THE WAGNER LAW GROUP
A PROFESSIONAL CORPORATION
99 SUMMER STREET, 13TH FLOOR • BOSTON, MA 02110 • (617) 357-5200

FACSIMILE
(617) 357-5250

E-MAIL
marcia@wagnerlawgroup.com

WEBSITE
www.erisa-lawyers.com
www.wagnerlawgroup.com

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ERISA, EMPLOYEE BENEFITS AND EXECUTIVE COMPENSATION NEWSLETTER

These past several months have been busy indeed with respect to tax and ERISA law changes affecting most types of tax-qualified, executive compensation and welfare benefit arrangements. This Newsletter highlights the salient issues of which you should be aware, including the new Internal Revenue Service and Department of Labor regulations, pension plan amendment requirements and employment law changes.

Every year, The 401kWire, an online news service for the defined contribution industry, publishes a list of the industry's top 100 most influential people. The list recognizes those who are in a position to affect the laws that govern such plans, who control the investments and services such plans receive, or whose views about the industry have an impact on how the industry operates. We are proud to announce that for the second year in a row, Marcia Wagner is on the list. We believe this recognition is a reflection of the efforts Ms. Wagner has made over the years to enhance the retirement benefits of working Americans.

As a member of the IRS Advisory Committee on Tax Exempt and Government Entities, Ms. Wagner has worked extensively this year on compliance, withholding and tax obligations in the international pension plan arena and assisted in authoring a report to the IRS (and available to the public at irs.gov) entitled "International Pension Issues in a Global Economy: A Survey and Assessment of IRS' Role in Breaking Down the Barriers." Dennis Blair assisted Marcia Wagner in creating a model publication for the IRS to use on its website to educate people regarding international pension tax compliance matters.

Steve Migausky and Marcia Wagner authored a very well received article for the American Society of Pension Plan Professionals and Actuaries ("ASPPA") regarding the definition of "plan assets" under ERISA. Mr. Migausky and Ms. Wagner also authored two white papers for Thornburg Investments for distribution to its clients regarding the security of pension investments and fiduciary matters.

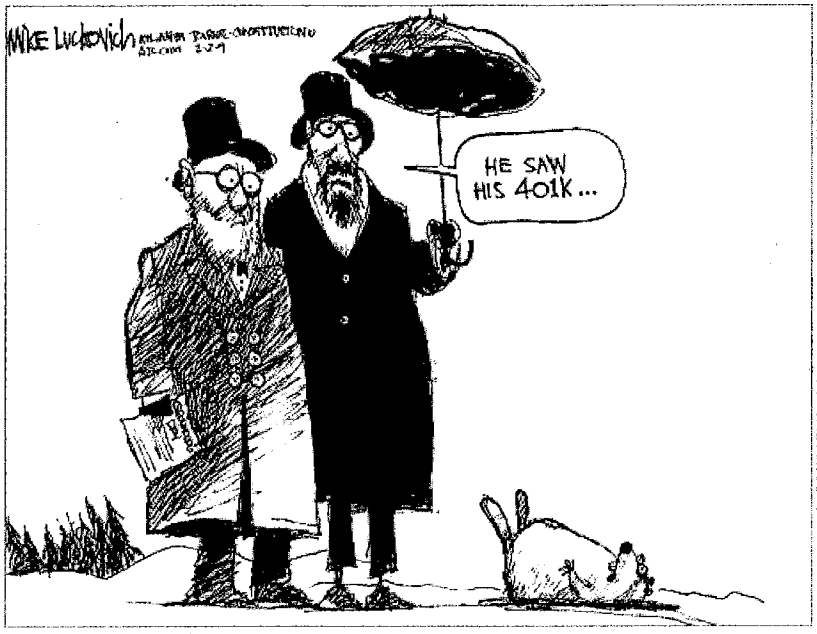
Russ Gaudreau, John Keegan and Marcia Wagner have been named by their peers as 2009 Super Lawyers in the field of ERISA/employee benefits, and Ms. Wagner has been named as a "Top 10 Corporate Lawyer" by Boston Women's Business Journal and The Boston Herald.

Al Lurie continues to publish extensively and has been featured on the LexisNexis Tax Law Center website.

Ms. Wagner continues to lecture extensively and has crisscrossed the country in the past several months on speaking engagements and client conferences, for, among others, John Hancock, ING, Deutsche Bank, Newport Advisor Conference, Raymond James, and the Massachusetts Society of Certified Public Accountants.

Ms. Wagner has recently been quoted in the Dow Jones Newswires, Pension & Investments, Pension & Benefits Daily and The 401(k) Wire.Com.

To learn more about our team and practice, please visit our website at www.erisa-lawyers.com. In the event you desire legal advice or consultation, please feel free to contact any member of The Wagner Law Group.



Current and back issues of this Newsletter are available on our website at www.erisa-lawyers.com.

Pursuant to Internal Revenue Service Circular 230, we hereby inform you that any advice set forth herein with respect to US federal tax issues is not intended or written by The Wagner Law Group to be used and cannot be used, by you or any taxpayer, for the purpose of avoiding penalties that may be imposed on you or any other person under the Internal Revenue Code.

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I. TAX QUALIFIED AND 403(b) PLANS

A. New Disclosure Requirements

There have been three significant developments concerning pension plan disclosure and transparency:

- The FASB's issuance of Statement of Financial Accounting Standard No. 157 ("FAS 157"), which helps the plan's named fiduciary develop a deeper understanding of the valuation methods used for the plan's investments or assets.

- The Department of Labor's ("DOL") November 2007 final regulations, which apply to the 2009 Form 5500 annual report and specifically to the Form's Schedule C.

- The DOL's November 2007 final regulations, which bring ERISA 403(b) plans fully into the Form 5500 reporting world beginning with the 2009 report.

1. Fair–Value Measurement Standard ("FAS 157")

FASB, the designated private sector organization that establishes financial accounting and reporting standards, issued FAS 157 known as the "fair value measurement" standard. This accounting standard, which applies to financial statements for plan years beginning after November 15, 2007, establishes a framework for the measurement of an asset's fair value. It does so by requiring additional disclosures about the fair value measurements being used.

FASB took its action to improve the usefulness of an employee benefit plan's financial statements. The purpose is to assist fiduciaries in judging the reliability of the investment valuation information and to improve the fiduciary's ability to make quality and comparability judgments amongst investments.

The DOL has taken a keen interest in the valuation of plan assets. In the DOL's view, the plan sponsor is responsible for understanding the methodology used to determine the fair value of each of the plan's investment options, especially for assets for which there is not a generally recognized independent market.

Fair value is now defined as "the price that a market participant would expect to receive in the sale of a plan asset or transfer of a plan liability." The ease or difficulty of determining the price of an investment is expressed in terms of inputs. FAS 157 defines these inputs and establishes a hierarchy for prioritizing them. That hierarchy is as follows:

- **Level 1 Inputs** are the quoted prices available in active markets for the identical investment such as, prices obtained from the NYSE or NASDAQ to value mutual funds or publicly-traded stock.

- **Level 2 Inputs** are inputs other than quoted market prices that are observable and use assumptions a market participant would use when pricing the investment based on market data. Examples of Level 2 inputs include matrix pricing or yield curves, such as those used in bond pricing.

- **Level 3 Inputs** are unobservable inputs, where no independent market price is available. The fiduciary must assess the investments' valuation making its best effort to use the kind of assumptions a market participant would use in pricing the investment.

For plan years beginning after November 15, 2007, the plan's financial statement must include disclosures that reflect the input levels of the significant categories of the plan's investments. For investments that are categorized as Level 3 inputs, additional disclosures on the effect the Level 3 investments have on the plan's current year financial activity are also required.

2. Changes in Form 5500 – Schedule C

On November 16, 2007, the DOL published final regulations governing the 2009 Form 5500 annual report. These regulatory changes amend the Form by heightening the plan fiduciary's obligation to report plan fees and expenses in greater levels of detail.

Large plans, i.e., those having 100 participants or more, are affected by these regulations. These plans are currently required to use Schedule C to report service provider information to the DOL. Smaller plans do not file a Schedule C.

Service providers are covered by Schedule C reporting if they receive $5,000 or more in direct and indirect compensation in relation to a plan. The former Schedule C captured any fees or expenses paid directly by the plan to its service providers. However, given that the industry practices have shifted toward structures under which plans pay an increasing amount of their expenses indirectly through investment options, such as revenue sharing, the DOL felt it was necessary to amend the Schedule C reporting requirements.

The new Schedule C reporting requirements are intended to increase the transparency of the fees and expenses that are being paid by the plan indirectly and to help sponsors understand direct payment arrangements, such as bundled fees. The changes to the Schedule C are also intended to help ensure that plan fiduciaries are provided the information they need to fully assess the total compensation paid for services rendered to the plan and to help plan fiduciaries recognize actual and/or potential conflicts of interest by the plan's service providers. This includes information on revenue-sharing arrangements among plan service providers.

The DOL has, therefore, updated the Schedule C reporting requirements to include compensation paid by a plan both directly and indirectly.

Direct compensation means payments made directly by the plan for services. For example, legal fees are direct compensation paid by a plan if they are deducted directly from plan funds, or participant accounts and paid to ERISA counsel.

Indirect compensation means commissions, fees or other amounts received by a service provider from sources other than directly from the plan or plan sponsor. It also includes "non-monetary compensation" such as meals, gifts and entertainment exceeding certain thresholds.

Some indirect compensation may qualify as "Eligible Indirect Compensation," including expenses charged against retirement accounts and reflected in the return on the investment for which the plan sponsor has received the appropriate written disclosures.[1] Schedule C need only show the name of the person who discloses the Eligible Indirect Compensation (no other information is reported on the Form) but the plan sponsor should keep a record of any Eligible Indirect Compensation disclosure and its review of this information. Indirect Compensation that does not meet the definition of Eligible Indirect Compensation (because the disclosures are not adequate, the compensation is not reflected in the value of the investment, or for some other reason) must be reflected on the Schedule C.

Comment: The Wagner Law Group is at the forefront of legal developments in this area and we would be pleased to assist you as you navigate this new terrain.

3. 403(b) Plans

An Internal Revenue Code (the "Code") Section 403(b) plan was previously viewed as less in the nature of a single retirement plan than as an arrangement under which an individual annuity would be purchased on behalf of an employee, or pursuant to which a mutual fund custodial account would be established on behalf of the employee. Amendments to Code Section 403(b) have gradually eroded the extent to which the rules governing Section 403(b) plans differ from the rules governing other employer-based plans, most notably Section 401(k) plans, making them more like retirement plans and less like aggregations of individual contracts and accounts. These and other contributing factors prompted the shift to expanded reporting requirements.

[1] The appropriate written disclosure plan sponsors must receive regarding Eligible Indirect Compensation must now describe the following: the existence of any indirect compensation; the services provided or purpose of this compensation; the amount, estimate or formula used to calculate this compensation; the identity of the person or persons receiving this compensation; the identity of the person or persons paying the compensation.

While the new Form allows service providers to "bundle" certain expenses and services into a package, some fees must be broken out and disclosed individually. A bundled service arrangement occurs when the plan hires one company to provide a range of services that are priced to the plan as a single-price package rather than priced on a service-by-service method. Payments among members of the bundled group generally are not separately reported on Schedule C. An exception is that certain fees are separately reported, which include: investment management fees and other fees charged against a plan's investment return; commissions and other transaction-based fees; finders' fees; float revenue; soft dollar; and non-monetary compensation.

