

**PALMER KAZANJIAN WOHL HODSON**  
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**IN THIS ISSUE**

**Administrative Exemption?** A recent Court of Appeal case sheds light on the test for determining whether an administrative employee is exempt from overtime regulations.

**Is Your Health Plan Grandfathered?** PPACA recognizes certain health plans as grandfathered; however, plan sponsors must be aware of certain changes that cause a plan to lose grandfathered status

**Cycle A Submissions Underway:** The new submission period for determination letters for indi-

vidually designed single employer plans in Cycle A began on February 1, 2011.

**Challenges to Healthcare Reform:** Judicial and legislative challenges regarding the constitutionality of PPACA continue to intensify the debate over healthcare reform as we hit the one year mark since the passage of PPACA.

**Red Flags Rules Clarification:** The Red Flag Rule Program Clarification Act of 2010 has clarified the definition of creditor for purposes of who is re-

quired to comply with the Red Flags Rules.

**Special Protections for Labor Picketing Held Unconstitutional:** A California Court of Appeals recently determined in, *Ralph's Grocery Co. v. United Food and Commercial Workers Union Local 8*, that the Moscone Act (Code of Civil Procedure § 527.3) and Labor Code section 1138.1 were unconstitutional.



**IS YOUR ADMINISTRATIVE EMPLOYEE EXEMPT?**

The California Court of Appeal recently issued a decision that sheds light on how an employer can determine whether an administrative employee is exempt from overtime regulations. In *Hodge v. Aon Insurance Services*, the Court held that insurance claim adjusters were persons employed in an administrative capacity and exempt from overtime regulations. The Court analyzed the job duties of the claims adjusters to determine whether they were employed in an adminis-

trative capacity, pursuant to Wage Order No. 4.

Wage Order No. 4, adopted by the Industrial Welfare Commission, requires an employer to pay overtime when an employee works more than eight (8) hours in a workday or forty (40) hours in a work week. Additionally, it provides that its overtime rules "shall not apply to persons employed in *administrative, executive, or professional capacities.*"

The Court explained that the

proper test to determine whether an employee is exempt from overtime pay is whether he/she is performing work related to managerial policies or the general business operations of his or her employer or customers, not whether the person's job has its nits.

Using this test, the Court explained that the claims adjusters were not mere "paper pushers." Instead, they were highly skilled, specialized employees doing work that was

***"The proper test to determine whether an employee is exempt from overtime pay is whether he/she is performing work related to managerial policies or the general business operations"***

## IS YOUR ADMINISTRATIVE EMPLOYEE EXEMPT CONT'D

critical and important to the operations of their clients. The Court further reasoned that although a significant portion of the adjusters' work involved "run-of-the-mill" claims, this did not remove the person from working in a position whose duties involve the performance of work directly related to the general business operations of the business.

Thus, the Court found that the adjusters were exempt administrative employees.

The Court's decision in *Hodge* departs from the holding in *Bell v. Farmers Insurance Exchange*, (2001) 87 Cal. App. 4th 805, which held that adjusters were not exempt because they were deemed to be only production workers. Finally, although the *Hodge* decision is a favorable one for employ-

ers, it highlights the importance for employers to properly classify all employees. As explained in this case, as job duties and descriptions change, so too may an employee's classification.



## RED FLAGS RULES CLARIFICATION

Many businesses such as doctor's offices, law firms, and veterinary clinics were inadvertently subjected to the Red Flags Rule promulgated by the Federal Trade Commission ("FTC") under the Fair and Accurate Credit Transactions Act of 2003.

The Red Flags Rule, if enforced, would have required a small business that extends credit incidental to the delivery of its service, such as a doctor providing medical care in exchange for future payment, to comply with identity theft prevention guidelines, resulting in a potentially unnecessary cost burden. The FTC repeatedly delayed the final rule to allow Congress to legislatively clarify which entities should be covered as "creditors."

