Benefits and Employment Briefing

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HEALTH CARE REFORM: SO WHERE ARE WE NOW?

It's been nearly a year since the passage of the two bills known as "health care reform." Although significant elements of this reform are already in effect, both the 2010 general elections and vigorous legal challenges have caused some to wonder whether the "meat" of the reform – slated for 2014 – will ever be implemented. Unfortunately, this question may not be answered for many months, or even years.

Legislative Repeal Efforts

Having reclaimed the House of Representatives in last November's elections, the Republican Party is generally intent on repealing all of health care reform. Although the Democratic majority in the Senate (not to mention President Obama's veto power) makes that highly unlikely, we can expect to see a number of other legislative efforts to limit or modify the legislation as enacted last spring.

Both parties have already agreed to repeal one aspect of that legislation. This is the requirement that all businesses file a Form 1099 with the IRS for any vendor to whom they paid more than $600 during a year. Although not directly related to health care reform, this provision was included in the law as a way of recovering nearly $20 billion of the costs associated with reform. In response to fierce resistance from the business community, both houses of Congress have already passed separate bills repealing this requirement, and the President is expected to sign any agreed-upon language.

Republican legislators have also promised to limit the scope of health care reform by starving the administrative agencies of the funding they would need to implement its provisions. Whether that effort will be successful is yet to be seen. It could lead to another government shutdown, of the type last seen when the Republicans took control of Congress during the Clinton Administration. In any event, certain aspects of health care reform (such as the early retiree reinsurance program and the statewide pools for the long-term uninsured) had their own multi-year appropriations hardwired into the reform legislation.

In addition to their policy of opposing the version of health care reform as enacted by the Democratically-controlled Congress, the House of Representatives has now directed its committees to report replacement legislation designed to achieve twelve specific goals. These Republican goals are listed in House Resolution 9. One of these twelve goals – prohibiting taxpayer funding of abortions – has already become a flashpoint of controversy.

Legal Challenges to Reform Legislation

At the same time that Republicans in Congress have been mounting *legislative* challenges to health care reform, some 28 states have launched challenges in *court*.

Most of these lawsuits have been dismissed on the ground that the parties bringing them (typically, state attorneys general) did not have "standing" to challenge those aspects of health care reform that do not take effect until 2014. These include the law's "individual mandate," which would require that all legal residents either have health insurance or pay a tax penalty for failing to do so (subject to certain religious and income-based exemptions).

As of today, however, four federal trial courts have reached the merits of these legal challenges. Two have upheld the law, but two have invalidated the individual mandate. One of these latter decisions went on to invalidate the entire statutory structure, on the ground that there is no basis for separating the invalid provision from the remainder of the law.

None of these trial courts has specifically enjoined the federal agencies from continuing to implement or administer the law. Moreover, it is clear that the question of the law's constitutionality will have to be decided at the appellate level – most likely by the U.S. Supreme Court. The timing of any appellate decision is unclear. Both the Fourth and Sixth U.S. Courts of Appeal have granted expedited review of lower court decisions, however, with oral arguments scheduled for May or June.

The Virginia Attorney General has even asked for direct review by the Supreme Court. Such direct review is extremely rare. Typically, the Supreme Court prefers to allow the intermediate courts of appeal to address legal issues first. If those appellate courts all agree, the Supreme Court may never need to address the question. At a minimum, appellate court opinions often help to focus the areas of legal inquiry. Given the large number of states challenging this law, however, it is conceivable that the Supreme Court will agree to decide the question of its constitutionality without waiting for the appellate courts to issue their rulings.

Once the issue does reach the Supreme Court, the composition of the Court will be significant. Although the Court currently has a working conservative majority, legal commentators have noted that even certain of the conservative jurists have shown a willingness to approve of fairly expansive federal powers. It is therefore quite possible that even a conservative Court would uphold the individual mandate and other controversial aspects of the reform legislation.

Recent Administrative Actions

In the meantime, the Obama Administration has continued to issue regulations and other guidance designed to implement the law. This all started with a surprisingly prolific regulatory summer. By the fall, the focus had shifted to less formal guidance (such as FAQs), often intended to ease compliance for insurers and employers. For instance, this guidance has included the following:

- A deferral (until further guidance is issued) of the nondiscrimination rules for insured health plans.
- Interim procedures by which a self-funded plan may comply with the requirement that non-grandfathered plans implement an external review process.
- A six-month deferral of certain other aspects of the new claims and appeals procedures.
- A six-month deferral (until June 30, 2011) of the time to amend Section 125 cafeteria plans to reflect the post-2010 prohibition on reimbursements for over-the-counter medicines or drugs unless the participant has a prescription (or the drug is insulin).
- A reversal of the original position concerning the effect on a plan's grandfathered status of changing insurance policies (allowing such changes, but only after November 15, 2010).
- Granting hundreds of waivers of the law's prohibition on placing low annual limits on "essential health benefits."
- Clarifying that neither the "automatic enrollment" nor the 60-day advance notice requirement of the law will be implemented until further guidance has been issued.
- Clarifying that certain age-based coverage distinctions may favor younger individuals over older individuals – so long as those distinctions apply to all covered individuals, and do not single out older *dependents*.
- Clarifying the permissibility of "value-based preventive care limitations," despite the requirement that non-grandfathered plans provide first-dollar coverage for preventive care services.
- Making the W-2 reporting of the value of health care coverage *optional* for 2011.

At the same time, the agencies have made clear that they will vigorously exercise their authority to review annual premium increases, particularly for increases exceeding 10%. They have also issued guidance to the states concerning procedures to be following when implementing the state-wide "exchanges" that are to become effective as of January 1, 2014.

At this point, it would likely take either a Supreme Court decision or a 2012 Republican sweep of both Congress and the White House to halt the 2014 implementation of health care reform. Employers and their advisors would therefore be well-advised to continue planning for that implementation.

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IRS CHANGES COURSE ON BREAST PUMPS

Responding to a November 23, 2010, request from several members of Congress, the Internal Revenue Service has reversed its position on an issue of interest to nursing mothers and their employers. In Announcement 2011-14, the IRS has concluded that breast pumps and supplies that assist lactation constitute "medical care" under Section 213(d) of the Tax Code. Accordingly, expenses for such pumps and supplies may be deducted by individual taxpayers (subject to the 7.5% adjusted gross income threshold), and they may be reimbursed on a tax-free basis from flexible spending accounts, health savings accounts, health reimbursement accounts, and Archer medical savings accounts.

