent of the employee's household income for the taxable year. Thus, there is a statutory guideline on how much premium the employer can pass on to the employee to pay without incurring a penalty.

Notice 2012-58: Determining "Full-Time" Employee Guidance

Notice 2012-58 expands on previously issued IRS guidance (IRS Notices 2011-36 and 2012-17) and provides safe harbors that applicable large employers may use (but are not required to use) to determine which employees will be treated as full-time employees for purposes of the shared employer responsibility rules.

Preliminarily, Notice 2012-58 states that if a large employer reasonably expects an employee to work an average of 30 or more hours per week when hired, then the employer must treat the individual as a full-time employee, *i.e.*, the employer must offer essential minimum coverage to the employee to be effective within 90 calendar days, or the employer may be subject to significant tax penalties. If, however, the employer reasonably expects the employee to work a variable schedule that may not average more than 30 hours per week, or the employee is employed only on a seasonal basis, then the employer can use the safe harbor rules set forth in Notice 2012-58 to determine whether to treat the individual as a full-time employee.

Ongoing Variable Employees

An employee is a "variable employee" if, based on the facts and circumstances at the date the employee begins to provide services, it cannot be determined that the employee is reasonably expected to work an average of at least 30 hours per week. In such situations, an employer has two options: (a) it can simply concede that the employee will work an average of at least 30 hours per week, dispense with the need to make the calculations described below and treat the employee as a full-time employee; or (b) the employer must make a series of determinations, as described below.

First, the employer must designate a "Standard Measurement Period," which is the period used to make the determination, and then must designate a "Stability Period," which is the period during which the coverage must be provided. The Standard Measurement Period must be between three and 12 consecutive months. The Stability Period must be the greater of six consecutive months or the same number of consecutive months as the Standard Measurement Period. For example, if the Standard Measurement Period is the calendar year, then the Stability Period would be the following calendar year.

Second, the employer can include an administrative period of up to 90 days between the end of the Standard Measurement Period and the commencement of the Stability Period, so that the employer can determine who is eligible for coverage and give them an opportunity to enroll. For example, an employer could make October 15 to October 14 of the following year the Standard Measurement Period, designate October 15 to December 31 as the Administrative Period and designate the following January 1 to December 31 as the Stability Period.

Assuming the employer designated the foregoing periods, then the employer would determine the employee's average hours worked during the Standard Measurement Period (*e.g.*, October 15, 2014 to October 14, 2015). If the employee averaged at least 30 hours per week during this period, then the employer could offer the employee an opportunity to enroll in the essential minimum coverage during the period of October 15, 2015 to December 31, 2015. If the employee enrolled, then the employer must provide coverage to the employee for the period of January 1, 2016 to December 31, 2016. In this scenario, the employer would not be obligated to pay an assessment for the employee. The foregoing analysis would then be repeated each year unless the employer concedes that the employee has become a full-time employee.

New Employees

For new employees, the foregoing rules apply, but with a few additional determinations. Specifically, in addition to having designated a "Standard Measurement Period," a "Stability Period" and, if elected, an "Administrative Period," the employer also must establish an "Initial Measurement Period," which is the period that will be used to determine the employee's initial eligibility, and must make certain adjustments to the initial Administrative Period.

The Initial Measurement Period must be between three and 12 months, and the combination of the Initial Measurement Period and the initial Administrative Period may not extend beyond the last day of the first calendar month beginning after the employee's one-year anniversary. If the employer uses the first calendar year of employment as the Initial Measurement Period, and if the employee works an average of 30 hours per week during that period (*e.g.*, May 15, 2014 to May 14, 2015), then the employee must be treated as a full-time employee, *i.e.*, the employer must offer the employee essential minimum coverage to be effective no later than July 1, 2015, for the period of July 1, 2015 through June 30, 2016, or be subject to significant tax penalties.

Finally, the foregoing analysis only applies until the employer can determine the employee's status as an ongoing employee under the Standard Measurement Period, as discussed above; however, again, there is a twist. In the preceding example, while the employee qualified as a full-time employee under the Initial Measurement Period (May 15, 2014 to May 14, 2015), the employer must again determine the employee's status under the Standard Measurement Period (October 15, 2014 to October 14, 2015). Assuming the employee qualifies as a full-time employee under this analysis, then the employer will pay a tax penalty, unless the employer offers the employee coverage for the Stability Period of January 1, 2016 through December 31, 2016 (which overlaps somewhat with the Stability Period following the Initial Measurement Period of July 1, 2015 to June 30, 2016).

If, however, the employee did not qualify as a full-time employee during the Standard Measurement Period, then the employer need not offer the employee coverage during the Stability Period of January 1, 2016 through December 31, 2016. Nonetheless, because the employee earned a right to coverage for the initial Stability Period of July 1, 2015 through June 30, 2016 based on the hours he worked during the Initial Measurement Period of May 15, 2014 to May 14, 2015, the employee's coverage would not end until June 30, 2016. In other words, the failure to earn full-time status based on the Standard Measurement Period cannot be used to reduce the potential for one-year of coverage the employee has based on the Initial Measurement Period.

Seasonal Employees

A "seasonal employee" is defined as a worker who performs labor or services on a seasonal basis, such as during the summer or the winter

holidays. Again, an employer has two options when dealing with "seasonal employees": (a) it can simply concede that the employee will work an average of at least 30 hours per week, dispense with the need to make the calculations described below and treat the employee as a full-time employee; or (b) the employer must make either one or two of the following determinations:

First, when determining whether the employer is a "large employer"—employed more than 50 full-time / full-time equivalent employees during the prior calendar year—the employer can exclude entirely all seasonal employees who were employed on no more than 120 days during the prior calendar year. If the employer employs less than 50 full-time/full-time equivalent employees during the prior calendar year (thus, not a "large employer"), the employer is not subject to the shared responsibility rules and thus, not required to provide health insurance coverage under the ACA.

Second, if the employer is still a "large employer," then the question of whether a seasonal employee has to be considered when deciding who must be offered minimum essential medical coverage turns on the same analysis used for variable part-time employees that is described above.

For example, if the employer uses the first calendar year of employment as the Initial Measurement Period, and if the seasonal employee works an average of 50 hours per week during a three-month season, but that does not amount to an annual average of at least 30 hours per week, the seasonal employee is not considered to be full-time employee and need not be considered when determining who is a full-time employee.

Notice 2012-59: 90-Day Waiting Period Limitation

Notice 2012-59 provides temporary guidance under Public Health Service Act (PHSA) Section 2708 that will remain in effect at least through the end of 2014 and until regulations or other guidance is issued by the agencies. PHSA Section 2708 provides that, for plan years beginning on or after January 1, 2014, a group health plan or group health insurance insurer shall not apply any waiting period that exceeds 90 days. PHSA Section 2704(b)(4), ERISA Section 701(b)(4), and Code Section 9801(b)(4) define a waiting period to be the period that must pass with respect to an individual before the individual is eligible to be covered for health benefits under the terms of the group health plan. The Notice clarifies that being "eligible for coverage" means having met the plan's substantive eligibility conditions, such as being in an eligible job classification or achieving job-related licensure requirements specified in the plan's terms while the 90-day limitation remains in effect.

If, under the terms of a group health plan, an employee may elect coverage that would begin on a date that does not exceed the 90-day waiting period limitation, the 90-day waiting period limitation will be satisfied. Accordingly, a plan or insurer will not be considered to have violated PHSA merely because employees take additional time to elect coverage.

The new guidance also recognizes and addresses cases where it might take time to determine whether a newly hired employee will reasonably be expected to work the number of hours that would classify the employee as full-time (*i.e.*, 30 hours per week). In these circumstances, the plan may take a reasonable time period of time to determine whether the employee meets the plan's eligibility requirements and conditions for participation.

By way of example, the Notice describes a situation where an employee begins working 25 hours per week on January 3 and is considered a part-time employee for purposes of the employer's health plan. Under the employer plan, part-time employees are eligible for health coverage after they complete a cumulative 1,200 hours of service. The employee satisfies the plan's cumulative hours of service on December 15. The Notice concludes under this example that the employer must provide coverage to the part-time employee no later than the 91st day after the employee works 1,200 hours.

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The New Era of Health Care Benefits: Engaging Employees to Become Better Health Care Consumers

Douglas Ghertner

Even as we await significant elements of the Affordable Care Act (ACA) that will be implemented in 2014, the health care industry is evolving in a way that will impact how all consumers think about their health care.

As employers grapple with rising health care costs, many are turning to high-deductible and consumer-directed health plans (CDHPs), which place more responsibility on the shoulders of their employees. In fact, in recent years, CDHPs have seen significant growth, while enrollment in other plan types has remained flat or fallen. The American Association of Preferred Provider Organizations (AAPPO) estimates that 33 million people were enrolled in CDHPs in 2011, up from 28 million in 2010, an increase of 18 percent.[1]

Meanwhile, states are implementing public health insurance exchanges and private exchanges are expanding—bringing a new era of individually driven health care choices. An estimated 27 million people are projected to participate in public exchanges by 2016, and more than half of employers expect to move to defined-contribution plans and private exchanges during this same time.[2]

It's a new age in health care: the consumer age.

Greater consumer involvement in health care presents significant opportunities to drive down health care costs. Costs of common treatments and tests can vary widely among different providers, even within the same zip code.[3]

The accompanying chart illustrates tremendous opportunities to save, but often, consumers are either unaware that such great disparities in cost exist, or they are ill equipped to identify savings opportunities. To navigate the new health benefits landscape, consumers must have simple, personalized tools to help them understand health care costs, identify high quality providers of care, and take advantage of savings opportunities. And then they must be engaged to use these tools on an ongoing basis.

According to a National Business Group on Health survey, employers report lack of engagement as the top barrier to health care-related behavior change.[4] A survey of human resources professionals by the Society for Human Resource Management found 77 percent of respondents said it was challenging to engage employees in getting the best value from their plan and to encourage them to focus on their health and wellness.[5]

To realize the significant opportunity to reduce health care costs through greater cost transparency, consumers must be engaged in their care now more than ever.

Keys to Engagement: Helping Employees Seek Out the Best Value

Engagement is more than just signing up for a service offered by an employer or health plan. To truly save on health care costs, consumers must understand and regularly seek out savings opportunities.

Cost Range for Services	Low	High	Price Variance
Computed Tomography (CT/CAT) scan—Chest	$347	$1,832	527%
Magnetic Resonance Imaging (MRI) —Arm	$439	$2,466	501%
Office Visit—Family Practitioner	$105	$292	278%
Physical Therapy (PT) Evaluation	$50	$233	466%
Prescription Simvastatin	$192	$259	134%

True engagement requires three key elements:

1. *Greater Benefits Education*: Benefits are complex and, with the rise of public and private insurance exchanges and high-deductible plans, consumers may no longer be able to rely solely on their company's human resources professionals to help them understand and get the most out of their health benefits. As more consumers are forced to shop for their own care, they will need greater knowledge about their benefits, health care consumerism, and legislation that impacts their care.

   Today, fewer than 20 percent of employees understand their health benefits, according to a survey by benefits company Unum.[6] Best practices reveal that, to help combat this, benefits education should start early and continue throughout the year. By presenting the information in a fun and visual way, and in multiple formats, employees will better understand, apply, and retain the information.
2. *Personalized and Relevant Cost Information*: Average cost information for a particular region isn't enough to help consumers become actively involved in shopping for their care. Consumers need to know what their provider charges and what their out-of-pocket costs will be based on their own health plan's co-pay levels, co-insurance, and other factors. To truly help consumers save on care, they need the ability to compare providers side-by-side, and savings must be personalized across the health care spectrum—prescription, medical, and dental services. Quality ratings should also go hand-in-hand with cost information, so consumers can seek out care based on the best value—identifying the highest quality providers and not just the lowest cost option. Finally, the information needs to be easy to understand and simple to find. Without relevant and personalized information, consumers are less inclined to act on a savings opportunity.
3. *Proactive Savings Opportunities Delivered on an Ongoing Basis*: Saving on health care isn't a one-time opportunity. Proactively alerting consumers to savings opportunities on an ongoing basis, based on services they are already using, is key to helping them stay engaged in their care all year long.