The Red Flag Program Clarifi-

cation Act of 2010 amended the Fair Credit Reporting Act ("FCRA"), with respect to federal agency guidelines regarding identity theft and the users of consumer reports, to define creditor to mean one that regularly and in the ordinary course of business:

- (i) obtains or uses consumer reports, directly or indirectly, in connection with a credit transaction;
- (ii) furnishes information to certain consumer reporting agencies in connection with a credit transaction; or
- (iii) advances funds to or on behalf of a person, based on the person's obligation to repay the funds or on repayment from specific property pledged by or on the person's behalf.

The amended definition of

"creditor" specifically excludes creditors "that advance funds on behalf of a person for expenses incidental to a service provided by the creditor to that person." The amended definition also includes a provision that will allow regulating authorities to promulgate a rule defining entities they regulate as a "creditor" upon making a "determination that such creditor offers or maintains accounts that are subject to a reasonably foreseeable risk of identity theft."

The FTC is in the process of updating and revising materials on the Red Flags Rule website to reflect the change in the law.

*Additional information may be found at: [www.ftc.gov/redflagsrule](http://www.ftc.gov/redflagsrule).*

***"The Red Flags Rule, if enforced, would have required a small business ... such as doctors ... to comply with identity theft prevention guidelines"***



## IS YOUR PLAN GRANDFATHERED?

When the Patient Protection and Affordable Care Act (“PPACA”) was enacted, one of the President’s stated goals was to allow Americans who already have healthcare coverage the ability to maintain that healthcare coverage. In an effort to meet this goal, PPACA recognizes certain plans as being “grandfathered.” Among other requirements, a grandfathered plan must have been in place the day PPACA was enacted, March 23, 2010. Grandfathered status exempts plans from some, but not all, of the healthcare reform requirements.

While it is a simple process to *determine* whether a plan is grandfathered, the process of *maintaining* grandfathered status is more difficult. To *maintain* status as a grandfathered plan, a health plan must refrain from making certain changes. Changes that will cause a health plan to lose grandfathered status include:

- Eliminating all or substantially all of the benefits to diagnose or treat a particular condition;
- Any increase, measured from March 23, 2010, in a percentage cost-sharing requirement (such as an individual's coinsurance requirement);
- Any increase in a fixed-amount cost-sharing requirement other than a copayment (for example, deductible or out-of-pocket limit), determined as of the effective date of the increase, if the total percentage increase in the cost-sharing requirement measured from March 23, 2010 exceeds

the maximum percentage increase (the medical inflation plus 15 percentage points);

- Any increase in a fixed-amount copayment, determined as of the effective date of the increase if the total increase in the copayment measured from March 23, 2010 exceeds the greater of:

- An amount equal to \$5 increased by medical inflation, or

- The maximum percentage increase, determined by expressing the total increase in the copayment as a percentage;

- Decreases in contribution rates by an employer or employee organization based on cost of coverage or based on a formula, towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010;

Similarly situated individuals by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010;

- Addition of an annual or lifetime limit if a group health plan, or group or individual health insurance coverage, that, on March 23, 2010, did not impose an overall annual or lifetime limit on the dollar value of all benefits;

- Decrease in limit for a plan or coverage with only a lifetime limit if a group health plan, or group or individual health insurance coverage that, on March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of

***“While it is a simple process to determine whether a plan is grandfathered, the process of maintaining grandfathered status is more difficult.”***

all benefits;

- Decrease in limit for a plan or coverage with an annual limit if a group health plan, or group or individual health insurance coverage that, on March 23, 2010, imposed an overall annual limit on the dollar value of all benefits.

One of the most potentially problematic limits on grandfathered plans is the provision which limits an employer’s ability to increase employee contributions by an amount greater than 5%. This provision comes up most often when an employer seeks to increase the portion of premium paid by employees.

For example, assume that as of March 23, 2010, the total premium cost was \$100 and the employer contributed \$80 (or 80%) and the employee contributed \$20 (or 20%). In 2011, the premium amount increases to \$200 and the employer wishes to increase the employee contribution amount. To maintain grandfathered status, the employer may only increase the employees’ contribution rate by 5% (to 25% of the total premium), resulting in the employee contributing \$50 and the employer contributing \$150.