The IRS reasoned that, like obstetric care, breast pumps and lactation supplies are "for the purpose of affecting a structure or function of the body of the lactating woman." This is the standard that applies under Section 213(d). The IRS will revise its Publication 502 ("Medical and Dental Expenses") to reflect this new position.

Sponsors of FSAs, HSAs, HRAs, and Archer MSAs are now free to reimburse these expenses on a tax-free basis. Before doing so, however, they should review their plan documents. A plan amendment may first be necessary. This is particularly true if, as is relatively common, a plan document describes these expenses as specifically excluded.

Assuming a plan does provide for the reimbursement of these expenses, employees should be informed of that fact. Unfortunately, existing IRS guidance would not allow for a mid-year election to increase the amount of contributions made to an FSA as a way of paying for these expenses. So this latest guidance may have come too late to help mothers who are currently using a breast pump or related lactation supplies.

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NEW GINA TITLE II REGULATIONS

On November 9, 2010, the EEOC issued its final employment regulations under Title II of the Genetic Information Nondiscrimination Act (GINA). The Title II regulations apply to private and government employers and became effective January 10, 2011.

GINA prohibits health insurers and employers from discriminating on the basis of genetic information. Title II prohibits use of genetic information when making hiring, firing, job placement, or promotion decisions. It also prohibits harassment based on genetic information and retaliation for opposing discrimination. Moreover, GINA restricts employers and other covered entities from requesting,

requiring, or purchasing genetic information, and strictly limits the disclosure of genetic information.

For employers, the inclusion of family medical history within the definition of "genetic information" is likely to create the most difficult problems. "Genetic information" includes information about an individual's genetic tests and the tests of the individual's family members; family medical history; an individual's requests for and receipt of genetic services or participation in clinical research that includes genetic services by the individual or a family member; and the genetic information of a fetus carried by an individual or family member, or an embryo legally held by the individual or family member using assisted reproductive technology.

GINA provides six exceptions to the prohibition against obtaining genetic information:

- First, inadvertent acquisitions of genetic information do not violate GINA, such as a "water cooler" situation where a manager or supervisor overhears someone talking about a family member's illness.
- Second, genetic information may be obtained as part of health services, such as wellness programs offered by the employer on a voluntary basis, even when the employer provides financial incentives for participation, as long as certain requirements are met.
- Third, information may be lawfully acquired as part of the certification process for FMLA leave or an Americans with Disabilities Act accommodation.
- Fourth, genetic information may be obtained through commercially and publicly available documents like newspapers. However, an employer is prohibited from searching these sources with the intent of finding genetic information or accessing sources where genetic information is likely to be acquired, like websites and on-line discussion groups that focus on issues such as genetic testing and genetic discrimination. Additionally, social networking sites that require permission from the creator of the profile to gain access to anything beyond basic information, or where access is limited to individuals in particular groups, are not considered commercially and publicly available.
- Fifth, genetic information may be acquired through a genetic monitoring program that monitors the biological effects of toxic substances in the workplace, where monitoring is required by law or, where the program is voluntary, if certain conditions are met.
- Sixth, acquisition of genetic information of employees by employers who engage in DNA testing for law enforcement purposes is not prohibited, but the information may only be used for analysis of DNA

markers for quality control to detect sample contamination.

The final regulations also provide model language employers can use when requesting medical information from employees and their healthcare providers to help avoid acquiring genetic information and to provide a safe harbor if genetic information is inadvertently obtained. The safe harbor language reads as follows:

> The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

While use of the safe harbor language is not mandatory, it will be helpful to use it when seeking medical information from the employee or employee's healthcare provider to support a request for reasonable accommodation, to support a request for FMLA leave for the employee's own serious health condition or to comply with FMLA return-to-work certification requirements, and to support non-FMLA leave requests.

One problem area that employers may encounter is when a vendor of a fringe benefit such as life or disability insurance seeks to obtain family medical history or asks open-ended enrollment questions that could result an employee providing family medical history. Unfortunately, neither the Title II regulations nor the explanatory Preamble specifically address this issue. However, the general prohibition on collecting genetic information would seem to apply to an employer's agents or vendors requesting information for fringe benefits other than health insurance. (Health insurance inquiries are specifically covered by *Title I* of GINA and the Title I regulations.) While such vendors may ask questions concerning current manifestations of an employee's medical conditions without violating GINA, employers should alert vendors not to use enrollment forms or questionnaires that request family medical history or other genetic information. Additionally, enrollment forms and questionnaires should include a copy of

the safe harbor language to caution the employee not to inadvertently volunteer genetic information in response to open-ended questions.

The regulations require more than the safe harbor language if the employer arranges for its own healthcare professionals to examine an employee. Here the employer must direct the healthcare professional not to collect genetic information, including family medical history, as part of a medical examination intended to determine the employee's ability to perform a job (e.g. a post-offer medical exam or a fitness-for-duty exam). Moreover, the regulations suggest the employer may need to cease using the services of a healthcare professional who requests or requires genetic information during medical examinations after being informed not to do so. This approach will be very problematic for employers if it extends to workers' compensation or similar examinations in which the healthcare professional may need family medical history to determine whether or not a condition or injury is likely one that occurred in the workplace. Unfortunately, neither the Title II regulations nor the explanatory notes in the Preamble to the regulations address the workers' compensation medical examination.

Finally, GINA makes it unlawful for covered entities to disclose genetic information about applicants, employees, or their family members. Genetic information must be kept confidential and in a separate medical file, and may be kept in the same file as other confidential medical information in compliance with the Americans with Disabilities Act. The nondisclosure rule contains limited exceptions, such as disclosure to government officials investigating compliance with Title II of GINA and those made pursuant to a court order.

Employers should now take the following steps:

- Post the revised EEOC nondiscrimination poster that includes the information on genetic nondiscrimination.
- Train HR personnel and supervisors regarding GINA.
- Review and revise forms to avoid gathering genetic information and supplement the forms with the safe harbor notice.
- Implement privacy practices to protect genetic information.
- Watch for developments concerning workers' compensation medical examinations, as well as enrollment questionnaires for non-health insurance fringe benefits.