   It is important to remember that sustainable engagement is the goal—not just single encounters. Consumers must do more than just register to use a tool. They've got to register and then engage in the process of shopping for care—again and again. Further, consumers who receive proactive, personalized savings information and act on that information are more than four times more likely to look up cost information in the future on their own.

   Proactively engaging consumers around new savings opportunities—personalized to their needs—keeps health care top of mind and turns shopping for care into a habit.

Shopping for Care Pays Off: Navigating the Road Ahead

Engaging employees to shop for their care can result in significant savings for employers. An analysis of savings opportunities for an international diversified technology company in the Midwest with more than 40,000 employees found the company and its employees could save $17.5 million a year, or roughly $450 per employee, on "shoppable services."

And it's not just employers that save. Employees in a CDHP who have access to cost transparency tools can substantially increase their health care savings. Faced with skyrocketing health care costs and new insurance rules under the ACA, more of the nation's biggest businesses will look to high-deductible plans, CDHPs, and defined-contribution plans to reduce their health care costs, compelling plan members to become more proactive, informed health care consumers. We know that savings opportunities exist. It's a matter of finding them and taking appropriate action.

To do this, consumers must have easy-to-use, personalized tools to keep them engaged in their own health care, and resources for staying abreast of the ever-changing health care landscape. The time has come to start shopping for health care the way we shop for everything else—with an eye for cost, quality, and convenience and ultimately, getting the best value.

Notes

1. American Association of Preferred Provider Organizations. AAPPO Survey of Consumer-Directed Health Plans. June 2012.
2. Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act, Congressional Budget Office, March 2012.
3. Analysis of Data from Change Healthcare's Customer Database.
4. "Performance in an Era of Uncertainty: 17th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care." National Business Group on Health. Web 3 Dec. 2012. *http://www.towerswatson.com/assets/pdf/6556/Towers-Watson-NBGH-2012.pdf.*
5. "The State of Consumer-Directed Health Plans in the Workplace: SHRM Poll." SHRM. Web 3 Dec. 2012. *http://www.shrm.org/Research/SurveyFindings/Articles/Pages/StateofConsumerDirectedHealthPlans.aspx.*
6. "Beyond the Usual Benefits: 2012; The Power of Employee Education to Influence Workforce Satisfaction." UNUM. Web 15 Feb. 2012. *http://forms.unum.com/StreamPDF.aspx?strURL=/FMS_099229-4.*

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Achieving a Physically Healthy Workforce and a Fiscally Healthy Workplace

Peter C. Savage

As the job market begins to turn the corner, potential and even current employees will have the luxury of being a bit more selective than they might have been three or four years ago. Then, the economy was looking so dismal that those who had jobs were not willing to risk giving up their current job to look for something better, and those who were looking would be happy to take whatever was offered. Benefits packages began to be seen as purely bonus and not much was expected of them.

As the country eases out of the recession, unemployment recedes, and additional economic indicators note an uptrend, suddenly benefits packages are being looked at much more closely once more. A strong benefits package can allow an employer to secure a more qualified candidate, and can ensure that valued employees are retained, which in turn cultivates a happy and productive work environment.

But how does an organization that may still be looking to cut or at least maintain expenses determine what the best health care plan is for their employees without sabotaging the budget in the process? And how did health care costs become so expensive in the first place?

In the late 1940s, veterans returning from World War II transitioned into civilian life and re-entered the workforce. To recruit these honored and skilled workers, employers offered health plans as a way of securing the highest level workforce possible. These plans provided catastrophic coverage, which addressed costs beyond routine medical expenses. As health care costs ballooned as a result of the construction of new medical facilities and the introduction of new medical procedures and medications, combined with outside elements such as inflation and government mandate, health care plans became even more attractive to employees. As such, insurers and employers began offering even richer health care plans, which, in cyclical fashion, drove health care costs even higher.

While today's employee demands a health care plan that provides comprehensive benefits, employers of the 21st century are now looking to insurers become more creative in structuring plans that address the steep rise in the cost of health care insurance. More recently, enactment of the federal government's Patient Protection and Affordable Care Act has led to further examination of the coverage and cost of health care insurance plans that employers can feasibly provide.

When conducting this review of health care options, several considerations should be kept in mind.

Plan Design

From both a fairness and a competitive perspective, plan design is the first consideration. Dozens of plan types are available, including Indemnity, Preferred Provider Organizations (PPOs), Point of Service (POS), and Health Maintenance Organizations (HMOs). Given this, it is important for an employer to decide whether to offer one plan or choices to employees and their families.

Indemnity plans allow for participants to make all the choices without management of care by a primary care provider. Given that these plans also allow a covered person to be treated by any provider and to receive services virtually without limit or cost controls, indemnity plans can become rather pricey rather quickly. Furthermore, indemnity plans have minimal enrollment, resulting in a lack of incentive for providers to negotiate discounted payments with insurers. Not surprisingly, indemnity plans are much less popular presently.

PPOs, on the other hand, are designed to control costs by limiting the choice of providers. This type of plan encourages those enrolled to utilize the care offered by network providers with whom the carrier has contracted for advantageous pricing. While an enrollee may venture outside of the provider network, he or she does so at additional personal cost. PPOs work to incorporate consumerism into health plans by involving the subscriber in the

decision-making process, with the expectation that additional costs will encourage the use of less expensive providers.

The POS plan is similar to the PPO plan in that enrollees can go outside the health care network at additional personal cost. However, a POS plan is an increased control model, in which a Primary Care Provider (PCP) is determined and given responsibility to oversee care and approve all additional needed providers (i.e., specialists) for the subscriber. This plan offers cost control by consolidating medical care responsibility with one physician.

Evolving from the POS concept, HMOs place further restrictions on an enrollee by requiring the enrollee to choose a PCP that will refer him or her to network providers only. As the in-network component of the POS, an HMO plan also requires the enrollee to be responsible for all costs should he or she choose to go outside the network.

The main difference between these newer plans and the older indemnity plans is that they cover the costs of preventive services such as annual physicals or screenings. The intent of such a strategy was to help people to stay healthier, with the end goal being that health care costs would be lessened as a result of a healthier subscriber base. Yet as sound as that strategy was and is, given the advancement of new medical procedures, technology, and pharmaceuticals, costs continue to rise.

As a result, Consumer Driven Plans have appeared on the health care scene. These plans offer more participation by enrollees in the decision-making process concerning their care, although they do include higher upfront deductibles. That said, the upfront deductible costs may be satisfied with pre-tax funds available through Flexible Spending Accounts (FSAs), Health Reimbursement Accounts (HRAs), or Health Savings Accounts (HSAs), which will be discussed further below.

Costs

As mentioned earlier, it can be challenging for an employer to find the right balance between how rich of an insurance plan to offer its employees, and how much the company can afford to pay for such a plan. While deciding on the overall cost can be quite simple (what percentage of company income are they willing to spend on health care), what is purchased with that amount can quickly become much more complicated.

Seemingly obvious, the more benefits provided by a plan, the higher the cost. Therefore, if an employer opts for a plan that provides coverage at low cost to the employee, a plan that offers fewer benefits results. However, if an employer opts for a shared cost model, a health care plan that offers more benefits is possible, with the cost shared by the employee.

Presently, consumer-driven plans are rather popular. Within these plans, a company would offer a fairly rich PPO or HMO that included a fairly substantial upfront deductible (*e.g.,* $2,000 for an individual or $4,000 for a family). Once the deductible has been satisfied, though, the plan would provide full coverage.

To assist in covering the cost of these deductibles, the IRS has approved several types of accounts (mentioned previously) that enrollees can use to pay deductibles and copays with pre-tax dollars. Three of the most common are the FSAs, HRAs and HSAs.

FSAs allow subscribers to identify a fixed amount to be deducted from wages before taxes and placed in an account that can be used to reimburse for allowable medical costs. Employees should err on the conservative side when determining the amount of money to be taken out and placed in this account, as any money not used by the end of the year reverts back to the employer.

In contrast, HRAs are funded entirely by the employer, which sets the guidelines for the account from which the subscriber can be reimbursed for medical expenses not covered by the health care plan. Employers might be motivated to choose this option as it offers employees a "promise to pay" up to established limits, yet once again the employer would keep any funds not used.

HSAs differ from both FSAs and HRAs in that both the employer and the subscriber may contribute to an HSA, and the HSA allows pre-tax funds to grow through investment. HSAs are selected due to their ability to combine with a high deductible health care plan in a way that encourages an employee to be involved in his or her health care decisions, which typically results in lower cost options. An HSA is the possession of the employee, and follows the employee into retirement, at which point funds may be withdrawn without being taxed to pay medical costs. HSAs can only be offered in combination with high deductible health care plans.

Contribution Ratios

Related to costs, another significant consideration for the employer is how the health care costs will be divided between the company and the employee. If the organization chooses to assume a large percentage of the costs, it bears to reason that they may be forced to offer a plan with fewer benefits.

Larger companies have the ability to offer several plans with different contribution ratios, based on benefits and plan design. This approach allows an employer to offer a choice of plans at different cost levels.

Funding Types

In most cases, smaller and mid-sized companies (150 or less employees) offer health care insurance on a premium pay basis. With this type of funding, the insurer pays all the claims, and usually results in high premiums.

Larger companies, however, may choose to self-insure their health

plan. In this model, the company, rather than the insurer, assumes the risk, which is mitigated through the purchase of reinsurance (usually either specific coverage or aggregate coverage). Companies can also opt to partially self-insure their health care plan.

Conclusion

Determining what health care plan is right for an organization is a careful balance of plan options and costs, to ensure that employees stay happy, healthy, and productive while the company maintains fiscal soundness. By carefully weighing options with regard to plan type, cost, contribution ratio and funding type, and by working with a health care consultant or broker to provide the information needed to navigate soundly through the realm of health care insurance, an organization can achieve a balance that ensures a healthy and successful workforce and a financially fit organization.

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Facebook Photos Doom Employee's FMLA Retaliation Claim

After working for Advantage Health Physician Network for about 18 months, the plaintiff in this case began taking intermittent leave under the Family and Medical Leave Act, claiming that she was incapacitated from pain from a back injury she had sustained years earlier. About five weeks into her leave, several of her coworkers saw pictures of her at a local festival on Facebook and brought the matter up with their supervisor. After reviewing the matter internally and meeting with the plaintiff, Advantage terminated her for fraud. The plaintiff sued Advantage, asserting that it had retaliated against her for taking FMLA leave. The district court granted summary judgment in favor of Advantage, and the plaintiff appealed.

The U.S. Court of Appeals for the Sixth Circuit found that Advantage had "rightfully considered workplace [FMLA] fraud to be a serious issue," and ruled that its termination of the plaintiff because of its "honest belief" that she had been dishonest concerning her claim that she was incapacitated constituted a nonretaliatory basis for her discharge. The circuit court found that Advantage's investigation had been adequate and found that the plaintiff had not refuted Advantage's honest belief that her behavior in the photos was inconsistent with her claims of total disability. Thus, the circuit court concluded, "as a result of her fraudulent behavior, her claim of FMLA retaliation fail[ed]." It therefore upheld the district court's decision in favor of Advantage. [*Jaszczyszy v. Advantage Health Physician Network*, 2012 U.S. App. LEXIS 23162 (6th Cir. Nov. 7, 2012).]

Circuit Court Reinstates Nurse's FMLA Interference Claim

The plaintiff in this case worked as a nurse in the rehabilitation unit of St. Therese of New Hope, a long term care facility in New Hope, Minnesota. Despite an understanding among employees that St. Therese's nursing staff could be "floated" to different units within the facility, the plaintiff received training only for the rehabilitation unit and worked there exclusively until she was reassigned to St. Therese's long term care unit.