There are essentially two distinct models for 403(b) plans. The first is the actively-sponsored model. With this model, the plan follows the rules for a 403(b) plan but operationally works similarly to a 401(k) plan. There is a plan document that defines the terms of the plan and how it operates. A plan sponsor monitors the appropriate administration and selects and monitors the investments under the plan. It operates just like any qualified plan covered under ERISA and such plans are governed by ERISA.

The other 403(b) model, the non-actively sponsored model, has traditionally allowed employees to buy retail annuities or mutual funds directly from a multitude of vendors, on an individual basis. There is no centralized control as there is with the actively-sponsored model. Such plans are not governed by ERISA.

Beginning with the 2009 plan year, a complete Form 5500 and associated schedules are now required of ERISA-covered 403(b) plans. The new rules that apply to these plans will bring the filing for plan sponsors in line with Form 5500 filing requirements for 401(k) plans. They will require more data to be compiled and independent audits performed if the plan has 100 participants or more at the beginning of the 2009 plan year.

The fact that sponsors of ERISA 403(b) plans will now have to file a complete Form 5500, including all asset information, will be a challenging task for those with ERISA-covered plans that have not kept close tabs on all of their plan's assets. This may be the case for more than a few sponsors, since many 403(b) plans have had assets with various providers. Previously, there was no need to annually gather and report all of the assets.

> **Comment**: Now that there are rigorous reporting rules, 403(b) plan sponsors must ensure that they are coordinating all asset information, beginning with their 2009 plan year Form 5500 filing.

Plan sponsors and service providers should have controls in place to help ensure the accuracy of an ERISA plan's financial transactions and reporting. These controls need to be reviewed in a plan audit (generally required if the plan has more than 100 participants). To help reduce the audit costs, an auditor may use a SAS 70 audit report to assess the controls of the service provider. Therefore, 403(b) plan sponsors should request a SAS 70 audit report that encompasses their 403(b) plan from all of the service providers.

Where plan assets are held by a service provider that does not produce a SAS 70 audit report, plan sponsors can expect to incur increased costs as part of the full financial audit because the auditor will have to review all processes associated with the plan assets at each service provider.

While service providers should send plan statements for the 2008 plan year to any plan sponsor whose 403(b) plan may be subject to the annual audit requirements, they may fail to do so. Plan sponsors must request a plan statement if they do not receive one automatically. The information on the 2008 plan statement will provide the preliminary financial information

necessary to complete the 2009 independent audit. Auditors may decide to go back to prior years to verify the accuracy of the beginning asset balances for the 2009 plan year.

Comment: In the beginning years, these changes may be a challenge, but once the process becomes a routine, the increased exposure to Form 5500 process and audit requirements will prove to be helpful in fulfilling the fiduciary responsibilities of 403(b) sponsors. Plan sponsors should contact their providers and accountants as soon as possible to ensure they will be getting appropriate plan statements.

B. Partial Plan Terminations

As a result of the economic downturn, many employers have experienced reductions in their workforce ("RIFs"). One unintended and costly consequence of a RIF is that an employer's tax-qualified plan may incur a so-called "partial plan termination," which is a significant reduction in plan participation that would cause the immediate vesting of affected participants. This Section I.B. summarizes the applicable law regarding partial plan terminations.

1. Potential Consequences of Failing to Treat a Plan as Having Incurred a Partial Termination

If a partial termination occurs with respect to a tax-qualified plan and the plan sponsor does not vest affected employees in their accrued benefits, the plan will cease to be tax-qualified. The consequences of disqualification of a retirement plan are as follows: (1) for open tax years, the employer loses its deduction for nonvested contributions made to the plan for such years; (2) for open tax years, participants recognize income with respect to their vested accrued benefits; (3) for open tax years, the plan's trust recognizes income on its earnings; (4) distributions from the disqualified plan are not eligible for rollover into another tax-qualified vehicle, such as an IRA; and (5) the plan sponsor and/or the plan fiduciaries responsible for failing to maintain the plan's tax-qualified status face the risk of lawsuits by participants who are forced to prematurely recognize income and for breach of fiduciary duty.

2. Discussion of the Partial Plan Termination Rule

The Code provides, in the event of a termination or "partial termination" of a tax-qualified retirement plan, the rights of affected participants to accrued benefits become nonforfeitable. The regulations provide that the question of whether a partial termination has occurred is resolved on the basis of "all the facts and circumstances" of the particular case.

Neither the Code nor the regulations explicitly define the term "partial termination." Therefore, the determination of whether a particular reduction in a plan sponsor's workforce results in a partial termination of the sponsor's tax-qualified plan is often problematic.

In Revenue Ruling 2007-43, the IRS adopted a 20 percent presumption standard. Thus, if the turnover rate is at least 20 percent, there is a "presumption" that a partial termination has occurred. However, the IRS noted that whether a partial termination occurs on account of participant turnover is ultimately dependent on all of the facts and circumstances in a particular case. Facts and circumstances indicating that the turnover rate for an applicable period is "routine" for the employer favor a finding that there is no partial termination for that period. For this purpose, information as to the turnover rate in other periods and the extent to which terminated employees were actually replaced, whether the new employees performed the same functions, had the same job classification or title, and received comparable compensation, are relevant to determining whether the turnover is routine for the employer.

3. Class of Affected Employees

In applying the 20% presumption standard, certain classes of separated plan participants are excluded from the terminated class. Revenue Ruling 2007-43 uses the term "employer-initiated severance" to describe the class of affected participants to be used in the applicable test. For these purposes, an employer-initiated severance from employment generally includes any severance from employment (even if caused by an event outside of the employer's control) other than a severance that is on account of death, disability, or retirement on or after normal retirement age. In addition, the IRS indicated that the employer may be able to verify that an employee's severance was not employer-initiated through supporting information as to its voluntary nature from personnel files, employee statements and other corporate records.

Another complicating issue has historically been whether the 20% presumption standard applies with respect to "all" participants or only to participants who are "actively employed" as of the dates being analyzed under the test. Revenue Ruling 2007-43 clarifies the IRS's position on this issue by providing that the test is to be applied with respect to active participants, i.e., participants who are employees.

4. The Relevant Time Period

Neither the Code, nor its legislative history, nor the applicable regulations specify whether aggregation of multiple plan years is required or permitted in determining whether a

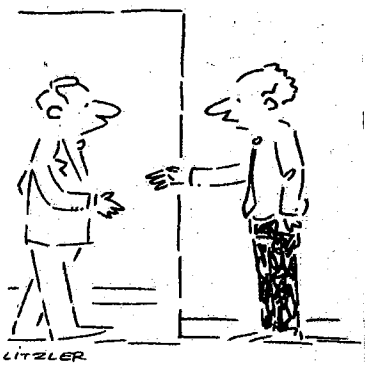
partial plan termination has occurred. Most IRS rulings and court decisions analyzing the partial termination rules have applied the 20% presumption standard on a plan year basis, without discussion of the merits of such decision. On this point, Revenue Ruling 2007-43 provides that the applicable period depends on the circumstances, and indicates that the applicable period is generally the plan year, but could be a longer period if there are a series of related severances from employment.

Court cases have used a facts and circumstances analysis to hold that employee terminations during consecutive plan years should be taken into account. These cases have stated that the applicable time period runs from the start of the event causing the employer-initiated terminations through its completion.

5. IRS Determination Letter Process

The IRS will, upon request for a determination through the filing of an IRS determination letter application, rule on the issue of whether a partial termination has occurred with respect to a particular plan. In this regard, the IRS has taken the position that a plan sponsor who requests a partial termination determination before fully vesting affected participants may rely on the qualified status of its plan if the IRS determines that a partial termination has occurred and the sponsor thereupon retroactively vests all affected participants as of the date of the partial termination. Thus, the plan will retain its qualified status if the employer vests affected participants after the occurrence of the partial termination so long as the vesting occurs within a fairly short period of time after the IRS's determination of the occurrence of a partial termination.

Comment: Because of the uncertainty in the application of the partial termination rule and the severe adverse consequences that could result from making an erroneous determination in this regard, an employer which has seen its workforce shrink in recent times should engage in careful analysis as to whether any of its tax-qualified plans have incurred a "partial termination." An employer might consider utilizing the IRS's determination letter program to seek a ruling from the IRS as to whether the applicable plan has incurred a partial termination. If the plan sponsor waits to receive a favorable determination from the IRS, rather than making an erroneous determination as to whether a "partial termination" has occurred without IRS guidance, it may avoid incurring additional costs of recalculating vested amounts, and locating terminated participants who have previously taken distributions that are entitled to additional benefits and processing the additional benefit payments.



"Thanks, Frank. I appreciate your taking the blame on such short notice."

C. Plan Loans Exempt from Truth-in-Lending Disclosure Requirements

The Federal Reserve System's Board of Governors has amended Regulation Z to exempt most retirement plan loans from the disclosure requirement of the federal Truth-in-Lending Act.

Generally, the Truth-in-Lending Act requires lenders to provide borrowers with a disclosure form explaining the full cost of a loan if the amount financed is $25,000 or less and the lender has made more than 25 loans per year in both the current and preceding calendar years. The Federal Reserve System's Board noted that retirement plan loans to participants are substantially different from other loans because there is no third-party creditor imposing finance charges, and the interest and principal are reinvested in the participant's own account.

The Board decided to exempt loans made by qualified plans subject to Code Section 401(a) if three conditions are met: (i) the loan must be made to a participant; (ii) the loan must be from fully vested funds in the participant's account; and (iii) the loan must be made in compliance with the requirements of the Code.

The exemption also applies to loans made by Code Section 403(b) plans and Code Section 457(b) governmental plans. The amended regulations become effective July 1, 2010.

D. Treasury Department Issues Final Regulations on Automatic Enrollment Plans

The Pension Protection Act of 2006 created two new types of automatic enrollment 401(k), 457(b) and 403(b) plans - the eligible automatic contribution arrangement ("EACA") and the qualified automatic contribution arrangement ("QACA"). On February 24, 2009, the Treasury Department published long-awaited final rules relating to these plans.

Generally, an EACA provides for automatic enrollment in the plan at a level percentage of an employee's compensation. The QACA, a type of EACA that is a new type of safe-harbor plan, combines automatic enrollment, automatic deferral escalation and a minimum required employer contribution in the form of a match or profit-sharing-type contribution.

1. Uniformity Requirement

One of the most significant changes in the final regulations is the modification of the application of automatic enrollment rules for EACAs to allow employers to adopt automatic enrollment only for employees who are specified under the plan as being covered by EACA. For instance, this allows employers to adopt automatic enrollment only for employees who are hired or become eligible after a certain date. Plans that choose this limited coverage option are not able to take advantage of the 6 month extended ADP and ACP testing period, touted as one of the key benefits of EACAs, however.

The final regulations confirm that a QACA may permit mid-year escalation (e.g., from 3% to 4% deferral rate) as long as the application is uniform. The IRS has indicated that in order

to comply with the uniformity requirement, the salary deferral increases must occur at the same time for all covered employees, not different times throughout the year (i.e., on a date certain and not on each participant's employment anniversary).

2. Permissible Withdrawals

Plans that otherwise satisfy all of the requirements to be an EACA may allow automatically enrolled employees to opt out of the plan and request a distribution within the first 30 to 90 days following auto enrollment. These so-called permissible withdrawals are: (i) excluded from the annual nondiscrimination test; (ii) included in the individuals' taxable income in the year of distribution; and (iii) excluded from the early withdrawal penalty.