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IRS PROVIDES GUIDANCE ON IN-PLAN ROTH CONVERSIONS

Congress and the IRS are encouraging individuals to convert their retirement savings into Roth accounts (as a means to increase revenue). Pursuant to changes to the Tax Code made by the Small Business Jobs Act of 2010 ("SBJA 2010"), sponsors of Section 401(k) plans, Section 403(b) plans, and governmental Section 457(b) plans may now allow participants to convert their pre-tax accounts into Roth accounts. And on November 26, 2010, the IRS issued Notice 2010-84 (the "Notice"), clarifying the mechanics of such conversions and providing timing relief for the necessary plan amendments. This article briefly summarizes the basics of Roth contributions, and then examines highlights of the statutory changes and the recent IRS guidance regarding conversions.

Designated Roth Contributions

If a Section 401(k), 403(b), or 457(b) plan has a "qualified Roth contribution program," participants may make Roth contributions in lieu of the pre-tax deferrals they might otherwise make. These contribution types differ in that (i) Roth contributions do not reduce the participant's taxable income, and (ii) distributions of Roth contributions are exempt from federal income tax, provided the distribution is "qualified." Roth contributions also differ from ordinary after-tax contributions, in that distributed *earnings* on Roth contributions are also tax-free—again, so long as the distribution is "qualified."

Qualified Roth Distributions. A distribution of Roth contributions is qualified only if it is made after (i) the participant attains age 59½, becomes disabled, or dies; and (ii) a five-year waiting period is complete. This five-year period consists of five consecutive years beginning with January 1 of the first calendar year in which the participant made designated Roth contributions to the Plan. (In the case of Roth contributions that are rolled over from one plan to another, the period begins on January 1 of the first calendar year in which the participant made a designated Roth contribution to the first plan.)

If a distribution is *not* qualified, the portion attributable to earnings on Roth contributions will be included in the participant's income for federal income tax purposes. In addition, the amount attributable to such earnings will also be subject to the 10% penalty tax for early distributions, unless an exception applies.

Characteristics of Roth Contributions. Aside from their special tax treatment, Roth contributions are, for most purposes, treated like elective deferrals. For example:

- They are subject to *the same distribution restrictions* (attainment of age 59½, termination of employment, disability, and death);

- Because Roth contributions are made in lieu of the pre-tax elective deferrals a participant could otherwise make, *the same annual limits* apply—each dollar of Roth contributions the participant makes for a year therefore reduces by one dollar the amount of pre-tax deferrals he or she can make for the year;
- *Catch-up contributions* may be designated as Roth contributions;
- Roth contributions are included in the plan's *ADP testing*;
- They may be the basis for a participant *loan*; and
- In a plan that features an automatic contribution arrangement, some or all *automatic deferrals* may be designated as Roth contributions, if the plan so provides.

In-Plan Conversions

In-plan Roth conversions are an optional feature of any plan that includes a qualified Roth contribution program. This feature allows participants to "roll over" any eligible rollover distribution of *non*-Roth amounts to a separate Roth account under the same plan. Before SBJA 2010 changed the Tax Code, participants could make such a conversion only by rolling the distribution out of the plan to a Roth IRA.

An in-plan conversion can be accomplished by either a direct rollover or a "60-day" rollover. In either case, the conversion is taxable as if the amount were distributed to the participant, although it is exempt from the 10% early withdrawal penalty that would otherwise apply.

Any plan that includes a qualified Roth contribution program may offer the in-plan conversion option. Any active or former participant may take advantage of it, as may surviving spouses of participants and alternate payees who are either the spouse or former spouse of a participant.

Requirements

Qualified Roth Contribution Program Must Be in Place. Only plans that have a qualified Roth contribution program in place may offer in-plan conversions. According to the Notice, a qualified Roth contribution program is "in place" when participants have the right to make designated Roth contributions. In other words, a plan cannot be amended to add in-plan conversions without *also* allowing participants to designate new deferrals as Roth contributions.

Eligible Rollover Distribution. To be converted, an amount must be an "eligible rollover distribution." Accordingly, the amount must be distributable under both the terms of the plan and the Code, and it cannot be a required minimum distribution, a hardship distribution, an annuity distribution, or any of the other ineligible distributions listed in IRS Publication 590. As explained more fully below, this requirement presents significant design flexibility for sponsors who are considering adding an in-plan conversion feature.

The following contribution types cannot be distributed (and therefore cannot be eligible rollover distributions) until the participant has either attained age 59½, become disabled, terminated employment, or become eligible for a qualified reservist distribution:

- Pre-tax elective deferrals to 401(k) and 403(b) plans;
- Qualified nonelective contributions ("QNECs");
- Qualified matching contributions ("QMACs"); and
- Employer contributions to 403(b)(7) custodial accounts.

Accordingly, these amounts cannot be *converted* in an in-plan Roth conversion until one of the specified events occurs—even though they would remain in the plan.

But other contribution types may be distributed sooner, depending on the terms of the plan. For example, *rollover* and *after-tax* contributions may be distributed (and therefore converted) at any time.

Most importantly, however, vested employer *matching* and *profit-sharing* contributions to 401(k) plans and 403(b) annuities may be distributed upon the attainment of a "specified age" or the occurrence of a "specified event." IRS guidelines for these "age and event" distribution triggers are not terribly helpful. They are described in some dated regulations and Revenue Rulings, and the IRS has steadfastly declined to clarify them.

Given the lack of clear guidance, some plan sponsors have been aggressive, making the "age" trigger for an in-service distribution the attainment of the plan's minimum participation age (usually 18 or 21). This has the effect of making all vested matching and nonelective contributions distributable (and therefore convertible) at any time. Limiting such in-service distributions to participants who have attained at least age 50 is clearly more defensible; but until the IRS issues clearer guidance, we cannot say that "age-related" distributions to younger participants are clearly impermissible.

The "specified event" trigger is slightly clearer because the IRS has provided two examples of events that will satisfy it. These are (i) the participant's completion of five years of participation in the plan, and (ii) "seasoning" of the amount to be distributed by virtue of its being held in the plan for at least two years.

New Distribution Options May Be Limited to In-Plan Conversions. SBJA 2010 and the Notice permit sponsors to add new distribution options that are available *only* for in-plan conversions. Sponsors may therefore apply the "age and event" triggers to craft new distribution options that expand participants' rights to convert their accounts to Roth accounts *without* allowing the money to leave the plan.

For example, a plan that allows in-service distributions at age 65 could allow in-plan conversions (of elective deferrals or employer contributions) between ages 59½ and 65, *without* allowing "real" distributions during that period. Or a plan that does not allow in-service distributions at all could allow in-plan conversions (only) of employer contributions for individuals with five years of participation, or with respect to amounts that had been held in the plan for at least two years. However, *existing* in-service distribution options cannot be restricted to in-plan Roth rollovers. Such an amendment would violate the Code's anti-cutback rule.

