BENEFITS UPDATE 2010

By: Christine P. Roberts, Esq. © 2010[1]

I. INTRODUCTION

Workplace benefits were the source of much news and controversy throughout 2009 and continuing into 2010. During this time, the Obama Administration pushed health care reform, and major stock market setbacks raised questions as to whether the 401(k) plan remains a viable method of retirement savings. Against this background, regulations and other guidance affecting employer-provided health insurance were passed, and several key trends emerged in the 401(k) arena. The following material summarize these changes and how they will affect your delivery of workplace benefits in 2010 and beyond.

II. NEW LAWS AFFECTING GROUP HEALTH PLANS

A. GINA (Genetic Privacy)

Currently over 500 diseases and medical conditions may be detected through genetic tests, including breast and ovarian cancer (BRCA 1 and 2), Alzheimer's, Tay-Sachs disease, and many others. In response to concerns that employers and insurers could discriminate against individuals known to have genetic markers of disease, Congress passed the Genetic Information Nondiscrimination Act of 2008 ("GINA"). GINA amends the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other laws with regard to "genetic information," which GINA defines as:

(a) results of an individual's genetic tests;

(b) results of the genetic tests of the individual's family members; and

(c) the manifestation of a disease or disorder in a family member (e.g., family medical history).

Genetic information might also include an individual's request for or receipt of genetic services. It does not include information about an individual's sex or age.

Interim final regulations under GINA were published on October 7, 2009 by the Department of Labor, the Department of Health and Human Services, and the Treasury Department. The regulations are effective January 1, 2010 for calendar year plans, and contain provisions that directly impact employer-sponsored health plans. Specifically, the GINA regulations prohibit health plans from:

(a) requesting genetic information "prior to or in connection with enrollment" in the plan; or

(b) collecting genetic information at any time "for underwriting purposes."

Under the regulations, the payment of virtually any type of financial incentive will be classified as "for underwriting purposes," including any discount or rebate in premiums/contributions, any discount, rebate, or other change in a deductible, co-payment or co-insurance, or qualifying for participation in a disease management program.

California law also prohibits employers, insurers and HMOs from discriminating on the basis of genetic factors (see, e.g., Government Code §§ 12925 et seq., 12940; Insurance Code §§ 10123.3, 10140(b) – (d). GINA is more comprehensive, however, and applies to all ERISA welfare benefit plans including health and disability, including self-funded plans not involving a California insurer or HMO.

1. GINA's Impact on Wellness Plans

Perhaps the GINA regulations' most immediate impact is on "wellness" plans or programs offered in the workplace. A wellness program may take many forms but its most common feature usually is a financial reward – such as reduced co-pays or premiums – in exchange for making healthy lifestyle changes. In order to assess which changes are most appropriate, employees may be asked to complete a health risk assessment ("HRA") containing a number of health-related questions, including about family medical history. The GINA regulations prohibit certain HRA practices that formerly were commonplace.

Effective January 1, 2010, an HRA may not contain questions related to genetic history – including family health history questions – in either of the following circumstances:

(a) When the HRA is to be completed prior to or in connection with enrollment in the group health plan; or

(b) When a financial reward is offered for completing the HRA, whether offered prior to, during or after enrollment.

The first example violates GINA's prohibition on requesting genetic information "prior to or in connection with enrollment," and the second example, which includes the financial reward, violates GINA's rule against requesting genetic information "for underwriting purposes." These are not the only ways an HRA can fall afoul of GINA regulations. A program that conditions eligibility for additional benefits such as enrollment in a disease management program on completion of an HRA that requests genetic information also violates GINA. Finally, "broadly worded" HRA questions that ask "is there anything else relevant to your health that you would like us to know or discuss with you?" violate GINA unless the same HRA expressly warns participants not to provide genetic information such as family medical history, genetic testing results, etc.

2. Wellness Plans That Meet GINA's Requirements

Under the GINA regulations, a Health Risk Assessment may continue to be permissible under several circumstances:

- If the HRA is stripped of any genetic information questions, including reference to family medical history, it will meet GINA requirements. An HRA of this type meets GINA standards whether it is provided before enrollment or otherwise.

- Alternatively, an HRA that requests genetic information but provides no rewards or financial incentives, and that is not to be completed until after enrollment, is permissible.

- A third strategy is to use to HRAs in tandem. In a tandem approach, two HRAs are provided. The first HRA does not request genetic information but offers a reward for completion. The second HRA, provided after enrollment, offers no reward for completion but request genetic

information. This second HRA must expressly state that its completion is totally voluntary and will not affect any rewards offered for completing the first HRA.

- Finally, providing financial incentives for HRA completion outside of the group health plan – such as in the form of taxable compensation – is permitted under GINA.

3. Other Laws Impacting Wellness Programs: HIPAA

In addition to GINA and regulations thereunder, wellness programs are subject to the nondiscrimination provisions of HIPAA, and to the Americans with Disabilities Act of 1990 ("ADA").