The plaintiff, who had earlier begun experiencing symptoms of an undiagnosed anxiety disorder, expressed apprehension about working in a unit for which she was not trained. She emphasized that she was not refusing to work, but requested that she receive unit-specific training prior to reassignment. The plaintiff claimed that her supervisors informed her that she had "no choice. You either work or you don't have a job and that's called patient abandonment and you can lose your license." The plaintiff went to St. Therese's human resources office, exhibited signs of a panic attack, was instructed to go home, and was told that something would be worked out the next day.

The plaintiff went to the doctor the next day; her doctor suggested the anxiety attack had been situationally triggered, advised therapy, and prescribed two medications. In a note addressed to St. Therese, the plaintiff's doctor recommended she take the remainder of the week off from work.

At 9:30 that same morning, the plaintiff delivered her doctor's note to St. Therese's human resources department. In return, the department provided her with Family and Medical Leave Act (FMLA) forms. Later that day, a member of St. Therese's human resources staff called the plaintiff at home to inform her that she had been terminated the previous day for walking off the job.

The plaintiff's doctor returned the FMLA forms two days later, describing the plaintiff as "suffering from anxiety and panic attacks" and requesting she be excused from work for one week due to the severity of her condition. A few days later, St. Therese registered a complaint regarding the plaintiff with the Minnesota Board of Nursing, alleging that she had "refused work assignment and walked out."

The plaintiff sued St. Therese, alleging among other things that St. Therese had impermissibly interfered with her right to take reasonable leave for medical reasons in violation of the FMLA. St. Therese moved for summary judgment, arguing that the plaintiff was not

entitled to FMLA rights because she had no longer been an employee at the time she asserted them and, in any case, she had been terminated for reasons "wholly unrelated to the FMLA." The district court granted summary judgment in St. Therese's favor, and the plaintiff appealed.

In its decision reversing the district court, the U.S. Court of Appeals for the Eighth Circuit explained that the FMLA entitles an employee to 12 workweeks of leave during any 12-month period if the employee has a "serious health condition" that makes the employee "unable to perform the functions of the position of such employee." A "serious health condition" is any "illness, injury, impairment, or physical or mental condition that involves (A) inpatient care in a hospital, hospice, or residential medical care facility; or (B) continuing treatment by a health care provider." Continuing treatment is defined as "[a] period of incapacity of more than three consecutive, full calendar days and any subsequent treatment or period of incapacity relating to the same condition."

Applying these definitions, the Eighth Circuit decided that the plaintiff's diagnosed incapacity for one full week, accompanied by two prescriptions for medication and an advised course of ongoing therapy, satisfied the FMLA standard for a "serious health condition."

The circuit court then examined whether the plaintiff had sufficiently asserted a case of interference with her FMLA rights. To have done so, the circuit court continued, the plaintiff must have given timely notice to St. Therese of her need for FMLA leave. It pointed out that the day after she had exhibited signs of severe distress and visible manifestations of anxiety as a result of her work reassignment, she provided St. Therese with a doctor's note indicating that she may have had a serious health condition.

The circuit court then rejected St. Therese's argument that the plaintiff was no longer an eligible employee when she put St. Therese on notice of her health condition because her supervisors had construed her leaving work as quitting. According to the circuit court, the plaintiff "only left the premises" upon the instruction of St. Therese. In addition, the circuit court continued, St. Therese admitted that the plaintiff's supervisors and the human resources staff did not discuss her allegedly voluntary termination until the same morning that plaintiff provided St. Therese with her doctor's note by 9:30 a.m., and that St. Therese's response to her submission of her doctor's note that morning was not to inform her that she was no longer employed, but to provide her with FMLA forms. Accordingly, the Eighth Circuit concluded, there was a question of material fact as to whether St. Therese was on notice of her potentially FMLA-qualifying condition prior to its determination that her employment had ended (whether voluntarily or involuntarily).

The Eighth Circuit therefore ruled that the district court had erred in concluding as a matter of law that the plaintiff could not establish an interference claim under the FMLA. [*Clinkscale v. St. Therese of New Hope*, 2012 U.S. App. LEXIS 23282 (8th Cir. Nov. 13, 2012).]

Circuit Court Affirms Decision Dismissing FMLA Interference and Retaliation Claims

In July 2009, the plaintiff in this case, a billing specialist with CommunityCare HMO, Inc. (CCH), requested nine to 12 weeks of leave under the Family and Medical Leave Act (FMLA) for a knee replacement surgery scheduled for October 2009. However, she used 64 hours of her available FMLA leave that August for a knee injury, and CCH's human resource manager sent the plaintiff written notice that she had used 64 of her 480 hours of annual FMLA leave. The plaintiff had her knee replacement surgery in October, using FMLA leave.

In November, CCH sent the plaintiff written notice that her remaining FMLA leave would expire on December 16, 2009. Three weeks later, the plaintiff requested an extended leave of absence, stating that if, after her next appointment on December 28, her doctor told her she was able to work, she might be able to return "around" January 4, 2010.

CCH denied the plaintiff's extended leave request, but offered to accommodate her medical needs in any manner upon a December 16 return, including reduced hours or work restrictions. The plaintiff did not respond to that offer.

On December 16, when the plaintiff did not return to work, CCH, which had a written FMLA policy that stated that any employee who failed to return to work at the expiration of FMLA leave would be subject to termination, terminated her employment. She then filed a complaint alleging CCH had terminated her in violation of the FMLA. The district court granted CCH's motion for summary judgment, and the plaintiff appealed.

In its decision affirming the district court's ruling, the U.S. Court of Appeals for the Tenth Circuit first held that the plaintiff had not presented any evidence that CCH had interfered with her rights under the FMLA. As the circuit court noted, it was "undisputed" that prior to her surgery, CCH had given her written notice of the amount of her available FMLA leave and had provided her the full amount of FMLA leave available to her. The circuit court also rejected the plaintiff's contention that CCH should have granted her extended leave request, explaining that CCH was not obligated to provide more than the statutorily-required amount of FMLA leave.

The circuit court then rejected the plaintiff's argument that CCH's stated

reason for terminating her was pretext for retaliation. It explained that CCH had stated that it was terminating the plaintiff's employment because she had exhausted her FMLA leave and had failed to return to work, adding that CCH's FMLA policy stated that employees could be terminated if they failed to return to work at the expiration of their FMLA leave. The circuit court then concluded that there was no evidence that suggested that CCH's proffered reason was implausible, inconsistent, incoherent, or otherwise pretextual. Accordingly, it affirmed the district court's summary judgment dismissal of the plaintiff's FMLA retaliation claim. [*McClelland v. CommunityCare HMO, Inc.*, 2012 U.S. App. LEXIS 24562 (10th Cir. Nov. 29, 2012).]

Circuit Court Rejects EEOC Contention that Medical Information Revealed in Response to Job-Related Inquiries Is Protected Under the ADA

The Equal Employment Opportunity Commission (EEOC) sued *Thrivent Financial for Lutherans* on behalf of Gary Messier, alleging that Thrivent had violated the medical record confidentiality requirements of the Americans with Disabilities Act (ADA). The EEOC asserted that Mr. Messier had been hired by *Omni Resources*, Inc., a technology consulting agency, to work as a temporary programmer for Thrivent pursuant to an agreement between Omni and Thrivent. According to the EEOC, after Mr. Messier left Omni and Thrivent, he had a difficult time finding a new job and began to suspect that Thrivent was saying negative things about him to prospective employers that called for reference checks. The EEOC alleged that during reference checks, Thrivent was revealing information about Mr. Messier's migraine condition to prospective employers in violation of the ADA's requirement that employee medical information obtained from "medical examinations and inquiries" be "treated as a confidential medical record."

The district court found that Thrivent had learned of Mr. Messier's migraine condition outside the context of a medical examination or inquiry and that the ADA's confidentiality provisions therefore did not apply. Accordingly, it granted summary judgment to Thrivent.

The EEOC appealed to the U.S. Court of Appeals for the Seventh Circuit, arguing that the ADA's confidentiality provisions protected all employee medical information revealed through "medical inquiries" as well as employee medical information revealed through "job-related" inquiries. The circuit court, however, rejected the EEOC's argument.

The Seventh Circuit explained that the title of the section of the ADA at issue was "[m]edical examinations and inquiries." It stated that the use of the inclusive conjunction "and" in the title—instead of a limiting or contrasting conjunction such as "or"—suggested that the examinations and inquiries referred to in the section title were within the same class or type: they both were medical. At the very least, it said, the use of the conjunction "and" indicated that the adjective "medical" modified both "examinations" and "inquiries."

The Seventh Circuit added that the subject matter discussed in the body of the section confirmed that the word "inquiries" did not refer to all generalized inquiries, but instead referred only to medical inquiries. As the circuit court noted, the entire section was devoted to a discussion of a disabled employee's "medical record," "medical condition or history," "medical files," and medical "treatment."

In sum, the circuit court concluded, the EEOC's argument that the word "inquiries" referred to all job-related inquiries, not to just medical ones, "ignore[d] the content of the rest of the section." Accordingly, it agreed with the district court that Thrivent had not violated the ADA by allegedly revealing Mr. Messier's migraine condition because the ADA did not apply. [*Equal Employment Opportunity Commission v. Thrivent Financial for Lutherans*, 700 F.3d 1044 (7th Cir. 2012).]

Plaintiff's Claim That She Was Fired Because She Was Ill Is Rejected

The plaintiff in this case contended that she was fired in violation of federal law and New York law because she was ill. In response, her employer contended that she was terminated as part of an effort to reduce costs during an economic downturn. The trial court granted the employer's motion for summary judgment, and the plaintiff appealed.

In its decision affirming the district court's ruling, the U.S. Court of Appeals for the Second Circuit first examined the plaintiff's claim under Section 510 of ERISA, which provides that it is unlawful for an employer to, among other things, terminate an employee either in retaliation for using a qualified employee health plan or to interfere with the employee's use of that plan. It explained that an "essential element" of this ERISA claim was that defendants were motivated by a specific intent to engage in activity prohibited by Section 510 so that the plaintiff's loss of health insurance benefits was not "a mere consequence

of, but . . . a motivating factor behind, a termination of employment."

Here, the Second Circuit found, there was no evidence that the supervisors who made the decision to lay off the plaintiff had any knowledge of her health insurance claims or claim history or had terminated the plaintiff to cut health care costs. Moreover, the circuit court rejected the plaintiff's argument that her employer's claim that her termination was part of an effort to reduce costs was undercut by the fact that it hired new employees around the same time it fired her, finding that those new employees filled different, preexisting positions.

Additionally, the circuit court rejected the plaintiff's contention that her firing violated New York law that made it unlawful, among other things, for an employer to discharge an employee because of his or her disability, finding no evidence that the plaintiff's employer's proffered reason for terminating her was pretextual or that discriminatory intent motivated her termination. Simply put, the Second Circuit pointed out, the plaintiff "was one of many employees laid off by [her employer] at a time when its business prospects were deteriorating." Short of speculation, it concluded, there was "no evidence" that the plaintiff's illness "played even a partial motivating role in the decision to terminate her." [*Goia v. Forbes Media LLC*, 2012 U.S. App. LEXIS 22689 (2d Cir. Nov. 5, 2012).]

Contractor's State Law Claims under Group Accident-Protection Policy Are Preempted by ERISA

The plaintiff in this case sued North American Benefits Co. (NABCO), BCS Insurance Co. (BCS), and OSJ Corp. d/b/a Mister Towing Services in a Texas state court, alleging that he was covered by a group accident-protection insurance policy that his former employer, Mister Towing Services, had obtained, but that the insurers had refused to pay him for all the medical expenses he incurred after he was injured in an accident at work. The plaintiff asserted claims under the Texas Insurance Code and for breach of the duty of good faith and fair dealing.

NABCO and BCS removed the case to federal court and moved to dismiss, arguing that the plaintiff's state law claims were preempted by ERISA.

