HIDDEN 401(K) PLAN FEES AND EXPENSES

AND

MASSACHUSETTS HEALTH CARE LAW

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RECENT ERISA LITIGATION AND RELATED MATTERS

I. HIDDEN 401(K) PLAN FEES AND EXPENSES

A. Background. An important part of a fiduciary's responsibility includes identifying, understanding, and evaluating fees and expenses associated with plan investments, investment options and services. When they initially consider a new investment, fiduciaries should be aware of all hard dollar payments made directly by plans as well as "revenue sharing" and similar payments made indirectly by third parties. The latter are sometimes referred to as "hidden fees." Fiduciaries should also monitor such payments to determine if they continue to be reasonable. While the reasonableness of fees and expenses is a concern for all qualified plans, it is particularly important for 401(k) plans, because they generally bear a higher proportion of the fees and expenses. Monitoring fees and expenses is an ongoing fiduciary responsibility.

B. Types of Hidden Fees. There are at least eight kinds of hidden 401(k) plan fees and expenses that fiduciaries need to be aware of: (i) SEC Rule 28(e) Soft Dollars, (ii) Sub-transfer Agent Fees, (iii) 12b-1 Fees, (iv) Variable Annuity Wrap Fees, (v) Investment Management Fees, (vi) Sales Charges, (vii) Revenue Sharing Arrangements, and (viii) Float.

1. *SEC Rule 28(e) Soft Dollars*. Brokerage firms may charge extra commission that can be used by investment advisors and others to purchase services, such as, valuable investment research. Such excess commission must be reasonable with respect to the services provided. Illegal Rule 28(e) fees violate ERISA Sections 403(c)(1), 404(a)(1) and 406(a)(1)(D). Fiduciaries should know whether they are being charged Rule 28(e) fees.

2. *Sub-transfer Agent Fees*. Brokerage firms and mutual funds often sub-contract recordkeeping and other services related to participant shares to a third party called a sub-transfer agent. Payments to these third parties are sub-transfer agent fees. The problem is not the receipt of such fees by the third parties, but whether the fee fairly represents the value of the services being rendered. The DOL, in its publication A Look at 401(k) Plan Fees, has made it clear that a plan sponsor must understand the value and associated compensation of each company providing services to the plan.

3. *12b-1 Fees*. 12b-1 fees are, in general, distribution expenses paid by mutual funds from fund assets. They may include commissions to brokers, advertising or other marketing expenses, and fees for administrative services provided by third parties to fund shareholders. 12b-1 fees can be as much as 1% of a fund's assets on an annual basis. Fiduciary audits have revealed that plan sponsors who have invested in mutual funds with high 12b-1 fees could have invested in a similar mutual fund without paying any 12b-1 fee or a lower 12(b)-1 fee.

4. *Variable Annuity Wrap Fees*. Variable annuities are insurance products that invest in mutual funds. Internal investment gains in such annuities are tax-

deferred but the product is subject to commissions. Therefore, one must ask if it is prudent to invest in a variable annuity and pay for commissions if gains under an ERISA-covered plan are already tax deferred. Also, variable annuities have expenses that may be greater than the costs charged by mutual funds. These are wrapped into a single aggregate fee called a "wrap fee." Wrap fees include investment management fees, surrender charges, mortality and expense risk charges, administrative fees, fees and charges for other features, and bonus credits. Investing in a variable annuity could be considered imprudent if the same underlying mutual funds are available at a lower cost outside of the variable annuity.

5. *Investment Management Fees*. Investment management fees are fees for managing investment assets and they are usually charged as a percentage of the assets invested. These fees are usually deducted directly from the investment return.

6. *Sales Charges*. Sales charges are also known as loads or commissions. These are transaction costs for buying and selling investment products.

7. *Revenue Sharing Arrangements*. Revenue sharing is the practice by mutual funds or other investment providers of paying other plan service providers, e.g., the plan's recordkeeper or other third party administrator, for performing services that the mutual fund might otherwise be required to perform.

8. *Float*. Float refers to earnings retained by a service provider (usually a bank or brokerage company) that result from short-term investments in liquid accounts used to facilitate cash transactions. Funds held in these accounts could include funds to cover checks issued for benefit payments by benefit plans that are not yet presented for payment by the recipient, or uninvested funds awaiting investment instructions from a plan fiduciary. The Department of Labor requires service providers to inform plan fiduciaries of the existence of float and the circumstances under which it will be earned and retained. See FAB 2002-3.