HIPAA generally prohibits discrimination, in the provision of health benefits, on the basis of health conditions, claims experience, genetic information, and other health factors. With specific respect to wellness programs, HIPAA distinguishes between participation-only programs that do not reward participants based on a health factor, and standard-based programs that provide rewards based on a health factor. HIPAA does not impose requirements on participation-only wellness programs, such as reimbursement of health club memberships, and reimbursements for smoking cessation programs, regardless of outcome. HIPAA does impose 5 separate requirements on the standard-based wellness programs that reward participants for meeting standards related to health factors:

- The reward must be equal to no more than 20% of the cost of coverage.

- The wellness program must be reasonably designed to promote health or prevent disease.

- The program must give individuals an opportunity to qualify for the reward at least once a year.

- The reward must be available to all similarly situated individuals. Objective distinctions based on bona fide business classifications, such as employees versus retirees, employees versus spouses/dependents, etc. are permissible.

- The wellness program must disclose that alternative standards (or waivers) are available, to account for

individuals with disabilities or other conditions that make successful completion of the wellness program difficult or impossible.

4. Other Laws Impacting Wellness Programs: ADA

The Equal Employment Opportunity Commission has issued informal opinion letters stating that disability-related questions are permissible only as part of a "voluntary wellness program" – where participants are not required to participate or penalized for failing to do so. The EEOC issued two additional informal opinion letters in 2009 on this topic. In its March 6, 2009 opinion letter the EEOC found that an employer who conditioned participation in a self-funded group health plan on completion of a health risk assessment violated the ADA. In its August 10, 2009 letter the EEOC explained that an employer may only ask disability-related questions of employees if the questions are "job related and consistent with business necessity." The EEOC went on to state that asking questions about various medical conditions that are typical of many HRAs – such as questions on heart disease, cancer, asthma, etc. – before granting reimbursement of health expenses was not job related or consistent with business necessity. These informal opinion letters are not binding but do provide some insight into how the EEOC is viewing the type of inquiries made in the HRA and wellness program context.

B. Mental Health Parity Laws

1. The Mental Health Parity Act of 1996

Federal law first demanded parity between mental and physical health benefits under the Mental Health Parity Act of 1996 ("MHPA"), which went into effect for plan years beginning on or after January 1, 1998. Subsequently many states, including California in 1999, adopted their own mental health parity laws. The MHPA, and state equivalents, affects employer group health plans, insurers and HMOs. It never required that these entities *provide* coverage for mental health benefits, but required that, where they do extend such coverage, annual and lifetime dollar limits on mental health benefits could be no lower than were applied to surgical and medical benefits. The MHPA did not prohibit imposing different financial requirements (such as co-payments, coinsurance) or treatment limitations – such as the number of visits – on mental versus medical/surgical benefits,

however. Over time it became clear that these permissible financial and treatment limitations on mental health care (particularly limits on the number of in- and outpatient treatment visits) were very prevalent in private employer plans, that they significantly limited access to mental health care and ultimately prevented true parity with medical/surgical benefits. Studies also showed that depression alone, among mental health conditions, cost private employers approximately $31 billion to $51 billion annually in lost productivity, and that employee impairment caused by mental illness resulted in more days of work loss and work impairment than various other chronic conditions including back pain and diabetes. With regard to what is called the "moral hazard" – the belief that individuals will use mental health benefits at a higher rate when they are not personally required to pay the cost – a study of use of these benefits by federal employees covered under the Federal Employees' Health Benefit Program found that the expected large increase in use of these services when made more accessible did not materialize.

2. The Mental Health Parity and Addiction Equity Act of 2008

These issues were addressed head-on in the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA," also called the Domenici-Wellstone Act after its sponsoring senators), which went into effect for calendar plan years beginning on or after January 1, 2010. The MHPAEA extended the annual and lifetime dollar limit protections of the MHPA for the first time to substance abuse and addiction treatment, which were not included in the MHPA's definition of "mental health benefits."[2] Also, for the first time, the MHPAEA applied "parity" not only to lifetime and annual dollar limits on coverage but to financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage).

Specifically it requires:

- That the financial requirements or treatment limits that apply to mental health and substance use disorder benefits be no more restrictive than the "predominant" financial

[2] The regulations use the term "substance use disorder" but "substance abuse" or addiction may also be used.

requirements or treatment limitations that apply to "substantially all" medical/surgical benefits;

- That this rule of parity be applied across classifications of coverage (e.g., in-network, out-patient care, in-network, in-patient care, etc.) and coverage units (such as individual or family coverage). The basic rule is "apples to apples" not "apples to oranges." This rule in application is very complex and best understood through use of the factual examples contained in MHPAEA regulations, discussed below.