In its decision dismissing the complaint, the court first found that the policy met the definition of an "employee welfare benefit plan" under ERISA because it had been purchased by Mister Towing Services to provide accidental death and dismemberment, accidental medical and dental expense, and accidental weekly indemnity insurance benefits to covered "Insureds."

The court then rejected the plaintiff's argument that ERISA's "safe harbor" provision excepted the policy from ERISA. As the court observed, the policy required Mister Towing Services to pay the premiums and required Mister Towing Services to provide enrollment documents and other information to help with administration. The policy also provided for an "ongoing administrative program" to identify those eligible for coverage and to calculate premium amounts. According to the court, these requirements disproved two of the safe harbor elements: (i) plans under which no contributions were made by an employer, and (ii) plans under which the sole functions of the employer were to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs, and to remit them to the insurer.

In addition, the court rejected the plaintiff's contention that as an independent contractor of Mister Towing Service and not an employee, he was not a participant or beneficiary and that ERISA therefore did not preempt his claims. The court reasoned that the policy defined an "Insured" as "an Eligible Person" who was covered under the policy and defined "Eligible Person" to include a "Contractor" if that person were identified by the "Policyholder or the Contractor" in one of three specified ways, as the plaintiff had been.

Accordingly, the court ruled that the plaintiff's state law claims—for violations of the Texas Insurance Code and for breach of the duty of good faith and fair dealing in the denial of benefits—were completely preempted by ERISA. The court concluded by adding that it also had to dismiss the plaintiff's jury demand, as there was no right to a jury trial in an ERISA case. [*Salman v. North American Benefits Co.*, 2012 U.S. Dist. LEXIS 174068 (S.D. Tex. Dec. 7, 2012).]

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Mark S. Weisberg

Employer Shared Responsibility Rules: Controlled Group Determinations and Coverage and Affordability Safe Harbors

Beginning in 2014, the Patient Protection and Affordable Care Act, as amended (the Act) requires large employers to provide affordable health coverage to full-time employees or pay a penalty. This requirement is commonly referred to as the Act's shared responsibility provisions. The Department of the Treasury recently issued proposed regulations clarifying the Act's shared responsibility provisions. While the proposed regulations generally follow previously issued guidance, the regulations contain significant new rules and safe harbors. This column covers rules that apply to employers in controlled groups and safe harbors that provide employers with added flexibility in administering the shared responsibility rules.

Background

The Act provides that an employer with an average of at least 50 full-time employees during the preceding calendar year (known as a large employer) is subject to a penalty if either:

- The employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in employer-sponsored minimum essential coverage and any full-time employee is certified to the employer as having received an applicable premium tax credit or cost sharing reduction; or
- The employer offers its full-time employees (and their dependents) the opportunity to enroll in employer-sponsored minimum essential coverage that is unaffordable and one or more full-time employees is certified to the employer as having received an applicable premium tax credit or cost sharing reduction.

The penalty for failing to provide coverage is, for each month, equal to the number of full-time employees (reduced by 30) multiplied by 1/12 of $2,000 (in 2014 and adjusted for inflation thereafter). The penalty for providing unaffordable coverage is, for each month, equal to the number of full-time employees who receive an applicable premium tax credit or cost-sharing reduction multiplied by 1/12th of $3,000 (in 2014 and adjusted for inflation thereafter). For purposes of determining whether an employer meets the 50 full-time employee threshold, part-time employees are aggregated to determine full-time equivalent employees.

Large Employer Determination Based on Controlled Group

The proposed rules address the application of the shared responsibility rules to employers who are part of a controlled group. Under the Act, the determination of large employer status is made on a controlled group basis by applying the aggregation rules under Internal Revenue Code Sections 414(b), (c), (m), and (o). As indicated above, in calculating penalties for failing to provide coverage, an employer is permitted one reduction of 30 full-time employees. This reduction is allocated ratably among the members of the employer's controlled group based on the number of each member's full-time employees.

The proposed rules provide that, although large employer status and the 30 employee reduction is determined on a controlled group basis, the determination of whether an employer is subject to a penalty and the amount of the penalty is determined on an individual member basis. For example, if a corporation owns 100 percent of the stock of 10 subsidiary corporations, the employees of the parent corporation and the subsidiary corporations are aggregated to determine if the shared responsibility rules apply. However, if three subsidiaries fail to provide coverage, only those three subsidiaries would be assessed a penalty. The penalty would be reduced to reflect each non-providing subsidiaries' share of the 30-employee reduction. Neither the parent nor any of the other seven subsidiaries would be liable for any share of the non-providing subsidiaries' penalty.

Many employers will easily be able to determine whether or not they are subject to the shared responsibility rules. However, employers that are on the cusp of employing 50 full-time employees, or employees with large part-time workforces, may have some difficulty determining whether they have met the threshold. The proposed rules provide transition relief for the 2014 calendar year. This relief provides an employer the option to determine its status as a large employer by reference to a period of at least six consecutive calendar months in 2013 (as opposed to the entire 2013 calendar year). Employers are given the flexibility to determine the six-month period. For example, an employer could use the period from March through August 2013 to determine if it is a large employer and the period from September through December 2013 to make any needed adjustments to its plans.

Coverage Safe Harbor

As indicated above, a large employer that fails to offer all full-time employees coverage may be subject to a penalty. If a penalty is triggered under this provision, the amount of the penalty is determined by reference to a member's total number of full-time employees (including full-time employees who have been provided coverage).

The proposed rules allow for a margin of error in determining whether an employer has failed to offer coverage to full-time employees. The proposed rules provide that a large employer (or a member of its controlled group) will be treated as offering coverage to all its full-time employees for a calendar month if, for that month, it offers coverage to all but the greater of five percent or five of its full-time employees. The five-employee limitation will generally apply only to smaller members of a controlled group who fail to offer coverage to a handful of employees. For example, if a member of a controlled group that is subject to the shared responsibility rules has 10 employees and it fails to offer coverage to three employees, it would not be treated as having failed to offer coverage to all its full-time employees despite exceeding the five percent limitation. The proposed rules indicate that this relief applies regardless of whether the failure to offer was inadvertent.

Affordability Safe Harbors

As indicated above, if a large employer fails to offer coverage that is affordable to its full-time employees, it may be subject to a penalty. Importantly, this penalty can be triggered in an employer offers coverage to at least 95 percent (or, if greater, five) but less than 100 percent of its full-time employees (thus meeting the safe harbor described above) and one or more of those employees who are not offered coverage receive a premium tax credit or cost-sharing reduction.

Coverage is generally not affordable if an employee is required to contribute more than 9.5 percent of his or her household income for the taxable year. For purposes of applying the 9.5 percent limitation, the proposed rules adopt an existing Form W-2-based safe harbor and provide for two additional safe harbors. Importantly, these safe harbors are all optional. An employer can use one or more of these safe harbors for all its employees or for any reasonable category of employees, if it does so on a uniform and consistent basis.

First, the 9.5 percent threshold can be calculated by measuring each employee's contributions against the total amount of wages required to be reported in Box 1 of Form W–2, Wage and Tax Statement (W-2 wages). For example, an employer would determine whether it met the Form W–2 safe harbor for 2014 for an employee by looking at that employee's 2014 Form W–2 wages and comparing 9.5 percent of that amount to the employee's 2014 employee contribution. An employer could also use this safe harbor prospectively at the beginning of a year by setting contribution levels so that employee contributions would not exceed 9.5 percent or W-2 wages. For new employees that are not allowed to participate immediately, the proposed rules provide that the 9.5 percent limit is applied only for the period in which coverage was offered to the employee. For example, if an employee worked eight months of a calendar year earning $24,000 in W-2 earnings, and he or she is offered coverage for only five of these months, the adjusted wages would be $24,000 multiplied by 5/8 or $15,000. That $15,000 would then treated as the Form W–2 wages for purposes of determining whether the employee share of the premium for each of the five months of coverage offered was affordable.

Second, the proposed rules introduce a rate of pay safe harbor under which the employer would (1) take the hourly rate of pay for each hourly employee who is eligible to participate in the plan as of the beginning of the plan year, (2) multiply that rate by 130 hours per month, and (3) determine affordability based on the resulting monthly wage amount. Coverage is affordable if the employee's monthly contribution amount is equal to or lower than 9.5 percent of the employee's applicable hourly rate of pay × 130 hours. For salaried employees, monthly salary would be used instead of hourly rate multiplied by 130.

Third, the proposed rules introduce a federal poverty line (FPL) safe harbor that provides that coverage is affordable if the employee's cost for coverage under the plan does not exceed 9.5 percent of the FPL for a single individual. For these purposes, employers are permitted to use the most recently published poverty guidelines as of the first day of the plan year.

Comments

It is expected that these proposed rules will become effective when finalized. Comments on these and other aspects of the proposed rules must be received by March 18, 2013.

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Michael Klachefsky

Encouraging Enrollment for Voluntary Products Among the Millennial Generation

By the year 2020, one in two employees will be a millennial.[1] This type of age density has not been seen since the baby boomers entered the workforce, and it is starting to influence the way employers interact with their employees. The oldest millennials—members of a group of individuals born between 1981 and 2000 who are coming of age in the new millennium[2]—are just turning 30 while the younger members are embarking on their future career endeavors.

Millennials in the workforce are currently facing a higher offering of voluntary benefits from their employers, compared with employer-funded benefits programs. As employers cover the increasing cost of health care, many are shifting the scope of benefits coverage for their employees. This shift is highly evident in the transition from employer-sponsored Life and Disability Insurance benefits to voluntary insurance.

Voluntary products allow employers to have additional products and services available for employees to purchase—but without additional expense to the employer. Many employers may undertake this cost shifting of disability benefits to employees, as it can result in a minor premium savings for employers, which they may consider to stay in the black during lean economic times.

During a time when voluntary coverage is playing a larger role in employers' benefit offerings, it is important for employers to find fresh, engaging ways to educate and assist employees on the importance of these benefits. For the millennial generation, which demands instant technology access and information right at its fingertips, using an online educational module is an opportunity to inform them of the need for coverage and, in turn, encourage enrollment.

Who Are the Millennials?

Like people, generations have personalities. Typically, their collective identities typically begin to reveal themselves when their oldest members move into their teens and 20s and begin to act upon their values, attitudes and worldviews. Millennials are in the middle of a coming-of-age phase of its life cycle. Its oldest members are approaching age 30; its youngest are approaching adolescence.[2]

Tech-savvy millennials are the first generation in history to view social media and Internet technology as an everyday part of their lives, not as an innovation of the digital era. They use Web sites such as Facebook, YouTube and Google, and send tweets and texts to better understand the world around them.

Although they excel with technology, they also have been subjected to the pressures of an uncertain economy and a lackluster workforce in recent years. According to the Pew Research Center, households headed by adults younger than 35 had 68 percent less wealth than households of their same-aged counterparts had in 1984.[3] This statistic calls into question whether millennials have the savings to withstand interruptions in their household incomes.

In 2009, 38 percent of adults under age 35 owned their own homes, compared with 40 percent of the same age group in 1984.[3]

Due to these factors, millennials are especially vulnerable to risks against which Disability and Life Insurance protect. One way to do this is to help them make decisions to help them make decisions for a secure financial future.

Bringing Information to Millennials

Employers can turn these insights about the millennial generation into educational initiatives. By harnessing this generation's demand for instant information and educational training, HR managers can bridge the information gap and educate millennial employees on the importance of voluntary Disability Insurance. Two types of initiatives can assist HR managers in this mission and encourage enrollment: informing millennials on the financial risk of disability and educating them on their own benefits offerings.

First, HR managers can help workers better understand the financial challenges that may arise if they experience a disabling disease

or injury by using an online educational program. The vast majority of workers—more than two-thirds—do not have the benefit of private long-term disability insurance.[4]

Industrywide educational initiatives, such as the Council for Disability Awareness' Defend Your Income Campaign, can equip this generation to take the important steps necessary to preserve their ability to earn an income, should they face a disabling illness or injury.