3. Notice Requirement

All automatic enrollment plans are required to provide a notice to participants within a reasonable time prior to the start of the plan year. For newly eligible employees, the notice must be provided within a reasonable period prior to their eligibility date. Reasonable is generally defined as 30 to 90 days; however, the regulations provide limited circumstances in which the notice may be provided less than 30 days in advance as long as employees have an effective opportunity to react.

4. Timing and Implementation

Existing 401(k) plans can only add an EACA or a QACA at the beginning of a plan year. To implement one of these arrangements for 2010, the participant notice must be distributed between October 1 and December 1 of 2009, and the plan must be formally amended by the last day of 2009.

Comment: The final regulations provide greater certainty for employers who sponsor a plan with a QACA or an EACA. For QACAs and EACAs already in existence, employers will want to ensure that the features of these plans are consistent with the final regulations as soon as possible. The final automatic enrollment regulations include many details that may pose traps for the unwary.

E. New Contribution Relief Announced for Employers Sponsoring Safe Harbor 401(k) Plans

On May 18, 2009, the IRS proposed a regulation that would permit employers that sponsor safe harbor defined contribution plans to reduce or suspend safe harbor nonelective contributions and safe harbor nonelective contributions under qualified automatic contribution arrangements (QACAs) after the start of the plan year if the employer has incurred a substantial business hardship and certain other requirements are met. The proposed change liberalizes current restrictions on the suspension or reduction of a safe harbor plan's nonelective contributions or safe harbor nonelective QACA contributions after the plan year has begun.

These proposed regulations are generally consistent with existing regulations that allow plan sponsors to suspend or reduce making safe harbor matching contributions if certain conditions are met. The primary difference is that in order for a plan sponsor to suspend nonelective contributions under these new proposed regulations, the employer must determine that it has incurred a "substantial business hardship".

1. Safe Harbor Plan Background

Employers that sponsor 401(k) plans may, but are not required to, design their plans to satisfy safe harbor rules under Code Section 401(k) and (m) of the Code. Compliance with these rules exempts the plan from the actual deferral percentage ("ADP") and/or the actual contribution percentage ("ACP") tests. Design-based safe harbor plans that consist solely of pre-tax deferrals and matching contributions or non-elective contributions are also excluded from the top-heavy rules. To qualify as a safe harbor design, the plan must provide for prescribed levels of employer nonelective or employer nonelective QACA contributions for non-highly compensated employees. Under either approach, safe harbor contribution provisions must be included in the plan document.

Safe harbor-designed plans are intended to provide assurances to participants that the employer will make a specified level of contribution on their behalf. Consequently, the safe harbor rules require employers to send a notice to employees before the beginning of the plan year, explaining the plan's contribution formula and other design features. In addition, these rules: (i) restrict an employer from reducing or suspending matching safe harbor contributions once the year has begun unless certain conditions are met, and (ii) permit employers to reduce or suspend nonelective safe harbor contributions generally only by terminating the plan.

2. New Ability to Reduce or Suspend Safe Harbor Nonelective and Safe Harbor Nonelective Contributions under QACAs

The proposed regulation now permits employers that have experienced a "substantial business hardship" to reduce or suspend safe harbor nonelective contributions and safe harbor nonelective contributions under QACAs if certain steps are taken. If an employer can meet that requirement, the following additional conditions must be met to reduce or suspend such safe harbor contributions:

- The employer must adopt a plan amendment that reflects the suspension or reduction in safe harbor nonelective or safe harbor nonelective QACA contributions.

- All eligible employees must be provided a supplemental notice informing them of the reduction or suspension. The notice must be provided at least 30 days prior to the effective date of the suspension or reduction.

- Eligible employees must be given a reasonable opportunity (including a period after receipt of the supplemental notice) prior to the reduction or

suspension to change their pre-tax deferral elections and, if applicable, any after-tax employee contribution elections.

- The plan amendment reducing or suspending contributions must provide that the ADP and/or ACP tests will be satisfied for the entire plan year in which the reduction or suspension occurs, using the current plan year testing method.

- The plan must continue to make the safe harbor nonelective contributions until the effective date of the amendment (which, as noted above, cannot be earlier than 30 days after the supplemental notice is distributed to employees).

The suspension or reduction can be effective no earlier than the later of: (i) 30 days after the supplemental notice is distributed, and (ii) the date on which the plan amendment reflecting the suspension or reduction is adopted by the employer. The notice must specifically address the consequences of the amendment that reduces or suspends future safe harbor contributions, such as the fact that employees will no longer be eligible to receive the same level of contributions that they could previously receive. In addition, the notice must explain the procedures that participants should follow to change their pre-tax deferral or after-tax contribution elections and must identify the date on which the suspension or reduction will take effect.

3. Substantial Business Hardship

The ability to suspend or reduce safe harbor nonelective contributions and safe harbor nonelective QACA contributions is conditioned on the employer having experienced a "substantial business hardship". The proposed regulations define this standard as "comparable to" the substantial business hardship standard that applies to a request for a minimum funding waiver for a defined benefit plan under Code Section 412(c). Under Section 412(c), the factors that the IRS takes into account in making such a determination include, but are not limited to, the following:

- Whether the employer is operating at an economic loss,

- Whether there is substantial unemployment or underemployment in the employer's trade or business and in the industry concerned, and

- Whether the sales and profits of the industry concerned are depressed or declining.

Unlike funding waiver requests for defined benefit plans, the proposed regulations do not provide for a prior determination by the IRS that the employer has experienced a substantial business hardship. Instead, employers that wish to reduce or suspend safe harbor contributions in reliance on the new regulation must make their own determination of the existence of a

substantial business hardship by applying the Section 412 standards to their own particular circumstances.

Comment: This analysis should not be undertaken lightly. The IRS traditionally has applied a relatively stringent level of review for minimum funding waiver requests. Employers and their advisers will need to carefully consider whether circumstances support the existence of such a business hardship and should be prepared to substantiate the specific basis for such a determination in the event of an IRS examination.

4. Consequences of Reducing or Suspending Safe Harbor Contributions

When an employer amends its plan to reduce or suspend either nonelective safe harbor contributions or safe harbor nonelective QACA contributions during the plan year, the employer will be required to make additional adjustments for that year.

- First, it will be required to satisfy all applicable ADP and ACP testing requirements for the entire year. Consequently, employers should anticipate how any testing failures would be corrected.

- Second, the plan will cease to be exempt from the Code Section 416 top-heavy rules for that year, which will necessitate testing under those rules.

5. Effective Date

The proposed regulation may be relied upon for amendments adopted after May 18, 2009. Employers that wish to utilize the new rule should keep in mind that the plan amendment reflecting the suspension or reduction must be adopted, and the supplemental notice must be distributed, no less than 30 days before the date on which the suspension or reduction will take effect. The IRS has confirmed that if the final regulation imposes new restrictions not contained in the proposed regulation, those new restrictions will not be applied retroactively.

F. Suspension of 2009 Required Minimum Distributions From Qualified Plans and IRAs

1. Background

The Worker, Retiree, and Employer Recovery Act of 2008 (the "Act") was signed into law on December 23, 2008. One very important feature of the Act is the 1-year moratorium on required minimum distributions.

With certain exceptions, the Code mandates that retirement plan participants and IRA account owners who have attained age 70½ must take annual required minimum distributions.

This requirement applies to: (i) non-owner plan participants who have both retired and have attained age 70½; (ii) owners who are plan participants and IRA account holders who have attained age 70½; and (iii) owners of inherited IRAs (i.e., benefit distributions to persons who have inherited the IRA accounts after the death of the original owner). Failure to take a required minimum distribution in any year results in a 50% non-deductible excise tax on the amount that should have been distributed.

Required minimum distributions must generally commence in the year the account holder turns 70½. However, the first year's minimum distributions may be deferred until April 1 of the following year. Because of the economic downturn, Congress felt it appropriate to waive the minimum distribution requirement for the 2009 year. The new law does not preclude a person from taking distributions, it just does not require that a person take a distribution.

2. 2008 Distribution Amounts

Individuals who delayed taking their first required distributions in 2008 should have taken those distributions by April 1, 2009, because the 2008 distribution requirements have not been waived.

3. Automatic Distributions From Financial Institutions

A number of financial institutions have set up their computerized systems in such a way that unless the account holder/beneficiary notifies them to the contrary, checks representing the annual required minimum distribution will be mailed to the account holder/beneficiary. If that happens this year and the recipient does not comply with the 60-day rollover rule, such distribution amounts would be subject to tax in 2009. Moreover, recipients of certain installment payouts, and beneficiaries of an inherited account, are never eligible to rollover a retirement benefit distribution; receipt of a 2009 distribution check by such persons will result in an unavoidable tax.

It is possible that individuals will receive minimum distribution checks from their financial institutions in 2009. However since such distributions are not required minimum distributions, they may be rolled over to another IRA (if otherwise so eligible). Such a rollover, if done within 60 days of the original distribution, would allow such amounts to continue their tax-deferred status.

Comment: Account holders and beneficiaries should contact their financial institutions to confirm that the institution either (i) will not be making required minimum distributions in 2009, or (ii) will note in their files that there is specific direction not to make any minimum distributions for 2009.

4. No Waiver for Defined Benefit Plans

The statutory waiver for 2009 is limited to IRAs and retirement plans with individual accounts, e.g., profit-sharing, 401(k) and 403(b) plans. Defined benefit pension plans are not included in the statutory waiver for 2009.

5. No Waiver in 2010

The special waiver only applies for 2009. Next year, the regular rules come back into play. In 2010, benefit distributions will be based on the distribution tables applicable to 2010 and will use the calculation methods otherwise applicable in that year. It will not be necessary to take any special steps to deal with the 2009 amounts that were skipped.

Comment: The beneficial tax treatment provided by the Act will be helpful to individuals who otherwise would be receiving required minimum distributions in 2009. Because of the intricacies of the rule, careful planning is needed.

G. DOL Issues Guidance on ERISA Fidelity Bonding Requirements

The Employee Retirement Income Security Act of 1974 ("ERISA") mandates that each person who handles plan "funds or other property" must be bonded. Following this seemingly simple mandate has been surprisingly complex, which is why the guidance in Field Assistance Bulletin ("FAB") No. 2008-4, issued by the Employee Benefits Security Administration ("EBSA") of the DOL on November 25, 2008, is welcome.[2] The guidelines in FAB 2008-4, which takes the form of questions and answers, clarifies many issues and should make compliance easier.

The minimum required amount of the bond per plan is 10% of the plan assets as of the beginning of the year (but at least $1,000) up to $500,000. For plan years beginning on or after January 1, 2007, the maximum required bond amount is $1,000,000 for plans that hold employer securities.

A fidelity bond is different from fiduciary liability insurance. A fidelity bond insures against losses due to fraud or dishonesty. Fiduciary liability insurance insures the plan against losses caused by breaches of fiduciary responsibilities; fiduciary liability insurance is not ERISA-mandated.

[2] FAB 2008-4 is available on the following page of the DOL's Web site: http://www.dol.gov/ebsa/pdf/fab-2008-4. pdf

1. The Guidance

This section summarizes much of the key guidance in FAB 2008-4.

