Welcome Letter
October 23, 2014

To Conference Attendees –

On behalf of NCFC, welcome to Chicago.

Ever-evolving technologies and new benefits requirements present daily challenges for human resources professionals. We hope that this conference will assist you in meeting these challenges through education, discussion, and networking opportunities.

Thank you for joining us. We hope to see you in San Diego February 11 through 13 for NCFC’s 86th Annual Meeting.

Regards,

Charles Conner
President & CEO

Marlis Carson
Senior Vice President & General Counsel
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NCFC Human Resources Conference
October 23-34
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Agenda
2014 NCFC
Human Resources Conference
October 23-24
Hyatt Regency Hotel
Rosemont, IL

THURSDAY, OCTOBER 23

2:00-3:00 pm  Marijuana in the Workplace: What Employers Need to Know
John F. Kuenstler, Barnes & Thornburg LLP, Chicago
Rosemont A

3:00-4:00 pm  Disability Accommodation in the Workplace
Mary M. Krakow, Fredrikson & Byron P.A., Minneapolis

4:00-4:15 pm  BREAK

4:15-5:15 pm  Cooperative Law for the HR Professional
Mike Droke, Dorsey & Whitney, Seattle

6:30 pm  Networking Dinner
Rosewood Restaurant
9421 West Higgins Road
Rosemont, IL
Please meet in the lobby by 6:15 to board the shuttle to dinner.

FRIDAY, OCTOBER 24

7:30-8:30 am  Breakfast
Lambert

8:30-9:30 am  The Catch 22 of Social Media Communications: How To Handle Social Media in the Workforce
Don Schindler, Dairy Management Inc., Chicago
Rosemont A

9:30-10:30 am  Current Issues with Retirement and Deferred Compensation Benefits
Marla Aspinwall, Loeb & Loeb, Los Angeles

10:30-10:45 am  BREAK

10:45-12:00 pm  Affordable Care Act Implementation and Challenges
Tim Goodman, Dorsey and Whitney, Minneapolis
Marijuana and the Workplace
John F. Kuenstler, Barnes & Thornburg LLP, Chicago

John F. Kuenstler is a partner in the Chicago office of Barnes & Thornburg LLP and a member of the Labor and Employment Department.

Mr. Kuenstler dedicates his practice exclusively to the representation of employers in labor and employment and business matters. He counsels and represents a diverse client base on a national and regional basis in virtually all aspects of labor and employment law, including defense of wrongful discharge, discrimination, sexual harassment, retaliation, Title VII, ADA, ADEA, Section 1981, FMLA, FLSA, ERISA, USERRA, WARN and OSHA claims in federal and state courts and administrative agencies, as well as collective and class actions.

Mr. Kuenstler routinely represents management's interests in workplace tort, breach of contract, non-compete, non-solicitation and other restrictive covenant cases. He is experienced in various forms of alternative dispute resolution, helping clients avoid the costs of prolonged legal disputes.

In addition to his litigation practice, Mr. Kuenstler also represents clients at all levels of administrative proceedings, including matters before the EEOC, NLRB, OSHA, and DOL. For clients with organized workforces or those striving to remain union free, Mr. Kuenstler acts as the lead company negotiator for collective bargaining, defends employers in union grievance hearings and arbitrations, helps craft union avoidance campaigns, and counsels on a range of issues that can arise under the NLRA.

Mr. Kuenstler has guided employers through workforce reorganizations, reductions in force, mass layoffs, plant closings, wage and hour investigations, and whistleblower claims, avoiding litigation through proactive responses and creative business strategies. He provides counseling on matters such as employment practice audits, effective human resources strategies and reviewing and drafting employment policies, social media policies, handbooks, employment contracts, independent contractor agreements, employee leasing agreements and severance agreements. To assist in effective implementation of best practices policies, Mr. Kuenstler provides training and seminars to managers on all matters that impact the employment relationship.

Mr. Kuenstler was selected as a 2012 BTI Client All-Star by the BTI Consulting Group, Inc., being one of merely 272 lawyers nationwide to receive this recognition. He is a member of the American, Illinois, and Chicago Bar Associations, the Bar Association of Metropolitan St. Louis, and the Society for Human Resource Management.
Is smoked marijuana a medication or an illegal substance?
• Some states believe that they can control distribution through regulation

• Distribution activities may help build a state’s tax base through revenue generation

• To date, medical marijuana laws have been passed in 23 states and the District of Columbia

  Algebra  
  California  
  Connecticut  
  District of Columbia  
  Illinois  
  Maryland  
  Michigan  
  Montana  
  New Hampshire  
  New Mexico  
  Oregon  
  Vermont  

  Arizona  
  Colorado  
  Delaware  
  Hawaii  
  Maine  
  Massachusetts  
  Minnesota  
  Nevada  
  New Jersey  
  New York  
  Rhode Island  
  Washington
• Each of these state’s laws vary greatly in content and scope, thereby presenting different challenges for human resource professionals and their organizations

• Three states, Connecticut, Maine and Rhode Island, have laws prohibiting organizations from discriminating against workers solely based on their status as medical marijuana patients

• Arizona and Delaware bar employers from discriminating against registered and qualifying patients who test positive for marijuana, except for employees who are impaired in the workplace
• Some states explicitly exempt businesses from accommodating marijuana use in or around the workplace. Colorado’s law states it “is not intended to require an employer to permit or accommodate the use, consumption, possession, transfer, display, transportation, sale or growing of marijuana in the workplace or affect the ability of employers to have policies restricting the use of marijuana by employees.”

• Similarly, the regulations implementing Massachusetts’ medical marijuana law make clear that employers are not required to offer “accommodation of any on-site medical use of marijuana in any place of employment.”

• Courts have also supported employers’ efforts to maintain a drug-free workplace. In Colorado an appellate court has held that the state’s “lawful activities” statute did not protect any employee from termination after he tested positive for marijuana, despite his status as a licensed medical marijuana patient. The court reasoned that, because marijuana is still illegal under federal law, its use is not a “lawful activity” receiving protection.

• The 6th U.S. Circuit Court of Appeals has also held that “private employees are not protected from disciplinary action as a result of their use of medical marijuana, nor are private employers required to accommodate the use of medical marijuana in the workplace.”
• While legislation continues on medical marijuana, laws are developing as more protective of the medical marijuana patient, as if medical marijuana were a prescription medication, when it is not.

**Gonzales v. Raich**

• Two California patients fought to cultivate and possess prescribed marijuana
• Supreme Court ruled the federal government may enforce the Controlled Substances Act prohibition on the use of marijuana for medical reasons against a person using marijuana under the state medical marijuana laws
• By affirming use of medical marijuana is illegal under federal law, employers could refuse to consider accommodations acknowledging/supporting illegal activity
Ross v Ragingwire Telecommunications, Inc.

• Initial decision published after Gonzales
• Employer not required to hire applicant after positive drug test, even if due to use of medical marijuana
• Lower court’s decision was upheld on appeal to California Court of Appeals
• Court of Appeals held that employers have legitimate interest in not employing persons who use illegal drugs

Ross v Ragingwire Telecommunications, Inc. cont.

• Appealed to California Supreme Court
• Supreme Court affirmed Court of Appeals’ decision
• Under California law, employer may require pre-employment drug tests and take legal use into consideration in making employment decisions
**Washburn v Columbia Forest Products, Inc.**

- Court ruled Oregon employers might have to make reasonable accommodation for disabled workers invoking the protection of Oregon’s Medical Marijuana Statute
- Court also ruled employee’s medical-use marijuana does not automatically entitle him to accommodation
  - Employer could argue certain accommodations unreasonable or create undue hardship

**More Cases**

- **Johnson v Columbia Falls Aluminum Co. and Emerald Steel Fabricators, Inc. v Bureau of Labor and Industries**
  - Courts held employer not required to accommodate employee use of medical marijuana
- **Casias v Wal-Mart Stores, Inc.**
  - Michigan court held that law says nothing about private employment rights only provides a potential defense to criminal prosecution by the state
• Companies should consider adopting workplace medical marijuana policies
• Each state’s laws are different, which can create a challenge for HR departments when developing medical marijuana policies
  – Consider current policies related to legal risk, workplace safety, workers’ compensation, discrimination, and Americans with Disabilities Act when developing medical marijuana policies

• Two states have legalized the “recreational” use of marijuana
  – Colorado
  – Washington
Colorado and Washington

- Colorado and Washington became first two states to legalize marijuana through referendum initiatives
- Accepting medical marijuana as medical explanation is an employer-policy election, however laws in Colorado and Washington do not require an employer to accept a marijuana explanation from a donor
- Per the U.S. Department of Transportation’s Office of Drug and Alcohol Policy and Compliance (ODAPC), marijuana is excluded from consideration as reasonable medical explanation for positive DOT drug tests

What should employers do?

- Given the varying and potentially inconsistent requirements, what should a company do to ensure both compliance with state and federal laws and protection of workplace safety?
  - Review your state’s laws on discrimination against marijuana users
  - Make sure your policies are consistent with state anti-discrimination statutes
  - Continue to comply with federal regulations
What should employers do?

- Review your drug-use and drug-testing policies to ensure that they clearly explain your expectations regarding impairment, marijuana use outside of company time and drug testing
- Make sure you are prepared to consistently follow your stated procedures
- As part of your review, articulate whether you wish to ban all employee drug use or merely impairment
- Train your managers about confidentiality relating to sensitive employee information including drug-test results and requests for accommodations for medical conditions for which marijuana is prescribed
- If you choose to have a zero-tolerance policy, be prepared to answer additional questions.
  - How will you handle employee recreational use that is permitted by law?
  - Will you look to federal law to justify a true zero-tolerance policy?
  - Are you an organization that is required to abide by federal law?

Questions?

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Disability Accommodation
Mary M. Krakow, Fredrikson & Byron P.A., Minneapolis

Mary provides employers practical, common-sense advice and training, from what to do with applicant background checks, to chronic absenteeism and leaves of absence, employee bad behavior and performance reviews, employee terminations and everything in-between.

Mary is a seasoned employment lawyer with extensive experience in disability accommodation, FMLA and other leaves of absence, discrimination and harassment prevention, retaliation and whistleblowing issues, classification of independent contractors, hiring and firing, performance improvement strategies, discipline methods to avoid legal claims, employee handbooks and policies, overtime and other wage compliance, layoffs and workforce reductions, drug and alcohol testing, and federal and state affirmative action planning and compliance. She also drafts employment agreements, and non-competition and confidentiality agreements.

Mary defends employers on federal and state agency claims before the EEOC, Minnesota Department of Human Rights, the OFCCP, and the state and federal DOL.

Mary skillfully advises employers of all types and sizes including, for example, healthcare clinics, hospitals and other healthcare providers, banks and financial service organizations, manufacturers, IT and other consultant groups, food service providers and property management companies.

Mary frequently trains executives, managers and supervisors on all areas of employment legal compliance.

PUBLICATIONS & PRESENTATIONS

- “Minnesota’s New Minimum Wage: A Cheat Sheet for Ensuring Compliance,” Care Providers of Minnesota, April 24, 2014
- “FMLA Dilemmas – Are There any Solutions?,” Fredrikson & Byron’s 29th Annual Employment & Labor Law Seminar, November 6, 2013
- “FMLA Dilemmas: What’s an Employer to Do?,” Fredrikson & Byron’s Annual Employment Law Seminar, Fargo and Bismarck, ND, October 24-25, 2013
- Speaker, “7 Wage and Hour Mistakes That Will Cost You Plenty,” Upper Midwest Employment Law Institute, Minnesota Continuing Legal Education, May 20, 2013
- Speaker, “The FMLA – Basic Law and Practice,” Upper Midwest Employment Law Institute, Minnesota Continuing Legal Education, May 20, 2013
- “Exempt or Non-Exempt? Classify your Workers Correctly,” Upper Midwest Employment Law Institute, Minnesota Continuing Legal Education, June 19, 2012
- “Give Me a Break: Nettlesome Problems with Meal, Rest, and Other Break Times,” Upper Midwest Employment Law Institute, Minnesota Continuing Legal Education, May 22, 2012
- Chapter author and editor, “Wage and Hour Handbook: Federal and Minnesota,” distributed by the Minnesota State Bar Association at the Upper Midwest Employment Law Institute, May 2011
• Presenter, “Social Media and Talent Acquisition: Are You in Compliance with the OFCCP and EEOC Requirements?,” May 11, 2011
• Chapter author, “Discipline and Discharge Handbook,” distributed by the Minnesota State Bar Association at the Upper Midwest Employment Law Institute, May 2010
• “Is Workplace Bullying Next on the Legislative Agenda?,” and “Traversing the FLSA: Exempt/Nonexempt Employees and OT Computation,” Fredrikson & Byron’s Fargo Employment Seminar, October 26, 2010
• “New Posting and Other Requirements for Financial Institutions,” FredNEWS: Bank & Finance, September 2010
• “New Minnesota Statute Limits Use of Criminal History Information in Civil Claims Against Employers,” FredNEWS: Employment & Labor, September 2009
• “Managing the Legal Risks of Behavior that Undermines A Culture of Safety,” Health Law Webinar Series, June 10, 2009
• Speaker, “Preventing Employee Problems: Managing Toxic Workplace Behavior,” April 14, 2009
• “Creating Enforceable Noncompete Agreements with Bank Officers and Other Key Employees,” co-authored with Emily Duke and Sarah Olson, Summer Associate, Banking Law Journal, March 2009
• Co-Chair, Wage and Hour Seminar, Minnesota CLE, February 2008

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• Minnesota State Bar Association, Labor & Employment Law Section
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Disability Accommodation in the Workplace

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Introduction

- Federal and state laws apply
  - The federal Americans with Disabilities Act, as amended
  - Applicable state law
    - No discrimination
    - “Reasonable accommodation”
Typical Questions

- When apply?
  - ADA – 15 EEs or more
  - Each state sets its own minimum coverage threshold

- At-will employment trump disability accommodation?
  - NO
• All medical limitations = disability?
  - Likely, yes

• May ER request medical info?
  - Yes, in most instances
• Should an employer request updated medical information?
  - Yes

• Should we segregate medical information?
  - Yes, keep confidential and limit availability
• Is the “interactive process” important?
  - YES

  How to comply:
  - Meet with/talk with the employee
  - Demonstrate good faith efforts

• What documentation to create?
  - All interactions with EE
  - All good faith efforts

  Where to keep it?
  - Confidential file
• Purpose of accommodation –
  - Enable a qualified disabled EE to perform the “essential” functions of the job

• How to define “essential”?  
  At least seven evidentiary factors: 
  - Employer’s judgment
  - Written job description
  - Amount of time on the function
  - Consequences if do not require
  - Terms of any CBA
  - Work experience of past incumbents in job
  - Experience of current incumbents
• May ER refuse to provide accommodation?
  - Yes, but ER’s burden to prove legitimate reason for the refusal

• How to prove “undue hardship”?
  - Try, try and try again
  - Document, document, document
  - Case-by-case analysis
• More leave after 12 workweeks of FMLA?
  - Yes, most likely

• A *case-by-case* analysis. Really?
  - Yes, really!
Case Study #1

Facts:
- Used 12 workweeks of FMLA leave (84 calendar days)
- Still medically needs more time off
- ER’s self-insured STD policy = 180 days
- Now what?