This program unites an online experience, a platform that this generation has embraced, with information designed to enable individuals, particularly those just entering the workforce, to take important steps to preserve their ability to earn an income. Including quizzes and interactive games, the program can inform millennials about these risks to their financial health.

According to a survey taken by the Council for Disability Awareness, over half of survey respondents thought only 1 in 100, or 1 in 50 working Americans are likely to become disabled during their working careers.[5] Because many young workers think they will never experience a disability, they have not taken the proper steps to protect their finances.

Second, employers can better engage millennials in the voluntary market by using an online interactive educational module to help them understand the voluntary life and disability benefits available to them through their employer. The modules can help millennials overcome enrollment barriers and allow them to make the right decision for their situation during enrollment. They also can help employees learn the basics of how their specific policy works, how to estimate their needs, select appropriate coverage and enroll. This approach gives employees an opportunity to take full advantage of their benefits and understand how their coverage meets their needs.

Features of these types of modules include other key features, including calculator tools that help motivate individuals to apply for coverage and protect their long-term finances and an intuitive step-by-step guide through the life and disability benefits decision-making process. In addition, users are provided with a direct link to the employer's enrollment website or form and video explanations.

For businesses with remote locations or a small number of employees, this tool allows employers an easy, yet effective, way to walk through enrollment materials when an on-site option is not feasible. This approach provides employees with relevant, consistent information about benefits in a cost-effective and simplified manner.

Preparing Millennials for the Future

Implementing these two online educational tools can help protect employees, especially those in the millennial generation, from the financial risks of serious illness or injuries. Educating them, in a manner in which they are accustomed to learning, on the need for voluntary Life and Disability Insurance also can lessen the risk of the financial impacts of a disability, better preparing them for the future.

By understanding the educational needs and inherent characteristics of the millennial generation entering the workforce, employers can adequately prepare for this new generation. Learning how to connect this generation with information on the needs of voluntary insurance translates into a win for both employers and their employees.

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Alan D. Berkowitz, Jennifer L. Burdick, and Jane Patullo

The Changing Landscape of Wage and Hour Laws: Part II

Employers continue to face significant litigation in the wage and hour area under both federal and state law. The wave of collective and class actions being filed has shown no sign of ebbing. There also has been a number of recent significant legal developments in this area. This is Part II of a two-part Special Report focusing on some of the key areas in which there have been developments in the wage and hour field, including recent state law developments in Pennsylvania, New York, and New Jersey.

Wage and Hour Potpourri

Overtime Calculation Issues

Fluctuating Workweek Method

The FLSA allows an employer to use a fluctuating workweek (FWW) method as an alternative to the fixed workweek standard for calculating overtime due to salaried nonexempt employees.[1] This method can only be used where:

1. The employee is paid a fixed salary that does not vary with the number of hours worked during the workweek (excluding overtime premiums);
2. The salary is large enough to ensure that straight time earnings do not fall below the statutory minimum wage in any workweek;
3. There is a clear material understanding between the employer and employee that the salary covers whatever hours the job demands in a workweek; and
4. The employee's hours fluctuate from week to week.

Using the FWW method, the regular rate is calculated by dividing the number of actual hours worked in the workweek, including those over 40, into the weekly salary. Thus, the regular rate will vary from week to week. Because the salary compensates the employee as straight time for all hours including overtime, the employer need only pay one-half of the regular hourly rate in overtime premium.

Under the FWW method, hourly overtime premium decreases with every overtime hour worked, likely making it unpopular with employees who work a lot of overtime. Perhaps for this reason, the method has been the source of recent litigation, with some surprising results.

In *Foster v. Kraft Foods Global, Inc.*,[2] a Pennsylvania district court held that the use of the FWW method was not permitted under the Pennsylvania Minimum Wage Act (PMWA). Foster, a sales representative for Kraft who serviced food stores in Pennsylvania, was paid overtime under the FWW method. Foster sued Kraft for unpaid overtime, seeking to represent a state-wide class of Kraft sales representatives subjected to the FWW method.

For many years, Pennsylvania employers assumed that the PMWA permitted use of the FWW method because Pennsylvania regulations describing calculating overtime were similar to the federal regulations. The *Foster* court, however, noted that no state regulation identical to the federal FWW provision exists.

The court rejected Kraft's argument that the FWW method complies with the substance of 34 Pa. Code Section 231.43(d)(3), which requires payment of overtime at time-and-a-half the basic rate to which the employee and employer have agreed. It opined that the Pennsylvania Department of Labor and Industry could have extended the FWW method to salaried employees had the agency wished to do so, but did not.

Commissions

In *Kornbau v. Frito Lay North America, Inc.*,[3] a federal court dismissed claims of 36 union-represented route sales representatives that Frito Lay improperly calculated overtime due to them using the FWW method. The employees were paid a weekly salary plus commissions.

The route sales representatives alleged Frito Lay failed to meet the requirements of the federal regulation permitting use of the FWW method[4]—Frito Lay did not disagree. Instead, Frito Lay argued that it regularly paid the employees salary plus commissions using a method of pay permissible under 29 C.F.R. Section 778.118, which states that when a commission is paid on a weekly basis, the commission is to be added to the employee's other

earnings for that workweek, the total divided by the number of total hours worked, and the employee must then be paid an extra one half the resulting hourly rate for each hour worked over 40. The court rejected the employees' argument that overtime worked should be subject to a bifurcated calculation–with overtime due on the weekly salary portion calculated by dividing it by 40 hours and paid at time and one half for the hours worked over 40 pursuant to Section 778.113 (salary divided by the number of hours it is intended to cover), and overtime on the commissions portion calculated pursuant to Section 778.118.

A federal court in Texas recently granted conditional certification to a class of inside sales associates who sold online advertising and claimed unpaid overtime under the FLSA. *Jones v. Supermedia Inc.*[5] The employees were paid a salary plus commissions. While some, but not all, of the named plaintiffs accepted a Rule 68 offer of judgment, those who rejected the offers amended their complaint and alleged they were due overtime because Supermedia had failed to include commissions in the regular rate for overtime pay purposes and to accurately track and record all hours worked. There was sufficient evidence that the employer knew that additional hours were being worked, and that time records may have been kept improperly, so certification was appropriate according to the court.

When Meeting FLSA Recordkeeping Requirements May Not Be Enough

Section 11(c) of FLSA requires employers to make and maintain records on employees and their wages, hours, and other conditions and practices of employment in accordance with DOL regulations. Those regulations, 29 C.F.R. Part 516, do not specifically describe the form in which required records must be kept. However, § 516.2(a) details the types of information that must be kept for non-exempt employees, including a record of the hours worked each workday and each work week. Simplified record-related requirements apply to exempt employees, for whom an employer need not maintain a record of actual hours worked.[6]

Most employers have pay record systems designed to comply with the FLSA and similar state laws. In *Kuebel v. Black & Decker, Inc.*,[7] the court ruled that the failure to maintain proper records of hours worked under the FLSA shifts the burden from the employee to the employer to rebut claims of unpaid wages if the employee has established a just and reasonable inference as to hours worked. If a plaintiff is found to lack credibility regarding his or her unpaid wages claim, however, the inadequate records are irrelevant.[8]

Even where an employer keeps records for FLSA purposes that conform to Part 516.3, those records may not be sufficient to shield the employer from liability under various federal or certain state wage and hour laws. Several recent cases illustrate this point.

The FMLA

The federal Family and Medical Leave Act (FMLA) provides job-protected leaves of absence for an eligible employee for various medical incapacities. To be eligible, an employee must have worked for the employer for 12 months and for at least 1,250 hours during the 12-month period prior to when the leave is to begin.[9] In *Donnelly v. Greenburgh Central School District No. 7*,[10] the court reversed summary judgment for the employer on a teacher's claim that he had been denied tenure in retaliation for taking leave pursuant to FMLA. The school district argued that Donnelly, an exempt employee, had not been eligible for FMLA leave because he had worked 3 hours less than the required 1,250. There were no records of his actual hours worked.

Donnelly contended that he and most teachers regularly worked over an hour before and after their class schedule each day, and that he had exceeded hours required for FMLA leave. His claim was supported by a note in one of his evaluations that he often stayed after hours working with students.

FMLA regulations make clear that when an employer does not maintain an accurate record of hours worked by an employee, the employer bears the burden of showing that the employee has not worked the requisite hours to qualify for leave.[11] Here, the school district was not required to keep records of hours worked for teachers and had not done so.

The court acknowledged that in order for the extra time Donnelly worked to be counted for FMLA eligibility purposes, it would need to qualify as compensable hours worked under FLSA. This required that the pre- and post-shift activities be integral and indispensable to his principal activity of teaching. Here, the court found that there was sufficient evidence to suggest the additional hours qualified as "integral" for FLSA purposes.

ERISA

In an action for unpaid contributions to several multiemployer pension plans, an employer's failure to maintain accurate records of hours its employees were performing for different types of work (for only some of which pension contributions were required) created a rebuttable presumption that pension contributions were due on all hours worked.[12]

Over the years, the company's main operations had changed from site work and excavation to selling landscaping products. The collective bargaining agreement (CBA) applied to work usually performed in connection with the sand and gravel industry by maintenance mechanics, and operators on shovels, cranes, bulldozers and similar machinery.

Pension contributions were required for all employees covered by the CBA. Presumably, sales or other non-sand industry work was not covered. Because the employer failed to maintain adequate records, it was presumed liable for contributions for all hours potentially representing covered work.

Automatic Meal Period Deductions

In *Frye v. Baptist Memorial Hospital, Inc.*,[13] the court upheld decertification in an FLSA collective action challenging the employer's policy of providing a daily unpaid 30-minute meal period and automatically deducting the time spent on those breaks. The employer also had a policy of paying employees for time worked during the breaks, and individual departments were responsible for maintaining systems to ensure payment. Many departments used paper exception logs which employees were instructed to use to document missed or interrupted meal breaks, with some variation by department.

The Sixth Circuit agreed with the district court that an automatic deduction policy did not per se violate the FLSA. Here, the hospital had a viable exception procedure, and payment was made based on the existing exception records, so the court declined to consider the employees' claims as a class.

Rounding

For many years, the DOL has taken the position that rounding employee time entries is lawful, provided the rounding is done in a manner that does not result in failure to compensate employees properly for all time actually worked. DOL regulations permit rounding to the nearest five minutes, or tenth, or quarter of an hour.[14] Many state agencies, including the California Division of Labor Standards Enforcement (DLSE), have adopted the DOL's position on rounding, although an agency's interpretation typically is not binding.[15] Also, the DOL and state agencies have long agreed that in recording working time, insubstantial or insignificant periods of time beyond scheduled work hours which cannot as a practical matter be precisely recorded for payroll purposes may be disregarded as de minimus. However, employers should not assume that rounding and reliance on the de minimus exception are a given.

In an electronic age where systems easily measure time by the minute, rounding challenges are on the rise. Recent cases in California have even targeted unbiased rounding procedures. Early last year, the San Diego Superior Court found that See's Candy Shops violated California Labor Code Section 204 (which requires that all wages earned be paid at least twice per calendar month) by rounding employees' time entries to the nearest six minutes. See's used a method which rounded three minutes up or three minutes down to the nearest tenth of an hour, and an expert testified that the practice was mathematically neutral. Plaintiffs apparently took the position that rounding to the nearest minute is more protective of employees, possible to achieve, and thus required.

In September 2012, the Fourth District of Appeals in California state court heard argument on an appeal of the decision in See's, and the outcome is being closely watched.[16] Other similar cases are pending in California, including one filed against JPMorgan Chase Bank NA, in which employees claim that the bank's rounding policy, which converts minutes to decimal hours, did not fully compensate them for time worked. The federal judge in that case recently denied the bank's motion to dismiss.