- That mental health/substance use disorder benefits, where offered, not be subject to any separate cost sharing requirements or treatment limitations that don't apply to medical/surgical benefits (such as different deductibles);

- That standards for medical-necessity determinations and reasons for any denial of benefits relating to mental health benefits and substance use disorders be made available in writing upon request to plan participants, under substantially the same terms that apply when a claim for ERISA benefits is denied.

The MHPAEA, like the MHPA, contains an exclusion for plans maintained by small employers – defined as those who employed an average of at least two but no more than 50 employees on business days during the preceding calendar year. It also continues an exemption available under the MHPA that could be claimed by any group health plan that could demonstrate that compliance with parity rules caused its coverage costs to increase by a set percentage. However it narrows the exemption, requiring group health plan sponsors to demonstrate that compliance with parity laws causes their costs of coverage to increase at least 2% in the first year (1% in subsequent years), in order to qualify for the exemption. The MHPA required only a 1% cost increase in any year.

3. Regulations Under MHPAEA

On February 2, 2010, regulations implementing MHPAEA were published by the Departments of Labor, Treasury, and Health and Human Services, which collectively enforce mental health parity laws. The interim final regulations, codified at 45 Code of Federal Regulations ("CFR") § 146.136, are effective April 5, 2010

and generally apply to group health plans and health insurance issuers for plan years beginning on or after July 1, 2010 (i.e., January 1, 2011 for calendar year plans). The Regulations require good faith compliance until that time. The regulations clarify a number of defined terms and parity requirements, providing helpful factual examples of fairly complex rules.

The basic parity rule under the MHPAEA regulations is as follows:

A group health plan (or health insurance offered in connection with a group health plan) that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any ***financial requirement*** *or* ***treatment limitation*** *to mental health or substance use disorder benefits in any* ***classification*** *that is more restrictive than the* ***predominant*** *financial requirement or treatment limitation of the* ***type*** *that is applied to* ***substantially all*** *medical/surgical benefits in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation.*

Each of the bolded terms has a definition in the regulations, summarized below.

a) Defined Terms

- **Financial requirements**: these include co-pays, coinsurance, deductibles, out-of-pocket limits. They must be equal as applied to medical/surgical and mental health/substance abuse disorders. The regulations specifically provide that "separate but equal" deductible and co-pays for each type of care are not permissible, mainly because mental health/substance abuse treatment comprises a small percentage of overall plan costs (e.g. 2 to 5%), hence the same dollar deductible applied to that category would be more burdensome than it would as applied to medical/surgical benefits.

- **Treatment Limitation – further divided into:**
    - **Quantitative treatment limitations**: these include limits that are expressed numerically such as the maximum number of visits or number of days in in-patient care.
    - **Non-quantitative treatment limitations**: these include limits on treatment that are not expressed numerically such as medical management, formulary design, step therapy, pre-authorization, and determination of usual and customary charges. The regulations provide a non-exclusive list and recognize that, due to the different nature of medical versus mental health illness and treatment methodologies, some differences may be permitted to the extent that they reflect recognized, clinically appropriate standards of care.
        - For instance, a plan that requires a participant to exhaust counseling sessions with an Employee Assistance Program (EAP) before he or she can receive mental health or substance abuse treatment would violate the MHPAEA if there are no comparable requirements imposed on medical/surgical benefits.
- **Classification:** this refers to a category of coverage; the regulations identify six different ones:
    - Inpatient in-network;
    - Outpatient in-network;
    - Inpatient out-of-network;
    - Outpatient out-of-network;
    - Emergency care; and
    - Prescription coverage.
- **Substantially All**: A financial requirement or treatment limitation – such as co-pay - applies to "substantially all" medical/surgical benefits in a

classification group if it applies to at least 2/3rds of the benefits in that classification. If the existing or intended limitation applies to less than 2/3rds of the medical/surgical benefits in a classification, it cannot be imposed on mental health/substance abuse benefits.

- **Type:** financial requirements and treatment limitations of the same nature. Coinsurance is a different "type" of financial requirement than co-payments, for instance. Again, apples must be compared to apples; co-payments need not be compared to coinsurance.

- **Level:** a difference in degree or magnitude, applied to a financial requirement or treatment limitation. A $20 co-pay is a different "level" of financial requirement than a $40 co-pay is.

- **Coverage unit**: e.g., individual coverage versus family coverage.

- **Predominant**: more than 50%.

b) How to Measure Plan Benefits

In order to apply the parity rules, the regulations establish standards for measuring plan benefits. The "substantially all" and "predominant" standards are determined by looking at the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year. Any reasonable method may be used to determine whether the dollar amount expected to be paid under the plan will constitute the 2/3rds (substantially all) or 51% or more (predominant) percentages. The complexity comes in when, for instance, there are different "**levels**" of co-payments (which is a **financial requirement**), or, in the case of **treatment limitations**, different "**types**" of limitations, and these differences exist across different **classifications** of coverage, and **coverage units**.

c) Examples:

(1) Single Co-Payment: If a plan is measuring the parity of a single co-pay amount applicable to medical/surgical treatment, and projects total medical/surgical costs of $800,000 subject to the co-

payment, versus $1,000,000 total medical/surgical costs under the plan for the year measured, then 80% of medical/surgical costs are subject to that co-payment. This is "substantially all." The same co-payment can be applied to mental health/substance abuse benefits.