Suggested response roadmap:
- Updated medical information
- Follow all policies re paid time
- Provide up to total of 180 days
- Even without STD, provide more leave
- Consider need for COBRA notice
- Interactive process
- Document
- Monitor & continue interactive process
Case Study #2

Facts:
- EE A absent for 3 days (Fri., Mon., Tues.)
- Medical note – depression & anxiety, exacerbated by stress at work
- EE A – Adjust work duties and schedule
- EE B sees A’s weekend pictures at football game on Facebook

Suggested response roadmap:
- Medical information
- Begin interactive process
- Consider interim accommodations
- Review essential functions
- Follow all paid leave policies
- Meet again with EE A
- Document
- Monitor & continue interactive process
Case Study #3

• Facts:
  – One of three surveyors - 63
  – Needs shortened work day
  – Two other surveyors – 62+
    • Accommodation soon?
  – Company needs 2.5 surveyors
  – Unsuccessful in recruiting so far

Suggested response roadmap:

• Obtain medical information
• Review applicable policies
• Begin interactive process
• Decide
• Meet with EE again
• Document
• Monitor & continue interactive process
• Be ready for requests from others
I. BACKGROUND

Both the federal Americans with Disabilities Act, as amended (ADA), and state anti-discrimination laws prohibit discrimination based on “disability” and require employers to provide applicants and employees “reasonable accommodation” so long as doing so does not cause “undue hardship” to the employer. While somewhat straightforward to say, compliance with these requirements can pose pitfalls and legal risk for employers. The purpose of this outline is to provide general guidelines for responding to employee and/or applicant accommodation requests. This outline is educational in nature and is not legal advice. Please contact your legal counsel if you have specific questions or concerns.

Let’s start with several questions that employers frequently ask:

1. **Do these laws apply to my company?**

   Yes, depending on the number of employees. The ADA applies to all employers with 15 or more employees. State disability discrimination laws also apply to employers within each respective state (and sometimes when an employee lives in a state but works in another state) depending on the size of the employer’s workforce. The minimum number of employees/workers for coverage in each identified state identified is as follows (with a few caveats, exceptions, and clarifications not included in this list):

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<th>Minimum Number</th>
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All these laws apply to applicants and employees. These laws prohibit discrimination against an individual on the basis of disability with regard to job application procedures, hiring, advancement, discharge, compensation, job training, and other terms, conditions and privileges of employment. Covered employers also must provide reasonable accommodation to enable disabled applicants to apply for open jobs and to all qualified disabled employees to enable them to perform the essential functions of the job starting from the very first day of employment.

2. **My employees are employed “at will,” so I am allowed to terminate a disabled employee without providing reasonable accommodation, right?**

Wrong. “At-will” employment does not negate the obligation to provide reasonable accommodation.

3. **Are all medical limitations a “disability” that must be accommodated?**

Likely, yes. A “disabled person” is a person with a known physical or mental impairment that substantially limits one or more major life activities (e.g., caring for oneself, walking, talking, seeing, hearing, sleeping, working, breathing, learning, etc.). The existence of an impairment is to be determined without regard to mitigating measures such as medicines, or assistive or prosthetic devices. The ADA Amendments Act of 2008 (“ADAAA”), which took effect on January 1, 2009, significantly expanded the scope of medical and mental health conditions the law protects. Congress enacted the ADAAA based on its belief that courts were excluding too many people with “substantially limiting impairments” from protection under the ADA.

4. **If an applicant or employee requests reasonable accommodation, may I request medical information to substantiate the need for the accommodation?**

Generally, yes, if the medical need is not obvious. For example, employers should not ask a person in a wheelchair for medical documentation if the requested accommodation relates to difficulties arising from being in a wheelchair (e.g., a special height desk, etc.). When the underlying medical reason for the accommodation request is not obvious or otherwise well-known, employers should not rely on an applicant’s or employee’s self-report of a medical limitation. The employer can and should request information from the applicant/employee regarding the medical condition the person has identified and how the medical condition affects the person’s work abilities and any limitations that apply. The employer does not need in-depth medical information, however, in most instances.

5. **My employee provided medical information six months ago and is requesting more of the same and/or a different accommodation. Should we ask for updated medical information?**

Yes, if the need for reasonable accommodation continues over time or a new accommodation request is received, employers should obtain updated medical information if needed and not rely on medical information that may be outdated or no longer apply.
6. **Should we segregate the medical information we receive?**

Yes, employers need to retain all medical information from an applicant or employee in a confidential file that is available only to people who need to know, usually HR and the employee’s manager or supervisor when addressing a reasonable accommodation request or another disability-related issue.

7. **Is the “interactive process” important and, if yes, how do we comply?**

Yes, it is important. The “interactive process” generally involves several (it can be one but usually is more) in-person or telephone meetings with the employee to discuss his/her work abilities, limitations, and medical information. The interactive process allows the employee to provide his/her input about what accommodation he/she thinks is needed. The employer also may provide the employee its assessment of the difficulties in providing the requested accommodation and ask for the employee’s suggested alternatives. The bottom line is that the employer needs to demonstrate its good faith (with documentation) in having worked with the employee to determine what accommodation is needed and might be viable.

8. **What documentation should we create?**

Employers need to keep a confidential file containing all relevant documentation regarding each employee’s request for accommodation, any medical information received, the interactive process, and any other disability-related information. The employer should document all interactions with the employee regarding its good faith efforts and include the original of the documentation in this file. Additionally, after HR or another employer representative meets with an employee regarding a reasonable accommodation request or other issue related to a potential disability, it is recommended that the employer provide the employee a follow-up email or memo summarizing the meeting and any agreed-upon next steps. The original of this documentation also needs to be kept in the confidential file.

9. **What is the purpose of an accommodation?**

The purpose of an accommodation is to enable an otherwise qualified individual to perform the “essential” functions of the position he/she holds or desires. Whether a function is “essential” (and not marginal) must be determined on a *case-by-case basis*. At least seven evidentiary factors are important:

- the employer’s judgment;
- the written job description prepared before hiring or interviewing;
- the amount of time spent on the function;
- consequences of not requiring the incumbent to perform the function;
- the terms of any collective bargaining agreement;
- the work experience of past incumbents in the job; and
- the current work experience of current incumbents in similar positions.
10. Are we ever able to refuse to provide a disabled employee the requested accommodation?

Yes, but it will be the employer’s burden to prove a legitimate reason for doing so. Employers may refuse to provide a disabled employee the requested accommodation if doing so would cause “undue hardship” to the employer. Employers also may refuse to provide a disabled employee the requested accommodation if, even with the accommodation, the employee will not be able to perform the essential functions of the job or will be a direct threat to the safety of the employee or anyone else.

11. How do we prove that the needed accommodation causes “undue hardship”?

In most cases, by trying, trying, and trying again. In practical terms, some hardship is to be expected because, by definition, an accommodation means changing the way work is usually performed. In other words, most accommodations, even when reasonable, cause the employer some “hardship.” But the legal standard for refusing to provide an accommodation that would enable an otherwise qualified employee to perform the essential functions of the job is “undue hardship,” which is a high threshold. To claim “undue hardship,” the employer must be ready to show how the needed accommodation creates “undue hardship” to the employer and not speculate as to how much hardship it anticipates. Often (but not always) this requires that the employer have tried, tried, and tried again, documenting each step. Undue hardship is a case-by-case determination and focuses on the resources and circumstances of the particular employer in relationship to the cost or difficulty of providing a specific accommodation. Undue hardship refers not only to financial difficulty, but also to reasonable accommodations that are unduly extensive, substantial, or disruptive, or those that would fundamentally alter the nature or operation of the business. An employer must assess on a case-by-case basis whether a particular reasonable accommodation would cause undue hardship. Documentation is very important on this step also because it will be the employer’s burden to prove undue hardship if ever legally challenged.

12. My company is covered by the federal Family and Medical Leave Act (FMLA) and we provided an employee the required 12 workweeks of leave for the employee’s “serious health condition” but the employee still is not able to return to work and has asked for more leave. Must we provide even more leave?

Yes, most likely at least some more leave, but how much must be determined on a case-by-case basis. Providing an employee leave under the FMLA for the employee’s own “serious health condition” qualifies as concurrent “reasonable accommodation” under the disability laws. But even after the 12 workweeks of FMLA leave have been used, an employer must provide more leave if needed as a reasonable accommodation unless doing so creates “undue hardship” for the employer. Updated medical information will be needed as part of that decision-making process.
13.  It sounds like a *case-by-case* analysis is needed for every disability situation, right?

Right, it is.  Doing a *case-by-case* analysis also means that there is no one-size-fits-all “roadmap” for responding to accommodation requests.  There are, however, several general principles that apply in most cases and which should be followed.
II. CASE STUDIES AND SUGGESTED RESPONSES

The following case studies provide examples of typical accommodation situations that pose significant decisions for the employer with suggested practical responsive steps.

Case Study #1:

The employee was on an approved leave of absence (LOA) under the federal Family and Medical Act (FMLA) from his full-time job (40 hours per workweek) for his own medical condition and used all 12 workweeks of FMLA (84 calendar days). While on FMLA leave, the employee used all accrued paid vacation and paid sick leave. After that, the employer’s self-insured short-term disability (STD) policy kicked in. It provides employees 60% of their wages for up to 180 calendar days of disability based on medical information provided to the employer. After that, the fully-insured long-term disability (LTD) policy may kick in. At the end of the 12 workweeks of FMLA leave, the employee provided the employer an updated medical note saying that the employee is not medically able to return to work but giving no estimate of a probable return-to-work date. What should the employer do now?

Suggested response roadmap:

1. Double check the date on the new medical note to ensure that the employer has updated medical information regarding the employee’s current medical status. Employers must not use out-of-date medical information when making employment decisions.

2. Ensure that the company is following all of its applicable policies providing paid time away from work. Examples include vacation, sick leave, paid time off (PTO), paid days off (PDO), personal leave, self-insured or fully-insured short-term disability, any self-insured or fully-insured long-term disability, etc. If the employer does not, the employee may assert that the employer’s failure to do so was a form of disability discrimination.

3. Because this employer provides self-insured STD benefits for 180 calendar days, the employer should continue to provide approved leave (most likely called personal leave) for the remainder of the available 180 days under the STD policy. Otherwise, it will look like the employer does not follow its own STD policy. In other words, why would the employer maintain a policy of providing 180 calendar days of STD if it is not going to approve an LOA that continues for the same period?

4. Even if the employer did not have the self-insured STD policy, the employer most likely will need to provide some additional amount of approved leave after the FMLA time has expired. This is because, unlike the FMLA, which provides 12 workweeks of job-protected leave, the disability laws do not identify any specific amount of time that leave must be granted. Rather, leave (unpaid unless a company policy or benefit provides for pay) must be provided if such leave does not result in undue hardship. This analysis must be undertaken on a case-by-case basis. But, here are at least three caveats:
a. Most courts have held that an employee’s request for a leave with no end date (an indefinite leave) is not a form of reasonable accommodation and need not be granted by the employer. While true, it is typically best to grant some period of leave for the employee to determine his/her prognosis and then consider ending the leave at some later date when time has passed and the need for on-going leave continues to be indefinite.

b. Also, the EEOC has found that “no fault” or “automatic termination” policies violate the ADA’s requirement that requests for medical leave, including extended leave, be assessed individually on a case-by-case basis.

c. And one more caution -- some employers seek to prevent employees from returning to work until they are able to return to work at 100% capacity or with no restrictions. This type of requirement is a violation of the disability laws, which require that employers allow an employee to return to work with work restrictions if the employer is able to reasonably accommodate the restrictions.

5. When the FMLA time has expired, the employer may need to give COBRA notice under the terms of its group health plan and other insurance plans covered by COBRA.

6. Engage in the interactive process with the employee to discuss the updated medical information and request for more leave time. This could be a telephone or in-person conversation.

7. As part of the interactive process, the employer should send the employee a letter (or possibly an email) stating how it will treat the employee’s continued absence from work (e.g., approved personal LOA) and covering other key issues such as use of any available accrued paid time, STD, COBRA notice, etc. The letter also should tell the employee by when the employer needs to receive updated medical information regarding the employee’s ability to return to work and give the employee the name and number of the person to whom he can direct the information and/or any questions.

8. Monitor and continue interactive process.
Study #2:

Employee A has been absent periodically and, after a three-day absence that included a Friday and the next Monday and Tuesday, brings in a note from her licensed therapist saying that Employee A is suffering from depression and anxiety and that her stressful work duties are exacerbating her condition and symptoms. The note asks the company to make appropriate adjustments to the Employee A’s work duties and schedule to help lessen her stress including absolutely no overtime or weekend work. Also, while Employee A was out on the three-day absence, Employee B reported that Employee A had posted pictures of herself with several friends while attending a local college football game over the weekend. What should the company do now?

Suggested response roadmap:

1. Double check the date on the medical note to ensure that the employer has updated medical information regarding the employee’s current medical status. Employers must not use out-of-date medical information when making employment decisions. Also, note the type of healthcare provider who signed the note for the diagnosis for depression and anxiety. If not a psychologist or other mental health provider, at least consider asking and paying for a second opinion with a mental health provider.

2. Begin the interactive process with the employee. Likely this will include an HR representative and the employee’s supervisor meeting with the employee to discuss the medical note and the information that the employee attended the local college football game over the weekend. If she was not well enough to come to work on Friday or again on Monday or Tuesday, how was it that she was well enough to go to the football game? Also discuss with the employee specifically what schedule changes she is requesting. Do not reject any requested accommodation without first giving the request good faith consideration. Most likely this first meeting will not lead to any type of “final” decision but hopefully can be a good first step toward deciding how to move forward. Create documentation of the meeting and send a copy to the employee and place the original in a confidential file.

3. Consider interim accommodations while the employer reviews the employee’s requests (and possibly waits for a second medical opinion). Create documentation of any interim measures that the company will provide and send a copy to the employee, placing the original in the confidential file.

4. Review the essential functions of the employee’s position. This will include a review of the job description (does it say that this job requires working under stressful conditions?) and other factors listed in the response to question #9 above. Determine what accommodation, if any, the employer can provide without “undue hardship.” If not the requested accommodation, offering an alternative accommodation will demonstrate the employer’s good faith efforts.

5. If the employee needs more time away from the workplace, ensure that the company is following all of its applicable policies providing paid time away from work. Examples include vacation, sick leave, paid time off, paid days off, paid personal leave, self-insured or full-insured
short-term disability, any self-insured or full-insured long-term disability, etc. If the employer
does not follow its own policies, the employee may assert that the employer’s failure to do so
was a form of disability discrimination. Also, be sure to consider whether leave under the
FMLA is appropriate.

6. As soon as possible after the first interactive meeting, meet again with the employee to
discuss next steps. Create documentation of the meeting and provide a copy to the employee.

7. Continue the interactive process as needed and monitor and assess whether, with the
provided accommodation (if any), the employee is able to perform the essential functions of the
job adequately and timely.
Case Study #3:

The company has three experienced surveyors for their road crews. One has told the company that he cannot work as many hours per day as the regular schedule requires (at least 8, often longer via overtime) and, while still able to walk and climb as needed, he is having some mobility and eyesight problems. This employee is 63 years old and has not given any indication that he plans to retire soon. The company knows that the other two surveyors also are 62+ years old and worries that they too may soon tell the company that they cannot work the required schedule (plus overtime) and/or are experiencing physical limitations. The company needs, at minimum, the equivalent of 2.5 full-time, experienced surveyors who also can work overtime if needed. The company has been unsuccessful in recruiting any new experienced surveyors over the prior year. What should the company do now?

Suggested responsive roadmap:

1. For the employee’s current request, ask the employee to provide medical documentation showing the employee’s medical need for the requested shorter schedule. The medical documentation should say how many hours per day the employee can work and any other limitations.

2. Review other potentially applicable policies. This could include the FMLA, paid vacation, paid sick leave, other paid time off, etc.