Misclassifying Employees As Independent Contractors or As Exempt From Minimum Wage and Overtime Requirements

Employees frequently initiate litigation challenging their treatment by employers as non-employees or employees not entitled to statutory overtime pay. The most common claims in recent cases are misclassification as independent contractors, outside sales workers, or executives.

Status As an Independent Contractor

Independent contractors, who comprise roughly seven percent of the U.S. workforce in a wide range of industries, often work in sales, transportation, information technology and communications, marketing, and other fields involving specialized skills. Rooting out misclassification of employees as independent contractors under a range of labor and employment, employee benefit, and tax laws continues to be a top enforcement priority of the DOL, the Internal Revenue Service (IRS), and a number of states, including those with whom the federal agencies are coordinating enforcement efforts and sharing information.

In 2011, the IRS launched an amnesty program permitting employers to voluntarily reclassify independent contractors as employees for federal employment tax purposes, with participants typically assessed only a small percentage of the tax liability on compensation for the workers for the prior tax year. Few employers have enrolled in the program, perhaps because of the effect participation may have on private litigation.

Risks of misclassification can include: liability for unpaid federal, state, and local income tax withholdings, Social Security and Medicare payments, premiums for workers' compensation and unemployment insurance; and costs associated with failing to cover workers under health and pension plans and other employee benefits. In the wage and hour context, employers can be liable for unpaid minimum wages and overtime.

The tests used to distinguish an independent contractor from an employee vary under different laws, although most focus on whether the

purported employer has the right to control the time, manner and means or method by which the worker accomplishes the end product of the work at issue. The "economic reality" test most often used under the FLSA focuses on the extent to which putative employers have the right of control of those workers. In *U.S. v. Silk*,[17] the Supreme Court found the following factors to be relevant in determining status as an employee: degree of control; investment in facilities; opportunity for profit/loss; permanency of the relationship; and, required skills. Several other courts have also considered whether the service rendered by the workers at issue is an integral part of the putative employer's business. Where classification is challenged under state wage and hour law, courts often apply a common law test of employment which also focuses on right of control.

Recently, in *Taylor v. Waddell & Reed*,[18] the court considered whether W&R, a business that sold financial products through a sales force of advisors, had misclassified its advisors as independent contractors under California's wage and hour law. In an earlier decision, the court had granted summary judgment to the employer on plaintiffs' FLSA overtime claim, concluding that even if they qualified as employees, the advisors were exempt under the federal outside sales exemption.

Prior to beginning work with W&R, the advisors were required to sign an agreement under which they were classified as independent contractors to be paid on a commission basis. The agreement specifically stated that they were free to use W&R office facilities and exercise their own judgment as to persons whom they solicited and the time, place, and manner of solicitation. In addition to selling W&R products to their customers, the advisors provided them with financial planning services independent of W&R.

Under California's common law test for determining worker status, the principal test of an employment relationship is whether the purported employer has the right to control the manner and means of accomplishing the work. Additional factors considered are: whether the worker is engaged in a distinct occupation or business; the kind of occupation, with reference to whether, in the locality, the work is usually done under the direction of a principal or by a specialist without supervision; the skill required in the occupation; whether the principal or workers supply tools, instrumentalities, and place of work; the length of time for which services are to be performed; the method of payment—by job or time; whether the work is part of the regular business of the principal; whether the principal has the right to discharge at will; and whether the parties believe they are creating an employment relationship. The factors must be weighed and considered as a whole, so even where some factors suggest an employment relationship, a worker may not qualify as an employee.

Here, plaintiffs were found to be independent contractors. The agreement they signed evidenced their understanding that they were independent contractors, and contained a notice of termination provision that supported independent contractor status. The document gave advisors freedom to conduct their sales work in the manner and place of their choosing. The advisors represented to FINRA that they were independent contractors, reported their earnings based on 1099s, deducted business expenses and certified on tax forms that they were independent proprietors. They ran their own business to provide financial planning services, investment products and insurance, had the licenses required to do so, and determined their own business strategies and whom to target as clients. They paid their own business expenses, could hire assistants, choose their work location (often away from the W&R office), and were paid only on commission. Most importantly, W&R had no significant right to control how they conducted their sales business because plaintiffs determined their own strategies, set the cost for financial plans, chose their clients, and were free to conduct other business activities in addition to the sales business within the boundaries of regulatory requirements. They attended but were not penalized for missing meetings at W&R. To the extent they received some supervision/monitoring to help improve sales, it was not enough to convert them into employees.

In two other recent misclassification cases, employers did not fare as well. Both involved workers who sold time share interests in vacation resorts. In *Whitehead, et al. v. Vacation Charters, Ltd.*,[19] the court awarded a class of 250 salespersons misclassified as independent contractors $2.2 million in wages, benefits and penalties, plus interest under the Pennsylvania Wage Payment and Collection Law.

Vacation Charters (VC) hired salespeople to sell timeshare interests to the public in one-on-one presentations at VC resorts or in store fronts. Salespeople's activities were overseen by a real estate broker, and VC controlled their work schedules, dress code, marketing protocols, and day-to-day services through scripts. VC also provided written company rules which the sales persons were required to sign and imposed penalties for non-compliance with the rules.

The salespeople were originally classified as employees, but then changed to independent contractors for financial reasons. At some point, the Pennsylvania Department of Labor and Industry had determined that the named plaintiff, Whitehead, was an employee for unemployment compensation purposes. The workers were required to sign form agreements classifying them as independent contractors, and making them responsible for payment of taxes on commissions. The agreement did not

specify that the wages they received were advances on commissions, or that a 10 percent holdback of wages earned applied for sales made that were financed on a deferred payment basis or a 50 percent holdback when a buyer had a low credit score. The court determined that the form agreement's classification of the workers was immaterial, and that they were employees.

In *Zanes v. Flagship Resort Development, LLC*,[20] the court granted certification to a class of salespeople who sold time shares and other related products and services on behalf of Flagship and claimed to have been misclassified as independent contractors and denied overtime. It ruled that the workers were employees under FLSA.

The court concluded that Flagship controlled the overall manner of their work by establishing working hours and approving days off, requiring workers to adhere to company policies in performing work, and by setting their pay structure. Although the workers were paid on a refundable draw against commission based on sales, the flow of their potential customers depended on Flagship's ability to attract them, not the workers' sales skills, and the workers had no meaningful opportunity for profit. Finally, while the workers' length of employment varied, one or more of them signed "Independent Contractor Sales Coordinator Agreements" containing a non-compete provision and confidentiality agreements, which weighed in favor of an employment relationship.

The Outside Sales Exemption

To qualify as exempt as an outside salesmen pursuant to the FLSA, an individual must have as a primary duty making sales as defined in the FLSA (i.e., any sale, exchange, contract to sell, consignment for sale, shipment for sale, or other disposition) or obtaining orders or contracts for services or for the use of facilities for which consideration will be paid by the client/customer; and, must be customarily and regularly engaged away from the employer's place of business or places of business in performing the primary duty.[21] Several recently decided large class actions have involved the outside salesmen exemption, and plaintiffs challenging it often have argued that they did not make sales or obtain orders/contracts, and/or that they were not regularly working away from the employer's place of business.

In *Christopher v. SmithKline Beecham Corporation*,[22] the U.S. Supreme Court determined that pharmaceutical sales representatives were exempt outside sales employees under FLSA, concluding that the nonbinding commitments they obtained from physicians to prescribe SmithKline's drugs fell within the catchall category "other disposition" contained in the FLSA's definition of "sale." The Court refused to defer to the DOL's argument that the sales representatives were not actually engaged in sales because they did not transfer title to any property. Noting that the outside sales representatives had been treated as exempt for years without any challenge from the DOL, the Court concluded that deference to DOL's own interpretation of its ambiguous regulation is unwarranted when there is reason to suspect that interpretation does not reflect the agency's fair and consistent judgment on the matter.

Recently, a settlement for $1.25 million was reached in a case involving a proposed class of over 1,000 account executives engaged in making calls to potential sales leads from Yelp's offices and trying to sell online advertising products to businesses. Yelp was not engaged in retail sales. The employees alleged that neither the outside sales nor any other exemption applied to them, and that they had been unlawfully denied overtime pay.[23]

Also, a federal court in *Toure v. Amerigroup*,[24] approved a $4.45 million settlement for a class of 943 Medicaid marketing representatives who alleged that they were misclassified as exempt outside sales employees. The employees' job duties involved signing up eligible New Yorkers for free or low-cost government-subsidized health insurance at locations throughout New York, including doctors' offices and pharmacies.

In a very similar case, brought by the same lawyers who represented the *Toure* class, a large settlement was reached for misclassified benefit consultants pursuant to the FLSA.[25] The benefits consultants' job was to find eligible Medicare/Medicaid beneficiaries and sign them up for the managed care services provided by Comprehensive. Their performance was measured, and they were paid a salary and commissions, based on the number of enrollments (or, "sales") they made. Plaintiffs worked in a range of sales jobs, and questions about application of the exemption across the board involved the amount of time they spent in non-sales work, doing telemarketing and customer service, and the location(s) from which sales were made (e.g., a CHM office, trailers, traveling on-the-street, etc.). After preliminary certification was granted to a class of 1,400 employees, the parties agreed to a settlement of $6.5 million, and filed a motion for its approval on September 21, 2012.

The Executive Exemption

Cases challenging the exempt status of managers and assistant managers of convenience stores, fast food restaurants and other retail establishments, especially at large chains, abound. The same exemption test applies for managers and assistants.

To qualify as exempt, an executive must: have as his/her primary duty managing the enterprise in which he/she is employed or a customarily recognized department or subdivision of it; customarily and regularly direct the work of at least two employees; and have the authority to hire and fire employees, or make suggestions and recommendations that are given

particular weight as to hiring, firing, advancement, promotion, or any other change of status of other employees.[26] Examples of management duties include: interviewing, selecting and training employees; setting or adjusting employees' rates of pay and hours of work; directing work; maintaining production or sales records for use in supervision or control; evaluating employees' productivity and efficiency for purposes of recommending promotion or other change in employee status; handling employee complaints; imposing discipline; planning and apportioning work; determining materials, equipment, and supplies to be used or merchandise to be bought, stocked or sold; controlling the flow/distribution of materials or merchandise; providing for safety of employees and/or property; budget planning/control; and monitoring or implementing legal compliance.[27]

Whether "management" is an employee's "primary" duty is a key question. If an employee devotes 50 percent or more of his or her work time to management duty(ies), it likely is "primary," but time alone is not determinative. Relevant factors include, but are not limited to:

- The relative importance of the exempt duties to other duties;
- The amount of time spent performing exempt work;
- The employee's relative freedom from direct supervision; and
- The relationship between the employee's salary and the wages paid other employees for the kind of nonexempt work performed by the employee.[28]

Exempt executives can be distinguished from non-exempt employees who may perform some management work. Generally, an exempt executive makes the decision regarding when to perform non-exempt duties and remains responsible for the success or failure of business operations under his or her management while performing nonexempt work. In contrast, a nonexempt employee generally is directed by the supervisor to perform the exempt work or does so for defined time periods.[29] Where a combination of corporate micromanagement and close supervision exist, employees in purported manager/assistant manager jobs are rarely found to be exempt.

In recent years, Family Dollar Stores, Inc. has been subjected to a number of lawsuits by store managers, with courts in different jurisdictions coming down on opposite sides of the exemption issue. Family Dollar fared more favorably in individual lawsuits than in collective actions, where its uniform policy of classifying all store managers as exempt was problematic.

In *Morgan v. Family Dollar Stores, Inc.*,[30] a class of 1,400 store managers successfully argued that they were misclassified as exempt employees because they performed few managerial duties and spent most of their time doing the same work as their hourly subordinates, and a jury awarded them $35.6 million. On appeal, the Eleventh Circuit affirmed. The managers spent 80 percent to 90 percent of their time performing nonexempt manual work that was of equal or greater importance to the store's function or success as were their supervisory tasks. They rarely exercised discretion because either the company's operations manuals or district managers' directives controlled virtually every aspect of their store's day-to-day operations. Finally, the court found that close district manager oversight, corporate micromanagement and fixed payroll budgets left managers with little choice in how to manage a store.