(2) Multiple Co-Payments. Same example as above, but five different co-payment levels apply to medical/surgical treatments. The "substantially all" test on co-payments in general is met, so a co-payment is a financial requirement that can be imposed on mental health/substance abuse treatment. However, of the five co-payments, no single one applies to 51% or more of total medical/surgical costs (i.e, each co-pay applies to $500,000 or less in medical/surgical benefits). In this instance, the plan can combine any levels of co-payment, including the highest levels, till 51% or more is reached. At that point the lowest co-pay of the combined group will be the "predominant" level that may be applied to mental health/substance abuse benefits.

d) Prescription Benefits

A special exception applies to prescription benefits which often have different levels of co-pays (e.g,. generic versus brand-name drugs) but which generally do not distinguish between drugs for mental health/substance abuse and medical/surgical conditions. If all generic drugs – psychoactive and for general medical conditions – have the same co-payment, this satisfies parity requirements. However if the plan formulary excludes psychoactive drugs that have "black label" (disfavored) status, but includes black label drugs for medical/surgical benefits, this violates parity.

e) Definition of Mental Health Disorder

As for what conditions constitute mental health/substance abuse disorders, the regulations allow this to be defined by the plan or insurer, but require that they be classified consistent with generally recognized independent standards of current medical practice, including but not limited to the Diagnostic and Statistical Manual of Mental Disorders ("DSM") and the International Classification of Diseases codes ("ICD"). The regulations also recognize that types of

treatment, and treatment settings, for medical/surgical conditions vary significantly from those for mental health/substance conditions and do not rule out restrictions on treatment and treatment settings that reflect that distinction.

f) Penalties

Compliance with the MHPAEA will be enforced by the Departments of Labor, Treasury, and Health and Human Services and violations of the law carries significant penalties, including excise taxes and penalties of up to $100 per day. There is a self-reporting duty for such taxes, discussed in Section C.

C. New Duty to Self-Report and Pay Excise Taxes on Health Plan Violations

Excise taxes under Internal Revenue Code ("Code") § 4980B et seq. have always potentially applied to certain group health plan violations discovered on audit. (Potential civil sanctions also may apply under ERISA.) However there was no requirement for employers sponsoring such plans to voluntarily report and pay such taxes. This is no longer the case. Under final regulations issued in September 2009, employers have a new duty to self-report and pay the tax beginning on January 1, 2010 using new IRS Form 8928. The taxes must be paid by the employer's tax return deadline, without application of any extensions, for the year in which the plan violation occurs. A 6-month extension to file Form 8928 may be obtained using Form 7004.

1. What Violations Trigger the Tax?

Excise taxes apply to violations of a number of different group health plan mandates, including:

- COBRA violations including failure to provide continuation coverage;
- HIPAA violations of portability, pre-existing condition exclusions, special enrollment and nondiscrimination requirements;
- GINA – including new restrictions on wellness programs/Health Risk Assessments that ask for family health history;

- Mental Health Parity and Addition Equity Act requirements;
- Newborns' and Mothers' Health Protection Act, guaranteeing minimum hospital stays for childbirth;
- Michelle's Law, providing extended status as a dependent for students who lose enrollment status while on medical leaves of absence;
- "Comparable employer contribution" requirements under Health Savings Accounts Archer Medical Savings Accounts

2. Amount of Excise Tax

The amount of the excise tax generally is $100 per day per individual affected by the failure, until the violation is corrected, however in the case of COBRA violations this is capped at $200 per day with respect to each affected family. The tax applicable to a "comparable employer" HSA or Archer MSA violation is equal to 35% of all employer contributions made to all HSAs or MSAs during the applicable calendar year.

Penalties applied to unintentional violations (i.e., those due to reasonable cause and not willful neglect) are subject to caps, but there are no maximum penalty amounts for intentional violations.

In addition, penalties and interest may apply for late filing of Form 8928 and for late payment of excise taxes. The late filing and penalty is equal to 5 percent of the unpaid excise tax for each month the form is late, up to 25% of the unpaid tax; the late payment penalty is ½ of 1% of the unpaid tax for each month the tax is not paid, up to 25% of the unpaid tax. Interest charges may also apply. Further, failure to file Form 8928 will prevent the statute of limitations on tax liability (normally 3 years) from beginning to run.

3. Defenses to the Tax

These excise taxes can be avoided under certain circumstances:

- Failures that are not known of/discovered despite the exercise of reasonable diligence; or

- Failures that are due to "reasonable cause" and not willful neglect, and that are timely corrected or "undone" within 30 days

For these purposes, "corrected" means retroactively undoing the violation (to the extent possible) within 30 days of the first date on which the error was known or should have been known, and placing any affected individual in at least the same financial position as he or she would have been in, had the failure not occurred.