3. Engage in the interactive process with the employee. This will include discussing the medical documentation, the employee’s proposed work schedule and any other work limitations, and possible accommodations. If possible, come to a conclusion with the employee about the next steps, for example, the employee’s new work schedule and any other accommodations. But it is also okay not to reach any final decisions during this meeting. The employer may want to take time to consider all of what it learned during this meeting and talk with others as needed at the company to decide what it can do.

4. It is recommended that HR and the employee’s supervisor/manager meet with the employee to deliver the company’s decision regarding accommodations.

5. Document the conversation and the company’s decision in a letter/memo/email to the employee. Be sure to cover all applicable issues, for example, the employee’s new schedule, what the new schedule means for eligibility for any ongoing benefits, etc.

6. As to the other surveyors and their possible need for a similar reduction in work hours or other accommodation, the company should continue its search for new hires. But, the company can keep in mind that one factor for determining “undue hardship” is the consequences of having one employee already on a shortened schedule and whether allowing a second and even a third employee the same or similar shortened schedule will create “undue hardship” for the employer.

III. RECENT COURT DECISIONS

The following four case summaries provide interesting and helpful examples of how employers responded to employee accommodation requests and the court rulings in disability discrimination cases.

A. *Hill v. Walker, 737 F.3d 1209 (8th Cir. 2013)*

1. **Facts:**

Hill worked as a family service worker for the Department of Human Services. Her job description stated that “frequent exposure to physical and verbal abuse is required,” and that “[f]ederally mandated service deadlines coupled with heavy case load and the life and death nature of the work creates a stressful environment.” Hill suffered from depression and anxiety, conditions that worsened under the stress of her job. Hill informed her supervisor and Department officials that she was removing herself from a case due to some unpleasant interactions with a client. The next day, Hill’s supervisor and Director met with her and explained that Hill could not unilaterally remove herself from the case and that her experience with the difficult client was the “nature of the business.” Hill’s supervisor and Director offered her several other ways to address the situation, including additional training, special staffing for the case, and accompaniment by a supervisor or security guard when Hill went on home visits for this particular case. Hill rejected these suggestions. During this meeting, Hill stated that she was on medication for job stress and was having anxiety attacks because of the stress.

The next day, Hill returned to work with a doctor’s note placing her under a physician’s care for an “illness” for a month. Because Hill was ineligible for FMLA, Hill asked to use her accrued compensatory time to cover her leave, which was approved. Several days later, Hill’s supervisor sent her a letter reversing the initial decision granting Hill all of her requested compensatory leave as it would “impose an unreasonable burden on the agency” because one of the other caseworkers had resigned that day and another was out on sick leave. The letter stated that the Department would work with Hill to allow her to use her compensatory time, but that she could not use it all in the weeks that followed and she was expected to return to work. Hill did not reply to the letter and did not return to work when requested. The Department later terminated Hill for violating the Department’s policy by failing to comply with reasonable work-related instructions. Hill sued for disability discrimination under the Americans with Disabilities Act and the Rehabilitation Act (which covers public entities).

2. **The Court’s Decision:**

Based on the job description’s statement that a requirement of the job was working in a stressful environment and the testimony of Hill’s supervisor confirming this requirement, the court found that Hill’s handling of a stressful caseload was an essential function of her position. The Department had offered to accommodate Hill by arranging other ways to deal with the difficult case, including special staffing and supervisor accompaniment on visits. The court rejected Hill’s argument that the only acceptable accommodation was removal of the difficult case from her caseload because the case was an essential function of the job and removing Hill from the
case would have required assumption of the duty by another social worker. Therefore, the court found that Hill could not show that she was able to perform the essential functions of her position with a reasonable accommodation and dismissed both disability discrimination claims.

(Hill also sued under the federal Family and Medical Leave Act and the federal Fair Labor Standards Act. The court also dismissed both of those claims on summary judgment.)


1. **Facts:**

The employee, Breaux, worked as a turret operator for Products Fabricators, Inc. (“PFI”). Almost a year before his termination, Breaux suffered a workplace injury on his right shoulder resulting from heavy lifting. His injury was diagnosed as a right rotator cuff tear and he received workers’ compensation benefits. PFI transferred Breaux to a supervisory position, which was less physically demanding and did not require him to work outside of his medical restrictions. PFI also allowed Breaux time off for medical appointments and physical therapy for his right shoulder injury.

Approximately a month before his termination, Breaux told his supervisor that his left shoulder was causing him pain, similar to the pain he previously felt in his right shoulder. A few days later, Breaux’s supervisor followed up with Breaux, who said that his left shoulder was okay. Breaux never provided any documentation to PFI requesting a leave of absence for surgery on his shoulder, but may have asked whether he could take off time for the surgery.

Breaux’s management performance was suffering and his department was performing in an untimely manner, which was impacting other departments at PFI. Breaux’s supervisor discussed these issues with him multiple times. Soon after, PFI terminated Breaux. Breaux filed a charge of disability discrimination and the EEOC issued a determination of reasonable cause to believe that the company had terminated Breaux in violation of the ADA.

2. **The Court’s Decision:**

Breaux argued that he specifically requested a reasonable accommodation – a leave of absence for surgery and recovery. The court found that Breaux had not made a specific request for any accommodation. The evidence revealed that Breaux had told his supervisor that he was feeling similar symptoms in his left shoulder and that he was going to request surgery. However, Breaux did not meet with his doctor to discuss surgery until after his termination and was not formally assessed for surgery until a month later. The court found that PFI was aware of Breaux’s shoulder issues; but that Breaux did not actually request time off for his surgery as an accommodation and, therefore, dismissed his claim of alleged disability discrimination.
C. **Kallail v. Alliant Energy Corporate Servs., 691 F.3d 925 (8th Cir. 2012)**

1. **Facts:**

Kallail was a Resource Coordinator at Alliant’s Distribution Dispatch Center. Alliant required the Resource Coordinators to work rotating schedules and work in teams of two on nine-week schedules that rotated between twelve-hour and eight hour shifts and day and night shifts. Kallail had Type I diabetes and was dependent on insulin. She also had Peripheral Vascular Disease, which limited the circulation in her legs and feet making it difficult to walk. By the fall of 2004, Kallail had experienced increased difficulty managing her diabetes while working a rotating shift. In November 2004, Kallail contacted human resources about a possible accommodation. Kallail’s physician was asked to complete a medical certification form and recommended that Kallail work only straight day shifts. Alliant denied Kallail’s request for straight day shifts as an accommodation because the “Resource Coordinator’s essential functions require rotating shifts and emergency call-ins to support daily electric and gas operations 24 hours a day 7 days a week to meet company and public safety requirements.” As an alternative accommodation, Alliant said that it would consider reassigning Kallail to another vacant position with a straight day shift.

The company later provided Kallail with a list of three open positions for which she could apply. Kallail was not interested in any of the three positions. Kallail went on FMLA medical leave due to surgery on her leg and resulting complications. She requested an extension to her leave, which was granted. While on leave, Kallail applied for an Administrator position. She was one of six applicants to receive an interview, but Alliant hired another candidate.

When Kallail returned to work, she was given a temporary light duty assignment to comply with her restrictions. Kallail later submitted to Alliant a second request for accommodation and submitted a proposed schedule in which she, along with a teammate, would work a regular eight-hour day shift, while the remaining Resource Coordinators continued to work rotating shifts.

Once Kallail’s temporary light duty assignment expired, Alliant allowed Kallail to use paid leave benefits while they explored possible open positions for which she was qualified and to which she could be assigned. Alliant offered her two other positions, both of which Kallail declined. She instead applied for short and long term disability benefits. She later sued and claimed that Alliant discriminated based on disability by failing to provide her with a reasonable accommodation.

2. **The Court’s Decision:**

The court found that the rotating shift was an essential function of the Resource Coordinator position based on Alliant’s business judgment, written job description, and the consequences of not requiring all the employees in the position to work rotating shifts (i.e., other Resource Coordinators would be required to work more night and weekend shifts). Because there was no reasonable accommodation that would allow Kallail to continue working in the Resource Coordinator position, this meant that Kallail was not a qualified disabled person for that position. Additionally, as yet another attempt at reasonable accommodation, Alliant had offered to
reassign Kallail to another open position. To turn down that offer, the court stated that Kallail needed to show that the position was both inferior to her former job and that a comparable position for which she was qualified was open. Kallail had not provided that evidence. Also, while Kallail argued that Alliant should have promoted her to the open Administrator position, the court explained that an employer need not make a promotion to satisfy the ADA.


1. Facts:

Johnson was a Detective in the City of Blaine’s Police Department. Johnson responded to several pedestrian fatalities on a highway and began experiencing symptoms of post-traumatic stress disorder (PTSD) and depression, for which he took a short leave of absence. Subsequently, Johnson responded to a homicide, again triggering PTSD. She had a breakdown at the scene and was unable to perform her job duties, and had to be driven back to the police station by another officer. This incident caused Johnson to take an extended leave of absence and to be hospitalized for suicide ideation. After this leave, Johnson transitioned back to a full-duty police officer.

For five years, Johnson did not exhibit any significant symptoms of depression or PTSD. Johnson, however, was confronted with several deaths (including a coworker, a friend, the mother of a friend, and her father) within a short period of time. She was then hospitalized with symptoms of depression and suicidal ideation. She requested an FMLA leave, but did not know how long her mental health condition would last. When the leave was about to expire, the Human Resources Director for the City of Blaine wrote to Johnson notifying her that her leave was to expire. Johnson responded that she was unable to return to work when her leave expired, but hoped to return to work in three months as recommended by her psychologist. The Human Resource Director granted an additional amount of leave, but did not allow Johnson to extend her leave for the full three months that Johnson had requested, and stated that Johnson would have to submit to a “Readiness for Duty” examination before returning to work.

Johnson replied that she needed all of the requested extended leave because she had registered and paid for a retreat to help public service workers overcome issues with PTSD, depression and anxiety. Johnson’s request again was denied. Johnson was released to return to work by the physician performing the Readiness for Duty examination. The physician, however, felt that Johnson would have difficulty handling stress and sadness in her work.

After returning to work, Johnson requested that she be removed from the mandatory overtime list. Johnson’s supervisor denied her request and explained that the list was “mandatory for all nonexempt sworn personnel as a way of distributing overtime as fairly as possible pursuant to the labor agreement.”

During Johnson’s ongoing employment, the City of Blaine’s Police Department received several complaints of Johnson engaging in misconduct, insubordination and harassment of supervisors and coworkers. After being criminally charged for disorderly conduct with an administrative assistant, Johnson resigned. She later sued the City of Blaine for disability discrimination and
failure to accommodate under the Americans with Disabilities Act and the Minnesota Human Rights Act (plus sex discrimination and constructive discharge).

2. **The Court’s Decision:**

Johnson argued that the City had failed to accommodate her by refusing to extend her FMLA leave to permit her to attend the retreat. The court rejected this argument and found that Johnson had been granted an extended leave and the City was not obligated to provide an indefinite leave of absence. Further, the City did allow Johnson to attend the retreat at any rate. The Court also rejected Johnson’s argument that the City’s failure to remove her from the mandatory overtime list was inappropriate. The court found that working overtime was an essential job duty for all officers, which was contained in the job description and collective bargaining agreement. Johnson could have requested a leave if she needed to go to a particular appointment, but could not show that she was forced to miss any appointment or treatment due to the overtime list.
Cooperative Law
Mr. Droke is a partner in the Labor and Employment and Ag/Cooperatives groups. He is also co-Chair of the Computer Fraud and Abuse Practice Group, and member of the Privacy Practice Group, Executive Compensation Team, and Electronic Discovery Practice Group. He is currently the Partner-in-Charge of LegalMine, Dorsey's state-of-the-art document review service. He was Dorsey & Whitney Partner of the Year in 2001. He previously served as a Co-Department Head for Labor and Employment, and Partner-in-Charge of the Seattle office.

Capabilities

- **Litigation Defense and Dispute Resolution**: defend technology, financial, manufacturing, agricultural, and other employers in. Successfully resolve lawsuits effectively and efficiently, consistent with the employer's strategic objectives.
- **Preventative Counseling**: regularly advise employers on practical, thorough legal compliance, with a focus on employers' operational and strategic needs. Provide strategic advice and operational expertise to clients in support of their strategic direction.
- **Union-Management Relations**: Chief negotiator for numerous collective bargaining agreements. Successfully obtained several mass picketing injunctions, defended arbitrations, and advised employers on NLRA compliance during strike to avoid 8(a)(5) and 8(a)(3) charges.
- **Preventative Training**: provide management training on all aspects of the law, including managing within the law, and fundamentals of effective leadership.

Representative Litigation

- Lead counsel in wage and hour misclassification class action for agricultural manufacturers
- Lead counsel for agricultural cooperative seeking insurance indemnity; full recovery obtained
- Lead counsel in antitrust case involving cooperative association
- Successfully obtained summary judgment on appeal on all claims related to a Top Hat ERISA plan (Sznewajs v. U.S. Bancorp, Ninth Circuit Case #07-16489)
- Successfully defended former software company executive in non-competition claim
- Lead counsel in trade secrets and non-competition claim; successfully defended against preliminary injunction and TRO
- Lead counsel in multi-million dollar retaliation, public policy wrongful discharge and commission pay claim against large international professional services company
- Lead counsel in age discrimination lawsuit against national bank; summary judgment obtained
- Lead counsel in race and national origin claim against national bank; summary judgment obtained
- Lead counsel in disability discrimination lawsuit against national bank; coordinated settlement before discovery
- Lead counsel in multi-million dollar commission pay claim against financial services company; summary judgment affirmed on appeal
- Lead employment counsel for merger of two manufacturing companies
- Lead counsel for national retail chain in lawsuit alleging race and national origin harassment and discrimination; resolved before discovery
- Lead counsel for manufacturing company in lawsuit alleging disability discrimination and workers' compensation retaliation; resolved before answer filed
- Lead counsel for national services company in lawsuit alleging graphic sexual harassment and discrimination on the basis of gender; resolved before answer filed
- Lead counsel for manufacturing company in lawsuit alleging race and national origin harassment and discrimination; summary judgment obtained
- Lead counsel for telecommunications company in significant commission pay claim; successfully resolved before answer filed
Lead counsel for services company in contractual binding arbitration brought by terminated employee claiming wrongful termination and discrimination; successfully resolved on eve of trial

Presentations
- FLSA – The Law We Love To Hate!, February 2014
- Keynote Speaker, Megatrends In Employment Law, SHRM Washington State Council, March 2013
- Executive Compensation for Cooperatives, January 2013 (Spokane, WA)
- Megatrends in United States Employment Law, Canadian Bar Assn. (Calgary Chapter), April 2012
- I Survived an ICE Audit, SHRM Washington State Council Webinar, January 2012
- US Labor & Employment Law, Vancouver, March 2011 and Calgary, Canada May 2011
- Keynote Speaker Employment Law Update, SHRM Conference, 2000 – 2011
- What's Work Got To Do With It? Off The Clock, Cyberworking, and The Laws Of Overtime
- Cyberstalking & The New “Harassment”
- Troublemakers in the Workplace: Avoiding The Legal Pitfalls Caused By Your Most Problematic Employees
- Legislative Update
- Facebook’s Workplace: Social Networking, New Media and The Law
- In the Hot Seat: Mock Deposition of an HR Representative
- Prescriptions (Rx) for Your Health Concerns: The Latest Programs and Innovations
- Panel Discussion: Preventing the Wage & Hour Class Action
- Social Media and Investigations: The 21st Century Water Cooler
- Quirky Questions in Employment Law
- Legislative Update
- EEOC’s Dramatic Regulatory Changes Under the ADAAA and GINA
- Cyber Unionism and Other Labor Law Updates
- The End in Mind: Employment Trials and Tribulations
- Going Global: Non-Competes, Trade Secrets, and Employee Mobility in the Global Marketplace
- When the Appletini Goes Sour: How Do You Keep Work/Personal Boundaries from Getting Blurry?, NW Human Resource Management Assn. Annual Conference, October 2011

Professional Activities
- Member, National Council of Farmer Cooperatives, Legal, Tax / Accounting Committee
- Member, Federal Bar Association
- Founding Member, The CHO Group, 2002-Present
- Founding Member and President, 1999 to Present, Association for Corporate Growth
- Founding Member, Board Member, President Elect, 2002-2009, Bainbridge Public Schools Trust
- Member, National Society of Human Resource Management and Northwest Human Resource Management Association
The material appearing in this presentation is for informational purposes only and is not legal or accounting advice. Communication of this information is not intended to create, and receipt does not constitute, a legal relationship, including, but not limited to, an accountant-client relationship. Although these materials may have been prepared by professionals, they should not be used as a substitute for professional services. If legal, accounting, or other professional advice is required, the services of a professional should be sought.
What is a Cooperative?