Comment: There is recently introduced classification of mutual funds of which employers should be aware. These are so-called "R funds" which generally offer the same types of mutual funds that can be purchased through normal brokerage systems, but they are specifically designed for pension plan investments and often carry one or more of the above-referenced hidden fees.

C. Hidden Fee Litigation. A not unexpected by-product of the increased public and regulatory interest in 401(k) plan fees and expenses has been the filing of lawsuits against some of the nation's largest employers and investment providers charging that they breached their fiduciary duties by failing to monitor hidden fees (as well as hard dollar payments) and to establish and follow procedures to determine whether such payments were reasonable. The complaints filed against plan sponsors allege that the defendants failed to

monitor and control, or even to inform themselves, of such payments, failed to establish procedures to determine that they were justified, and also failed to disclose such fees to plan participants.

1. The First Salvo. Claims by plan fiduciaries against service providers contending that the providers violated ERISA Section 406(b)(1) (self-dealing) and 406(b)(3) (kickbacks).

a. Haddock v. Nationwide Financial Services, Inc. (D. Conn. 2006). This decision denied a motion for summary judgment by an investment provider that had been sued by the trustees of five employer sponsored retirement plans over the provider's receipt of fees from mutual funds offered as investment options under variable annuity contracts. The Court held that there were triable issues of fact as to the following issues:

i. Whether Nationwide was a plan fiduciary because it retained the discretion to add or delete fund options to the investment mix or whether it was a fiduciary merely as a result of initially choosing funds for its investment platform;

ii. Whether revenue sharing payments made to Nationwide were plan "assets" within the meaning of the prohibited transaction provisions of ERISA, notwithstanding an acknowledgement by the Court that assets held by mutual funds are not plan assets; and

iii. Whether Nationwide's receipt of revenue sharing could have involved prohibited transactions even if revenue sharing payments are not plan "assets." The Court noted that a trier of fact might be able draw the inference that Nationwide provided only nominal services to the plan and that service contracts with mutual funds pursuant to which revenue was shared were merely shelf space arrangements.

b. Ruppert v. Principal Life Insurance Company S.D. ILL.). Complaint alleges that Principal is a fiduciary by virtue of providing investment advice to plan participants and that it committed violations of Sections 406(b)(1) and 406(b)(3) of ERISA by receiving revenue sharing payments from mutual funds. The complaint contains additional allegations that Principal's failure to disclose the existence of its revenue sharing arrangements to the plans and to participants was a fiduciary breach.

c. Phones Plus, Inc. v. Hartford Financial Services (D.Conn). Complaint brought by a 401(k) plan fiduciary against the Hartford alleging that revenue sharing payments were for services that the Hartford was already obligated to provide to its plan clients. As in the *Haddock* and *Ruppert* complaints, there is an allegation that revenue sharing payments are plan assets.

2. The Main Thrust. Participant claims against plan sponsors and related plan fiduciaries were filed in September and October of 2006 by the law firm of Schlicter, Bogert & Denton of St. Louis, Mo. Defendants include sponsoring employers, plan committees, company officers, directors and employees, but not plan providers. The core allegation is that these defendants breached their fiduciary duties under Section 404(a) of ERISA by causing or allowing plan providers to be paid excessive fees for their services. The alleged excessive payments included hard dollar payments made directly by plans as well as revenue sharing payments made by third parties. A novel aspect of these complaints is the allegation that the plan fiduciaries failed to capture revenue sharing monies embedded in the expense ratios of mutual funds offered under the plans even though these funds were not paid to any service providers. Notwithstanding the fact that the mutual funds themselves were not joined as defendants, this claim is an indirect attack on excessive mutual fund expense ratios based on the contention that plan fiduciaries had a duty to challenge such fees.

a. List of cases:

i. Abbot v. Lockheed Martin Corp. (S.D. Ill.)
ii. Beesley v. International Paper Company (S.D. Ill.)
iii. George v. Kraft Foods Global, Inc. (S.D. Ill.)
iv Kanawi v. Bechtel corp. (N.D. Cal.)
v. Loomis v. Exelon Corp. (N.D. Ill.) The claim for damages for investment losses in this case was dismissed on February 21, 2007).
vi Martin v. Caterpillar, Inc. (W.D. Mo.)
vii. Spano v. Boeing Co. (S.D. Ill.)
viii. Taylor v. United Technologies Corp. (D. Conn.)
ix. Will v. General Dynamics corp. (S.D. Ill.)

