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Legal Update for Employers

As a service to our clients, Holifield Janich Rachal & Associates, PLLC periodically issues a newsletter to keep you informed of developments in statutes, regulations and case law that may impact you. If you would like assistance or further information about any of the matters described in this update, please contact us and we will be happy to discuss these issues with you further.

Holifield Janich Rachal
&
Associates
is pleased to announce:

Al Holifield was recently recognized as a Top Attorney in CITYVIEW Magazine, July 2017. He has been selected by his peers for inclusion in 2018 Mid-South Super Lawyers list.

Daniel Janich has been selected by his peers for inclusion in 2018 Illinois Super Lawyers/Rising Stars list.

Robert Rachal has been selected by his peers for inclusion in 2018 Louisiana Super Lawyers and The Best Lawyers in America© 2018 list in the field of Litigation - ERISA.

MARK YOUR CALENDARS!

Fifth Annual Employee Benefit Seminar 2018
Bridgewater Place, Knoxville
August 14, 2018

Fourth Annual Employee Benefit Seminar 2018
Hillwood Country Club, Nashville
August 16, 2018

MORE DETAILS TO COME!

401(k) Fee Litigation Begins Targeting Midsize and Smaller Plans

By Robert Rachal

Since 2015, there has been a substantial uptick in settlements, judgments and in cases filed challenging fees and the prudence of investments offered in 401(k) and now 403(b) plans. Unfortunately, as we expected, plaintiffs' counsel have begun targeting employers and plan fiduciaries of midsize and smaller plans with this burdensome, high-risk fee litigation, including in two lawsuits filed in September 2017. According to the complaint allegations, in these new lawsuits the plans did not follow a best practice that we recommend, to include low-cost index funds in their mix of investment options. These cases also highlight that now is the time for preventative maintenance, *i.e.*, for a fiduciary legal "best practices" audit to ensure that you are taking steps to minimize the risk of becoming a target for this fee litigation.

Background

Fee litigation has become highly profitable for plaintiffs' counsel. From 2009 through 2016, ERISA plan sponsors and fiduciaries paid nearly $700 million in fines, penalties and settlements in connection with fee litigation lawsuits, **while plaintiffs' counsel collected more than $200 million in fees and expenses**.[1] Exposures, even on smaller plans, can reach into the tens of millions of dollars, while ERISA includes fee-shifting provisions under ERISA § 502(g)(1) that can entitle plaintiffs' counsel to payment of their fees and expenses by defendants, even when they lose on most claims they bring. Fee litigation operates like hydraulic pressure, probing for any weakness in plan administration, even if the 401(k) plan is overall well run. In addition, discovery in these cases can costs millions, and puts increased pressure on defendants to settle. Yet because the cases often turn on fiduciary process and standards, winning them on a motion to dismiss (which often is the only practical way to avoid expensive, burdensome discovery) can too often be unduly difficult. Our article discussing recent cases when that has occurred (and the plan practices that supported these quick wins) is on our website at Pension & Benefits Daily November 2016.

Recent Cases and Issues

Plaintiffs' counsel receipt of large fee awards has led to an expansion of claims and targets in fee litigation. In dozens of new lawsuits, plaintiffs have expanded their claims by alleging that fiduciaries breached their ERISA duties by offering:

- Vanguard and other index funds, which are typically regarded as low cost options, because there were allegedly even cheaper comparable investment funds available;
- Stable value funds, which are typically regarded as conservative, low-risk options (and for that reason have generated claims when not offered) because they did not perform as well as asserted benchmarks;

- Non-traditional investments, such as hedge funds or natural resources and real estate limited partnerships, including when offered through target date funds, that did not perform well relative to the equity markets.

- Guaranteed benefit contracts that plaintiffs contend do not meet the requirements to be considered exempt from ERISA's fiduciary requirements; and

- Investments in target date funds that plaintiffs contend charged excessive fees or underperformed.