- ERISA fidelity bonds must cover "fraud and dishonesty" as defined in DOL regulations.[3] Under the DOL's definition, "the bond must provide recovery for loss occasioned by such acts even though no personal gain accrues to the person committing the act." This is important to note because many commercial crime bonds provide "theft" coverage and need to be amended to include this "fraud and dishonesty" coverage for any insured ERISA plans. There are many examples of embezzlements where the person committing the loss does not personally gain.

- ERISA fidelity bonds must cover every person "who handles plan funds or other property." Service providers that "handle" plan assets must be bonded, but service providers that are "solely" rendering investment advice do not. Certain entities, such as a bank or insurance company, may not need a bond. The bonding requirements do not apply to employee benefit plans that are unfunded (e.g., plans that pay benefits only from the general assets of a union or employer), or that are not subject to Title I of ERISA (for instance, plans covering only owners or owners and spouses are exempt from Title I of ERISA).

"OK—here's the new business plan: Keep expanding 'til we're too big to fail."

- The concept of "handling," while complex, is essentially the exposure that a person's "duties or activities…are such that there is a risk that such funds or other property could be lost in the event of fraud or dishonesty on the part of such person."

- More than one bond can be used. Where a service provider must be bonded, either the service provider can provide its own bond or the plan can add the service provider to the plan's bond. If the service provider is offering its own bond, the plan must be named as an insured.

- The plan may use plan assets to purchase the bond, even if it includes coverage for service providers.

- More than one plan can be insured under a single ERISA fidelity bond provided the bond amount is sufficient to insure each plan as though such plan were bonded separately.

[3] See 29 CFR §2580.412-9, which is available on the following page of the DOL's Web site: http://www.dol.gov/dol/allcfr/ebsa/title_29/Part_2580/29CFR2580.412-9.htm

- The ERISA minimum required bond may not have a deductible. However, ERISA does not prohibit a deductible for limits purchased in excess of the minimum required amount.

- Trustees can purchase a limit of liability greater than the $1,000,000 maximum amount required by ERISA.

In summary, FAB 2008-4 notes that there is "substantial flexibility" in the form of fidelity bonds "as long as the bond terms meet the substantive requirements of [ERISA]." In addition, the FAB confirms that "choosing an appropriate bonding arrangement that meets the requirements of ERISA and the regulations is a fiduciary responsibility."

2. Implications for Plan Sponsors

FAB 2008-4 provides many welcome clarifications that will help plan fiduciaries in fulfilling the fidelity bond mandate. The FAB also supports consideration of either broader coverage to include service providers or a review of plan procedures for documenting service provider coverage, higher limits of liability and coverage for non-ERISA areas such as third-party computer fraud, wire transfers fraud and forgery. While the FAB makes clear a deductible is permissible in excess of the required limit of liability, we recommend against using deductibles for the "fraud and dishonesty" coverage for ERISA plans.

H. Written Plan Compliance Deadline for Section 403(b) Plans is Extended

In late December 2008, the IRS issued Notice 2009-3 extending the deadline for sponsors of 403(b) plans to adopt new written plans or amend existing plans to satisfy the written plan requirement of the final 403(b) regulations. This relief was granted due to the difficulties faced by plan administrators in meeting the then deadline of December 31, 2008. This extension gives plan sponsors additional time to put their plan documents in place.

The IRS intends to treat plans as meeting the requirements of Section 403(b) and the final regulations during the 2009 calendar year if:

(i) By December 31, 2009, the plan sponsor has adopted a written 403(b) plan that is intended to satisfy the requirements of Section 403(b) and the final regulations;

(ii) During 2009, the plan sponsor operates the plan in accordance with a reasonable interpretation of Section 403(b) and the final regulations; and

(iii) By December 31, 2009, the plan sponsor makes its best effort to retroactively correct any operational failure during the 2009 calendar year to conform to the written plan.

The IRS intends to issue a revenue procedure this year establishing a prototype document approval program for 403(b) plans and sample plan language for prototype 403(b) plans. The IRS also intends to establish a determination letter program for individually designed 403(b) plans. Additional guidance should also allow 403(b) plans to make remedial amendments to retroactively correct plan provisions under rules similar to those that apply to 401(a) tax-qualified plans.

Comment: Please note that the effective date of the final 403(b) regulations has not changed; it is still January 1, 2009. Plan sponsors are required to operate their plans in compliance with the regulations. In fact, as described above, they are required to do so in order to take advantage of the extended deadline of the plan writing requirement. Therefore, it is important for plan sponsors to review their plans to ensure that they comply with the final regulations in operation on and after January 1, 2009. For example, the plan eligibility provisions need to be reviewed to ensure that the universal availability requirements of the final 403(b) regulations are satisfied.

I. Summary of Key Provisions of the Worker, Retiree, and Employer Recovery Act of 2008

President Bush signed the Worker, Retiree, and Employer Recover Act of 2008 (the "Act") on December 23, 2008. The most significant part of the Act provides funding relief for defined benefit pension plans in response to the economic crisis. Additionally, the Act contains a 2009 waiver of required minimum distributions for defined contribution plans and individual retirement accounts (discussed above in Section I.F. hereof). Finally, the Act makes technical corrections to the Pension Protection Act ("PPA"), which will affect the administration of defined benefit and defined contribution plans.

1. Pension Funding Relief

With markets down so significantly, defined benefit plan sponsors have been worried about the impact of higher 2009 pension contributions on their businesses.

a. *Asset "smoothing"*. Defined benefit plans are required to perform actuarial valuations each year. The main purpose of these valuations is to assess the plan's benefit liabilities compared to the value of plan assets. Depending on the results of the valuation, a defined benefit plan sponsor may be required to make additional funding contributions to the plan.

Averaging of assets allows defined benefit plans to smooth out unexpected losses in asset values from year to year. Averaging, or smoothing, has always been allowed, but PPA tightened the rules. Under PPA, the averaging period could not exceed 24 months and the resulting value had to fall within a 10% corridor above and below the fair market value ("FMV") of plan assets.

In other words, regardless of the averaged value of assets, the asset value used in the valuation cannot be less than 90% of the FMV of assets or more than 110% of the FMV of assets.

The IRS interpreted PPA as requiring the FMV of assets from the past three years to be simply added together, adjusted for benefit payments and contributions, and then divided by three. No adjustment for an expected investment return was allowed. This produces an "averaged" value of assets with a downward bias.

The Act adjusts such averages for expected earnings, resulting in higher averaged values. Expected earnings are based on an assumed earnings rate specified by the plan and the plan's actuary, but are limited by interest rates used for valuations under PPA.

b. *Adjustment to PPA Funding Transition Rule*. Under PPA, the minimum funding requirement is, generally, the sum of the "target normal cost" and the "shortfall amortization charge." The target normal cost is the present value of benefits earned during the plan year. The "funding shortfall" is the difference between the "funding target" (i.e., the current plan liabilities) and the value of assets. The shortfall amortization charge is the amount necessary to pay off this difference (i.e., the unfunded liabilities) over a period of seven years.

PPA set up a phase-in, allowing well-funded plans (i.e., plans that stayed above the following percentage of funding target: 92% in 2008; 94% in 2009; 96% in 2010; and 100% in 2011) to be exempt from amortizing any funding shortfall. If a plan was not exempt from the funding shortfall, then the full difference between 100% of the funding target and plan assets was used to set up a "shortfall amortization base," which is amortized over seven years.

The Act provides that if an eligible plan falls below the applicable funding provision (92% in 2008; 94% in 2009; 96% in 2010; and 100% in 2011), only the applicable funding percentage of the "funding target" is used to create the "shortfall amortization base." For example, if an eligible plan in 2009 has a funding percentage of 93% (i.e., less than the 94% stated in the transition rule) the "shortfall amortization base" would be the difference between 94% of the "funding target" and the value of plan assets.

The aim of this provision is to mitigate the steep increase in a plan's minimum funding requirement contribution as a result of the current economic downturn.

c. *Temporary Provisions Regarding Restriction of Benefit Accruals*. PPA restricted benefit formula increases, lump sum distributions, and continued accrual of benefits depending on the funded status of the plan. Generally, the funded status is the ratio of plan liabilities to the value of plan assets. PPA prevents plan amendments that increase benefits if the funding percentage is less than 80% (or would be less than 80% when the benefit increase is considered).

If a plan is less than 60% funded for a plan year, the plan is not permitted to pay lump-sum distributions, and a statutory mandatory freeze on benefit accruals is imposed. If the plan is

funded between 60% and 80% for a plan year, PPA limits lump-sum distributions. Generally lump-sums are limited to 50% of the amount otherwise payable under the plan.

The Act provides temporary relief from the most onerous benefit restrictions. For plan years beginning on or after October 1, 2008, through September 30, 2009, the restriction on benefit accruals (i.e., the statutory mandatory freeze of benefit accruals) can be based on the funded status for the preceding year. This means that for plan years beginning January 1, 2009, a plan's funded status as of January 1, 2008, would be used.

2. PPA Technical Corrections

a. *Nonspouse Beneficiary Rollovers*. Prior to PPA, a nonspouse beneficiary of a deceased plan participant was not able to roll over death benefits. Furthermore, depending on the provisions of the plan, the nonspouse beneficiary could be required to immediately recognize the death benefit as taxable income. PPA provided that a plan could extend rollover provisions previously limited to surviving spouses to nonspouse beneficiaries. There were questions as to whether Congress intended this to be a mandatory or optional provision.

The Act clarifies that the nonspouse beneficiary rollover provision is mandatory. This change, however, is not effective until plan years beginning after December 31, 2009.

Comment: Many qualified plans drafted by The Wagner Law Group have already adopted the nonspouse beneficiary rollover provisions. We will be working with plans that have not adopted this rollover provision to facilitate compliance for 2010.

b. *Changes for Eligible Automatic Contribution Arrangements*. The PPA created the concept of an eligible automatic contribution arrangement ("EACA") (see discussion in Section I.D. hereof). PPA required an EACA to designate a qualified default investment alternative ("QDIA").

The Act repeals the requirement that an EACA must invest contributions on behalf of a participant in a QDIA in the absence of an investment election by a participant. The Act also provides that permissive withdrawals (generally required within 90 days of entry into an EACA) are not to be included in determining the elective deferral limit under Code Section 402(g) ($16,500 for 2009) for a participant.

c. *No Gap Period Income on Distributions of Excess Deferrals*. PPA provided that gap period income is not required on distributions of excess contributions and excess aggregate contributions (i.e., actual deferral percentage ("ADP") and actual contribution percentage ("ACP") excesses). The "gap period" is that period from the end of taxable year to the distribution date. The Act applies the same rule against the payment of no gap period income to distributions of deferral amounts in excess of the Code Section 402(g) limit.

d. *Cash Balance Plan Vesting*. The law clarifies that PPA-provided minimum vesting schedule (100% after three years) for cash balance plans does not apply to participants who fail to complete an hour of service after the effective date of the minimum vesting requirement.

e. *Involuntary Pay-Out of Smaller Lump Sums Allowed from Defined Benefit Plans without Regard to Funding Status*. The Act specifically excludes from the lump sum distribution restriction benefit payments whose present value is $5,000 or less. This effectively permits defined benefit plans to continue to make involuntary distributions to participants despite being in a restricted status.