Rochdale principles

1. Voluntary and open
2. Democratic membership control
3. Member economic participation
4. Autonomy and independence
5. Education, training, and information
6. Cooperation among cooperatives
7. Concern for community

What is a Cooperative?

• Common theme—allocation of profits to users not investors
• Common theme—conflict of interest
• Common theme—confidentiality
Why Do Co-ops Form?

- To develop a market for products
- To add value to raw commodities
- To allow independent operators to compete with chains
- To establish a service not provided by the for-profit sector
- To permit greater customer or employee control over product quality or characteristics

Industries Where Co-ops are Prevalent

- Agriculture—Farm Supply and Marketing Systems
- Rural Electric & Rural Telephone
Industries Where Co-ops are Prevalent (cont.)

• Purchasing Co-ops—retail owned distribution centers, joint buying groups

 ACE Hardware  MID STATES DISTRIBUTING COMPANY, INC.  Shur Fine  True Value

• Farm Credit Banks and Credit Unions

 SPIRE™  CRC  National Rural Utilities Cooperative Finance Corporation  COBANK  AGSTAR  DORSEY

Industries Where Co-ops are Prevalent (cont.)

• Housing Co-ops

• Mutual Insurance

 Nationwide Insurance  Northwestern Mutual Life  The Quiet Company

• Consumer Co-ops

Formation of Co-ops

• State co-op laws
  – Washington, Oregon, California, Minnesota, Wisconsin, California, Kansas, Wyoming, Tennessee, Iowa, etc.
  – Articles, Bylaws, Member Agreement

• DE corporate law (or other state corporate laws)

What is a Cooperative?

• Tax law definition(s)
  - Subchapter T—operating on a cooperative basis, pre-existing duty to allocate earnings to patrons, distribution of 20% in cash within 8 ½ months, democratic control
  - 501(c)(12) (rural utilities)
  - 501(c)(14) (credit unions)
  - 501(c)(15) (mutual insurance)
Choice of Entity for an Organization to Act Collectively

There is no “one size fits all” model:

• **Cooperative Model**: mostly tax neutral using Subch. T; borrowing eligibility; securities exemption in some cases; self-employment tax; utilization of tax credits; special programs; the equity limitation

• **LLC/Partnership Model**: tax pass-through under Subch. K, but tax and accounting complexity for members

• **Corporate Model**: Management of taxable income & use of a rebate program

• **Joint Venture/Buying Group Model**: Simplicity?

Unique Tax Treatment

• Cooperative tax treatment is available to any organization that “operates on a cooperative basis”

• The general principal of cooperative income taxation is that money flows through the cooperative and on to patrons, leaving no margins to be retained as profit by the cooperative.
  – Hence one level of tax on patrons
Taxes:
Operate at Cost Principal

- Doesn’t mean the cooperative won’t have a margin (profit)
- It just means the cooperative has a legal obligation to distribute the margin to its patrons
- A cooperative does this by paying patronage dividends

Patronage Dividends

- Can be paid in cash or certificates ("equity")
- Certificates allow a cooperative to retain funds needed to operate
- Certificates are issued in the patrons name and are paid out in the future
Cooperatives and Competition

- Cooperative model offers limited protection from antitrust laws
  - Capper-Volstead protection for producer-owned cooperatives
  - Robinson-Patman exemption for rebates or dividends returning share of net earnings in proportion to member’s sales/purchases
- Cooperative, like other legal models of competitor collaboration, entails risk

Some Common Antitrust Issues

- Does a purchasing cooperative have to admit all applicants?
  - No, a cooperative certainly can have legitimate membership criteria (*Northwest Wholesalers*)
  - Cooperative should be careful about who makes the membership decisions and how they are made
Common Antitrust Issues (cont’d)

• Can a purchasing cooperative assign territories to its members and prohibit sales of cooperative-sourced products in other members’ territories
  – *Topco* case says “no”

Common Antitrust Issues (cont’d)

• Can a purchasing cooperative set minimum resale prices for cooperative-sourced products?
  – If set by members: a definite “no”
  – If set by cooperative’s professional and independent management: still probably no, and definitely not without very close legal review
Common Antitrust Issues (cont’d)

• Is a purchasing cooperative liable if it gets better pricing from suppliers than other buyers get?
  – No buyer liability unless seller is also liable
  – No buyer liability unless buyer “knowingly” induces the discrimination
  – Difference between seeking better prices, and seeking prices that are better than what other buyers pay (particularly with a contractual commitment)

Common Antitrust Issues (cont’d)

• Can a purchasing cooperative “discriminate” among its members?
  – Threshold cultural and philosophical issue
  – Potential *Copperweld* defense for wholly owned subsidiary relationships
Cooperatives that Rely on Capper-Volstead

Dairy
Fruits
Vegetables
Nuts
Sugar
Wheat

Feed grains
Rice
Oilseeds
Cotton
Livestock

Board of Directors and Governance

• Basic Structure
  – Members
  – Board of Directors
  – Executives
  – Employees
Governance: Board Duties Generally

- Represent cooperative members
- Establish the policies of the cooperative
- Hire and supervise management
- Ensure sound management of the cooperative
- Acquire and preserve cooperative assets
- Preserve the cooperative character of the organization
- Assess the cooperative’s performance
- Inform members

Overview of Fiduciary Duties

- Duty of care
  - Oversight
  - Decision-making
  - Business judgment rule
  - Entire fairness
- Enhanced scrutiny where conflicts of interest (less so with cooperatives)
- Exculpation and indemnification
Overview of Fiduciary Duties

• Duty of loyalty
  – Conflict-of-interest transactions
  – Competing with corporation
  – Using corporate information or position
  – Taking corporate opportunities
  – Entire fairness
  – Burden of proof
  – Disinterested decision-making body: special committee; disinterested shareholder approval

• “Conscious disregard” of fiduciary duty: transforming duty-of-care breach into duty-of-loyalty breach
  – Not exculpable?
  – Not indemnified?
  – Not insurable?

Business Judgment Rule

• Directors of a commercial corporation may take chances, as a prudent man would in his own business.

• The court will not hold directors liable for honest errors, or mistakes of judgment, as long as they act in good faith.
Confidentiality
(Confidentially Speaking)

Employment Law: Special Issues

• Prime contact point to members/owners
• Conflicts of interest exist
• Jurisdiction based on cooperative business size, not member business size
Questions

Helpful Resources

  - Look under legal and taxation
    - CIR 44 Part 1 through Part 5
    - CIR 1, Section 9
    - CIR 23
- U. Wisconsin Center: [http://www.uwcc.wisc.edu/](http://www.uwcc.wisc.edu/)
Social Media
Don Schindler, Dairy Management Inc., Chicago

As Senior Vice President of Digital Initiatives, Don Schindler is responsible for the digital architecture and integration of all digital properties at Dairy Management Inc. He is also training farmers, DMI staff and dairy industry professionals in digital communications and social media.

Before coming to DMI, Don managed the creative services of University Communications at the University of Notre Dame. University Communications maintains many websites including nd.edu as well as handles many internal clients like Arts & Letters, College of Science, University Relations, Alumni, etc... The University Communications won several awards including top five Social Media in Higher Education and best website redesign for nd.edu.

Don taught both graduate and undergraduate classes in digital technology and social media at the University of Notre Dame's Mendoza College of Business. Before coming to Notre Dame, Don worked as a digital strategist and executive creative director at Indianapolis-based digital agency, Mediasauce.
HOW TO HANDLE SOCIAL MEDIA IN THE WORKFORCE
Conversation Skills
How to listen, show empathy, respond gracefully, and gain trust.
FROM 2009 TO 2014, SIGNIFICANT GAINS FOR REGULAR EMPLOYEES, A PERSON LIKE YOURSELF. CEOS FLAT FROM 2013.

CREDIBILITY OF SPOKESPEOPLE

**2009**  
- Academic or Expert: 62%
- Technical Expert*: 47%
- Financial or Industry Analyst: 49%
- NGO Representative: 41%
- Regular Employee: 32%
- CEO: 31%
- Government Official or Regulator: 29%

**2014**  
- Academic or Expert: 67% (+5)
- Technical Expert*: 66%
- Financial or Industry Analyst: 53% (+4)
- NGO Representative: 62% (+9)
- Regular Employee: 62% (+20)
- CEO: 43% (+12)
- Government Official or Regulator: 38% (+7)

* Not tested in 2009
All platforms will be adding buttons to directly shop from their networks.
Nurse Firing Highlights Hazards of Social Media in Hospitals

Jul 8, 2014, 5:26 AM ET

By LIZ NEPORENT via GOOD MORNING AMERICA

Nurse Fired Over 'Man vs 6 Train' Instagram Post

OPINIONS ARE MY OWN!
Confusing?
Still lots of gray area here.

What to do?
Get a policy and/or review your policy. Work it with legal, marketing and yourself.

http://socialmediagovernance.com/policies/

Monitor your company name but not employees.
Get involved in social media and get some professional training.

Social Media Compliance Training like other HR training for office settings.
Top Takeaways

01 Employee use of social media is heavy.

02 Marketing and Communications want to create employee advocates.

03 Protect the employee and the company by having smart practices in place.
Retirement
Marla Aspinwall concentrates her practice in the tax, ERISA, labor and securities aspects of executive compensation for publicly held, private, and tax exempt organizations, including employment agreements; nonqualified deferred compensation; and equity, retirement, incentive, and welfare benefit plans. Ms. Aspinwall has extensive knowledge of insurance-funded executive benefits and estate planning arrangements. She also specializes in the tax and business aspects of agricultural cooperative organizations and has represented many large agricultural cooperatives.
QUALIFIED PLANS

IRS Approves Qualified Longevity Annuity Contract (“QLAC”) for Defined Contribution Plans and IRAs

- On July 1, 2014, the IRS issued final regulations on Qualified Longevity Annuity Contracts (“QLACs”).

- Can now be offered in qualified defined contribution plans and IRC Section 457(b) governmental plans as well as non-Roth IRAs.

- The QLAC is a special form of deferred annuity that guarantees lifetime income starting no later than age 85.

- Prior regulations had limited the premium payments for a QLAC to $100,000. Final regulations increase the limit to the lesser of $125,000 (indexed for inflation) or 25% of the participant’s account balance.
QUALIFIED PLANS

Plans must be amended to comply with *United States v. Windsor* by year end


- The Notice requires that effective June 26, 2013 (or if applicable, September 16, 2013), a qualified retirement plan must treat same-sex spouses as spouses for all plan purposes.

- Notice 2014-19 clarifies that an amendment to conform a non-governmental plan to the *Windsor* holding is necessary if the plan refers to Section 3 of DOMA or is otherwise inconsistent with *Windsor* must be adopted by the later of (i) the end of the plan year in which the change is first effective or the due date of the employer’s tax return for the tax year that includes the date the change is first effective; or (ii) December 31, 2014.

QUALIFIED PLANS

IRS Guidance Extends Pension Fund Stabilization Provisions

- Highway and Transportation Funding Act (“HATFA”) extended certain interest rate smoothing provisions for an additional 5 years.

- Single employer defined benefit plans are subject to minimum funding requirements. HATFA retains the current minimum and maximum range through 2017 such that for plan years beginning in 2012 through 2017, each segment rate is adjusted so that it is no less than 90% and no more than 110% of the corresponding 25-year average segment rates.

- Changes are effective with respect to plan years beginning after December 31, 2012, however, the plan sponsor can elect not to have the modifications apply to any plan year beginning in 2013, either for all purposes or solely for purposes of determining the plan’s adjusted funding target attainment percentage (“AFTAP”).

- The IRS released Notice 2014-53 providing guidance with respect to the foregoing.
IRS Issues Final and Proposed Regulations for Hybrid Retirement Plans

- The IRS released final and proposed Treasury regulations regarding defined benefit plans that use a lump sum based benefit formula, including cash balance plans and pension equity plans, as well as other hybrid retirement plans that have a similar effect.

- In general, a defined benefit plan must satisfy the minimum vesting standards and the accrual requirements of Code Section 411 to be qualified under Code Section 401(a).

- These final and proposed regulations modify the existing rules under Code Sections 411(a)(13), 411(b)(1), and 411(b)(5) and generally apply to plan years beginning in 2016.

IRS Releases Pilot Penalty Relief Program for Late Form 5500-EZ Filings

- Revenue Procedure 2014-32 provides relief to one-participant retirement plans exempt from ERISA and certain foreign plans from penalties for failure to file returns.