However, in *Ward v. Family Dollar Stores, Inc.*,[31] the plaintiff store manager was found to be exempt. He spent 81 percent of his time directing subordinates, and performed certain non-exempt work such as customer service, but did so concurrently with performing managerial duties. He worked generally free of supervision, and his exempt duties included handling internal/external complaints, delegating work, training employees, and ordering merchandise. He interviewed applicants, and his hiring recommendations were closely followed. Overall, his management tasks were clearly found to be considerably more important than his nonmanagement work.

Most recently, on September 12, 2012, Family Dollar agreed to settle a lawsuit brought by a class of 1,700 store managers alleging misclassification and failure to pay overtime for $14 million.[32] Family Dollar's success in *Ward* suggests that the retailer can meet the executive exemption for at least some store managers, but the facts and risks associated with defending a large class of employees working under varying conditions apparently made the New York settlement prudent.

While pressure to settle a collective action can be great, pressing on in discovery after initial class certification can be fruitful. On September 19, 2012, a federal court in Alabama identified a nationwide class of several thousand store managers who alleged they were misclassified as FLSA exempt executives.[33] Although Dollar Tree had a policy of classifying all store managers as exempt, and according to plaintiffs had the same operational controls in place at all stores regardless of size, the court concluded that evidence pertaining to the different store settings and range of duties performed by the managers made class members not similarly situated. Store size and location contributed to differences among managers' duties. Those in smaller stores with fewer subordinates had more time for manual labor. Those at stores in high crime areas had to spend more time managing safety and protecting company assets. Managers at stores in different areas experienced higher turnover of workers, and had to spend more time interviewing and hiring. The mix and relative

importance of the store managers' duties made the class untenable.

Results in several other cases involving misclassified managers are worth noting. In May 2012, the DOL reported reaching an agreement with Wal-Mart totaling $5.3 million in back wages, penalties and damages for its alleged misclassification of vision center managers and asset protection coordinators at thousands of Wal-Mart stores, Sam's Club Warehouses, and Neighborhood Markets. Following an investigation during which DOL concluded the managers were not exempt executives and that the coordinators did not fall under any exemption, the agency pursued relief for all employees in the jobs across the U.S.

In July 2012, a federal district court in Pennsylvania gave preliminary approval to a $20.9 million settlement in *Shirley Craig, et al. v. Rite Aid Corp.*[34] of 15 lawsuits filed across 30 states and the District of Columbia. Plaintiffs were assistant store managers and co-managers who claimed they were misclassified as exempt executives under FLSA and denied overtime.

In *Cuevas v. Citizens Financial Group, Inc.*,[35] a federal district court granted initial certification to a class of all assistant branch managers (ABM) employed by Citizens in New York State. In analyzing whether the evidence required to prove liability would be predominately common (as opposed to individual), the court noted that Citizens' blanket exemption policy for ABMs was not determinative of the issue, but that policy coupled with company-wide policies defining primary duties for all ABMs made the class sufficiently cohesive for certification.

In July 2012, the Second Circuit found that the executive exemption applied to captains who supervised pickers in their employer's wholesale food warehouse.[36] The captains, who reported to a night warehouse manager, regularly supervised a team of three to six pickers in the warehouse. The captains' exempt managerial duties included supervising subordinates' work, assigning different types of work to pickers, improving team performance and efficiency over time, and preparing individual picker production reports. Each team was a customarily recognized subdivision of the warehouse with a continuing status and function. The court rejected as immaterial the captains' argument that the job duties of each of their teams were identical to all of the other teams.

Finally, while job duties are the focus of most challenges to the executive exemption, even where an employee's duties meet the test, the employee will not qualify for exemption under FLSA unless paid at least $455 per week on a salary basis.[37] In *Orton v. Johnny's Lunch Franchise, LLC*,[38] the court restored the FLSA and analogous state law misclassification claims of a Vice President of Real Estate and Site Selection which had been dismissed by the district court. For a four-month period from August 2008 until December 2008 when the entire executive staff was laid off, the employer had ceased paying Orton, although he had not stopped working. The lower court had improperly placed on Orton the burden of proving that he was not exempt, rather than requiring that the employer to prove the exemption.

Assertive Enforcement by DOL

Under the current Administration, DOL is vigorously enforcing the FLSA. Government news releases indicate that substantial resources are being allocated to broad-based regional, state and local initiatives focused on certain industries. Under partnership arrangements with a number of states and several forms of memoranda of understanding, DOL has been sharing information and, in some cases, participating in joint enforcement efforts. With increased manpower to implement its initiatives, DOL has been reporting significant "voluntary" settlements with employers.

Targeted Industries

In 2011 and 2012, industries that have most frequently been subject to widespread investigation are those with low profit margins in which the DOL considers employees most vulnerable, such as: agriculture and landscaping; restaurants; day/care and residential care; health care; hotels and motels; guard services; janitorial services; garment manufacturing; and temporary workers. Of course, enforcement has not been limited to these businesses. Details of initiatives in certain of the high focus industries are noteworthy, and should alert employers to be vigilant in their compliance efforts.

Restaurants: Initiatives in the following locales garnered the indicated back wages, civil money penalties, and in some cases, liquidated damages—$2.3 million in Long Island, NY; $681,000 in south Florida; $1.6 million in Massachusetts; $2.1 million in San Francisco; over $12 million along the West Coast.

Construction: An initiative in Connecticut and Rhode Island garnered $3.3 million in back wages.

Gas Stations: The agency collected over $1 million in back wages from 74 compliance investigations in New Jersey.

Agriculture/Hand-Harvested Crops: An initiative in Florida resulted in payment of $836,000 in back pay and civil money penalties.

Another industry experiencing increased attention is vehicle dealerships. For years, many of those employers have classified their service salespeople and service writers or advisers as exempt from overtime payment under § 13(b)(10)(A) of FLSA, which applies to any salesman, parts man, or mechanic who is primarily engaged in selling or servicing cars, trucks or farm implements if employed by a non-manufacturing establishment primarily engaged in selling such vehicles/implements to ultimate purchasers. While DOL regulations at 29 CFR § 779.372(c) state that service managers and

service writers are not covered by the exemption, in *Walton v. Greenbrier Ford, Inc.*,[39] an appellate court ruled this interpretative regulation was unreasonable. Thus, until recently, it was rarely enforced. Now, DOL investigators are pressing employers on the exemption.

Enforcement Techniques

After a DOL investigation uncovers alleged violations, the investigator holds a final conference during which he or she seeks to obtain the employer's agreement to pay back wages for those violations, typically for a period of two years, and a promise of future compliance.[40] In addition to back wages, the agency is authorized to assess civil monetary penalties for repeated or willful minimum wage and overtime violations, and can sue on behalf of employees for unpaid wages plus an equal amount as liquidated damages. Historically, DOL rarely imposed penalties after an audit, and did not seek liquidated damages outside litigation. More recently, the agency has been routinely demanding payment of penalties and liquidated damages after an investigation, and in some cases seeking three years of back pay where it contends there has been a willful violation.

In August 2012, DOL reported that Frank Donio, Inc., a wholesale produce broker in New Jersey, had agreed to pay $657,069 in back wages and liquidated damages to line workers at its packing facility. The DOL found that the workers (who were employed and paid by a temporary employment agency and only supplied to Donio) were paid less than minimum wage, and DOL concluded that Donio was a joint employer. Donio had already fully paid the temporary agency for the labor, but was held jointly responsible for the temporary agency's malfeasance.

Also alarming was DOL's approach in recently settling an alleged failure by three Oregon farmers to pay blueberry pickers minimum wage. DOL investigators claimed the farmers had allowed multiple workers to hand pick berries on a single employee's ticket, and then paid wages only to that employee.

DOL threatened to invoke the FLSA's hot goods provision[41] against the farmers if they refused to enter into a consent judgment. Under that provision, the agency would have sought approval from a court to place an embargo on the blueberries, resulting in almost certain loss of the perishable product. The DOL rejected the farmers' offer to place the disputed back wages in a court-controlled escrow account while they pursued normal procedures to resolve the matter, and instead demanded prompt signature of the consent judgments, which contained a waiver of any recourse if findings of fact or law later established that the farmer was not liable. In essence, faced with almost certain significant loss, the farmers were forced to cede their ability to appeal or contest assessed civil penalties.

DOL Defense of "Informer's Privilege"

Historically, DOL has refused to divulge to employers the identity of sources outside the agency that provided information to DOL indicating a reasonable probability of an FLSA violation, including employees. Often, when the agency chooses to file a lawsuit against an employer, statements by employees (including informers) from DOL interviews during the underlying investigation are key evidence.

Recently, DOL has vigorously fought efforts by employers in discovery to obtain any information about employees who provided information during an investigation. With this impeding their ability to defend, employers have moved to compel, and in response the Secretary of Labor has strongly asserted that its informer's privilege applies broadly. In *Solis v. Delta Oil Co.*,[42] the Secretary argued that the privilege applied to all of the contents of its investigation file, as well as all statements taken from any witness during the investigation. The court disagreed, ordering the agency to produce the documents, but with all identifying information of persons who provided protected information redacted.

In *Solis v. La Familia Corp.*,[43] the employer challenged the DOL assertion of informer's privilege with respect to the identity of persons who provided information to the agency during its investigation. La Familia argued that employees were interviewed in plain sight of its representatives. Noting a distinction between informers and mere interviewees, and the fact that redacted statements already had been produced by DOL, the court concluded that the employer had not shown a substantial need for non-disclosed information.

Employers can expect that during discovery, they will have difficulty discovering the identity of DOL interviewees. However, they should be able to obtain access to redacted witness statements.

PA, NJ, and NY Wage and Hour State Legislative Update

Over the past year, several noteworthy changes to wage and hour laws have been enacted in Pennsylvania, New York and New Jersey. A few significant pending bills also are worth mentioning.

Pennsylvania

PMWA Amended to Permit Use of 8/80 Method

For many years, employers in Pennsylvania presumed that an exemption under Section 7(j) of the federal FLSA, allowing hospital and residential care employers to use a 14-day period instead of a seven-day workweek to calculate overtime, was also available under the PMWA. Commonly known as the 8/80 exemption, the federal provision requires payment of statutory

overtime for all hours worked in excess of eight in any workday and 80 in the 14-day period, provided there is an agreement in place between the employer and employee to use the 8/80 system, a 14-day period is used to calculate overtime, and overtime is paid at time and a half the regular rate, with daily overtime creditable towards overtime due for work over 80 hours.

Consequently, a PA court stunned the health care community in March 2010 when it ruled that the PMWA prohibited use of the 8/80 method.[44] Restoring what many had presumed was the status quo, Pennsylvania Governor Tom Corbett signed into law H.B. 1820 on July 5, 2012, amending the PMWA to permit hospitals and residential care establishments in the state, including nursing facilities, skilled nursing facilities, assisted living facilities, residential care facilities, and intermediate care facilities for persons with disabilities, to use the 8/80 method. As the amendment is not retroactive, employers at least theoretically may be held liable under state law for use of the method prior to July 2012.

Construction Workplace Misclassification Act (2009-10 H.B. 400)

In 2011, this state law took effect, curtailing circumstances under which individuals and businesses can classify construction workers as independent contractors for purposes of workers' compensation and unemployment insurance. The Act subjects construction industry employers, including their officers, agents, and certain of their contractors, to stiff fines or incarceration for violations.

Under the Act, to qualify as an independent contractor, a construction worker must: (1) have a written contract to perform services; (2) be free from control or direction by the hiring person when performing services; and (3) be continuously engaged in an independent trade, occupation, profession or business. Among indicia of such independent engagement are: performing services through a business the person owns, at least in part; maintaining individual liability insurance of at least $50,000 during the term of a contract; and, maintaining an independent business location.