J. IRS Determination Letter Program for Tax-Qualified Retirement Plans

As discussed in our previous Newsletters, the IRS processes applications for determination letters using a staggered five-year system. A determination letter is the method by which a plan sponsor seeks the Internal Revenue Service's approval that the form of a plan complies with all legal requirements. Under this system, each individually designed retirement plan is assigned to one of five "cycles" (12-month periods starting on February 1 and ending the following January 31) based upon the last digit of the sponsor's federal employer identification number ("EIN"). These cycles are as follows:

EIN ends in:	*Cycle:*	*First day of cycle:*	*Last day of cycle:*
1 or 6	A	February 1, 2006	January 31, 2007
2 or 7	B	February 1, 2007	January 31, 2008
3 or 8	C	February 1, 2008	January 31, 2009
4 or 9	D	February 1, 2009	January 31, 2010
5 or 0	E	February 1, 2010	January 31, 2011

The cycles will begin again on February 1, 2011, when the second Cycle A opens.

The initial Cycle A, Cycle B, and Cycle C have closed, and we are currently in Cycle D. If your EIN ends in a 1, 2, 3, 6, 7, or 8, and you sponsor an individually-designed qualified retirement plan that was not submitted for a determination letter during the applicable period, please contact our office as soon as possible to discuss your options. If your EIN ends in a 4 or 9, your individually-designed qualified retirement plan will have to be submitted for a determination letter by January 31, 2010.

Because this firm, and more importantly the IRS, believes that having a current determination letter represents a best practice for all plan sponsors, we strongly recommend that we apply on behalf of our clients for updated determination letters during the appropriate cycle. The determination letter system anticipates that plans will file for a new determination letter only once every five years, but plans must still be amended from time to time as the law and regulations governing tax-qualified plans change.

II. EXECUTIVE COMPENATION

A. Stimulus Package Significantly Expands Executive Compensation Limits for Recipients of TARP Funds

The American Recovery and Reinvestment Act of 2009 (the "Stimulus Package Act") limits executive compensation for financial institutions receiving assistance under the Troubled Asset Relief Program ("TARP") enacted in the Emergency Economic Stabilization Act of 2008 ("EESA"). In particular, the Stimulus Package Act prohibits all severance payments for the top five executives, prohibits all incentive compensation other than restricted stock equal to a maximum of one-third of total compensation, expands the number of executives subject to these limitations, and imposes new corporate governance requirements on TARP recipients.

Among the new rules is a requirement that TARP-recipient shareholders be given an annual, non-binding "say on pay." All of these rules apply only during the time the TARP recipient has outstanding obligations to the federal government arising from its financial assistance (the "TARP Obligation Period").

1. Compensation Standards

The Stimulus Package Act requires the Secretary of the Treasury to establish standards to apply to TARP recipients during the TARP Obligation Period. The standards include compensation and corporate governance provisions, as well as the following limitations that apply to the five most highly paid senior executive officers ("SEOs") whose compensation is reported on the TARP recipient's proxy statement, and in some cases to a broader group of employees. The standards include the requirement that the TARP recipient have the following:

a. *Limits on Risk Exposure Incentives*. Limits on compensation arrangements that foster the taking of unnecessary and excessive risks that threaten the value of the TARP recipient.

b. *Bonus Clawback*. An arrangement to recover any bonus, retention award or incentive compensation based on earnings, revenues, gains or other criteria that are later found to be materially inaccurate. The clawback extends to any SEO and the next 20 most highly compensated employees.

c. *Prohibited Severance*. A prohibition on "golden parachute" payments, defined to include any payment to an SEO and the next five most highly compensated employees for departure from a company for any reason, except for payments for services performed or benefits accrued.

d. *Limit Incentive Compensation Except for Certain Restricted Stock*. A prohibition on paying certain executives any bonus, retention or incentive

compensation other than certain long-term restricted stock that meets the following criteria: (i) does not fully vest during the TARP Obligation Period, (ii) has a value not greater than one-third of the total annual compensation of the employee receiving the stock, and (iii) is subject to such other restrictions as the Secretary of the Treasury may determine are in the public interest. However, the scope of executives subject to these limitations on incentive compensation depends on the magnitude of the federal assistance received by the TARP recipient as indicated in the following table, and arrangements pursuant to a written employment agreement executed on or before February 11, 2009, are grandfathered from the limitation on incentive compensation:

TARP Financial Assistance	**Covered Executives**
< $25,000,000	Most highly compensated employee only
$25,000,000 to < $250,000,000	Five most highly compensated employees or higher public interest number
$250,000,000 to < $500,000,000	SEOs and 10 next most highly compensated employees or higher public interest number
$500,000,000 or more	SEOs and 20 next most highly compensated employees or higher public interest number

e. *Ban on Plans that Encourage Earnings Manipulation*. A prohibition on any compensation plan that would encourage manipulation of the reported earnings of a TARP recipient to enhance the compensation of any of its employees.

f. *Required Compensation Committee and Functions*. The Stimulus Package Act requires that TARP recipients have a compensation committee that satisfies the following: (i) is comprised entirely of independent directors (except that the functions can be performed by the board of directors as a whole for a TARP recipient who has received less than $25,000,000), and (ii) meets at least semiannually to discuss and evaluate employee compensation plans in light of any risks posed to the TARP recipient by such plans.

2. Limitation on TARP Recipient's Compensation Tax Deduction

The TARP recipient is subject to the provisions of Section 162(m)(5) of the Code, which limits the deduction for compensation paid to certain senior executives to $500,000.

3. Limits on Luxury Expenditures

The board of directors of each TARP recipient must have in place a company-wide policy regarding excessive or luxury expenditures, as identified by the Secretary of the Treasury, which may include entertainment or events, office and facility renovations, aviation or other transportation services, or other activities or events that "are not reasonable expenditures for staff development, reasonable performance incentives, or other similar measures conducted in the normal course of the business operation of the TARP recipient."

4. Shareholder Non-Binding "Say on Pay"

Each TARP recipient must provide its shareholders during the TARP Obligation Period with a non-binding vote on senior executive compensation annually. For a public company, this can be accomplished through a non-binding resolution voted as a separate shareholder vote to approve the compensation of executives as disclosed pursuant to the SEC rules, including the compensation discussion and analysis, compensation tables, and any related material.

5. Compliance Certifications

The Stimulus Package Act also includes provisions requiring a written certification by the TARP recipient's chief executive officer and chief financial officer of compliance with these requirements. For a public company, the certification is to be made to the SEC with its annual filings, and in the case of other TARP recipients, to the Secretary of the Treasury.

6. Treasury Review Excessive Bonuses Previously Paid

The Secretary of Treasury is also directed under the Stimulus Package Act to review all compensation paid to SEOs and the next 20 most highly compensated employees of each entity that was a TARP recipient before the date of enactment to determine whether any such payments were "inconsistent with the purposes" of the new rules or were "otherwise contrary to the public interest," and if so, is directed to negotiate for appropriate reimbursements to the federal government.

7. Retroactive Effect

The executive compensation limitations and governance provisions are intended to apply retroactively to all TARP recipients.

B. 409A Operational Failure Relief

1. Relief Limited to Operational Failure

The new corrections program provides a limited opportunity to correct certain failures that arise in the operation of a plan. The new corrections program does not cover failures by nonqualified deferred compensation plan documents to comply with Section 409A in form (i.e., a failure of the plan to meet the written plan document requirements specified in applicable

regulations). Such plan document failures may be eligible for relief under certain other limited circumstances, as discussed below:

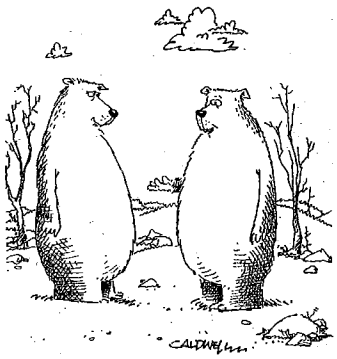
2. Failures Eligible for Correction

Only certain types of operational failures may be corrected under the new corrections program. They can be grouped into four categories:

- **Failures to defer, early payments, excess deferrals and below-market stock rights corrected in the same taxable year in which the failure occurs.**

  Generally, if the failure is caught and corrected in the same taxable year in which it occurs, there are no Section 409A penalties associated with the failure. The corrections program thereby creates a premium on catching an operational failure as quickly as possible.

- **Failures to defer, early payments, excess deferrals and below-market stock rights corrected in the taxable year immediately subsequent to the taxable year in which the failure occurs.**



"With the market such as it is, who has time to hibernate?"

  The new corrections program adds relief for certain failures that are corrected in the year after the failures occur. Like the first correction method, this correction method generally results in no Section 409A penalties. However, it is more onerous than the first method in certain respects (for example, it requires the participant to pay interest on any repayment that the participant is required to make to the plan sponsor of an amount that was not deferred or that was paid early). In addition, this correction is not available for amounts deferred by "insiders," as described below.

- **Failures to defer, early payments and excess deferrals that do not exceed a threshold amount.**

  A failure that is not corrected in the same year in which it occurs or in the immediately subsequent year may still be corrected by the end of the second taxable year following the year in which the failure occurred. However, the correction only limits the Section 409A penalties to the deferred compensation amount involved in the failure, instead of (like the first two corrections methods) eliminating the penalties completely. This correction method is also only applicable if the amount involved in the failure does not exceed a specified dollar amount tied to the limit on elective deferrals under tax-qualified plans ($16,500 for 2009).

- **Failures to defer, early payments and excess deferrals regardless of the amount.**

  Like the third correction method, this correction method only limits the Section 409A penalties to the deferred compensation amount involved in the failure, and does not eliminate the penalties completely. It is also more onerous in certain respects than the third correction method (for example, by requiring the participant to repay to the plan sponsor any amounts that were not deferred or were paid early).

The correction program offers a special transition rule for "non-insiders" for certain operational failures that occurred on or before December 31, 2007. Under this transition rule, 2009 will be treated as the taxable year immediately subsequent to the year of the failure for purposes of applying the above correction methods.

3. Correction Methods

The correction program specifies the methods by which corrections must occur in order to obtain relief from adverse tax consequences.

- **Failures to Defer/Early Payments**: In general, for failures involving early payments or failures to defer, the correction method requires the employee to repay to the plan sponsor the amounts that should have been deferred. If the employee is not an insider, the repayments can generally be made with interest over a period of 24-months. If the failure was a failure to comply with the six-month delay rule for specified employees, or involved an early payment of an amount otherwise payable in the same taxable year, the amount must be held by the plan sponsor before it can be paid back to the employee for a period equal to the number of days between the date of the early payment and the date the payment was otherwise scheduled to be made. Earnings adjustments are generally permissible, but may not be made in the case of a failure to comply with the six-month delay rule and certain other cases.

- **Excess Deferrals**: For failures involving excess deferrals, the correction method generally requires the plan sponsor to distribute the amount of the excess deferral. Earnings adjustments are generally required for insiders but are only permissible for non-insiders.

- **Below-Market Stock Rights**. Failures involving below-market stock rights can generally be corrected by increasing the exercise price of the stock so that it equals the fair market value of the underlying stock on the date of the grant. Stock rights that are exercised before the correction is made are not eligible for this correction method.

4. Other Requirements

All of the correction methods described above require the plan sponsor to provide disclosure to both the IRS and the affected employees regarding the failure. Generally, this disclosure is provided at the time the plan sponsor files its federal income tax return or information return for the year in which the failure occurs or in which it discovers the failure, whichever is applicable.

In addition, the correction methods are only available to the extent the plan sponsor takes reasonable steps to ensure the same or similar failures do not recur in the future. This requirement may substantially reduce a plan sponsor's ability to correct the same or similar operational failure more than once.