Plaintiffs' counsel have also challenged plans for allegedly offering too many investment options, which allegedly dilute the individual investment size and the plan's overall ability to negotiate for lower-cost institutional share class funds, and for paying too much in recordkeeping fees as compared to alleged reasonable benchmarks. The recordkeeping claim can be particularly vexing for small and midsized plans, which do not have the economies of scale to spread fixed recordkeeping costs among a large number of participants. Thus, plaintiffs' asserted benchmarks often offer flawed comparisons.

Of particular concern for many of our clients is that plaintiffs' counsel are expanding their targets to include employers and plan fiduciaries of midsize and smaller plans. Plaintiffs' counsel have recently sued 401(k) plans with as little as $9 million and $25 million in plan assets. And in two cases filed in September 2017, plaintiffs' counsel targeted Gucci's 401(k) plan with $96 million in assets, and Novitex's 401(k) plan with $157 million in assets.

In the Gucci lawsuit, the plaintiff claimed the plan had "significant bargaining power" with $96 million in assets to demand low-cost administrative and investment management services. Plaintiffs claimed that the Gucci fiduciary defendants did not properly monitor and oversee payments to Transamerica, which acted as recordkeeper and investment manager for many of the mutual funds offered in the plan. Plaintiffs also argued that the other investment options offered (where the expenses ran from .47% to 1.14%) were unduly expensive. If plaintiff's allegations are accurate, it appears that the Gucci 401(k) plan does not offer any index funds as investment options. The Novitex lawsuit has similar allegations, focusing on that all but one fund are actively managed, with fees ranging from .69% to 1.08%, and that the Novitex 401(k) plan failed to utilize the least expensive, institutional share class.

Perspectives and Guidance

While this uptick in fee litigation is cause for concern, there are things you can do now to make your plan an unattractive target. Our recent presentation and article providing an overview on best practices to mitigate exposure is on our website at Best Practices 401(k) and (403)(b) 2017 and ERISA Fee Litigation Recent Developments and Best Practices (FINAL PUBLISHED)(BNA Notice). As example, we recommend as a best practice to provide participants a diversified mix (styles and costs) of investment options, including low-cost index funds. Based on the complaint allegations, the Gucci and Novitex plans offered few or no low-cost index funds; although only plaintiffs' counsel know their true motivation for who they target, this is one thing that plaintiffs' counsel have trolled for when deciding who to sue.

From our experience in advising and defending companies and plan fiduciaries, we recommend a fiduciary legal "best practices" audit to ensure that, among other things, you are taking steps to make yourself an unattractive target for this fee litigation. This is a critical part of preventative maintenance, and the due diligence shown by this process can provide powerful defenses if you are sued. We also recommend that you have fiduciary liability insurance to protect yourself from risks in this area, and we can help advise you on types of coverage needed. For more information on issues relating to retirement plan service providers and fiduciary duties, see *"What Plan Sponsors Should Know About Engaging Fiduciary Services"* by Al Holifield and Tina Haley in this newsletter.

[1] **See Tom Kmak, Fiduciary Benchmarks: Protect Yourself at All Times, DC DIMENSIONS (Summer 2016).**

https://us.dimensional.com/-/media/Dimensional/Documents/US/Auxiliary/Defined-Contribution/Summer-2016/02-Fiduciary-Benchmarks-Protect-Yourself-at-All-Times.pdf**.**

WHAT PLAN SPONSORS SHOULD KNOW ABOUT ENGAGING FIDUCIARY SERVICES?

By Al Holifield & Tina Haley

If you have read any recent marketing materials from retirement plan service providers, it is clear that more service providers are offering fiduciary services as part of the catalog of services available to retirement plan sponsors. In these materials, service providers often refer to themselves as "3(16)", "3(21)", or "3(38)" fiduciaries. What do these designations mean? Can anyone explain this in plain English? The goal of this article is to clarify what these terms mean and identify important issues plan sponsors should be aware of in reviewing their service contracts to ensure they are following best practices on behalf of their retirement plans.