Amendments

Before participants may elect an in-plan Roth conversion, the plan must include (i) a qualified Roth contribution program, (ii) provisions allowing in-plan conversions, and (iii) a distribution option that allows the amounts to be converted. Typically, an amendment adding such features would have to be adopted before the end of the plan year in which they take effect, or even earlier. In the Notice, however, the IRS has provided extended amendment deadlines for the following changes:

- Adding a qualified Roth contribution program;
- Adding an in-plan Roth conversion feature;
- Adding distribution options; and
- Adding distribution options linked to in-plan conversions.

It is not permissible, however, to retroactively amend a plan to add a pre-tax deferral feature. Thus, for example, the extended deadlines are not available for a qualified plan if the plan does not already provide a 401(k) feature.

The extended amendment deadlines are as follows:

- For *401(k) plans*, the later of: (i) the last day of the first plan year in which the amendment is effective, or (ii) December 31, 2011.
- For *safe-harbor 401(k) plans*, the later of: (i) the day before the first day of the first plan year in which the amendment is effective, or (ii) December 31, 2011.
- For *403(b) plans*, the later of: (i) the end of the plan's remedial amendment period (if any), or (ii) the last day of the first plan year in which the amendment is effective.
- For *457(b) plans*: we are still awaiting IRS guidance.

Thus, for example, a "generic" (*i.e.*, calendar-year, non-safe-harbor) 401(k) plan may *administratively* establish a qualified Roth contribution program and provide for in-plan conversions anytime during 2011, so long as it is amended accordingly no later than December 31, 2011.

Exceptions to Treatment as Distributions

For *tax* purposes, an in-plan Roth conversion is treated as a distribution. For most other purposes, however, in-plan conversions are not treated as distributions. Thus, for example:

- If a participant's account includes an outstanding *plan loan*, the repayment schedule of the loan will remain the same;
- *Spousal consent* is not required for an in-plan conversion;
- The rolled-over amount is taken into account in determining whether the participant must *consent to a distribution* (instead of being cashed out); and
- The converted amount is also taken into consideration when determining whether the participant is eligible for an *optional form of payment* (such as an annuity).

Notices

If a plan includes an in-plan conversion feature, the Section 402(f) "Special Tax Notice" sent to participants must describe that feature. Thus, plan sponsors who add an in-plan conversion feature will also need to update their Special Tax Notices.

Recordkeeping

Designated Roth contributions must be accounted for separately from other contributions. *Converted* amounts must also be accounted for separately, even from *designated* Roth contributions. This is because subsequent distributions must differentiate (for reporting purposes) between designated Roth contributions (and associated earnings) and converted amounts. In addition, designated Roth contributions are generally subject to withdrawal restrictions that cannot be applied to converted amounts (which, by definition, are *already* eligible rollover distributions).

Taxation

Beginning with 2011, in-plan Roth conversions are taxable in the year of conversion. (A special rule applied to in-plan conversions made during 2010.) The participant is taxed on the fair market value of the distribution, less any basis. There is no 20% mandatory withholding from a conversion made as a direct rollover. Instead, the *participant* is responsible for any estimated tax reporting and payment. If the participant leaves the converted amount in the plan for five calendar years (counting the year of conversion), there will be no 10% early distribution penalty.

Reporting

The "payor" of the conversion (typically, the plan's recordkeeper) must report the conversion on a Form 1099-R for the year of conversion. The converted amount must be included in Box 1, and the taxable amount of the conversion must be included in Box 2a. The participant's basis in the distribution must be reported in Box 5, and Code "G" should be checked in Box 7.

What Should Plan Sponsors Do?

SBJA 2010 encourages Roth conversions in at least three ways. For participants, it simplifies the process by eliminating the extra step of distributing the amounts to a Roth IRA. It also allows them to take advantage of the plan's familiar administrative procedures and investment options. In many cases, the plan's size and the employer's bargaining power will also result in lower administrative fees than the participant could obtain from an IRA custodian. Many participants—particularly those who take an active interest in tax planning—will therefore be interested in the in-plan conversion option. For sponsors, in-plan conversions offer a means of keeping converted amounts in the plan, rather than distributing them to the participant or an IRA custodian.

If a plan sponsor decides to add an in-plan Roth conversion feature, the option must be communicated to all participants through an updated summary plan description or a summary of material modifications. As noted above, the sponsor must also revise its Section 402(f) Special Tax Notice to explain the tax treatment of converted amounts. (The IRS has provided sample language in the Notice.)

Thus, plan sponsors interested in adding an in-plan conversion feature should take the following steps:

- Consider whether an in-plan conversion feature is right for their 401(k), 403(b) or governmental 457(b) plan;
- Consider whether new distribution options should be added to the plan, and if so, what the triggers should be;
- Communicate with their recordkeeper about implementing the new feature;
- Prepare the necessary plan amendments;
- Prepare and distribute the necessary participant communications explaining the new feature;
- Prepare revised Special Tax Notices; and
- Update their administrative procedures.

Spencer Fane's Benefits Group would be pleased to assist with each step of this process.

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APPLYING NONDISCRIMINATION REQUIREMENTS TO FULLY INSURED HEALTH PLANS: WHEN, AND HOW?

One of the most common questions we receive from employers sponsoring group health plans is, "Can we offer different health benefits to different employees?" Related questions include, "Can we make our hourly employees pay a greater percentage of the cost of the plan than our higher-paid salaried employees?" or "Can we limit health benefits solely to managers and executive level employees?" And for

the last 20 years, the answer has been, "Yes, *so long as* your plan is fully-insured."

This answer reflects the fact that, prior to health care reform, Section 105(h) of the Tax Code (which prohibits discrimination in favor of certain "highly compensated individuals") applied solely to "self-funded" or "self-insured" group health plans. Under Code Section 105(h), highly compensated individuals ("HCIs") are taxed on some or all of the benefits they receive under a self-funded health plan if that plan discriminates (in favor of such HCIs) in terms of either (i) their eligibility to participate in the plan, or (ii) the benefits they receive under the plan.