The correction methods for failure to defer or early payment are generally only available to the extent the failure does not occur during a taxable year of the plan sponsor in which the plan sponsor experiences a "substantial financial downturn." The downturn must indicate a "significant risk" that the plan sponsor would not have been able to pay the deferred amount at the time it was otherwise due. In light of the current economic situation, this requirement may pose a substantial hindrance to plan sponsors otherwise eligible to use the correction methods.

5. Insiders

Relief under the correction program is limited, and in some cases completely unavailable, for failures involving an "insider." For these purposes, an "insider" is generally any service provider that is a director or officer or is directly or indirectly the beneficial owner of more than 10% of any class of any equity security of the plan sponsor, regardless of whether any class of stock of the plan sponsor is publicly traded. These determinations are made based on the rules under Section 16 of the Securities Exchange Act of 1934. While public company plan sponsors should be able to readily identify such persons, other plan sponsors may have some difficulty making such determinations.

6. Plan Document Errors

Despite the inability to correct plan document errors under the correction program, recently proposed regulations on determining the tax consequenses of violating Section 409A provide limited relief for certain plan document errors where none of the deferred compensation amounts under the defective plan have vested. Such a plan may generally be amended to comply with Section 409A before the first taxable year in which any of the deferred compensation amounts vest, provided that, under the facts and circumstances, the plan sponsor does not have a "pattern or practice" of allowing impermissible changes in the time or form of payment with respect to such nonvested amounts.

III. WELFARE AND FRINGE BENEFITS

A. Commuters

1. Economic Recovery Act Increases Monthly Limit for Transit to Same Level as Parking

The Economic Recovery Act, Part VI – "Parity for Transportation Fringe Benefits" increases the monthly public transit allowance (originally at $120 per month) to the level of the monthly parking allowance, which is $230 per month. This means that starting March 1, 2009, the monthly limits for transit and parking will each be $230. Both the transit and parking benefits will be indexed annually.

2. New Benefits Available to Bicycle Commuters in 2009

The Energy Improvement and Extension Act of 2008, signed into law on October 3, 2008 (the "Act"), creates a new fringe benefit for bicycle commuters effective January 1, 2009.

Under the Code's "fringe benefit" rules, employers may reimburse employee commuters for "qualified transportation fringes." Employees may, within certain limits, exclude these reimbursements from gross income. Prior to the Act, the list of qualified transportation fringes consisted of transit passes, parking, and transportation in a commuter highway vehicle, in each case provided by an employer to an employee. The Act adds "qualified bicycle commuting reimbursements" to this list of qualified transportation fringes.

An employer may reimburse an employee for reasonable expenses incurred by the employee for the purchase of a bicycle and bicycle improvements, repairs, and storage. The Act does not define "reasonable expenses," nor is it clear whether "bicycle improvements" may include helmets or other gear.

The Act requires that the bicycle be regularly used for travel between the employee's residence and place of employment.

The reimbursement is limited to $20 per "qualified bicycle commuting month." A qualified bicycle commuting month is defined as any month during which such employee:

- regularly uses the bicycle for a substantial portion of the travel between the employee's residence and the place of employment; and

- does not receive any benefit for transit passes, parking, and transportation in a commuter highway vehicle.

Thus, seasonal bicycle commuters are only entitled to reimbursement for the months in which they are actually commuting by bicycle. As well, employees who receive benefits for

parking, transit passes, or commuter highway vehicles in a given month may not also receive a bicycle reimbursement for that month.

Unlike the other qualified transportation fringes, the $20 per month limit on the qualified bicycle commuting reimbursement will not be inflation-adjusted.

The Act does not allow for the benefit to be funded through employee salary deductions.

B. HIPAA Privacy Notice Reminder

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), large group health plans (i.e., plans with more than $5 million in annual receipts) are required to provide plan participants with a reminder of the availability of the privacy notice and information on how to obtain the notice by April 14, 2009. Large group health plans were initially required to provide a copy of the plan's privacy notice by April 14, 2003. Thereafter, the plan is required to provide a copy of the privacy notice (or a reminder about the privacy notice) to plan participants once every three years (e.g., April 14, 2006, April 14, 2009, etc.). The notice can be hand-delivered or sent via U.S. mail to the named insured or covered employee. The reminder notice can be sent via email only if: (i) the named insured or covered employee has agreed to receive the notice electronically; (ii) the agreement to receive the notice electronically has not been withdrawn; and (iii) a paper copy of the notice is provided if the plan knows that the email transmission has failed.

Comment: Plan sponsors who distribute the notice annually (e.g., with open enrollment materials) are already in compliance and do not need to take any additional actions.

C. New Special Enrollment Rules and Reporting Requirements

The Children's Health Insurance Program Reauthorization Act of 2009 (the "CHIP Act"), not only expanded CHIP to cover approximately 4 million more children, it also imposed several new enrollment and disclosure requirements on employer-provided group health plans by amending the Code, ERISA and the Public Health Service Act.

First, the CHIP Act added two new special enrollment rights, similar to those required under HIPAA. Under one new rule, if an employee or the employee's dependent has his Medicaid or CHIP coverage terminated, the employee may request coverage under the employer's group health plan within 60 days after the other coverage has been terminated. (Note that while the HIPAA special enrollment rules for events, such as marriage, birth of a child or loss of other group health plan coverage, only provide a 30-day window to request employer-provided coverage, this new rule allows 60 days.)

Next, the CHIP Act provides that if an employee or dependent becomes eligible for Medicaid or CHIP, the state where they live may decide to subsidize employee contributions to an employer-provided group health plan, rather than having the employee or dependent participate in a state-sponsored plan. The state may pay the "premium assistance subsidy" to either the employee or the employer. However, the employer has the right to elect out of direct payments and therefore require the employee to pay employee contributions and be reimbursed by the state.

Under the second special enrollment right, if an employee or the employee's dependent becomes eligible for these contribution subsidies, the employee will have a 60-day period from the time he becomes eligible for the subsidies to request coverage under the employer's plan.

> **Comment**: These new special enrollment rules became effective April 1, 2009. Employers should amend their plan documents to incorporate these new special enrollment requirements by the end of the current plan year.

The CHIP Act also requires that employers notify employees of the potential opportunity for contribution assistance subsidies from Medicaid or CHIP, in those states that decide to provide such assistance. The Department of Health and Human Services is charged with developing "national and state-specific" model notices by February 4, 2010 and this notice requirement will not be effective until Health and Human Services ("HHS") issues the model notices.

Finally, employers sponsoring group health plans will be required to report to the states on the benefits provided under their plans, so that the state can determine if it makes economic sense to provide subsidies to affected employees and dependents, rather than enrolling these individuals in a state-sponsored program. HHS and the DOL are to develop a model form for

this purpose. Employers will not be responsible for filing this form with the states until the first plan year that begins after the agencies issue the model form.

D. American Recovery and Reinvestment Act Creates COBRA Subsidies and Changes HIPAA Privacy Rules

1. COBRA

The American Recovery and Reinvestment Act of 2009 ("ARRA") created a federal subsidy for COBRA premiums for employees who are involuntarily terminated between September 1, 2008 and December 31, 2009 and gives certain affected individuals a second COBRA election period. Under ARRA, employers will be required to notify affected employees of the new subsidy and their right to a second COBRA election.

Comment: Employers should immediately take steps to comply with the new COBRA requirement, it they have not already done so.

Generally, the subsidy will pay 65% of a qualified beneficiary's COBRA premium for an Assistance Eligible Individual ("AEI"). The subsidy can last for a maximum of nine months or, if less, until the qualified beneficiary is eligible for other group health plan coverage. It applies to premiums for affected employees, as well as their spouses and dependents. The subsidy is effective for periods of coverage beginning on or after February 17, 2009, the date ARRA was enacted. If individuals pay the full premium for months in which they are eligible for the subsidy, they may receive a refund of their overpayments from the employer or the overpayments may be applied as a credit against future payments.

The subsidy begins to be phased out for individuals whose adjusted gross income is $125,000 per year ($250,000 for joint returns) and is not available to individuals whose adjusted gross income exceeds $145,000 ($290,000 for joint returns). When taxpayers whose incomes exceed these amounts receive a subsidy, they will be required to return the excess subsidy payments when completing their income tax returns for the year.

Qualified beneficiaries must receive a notice describing the availability of the premium subsidy from the employer and, if not already enrolled in COBRA, information regarding the availability of a second enrollment period. The new COBRA enrollment period began on February 17, 2009, and ends 60 days after the former employee is notified of his new rights.

Under the subsidy, qualified COBRA beneficiaries need only pay the employer 35% of the total COBRA premiums. Employers will pay the remaining 65% of the COBRA premium but will recoup that amount from the federal government by claiming a credit against their federal payroll taxes (including income tax withholding) or, if necessary, through a direct payment from the government.

The DOL has issued a series of model notices to enable employers to comply with the new notice requirements for COBRA subsidies and second elections. The notices include:

- General Notice (full version). This notice is to be sent to all qualified beneficiaries, not just covered employees, who experienced a qualifying event at any time from September 1, 2008 through December 31, 2009, regardless of the type of qualifying event, and who either have not yet been provided an election notice or who were provided an election notice on or after February 17, 2009 that did not include the additional information required by ARRA.

- General Notice (abbreviated version). This version is to be sent to COBRA qualified beneficiaries who: have not received the revised full version of the General Notice; have a qualifying event on or after September 1, 2008; and are currently enrolled in COBRA. It allows them to apply for the premium subsidy if they are AEIs.

- Notice in Connection with Extended Election Periods. A notice and election form for qualified beneficiaries who have a qualifying event at any time from September 1, 2008 through February 17, 2009 and are eligible for the COBRA subsidy, but who are not currently enrolled in COBRA (including individuals who elected COBRA but later discontinued coverage). This notice includes information on ARRA's second COBRA election period, as well as the COBRA subsidy.

- Alternative Notice. This notice is for insurers who must send a notice to individuals who became eligible for continuation coverage under a state law. The insurer will have to modify this notice to conform to individual state laws.

The IRS has issued Notice 2009-27 to provide guidance on the rules for COBRA subsidies under ARRA. The significant aspects of the guidance include the following:

- Involuntary Termination

  The IRS defines an involuntary termination as "a severance from employment due to the independent exercise...of the employer." The term includes the failure to renew an employment contract as well as an employee's decision to terminate employment "due to an employer action that causes a material negative change in the employment relationship for the employee."

  The death of the employee, an absence due to illness (without a formal termination of employment by the employer), a strike or a reduction in hours (except a reduction to zero) are not, by themselves, involuntary terminations. However, a lay-off or other complete suspension of employment is an involuntary termination. Also, a material change in geographic location of employment can be an involuntary termination.

A termination of employment under a "voluntary" severance program is an involuntary termination if the employer indicates that after the offer period for the severance program, a certain number of remaining employees in the employee's group will be terminated.

- Assistance Eligible Individual

  The Notice clarifies that in order to be an AEI and, therefore, eligible for the COBRA subsidy, both the involuntary termination and the initial eligibility for COBRA must have occurred during the period of September 1, 2008 through December 31, 2009.

  For example, if an employee is involuntarily terminated in November 2009 but his employer continues his health care coverage through January of 2010, without declaring this to be COBRA continuation, the individual would not be eligible for the COBRA subsidy because he would not have been eligible for COBRA by December 31, 2009. Similarly, if an individual was terminated and lost coverage on August 15, 2008 and elected COBRA on September 15, 2008, he would also not be eligible for the subsidy because his COBRA eligibility began before September 1, 2008.