Additionally, the IRS may waive all or part of the excise tax in instances where the amount of tax is deemed excessive relative to the failure involved, and the failure was attributable to reasonable cause and not to willful neglect.

4. Action Items for Employers

- Review your group health plan arrangements and identify tax-triggering mandates (e.g, COBRA, GINA, etc.)

- Review related forms and procedures for compliance with those laws; if none exist, work with benefits advisors to put them in place.

- Contact third party administrators and other vendors to determine what steps they are taking to prevent failures leading to the tax; review applicable service agreements.

III. 401(K) PLANS – POST MELTDOWN DEVELOPMENTS

A. 401(k) Plans Come Back from the Brink

The stock market meltdown that began in September 2008 and continued into 2009 had a brutal effect on 401(k) plan balances. By March 2009, the average 401(k) plan balance with Fidelity Investments had dropped 31% from late 2007 levels ($69,200 down to $47,400). The fate of early baby-boomers who were retiring at that time and saw their retirement accounts halved, caused many jokes about the "201(k) plan." In all seriousness, however, the 401(k) plan's heavy reliance on equity investments caused many to question its validity as a long-term retirement savings vehicle. In October 2009, Time Magazine ran a cover article titled "Why Its Time to Retire the 401(k)."

Time Magazine was just a bit behind the curve, however, as the average 401(k) balance had already rebounded to $60,700 as of

September 30, 2009. And the many companies that had discontinued employer matching contributions in late 2008 and early 2009 had, by the first quarter of 2010, already reinstated them or were planning to do so.

Against this background, several developments in the law will affect 401(k) plan operation in 2010 and the years to come. These are summarized below.

B. Safe Harbor for "Small Plan" 401(k) Deferrals

1. Department of Labor Definition of Plan Assets

Employers usually are aware that they must deposit employees' 401(k) and 403(b) salary deferrals in the plan trust account within a certain period of time. However, many employers are vague on why this is the case and what time periods apply. The rules in this area are driven by Department of Labor regulations that define "plan assets" for ERISA purposes. Once participant salary deferrals (and loan repayments) fall within the definition of "plan assets," ERISA's fiduciary rules apply. Once ERISA's fiduciary rules apply to these amounts – now "plan assets" - an employer's retention of them is a "prohibited transaction" that could result in the plan's loss of qualified tax status as well as trigger excise taxes. In effect, the Department of Labor views this as an illegal loan of plan assets, by the employer. So, in sum, employer retention of plan assets is something to be avoided if at all possible.

The problem is that, until recently, the key regulation defining plan assets was frustratingly vague. Specifically, Department of Labor Regulations at 29 CFR § 2510.3-102 provides that amounts withheld from an employees wages, including loan repayments, become plan assets "as of the earliest date on which such contributions can reasonably be segregated from the employer's general assets," but no later than the 15th business day of the month following the month in which the amounts are withheld.

The 15-day period was often misinterpreted by employers (and even third party administrators) as a "safe harbor" such that contribution deposits would be timely provided they were made within that time period. However this was never the case. The Department of Labor states clearly in preambles to the plan asset regulations that the "deadline" has always been the "earliest reasonable segregation" date and not the 15th business day date.

The Department of Labor has also suggested that the earliest reasonable segregation date could be construed as the date on which the employer withholds income and payroll taxes from wages. In the absence of clear guidance, many employers, especially smaller employers dependent on third party payroll processing companies, adopted a 5-business day rule of thumb for deposit of 401(k) salary deferrals and loan repayments. The problem is that, if the employer could occasionally make 401(k) deposits within 2 or 3 business days, it could be hard to justify the 5-business-day period as the "earliest reasonable" segregation date.

2. Final Regulations Create Safe Harbor for Small Plans

The "earliest reasonable" segregation date deadline still applies to retirement plans with 100 or more participants. However for small plans – those with fewer than 100 participants as of the beginning of the plan year, the Department of Labor created a 7-business day safe harbor for deposit of contributions taken from employee wages. Employers sponsoring small plans will be deemed to have met the "earliest reasonable" segregation deadline if they deposit deferrals and loan repayments in the plan no later than the 7th business day following the applicable payday. This rule was first put forth in proposed regulations in 2008; the Department of Labor issued final regulations on January 14, 2010 and made them effective that date. Employers should keep in mind that, if they fail to make plan deposits by the 7 business-day safe harbor, the resulting delinquency will be counted back to the "earliest reasonable" date, not the date that is the seventh business day from payroll.