## IS YOUR PLAN GRANDFATHERED? CONT'D

All plans, including grandfathered plans, commencing with plans years beginning after September 23, 2010, must comply with PPACA's prohibitions on (i) denying coverage based on pre-existing conditions for children under the age of 19; (ii) the requirement to extend coverage to dependents until the age of 26; (iii) limits on annual and lifetime limits; and (iv) new rules regarding when a re-

scission of coverage is appropriate.

If a health plan was not in existence on March 23, 2010, or was in existence on March 23, 2010 but is unable to comply with the limits on grandfathered plans, then the health plan must comply with new requirements for health plans contained in PPACA. These new requirements include a series

of new patient protections, increased external and internal appeals processes, and non-discrimination rules.

Plan sponsors need to assess the pros and cons of maintaining grandfathered status. If a decision is made for a plan to remain grandfathered, procedures should be put in place to protect that status.



## CYCLE A SUBMISSION UNDERWAY

Sponsors with Cycle A plans should begin preparing for submission by making certain their plans are amended in accordance with the 2010 Cumulative List and any other relevant qualification requirements.

The Cycle A submission period opened on February 1, 2011 and runs through January 31, 2012 for individually designed single employer plans to file determination letter applications. Cycle A plans generally include plan sponsors with an EIN ending in 1 or 6.

This submission period begins the second 5-year remedial amendment cycle for individually designed plans. As in previous cycles, the IRS will review all plans for compliance according to the most recent Cumulative List. Plans submitting applications in Cycle A must comply with the 2010 Cumulative List which was issued in IRS Notice 2010-90.

In accordance with provisions in the 2010 Cumulative List, the IRS will not consider in its review of any Cycle A determination

letter application any: (i) guidance issued after October 1, 2010; (ii) statutes enacted after October 1, 2010; (iii) qualification requirements first effective in 2012 or later; or (iv) statutory provisions that are first effective in 2011, for which there is no guidance identified in the 2010 Cumulative List.

While the 2010 list does not include any of the items described in (i)-(iv) above, a plan must comply with all relevant qualification requirements, not only those on the cumulative list. Failure to comply with all requirements may result in plan disqualification. In addition, terminating plans must include all statutory changes in effect at the time of termination.

## Coming Soon ...

Watch for news regarding our upcoming spring legal seminar. Come join us for refreshments and get up to date on topics such as

- meal and rest period obligations;
- employee privacy;
- leaves of absence;
- state law limitations on free speech and labor picketing;
- independent contractor and employment relationship; and
- liability for enforcing illegal covenants not to compete .

## CHALLENGES TO HEALTHCARE REFORM LAW

On January 31, 2011, a federal district court in Florida ruled that the federal healthcare reform law, the Patient Protection and Affordable Care Act ("PPACA"), is unconstitutional. The Florida court's ruling came less than two weeks after the House voted to repeal the controversial law and many Americans are left wondering if the healthcare reform laws are really here to stay.

Although these challenges to PPACA are serious and could result in the law eventually being overturned, it remains unclear whether these challenges will actually have any immediate effect on the law. The ultimate success of the myriad of judicial challenges to the law will likely depend on the opinion of the U.S. Supreme Court. It is difficult to estimate how long the appellate process will take. In the meantime, the House's vote to repeal the law will likely remain a symbolic gesture, unless the Democrats lose their majority in the Senate or lose the presidency in 2012.

### Judicial Challenges

The federal court in Florida held that the individual mandate, requiring all Americans to obtain health insurance was an unconstitutional exercise of authority by the federal government. The court reasoned that the federal government's powers under the Commerce Clause of the United States Constitution, which allows the federal government to

"regulate commerce with foreign nations, and among the several states, and with the Indian tribes," were not so great that the federal government could actually require Americans to obtain health insurance. The court went on



to find that the individual mandate was an essential part of the healthcare reform legislation and could not be severed from the rest of the law. As a result, the judge found the entire law unconstitutional. As expected, the federal government immediately appealed this decision.