Efforts to Pare Back State's Prevailing Wage

In late 2011 and early 2012, PA House Republicans introduced a package of bills seeking to lighten the burden of prevailing wage requirements on construction industry businesses. One bill (H.B. 1329) would raise the current prevailing wage contract threshold from $25,000 to $185,000, while another (H.B. 1271) would narrow the definition of covered maintenance work as related to the repair of roads and bridges. A third (H.B. 1367) would require the PA Department of Labor and Industry to use its Center for Workforce and Analysis Occupational wage rate data when setting prevailing wage rates for each county, and a fourth (H.B. 1191) would exclude the state's municipalities and local authorities from coverage under the state prevailing wage requirements. These bills remain pending, and if passed, may help stimulate the sluggish construction industry.

New York

Amended NY Labor Law Section 193 Expanding Deductions

On September 7, 2012, NY Governor Cuomo signed into law an act amending New York Labor Law Section 193 to include several new categories of deductions that can be made to wages for an employee's benefit. The amendment reversed a number of recent NY Department of Labor (NY DOL) rulings severely restricting deductions. Effective November 6, 2012, the law has a three-year sunset provision (which later may be changed), and will require employers to wait until NY DOL issues relevant regulations before their start to make certain significant new categories of deductions.

Until recently, Section 193 permitted only a few deductions – payments for insurance premiums, pension and health and welfare benefits, U.S. bonds, and union dues; contributions to charitable organizations; and, payments for the benefit of the employee "similar" to the foregoing enumerated categories and, which in the aggregate, did not exceed 10 percent of gross wages due to the employee in the payroll period. In its opinions, NY DOL routinely found very few types of payment to be "similar," rejecting, for example, deductions for repayment of salary advances and for various amenities desired by employees.

Going forward, employers will be allowed to make deductions for the following previously prohibited reasons: purchases at events sponsored by a charitable organization affiliated with the employer; discounted passes for parking or discounted passes, tokens, or other items entitling the employee to use mass transit; fitness center, health club or gym dues; cafeteria, vending machines and/or pharmacy purchases made at the employer's place of business; tuition, room, board, and fees at educational institutions ranging from preschool to post-secondary; daycare and before/after school expenses; and payments for housing provided at no more than market rates by nonprofit hospitals and their affiliates. The law also will allow employers to recover wage overpayments resulting from mathematical or clerical error, and to recoup salary advances, but these deductions must be made in accordance with regulations yet to be issued by the NY DOL governing their timing, frequency and amount, notices to be provided to the employee, procedures for disputing repayment, etc.

As prior to its amendment, Section 193 permits deductions in general that are for the benefit of the employee. Other than those made in accordance with law

(*e.g.,* taxes, court-ordered garnishment) or in accordance with the anticipated NY DOL regulations governing recovery of overpayments/repayment of advances, a deduction must be expressly and voluntarily authorized in writing by the employee. Prior to the authorization, the employer must give the employee written notice of all terms and conditions of payment and/or its benefits and details of the manner in which deductions will be made. The employer must provide additional notice prior to implementing any substantial change in the terms or conditions of payment. Authorizations must be retained on file throughout employment and for six years after employment ends.

Limits on the aggregate amount of deductions that can be made for each pay period may not exceed the maximums set by the employer and employee. Employers also must comply with state laws related to assignment of earnings and company stores, and any other law applicable to deductions from wages. Finally, employers cannot require any payment from an employee by separate transaction unless the payment is otherwise permitted as a deduction under Section 193.

Employers with employees in New York are advised to review and may wish to update their payroll practices and policies, use of notices and authorizations related to deductions, and recordkeeping procedures. However, employers should avoid making deductions to recoup inadvertent overpayment of wages or for repayment of advances until the state DOL issues its new regulations.

NY Wage Theft Prevention Act

Effective April 9, 2011, the NY Wage Theft Prevention Act amended several sections of the state's Labor Law. Most notably, Section 195.1 was changed to require that private employers provide all newly hired employees and all incumbent employees annually a written pay notice. The notice must include: the employee's rate or rates of pay; the overtime rate of pay if the employee is non-exempt; the basis of wage payment (per hour, shift, etc.); any allowances the employer intends to claim as part of the minimum wage, including tip, meal, and lodging allowances; the regular payday; the employer's name and any name under which the employer does business; the address of the employer's main office; and the employer's telephone number. NY DOL published sample notices for employer use. Notices issued by employers are subject to a six-year record retention requirement.

In February 2012, the NY State Senate passed a bill (S06063A) that would eliminate the annual notice requirement under the Act. Whether the State's Assembly will follow suit remains to be seen, but employers likely would welcome the change.

New Jersey

Revision of White Collar Exemption Regulations

In September 2011, the New Jersey Department of Labor and Workforce Development (NJ DOL) amended the State's wage and hour regulations to adopt the federal FLSA's white collar exemptions from minimum wage and overtime requirements. While attempting to simplify compliance by eliminating inconsistencies between state and federal law, in making the change the NJ DOL inadvertently dropped from its own regulatory definition of "administrative employee" a provision exempting commissioned sales workers similar to the FLSA overtime exemption at 29 U.S.C. Section 207(i) applicable to commissioned sales persons in retail and service establishments.

With employers suddenly at risk of misclassification claims for previously properly classified commissioned sales workers, the NJ DOL moved to correct the error, and in February 2012 fully restored the exemption. Once again, under the New Jersey regulations, "administrative employee" includes one whose primary duty consists of sales activity and who receives at least 50 percent of his or her total compensation from commissions and a total compensation of not less than $400 per week.

New Mandatory Posting Notice to Employees

In 2010, New Jersey passed a law establishing a mechanism for the state to suspend or revoke certain licenses necessary to do business in New Jersey in the event an employer has failed to maintain and report for one or more employees every record regarding wages, benefits and taxes required under state law (i.e., New Jersey's Wage Payment Law, Wage and Hour Law, Prevailing Wage Act, Unemployment Compensation Law, Temporary Disability Benefits Law, Family Leave Insurance Benefits Law, Workers' Compensation Law, and Gross Income Tax Act.), and also to pay wages, benefits, taxes, or other contributions and assessments required under those laws.[45]

The new law required NJ DOL to issue for employers' use a form of notice to employees concerning an employer's obligation to maintain and report records, and on November 7, 2011 the agency did so.[46] Employers in New Jersey must post the notice, give a copy of it to anyone hired after November 7, 2011, and also were required to provide a copy to all existing employees on or before December 7, 2011. A copy of the notice (originally six pages and more recently streamlined) is available on the NJ DOL's website. Failure to comply with the posting and notice requirements can result in conviction of a disorderly person offense and a fine of up to $1,000.

New Jersey employers are advised to include the new notice in with standard forms provided to new hires, ensure distribution of it to any incumbent employees who may not have already received it, and post it.

Proposed Wage Protection Act

Currently, parallel bills (A.B. 1094 and S.B. 969) remain pending in the New Jersey legislature that would strengthen enforcement procedures and penalties against employers who fail to pay wages, compensation or benefits due employees, and would impose criminal sanctions on those who retaliate against employees who file complaints under the statute. If passed, the bills would allow an employee alleging a violation to file a citizen's complaint in municipal court.

If a failure to pay wages owed is found, an employer would be required to pay the wages, a liquidated amount equal to 100 percent of wages owed, a fine of $1,000 ($2,500 for any subsequent offense) plus 20 percent of the wages owed, and an employer found guilty of retaliation would be guilty of a disorderly person offense.

Proposed Trucking Industry Misclassification Law

Currently, parallel bills (A.B. 1578 and S.B. 1450) remain pending in the New Jersey legislature which would impose severe penalties on certain trucking industry employees who misclassify trucking services employers as independent contractors. If passed, the bills would create a presumption of an employer-employee relationship in the parcel delivery or drayage trucking industry unless the NJ DOL concludes: (1) the worker has control and discretion over the performance of the service; (2) the service is outside the purported employer's usual course of business or outside of all of its places of business; and (3) the worker is customarily engaged in an independently established trade, occupation, profession or business. Violators who misclassify workers as independent contractors would be subject to significant fines, second degree criminal penalties, and individual and class action law suits.

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Notes

1. 29 C.F.R. § 778.114.
2. _ F. Supp. 2d _, 2012 WL 3704992 (W.D. Pa., Aug. 27, 2012).
3. 4:11-cv-02630, 2012 WL 3778977 (N.D. OH., Aug. 30, 2012).
4. 29 C.F.R. §778.114.
5. 281 F.R.D. 282 (N.D. Tex. 2012).
6. § 516.3.
7. 643 F.3d 352 (2nd Cir. 2011).
8. Jarmon v. Vinson Guard Services, No. 11-13708, 2012 WL 3792030 (11th Cir. Aug. 30, 2012).
9. 29 U.S.C. § 2611(2)(A)(ii).
10. 691 F.3d 134 (2nd Cir. 2012).
11. 29 C.F.R. § 825.110(c)(3).
12. Central Pension Fund of International Union of Operating Engineers v. Ray Haluch Gravel Co., – F.3d –, 2012 WL 3984621 (1st Cir. Sept. 12, 2012).
13. No. 11-5648, 2012 WL 3570657 (6th Cir., Aug. 21, 2012).
14. 29 CFR § 785.48(b).
15. *See* DLSE Enforcement Manual, Sections 74.1-.3.
16. See's Candy Shops v. Superior Court (Silva), Case No. 5197901.
17. 331 U.S. 704 (1947).
18. No. 09-cv-2909, 2012 WL 3584942 (S.D. Cal. Aug. 20, 2012).
19. 2008-cv-3764 (Phila. CCP, Apr. 29, 2011).
20. No. 09-3736, 2012 WL 589556 (D.N.J. Feb. 22, 2012).
21. 29 C.F.R. § 541.500(a).
22. 132 S. Ct. 2156 (2012).
23. Larkin, et al. v. Yelp!, Inc., 3:11-cv-01503 (N.D. Cal., Apr. 27, 2012).
24. No. 10-cv-5391, 2012 WL 3240461 (E.D.N.Y. Aug. 6, 2012).
25. Aponte v. Comprehensive Health Management, Inc., 10-CV-4825 (S.D.N.Y., Sept. 21, 2012).
26. 29 C.F.R. § 541.100.
27. 29 C.F.R. § 541.102.
28. § 541.700.
29. 60 Fed. Reg. 22, 121, 22, 136 (Apr. 23, 2004).
30. 551 F. 3d 1233 (11th Cir. 2008), *cert. den.*, 130 S. Ct. 59 (2009).
31. 830 F. Supp. 2d 102 (W.D. N.C. 2011).
32. Rancharan v. Family Dollar Stores, Inc., 1:10-cv- 07850 (S.D.N.Y. Aug. 12, 2012).
33. Knott v. Dollar Tree Stores, 7:06-cv-01553 (N.D. Ala., Aug.19, 2012).
34. 4:08-cv-02317 (M.D. Pa. June 18, 2012).
35. No. 10-cv-5582, 2012 WL 1865564 (E.D.N.Y. May 22, 2012).
36. Ramos v. Baldor Specialty Foods, Inc., 687 F.3d 554 (2d Cir. 2012).
37. § 541.100(a)(1).
38. 668 F.3d 843 (6th Cir. 2012).
39. 370 F.3d 446 (4th Cir. 2004).
40. DOL Field Operations Handbook §§ 53b and 53c.
41. 29 U.S.C. § 215.
42. 1:11-cv-233, 2012 WL 1680101 (S.D.N.Y. May 14, 2012).
43. No. 10-cv-2400, 2012 WL 1906508 (D. Kan. May 25, 2012).
44. Turner v. Mercy Health System, et al., Nos. 3670 and 5155 (Phila. CCP, filed Mar. 10, 2010).
45. N.J.S.A § 34:1A-1.11 thru 1.13.
46. *See* N.J.A.C. §12:2.