  The covered spouse and dependents of an employee who lost coverage because the employee is involuntarily terminated are AEIs. However, they will not be AEIs if they first received COBRA because of any other qualifying event. For example, if a spouse became eligible for COBRA because he divorced the employee and the employee is later involuntarily terminated, the spouse would not be eligible for the subsidy.

  Also, a spouse or dependent who was not covered by the employer's group health plan on the day before the qualifying event would not be an AEI, even if this individual is later added to the terminated employee's COBRA coverage during a subsequent open enrollment period.

- Calculation of COBRA Subsidy

  The IRS states that the premium used to calculate the amount of the subsidy is the cost that would have been charged to the individual if he were not an AEI. Thus, if the employer reduces terminated employees' required continuation payments under a severance benefit plan, this reduced amount is used to determine the 65% subsidy and the AEI's required 35% payment.

  For example, if the normal COBRA premium is $1,000 per month and, under a severance benefit plan, terminated employees can have COBRA coverage at a cost of $200 per month for the first six months, the AEI will have to pay $70 per

month (35% x $200) for the first six months of the subsidy period and will then have to pay $350 (35% x $1,000) for the three remaining months of the nine-month subsidy period.

Comment: Any employer considering a reduction in force should take this subsidy into consideration when designing a severance package.

- Second Election Period

The Notice clarifies that each AEI has a separate right to a second election. Thus, if an employee is terminated and elects COBRA while his covered spouse does not, the spouse will still be eligible for a second election.

- Recovery of Subsidy

The IRS has revised Form 941 "Employer's Quarterly Federal Tax Return" to enable employers to recover COBRA subsidies made under ARRA.

The Form requires the employer to report, in Items 12a and 12b, the total amount of the subsidy it paid and the number of individuals for whom the employer provided COBRA subsidies. However, the IRS says the employer must "maintain supporting documentation for the credit claimed" including: (i) information on the receipt, including dates and amounts, of the qualified beneficiary's share of the COBRA premium; (ii) a copy of an invoice or statement from the insurer of premium payments or, for self funded plans, proof of coverage; (iii) attestation of the date of involuntary termination and proof of the qualified beneficiary's eligibility for COBRA: and (iv) a record of the qualified beneficiary's Social Security number, the amount of the subsidy and whether the subsidy was for one individual or two or more individuals.

However, the Notice provides that in the case of an insured plan subject solely to state continuation law (e.g., a plan of an employer with fewer than 20 employees), the insurer is the only entity entitled to be reimbursed for the subsidy through the payroll credit.

2. HIPAA Privacy

In addition to the COBRA rules, ARRA has made significant changes to the HIPAA privacy and security rules for covered entities and business associates. The more important of these changes are described below:

- Security Rules

  The Security Rules require administrative, physical and technical safeguards for protected health information ("PHI"), as well as training requirements to protect electronic systems and data from unauthorized access. These safeguards previously applied only to covered entities (e.g., group health plans and insurers) but will now apply directly to business associates for the first time. A business associate will need to (i) appoint a security officer, (ii) adopt written polices and procedures, and (iii) train its workforce on how to protect electronic protected health information ("ePHI"). Business associates will need to comply with both the physical and technical safeguards related to ePHI.

  Comment: Entities conducting business in Massachusetts may be able to coordinate with a new requirement effective January 1, 2010 requiring the development and implementation of a security system to protect personal information (e.g., names and social security numbers).

  In the event of a breach due to unsecured PHI, the covered entity or business associate agreement must notify each individual affected by the breach. ARRA specifies who must be notified of the breach and the information they must receive. There is an exception for unintentional breaches.

  Under ARRA, the Department of Health and Human Services ("HHS") must provide annual guidance on the most effective and appropriate technical safeguards for protecting electronic health information.

  In its technical guidance, HHS has said that a breach occurs when there is an unauthorized acquisition, access, use or disclosure of PHI which compromises the security or privacy of such information. However an inadvertent disclosure by an otherwise authorized person is not a breach if the PHI "is not further acquired, accessed, used or disclosed."

  HHS goes on to say that PHI can be secured, and therefore exempted from the notice of breach requirement, by rendering it "unusable, unreadable or indecipherable to unauthorized individuals." For electronic records, this can be done by having the PHI encrypted "by the use of an algorithmic process to transform data into a form in which there is a low probability of assigning

meaning without use of a confidential process or key." The guidance then lists encryption processes that meet this standard.

Comment: These new security rules will require covered entities to modify their business associate agreements. Covered entities should review their list of business associates so that current agreements can be updated. Covered entities should also review their current forms and policy and procedures manuals as they will also need to be updated to comply with the new security rules.

- Privacy Rules.

The Privacy Rules will also apply directly to business associates for the first time, including the requirement to have and follow a business associate agreement. Previously, it was the covered entity's responsibility to identify all business associates and have a valid business associate agreement in place (e.g., a business associate did not need to determine if it was a business associate).

Also, under the current rules, an individual may request that certain protected health information not be used by the covered entity or business associate. The covered entity may decline such requests. ARRA provides that a covered entity must comply with the restriction unless certain exceptions apply (i.e., if the disclosure is to a health plan for purposes of carrying out payment or health care operations (not treatment) and the PHI relates solely to a health care item or service for which the health care provider has been paid in full).

Previously, a covered entity did not have to account for disclosures of PHI if they were used for treatment, payment or health care operations. Under ARRA, this rule has been reversed so that records of these disclosures will have to be kept.

Comment: These new privacy rules will require covered entities to modify their current forms and policy and procedures manuals.

- Civil Monetary Penalties

The penalties for HIPAA violations have been increased, effective immediately to:

-- $1,000 per violation if the violation is due to reasonable cause and not willful neglect up to a maximum of $100,000;
-- $10,000 per violation if the violation is due to willful neglect and is corrected up to a maximum of $250,000; and
-- $50,000 per violation if the violation is not corrected properly up to a maximum of $1,500,000 during a calendar year.

Furthermore, state attorneys general can now bring a HIPAA enforcement action against a covered entity or business associate that violates the HIPAA privacy rules. The state attorneys general can also obtain attorney's fees.

During the next three years, HHS must issue regulations providing that individuals affected by a HIPAA violation may receive a percentage of any civil monetary penalty or monetary settlement.

Comment: This change may encourage individuals to file complaints with HHS.

- HHS Audits

HHS, which is responsible for enforcing the HIPAA privacy and security rules, is now required to conduct periodic audits of covered entities and business associates. HHS now has received the funding to conduct these audits.

Comment: Covered entities and business associates can expect to see increased audits and enforcement actions. Covered entities should review their current practices for compliance with the HIPAA privacy and security rules.

- Effective Dates

Effective dates for the provisions described above vary. Most of the security provisions are effective later this year (30 days after HHS issues regulations). Most of the privacy rules take effect in one year. However, the earliest date for the disclosure recordkeeping requirement will be January 1, 2011.

Employers should start reviewing current forms, policy and procedure manuals, and training programs to ensure they are compliant with these new rules and update accordingly.

E. Mass Health Care Reform Act

1. Some Employers Must Make Quarterly Filings to Division of Unemployment Assistance

For 2009, the Massachusetts Division of Unemployment Assistance ("DUA") and the Massachusetts Division of Health Care Finance and Policy ("HCFP") have changed the way employers must file information about the Fair Share Contribution ("FSC") Test and the Employer Health Insurance Responsibility Disclosure ("HIRD") under the Massachusetts Health Care Reform Act (the "Act").

Previously, the information for the FSC Test and the Employer HIRD were reported together, once a year, to the DUA website. However, last year, the law was changed, effective October 1, 2008, to create a quarterly reporting schedule for the FSC and for the Employer HIRD.

The quarterly reporting schedule is as follows:

- 10/1/08 to 12/31/08: Report due 2/15/09
- 1/1/09 to 3/31/09: Report due 5/15/09
- 4/1/09 to 6/30/09: Report due 8/15/09
- 7/1/09 to 9/30/09: Report due 11/15/09

All covered employers were required to make the initial quarterly filing. However, subsequent quarterly filings are only required if the employer is liable or "at risk of becoming liable" for FSC penalties.

The 2/15/09 report required FSC Test information but not Employer HIRD information. For subsequent quarters, the FSC information will continue to be reported electronically to DUA and, after employers complete this information, they will be directed to the HCFP's website where the employers will report the Employer HIRD information.

2. Creditable Coverage Definition

The Commonwealth Health Insurance Connector Authority (the "Connector") has issued the final regulations defining the term "creditable coverage."

Under the Act, almost all Massachusetts residents must have health care coverage that meets the definition of "creditable coverage," either acquired through their employer or purchased on their own. Those who do not have this coverage are subject to state income tax penalties.

The maximum penalty in 2009 for failure to have "creditable" insurance coverage will be $89 per month ($1,068 for the entire year).

The penalty is based on one half of the lowest cost plan available through the Connector. However, the Massachusetts Department of Revenue adjusts the penalty based on age and income. For example, individuals who are age 26 or less will have a maximum penalty of $52 per month ($624 per year) and those who earn less than 150% of the federal poverty level ($15,612 for an individual) will not be subject to any penalty.

Although the creditable coverage regulations are directed at individuals and not employers (and, therefore, do not affect the FSC Test that employers must pass to avoid the assessment of penalties), if an employer's group health care plan fails to comply with the creditable coverage regulations, its employees would be obligated to purchase their own

insurance in order to meet the Act's health insurance coverage requirements. Therefore, employers are under pressure to comply with these regulations.

Under the final regulations, until the end of 2008, creditable coverage included any health insurance policy issued by an insurer licensed in Massachusetts and any self funded health plan that met the definition of a welfare benefit plan under ERISA. However, beginning in 2009, to meet the creditable coverage requirements, individuals must have health insurance covering "a broad range of medical benefits" that includes "core services," (physician services, in-patient acute care services, day surgery and diagnostic procedures and tests) plus preventive care, emergency services, hospitalization, ambulatory patient services, mental health and substance abuse services, and prescription drug coverage. Beginning January 1, 2010, coverage must also include medical/surgical care, diagnostic imaging and screening, maternity and newborn care and radiation therapy and chemotherapy.

To meet the requirements for creditable coverage, a plan may impose different levels of coverage for in-network and out-of-network providers if it discloses the deductibles, copays and coinsurance amounts. However, for individuals, the maximum deductible for in-network covered services cannot exceed $2,000 and the annual limit on out-of-pocket spending cannot exceed $5,000. These numbers are doubled for family coverage.

In addition, prescription drug coverage may have a separate deductible with a maximum of $250 for individuals and $500 for families.

The plan cannot have an overall annual maximum benefit limit that applies to all covered services collectively. It also cannot have an annual maximum for "core services." However, the plan may have maximum benefit limitations for non-core services such as inpatient rehabilitative care or physical therapy. In addition, a plan may not limit its contractual commitment for core services to an indemnity schedule of benefits.

The plan must provide at least three preventive care visits for an individual and six preventive care visits for a family before imposing an in-network deductible. (Preventive care services are defined to include routine physical exams, well baby care, medically necessary immunizations, and routine GYN exams.) Alternatively, the plan may cover preventive care in accordance with "nationally recognized preventive care guidelines."

For 2009 only, creditable coverage will also include any employer-sponsored plan that meets the requirements of a high deductible health plan ("HDHP") as defined under the federal law for health savings accounts ("HSAs"). In 2010, the HDHP must meet certain additional criteria, including: the requirement for "a broad range of medical benefits;" the prohibition on an annual maximum payment for core benefits; and the rules for preventive care services.