The designations mentioned above refer to sections in the Employee Retirement Income Security Act of 1974, commonly referred to as "ERISA." A "3(16)" fiduciary is a person or entity that accepts responsibility as the plan administrator and is specifically designated by the terms of the plan to be a fiduciary as to the plan administrator duties identified in the plan document. Typically, a 3(16) fiduciary represents the most fiduciary responsibility an individual or entity can assume.

A "3(21)" fiduciary is a person or entity who, based solely on their actions, is a fiduciary with respect to the plan. Specifically, a 3(21) fiduciary is someone who exercises discretionary authority or control respecting the management or administration of the plan, exercises authority or control respecting the management or disposition of plan assets or renders investment advice for a fee or other compensation. 3(21) fiduciary status is not conferred by a provision in the plan document. Instead, fiduciary status is based strictly on the functions that individual or entity performs. Under this standard, it is possible for a person to contractually deny responsibility for any and all fiduciary duties and still be held to be a fiduciary based upon the discretion exercised regarding the assets, administration or management of the plan.

A "3(38)" fiduciary is a person or entity that acts as an "investment manager." ERISA defines an "investment manager" as an individual or entity (generally a registered investment advisor) with the power to "manage, acquire or dispose of the assets of a plan" and who has acknowledged such duties in writing that they are a fiduciary with regard to the plan. This is the individual or entity providing investment advice to the plan and making the investment decisions on behalf of the plan.

These are the three categories of fiduciary services generally available to a plan sponsor from plan service providers. There is no requirement that a plan sponsor contract with an outside third party to provide these fiduciary services. However, if a plan sponsor chooses to forgo such outside services, the plan sponsor by default is accepting the responsibility for providing these services to the plan and is subject to the fiduciary standards applicable to such services.

The question most plan sponsors ask is whether it is advisable or advantageous for them to enter a service contract to provide such fiduciary services to their plan. The answer to this question depends, to some extent, on the plan sponsor. Most plan sponsors are not experts in management and investment of retirement plan assets. The ability to delegate such responsibilities to someone else who is knowledgeable in these areas can be very helpful to a plan sponsor. We recommend that any delegation of fiduciary duties to a service provider be expressed in a written document to clearly identify the fiduciaries of the plan and what fiduciary functions each one is performing. In addition to providing clarification as to which party has responsibility for fiduciary functions, a written document also clarifies what fiduciary duties remain with the plan sponsor and/or any employee benefit committee established by the plan sponsor. A clear delineation of which party is accepting responsibility for which duties is paramount to a successful plan.

It is important to remember that despite the delegation of certain fiduciary tasks to an outside service provider, a plan sponsor still has certain fiduciary standards to which it must adhere. The plan sponsor has a duty to monitor the service provider to ensure it is complying with the terms of its contract with respect to the plan and that it is acting in the best interests of the plan and its participants. In addition, the plan sponsor may only pay reasonable compensation to a service provider for its services. How does a plan sponsor determine if it is paying reasonable compensation? It is certainly a best practice (and evidence of compliance with its fiduciary duty) for a plan sponsor to make an effort to determine whether the compensation paid to a service provider is in line with what the marketplace is paying for such services. There are services such as Fi360 and others that are a source of information regarding costs for a variety of retirement plan services. Similar to Kelly Blue Book providing prices for cars, this information allows a plan

sponsor to gauge what is a reasonable cost for the services. There is nothing in ERISA that requires a plan sponsor to choose the lowest cost service provider. However, there is a prohibition on paying "Cadillac" fees for "Pinto" services.

In light of the prevalence of fee litigation lawsuits and other issues facing plan sponsors, it is our strong recommendation that you identify and understand who are the fiduciaries of your plan, what services are provided by each fiduciary and the compensation paid to each fiduciary. If you do not know the answer to these questions, we recommend a "fiduciary" audit of your plan. Such an audit can identify any issues relating to fiduciary duties and responsibilities for your plan as well as provide evidence of compliance with your fiduciary duty as the plan sponsor and adherence to "best practices" regarding the administration of your plan. Please contact us if you would like to discuss whether a fiduciary audit would be useful to you. For more information regarding 401(k) fee litigation, see Robert Rachal's article entitled "*401(k) Fee Litigation Begins Targeting Midsize and Smaller Plans"* in this newsletter.