ERISA Plan Fiduciaries May Be Able to Rely on Advice of Counsel or Other Advisors in Discharging Fiduciary Duties

- In Clark v. Feder Semo and Bard, P.C., No. 12-7092 (D.C. Cir. January 7, 2014), court concluded that, based on the outside counsel’s familiarity with the plan and the diligence applied in formulating his advice, the plan fiduciaries were entitled to rely on the counsel’s advice without failing to discharge their fiduciary duties to the plan and its participants.
NONQUALIFIED PLANS

IRS Announces New Program to Audit IRC Section 409A Compliance

- Section 409A provides extensive deferral and distribution rules to non-qualified deferred compensation and include substantial penalties for failure to comply
- IRS is finally getting ready to enforce rules and has proposed a pilot enforcement program
- Will focus on 50 companies and send Information Document Requests (“IDRs”)
- Initially will limit requests to top 10 highest paid employees
- Information gained in pilot program used to form future audit procedures
- Correction procedures not available once you are under audit
- Recommend internal audits now – review all compensation arrangements for 409A compliance

NONQUALIFIED PLANS

Final IRC Section 83 Regulations and Tax Court Clarify “Substantial of Risk of Forfeiture”

- A “substantial risk of forfeiture” requires a service condition (i.e., performance of future services) and/or a condition related to the purpose of the transfer (i.e., a performance condition)
- Likelihood that a forfeiture event will occur and the likelihood that the forfeiture will be enforced must both be considered
- Transfer restrictions related to securities limitations generally will not create a substantial risk of forfeiture, even if a violation may result in penalties or disgorgement
- Preamble says acceleration of vesting on involuntary separation from service without cause will not prevent a service requirement from being considered substantial, provided that facts and circumstances do not demonstrate that such an involuntary separation is likely to occur
- Note that risk forfeiture on termination for cause generally will not be considered substantial but see Austin v. Commissioner, 141 T.C. No. 16 (December 16, 2013) where definition of cause was so broad as to include voluntary termination by employee so court found substantial risk of forfeiture
NONQUALIFIED PLANS

Development in FICA Tax Special Timing Rule for Nonqualified Deferred Compensation

• Special timing rules in IRC Section 3121(v) for NQDC subjects plan credits to FICA taxes at the time of deferral or vesting

• Intended to advantage employees typically over the wage based at such times

• Employers may be liable to employees for failure to include resulting in benefits subject to FICA

• No recovery mechanism for taxes paid on amounts never received - see Balestra v. United States, 113 AFTR 2d ¶ 2014-887 (Cl. Fed Claims, 2014)

DOL Proposes to Require Electronic Filing of Top Hat Letters

IRAS

Development in IRA Rollover Rules

• Bobrow v. Commissioner, T.C. Memo 2014-21 which holds that the one-rollover-per-year rule under IRC Section 408(d)(3)(B) applies to all of a taxpayer’s IRAs in the aggregate, not to each IRA separately
NCFC 2014 Human Resources Conference
Employment and Benefits Law
Current Issues with Retirement and Deferred Compensation Benefits
Marla Aspinwall, Loeb & Loeb LLP

A. QUALIFIED PLANS

IRS Approves Qualified Longevity Annuity Contract for Defined Contribution Plans and IRAs

On July 1, 2014, the IRS issued final regulations on Qualified Longevity Annuity Contracts (“QLACs”). These annuity contracts can now be offered in qualified defined contribution plans and IRC Section 457(b) governmental plans as well as non-Roth IRAs. The QLAC is a special form of deferred annuity that guarantees lifetime income starting no later than age 85. They are designed to pick up where typical retirement benefits leave off and assure that participants do not outlive their benefits. If the annuity meets the requirements, the premium is not used in the calculation of the required minimum distribution amount under the plan or IRA. To be a QLAC, the annuity must be purchased by the plan and the plan must have the ability to distribute it to the participant, whereupon the plan will have no further responsibility for the QLAC. Prior regulations had limited the premiums payable for a QLAC to $100,000. Final regulations increase the limit to the lesser of $125,000 or 25% of the participant’s account balance. The annuity must be a simple straight life annuity, the only death benefit payable is a joint and survivor or return of premium provision. The insurance company issuing the QLAC must file special reports to the IRS with copies to the participant.

IRS Issues Guidance Addressing Application of United States v. Windsor to Qualified Retirement Plans


Earlier IRS guidance (Notice 2013-17) resolved that for federal tax purposes, (1) the terms “spouse,” “husband and wife,” “husband,” and “wife” include an individual married to a person of the same sex if the individuals are lawfully married under state law, and the term “marriage” includes such a marriage between individuals of the same sex; (2) the IRS adopts a general rule recognizing a marriage of same-sex individuals that was validly entered into in a state whose laws authorize the marriage of two individuals of the same sex even if the married couple is domiciled in a state that does not recognize the validity of same-sex marriages; and (3) a domestic partner or civil union partner is not recognized as a “spouse”. These holdings apply for all federal tax purposes, including as applied to qualified retirement plans under IRC Section 401(a). The Notice requires that effective June 26, 2013 (or if applicable, September 16, 2013), a qualified retirement plan must treat same-sex spouses as spouses for all plan purposes.

Notice 2014-19 clarifies that an amendment to conform a non-governmental plan to the Windsor holding is necessary if the plan refers to Section 3 of DOMA or is otherwise inconsistent with Windsor (or the subsequent IRS guidance) and must be adopted by the later of (i) the end of the plan year in...
which the change is first effective or the due date of the employer’s tax return for the tax year that includes the date the change is first effective; or (ii) December 31, 2014 (“Required Amendment Date”). A plan amendment, specifying the date as of which and the purposes for which the rules are applied, is required as of the Required Amendment Date if a plan sponsor chooses to apply the Windsor rules to qualified retirement plans for periods before June 26, 2013.

IRS Guidance Extends Pension Fund Stabilization Provisions

In August of 2014, the Highway and Transportation Funding Act (“HATFA”) extended certain interest rate smoothing provisions for an additional 5 years. Single employer defined benefit plans are subject to minimum funding requirements that are calculated using 3 segment interest rates, that are adjusted to fall within a specified range that is determined based on an average of the corresponding segment rates for the 25-year period ending on September 30 of the calendar year preceding the first day of the plan year. HATFA retains the minimum and maximum range through 2017 such that for plan years beginning in 2012 through 2017, each segment rate is adjusted so that it is no less than 90% and no more than 110% of the corresponding 25-year average segment rates. These changes are effective with respect to plan years beginning after December 31, 2012, however, the plan sponsor can elect not to have the modifications apply to any plan year beginning in 2013, either for all purposes or solely for purposes of determining the plan’s adjusted funding target attainment percentage (“AFTAP”). The IRS released Notice 2014-53 providing guidance with respect to the foregoing.

To elect to defer use of the HATFA segment rates, until the first plan year beginning on or after January 1, 2014, the plan sponsor must provide written notice to the enrolled actuary for the plan and to the plan administrator, specifying the name of the plan, the EIN and plan number, and whether the use of the HATFA segment rates is deferred for all purposes or only for determination of the AFTAP. The election is irrevocable and must be made no later than the later of the deadline for filing the applicable Form 5500 (including extensions) for the plan year beginning in 2013 or December 31, 2014.

With respect to a plan year beginning in 2013, if, on or before December 31, 2014, the applicable Form 5500, is filed and the Schedule SB reflects the MAP-21 segment rates, then an election to defer use of the HATFA segment rates for purposes of both §§ 430 and 436 until the first plan year beginning on or after January 1, 2014 is deemed made. This deemed election can be revoked by filing the applicable amended Form 5500 and revised Schedule SB reflecting HATFA rates by December 31, 2014. The deemed election can be revoked to defer HATFA rates only for Code Section 436 purposes by providing written notice of revocation to the enrolled actuary for the plan and the plan administrator, together with an e-mail to the PBGC on or before December 31, 2014, provided the plan sponsor is not a debtor under Chapter 11.

A plan sponsor can elect to reverse all or part of any election to reduce the plan’s funding standard carryover balance or prefunding balance as of the first day of a plan year beginning in 2013 if the HATFA segment rates apply for purposes of determining the minimum required contribution for the plan year and the reduction election was made on or before September 30, 2014. A deemed election to reduce these balances made in conjunction with a certification of the plan’s AFTAP for the plan year generally
will also be reversed if the HATFA segment rates apply for such year. Any reduction election made to avoid or remove benefit restrictions under Code Section 436 during the period before the original AFTAP certification date for the 2013 plan year cannot be reversed.

A plan sponsor can choose to redesignate all or a portion of a contribution that was originally designated as applying to the plan year beginning in 2013 to apply to a plan year that begins in 2014 if the contribution was made after the end of the 2013 plan year and on or before September 30, 2014 and the original designation on Schedule SB for the 2013 plan year that is filed by December 31, 2014.

The Notice also provides special rules relating to the application of the benefit restrictions under Code Section 436 and related rules for a plan year beginning after December 31, 2012 and before October 1, 2014 for a plan for which the modifications made by HATFA are applied for purposes of determining the plan’s AFTAP for the plan year.

**IRS Final and Proposed Regulations for Hybrid Retirement Plans**

The IRS released final and proposed Treasury regulations regarding defined benefit plans that use a lump sum based benefit formula, including cash balance plans and pension equity plans, as well as other hybrid retirement plans that have a similar effect. In general, a defined benefit plan must satisfy the minimum vesting standards and the accrual requirements of Code Section 411 to be qualified under Code Section 401(a). These final and proposed regulations modify the existing rules under Code Sections 411(a)(13), 411(b)(1), and 411(b)(5) and generally apply to plan years beginning in 2016.

With respect to Code Section 411(a)(13)(A), the regulations (i) expand the definition of a pension equity plan formula to include a benefit formula expressed as a current single-sum dollar amount equal to a percentage of the participant’s highest average compensation; and (ii) provide that a benefit formula does not constitute a lump sum-based benefit formula unless a distribution of the benefits under that formula in the form of a single-sum payment equals the accumulated benefit under that formula. The regulations also clarify (i) the requirements that apply to the cash balance account or pension equity plan accumulation and (ii) that a reduction the pension equity plan accumulation is permitted to the extent that it results from a decrease in the participant’s final average compensation or from an increase in the integration level (in cases where a formula is integrated with Social Security). A cash balance formula or pension equity plan formula is treated as a lump sum-based benefit formula to which the relief of Code section 411(a)(13)(A) applies if the portion of the participant’s accrued benefit that is determined under that formula is actuarially equivalent to the cash balance account or pension equity accumulation either upon reaching normal retirement age or at the annuity starting date for a distribution with respect to that portion. The regulations clarify that the relief of Code Section 411(a)(13)(A) also applies to a subsidized optional form of benefit under a lump sum-based benefit formula, including an early retirement subsidy or a subsidized survivor portion of a qualified joint and survivor annuity, provided such benefit is at least equal to the actuarial equivalent of the cash balance account or pension equity plan accumulation. The regulations clarify certain of the rules related to the determination as to whether a formula constitutes a formula with an effect similar to a lump sum-based benefit formula such that it constitutes a statutory hybrid benefit formula subject to the 3 year vesting
rule of Code section 411(a)(13)(B) and the rules of Code section 411(b)(5), including the market rate of return and conversion protection requirements. The definition of variable annuity benefit formula has been broadened to mean any benefit formula under a defined benefit plan which provides that the amount payable is periodically adjusted by reference to the difference between a rate of return and a specified assumed interest rate and the exception from treatment as a formula with an effect similar to a lump sum-based benefit formula for a variable annuity benefit formula with an assumed interest rate of 5% or higher has been revised to be available for a variable annuity benefit formula that adjusts the amounts payable by reference to any rate of return that is permissible as an interest crediting rate under the regulations.

The final regulations adopt from prior proposed regulations the provision applying the 133-1/3% rule of Code Section 411(b)(1)(B) to statutory hybrid plans that adjust benefits using a variable interest rate that may be negative in any given year, but permitting a taxpayer to elect to apply it at an earlier date.

The final regulations clarify that the age discrimination safe harbor under Code Section 411(b)(5) for cash balance formulas and pension equity plan formulas apply only for formulas that are lump sum-based benefit formulas and extend the safe harbor to a plan that expresses a participant’s accumulated benefit as the lesser of benefits under two or more formulas. In addition, the relief of Code section 411(a)(13)(A) applies only to benefits determined under a cash balance or pension equity plan formula.

The final regulations only permit the conversion alternative (e.g., the alternative method available to satisfy the conversion protection requirements when an amendment converts the benefit formula from a non-statutory hybrid benefit formula to a statutory hybrid benefit formula) when an opening hypothetical account balance or opening accumulated percentage of the participant’s final average compensation is established and benefits are compared at the annuity starting date.

The regulations expand the list of interest crediting rates satisfy the market rate of return requirement to include some additional rates not previously permitted and allow the IRS to provide further guidance to increase the specific interest crediting rates and to allow for the IRS to provide for additional interest crediting rates that satisfy the requirement that they not exceed a market rate of return for purposes of Code section 411(b)(5)(B).

The regulations expand the list of permissible interest crediting rates to allow a variable annuity benefit formula to provide adjustments using the rate of return on a subset of plan assets. The regulations clarify that a fixed 6% interest rate satisfies the market rate of return requirement and that a plan can use an annual floor of up to 5% and a cumulative floor of 3%. They clarify that the preservation of capital requirement involves a comparison of the accumulated benefit to the sum of all principal credits and that the requirement is applied only as of an annuity starting date with respect to which a distribution of the participant’s entire vested benefit under the plan’s statutory hybrid benefit formula as of that date commences. The final regulations provide that interest crediting rate used to determine benefits after a plan termination date, and further guidance on annuity conversion rates, factors, and mortality tables.
The final regulations clarify that the right to future interest credits determined in the manner specified under the plan and not conditioned on future service is a factor that is used to determine the participant’s accrued benefit for purposes of Code section 411(d)(6).

**IRS Releases Pilot Penalty Relief Program for Late Form 5500-EZ Filings**

Revenue Procedure 2014-32 establishes a temporary one-year Pilot Program providing administrative relief to plan administrators (as defined in IRC Section 414(g)) and plan sponsors of certain retirement plans from the imposition of failure to timely file penalties for Form 5500-EZ and similar filers. Both the IRC and ERISA impose annual reporting requirements and penalties for failure to file returns with respect to certain retirement plans including plans required to file from 5500-EZ. This form includes one-participant plans exempt from coverage under ERISA. The DOL has previously instituted a Delinquent Filer Voluntary Compliance program to reduce penalties applied by ERISA for failure to timely file Form 5500s. However, the prior program was not available to Form 5500-EZ filers not covered by ERISA. Revenue Procedure 2014-32 provides relief to one-participant retirement plans exempt from ERISA and certain foreign plans from penalties for failure to file returns under IRC Sections 6652(e), 6692, 6047(e), 6058 and 6059. In addition, no fees are imposed for eligible plans taking advantage of the program.

**ERISA Plan Fiduciaries May Be Able to Rely on Advice of Counsel or Other Advisors in Discharging Fiduciary Duties**

In *Clark v. Feder Semo and Bard, P.C.*, No. 12-7092 (D.C. Cir. January 7, 2014), plan fiduciaries were required to assign plan participants into one of two categories in order to calculate final distributions from a terminated retirement plan. The plaintiff alleged that the fiduciaries assigned her to the wrong category and that, in relying on the advice of legal counsel regarding this assignment, the plan fiduciaries breached their fiduciary duties to the plan and its participants. The Court concluded that, based on the outside counsel’s familiarity with the plan and the diligence applied in formulating his advice, the plan fiduciaries were entitled to rely on the counsel’s advice without failing to discharge their fiduciary duties to the plan and its participants.

Nothing in the Clark opinion or the relevant provisions of ERISA limit the applicability of this decision solely to the advice of legal counsel. Accordingly, guidance provided by a lawyer or other professional advisor familiar with ERISA and the relevant plan may offer protection to the plan fiduciary against a breach of fiduciary duty claim if that guidance would appear reliable to a prudent plan fiduciary. Advisors to fiduciaries and third-party administrators of ERISA plans can provide additional value to their clients by maximizing the reliability of their guidance for plan fiduciaries. At a minimum, plan advisors should: (1) ensure their familiarity with ERISA’s requirements and the governing documents of the relevant ERISA-covered plan, (2) review the documents and all relevant facts before providing guidance, and (3) document the steps they took to derive their advice and the relevant facts underlying their conclusions.
B. NONQUALIFIED PLANS

IRS Announces New Program to Audit IRC Section 409A Compliance

The IRS is getting ready to mount a strong enforcement of IRC Section 409A compliance with respect to non-qualified deferred compensation arrangements. This new compliance initiative project (“CIP”) for Section 409A will focus on fifty large companies. But this merely foreshadows a much broader Section 409A enforcement initiative. The Service plans to issue Information Document Requests (“IDRs”) to about 50 large employers. These initial IDRs will request documents regarding deferred compensation elections and payouts. The IRS informally indicated that these will focus on three issues: 1) initial deferral elections, 2) subsequent changes in deferral elections, and 3) timing of payouts. Requested data would initially be limited to the top 10 highest paid employees in each company. Information gained from the first 50 audits will be used by the IRS to target future Section 409A audit and enforcement activity.

As a reminder, Section 409A governs the tax treatment of non-qualified deferred compensation and retirement plans which are often funded by corporate owned life insurance. However, the rules of Section 409A have been broadly interpreted by regulations to impact almost every type of compensation arrangement including employment, severance and change in control agreements, short and long term equity, incentive and bonus plans and other contingent compensation arrangements.