The Affordable Care Act extends these nondiscrimination principles to fully-insured group health plans through a combination of (i) a new provision (Section 2716) of the Public Health Service Act ("PHSA") (which generally applies to governmental employers), and (ii) new sections of the Internal Revenue Code and ERISA that make Section 2716 and several other provisions of the PHSA applicable to non-governmental group health plans. Section 2716 of the PHSA provides that "rules similar to" the nondiscrimination provisions set forth in Code Section 105(h) shall apply to group health plans *other than* self-insured plans (i.e., to insured plans). These rules are effective for plan years beginning on or after September 23, 2010, but they do not apply to "grandfathered" plans. The non-discrimination requirements of Section 105(h) continue to apply to self-insured plans.

There are two key differences between these two sets of nondiscrimination rules. The most significant difference is the consequence of violating the rules. As noted above, if a self-funded plan is determined to be discriminatory, the HCIs in whose favor the plan discriminates are taxed (under Code Section 105(h)) on some or all of the "discriminatory" benefits they receive. For example, if a group health plan provides coverage for refractive eye surgery, but limits such coverage solely to executives, then an executive who receives $5,000 of reimbursements (or payments) for refractive eye surgery will have an additional $5,000 of taxable income for that year.

By contrast, if a fully-insured plan violates the requirements of PHSA Section 2716, there are no adverse tax consequences to the HCIs. Instead, the employer is subject to an excise tax (or, in the case of certain governmental employers, a civil penalty) of $100 per day per non-HCI discriminated against. The employer may also be subject to a civil action (filed by affected participants or the Department of Labor) to compel it to provide nondiscriminatory benefits (or to stop providing "discriminatory" benefits).

The other key difference is that PHSA Section 2716 applies solely to "non-grandfathered" plans (generally, plans that

either were not in existence on March 23, 2010, or have made significant changes in costs or benefits since that date). By contrast, Section 105(h) applies to *all* self-insured/self-funded plans, regardless of whether they are considered "grandfathered" plans for purposes of Health Care Reform.

As noted above, Section 2716 of the PHSA was scheduled to apply to non-grandfathered insured health plans as of the first plan year beginning on or after September 23, 2010 (i.e., January 1, 2011 for calendar year plans, but earlier for certain fiscal year plans). In September of 2010, the IRS issued Notice 2010-63, requesting public comments on these new discrimination requirements for insured plans. Comments were due by November 4, 2010. However, the aspect of Notice 2010-63 that caught the public's eye was the explanation of the penalty for non-compliance: $100 per day *per non-highly compensated individual discriminated against,* plus a possible civil action to enjoin the discriminatory practice. Because "HCIs" are (by definition) limited to 10% owners, the five most highly-paid officers and the top 25% most highly paid employees of the employer, this means that providing a "discriminatory benefit" to even one HCI could trigger a penalty of $100 per day times 75% of the total number of employees in the employer's workforce. For an employer with 1000 employees, this means a penalty of up to $75,000 per day!

The benefits community's reaction to Notice 2010-63 was intense. In response to the comments it received, the IRS recently issued Notice 2011-1, which addresses the timing (i.e., the effective date) of the new nondiscrimination requirements for insured group health plans (other than grandfathered plans). Notice 2011-1 provides that:

1. Compliance with the nondiscrimination requirements of PHSA Section 2716 will not be required until *after* regulations (or other guidance of general applicability) have been issued with respect to that new statutory requirement; and
2. Compliance with the nondiscrimination requirements for insured plans will not be required until plan years beginning a specific period *after* such guidance is issued.

Therefore, sponsors of fully-insured plans that are not "grandfathered" from the provisions of Health Care Reform (as well as fully-insured plans that lose their grandfathered status) now have a temporary reprieve from the nondiscrimination requirements and the onerous penalties associated with noncompliance. However, absent a statutory repeal of Section 2716, non-grandfathered insured plans will *eventually* be subject to nondiscrimination requirements that are similar to the "nondiscriminatory eligibility" and the "nondiscriminatory benefits" tests currently

applicable to self-funded plans under Code Section 105(h).

Planning for the eventual application of the discrimination rules to fully insured plans is difficult, because at this point, no one knows how "similar" the new rules will be to the existing rules under Section 105(h). To complicate matters, there are many open questions regarding how to apply the *current* Section 105(h) rules to self-funded plans. The regulations under that Code Section are now over 30 years old. Health plans and health reimbursement arrangements have changed significantly since that time. Therefore, it is possible, if not even likely, that the IRS may issue guidance that addresses *both* the application of Code Section 105(h) to self-funded plans *and* the application of PHSA Section 2716 to non-grandfathered insured plans.

In addition to providing for a temporary delay in the effective date of Section 2716, Notice 2011-1 also requests additional comments from the public regarding some of the issues that have already been identified (either by the IRS or by comments in response to Notice 2010-63) in applying the nondiscrimination rules of Section 105(h) to fully-insured plans. Specifically, the IRS is requesting comments on:

- What is a "discriminatory" benefit (i.e., is a higher percentage of cost paid by the employer, or a shorter waiting period, a "benefit")?
- Can the "eligibility" test be based on the percentage of "highly compensated employees" (those making more than $110,000 per year) that are eligible to benefit (rather than on the definition of HCI in Section 105(h), which is generally the top-paid 25% of employees of the employer)?
- Can/should the eligibility test be applied separately to employees in geographically separate locations?
- Should the IRS set forth any "safe harbor" plan designs (rather than mathematical eligibility tests)?
- Should the IRS allow employers to aggregate plans with different, but "substantially similar," benefits?
- How should the rules apply to "expatriate" or "inpatriate" coverage?
- How should the rules apply to multiemployer (i.e., union) plans?
- Can plans avoid penalties if HCIs pay for coverage with after-tax dollars (a common practice to avoid taxation under 105(h))?
- Will there be "transition rules" for corporate mergers/acquisitions (like the current transition rule for qualified retirement plans)?
- How will the rules apply in 2014 when other aspects of Health Care Reform (such as the individual mandate and additional employer requirements) become effective?

The IRS will also need to address issues such as (i) how the rules apply to retirees, (ii) how the rules apply to former employees electing (or receiving

employer-paid) COBRA benefits, and (iii) which employees may be excluded from the tests. Other issues include how to apply the rules when one benefit option under an insured plan is "grandfathered" but another benefit option is not, or how to apply the rules when one plan is insured and another is self-funded.

Until such guidance is issued, employers sponsoring "grandfathered" plans may want to preserve that status as long as possible. Insured plans that are not grandfathered (or that cannot economically remain grandfathered) will need to plan for the eventual application of the nondiscrimination requirements. For example, insured plans that currently provide benefits solely to executives, or that provide better benefits (or lower cost structures) for their more highly paid employees, will likely require significant redesign once the nondiscrimination requirements become effective.