b. Issues.

i. Whether defendants acted prudently in selecting investment options.

ii Whether defendants are entitled to protection under Section 404(c) of ERISA.

iii. Whether plan fiduciaries have a duty to seek mutual funds with the lowest expense ratios.

iv. Whether the protection of Section 404(c) of ERISA is lost as a result of the failure to fully disclose to participants the amounts and nature of direct as well as hidden fees.

v. Whether the failure to disclose direct and hidden fees to participants constitutes a fiduciary breach.

3. New Tactics - Additional Complaints Joining Providers. In December of 2006, the Schlicter law firm filed three new complaints against plan sponsors and related fiduciaries seeking the same relief as in the cases filed earlier. In addition, the new round of complaints made defendants of plan service providers such as Fidelity Management Trust Company and Fidelity Management & Research Company claiming that they had breached their fiduciary duties by (i) causing or allowing plans to pay plan service providers excessive fees either directly or through revenue sharing and (ii) "secretly" charging and retaining revenue sharing payments that should have been used to benefit plans and participants.

a. List of cases:

i. Hecker v. Deere & co. (W.D. Wis.)
ii. Renfro v. Unisys Corp. (C.D. Cal.)
iii. Kennedy v. ABB, Inc. (W.D. Mo.)

4. Implications of Hidden Fee Cases.

a. Since most of the cases are in the preliminary phases of litigation, it is unclear whether they will result in significant recoveries for the plaintiffs.

b. Since the facts in these cases are very similar to those of many other employer sponsored 401(k) plans, victory by the plaintiffs would mean that these plans would face a significant exposure to liability.

c. Additional law suits are likely to be filed and some copycat claims have already been made.

d. Publicity generated by the litigation will increase the pressure to make regulatory as well as legislative changes that will require detailed fee disclosures by plan sponsors. In any event sponsors are, themselves, likely to demand more extensive disclosure from plan providers in order to protect themselves against claims.

D. Department of Labor Initiatives on Disclosure.

1. Form 5500 Reporting.

a. Current Rule. Fees and expenses paid by the plan must be disclosed on the Form 5500 using either the Schedule A which is used to report commissions or related fees paid to insurance companies or the Schedule C which is used to report fees paid to service providers. Service providers, such as insurance companies, have traditionally narrowly interpreted their duty to disclose. For example, investment management fees, soft dollars and internal fund expenses are not disclosed on either Schedule A or C of the Form 5500. There is little reporting of hidden fees.

b. Proposal. In July of 2006, the Department of Labor proposed changes to Schedule C that would require reporting of virtually all "indirect compensation," i.e., payments to plan service providers by third parties "in connection with that person's position with the plan or services rendered to the plan." This would effectively place the burden of obtaining such information on the plan administrator and in this regard does not necessarily require the cooperation of service providers.

2. Change to Prohibited Transaction Regulations. Plan service providers are parties in interest to a plan, and as such, must satisfy the statutory and regulatory conditions for exemption from the prohibited transaction rules. Under DOL Regulation Section 2550.

408b-2(a), these conditions require the services to be "necessary," that the arrangement under which they are provided be "reasonable," and that no more than "reasonable compensation" be paid for the services. The Department of Labor is reported to be considering a proposal to amend this regulation to make disclosure by the service provider a condition of exemption. The required disclosure would likely be designed to ensure that service providers furnish a plan fiduciary with information sufficient to allow the plan fiduciary to determine

a. Whether the plan is paying reasonable fees for services,

b. Whether the service provider's total compensation, including indirect payments from third parties, is reasonable, and

c. Whether the service provider's advice is affected by conflicts of interest.

E. Best Practices. The Department of Labor ("DOL") has made it clear that in enforcing ERISA they will not judge fiduciaries on the results they achieve, but on the processes they follow. Such processes should not be static but should change with the times. For example, processes that were appropriate in 1974 would not necessarily be appropriate in 2007, because fiduciaries are being held to increasingly greater expectations. So, as standards for fiduciaries evolve, fiduciaries should take the steps to withstand a challenge from the DOL. Such steps include the following:

1. Identify Fees. Make a concerted effort to learn how much the plan and participants are actually paying in fees and expenses. Obtain an exact dollar breakdown of the amounts being charged.