3. How to Determine Small Plan Status

The safe harbor applies to plans with fewer than 100 participants as of the first day of the plan year. In order to determine whether or not your plan is a "small" plan that can take advantage of the safe harbor, look on Line 7(f) of the Form 5500 filed for the prior year (on Forms for 2008 and prior; use the equivalent line item for updated Form 5500s). This shows the number of plan participants as of the *last* day of the *prior* plan year – which will be the same number as the participants on the first day of the *current* plan year. Note that the 100 participant count is a "hard line" rule. Employers cannot take advantage of the 80/120 participant rule that is used to determine Form 5500 filing status. Please also note that the safe harbor applies to

employee contributions to welfare (health) benefit plans, but does not overrule prior guidance providing that employee contributions to welfare plans become plan assets as of the earliest date they reasonably are able to be segregated from the employer's general assets, but in no event later than 90 days from receipt by the employer. Finally, note that employ***er*** contributions to retirement plans are subject to different deposit deadlines than are employee contributions; the deadline may depend on the terms of the plan document but generally may be no later than the employer's tax return deadline for the year in question.

C. Target Date Fund Concerns Lead to New Focus on Annuities

A target date fund is a pooled investment fund, commonly a mutual fund or variable annuity contract, whose investment mix – particularly its equity to bond ratio – becomes gradually more conservative over time as an anticipated year of retirement approaches. Thus, someone who is 35 in 2010 and who expects to retire at age 65 (should he or she be so lucky) would choose a 2040 target date fund. Target date is just a variation on the theme of "lifecycle" funds which have been popular features of the 401(k) investment menu for years.

1. Target Date Funds Approved as QDIAs

The Department of Labor gave target date mutual funds a big stamp of approval in 2007 when it approved such funds as one of several options that will constitute "qualified default investment alternatives" or QDIAs as defined by the Pension Protection Act of 2006. As their name suggests, QDIAs are default investment options used for participants who are automatically enrolled in a 401(k) plan, or who voluntarily enroll in the plan but fail to direct investment of their contributions. Provided that participants are given notice about the QDIA, and of their right to choose other investment alternatives, and so long as the sponsor and other fiduciaries are prudent in selecting and monitoring the QDIA mutual fund provider(s) as a whole, no fiduciary liability can fall on the plan sponsor as a result of QDIA investments. The other QDIA options besides target date funds are professionally managed accounts, and group investment products consisting of a mixture of equity and fixed income exposures for the plan as a whole (e.g., a balanced fund). However target date funds have proven to be overwhelmingly popular. It is now estimated that there is more 401(k) money

invested in target date funds than from any other source. F. Reish & B. Ashton, "*Washington, D.C. Update: The Feds Have a Full Agenda*," Reish & Reicher Bulletin February 2010.

The stock market meltdown resulted in a new focus on target date funds, which in some cases were found to have a much higher percentage of equity investments than would seem appropriate for target date retirements that were only a year or two away. The average 2010 target date fund lost approximately 25% of its value during the crash and one Oppenheimer target date fund for 2010 lost as much as 41% of its investment value. This in turn prompted Congressional hearings on target date funds in 2009. Managers of target date funds, like all mutual fund managers, currently are exempt from fiduciary regulation under ERISA, but concerns about the great reliance on target date funds and the significant degree to which they fell short (at least under market crash conditions) may have opened the door to ERISA fiduciary regulation of fund managers. Proposed regulations addressing fiduciary issues related to target date funds may be forthcoming from Senator Herb Kohl (D-WI), chairman of the Senate Special Committee on Aging, and regulations on disclosure requirements under target date funds may also come in 2010 from the Securities and Exchange Commission (and perhaps the Department of Labor). Expect more developments in this area as the year progresses.

2. New Focus on Annuity and Fixed Income Investments

In addition to scrutinizing target date funds, Washington D.C. and the investment industry have seized on annuities and guaranteed income investment options as the best way to protect Americans' long-term retirement savings against another stock market blowout. The IRS and DOL together have solicited comments on adding annuity features to 401(k) plans and IRAs, and a proposed "Lifetime Income Disclosure Act" would require 401(k) account balances to also be reported, on quarterly statements, as a stream of retirement income.

Most recently, as the stock market has begun to recover somewhat, and the urgency of "rescuing" 401(k) plan investments has eased, the industry is looking more objectively at annuities and guaranteed income options, which have their own problems. First and foremost these type of investments usually "cost" more in terms of fees taken off of invested

amounts, and those fees are generally even harder to identify and differentiate from one another than is the case with more common mutual fund investments. Annuity and guaranteed income investments are also not nearly as portable as are mutual fund investments, but rather are tied to one large insurer or financial institution. Teamed with this lack of mobility are investors' concerns and doubts about the stability of any one financial firm, given the many insurance companies and other august financial firms that simply disappeared in the past 18 months. Lastly, annuity forms of payout were long a feature of 401(k) plans, but were gradually dropped over the years due to very low use by participants (some say less than 2%). In sum, annuity and fixed income investments may become an investment option under 401(k) plans in years to come but employers will need to do some homework to understand whether their costs and drawbacks are worth the additional income security they provide in volatile market environments.