Tennessee Allows Most Employers Flexibility in Paying Wages

By Sarah Johnson

On May 11, 2017, a new law went into effect in Tennessee that gives private employers with five or more employees additional flexibility in paying wages and other compensation.

The new law specifies that private employers must pay wages and other compensation only once per month. Companies that issue paychecks once per month must pay all wages earned and unpaid as of the end of the month, no later than the fifth day of the following month.

For private employers that pay wages twice or more each month, the requirements remain the same. All wages earned and unpaid as of the end of the month must be paid no later than the 20th day of the next month, and all wages earned and unpaid as of the 16th day of the month must be paid no later than the fifth day of the next month.

The law does not prohibit employers from paying wages more frequently than once or twice per month. As such, weekly paychecks are still allowed in Tennessee.

Failing to Investigate Sexual Harassment Claims Costs Tennessee Employers

By Sarah Johnson

Two recent cases demonstrate that Tennessee employers must promptly act on every sexual harassment complaint, even if the complaint seems illegitimate. In *Smith v. Rock-Tenn Services, Inc.*, 813 F.3d 298 (6th Cir. 2016), the Court determined that the employer's failure to act on a sexual harassment claim for ten days, and the employer's ultimate failure to take appropriate action after the postponement, triggered liability on the employer for the sexual harassment. The Plaintiff, a male employee, initiated a complaint to his direct supervisor accusing a male co-worker of pinching and slapping his rear and grinding his genitals into his rear after Plaintiff voiced a request to cease the behavior directly to the alleged harasser. Plaintiff's supervisor determined that no action could be taken until the alleged harasser's supervisor returned from vacation, which postponed any action for ten days. During the postponement, Plaintiff and the alleged harasser were sent back to work near each other. Once an investigation was initiated by the plant supervisor, interviews were conducted but written statements were not obtained and an investigation report was not prepared. The alleged harasser was suspended with pay for two days.

In its defense, the Defendant focused on the U.S. Supreme Court's continuous determinations that male-on-male horseplay is not sexual harassment. However, the trial court determined that the alleged harasser's behavior went far beyond horseplay here, and the Sixth Circuit agreed. An employer that receives a complaint of sexual harassment is required to "take prompt and appropriate corrective action" to avoid liability. *Smith*, 813 F.3d 298 at 311 (citations omitted). The Sixth Circuit Court of Appeals determined that a reasonable jury would find that the employer's failure to act for ten days, and failure to separate the men during this time frame, was unreasonable and affirmed a $300,000.00 jury verdict in favor of the Plaintiff.

In *Andriano v. Tyson Foods, Inc., et al.*, No. 3:15-CV-00863, 2017 WL 2797378 (M.D. Tenn. June 28, 2017), the Plaintiff reported incidents of sexual harassment from a co-worker to her direct supervisor at least weekly, even after the Plaintiff asked the co-worker to stop the behavior. The behavior worsened to the point that the Plaintiff locked herself in her office to avoid the co-worker. The supervisor told Plaintiff the behavior was "harmless" and directed Plaintiff to not report the incidents to Human Resources. The supervisor and another manager later criticized the Plaintiff for locking herself in her office and using a radio to call for help. The Plaintiff later stated she felt harassed and resigned.

The Defendant argued that the Plaintiff did not have proof that the alleged harassment was severe or pervasive. The standard set forth by the U.S. Supreme Court includes a list of factors to analyze the severe or pervasive nature of harassing conduct: "the frequency of the discriminatory conduct; its severity; whether it is physically threatening, or a mere utterance; and whether it unreasonably interferes with an employee's performance." *Harris v. Forklift Sys., Inc.*, 510 U.S. 17, 23 (1993). The Court determined the conduct met the standard.