2. Disclosure. Make sure that all fees, including soft dollar and revenue sharing arrangements, are fully disclosed to participants.

3. Draft and Follow a Written Investment Policy Statement. ERISA requires an investment policy. While not required to be in writing, it is easier to demonstrate compliance with the policy statement if it is in writing. A policy statement should include clear standards for choosing investments, how they will be monitored and what triggers must occur to place an investment manager on a watch list. The roles of interested parties should also be clearly stated. The policy should contain enough detail so that the DOL (or a plaintiff's counsel) can clearly understand how or why an investment decision was made. The investment policy should be reviewed annually and modified as necessary.

4. Document Reviews of Investment Vehicles. Fiduciaries should document their reviews of investment vehicles, including negotiations related to direct as well as hidden fees. Such documentation should address key questions or discussions, and decisions made. The ability to provide documentation demonstrates a thoughtful process and alleviates the need to rely on memory.

5. Continuous Monitoring. Continuous monitoring should be the standard for all plans, and when appropriate, quarterly reporting for all but the smallest plans. Monitoring should directly reference back to the investment policy. Monitoring should also include a broad range of qualitative and quantitative metrics for each fund and/or manager. Fiduciaries should understand what the analysis means for the plan and the participants (*e.g.*, what are the fees? are they reasonable with respect to the services being provided?)

6. Utilize an Independent Third Party Investment Expert. Vendors often provide reporting and recommendations for analysis, placing funds on watch or replacing funds. However, there is an inherent conflict of interest when vendors report on proprietary funds, sub-advised funds and even nonproprietary funds where long-term business relationships and revenue agreements entwine with the investment decision process. As a result, fiduciaries should consider using the advice of an independent third party investment expert.

7. Replace Funds that Do Not Meet Investment Criteria. Many fiduciaries are reluctant to make decisions to replace poorly performing funds, and as a result, often add investment vehicles without removing the fund that the new investment vehicle was intended to replace. This could demonstrate an unwillingness on the fiduciary's part to perform his or her duties as required under ERISA.

8. Expense Ratios/Fees. An investment's expense ratio or manager's fees should not be above the median of its peer group (exceptions may be made for funds or managers with superior performance).

9. Conduct Fiduciary Audit. When appropriate, the fiduciary should hire an independent third party to conduct a fiduciary audit. A fiduciary audit should be conducted when vendors fail to adequately disclose fees or fees do not seem reasonable.

II. MASSACHUSETTS HEALTH CARE LAW

A. Introduction

In April 2006, Massachusetts enacted legislation requiring most state residents to carry health insurance either through their employers or individually. Employers that fail to provide health insurance to their employees may be subject to a surcharge of $295 annually per employee plus additional penalties. The new law imposes several obligations on employers, even if they are already offering health insurance coverage to their employees.

This legislation, which is administered by the Division of Health Care Finance and Policy (the "Division"), imposes multiple requirements on employers. The five most significant obligations are:

- Adopting and maintaining a premium conversion plan;

- Filing Employer Health Insurance Responsibility Disclosure ("Employer HIRD") Forms with the Division;

- Collecting Employee Health Insurance Responsibility Disclosure ("Employee HIRD") Forms;

- Demonstrating the employer's Fair Share Contribution; and

- Providing Certificates of Creditable Coverage.

B. Employer Obligations

Premium Conversion Plan. By July 1, 2007, all employers doing business in Massachusetts must adopt and maintain a premium conversion (also known as a Code Section 125 or cafeteria) plan that allows employees to pay their share of health care premiums with pre-tax dollars. Such premium conversion plans must also allow employees who obtain health care through the Commonwealth's newly-created Health Insurance Connector Plan (the "Connector") to pay their Connector premiums with pre-tax contributions. Employers will be required to file a copy of their premium conversion plans with the Commonwealth when regulations are issued.

Comment: Most premium conversion plans will need to be amended to comply with the Connector requirement to allow employees to pay their Connector premiums with pre-tax dollars. The Wagner Law Group would be happy to assist in this regard.