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TAXATION OF DEPENDENT COVERAGE AFTER HEALTH CARE REFORM

By now, most people involved in the administration of group health plans are familiar with the requirement that plans offering dependent coverage make that coverage available to adult children until they attain age 26. This new requirement applies to both insured and self-insured plans (regardless of the plan's status as a "grandfathered" plan), and is effective for plans years beginning on or after September 23, 2010 (January 1, 2011, for calendar-year plans). Many of us, however, are not as familiar with the corresponding change to the Tax Code that allows these benefits to be provided on a tax-free basis.

For periods after March 30, 2010, a covered employee's child who is under age 27 as of the end of the taxable year may receive employer-paid health coverage on a tax-free basis (and the employee may pay for some or all of such coverage with pre-tax dollars under a cafeteria plan), even if the child does *not* qualify as the covered employee's Tax Code dependent (i.e., even if the child is not a qualifying child or qualifying relative under Code Section 152, and therefore cannot be claimed as a dependent on the employee's federal income tax return). In other words, even though plans are only *required* to offer dependent coverage until the child's 26th birthday, the covered employee's child may receive tax-free coverage (or tax-free reimbursements) through the *end* of the calendar year in which the child turns age 26.

This tax change also applies to the reimbursement of qualifying medical expenses under health reimbursement arrangements ("HRAs") and health flexible spending accounts ("FSAs") – though *not* to health savings accounts ("HSAs").

Accordingly, plan sponsors that have not already done so, may wish to amend their Section 125 cafeteria plans to allow for the payment of health care premiums and/or FSA reimbursements on behalf of adult children who will not attain age 27 by the last day of the year. Plan sponsors may also want to amend their HRAs for the same reason.

For purposes of this change in the tax treatment of dependent coverage, a "child" is an individual who is the employee's son, daughter, stepson or stepdaughter, and includes both a legally adopted individual and an individual lawfully placed with the employee for adoption. The term "child" also includes an eligible foster child—defined as a child placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. As a result of this tax change, traditional dependency requirements involving age limits, residency, support and other tests that would otherwise need to be satisfied for an individual to qualify as a tax dependent do not apply for purposes of the tax-favored treatment of health reimbursements and coverage for adult children who are younger than 27 for the entire tax year.

This tax change significantly eases the burden associated with analyzing the taxability of dependent coverage for a covered employee's adult children. Now, under Code Section 105(b), a covered employee may be reimbursed (without tax consequences) for amounts expended for medical care of the employee's children who are under age 27 as of the end of the employee's taxable year (generally, the calendar year). It is important to note that not every state follows the federal taxation scheme, and thus some benefits that are not taxable for federal income tax purposes may be taxable for state income tax purposes.

If, however, a covered employee's adult child receives coverage or benefits after the end of the year in which the child turns age 26, the value of the coverage or reimbursements will be taxable to the covered employee unless the child is a "qualifying child" or "qualifying relative" under Code Section 152. This situation could arise in a plan that voluntarily provides extended dependent coverage, or in an insured plan that is required (by a state insurance law) to provide coverage beyond age 26.

Who is a Qualifying Child? Under Code Section 152, a qualifying child is an individual who (1) bears a specified relationship to the employee; (2) has the same principal place of abode as the employee for more than half of the year; (3) meets certain age requirements; (4) has not provided more than half of his or her own support for the year; and (5) has not filed a joint tax return with his or her spouse for the year. The qualifying child relationship requirement is satisfied if the individual's relationship to the covered employee falls within any of the categories

described above under the definition of "child," or if the individual is a descendant of an employee's "child" (e.g., grandchild). Additionally, the relationship requirement may be met if the individual is the employee's sibling, half-sibling, step-sibling, or a descendent of any such individual (e.g., a nephew or niece). A qualifying child must be younger than the employee *and* under age 19 (or under age 24 if a full-time student) as of the close of the calendar year in which the employee's taxable year begins.

Who is a Qualifying Relative? Under Code Section 152, a qualifying relative is an individual (1) who bears a specified relationship to the employee; (2) whose gross income is less than the exemption amount in Code Section 151(d); (3) with respect to whom the employee provides over half of the individual's support; and (4) who is not anyone's qualifying child. The qualifying relative relationship requirement is quite broad. It is satisfied if the individual's relationship to the covered employee falls within any of the categories described above under the qualifying child relationship requirement. The relationship requirement may also be satisfied if the individual is the employee's parent, grandparent, aunt, uncle, in-law, or other individual (other than a spouse) if the relationship does not violate local law. The Code Section 151(d) income limitation does not apply for health coverage purposes.

In summary, status as a qualifying child or qualifying relative remains relevant for determining the tax treatment of health coverage and reimbursements for individuals who do not qualify as the employee's "spouse" or "child." Fortunately, such status is relevant only for purposes of determining the taxability of coverage or reimbursements for an employee's adult child when the child receives coverage after the end of the year in which he or she turns age 26. Thus, for the majority of group health plans, the new coverage mandate and corresponding tax change should simplify the process of determining when health benefits for dependents create taxable income for employees, and should provide much needed relief to plan sponsors.

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BULL'S-EYE ON TARGET-DATE FUNDS

Target-date funds have become increasingly popular with 401(k) plan investors in recent years. A target-date fund ("TDF") is typically a mutual fund that contains a mix of underlying investments and automatically adjusts the asset allocation (stocks, bonds, cash equivalents) within the fund's portfolio according to a selected "target date" such as retirement. As a participant approaches the "target date," the fund moves its allocation to more conservative investments (e.g., bonds and cash) and

away from riskier investments (e.g., equities).

Many plan sponsors have opted to use TDFs as their plan's qualified default investment alternative ("QDIA"). A QDIA is a default investment option, chosen by a plan fiduciary, for those participants who fail to make an election regarding investment of their account balances. If the default option meets the QDIA requirements, the plan fiduciaries are protected from liability for investment losses in the default investment option chosen. Final DOL regulations expressly permit the use of TDFs as a QDIA.

Nonetheless, the DOL has recently expressed concern that the investment styles and strategies of TDFs can be very different, particularly because different TDFs use different "glide-paths" to adjust participants' investments as they age. Thus, a proposed DOL regulation would amend the QDIA regulations to expand the information that must be disclosed in the required QDIA notice to participants and beneficiaries concerning investments in TDFs. A similar disclosure would be required to be provided to all participants as part of new fee disclosure regulations.