D. Fee Transparency and Conflict of Interest Disclosures

One byproduct of the market meltdown is that many 401(k) investors now understand that their retirement nest egg is affected not just by the investments they choose, but also about the "cost" of those investments – fees that are incrementally subtracted from their account over time by the mutual fund companies, broker-dealers, and other intermediaries, and that cumulatively can take a big bite out of their ultimate retirement savings. However, these sources of professional investment advice are crucial to the task of accumulating meaningful retirement savings, and limiting plan participants to mere investment "education" – i.e., explaining the difference between a stock and a bond – was crippling their earnings potential.

1. Statutory Exemption in Pension Protection Act of 2006

The Pension Protection Act of 2006 contained a statutory exemption, from prohibited transaction rules, to allow "fiduciary advisers" to provide investment advice to plan participants on investment products offered by the fiduciary adviser's affiliates under an "eligible investment advice arrangement." Under prior law, only objective investment "education" was permitted and no guidelines specified how to provide advice tailored to a participant's individual needs without incurring fiduciary liability. The permitted methods set forth in the PPA were to provide advice in exchange for a level fee –i.e., no variations depending on the investments chosen – or pursuant to an

objective computer-generated model. Under the last presidential administration, the Department of Labor issued corresponding regulations that permitted this "conflicted" advice. The proposed regulation, which was ultimately finalized before being withdrawn, was accompanied by a proposed "class" exemption from prohibited transactions. The proposed guidance would have provided a shield from fiduciary liability in instances where advisers recommended products sold by the adviser's direct employer (rather than by an affiliate organization), and also permitted "off-model" advice given in response to participant questions on the computer-generated model advice. The proposed regulations and class exemption were stalled and ultimately withdrawn due in large part to the change in presidential administrations.

2. Revamped Regulations Published in March 2010

On February 26, 2010, the Department of Labor released a revamped proposed regulation on conflicted investment advice which was published in the Federal Register on March 2, 2010. The proposed regulation is codified at 29 C.F.R. § 2550.408g-1.

The revamped investment advice regulation is stricter than prior versions and does not include the class prohibited transaction exemption. Thus, it provides protection from fiduciary liability only if the level fee or computer models are strictly followed.

As expected, it disallows "off-model" advice and "modified level-fee" advice from advisers directly employed by company providing the investment product. However the regulation does not go as far as was expected, in some areas. For instance it was expected that the new regulation would apply the level fee requirement not only to the adviser directly providing investment advice (which may be a registered investment advisor or broker-dealer) but also to all entities that are affiliated with the broker/advisor, and hence that indirectly benefit from the conflicted advice, such as mutual fund management or insurance companies. However the re-proposed regulation permits the affiliates' compensation to vary depending on investment choices. On the other hand, the regulation prohibits the affiliate organization from "sharing" this compensation with the adviser (or its employees, agents, etc.) in the form of bonuses or other compensation.

The new regulation also adds a new condition to the computer model approach, requiring that the model be designed and operated to avoid investment recommendations that "[i]nappropriately distinguish among investment options within a single asset class on the basis of unreliable factors – worded by the Department as "factor[s] that cannot confidently be expected to persist in the future." The regulation does not specify which factors are likely to be less reliable than others, but in the preamble to the regulation singles out "differences in historical performance," as opposed to fees and investment style, as a less trustworthy basis for asset allocation. To date, historical performance has been a significant factor influencing investment allocations, but advisers will no longer be able to rely so heavily on this component if they wish their recommendations to be insulated from fiduciary liability.

3. Form 5500 Schedule C Fee Disclosures

Effective for 2009 plan years, retirement plans filing Form 5500 must provide detailed disclosures of direct and indirect fees and other compensation received from plan assets, on Schedule C to Form 5500. All fees or compensation in excess of $5,000 must be disclosed on the schedule, and service providers that refuse to disclose fees received must be identified on the Schedule as such. Small plans (those with fewer than 100 participants as of the beginning of the plan year) need not file Schedule C with new Form 5500-SF (short form) now applicable to those plans. However plan sponsors should expect continued scrutiny and heightened compliance duties in the area of plan fees and should not go into "auto-pilot" mode in this important area.

IV. COBRA SUBSIDY: EXTENDED FOR A SECOND TIME

A. COBRA Subsidy Basics

The stimulus bill enacted in February 2009 (the "American Reinvestment and Recovery Act," or "ARRA") included provisions for a government subsidy of COBRA premiums for individuals who experienced an "involuntary termination" of employment as a result of the downturn in the financial markets and overall economy in late 2008. As originally enacted, the subsidy applied to those persons who were involuntarily terminated on or after September 1, 2008 and who became eligible for COBRA by December 31, 2009. Individuals in that group who were eligible for and elected COBRA were only required to pay 35% of the COBRA premium to their former employer; the

employer forwarded the full 100% on to the insurance carrier, then "skimmed" from payroll taxes that quarter in an amount equal to the 65% subsidy provided to former employees. In effect employers "fronted" the COBRA money for former employees (and other COBRA recipients) and were reimbursed by the federal government in the form of reduced payroll taxes. The maximum period for the subsidy in its original form was nine months and was set to expire on December 31, 2009.