Employer HIRD Forms. Effective July, 1, 2007, employers with more than 10 employees doing business in Massachusetts will be required to file information about the health coverage they provide to their employees on an Employer HIRD Form to be made available by the Division. Emergency regulations implementing this requirement were issued on January 1, 2007 and have since been repealed due to changes in the law. New proposed regulations should be issued shortly. The emergency regulations described below, however, do provide insight regarding the information employers may be required to file. The emergency regulations would have required employers to file the following information each year:

- Employer's legal name, employer's d/b/a name, federal employer identification number and Division of Unemployment Assistance account number;

- Number of full-time employees (includes seasonal and temporary employees, but not independent contractors);

- Number of part-time employees (includes seasonal and temporary employees, but not independent contractors);

- Whether the employer offers subsidized health insurance to full-time employees;

- Whether the employer offers subsidized health insurance to part-time employees; and

- Whether the employer has filed its premium conversion plan with the Commonwealth.

Employers should consider taking steps to determine how to capture required information. Furthermore, employers should consider designating a responsible individual authorized to verify and certify the accuracy of the information submitted in the Employer HIRD Form.

The Division will conduct data matches with the Division of Unemployment Assistance and the Department of Revenue to verify the accuracy of the information filed on Employer HIRD Forms. Emergency regulations would have imposed a penalty of not less than $1,000 and not more than $5,000 on employers that knowingly falsify or fail to file required information.

New employers may be required to register with the Division when they register with the Division of Unemployment Assistance.

The emergency regulations stated that an employer has more than 10 employees if the sum of the total payroll hours for all employees for the period October 1 through September 30 divided by 1,820 is greater than 10. Payroll hours included regular hours, vacation, sick, FMLA leave, short-term disability, long-term disability, overtime and holiday hours. As a result, employers may not be able to simply count the number of employees to determine if they exceed the 10-employee threshold.

Employee HIRD Forms. Emergency regulations also would have required each Massachusetts employer who files an Employer HIRD Form to also collect a signed Employee HIRD Form from each employee who declines:

- employer-sponsored health coverage;

- employer-arranged health coverage (i.e., through the Connector plan with pre-tax dollars); or

- participation in the employer's premium conversion plan.

Employers would have been required to obtain signed Employee HIRD Forms within 15 days after the close of the open enrollment period for the employer's health insurance, or if earlier, July 1 of the reporting year. New hires would have been required to sign the Employee HIRD Form within 15 days of their date of hire. If an employee failed to return the signed Form, the employer would have needed to document diligent efforts to obtain the signed Employee HIRD Form and maintain the documentation for three years.

Employers would have been required to maintain signed Employee HIRD Forms for at least three years and make them available to the Division upon request. Employers that

knowingly falsify required information would have been subject to a penalty of not less than $1,000 and not more than $5,000.

Employer's Fair Share Contribution. Massachusetts employers with more than 10 employees that fail to make a "fair and reasonable" contribution toward the cost of health coverage must pay an annual "Fair Share Contribution" not to exceed $295 per employee. To be exempt from the requirement to pay a Fair Share Contribution, the employer must pass one of the following two tests:

- *25% Test.* The employer must cover under its health insurance plan at least 25% of its employees employed at Massachusetts locations who work at least 35 hours per week, whether or not they are Massachusetts residents for the period from October 1 through September 30 of each year.

- *33% Test.* An employer that fails the 25% test must pay at least 33% of the premium cost for all of its Massachusetts employees who are regularly scheduled to work at least 35 hours per week and who work at least 90 days during the period October 1, 2006 through September 30, 2007.

Comment: It appears that the 33% test only applies for the year ending September 30, 2007. Therefore, all employers may be required to demonstrate compliance with the 25% test for years ending after that date. Employers who pass using the 33% test as of September 30, 2007, may need to modify their programs to ensure compliance with the 25% test for later years.

In accordance with the final regulations, each employer will have to file or make available information that will enable the Division to calculate the Fair Share Contribution. The Fair Share determination rules are effective October 1, 2006, and the initial reporting obligation is for the period ending on September 30, 2007.