The key here is that the Court held the employer liable for the conduct because the employer's response to the Plaintiff's complaint was inadequate. "An employer is liable for coworker harassment if its 'response manifests indifference or unreasonableness in light of the facts the employer knew or should have known.' " *Andriano,* 2017 WL 2797378, at *8 (citations omitted). "A response is generally adequate if it is 'reasonably calculated to end the harassment.' " *Id.* Here, the supervisor ignored the complaints, claiming the co-worker was harmless, and the Court held the Defendant liable for the co-worker's harassing conduct.

Employers must take immediate and proper action to respond to all claims of sexual harassment, even if the immediate action is simple and temporary (i.e. separation of the employees until a full investigation is completed). Always take every claim of harassment seriously, even if it may seem petty, and begin a full investigation as soon as possible. Our firm routinely assist clients in performing sexual harassment investigations. Please contact our office if you need further guidance regarding sexual harassment claims in the workplace.

WELLNESS PLANS: DOL Enforcement and Status of EEOC Regulations Under ADA and GINA

By Tina Haley

DOL Enforcement: The Department of Labor has joined the EEOC in filing lawsuits against an employer in relation to its wellness program. On August 16, 2017, the DOL filed a complaint in Ohio federal Court against Macy's and subsidiaries of Cigna and Anthem, the third-party administrators of Macy's self-funded group health plan. The lawsuit alleges that the wellness program sponsored by Macy's violated ERISA's regulatory requirements because it failed to provide participants a reasonable alternative to avoid a tobacco surcharge. In addition, the lawsuit claims that Macy's violated its fiduciary duty when it instructed Cigna and Anthem to use less-than-favorable reimbursement rates in processing out-of-network claims under its group health plan and then failed to update plan documents to notify participants of the change in reimbursement rates.

While the EEOC has brought numerous actions against employers claiming that their wellness programs do not meet its regulatory requirements, this lawsuit against Macy's is the first filed by the DOL, challenging that a wellness program failed to meet applicable HIPAA regulations governing such programs.

The DOL's lawsuit focuses on the monthly tobacco surcharge, which ranged from $35 to $45, assessed against tobacco users enrolled in Macy's group health plan. Macy's deposited the surcharges in a trust for its group health plan and used them to pay claims and administrative expenses under the health plan. Beginning in 2011, the wellness program offered participants a one-time opportunity to avoid the surcharge if they declared their tobacco status, enrolled in a tobacco cessation program and provided an affidavit stating that they had been tobacco free for six

consecutive months. Then in 2012, the wellness program provided that the surcharge would be assessed unless the participant certified that they were enrolled in a tobacco cessation program and had been tobacco-free for six months. Once a participant provided this certification the surcharge was waived going forward, but the participants did not receive reimbursement for previous surcharges that were assessed. In 2013, the wellness program allowed participants to avoid the surcharge by requesting a reasonable alternative only where it was "medically inadvisable" for them to stop using tobacco. As in 2012, upon meeting the reasonable alternative the surcharge was waived going forward but the participant was not reimbursed for previously assessed surcharges. Finally, beginning in 2014, the wellness program waived the surcharge for tobacco users who met the reasonable alternative of certifying that they were either tobacco free or "working toward" being tobacco free.

The DOL challenged the wellness program alleging that it violates the HIPAA rules governing wellness programs in three aspects: (1) it did not allow a reasonable alternative to avoid the surcharge; (2) it did not provide notice of such a reasonable alternative standard; and (3) it did not reimburse the surcharge retroactively for participants who completed a reasonable alternative standard. The lawsuit asks that Macy's be ordered to reimburse all participants who paid a tobacco surcharge from July 1, 2011 to the present, including interest, and revise the wellness program to comply with the HIPAA regulations. In addition, the DOL also asked the court to enjoin Macy's from collecting tobacco surcharges until the wellness program is revised to comply with the HIPAA regulations.

This lawsuit could signal an increased enforcement stance by the DOL regarding wellness programs and compliance with the HIPAA rules and regulations governing these programs. While the DOL had previously challenged wellness programs in informal inquiries and audits, this is the first instance where it has made a challenge by filing suit. Of further note is the fact that the DOL challenged not only the wellness program but also brought separate claims related to the administration of Macy's group health plan. This should put employers on alert that a DOL challenge to one benefit program could mean a challenge to any of the other benefit programs the employer offers.