On May 9 of this year, an IRS attorney informed the American Bar Association Taxation Section that the IRS is beginning a CIP focused on Section 409A compliance. The recently announced CIP is quite narrow (50 large employers; 10 highest paid employees at each), but it is intended as the first phase of a much larger Section 409A enforcement initiative.

Section 409A is complicated, confusing and often ambiguous. Many employers had hoped that the IRS would issue clearer guidance before beginning broad enforcement initiatives. Section 409A creates special complications, because actions of the employer can cause large tax liabilities for its employees - often key executives. Employer noncompliance in both documentation and administration can lead to harsh results for employees. These include accelerated taxes and excise taxes (generally full, immediate income inclusion, a 20% additional federal tax and interest during the deferral period of all vested amounts; and, sometimes, additional state tax liability.) It is not yet clear how the IRS might use information from the planned employer audits to assert claims against employees.

We do not yet know the scope of the IDRs planned under the newly announced CIP. The IRS previously released draft Section 409A IDRs that require employers to provide detailed information regarding deferred compensation, plans, payments made and deferral elections. Prior draft IDRs also required employers to take legal positions on whether particular arrangements were covered by Section 409A, and to identify any violations of Section 409A. This requires key tactical decisions to be made very early in the audit process. Employers being audited need to be very careful regarding the information provided and the legal positions taken – to avoid generating tax liability for their employees.
The IRS has issued correction procedures which allow for less harsh treatment when documentary or administrative errors are self-discovered and voluntarily disclosed. However, taxpayers are generally ineligible for this program if the issues are disclosed after an audit begins. Therefore, this is a good opportunity for employers large and small to make sure all of their compensation arrangements are in compliance with Section 409A.

Final IRC Section 83 Regulations and Tax Court Clarify “Substantial of Risk of Forfeiture”

The IRS recently issued final Treasury regulations (Treasury Regulations Section 1.83-3(c), 26 CFR Part 1) clarifying the definition of “substantial risk of forfeiture” under IRC Section 83 which determines when employees will be subject to federal income tax on property, such as insurance policies or shares of stock, transferred to them by their employer in exchange for their services. Since income taxation generally is delayed while transferred property remains subject to a “substantial risk of forfeiture,” the definition of this term is important.

The final Treasury regulations clarify that a “substantial risk of forfeiture” may only be established if rights in the property transferred are subject to a “service condition” (i.e., performance of future services) or a “condition related to the purpose of the transfer” (i.e., a performance condition). In determining whether a “substantial risk of forfeiture” exists, the final Treasury regulations clarify that both the likelihood that a forfeiture event will occur and the likelihood that the forfeiture will be enforced must be considered. The final regulations also clarify that transfer restrictions related to securities limitations generally will not create a substantial risk of forfeiture, even if a violation may result in penalties or disgorgement of some or all the property.

The preamble to the final Treasury regulations addresses the question of whether a risk of forfeiture which lapses on “involuntary separation from service without cause” could establish a “substantial risk of forfeiture.” The preamble concludes that an acceleration of vesting on involuntary separation from service without cause will not prevent a service requirement from being considered substantial, provided that facts and circumstances do not demonstrate that such an involuntary separation is likely to occur.

This position is consistent with a recent Tax Court case Austin v. Commissioner, 141 T.C. No. 18 (December 16, 2013), involving a forfeiture of restricted stock on termination for cause. Although forfeiture of property received for services on termination for cause or for commission of a crime generally is not considered to be a substantial enough risk to delay income taxation under IRC Section 83, the facts in this case indicated that any voluntary termination of employment by the employee would necessarily come under the definition of termination for cause as defined in the applicable agreement (which included the employee’s failure or refusal to perform customary duties of employment) such that the risk of forfeiture in that case was determined by the Court to be substantial.

Development in FICA Tax Special Timing Rule for Nonqualified Deferred Compensation

Balestra v. United States, 113 AFTR 2d ¶ 2014-887 (Ct. Fed Claims, 2014) is an astounding application of the FICA special timing rule (IRC Section 3121(v); Treasury Regulations Section 31.3121(v)(2)-1) where
an individual is required to pay a FICA tax on amounts he will never receive. The Court of Federal Claims held that the “special timing rule” applied to subject the plaintiff’s non-qualified deferred compensation to FICA tax upon his retirement (when he became fully vested), even though he never received most of the payments because the employer’s obligation to pay was discharged in bankruptcy.

The special timing rule generally works to an employee’s advantage by taking deferred amounts into account for Social Security tax purposes at the time of contribution or vesting (when the employee’s total wages are likely to exceed the FICA wage limit) rather than during retirement when employees may be subject to higher FICA taxes. However, the special timing rule can occasionally be a disadvantage if, as in this case, deferred amounts are never paid. When employers do not include deferred amounts in FICA income at the time of contribution or vesting, employees may be subject to substantial additional FICA taxes on the date of retirement. Regardless of whether or not it is “fair,” Treasury regulations do not allow employees to recover FICA taxes paid on deferred amounts that are ultimately never received. It is important for employers and employees to be aware of the nuances of the special timing rule and to remember that it applies not just to voluntary deferrals, but also to company contributions, matches and deferred incentive or performance awards.

The court in Balestra upheld the special timing rule to subject the plaintiff’s non-qualified deferred compensation to FICA tax upon vesting, even though his employer’s obligation to pay the majority of such amounts was ultimately discharged in bankruptcy. The plaintiff’s employer withheld FICA taxes based on the present value of his anticipated plan benefits at the time of his retirement when his deferred compensation benefits became fully vested. As a result, the plaintiff paid FICA tax on amounts he will never receive!

The Treasury regulations with respect to the special timing rule make clear that the present value of nonqualified deferred compensation cannot be discounted for factors such as:

(i) the probability that payments will not be made (or will be reduced) because of the unfunded status of the plan,

(ii) the risk associated with any deemed or actual investment of amounts deferred under the plan,

(iii) the risk that the employer, trustee or another party will be unwilling or unable to pay,

(iv) the possibility of future plan amendments or changes in the law effective benefits, or (v) any other similar risks or contingencies.

Treasury regulations do not include any type of a true-up feature in the event that deferred payments are not received or turn out to be substantially less than the anticipated value subjected to tax. The Balestra court held that the special timing rule was properly applied to the benefits promised to the plaintiff and that the applicable statutory provisions required the benefits to be calculated and taxed when plaintiff became vested in the benefits without any risk-adjusted discount rate. The Court further
concluded that the plaintiff was not entitled to any refund corresponding to the benefits plaintiff never received.

**DOL Proposed to Require Electronic Filing of Top Hat Letters**

Under ERISA “top hat” plans (i.e., unfunded plans established for a “select group of management or highly compensated employees”) are exempt from most reporting requirements such as the obligation to file annual Form 5500s if the plan administrator files with the Secretary of Labor within 120 days of adoption a statement that includes the following: the name and address of the employer; the employer identification number; a declaration that the employer maintains a plan or plans primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees; and a statement of the number of such plans and the number of participants in each plan (29 CFR 2520.104-23). The Department of Labor has issued a proposed rule that would mandate the filing of such letters electronically instead by hard copy. The idea would be for the administrator to complete the form on the DOL web site. The only new requirement the DOL is proposing is that, in addition to the employer information, the name, mailing address, and email address of the plan administrator be provided.

**C. IRAS**

**Development in IRA Rollover Rules**

The IRS issued Announcement 2014-15 which provides that it will be following the decision in *Bobrow v. Commissioner*, T.C. Memo 2014-21 which holds that the one-rollover-per-year rule under IRC Section 408(d)(3)(B) applies to all of a taxpayer’s IRAs in the aggregate, not to each IRA separately. The IRS has indicated that it will be reflecting this change in its prior position in a revised Publication 590. This means that the one-rollover-per-year rule (applied on a 12 month basis, not a calendar year basis) will now apply on a taxpayer basis, rather than an IRA by IRA basis. Note that there is no limit on the number of direct transfers of IRA funds from one IRA trustee directly to another. The IRS has announced that it will not apply the new rule to any rollover that involves an IRA distribution occurring before January 1, 2015.
ACA Implementation
Tim Goodman’s practice focuses on assisting employers with executive compensation, health insurance, and employee benefit plans. Tim assists a broad array of employers, with a special focus on assisting cooperatives, agribusiness companies, tax-exempt organizations (primarily hospitals and health care entities), Alaskan Native Corporations, and governmental entities (primarily Indian tribes). This includes assisting employers on health care reform, wellness plans, and other welfare issues and welfare plan matters (including cafeteria, dependent care, education assistance, health FSAs, HRAs, HSAs, parking, and tuition plans), and severance. With respect to health care reform, Tim advises employers on the new fees imposed on employer health plans (the patient-centered outcomes research (PCOR) fee, the transition reinsurance fee, and the employer shared responsibility (play or pay) fee) and the new requirements ranging from coverage of adult children and the summary of benefits coverage to essential health benefits.

Tim advises employers on qualified and nonqualified retirement plans (including pension, defined benefit, 401(k), 403(b), 457(b), and 457(f) plans, and section 409A). Tim has worked with employers on a range of retirement plan matters, including Roth contributions and in-plan Roth conversions. Employers also turn to Tim for advice on executive compensation and deferred compensation programs (including excess plans, SERPs, and other deferred compensation). His assistance includes advising employers on responding to benefit claims, answering questions regarding the extension of health coverage under COBRA and state law, drafting employee communications, complying with fringe benefit rules, payroll reporting of benefits, USERRA and HEART, complying with the HIPAA privacy and security rules, and addressing worker classification.

Tim also advises employers by updating them on legislation (such as the Affordable Care Act (ACA or PPACA – health care reform), the Pension Protection Act, the American Jobs Creation Act, the Veterans Benefits Improvement Act, and the Sarbanes-Oxley Act). This includes advising employers on the impact of section 409A on nonqualified deferred compensation plans. Tim also assists employers with new regulations, such as the health care reform regulations, GINA Part I regulations issued by the DOL, IRS, and Centers for Medicare & Medicaid Services; and the GINA Part II regulations issued by the EEOC. In addition to advice, Tim works with employers on taxation of benefits with respect to FICA taxes under section 3121(v)(2), nonresident taxes for work performed in multiple states, taxation of health benefits, and taxation and design of benefits employers provide to same-sex spouses and domestic partners. Tim also works with employers on benefits in M&A transactions and employer securities in retirement plans. Employers regularly have Tim assist them with plan drafting and design, including plan formation, IRS qualification, administration, merger, and termination of employee benefit plans, and the submission of errors under voluntary correction programs including the IRS employee plan correction program (EPCRS) and the delinquent filer program (DFVC).

Representative examples of employee benefit matters that Tim has assisted employers with recently include:
- assisting employers with questions regarding compliance with the Affordable Care Act;
- assisting employers with the design of wellness programs;
- working with employers to respond to IRS and DOL audits of 401(k) plans;
- assisting employers with correcting errors under 401(k) and money purchase pension plans;
- assisting health care entities in establishing 457(b) plans;
assisting health care entities with 457(f) plans and section 409A;
assisting health care entities and tax-exempt organizations with executive employment agreements;
assisting private and public employers reviewing retiree medical benefits;
assisting employers with DOL investigations of demutualization of proceeds and plan contributions;
assisting employers with plan submissions to the IRS for favorable determination letters;
preparing retirement plan amendments for employers to address law and regulatory changes, including HEART, WRERA, PPA, EGTRRA, GUST, and minimum required distributions;
preparing model domestic relation orders for employers;
preparing HIPAA health privacy documents for employers including plan amendments, policies and procedures, and privacy notices; and
assisting tribal entities with questions regarding the applicability of ERISA and plan qualification.

Professional Activities
• Advisory Council Member, Employee Benefits Section, Minnesota State Bar Association
• President, Midwest Pension Conference
• Past Adjunct Professor, University of Minnesota Law School
• Past President, Minneapolis Pension Council
• Member, American Bar Association, Labor and Employment Law Section and Taxation Section
• Member, Minnesota State Bar Association, Employee Benefits Section and Taxation Section
• Member, Hennepin County Bar Association
• President on the Board of Directors, Minnesota Justice Foundation (a non-profit corporation that promotes pro bono opportunities for law students and fundraises to support clerkships at public interest agencies serving low-income individuals)
Timeline and Key Dates
2014 Key Dates

- July 31, 2014
  - Due date for the patient centered outcomes research (PCOR) fee for employer-provided health coverage provided in 2013
- October 2014
  - Open enrollment – review coverage to avoid potential employer shared responsibility fees being imposed
- November 1, 2014 (as late as November 15, 2014)
  - Calculate covered lives for transition reinsurance fees for 2014
- November 15, 2014
  - Insurer or TPA submits information on transition reinsurance fees for 2014 to Pay.gov
Timeline and Key Dates
2015 Key Dates

- January 1, 2015
  - Employer shared responsibility fee effective date
  - Transition relief for 2015
- January 15, 2015
  - Payment of all or first part of transition reinsurance fees for 2014
- July 31, 2015
  - Due date for the patient centered outcomes research (PCOR) fee for employer-provided health coverage provided in 2014
- October 2015
  - Open enrollment – review coverage to avoid potential employer shared responsibility fees being imposed
- November 15, 2015
  - Payment of second part of transition reinsurance fees for 2014 (if not already paid)

Timeline and Key Dates
2015 Key Dates (Continued)

- November 1, 2015 (as late as November 15, 2015)
  - Calculate covered lives for transition reinsurance fees for 2015
- November 15, 2015
  - Insurer or TPA submits information on transition reinsurance fees for 2015 to Pay.gov
The employer shared responsibility fee is to encourage employers to offer health coverage or pay an amount to subsidize coverage through an exchange.