According to the proposed regulations, the following new disclosures regarding TDFs would be required:

- An explanation of the TDF's asset allocation, how the asset allocation will change over time, and the point in time when the TDF will reach its most conservative asset allocation (including a chart or table that illustrates the asset allocation over time and does not obscure or impede a participant's or beneficiary's understanding of the information);
- If the TDF is named, or otherwise described, with reference to a particular date (e.g., a target date), an explanation of the age group for whom the alternative is designed, the relevance of the date, and any assumptions about a participant's or beneficiary's contribution and withdrawal intentions on or after such date;
- A statement that the participant or beneficiary may lose money by investing in the TDF, including losses near and following retirement, and that there is no guarantee that the TDF will provide adequate retirement income;
- A description of the right of the participants and beneficiaries on whose behalf assets are invested in a QDIA to transfer the investment of those assets to any other investment alternative under the plan and, if applicable, a statement that certain fees and limitations may apply in connection with such transfer; and
- An explanation of where the participants and beneficiaries can obtain additional investment information concerning the QDIA and the other investment alternatives available under the plan.

While no action is required yet, plan sponsors should check with their service providers and consultants to be sure that they will be prepared to respond when the regulations are finalized.

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A NEW VEBA BOOMLET?

Inevitably, anything as massive as health care reform will have unanticipated consequences. One of those appears to be a renewed demand for welfare benefit trust funds. This demand arises in a specific context: self-insured, stand-alone retiree health plans. To understand this recent phenomenon, some history is in order.

Those who have been in the benefits field for twenty or more years can remember a time when most self-insured, employer health plans were funded through trusts. These were designed to comply with ERISA's requirement that "plan assets" (such as participant contributions) be held in trust, for the exclusive benefit of plan participants and their beneficiaries. Most of these trusts were also designed to be exempt from federal income tax under Section 501(c)(9) of the Tax Code, thereby constituting "voluntary employees' beneficiary associations" (or "VEBAs").

Then something happened that drove VEBAs into near extinction. This was the Department of Labor's 1988 announcement (in its Technical Release 88-01) that it would not enforce ERISA's trust requirement with respect to participant contributions to welfare plans *if* those contributions were made through a Code Section 125 "cafeteria plan." Four years later (in Technical Release 92-01), the DOL confirmed that this "trust nonenforcement policy" applies for annual reporting purposes, as well.

This was an important clarification. Both then and now, an unfunded welfare plan (i.e., one with no "plan assets") is exempt from ERISA's requirement to file an Annual Report (Form 5500) if it has fewer than 100 participants. And although larger plans must file an Annual Report, they are exempt from the related audit requirement if they are unfunded. Technical Release 92-01 made clear that any welfare plan that was excused from holding participant contributions in trust could *also* take the position that it was "unfunded" for purpose of these annual reporting requirements.

As a way of avoiding these additional reporting requirements, sponsors of self-insured health plans began rushing to terminate their VEBAs. This approach carried the additional advantage of relieving the VEBA, itself, from the obligation of filing a tax return (on Form 990) with the IRS each year. About the only exceptions to this VEBA-termination trend were collectively bargained plans, where trusts were required under collective bargaining agreements (and, in

the case of multiemployer plans, compliance with the Taft-Hartley Act).

So what has now changed to stem this anti-VEBA tide? Oddly enough, it is health care reform. More specifically, it is the desire on the part of many sponsors of self-insured health plans to avoid having to comply with the health care reform *mandates* in the context of their *retiree* health coverage. By splitting a health plan into two separate plans – one for active employees and one for retirees – the sponsoring employer can achieve this goal.

The retiree-only plan will be exempt from *all* of the health care reform mandates, and not just those from which "grandfathered" plans are exempt. Thus, for instance, a retiree-only plan may continue to apply lifetime limits on essential health benefits, low annual limits on such benefits, preexisting condition limitations or exclusions on individuals under age nineteen, and a maximum dependent age of less than twenty-six.

How can that be? It is because the health care reform mandates do not apply to any plan that is exempt from the requirements of the Health Insurance Portability and Accountability Act ("HIPAA"). One such HIPAA exemption applies to "certain small group health plans." These are defined in DOL regulations as any plan that, "on the first day of the plan year, has fewer than two participants who are current employees." Although initially viewed as an exemption for single-employee plans, the preamble to regulations interpreting the health care reform mandates concedes that this exemption applies to "retiree-only" plans, as well.

As a result, many sponsors of health plans that had covered both active and retired employees have elected to spin off their retirees into a separate plan. To ensure that the agencies charged with administering health care reform do not view the retirees as continuing to participate in the same plan as the active employees (which would undermine the retiree plan's exemption from the health care reform mandates), most of these employers have taken pains to characterize the retiree-only plan as a separate ERISA "plan." This requires the drafting of a separate plan document and summary plan description, the assignment of a separate plan number, and (when the time comes) the filing of a separate Annual Report.

So far, so good. So what exactly is the problem? Well, it has to do with the precise scope of the DOL's trust nonenforcement policy.

On its face, Technical Release 92-01 applies only to participant contributions that are made through a cafeteria plan. (Although the nonenforcement policy also applies to participant contributions that are forwarded to a plan's insurer within 90 days of their receipt by the employer, this aspect of the policy has no application to a

self-insured plan.) Typically, only active employees are allowed to participate in a cafeteria plan. This is because they are the only participants who have any salary that can be recharacterized as an employer contribution. For this reason, the DOL was asked to extend its trust nonenforcement policy to welfare plans under which retirees or COBRA beneficiaries make their contributions on an *after*-tax basis.

Responding to a question raised during a 1996 American Bar Association committee meeting, a DOL representative stated that the trust nonenforcement policy would apply to *all* participant contributions – so long as any contributions made by *active* employees are made through a cafeteria plan. Thanks to this clarification, plans covering both active and retired employees have been able to rely on this trust nonenforcement policy with respect to all of their participants.

In responding to this same 1996 question, however, the DOL representative cautioned that the trust nonenforcement policy would *not* apply to either retiree or COBRA contributions if Technical Release 92-01 is not otherwise applicable to the plan. This would appear to be the case for a self-insured, retiree-only plan. IRS regulations specifically bar a cafeteria plan from being "established or maintained predominantly for the benefit of former employees." And while it is permissible for *some* cafeteria plan participants to be former employees, there is a significant risk that characterizing retirees as participants in the same cafeteria plan as active employees would undermine the degree of "separateness" required to bring the retiree-only plan within the scope of the HIPAA exemption.