In a "safe harbor" rule, the regulations provide that if a plan "does not meet every element" of the creditable coverage requirement, it may still be considered to be creditable coverage if the Connector determines that it has a broad range of coverage (including core

services), and has an actuarial value at least equal to the Bronze-level plan offered by the Connector under the Commonwealth Choice program.

The regulations will generally apply to collectively bargained plans one year after the expiration of the current collective bargaining agreement.

Comment: The Connector has attempted to respond to employers' comments on the proposed regulations by making certain provisions effective in 2010 and by creating the actuarial safe harbor. However, the January 1, 2009 effective date may still create difficulties for many employers and their participants.

Creditable Coverage Certification

The Connector also issued an Administrative Bulletin containing guidance on how group health plans can receive a Minimum Creditable Coverage ("MCC") Certification under the safe harbor rule.

The Connector has clarified the elements of this safe harbor and has issued procedures that employers, carriers and plan sponsors may use to have the Connector determine if their plans meet this safe harbor.

First, the Connector clarified that the coverage may only "deviate modestly" from the creditable coverage standards. A plan must still provide for all core services and must still provide coverage for all of the items listed in the "broad range of medical benefits."

According to the Administrative Bulletin, some examples of deviations for which a plan may seek MCC Certification are:

- coverage of preventive care services which deviates from the pre-deductible or nationally recognized standards of the regulations;
- deductible amounts which exceed the limits in the regulations or which are applied in a different manner than contemplated in the regulations; and
- out-of-pocket maximums which exceed the limits in the regulations or which are applied in a different manner than contemplated in the regulations.

The Connector also stated that most plans will not need certification by the Connector because "carriers are required to disclose the creditable coverage status of their fully insured health benefit plans sold in the Commonwealth of Massachusetts." In addition, if an employer or plan sponsor determines that its plan meets the creditable coverage standards set forth in the regulations, there is no requirement to seek any form of approval or certification from the Connector.

The Connector has issued a draft of an MCC Certification Application Form for those who wish to apply under the safe harbor. A completed application will include the plan's schedule of benefits, and identify the plan's deviations from the creditable coverage standards. Applicants will be required to say if they believe their health plan meets the actuarial equivalent of a Bronze-level Commonwealth Choice plan but will not be required to provide an actuarial attestation unless specifically requested to do so by the Connector.

F. Coverage of Former Spouse Not Subject to Imputed Income

The Massachusetts Department of Revenue has issued a directive which exempts the value of a former spouse's health care coverage from state income tax.

Under federal income tax law, the value of health care coverage to an individual who is not a dependent of the employee will be taxed to the extent that the employer's plan subsidizes this coverage. The amount of the subsidy is imputed income to the employee for federal income tax purposes and must be reported on the employee's W-2 Form.

However, Massachusetts law says that the state will not apply these imputed income tax rules in instances where the group health coverage of a non-dependent is mandated by law.

Massachusetts health care continuation law provides that a former spouse has the right to continue coverage under the employee's group health care plan. The spouse can remain covered until the employee remarries or until the time provided in the divorce decree.

Therefore, the directive says that since continuation coverage for a former spouse is coverage mandated by law, the value of the employer-provided coverage is excluded from state (but not federal) income tax.

G. New Law Requires Continued Medical Coverage for Students on a Medical Leave of Absence

President Bush signed into law "Michelle's Law" on October 9, 2008. This new law ensures continuity of medical coverage under parents' plans for college students who take a medically necessary leave of absence from college.

1. Background

Michelle's Law was prompted by the case of Michelle Morse, a full-time college student who was diagnosed with colon cancer in 2003. Michelle was told that she would lose her medical coverage under her parents' health insurance plan if she reduced her course load while undergoing chemotherapy treatment, because she would no longer qualify as a dependent child under the plan. Michelle was forced to remain in school as a full-time student while undergoing 14 rounds of chemotherapy. In 2005, Michelle lost her battle with cancer.

2. Summary of Michelle's Law

Michelle's Law prohibits a group health plan, or a health insurance issuer that provides health insurance coverage in connection with a group health plan, from terminating coverage of a dependent child due to a qualifying "medically necessary leave of absence" from, or other change in enrollment at, a postsecondary educational institution prior to the earlier of:

- the date that is one year after the first day of the medically necessary leave of absence; or
- the date on which such coverage would otherwise terminate under the terms of the plan.

In order to be a "medically necessary leave of absence," the student's leave must:

- commence while the dependent child is suffering from a serious illness or injury;
- be medically necessary; and
- cause the dependent child to lose student status for purposes of coverage under the terms of the parents' plan or coverage.

A child is a "dependent child" under the law if he or she:

- is a dependent child, under the terms of the plan or coverage, of a participant or beneficiary under the plan or coverage; and
- was enrolled in the plan or coverage, on the basis of being a student at a postsecondary educational institution, immediately before the first day of the medically necessary leave of absence.

3. Additional Features

A treating physician of the dependent child must certify that the dependent child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) described is medically necessary.

A plan or issuer must include a description of the Michelle's Law requirements as part of any notice regarding a requirement for certification of student status for coverage under the plan.

The dependent child must be entitled to the same benefits under the group health plan as if he or she had continued as an active student. If the dependent child's coverage changes (e.g., due to a change in health insurance coverage or health insurance issuer) the law shall apply to changed coverage in the same manner as it would have applied to the previous coverage.

Comment: Regulations should be forthcoming defining medically necessary. Also, such regulations should address the relationship to the dependent's medical leave and COBRA.

4. Effective Date

These amendments are effective with respect to plan years beginning on or after October 9, 2009, and to medically necessary leaves of absence beginning during such plan years.

IV. EMPLOYMENT LAW MATTERS

A. Obama Signs Ledbetter Act

On January 29, 2009, President Obama signed into law the Lilly Ledbetter Fair Pay Act of 2009. The Ledbetter Act is a Congressional response to a 2007 Supreme Court decision, *Ledbetter v. Goodyear Tire & Rubber Co.,* which significantly limited the ability of plaintiffs to recover back pay in certain circumstances. Ledbetter arose when, after 19 years of employment with Goodyear Tire & Rubber, Ms. Ledbetter learned that she had been earning substantially less than her male counterparts. She sued, asserting a disparate pay claim under Title VII of the Civil Rights Act of 1964. The Supreme Court held that the statute-of-limitations period began to run on the day compensation is first set, not on the day of the most recent paycheck as the plaintiff had argued. As a result, the Supreme Court found that the 180-day statute of limitations applicable to Tile VII claims barred Ms. Ledbetter's claim in full.

The Ledbetter Act overturns the Supreme Court's decision. Specifically, the Ledbetter Act amends Title VII and the Age Discrimination in Employment Act and modifies the application of the Americans with Disabilities Act and the Rehabilitation Act, to the effect that each time "wages, benefits or other compensation" are paid, the statute of limitations starts anew. Although the Ledbetter Act, by its terms, applies only to the specifically enumerated federal laws, the standards developed through case law as a result of the Ledbetter Act will likely apply to other laws as well.

Comment: The Ledbetter Act will increase the likelihood that employers will be sued for pay discrimination because even pay practices and pay scales established long ago will now be subject to attack on discrimination grounds. Employers may find these claims difficult to defend, given that decision makers may have left and relevant documents may have been discarded. The Ledbetter Act will likely lead to more lawsuits and greater potential liability. Employers should stay tuned to developments and should work with counsel to understand the impact of these new laws on wage-related obligations.

"I'm sorry, but Mr. Philbrick has stepped away from his desk. Would you like me to twitter him?"

B. California Supreme Court Upholds Ban on Same-Sex Marriage, but Recognizes Marriages Performed in 2008

On May 26, 2009, the California Supreme Court upheld Proposition 8, the November 2008 ballot measure that amended the California state constitution to define marriage as a union between a man and a woman. Notably, the court unanimously ruled that the more than 18,000 same-sex marriages performed in California during the interval when same-sex marriage was legal in California will continue to be valid and recognized under state law. In 2008, the California Supreme Court ruled that state laws limited marriage to opposite-sex couples violated same-sex couples' right to equal protection of the laws as guaranteed by the state constitution prior to the Proposition 8 amendment.

1. The Court's Analysis of Proposition 8

The California Supreme Court had to analyze whether Proposition 8 was a "revision" to the state constitution, which requires approval by at least two-thirds of both houses of the state legislature before going to voters, or an "amendment," which can proceed directly to voters without prior legislative approval. The court determined that Proposition 8 is not a revision to the constitution because it does not alter the nature of the government plan or framework set forth in the state constitution.

2. Proposition 8's Impact on Prior Same-Sex Marriages

In deciding to recognize the same-sex marriages performed prior to the passage of Proposition 8, the Court determined that there was insufficient evidence that voters intended for Proposition 8 to have a retroactive effect. The Court examined the materials provided in the ballot pamphlet mailed to voters in advance of the election and the ballot itself, and determined that the language was "insufficient to demonstrate, clearly and unambiguously, that the voters must have intended a retroactive application." According to the Court, same-sex couples who entered into marriages prior to the passage of Proposition 8 did so in reliance on the law as it existed at that time, and to retroactively invalidate their marriages would deprive these couples of vested rights without the due process of law. Therefore, same-sex couples who married in California prior to November 4, 2008, will continue to be legally married and will continue to be entitled to all the rights, benefits and protections that California law affords to legally married spouses.

3. Implications for Employee Benefit Plans

The immediate impact of the Court's ruling is that approximately 18,000 same-sex marriages have been ruled valid (unlike the same-sex marriages performed in San Francisco in 2004). As a result, employers will need to review their employee benefit plans to determine whether changes are necessary or desirable in light of the fact that spousal benefits may be provided indefinitely to a limited number of same-sex couples. For instance, employers may need to revise eligibility descriptions in summary plan descriptions ("SPDs") and enrollment forms to address the types of same-sex marriages eligible for spousal benefits. In addition,

employers will have to be careful and specific in defining the term "spouse" in their benefit plan documents and SPDs.

More broadly, the California Insurance Equality Act already requires insurance plans to offer spousal equivalent benefits to registered domestic partners in California. Because this act remains intact after Proposition 8, same-sex partners will continue to receive protection and coverage under insurance plans in the state, so long as they register their domestic partnership under California law. However, it is important to note that the California Insurance Equality Act does not apply to self-funded plans, plans that are insured using insurance contracts issued outside of the State of California or other types of employee benefit programs (such as qualified and nonqualified retirement plans).

Comment: Employers should review their benefit plans and programs in light of the California developments to ensure that their plans are properly drafted to reflect the intended coverage or exclusion of same-sex partners and compliance with applicable laws.

C. Same-Sex Marriage In Other States

The Iowa Supreme Court has ruled that a state law banning same-sex marriage violates the state constitution's equal protection clause. As happened in California, Iowa could vote to amend its constitution to reinstate the prohibition. However, the process for amending the constitution is far more complicated in Iowa and would take several years.

The Vermont legislature overrode a veto by Governor Jim Douglas to legalize same-sex marriage in that state as well. Vermont therefore became the first state to voluntarily introduce same sex marriage.

Maine and New Hampshire followed shortly thereafter with their own legislation legalizing same sex marriage.

Massachusetts and Connecticut, the only other two states to permit same-sex marriages, were required to do so under court rulings similar to the one in Iowa.

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