Two penalties:
- Big penalty
  - If employer does not offer minimum essential coverage ("MEC") to 95% of full-time employees ("FTs"); and
  - 1 employee enrolls on exchange and receives subsidy
  - Penalty is $2,000 x (number of employees – 30)
- Not as big penalty
  - If employer does offer MEC to at least 95% of FTs, but coverage is not both (a) minimum value, and (b) affordable; and
  - 1 employee enrolls on exchange and receives subsidy
  - $3,000 x number of employees who go to the exchange for coverage and qualify for premium subsidy or cost sharing
  - Capped at big penalty

Fee applies to employers with 50 or more full-time equivalent employees (FTEs)
- Part-time employees are used to determine if employer is covered (even though penalty not due on employees working less than 30 hours)

Fee assessed on FTs (not FTEs) – employees working 30 hours a week or more

Employee means a common law employee
- Guidance indicates employee includes (or may include)
  - Long-term leased employees
  - Independent contractors
  - Interns
  - Seasonal employees
  - Temporary employees
- An employer may not owe an employer shared fee on all of these workers, but should review

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Fees and Taxes
2015 – Employer Shared Responsibility Fee

• Fee is assessed on a month-by-month basis
  – Two methods of measuring
    • Monthly method
    • Look-back method
  – Both methods require hour counting
• Hour counting
  – Actual hours for hourly employees
  – Equivalency for exempt employees
    • 8 hours if employee works during day
    • 40 hours if employee works during week
  – Need to count on-call and other hours
• Nature of employees will drive method and coverage
  – If employer has lots of variable hour employees, may use look-back
  – If employer has interns, may offer them coverage
  – If employer has part-time exempt, may offer them coverage

• 2015 transition relief
  • Employers with 50 but less than 100 full-time employees
    – For 2015, these employers will not be subject to fee
    – May not reduce workforce or overall hours before 12/31/14 (other than for bona fide business reasons)
    – May not reduce or eliminate coverage before 12/31/14
    – Must certify eligibility under section 6056
• Coverage percentage
  – For 2015, section 4980H(a) will not apply if employer covers at least 70% of full-time employees (rather than 95%, which starts in 2016)
  – Note: The not as big penalty (section 4980H(b)) still applies
• Calculation of the big penalty
  – For 2015, section 4980H(a) will have an exclusion for 80 employees rather than 30 employees
• See final regs preamble XV.6 & 7 (for transition relief)
• See 26 C.F.R. § 54.4980H-1 et seq.
• See Code 4980H
Fees and Taxes
2015 – Employer Shared Responsibility Fee

• Steps an employer should take
• Review employer controlled group
  – Are there other related employers
• Review workforce
  – Identify categories of workers
  – Consider interns, temp employees, leased employees, independent contractors
• Review coverage
  – Which employees are covered
  – Are children covered
• Review value and affordability
  – Does employer pay at least 60% of cost
  – Does coverage cost any employee more than 9.5% of pay
• Determine measurement method (monthly vs. look-back)
  – If employer has significant part-time employees or seasonal employees, may wish to use look-back method
  – If not, monthly method may be simpler

Taxes on Employers
2013 – Patient-Centered Outcomes Research Fee

• Applies to insured and self-insured major medical plans and includes retiree medical coverage and individuals on continuation coverage
• Excludes
  – HIPAA excepted benefits
    • Benefits exempt (e.g., accident and disability insurance)
    • Separately offered benefits (stand alone dental and vision plans)
    • Certain independent benefits (specified disease and indemnity)
    • Certain supplemental benefits
  – Employee assistance, wellness, and disease management programs
    • If program does not provide significant benefits in the nature of medical care or treatment
  – Health FSAs that are salary reduction only
  – HRAs integrated with a major medical plan
  – Expatriate plans that cover primarily employees working outside U.S.
**Taxes on Employers**

2013 – Patient-Centered Outcomes Research Fee

- Counting covered lives
  - Actual count method
    - Count all lives (not only participants) on each day and divide by number of days in year
  - Snapshot method
    - Count lives on at least one day in each of four quarters and divide by dates used (if family coverage offered, multiply total by 2.35)
  - Form 5500 method (using current year Form 5500 – Form 5500 filed no later than due date for PCOR fee)
    - If employee-only coverage offered, count participants at start and end of year and divide by 2
    - If family coverage offered, count participants at start and end of year and do not divide by 2

**Fees and Taxes**

2012 – Patient Centered Outcomes Research Fee

- The patient centered outcomes research (PCOR) fee is to provide funds to improve health care design and delivery
- Amount of fee
  - $2 per covered life for plan years ending on and after 10/1/13 through 9/30/14
  - Fee indexed for plan years beginning after 9/30/14
- Payment
  - To be paid by employer for self-insured plans and insurer for insured plans
  - Due on July 31 following end of plan year
  - Reported using Form 720
- See 26 C.F.R. §§ 46.4375 to 46.4377
- See IRC §§ 4375-77 (PPACA § 6301(e))
Taxes on Employers
2014 – Transitional Reinsurance Fee

• Applies to insured and self-insured major medical plans and includes certain retiree medical coverage and individuals on continuation coverage

• Excludes
  – HIPAA excepted benefits
    • Benefits exempt (e.g., accident and disability insurance)
    • Separately offered benefits (stand alone dental and vision plans)
    • Certain independent benefits (specified disease and indemnity)
    • Certain supplemental benefits
  – Employee assistance, wellness, and disease management programs
    • If program does not provide significant benefits in the nature of medical care or treatment
  – Health FSAs
  – HRAs
  – Expatriate coverage as defined by the Secretary
  – Retiree coverage that is secondary to Medicare coverage

Taxes on Employers
2014 – Transitional Reinsurance Fee

• Multiple plans treated as a single plan (double counting)
  – An employer that maintains multiple plans that provides health coverage can treat them as a single plan for purposes of reinsurance fee if plans have same plan year
    • Excludes prescription-drug plans, health reimbursement arrangements, and HSAs
  – An employer with self-insured and fully-insured health plan options need not count lives covered only under the fully-insured options
  – If an employer with a multiple plans, one of which is fully-insured, wishes to avoid double counting
    • The employer and the insurer across the plans must use the actual life count method or the snapshot count method, and
    • The employer must provide additional information to HHS
  – If an employer with multiple plans, all of which are self-insured, wishes to avoid double counting
    • The employer across the plans must use the actual life count method, the snapshot count method, or the snapshot factor method, and
    • The employer must provide additional information to HHS
Taxes on Employers
2014 – Transitional Reinsurance Fee

• Counting covered lives
  – Actual count method
    • Count all lives (not only participants) on each day of the first nine months and divide by number of days in those months
  – Snapshot method
    • Count lives on at least one day in each of the first three quarters and divide by dates used (if family coverage offered, multiply total by 2.35)
  – Form 5500 method (using prior year Form 5500)
    • If employee-only coverage offered, count participants at start and end of year and divide by 2
    • If family coverage offered, count participants at start and end of year and do not divide by 2

• There are similarities among transitional reinsurance fee to PCOR fee rules, but there are also differences
  – Differences to note
    • The Department of Health and Human Services (HHS) rather than the Department of the Treasury is in charge of the fee
    • Collected in same calendar year as coverage rather than following end of plan year
    • May use plan assets to pay transitional reinsurance fee

• Payment
  – To be paid by third-party administrator (TPA) for self-insured plans (although ultimate liability is on employer) and insurer for insured plans
    • May lead to disagreements between TPA and employer
  – Due within 30 days of HHS notice of liability (between November 15 of same year and January 14 of following year depending on when notice is received)
**Fees and Taxes**

**2014 – Transitional Reinsurance Fee**

- The transitional reinsurance fee is to provide payments to insurers covering high risk individuals in individual market
  - Intended to reduce the uncertainty in the individual market
- Amount of fee
  - Law specifies the cumulative amount to be raised, not an amount per person
  - For 2014 – $12 billion, 2015 – $8 billion, 2016 – $5 billion
  - Fee will be between $63 per life in 2014
- States have right to charge additional fees with respect to individual and group insured coverage (not self-insured)
- See 45 C.F.R. § 153.400 et seq.
- See PPACA § 1341

**2018 – Cadillac Tax**

- The Cadillac tax is designed to penalize employers offering generous health plans
  - Intent is to target health plans for executives
  - Appears likely to also affect generous health plans for unions and retiree medical plans
- The Cadillac tax is a 40% excise tax on the value of employer-provided coverage that exceeds
  - $10,200 for single coverage (as adjusted annually)
  - $27,500 for family coverage (as adjusted annually)
- The tax is non-deductible, so employers will seek to avoid
- The IRS has not yet issued guidance
- Code § 4980I
Fees and Taxes
2013 – Medicare Taxes

• 90% Medicare tax
  – Health care reform amended the Internal Revenue Code to increase Medicare tax rate by .90% (from 1.45% to 2.35%) on employees who earn more than $200,000
  – IRC § 3102(f) (PPACA § 9015(a)(2)

• 3.80% Medicare tax
  – Health care reform amended the Internal Revenue Code to add a 3.80% tax to the lesser of:
    • Net investment income
    • Modified adjusted gross income (“MAGI”) above the threshold ($200,000 for single filers, $250,000 for joint filers)
  – Net investment income includes income from interest, dividends, annuities, royalties, rents, substitute interest and dividend payments, and other income
  – See 26 C.F.R. § 1.1411-1 et seq.
  – See IRC § 1141 (HCERA § 1402)

Reporting – Forms
2012 and Beyond

• To assess fees, the federal government needs information – that means employers (and / or insurers) need to submit forms
• Form for 6055 (minimum essential coverage) – Form 1094 and Form 1095
• Form for 6056 (whether employer offered coverage) – Form 1094 and Form 1095
• Form for transition reinsurance
• Form for 4375-77(PCOR fee) – Form 720
• Form W-2 – Value of health benefits (may be used in future for Cadillac tax)
Reporting Form W-2

• Reporting of health coverage on Form W-2 (effective 1/1/12 for Forms W-2 issued in 2013)
• Requirement to report “applicable employer-sponsored coverage” on an employee’s Form W-2
  – Reporting will be done in Box 12 using Code DD
• Relief in Notice 2012-09
  – Small employers filing fewer than 250 Forms W-2 do not need to comply until further guidance is issued (Q&A 3)
  – Do not need to report in Form W-2 requested before end of year in which employee terminated (Q&A 6)
  – No reporting required if former employee does not otherwise receive a Form W-2 (Q&A 9)
    • Helpful if employee is receiving retiree medical benefits
    • Requires reporting for deferred compensation or severance
• See Code § 6051(a)(14) (PPACA § 9002)

Reporting Form 720 – PCOR Fee

• Reporting of patient-centered outcomes research fee on Form 720 (effective 1/1/13 for plans years ending by 12/31/12)
• Entity responsible for the reporting
  – For self-insured plan that is the plan sponsor (the employer or the board of trustees for the multiemployer welfare plan)
  – For insured plan, the insurer
• If entity files Form 720 only to report the PCOR fee, the entity does not need to file the Form 720 for the other quarters of the year
Reporting
Forms 1094 & 1095 – Section 6055

• Minimum essential coverage reporting (for individual mandate tax)
• Entity responsible for the reporting
  – For self-insured plan that is the plan sponsor (the employer or the board of trustees for the multiemployer welfare plan)
  • Note, aggregation rules under Code § 414 do not apply
  • Each employer responsible for reporting
  • However, one group member may file on behalf of others
  – For insured plan, the insurer
• Reporting is not required for coverage that supplements minimum essential coverage
  – Health reimbursement arrangements
  – On-site medical clinics
  – Wellness programs (providing incentives under a group health plan)
  – Employee assistance programs (that provide no significant benefits or where the employee has other minimum essential coverage)
  – Retiree medical that supplements Medicare

Reporting
Forms 1094 & 1095 – Section 6055

• Required information
  – The employer’s name, address, and EIN
  – The name, address, and TIN (or date of birth if a TIN is not available) of the responsible individual
  – The name, address, and TIN (or date of birth if a TIN is not available) of each individual covered
  – For each individual covered, the months for which for at least one day the individual was enrolled in coverage and entitled to receive benefits (one day equals one month of coverage)
  – Any additional information specified in the forms
### Reporting
**Forms 1094 & 1095 – Section 6055**

- The form used depends on who is reporting
  - For self-insured plan
    - Form 1094-C (transmittal)
    - Form 1095-C (return)
  - For insured plan
    - Form 1094-B (transmittal)
    - Form 1095-B (return)
- **Due dates**
  - 1/31 for returns provided to the responsible individual
  - 2/28 for returns filed with IRS (3/31 if returns are filed electronically)
- Electronic filing required if filing 250 or more returns
- Can furnish electronically to responsible individual if responsible individual consents
- For employers with self-insured plans, possibility of combined reporting with section 6056 (see section 6056)

### Reporting
**Forms 1094 & 1095 – Section 6056**

- Applicable large employer reporting (for employer shared responsibility fee, individual shared responsibility fee, and tax credits)
- Applicable large employer is responsible for the reporting
  - Aggregation rules under Code § 414 apply to determine if an employer is an applicable large employer
  - Each employer, however, is responsible for reporting
  - However, one group member may file on behalf of others
Reporting
Forms 1094 & 1095 – Section 6056

• Required information
  – The employer’s name, address, and EIN
  – The employer contact’s name and telephone number
  – The calendar year
  – A certification as to whether the employer offered its full-time employees (and dependents) minimum essential coverage by calendar month
  – The months under the calendar year for which minimum essential coverage
  – Each full-time employee’s share of the lowest cost monthly premium (self-only) for coverage providing minimum value by calendar month
  – The name, address, and taxpayer identification number of each full-time employee during the calendar year and the months, if any, during which the employee was covered
  – Any additional information specified in the forms

• Continued

Reporting
Forms 1094 & 1095 – Section 6056

• Additional information in preamble
  – Information on why coverage was not offered
    • Employee was not employed
  – Whether coverage was minimum value
  – Whether coverage was offered in a month the employee was not a full-time employee
  – Whether the employee met an affordability safe harbor
  – The employer’s total number of employees

• Alternative methods
  – Certification of qualifying offers
    • May certify that for all months of the calendar year an employee was a full-time employee an qualifying offer was made
    • This is an offer of affordable, minimum value, employee only coverage
  – Certification of 98% offer
    • May certify that it has offered affordable, minimum value coverage to at least 98% of employees on whom it is reporting
Reporting
Forms 1094 & 1095 – Section 6056

- The form used
  - Form 1094-C (transmittal)
  - Form 1095-C (return)
- Due dates
  - 1/31 for returns provided to the responsible individual
  - 2/28 for returns filed with IRS (3/31 if returns are filed electronically)
- Electronic filing required if filing 250 or more returns
- Can furnish electronically to responsible individual if responsible individual consents

Plan Mandates and More

- The ACA since 2011 has imposed and continues each year to impose mandates on group health plans and health insurance
- The mandates include
  - Covering adult children
  - Including a non-English language statement in communications
  - Prohibiting waiting periods exceeding 90 days
  - Capping cost sharing limits
  - Covering certain clinical trials
  - Adding wellness and tobacco premium rules
- Other ACA requirements include
  - Prohibiting discrimination in favor of highly paid
  - Specifying uses of refunds from insurance companies (medical loss ratio (“MLR”) rebates)
Plan Mandates
2011 – Covering Adult Children

• Must offer coverage to adult children until the date on which the child attains age 26 (if dependent coverage is offered)
  – Mandate does not apply to HIPAA excepted benefits
  • Most health FSAs are HIPAA excepted benefits if employees have access to a major medical plan
  • Mandate will apply to most HRAs (except retiree-only HRAs)
  – See PHSA § 2714(a) (PPACA § 1001(5); HCERA § 2301(b))
• Tax-favored treatment – separate issue from the coverage mandate
  – Coverage and reimbursements under an employer-provided plan are excluded from income under federal tax law through the end of the year in which the child attains age 26
  – Applies to health FSAs, HRAs
  – See IRC § 105(b) (HCERA § 1004(d))

Plan Mandates
2012 – Non-English Language

• If English is not the primary language of 10% or more of the individuals in the county, need to include one sentence statement in non-English language indicating how employees can access language services
• Need to provide translation services for communications
• Covered counties for 2014
  – Minnesota, Montana, North Dakota, South Dakota, & Wisconsin: None
  – Illinois: Kane County
  – Iowa: Buena Vista County & Crawford County
  – Nebraska: Colfax County, Dakota County, & Dawson County
  – Other states have covered counties
• See 45 C.F.R. §147.136
• PHSA § 2719 (PPACA § 1001(5))
Plan Mandates
2014 – 90-Day Waiting Period

- Waiting periods in excess of 90 days for eligible employees are prohibited
- In general, a waiting period of other than 90 days is OK if:
  - It relates to criteria other than passage of time
  - It requires completion of a set number of hours (no more than 1,200)
  - For variable hour employees, it requires completion of 12 months plus a short administrative period
- Final regs (effective 1/1/2015):
  - Provide for employment-based orientation period in addition to the 90-day period (allows an employer to delay commencement of 90-day waiting period until one-month after hire)
  - Rehires and job transfers may be required to complete a new 90-day waiting period (under employer shared responsibility a rehire must have a 13-week break in service to be a new employee)
- Final regs published in Federal Register on 2/24/2014
- See 26 C.F.R. § 54.9815-2708; 29 C.F.R. § 2590.715-2708
- See PHSA § 2708 (PPACA § 1201)