As a result, any self-insured, retiree-only health plan sponsored by an employer to whom ERISA applies (i.e., not a governmental or church plan) should hold any retiree contributions in trust. This, in turn, would cause the plan to be "funded" for purposes of the annual reporting requirements

So what are the practical implications of this conclusion? Among other things, any sponsor of a self-insured, retiree-only health plan should take the following steps to remain in compliance with both ERISA and the Tax Code:

1. Draft a trust agreement sufficient to create a trust for the holding of retiree contributions.
2. Identify and appoint one or more trustees of that trust. This could be either a financial institution or one or more employees of the plan's sponsoring employer.
3. Coordinate the proper flow of funds with any third-party administrator or other parties involved in collecting retiree premiums. The only *legal* requirement is that retiree contributions be deposited into the trust as soon as they can reasonably be segregated from the sponsoring employer's

general assets. To keep the trust assets at a bare minimum, however – thereby avoiding the question of how those assets should be invested – the contributions should probably be sent to the third-party administrator on a frequent basis. Remember that those assets can be used to pay claims incurred only by retirees and their dependents (i.e., participants in the retiree-only plan).

4. File an Annual Report each year on behalf of the retiree-only plan. This is due within 7 months following the close of each plan year (subject to an automatic 2½-month extension).
5. For any plan year during which the retiree-only plan covers more than 100 participants, commission an independent audit of the plan and then attach that audit to the plan's Annual Report.
6. Although not required to comply with ERISA, the plan's sponsor will likely also want to apply to the IRS for tax-exempt status on behalf of the VEBA. This must be done by completing and filing an IRS Form 1024 within 15 months following the VEBA's effective date.
7. Assuming the trust is intended to be a VEBA, an IRS Form 990 should be filed with the IRS within 4½ months following the close of each fiscal year. If the VEBA has any "unrelated business taxable income," this should be reported on an IRS Form 990-T. (If an employer elects not to obtain tax-exempt status for the trust, other tax-reporting rules would apply.)

Of course, this new VEBA boomlet could be brought to an end if the DOL chooses to expand its trust nonenforcement policy to apply to retiree-only plans. Although it is hard to see any policy basis for doing so, the DOL did not bother to justify its existing policy, so anything is certainly possible.

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SELECTING A 401(K) FUND LINEUP: RISK AND OPPORTUNITY

In late January the United States Court of Appeals for the Seventh Circuit (whose jurisdiction includes Illinois, Indiana, and Wisconsin) weighed in yet again on the extent to which ERISA's fiduciary duty rules apply to the selection of 401(k) plan investments. As you may recall, the Seventh Circuit issued one of the most important rulings on this topic in recent years in *Hecker v. Deere & Co.* (2009), a case challenging as imprudent the fees attached to such investment options. Now, just two years later, the court appears to have reconsidered its analysis in *Hecker*, adding even more murkiness to these muddy waters.

The Department of Labor has taken the position for many years that the selection of the core investment funds from which

401(k) plan participants may choose is a fiduciary act under ERISA. The DOL argues that setting the fund lineup is not an act that is shielded from liability by Section 404(c) of ERISA, which otherwise makes participants solely responsible for investment losses attributable to their own investment decisions. Thus, according to the DOL, a fiduciary who includes an imprudent fund in the menu of options may be liable to participants who suffer losses as a result of investing in such a fund.

The courts, however, have not always agreed with the DOL's position. The Seventh Circuit, in particular, hinted in *Hecker* that as long as a plan offered a sufficient number of investment options, the presence of a few imprudent options would not subject the plan's fiduciaries to liability.

In companion rulings handed down on January 21, 2011, however, the Seventh Circuit appears to have abandoned its earlier reasoning in favor of the DOL's interpretation of Section 404(c). (*Howell v. Motorola, Inc.* and *Spano v. Boeing Co.*). According to the court, the Section 404(c) safe harbor protects fiduciaries from losses incurred in participant-directed accounts "only with respect to decisions that the participant can make." Because participants do not set the menu of investment options, Section 404(c) does not apply to those decisions. Instead, the plan's fiduciaries remain liable for the selection and monitoring of that lineup. Somewhat remarkably, the *Howell* decision was drafted by the same judge who wrote the court's earlier decision in *Hecker*.

While reaching what is undoubtedly a participant-friendly result in *Howell*, however, the Seventh Circuit gave plan sponsors and fiduciaries reason for hope in *Spano v. Boeing Co.* In *Spano*, the court created significant procedural obstacles for participants (and their lawyers) who wish to bring ERISA class actions. Class actions allow large numbers of participants to bring suit collectively, thus leveraging what might otherwise be small individual claims. Without the leverage of a class action, many ERISA claims would be prohibitively costly to pursue.

Like *Hecker*, the plaintiffs in *Spano* alleged that plan fiduciaries selected an investment lineup that included excessively expensive options. The district court concluded that the *Spano* plaintiffs could pursue their claims as a class. Reviewing the lower court's order on that subject, the Seventh Circuit ruled that, while such cases might be amenable to class status in some circumstances, this case was not one of them. The appellate court therefore overruled the class certification order and sent the case back to the district court.

In doing so, the Seventh Circuit strongly hinted that the individual investment decisions that permeate participant-directed 401(k) plans might make class

actions involving such plans difficult to pursue. When, as was the case here, the plan's administrative fees vary from investment fund to investment fund, and when individual participants can choose on a daily basis whether to invest in one or more of those funds, defining a class of participants who were assessed the same fee, and thus whose interests are sufficiently similar – or "typical," in the parlance of the Federal Rules of Civil Procedure that govern class actions – may be extremely difficult.

The *Spano* ruling suggests a number of considerations that employers should take into account when designing participant-directed plans. Some of these decisions could strengthen the employer's position in the event that plan-wide litigation is filed. For instance, the Seventh Circuit's ruling hints that plans with a large number of investment options – particularly those with brokerage windows – may make it difficult for potential plaintiffs to demonstrate a sufficient commonality of interest to justify a class action.

It remains to be seen whether other courts will adopt the Seventh Circuit's rationale, either with respect to the Section 404(c) defense or class certification issues. Until that becomes more clear, plan sponsors and fiduciaries would be wise to follow a prudent process when selecting and monitoring their 401(k) plan fund lineup. In light of the class action analysis in *Spano*, sponsors also should discuss with their counsel the advisability of creating a fund and fee structure that makes it more difficult for plaintiffs' lawyers to create a "typical" class.

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