B. The First Subsidy Extension

The COBRA subsidy proved very popular, resulting in a marked increase in the percentage of individuals electing COBRA coverage for themselves and their family. Towards the end of 2009 questions arose as to whether individuals who lost their job in December 2009 would qualify for the subsidy, because in most instances they remained on group health coverage through December 31, 2009 and would not be eligible for COBRA until January 1, 2010.

On December 19, 2009, President Obama signed the Department of Defense Appropriations Act for Fiscal Year 2010 ("DODAA") which contained provisions extending the period to qualify for the COBRA subsidy until February 28, 2010, and increased the maximum premium reduction period from nine months to 15 months. Further, the extension made it clear that it was no longer a requirement that an individual be eligible for COBRA between September 1, 2008 and the new cutoff of February 28, 2010, only that they experience an involuntary termination of employment during that time.

The first subsidy extension gave rise to a transition period for subsidy-eligible persons – called "Assistance Eligible Individuals" or "AEIs" – who exhausted the nine-month original subsidy period before the first, DODAA extension was enacted and who remained eligible for the subsidy as extended. An AEI may have either dropped COBRA coverage when the subsidy expired – in which case they became eligible to re-enroll – or may have continued COBRA at the full premium rate - in which case they were eligible for reimbursement of excess premiums.

C. The Second Subsidy Extension

On March 2, 2010, President Obama signed the Temporary Extension Act of 2010, which extends the COBRA subsidy by one month, to include involuntary terminations occurring on or before March 31, 2010. The Act also "clarifies" that the subsidy is available to

individuals who first were eligible for COBRA due to a reduction in hours of service, and later experienced an involuntary termination. Specifically, the subsidy is now available to employees who meet all of the following requirements:

- The employee's hours were reduced between September 1, 2008 and March 2, 2010;

- The reduction in hours triggered COBRA coverage; and

- The employee was later involuntarily terminated on or after March 2, 2010 (but before the subsidy's expiration date).

There are some tricky elements to implementing this latest subsidy extension. First, the "qualifying event" in the above scenario is the reduction in hours of service, not the involuntary termination, and the maximum COBRA period (18 months) does not change. This is the case whether the individual declined COBRA altogether after the reduction in hours, or elected COBRA but dropped it later. The COBRA subsidy, however, is triggered by the involuntary termination, and would run for up to 15 months.

Example: Jim's hours were reduced in September 2009 but he declined COBRA. On March 10, 2010, he was involuntarily terminated from his job. Jim could elect COBRA and would qualify for the subsidy, but the maximum remaining federal COBRA coverage period (with subsidy) would be 12 months. ("Original" COBRA started running in October 2009 and thus would expire at the end of March 2011). The subsidy would run for 15 months, however, as it is counted off of Jim's involuntary termination. Jim is employed in California thus gets an additional 18 months of continuation coverage under Cal-COBRA, for the first three months of which the federal subsidy would apply.

Employers will need to notify individuals who experienced a reduction of hours on or after September 1, 2008 and who are involuntarily terminated March 2, 2010 or afterwards, of this election right. The notice must be provided within 60 days following the involuntary termination. The Department of Labor has not yet specified the format for any such notice. Nor is it clear if a notice must be provided to individuals whose entire federal COBRA period following the reduction in hours expired before their involuntary termination occurring on or after March 2, 2010. However it does not appear at this point that the extension applies retroactively to persons

who were involuntarily terminated before that date, or that the subsidy applies retroactively to persons who elected and kept COBRA after the reduction in hours.

Additionally, the Temporary Extension Act of 2010 grants the Secretaries of Labor or Health and Human Services to impose a penalty of up to $110 per day on employers who fail to provide the subsidy following a decision in favor of a former employee who has appealed the employer's denial of eligibility for the subsidy (a 10-day grace period applies). This penalty is in addition to other excise taxes and penalties that may apply to COBRA violations. The Secretaries of Labor and HHS also may sue the employer to enforce the decision on subsidy eligibility. To date the Department of Labor has ruled in the former employee's favor (i.e., overruling the employer's denial of the subsidy) close to 80% of the time in over 6,000 requests for review.

Pending the release of model notification forms from the Department of Labor applicable to involuntary terminations that follow a reduction in hours, employers should change their current COBRA notices to insert March 31, 2010 in place of February 28, 2010, as the end-date of the subsidy eligibility period.

An additional extension of the COBRA subsidy through December 31, 2010 is set forth in the in American Workers, State and Business Relief Act of 2010 currently pending in the Senate. It is also possible that health reform legislation, if passed, would extend COBRA to the point at which an individual re-qualifies for group coverage, for instance through a new job. In sum, stay tuned for more developments in this fast-changing area of the law.