Plan Mandates
2014 – Cost-Sharing Limits

- Health care reform places limits on cost-sharing provisions under group health plans
  - Out-of-pocket costs for group health plans for 2014 are capped at $6,350 for individual coverage and $12,700 for family coverage
  - FAQs provide some guidance
    - A plan is not required to count out-of-pocket spending for out-of-network items and services
    - A plan is not required to count out-of-pocket spending for non-covered services
    - A plan can have separate out-of-pocket limits for benefits provided that the separate limits combined do not exceed the annual maximum
    - See FAQ XVIII (Jan. 9, 2014)
  - This provision does not apply to grandfathered plans, but as time goes on there are fewer and fewer grandfathered plans because of the increase in health care costs
- See PHSA § 2707(b); PPACA § 1302(c)(1) & (2)
Plan Mandates
2014 – Clinical Trials

• Effective 1/1/14
• Group health plans and insurers may not deny individuals with life-threatening diseases participation in approved clinical trials
  – Likely to increase costs
  – This provision does not apply to grandfathered plans, but as time goes on there are fewer and fewer grandfathered plans because of the increase in health care costs
• See PHSA § 2709 (PPACA § 10103(c))

Plan Mandates
2014 – Wellness Programs

• Effective 1/1/14
• New requirements on wellness program designs
  – Three types of programs
    • Participation only
      – Example: Receive incentive for HRA regardless of outcome
    • Health-contingent – activity based
      – Examples: walking, exercise, diet
    • Health-contingent – outcome based
      – Examples: smoking cessation, achieving a BMI level
  – Reasonable alternatives for health-contingent programs have become more complex
  – Employers need to update disclosures in plan documents and summaries regarding reasonable alternatives
• Final regs published in Federal Register on 6/3/13
• See 26 C.F.R. § 54.9802-1; 29 C.F.R. § 2590.702
• See PHSA § 2705(j) (PPACA § 1201)
Group Health Plan Requirements
2014 – Tobacco Use and Premium Restrictions

• Effective 1/1/14
• Limits on premium discrimination for tobacco use
  – Premiums charged for an employee who uses tobacco cannot be more than 150% of the amount of the premium charged for an employee who does not use tobacco
  – This includes other wellness programs offered to employees
    • Thus, if employer reduces premiums by 20% for satisfying certain requirements, then only an additional 30% can be imposed on tobacco use
• Final regs published in Federal Register on 2/27/13
• See 45 C.F.R. §147.102
• See PHSA § 2701 (PPACA § 1201))

Group Health Plan Requirements
2014 – Pre-Existing Conditions

• Effective 1/1/14
• Complete ban on pre-existing conditions in employer-sponsored health plans
  – Pre-existing condition exclusions prohibit the restriction of coverage based on a pre-existing condition
  – Since 2010, there has been a prohibition on imposing pre-existing conditions on individuals under age 19
• Final regs published in Federal Register on 6/28/10
• See PHSA § 2704(a) (PPACA § 1201))
Group Health Plan Requirements
2014 and Beyond – Additional Items

- Transparency (on hold awaiting guidance)
  - Requirement to report plan information
    - Statute – effective plan years beginning on and after 9/23/10
    - Does not apply to grandfathered plans
    - See PHSA § 2715A (PPACA § 10101(c); § 10104(f)(2))
- Nondiscrimination and insured plans (on hold awaiting guidance)
  - Requirement to not favor highly compensated individuals
    - Statute – effective plan years beginning on and after 9/23/10
    - Does not apply to grandfathered plans
    - See PHSA § 2716 (PPACA § 1001(5) and § 10101(d))
- Quality care reporting (on hold awaiting guidance)
  - Annual report to HHS
    - Statute – effective plan years beginning on and after 9/23/12
    - See PHSA § 2717 (PPACA § 1001(5) and § 10101(e))

Other ACA Requirements
Medical Loss Ratio Rebates

- Effective plan years beginning on and after 1/1/11
- If an employer’s plan is insured and an insurer earns more than a set amount, the insurer is to provide a rebate
  - A medical loss ratio (MLR) is the ratio of an insurer’s cost of claims and amounts spent to improve health care quality divided by the actual premiums received for a plan
    - For a large group market the MLR is 85%
    - For a small group market the MLR is 80%
  - Rebates to be provided by August 1 following end of plan year
  - What plans covered by ERISA should do with an MLR rebate
    - The rebate may (likely) in all or part constitute plan assets (fiduciary decision)
    - May make refund to participants, reduce future premiums, or enhance benefits
    - Must use within three months of receipt (if not placed in a welfare trust)
  - Governmental and church plans also to use to benefit participants
- Final regs published in Federal Register on 12/7/11
- See DOL Tech. Rel. 2011-04 (guidance on use of MLRs)
- See PHSA § 2718 (PPACA § 1001(5) and § 10101(f))
Exchanges
2014

- Exchanges offer small employers and individuals the opportunity to purchase health insurance from a number of insurers on a guaranteed issue basis
  - State exchange or if state fails to establish then federal exchange
  - Small employer – employer with 100 or fewer FTs
    - Initially, state may restrict to 50 or fewer FTs
    - Effective 1/1/17, state may allow any size employer
  - “Qualified Health Plans” providing minimum essential benefits
  - Premium tax credits and cost-sharing reductions available to certain low income individuals
- Individual mandate – Almost all individuals who fail to have minimum health coverage are subject to a tax
  - The tax is the greater of the following two amounts:
    - A flat dollar amount for each family member without coverage capped at three times the flat dollar amount for the year
    - A percentage of income
  - 2014 – $95 each ($285 cap) or 1.0% of adjusted income
  - See IRC § 5000A (PPACA § 1501; PPACA § 10106)

Small Employers
SHOP Program

- Small Business Health Options Program (SHOP) exchanges
  - 50 or fewer employees in 2015
- Participation is voluntary
  - However, SHOP participation required to claim small business health care tax credit
- No employer contribution required
  - However, employer contribution required to claim small business health care tax credit
- In general, there has been very low participation in the SHOP program
  - Enrollment difficulties
Small Employers
Simple Cafeteria Plan

• Effective 1/1/11
• Small employers may sponsor a cafeteria plan that is treated as meeting certain nondiscrimination rules
  – Section 79(d)
  – Group term life insurance
  – Section 105(h)
  – Health flexible spending accounts / reimbursement accounts
  – Sections 125(b) and 125(d)(2), (3), (4), & (8)
    • Cafeteria plan nondiscrimination rules

Small Employers
Simple Cafeteria Plan (Continued)

• Limited guidance
  – Employers eligible to maintain
    • Employer has on average 100 or fewer employees during either of 2 preceding years (or is a new employer with fewer than 100)
    • Employer loses eligibility when it employs 200 or more employees
  – Employee eligibility
    • Each employee must be eligible, with following exceptions
      – Employee worked less than 1,000 hours in prior year
      – Employee had not attained age 22 by end of year
      – Employee covered by a collective bargaining agreement
      – Employee was a nonresident alien working outside U.S.
  – Employer must contribute one of following
    • A uniform percentage of pay (not less than 2%)
    • The lesser of at least 6% of pay or twice the amount of employee elective contributions
    – See IRS Publication 15-B (2012)
• See IRC § 125(j) (PPACA § 9022)
Small Employers (and Other Employers)
Health Reimbursement Arrangements

- Employers sometimes seek to reimburse employees on a pre-tax or after-tax basis for health expenses
  - More common with small employers
- IRS has issued guidance that generally an employer is unable to reimburse medical expenses for cost of health coverage on a pre-tax basis for current employees
  - The guidance indicates that doing so is likely to run afoul of the ACA and may trigger penalties of $100 per day per participant for failing to comply with the mandates under the ACA
  - See Notice 2013-54
- Reimbursement of medical expenses may also create a group health plan under ERISA
  - Need to review whether voluntary program exception applies
- If an employer has such a program, should review

FLSA
2013 – Exchange Notice

- Employers are required to provide a notice to all employees describing exchange
  - Existing employees were to have received the notice by 10/1/13
  - New hires at time of eligibility
- The DOL has prepared model notices
  - However, employers may modify model notice
- Employer must provide notice only once (not an annual notice)
- See DOL web site for model notices: www.dol.gov/ebsa/faqs/faq-noticeofcoveragetoptions.html
- See DOL Technical Release 2013-02
- See FLSA § 18B (PPACA § 1512)
FLSA 2013 – Whistleblower Protections

• Employers are prohibited from retaliating against employees (including applicants and former employees)
  – For reporting a violation of Title I of the ACA
  – For testifying or assisting in a proceeding investigating such a potential violation of Title I of the ACA
  – For refusing to participate in activity that might violate Title I of ACA

• Employees are required to file complaints of retaliation with OSHA within 180 days of the alleged violation

• Remedies include reinstatement, back wages, restoration of benefits, and attorney fees

• Is limiting hours to under 30 a week a basis for a claim?

• See OSHA fact sheet: www.osha.gov/Publications/whistleblower/OSHAFS-3641.pdf
• See FLSA § 18C (PPACA § 1558)

FLSA 2015 – Automatic Enrollment

• Employers required to automatically enroll employees
  – Applies to employers with more than 200 full-time employees

• DOL has not yet issued guidance

• Difficult questions
  – Who needs to be automatically enrolled?
    • Employee only or whole family?
  – What level of coverage?
    • If employer has more than one level, the lowest cost?
  – Can employee change coverage once automatically enrolled?
    • What if spouse already had coverage for employee and family?
    • What if employee wants a better level of coverage?

• See DOL Tech Release 2012-01
• See FLSA § 18A (PPACA § 1511)
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This checklist provides a list of questions to ask an employer with respect to ACA compliance. The checklist starts with by identifying the employer’s health plans, affiliates, and workforce.

I. Review Employer Information

A. Employer’s Health Plans

1. Identify the employer’s health plans that may be subject to the ACA.
   • What is the main medical plan and are there multiple options (HMO, PPO, high-deductible health plan, etc.).
   • Does the employer have a retiree medical plan?
   • Does the employer have a health reimbursement arrangement (an HRA)?
   • Does the employer have an employee assistance program (an EAP) that provides significant medical benefits or allows employees to receive counseling? (Note: Whether an EAP is a health plan for purposes of the ACA is complex and should be reviewed.)
   • Does the employer make contributions to health flexible spending accounts?

2. Are the health plans insured or self-insured?
   • An insured health plan is a health plan where the insurer bears the risk of claims. The smaller the employer the more likely it is that the employer’s health plan is insured.
   • A self-insured health plan is a health plan where an employer usually hires an insurance company or other third-party administrator to administer the plan, but the employer is responsible for the claims. To limit its risk, the employer usually purchases stop-loss insurance.

B. Employer’s Corporate Structure and Workforce

1. Identify the employer’s corporate structure.
   • Does the employer have subsidiaries, affiliates, or joint ventures?
   • Are these other entities under common control with the employer?
     In general, an entity controls another entity if it owns 80% or more of the other entity. This is referred to as a parent-subsidiary controlled group. In addition, entities with similar owners may be under common control. This is referred to as a brother-sister controlled group.
2. Identify the employer’s workforce
   • Does the employer have collectively bargained or union employees?
   • Does the employer have seasonal or temporary employees?
   • Does the employer have on-call employees?
   • Does the employer have paid interns?
   • Does the employer have leased employees?
   • Does the employer have independent contractors?

II. Fees

A. Employer Shared Responsibility Fee

1. Does the employer have 50 or more full-time equivalent employees?
   Note: For 2015, there is transition relief if an employer has less than 100 full-time equivalent employees.

2. Does the employer’s health plan cover at least 95% of the employer’s full-time employees (employees working 30 hours a week or more)?
   Note: For 2015, there is transition relief if an employer’s health plan covers at least 70% of the employer’s full-time employees.

3. Does the employer’s health plan cover dependents (children)?

4. Does the employer’s health plan cover all employees working 30 hours a week or more?

5. Does the employer’s health plan cover all exempt employees?
   Note: If not, then the employer has to apply the equivalency rules for determining hours. For simplicity, the employer may wish to cover all exempt employees.

6. Has the employer determined whether it will use the look-back measurement method or the monthly measurement method?
   a. Does the employer have a significant number of variable hour employees?
      If so, it may wish to use the look-back measurement method.
   b. Does the employer have a significant number of seasonal employees?
      If so, it may wish to use the look-back measurement method.

7. Does the employer use long-term leased employees?
   If so, the employer should review its leased-employee agreement to assure that the leased employees have health coverage and that it is clear the employer is paying extra for the cost of the coverage (see the regulations for the guidance on this).

7. Does the employer use independent contractors?
   If so, the employer should review its classification of these workers.
B. Transition Reinsurance Fee
If the employer has a self-insured health plan, has the employer budgeted for the transition reinsurance fee?
For 2014, the cost will be approximately $150 per employee covered under the health plan. Note: If the employer has multiple health plans (for example, an insured plan and a health reimbursement arrangement), the employer may owe a fee for each plan.

C. PCOR Fee
1. If the employer has a self-insured health plan, has the employer budgeted for the PCOR fee?
For 2013 and 2014, the cost will be approximately $5 per employee covered under the health plan. Note: If the employer has multiple health plans, the employer may owe a fee for each plan.

2. If the employer has a self-insured health plan, has the employer paid the PCOR fee for the 2012 plan year (due July 31, 2013)?

3. If the employer has a self-insured health plan, has the employer paid the PCOR fee for the 2013 plan year (due July 31, 2014)?

D. Cadillac Tax
Has the employer examined the current value of its health plan coverage and projected these costs forward to 2018 to determine whether the coverage may be subject to the Cadillac tax?
   a. If the employer has retiree medical benefits, this is more important to consider.
   b. If the employer has union employees covered under a multiemployer plan, this is more important to consider.
   c. If the employer has employees in states where health care costs are higher (for example, the Northeastern United States, California, or Florida), this is more important to consider.

III. Mandates

A. In General
Has the employer gone through its health plan to assure it complies with the mandates (covers adult children if children are covered, no annual or lifetime limits on essential health benefits, offers external review of claims denied on appeal, etc.)?
B. Selected Mandates

1. Does the employer have a system in place to assure that a summary of benefits coverage is distributed to each new employee and at open enrollment? (Failure to do so can result in a fine.)

2. Has the employer reviewed whether any of its employees [live check work] in counties where more than 10% of the population have a primary language other than English?
   a. If they have employees in such a county, do communications (SPDs, claim letters, etc.) include the sentence noting assistance is available in the other language?
   b. Has the employer assured that its insurer or administrator can handle calls in the other language?

3. Does anyone (employee, spouse, or dependent) need to wait more than 90-days before they can become covered under the health plan?

4. If the employer has a wellness program, has it reviewed it in light of the new wellness regulations?
   a. Has the employer updated the disclosure language regarding the wellness program?
   b. Does the wellness program satisfy the new reasonable alternatives requirements?

5. If the employer offers incentives to employees who do not use tobacco, are the incentives within the new restrictions on such incentives?

IV. Additional Points

A. Medical Loss Ratio Rebate
   If the employer’s plan is insured:
   a. Has the employer received a medical loss ratio rebate?
   b. If so, did the employer allocate the rebate according to the DOL and other guidance?

B. Nondiscrimination
   If the plan is insured:
   a. Does the employer provide better insurance coverage for executives?
   b. Does the employer have executive agreements that provide for coverage after termination from employment?

V. Communications

A. Exchange Notice
   Has the employer revised the exchange notice to indicate the value of employer-provided health coverage (employer payment of part of the premium and pre-tax payment of the premium)?

B. COBRA Notice
   Has the employer revised its COBRA notices to indicate that as an alternative to COBRA the employee can elect coverage under an exchange?
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