We will continue to monitor this case as it goes forward and alert our clients to any developments. In light of this apparent shift in enforcement strategy, we recommend that employers closely review their benefit programs, including wellness programs, to ensure compliance with all applicable federal laws and regulations.

EEOC Regulations: In October 2016, AARP filed suit against the Equal Employment Opportunity Commission (EEOC) challenging the regulations issued by the EEOC under the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA) relating to wellness plans. These regulations were issued in May 2016. They generally provide that wellness programs that make inquiries related to an employee's disability or require an employee to take a medical exam may offer an incentive and still meet the requirement that such programs be "voluntary" as long as the incentive offered by the wellness program cannot exceed 30 percent of the cost of self-only health coverage.

AARP filed suit in the District Court of the District of Columbia challenging these regulations and asking that they be vacated. AARP claims that the 30 percent limit on incentives is not consistent with the "voluntary" requirement found in the ADA and GINA. AARP further argued that the

justification for the 30 percent incentive limit provided by the EEOC in the preamble to the regulations was inadequate.

On August 22, 2017, Judge John D. Bates issued an opinion denying the EEOC's motion to dismiss the lawsuit or grant a summary judgment. Judge Bates held that the EEOC acted arbitrarily in issuing the regulations by failing to provide adequate reasoning to justify the 30 percent cap on incentives. Judge Bates reviewed the reasoning provided by the EEOC in the preamble to the regulations and the administrative record relating to the regulations and found a lack of any "concrete data, studies, or analysis that would support any particular incentive level as the threshold past which an incentive becomes involuntary in violation of the ADA and GINA." Judge Bates stopped short of vacating the regulations and instead remanded them back to the EEOC for reconsideration.

Shortly after the Court issued its opinion on August 22, 2017, AARP filed a motion to amend the court's order, to which the EEOC has responded. AARP must file any reply to the EEOC response by September 28, 2017. On September 21, 2017, the EEOC filed a status report with the District Court in which it stated that it intends to issue new proposed regulations by August 2018 and final regulations by October 2019. The EEOC also stated that a decision had not been made as to whether it would appeal the judge's August 22, 2017 order. The time period within which the EEOC must file an appeal will not begin until the court rules on AARP's motion to amend.

So what does this mean for employers? Because Judge Bates' order remanded the regulations instead of vacating them, they are still in force and applicable to wellness programs. If Judge Bates ultimately grants AARP's motion to amend his order and decides to vacate the regulations, the regulations allowing incentives up to 30 percent would no longer be applicable and such incentives could no longer be offered in exchange for disability related information, submitting to a medical exam or providing a spouse's medical history. The future of these regulations is uncertain given the EEOC's right to appeal and its indication in the status report that it intends to propose new regulations. In the interim, we recommend that employers review their wellness plans to ensure that they comply with the regulations as they currently stand and stay tuned for further developments.

MEDICAL LEAVE AS A REASONABLE ACCOMMODATION UNDER THE ADA: WHEN IS ENOUGH LEAVE "ENOUGH"? THE *SEVERSON* COURT MAY PROVIDE SOME NEW ANSWERS FOR EMPLOYERS

By Daniel N. Janich

One of the biggest challenges for employers today is determining how to manage an employee's request for extended or intermittent leave from work. How much leave should be considered as a "reasonable accommodation" under the Americans With Disabilities Act (ADA)? How do you deal with an employee who cannot return to work after FMLA leave expires? In sum, how much leave is an employer obligated to provide?

Over the years, the Equal Employment Opportunity Commission (EEOC) as well as the federal courts have provided limited guidance for employers to help them determine where to draw the line in determining when a requested accommodation is "reasonable" or would constitute an "undue hardship."

Recent EEOC Guidance

In its May 9, 2016, guidance the EEOC offered its view of when a leave request should be treated by an employer as a reasonable accommodation under the ADA and when it need not. The agency provided the following key points:

There must be equal access to leave under an employer's paid leave policies. An employer cannot impose greater conditions on an employee seeking a disability related leave under a company's paid leave policy than it would for any other type of leave request.