Free Rider Surcharge. Effective July 1, 2007, in addition to the Fair Share Contribution, an employer with more than 10 employees that does not provide the required health care, or does not conform to the premium conversion plan rules, can be assessed a "free rider surcharge" if five or more of its employees or their dependents use free health care during a year or if one employee or his or her dependents uses state-funded care more than three times in a year. Final regulations, issued on December 22, 2006, have recently been repealed due to changes in the law. However, the repealed regulations do provide some insight regarding how the Division will implement the Free Rider Surcharge. In accordance with the repealed regulations, the surcharge ranged from 10% to 55% of the Commonwealth's costs for these services. However, the first $50,000 of health care provided to the employer's employees would have been exempt from the surcharge. The surcharge would have been based on services provided after June 30, 2007.

In accordance with the repealed regulations, each employer would have been required to file or make available information required by the Division to calculate and collect the surcharge. If an employer failed to provide information within two weeks after receiving written notice or

falsified information, the employer would have been subject to a civil penalty of not more than $5,000 for each week on which such violation occurs or continues.

Creditable Coverage Certificates. Effective January 1, 2008, employers (and insurers) must issue certificates of creditable coverage similar to those required by the portability provisions of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Failure to provide the certificates could result in penalties of $50 per individual up to $50,000 per year.

C. Individual Obligations

The law requires all residents of the Commonwealth to have health insurance, either acquired through their employer or purchased on their own, by July 1, 2007. Those individuals who do not obtain insurance through their employer may purchase it through the Connector, which will have the task of connecting individuals and small groups with insurers. These individuals and groups may be combined by the Connector in an effort to reduce costs.

Individuals may receive a subsidy for heath insurance coverage. Those who are under the federal poverty level will receive health coverage at no cost, while those who earn up to 300% of the poverty level will have subsidized coverage. For 2007, 300% of the federal poverty rate is approximately $29,400 for an individual and $60,000 for a family of four.

On their 2007 state income tax returns, individuals will have to affirm that they have health insurance coverage. Those that do not have health insurance can lose their state personal income tax exemption. If uninsured in subsequent years, penalties will be assessed based on the cost of individual coverage.

D. Insurers' Obligations

Nondiscrimination Rule. Effective July 1, 2007, a group health insurance policy or contract (including HMOs but excluding stand-alone dental plan arrangements) cannot be issued in Massachusetts if the employer contributes a smaller percentage of the insurance premium for one employee than for another employee who receives an equal or greater salary. To date, Massachusetts has not issued any regulations or guidance on how this provision should be interpreted. This nondiscrimination rule does not apply to self-insured group health plans.

Comment: It is important to remember that this provision is directed at the insurance companies, and it is the insurers, and not employers, that are responsible for compliance. In fact, ERISA is likely to preempt (invalidate) any attempt to apply this rule directly to employers.

Dependent Coverage. Effective January 1, 2007, group health insurance policies and contracts (but not self-insured plans) are required to cover dependent children for the first two years after they can no longer be claimed as dependents for federal income tax purposes or until they reach the age of 26, whichever occurs first. Presumably, for purposes of the first rule, the two-year period will begin on the first day of the calendar year following the last year that the

employee claims the child as a dependent on IRS Form 1040. There does not appear to be any requirement that the employer continue to make contributions for dependents who are no longer covered under the plan. Thus, the former dependent child may have to pay the entire cost of coverage. The new Massachusetts dependent coverage requirement is in addition to and independent of the COBRA continuation coverage requirement.

E. Conclusion

The new health care law was written in an effort to extend health coverage to the majority of Massachusetts residents. There are many questions that remain to be answered. The law imposes several new obligations on employers. It also imposes penalties on individuals who, while having incomes above the poverty level, simply do not have the means to pay for mandatory insurance.

Another issue yet to be determined is whether and to what degree the Massachusetts law will be preempted by ERISA. In general terms, ERISA "preempts" (that is, negates) any state law that "relates to" or "has a connection with or reference to" an ERISA-covered plan. Some employers have argued that the Massachusetts law, in practice, forces employers to create an ERISA-covered plan; dictates, to a certain extent, the level of employer contributions that are required for the plan; and, through the cafeteria plan requirements, interferes with the administration of an ERISA-covered plan. Therefore, they argue, ERISA preempts the Massachusetts law.

The ERISA preemption issue must ultimately be resolved in the courts, likely the U.S. Supreme Court. However, many, if not all, of the new law's provisions are likely to be in effect before it can be tested in the courts. Consequently, employers should be prepared to comply with the Massachusetts law's provisions, at least for the next few years, and possibly on a permanent basis.