A federal court in Virginia has also held the portion of the law relating to the individual mandate, rather than the entire law, unconstitutional. Conversely, two additional challenges to healthcare reform were decided in favor of the law.

Each of these challenges to healthcare reform has been appealed; however, before a case may be heard by the U.S. Supreme Court it must generally be heard first by the appropriate federal court of appeals.

Once the appeals process is complete, the Supreme Court must issue a writ of certiorari agreeing to take the case. The appeals process can take months, if not years, before the Supreme Court issues a final decision.

In rare circumstances the Supreme Court will hear a case before a court of appeals issues a decision. Cases not yet decided by a court of appeals may be heard by the Supreme Court if the Court decides the case is of such imperative public importance that deviation from normal appellate practice and immediate determination by the Supreme Court is justified. Virginia Governor Bob McDonnell, a plaintiff in the recent Virginia challenge, has sought this type of expedited review; however, it has not been decided whether the Court will agree to hear the case on an accelerated basis.

At this time it is uncertain how long it will take the Supreme Court to issue a final decision on the constitutionality of PPACA. Even if the Court allows the Virginia case to circumvent

the appeals court, it may be months before a decision is issued. Furthermore, there is no guarantee the Supreme Court will decide the healthcare reform debate once and for all, as it is possible the Court could find the individual mandate unconstitutional but uphold the remainder of the law.

### Legislative Challenges

On January 19, 2011, the House voted to repeal PPACA, but the immediate practical effect of this vote is primarily symbolic. In order for the law to be repealed, the Senate would also need to vote to repeal the law; however, because the Senate has a Democratic majority, it has refused to allow such a vote. Moreover, even if a change of heart occurs in the Senate, the law's champion, President Obama, would likely veto any repeal. Consequently, it is unlikely that any legislative challenges to healthcare reform will be successful until after the next presidential election in 2012.

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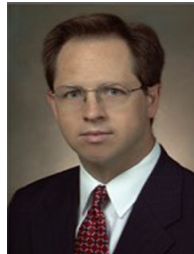
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## THE PKWH PHILOSOPHY

We exist to serve our clients. This recognition is at the heart of our philosophy. It seems simple, but it is something that many organizations in the “service” industry do not recognize. We do.

Providing outstanding service requires an understanding that you and your organization are unique, and the commitment to become familiar with the qualities and circumstances that make up that uniqueness. It also requires a willingness to customize our services to complement that uniqueness. We are committed to flexible and customized service delivery. We are also committed to unparalleled responsiveness. That means serving you on your time table, not ours. We believe adherence to these commitments is the only way to ensure that your goals are achieved.

Our success as a provider of legal service is dependent upon client trust. We understand that trust is not automatic – it must be earned. We endeavor to earn your complete trust by actively listening to you. Only by carefully listening can we understand your needs and provide the highest quality representation you deserve.

## CALIFORNIA'S SPECIAL PROTECTIONS FOR LABOR PICKETING HELD UNCONSTITUTIONAL

The California Court of Appeals recently determined in, *Ralph's Grocery Co. v. United Food and Commercial Workers Union Local 8*, that the Moscone Act (Code of Civil Procedure § 527.3) and Labor Code section 1138.1 which prohibit courts from enjoining union picketing during a labor dispute, were unconstitutional because the laws interfered with the rights of property owners. The Moscone Act prohibits California courts from issuing

restraining orders or injunctions that would prohibit labor picketing, even when that picketing occurs on an employer's private property. Likewise, Labor Code section 1138.1 prohibits courts from issuing an injunction in “any case involving or growing out of a labor dispute,” unless certain procedural requirements are satisfied.

In *Ralph's Grocery Store*, the Court found that the Legislature could not protect only speech relating to labor dis-

putes, while not protecting other kinds of speech. The Court held that the Legislature could not “selectively create a free speech right applicable only to the few, while excluding all others” in this way.

This issue is now before the California Supreme Court. Uncertainty in this area accentuates the need for employers faced with labor picketing to always confer with legal counsel prior to taking responsive action.

**“the Moscone Act prohibits California courts from issuing restraining orders or injunctions that would prohibit labor picketing”**