- Unpaid leave must be considered as a reasonable accommodation. An employer must consider providing unpaid leave to a disabled employee as a reasonable accommodation when the employee requires it and it does not cause an undue hardship on the employer.

- All requests for leave must be treated as a request for a reasonable accommodation. When a serious medical condition is involved, an employer should analyze the leave request under both the FMLA and ADA.

- Automatic termination provisions are frowned upon. The EEOC advocates against policies that call for employment termination after the absence of an employee for a set period of time rather than using a case-by-case assessment of the employee's situation.

- When all else fails, reassign the employee to a vacant position. When the employee's disability prevents the employee from performing one or more essential functions of his job—even with a reasonable accommodation—or the accommodation would result in undue hardship upon the employer, an employer must still consider whether a reassignment is feasible.

- Determining "undue hardship" is a fact and circumstance inquiry with little, if any, overall guidance. The point at which a request for intermittent leave or repeated extensions of leave creates an undue hardship on an employer remains somewhat of a mystery. Factors such as the length of the leave required, frequency of the leave, flexibility when leave is to be taken, need for specific dates that are predictable or unpredictable for intermittent leave, impact of employee's absence on other workers, and impact on employer's operations can all be considered in making the assessment.

The *Severson* Decision

It is a fairly easy decision for most courts to rule that an open-ended, indefinite leave of absence is not protected by the ADA. An employee who has already been granted leave as an accommodation but has no clear date of when he can return to work has no basis to claim a violation of the ADA when he is terminated. The more difficult, and perhaps more common situation, is where the employee experiences a medical condition that may require a few months additional leave beyond that afforded by the FMLA before he can return to work.

In *Severson v. Heartland Woodcraft, Inc.* the Seventh Circuit Court of Appeals unequivocally stated that "the ADA is an antidiscrimination statute, not a medical-leave entitlement." The Court dispelled any notion that the ADA requires a "reasonable accommodation" of an employee for a several month leave upon expiration of FMLA leave: "The term 'reasonable accommodation' is expressly limited to those measures that will enable the employee to work. An employee who needs long-term medical leave cannot work and thus is not a 'qualified individual' under the ADA. . . A multi-month leave of absence is beyond the scope of a reasonable accommodation under the ADA."

The facts in the case are straightforward. Raymond Severson worked for Heartland Woodcraft, Inc. in a physically demanding job. Severson underwent surgery for his continued serious back pain on the last day of his FMLA leave, and asked for continued medical leave for his 3-month recovery period. The additional leave was denied by his employer who subsequently terminated his

employment. In addition to refusing his request for an additional 3-month leave, Severson's employer refused to offer him other accommodations, such as a vacant job or temporary light duty position.

The district court granted judgment in favor of the employer. The Seventh Circuit upheld the decision but took issue with the EEOC's interpretation of "reasonable accommodation" finding that the ADA's definition states what the term *may* include, not what it must. In the Court's view a leave extending over several months past the FMLA deadline is too much, but a "brief period of leave to deal with a medical condition could be a reasonable accommodation in some circumstances." The Court cited as an example an intermittent condition where an employee otherwise satisfies the essential requirements of the job:

"Intermittent time off or a short leave of absence - say, a couple of days or even a couple of weeks — may, in appropriate circumstances, be analogous to a part-time or modified work schedule… But a medical leave spanning multiple months does not permit the employee to perform the essential functions of his job."

What Should Employers Do Now?

Employers should be aware of the fact that the law continues to evolve in this complex area where the FMLA and ADA intersect. Employers must be mindful of the manner in which the Courts in their circuit treat this reasonable accommodation issue. We will continue to monitor the case decisions for trends that will allow you to anticipate and modify your employee leave policies as appropriate. One thing we know for sure now is that the Seventh Circuit may be the first one to take a step to clarify that the ADA is not a medical leave statute, but it likely will not be the last court to do so. Stay tuned for more on this important topic.