Benefits and Employment Briefing

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HEALTH CARE REFORM UPDATE

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IRS PROVIDES GUIDANCE ON SCOPE OF "UNFORESEEABLE EMERGENCY"

Most sponsors of Section 401(k) plans are familiar with the IRS standards for allowing active employees to withdraw their elective deferrals on account of "financial hardship." The same hardship withdrawal standards apply to Section 403(b) deferrals. However, far more stringent in-service withdrawal standards apply to nonqualified deferred compensation arrangements that are subject to Code Section 409A.

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FORM 8955-SSA REPLACES SCHEDULE SSA

The Internal Revenue Service has announced that a new Form 8955-SSA ("Annual Registration Statement Identifying Separated Participants with Deferred Vested Benefits") has replaced Schedule SSA to the Form 5500. Under Section 6057(a) of the Internal Revenue Code, a plan administrator must report certain information regarding plan participants who separated from service with deferred vested benefits.

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HEALTH CARE REFORM UPDATE

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Congressional Actions

As we predicted in February, Congress and the President eventually agreed on legislation repealing the ACA's expanded Form 1099 reporting requirements. Those requirements were described in our April 2011 article, along with a summary of the changes that were made to the ACA as a way of offsetting the cost of this repeal.

Somewhat more surprisingly, Congress and the President also agreed to repeal the ACA provisions that would have required employers to issue "free choice vouchers." The coalition backing that repeal included both large employers and unions. The "adverse selection" concerns underlying this repeal were outlined in a second April 2011 article. That article also noted some of the practical concerns arising from the need to determine each employee's *household* income in order to determine which employees would have been entitled to a free choice voucher.

It seems unlikely that other significant elements of the ACA will be repealed before the 2012 elections. The Republican-controlled House of Representatives has been approving bills to rescind the authority to spend money that was appropriated by the ACA. At least five such rescission bills are on the GOP agenda. Because these rescissions are not favored by either the Democratic Senate or President Obama, they seem unlikely to be enacted in their current form. Given the nation's current budget constraints, however, it is conceivable that some portion of these funding rescissions may eventually become law.

Decisions by the Courts

The courts have continued to address a number of challenges to the ACA's constitutionality. In late April, the U.S. Supreme Court denied Virginia's request for immediate review of two conflicting decisions issued by federal district courts in that state. As predicted in our February 2011 article, the Supreme Court has elected to let the appellate courts (in this case, the Fourth Circuit Court of Appeals) deal with the issue first.

Most knowledgeable observers now believe that any Supreme Court pronouncement on the ACA's constitutionality will not come until 2012. Even then, the Court may not address all aspects of the issue. For instance, even if the ACA's "individual mandate" is held to be beyond the scope of Congress's authority, the remainder of the law may stay intact. If so, employers will remain subject to the ACA's other mandates and potential tax penalties.

Guidance from the Executive Branch
That leaves only the executive branch of government. Although the three agencies charged with administering the ACA (the IRS, the Department of Labor, and the Department of Health and Human Services) have issued no formal regulations in this area since February, they have continued to issue less formal guidance.

For instance, in Technical Release 2011-01 (issued on March 18, 2011), the DOL granted a further limited extension of the deadline for employer health plans to comply with certain of the ACA's new internal claims and appeals procedures. An article summarizing this latest extension appears elsewhere in this newsletter.

The DOL also posted yet another round of frequently asked questions. This sixth round of FAQs (dated April 1, 2011) answers a number of questions concerning the ACA's "grandfathering" rules. The topics include the following:

- Guidance on the scope of the anti-abuse rule applicable to employees who are transferred from one benefit package to another;
- Flexibility to move prescription drugs among tiers of a drug formulary without losing grandfathered status;
- Clarification that "value-based insurance designs" may be applied to preventive care services (again, without undermining grandfathered status);
- Application of the "5% premium shifting rule" when an employer's premium subsidy is based on a specified formula that effectively shifts any *increase* in cost to employees or retirees as the overall cost of providing a plan's benefits increases; and
- The date as of which a change in a plan's terms will cause a loss of grandfathered status.

The other key administrative guidance issued since February was IRS Notice 2011-36. Although phrased as a request for comments, this Notice actually telegraphs much of the IRS's current thinking on issues associated with the tax penalties the ACA will impose on larger employers failing to provide affordable health coverage to their employees.

Once these "shared responsibility" provisions take effect (in 2014), a "larger employer" will owe a tax penalty if any full-time employee obtains federally subsidized coverage through a state-wide exchange and *either* (1) the employer fails to offer its full-time employees the opportunity to enroll in "minimum essential coverage" (a term that is yet to be defined), *or* (2) the employer offers such coverage but at a cost that is deemed to be "unaffordable" for any full-time employee (based on the employee's household income). Obviously, these provisions require that an employer be able to *identify* all of its "full-time" employees.

Moreover, a "larger employer" is defined for this purpose as an employer that employed an average of 50 or more full-time employees – including "full-time equivalents" – on business days during the preceding calendar year. So any employer whose regular, full-time work force comes *close* to the 50-employee threshold will also need to know how to count full-time equivalents for this purpose.

The ACA defines a "full-time employee" as one working 30 or more hours per week. In Notice 2011-36, the IRS explains that its eventual regulatory guidance will likely treat 130 hours per month as equivalent to 30 hours per week. The IRS also proposes a 6-step process for calculating the number of full-time employees (including full-time equivalents) an employer had during the prior calendar year. This process includes a special rule allowing certain full-time, but "seasonal," employees to be disregarded when determining an employer's average number of full-time employees.

Technically, the ACA calls for any employer penalties to be calculated on a monthly basis. It would therefore be necessary to determine an employer's number of full-time employees *each month.* To ease the administrative burdens associated with such monthly calculations, the Notice offers the possibility of allowing employers to determine their number of full-time employees by using a "look-back/stability period safe-harbor."

Under this proposed safe harbor, an employer could elect to use a "look-back period" of 3 to 12 months to determine whether each employee had worked an average of 30 or more hours per week (or 130 or more hours per month). If an employee is found to be full-time under this standard, the employer could continue to treat that employee as full-time for a "stability period" of at least 6 months (but no less than the duration of the look-back period). Similarly, an employee who is found *not* to be full-time under the look-back approach would not be considered full-time for the duration of the stability period.

Notice 2011-36 also asks for comments on an unrelated ACA provision. This is the requirement (also effective in 2014) that employer health plans limit any eligibility waiting period to 90 days or less. The Notice lists a number of questions that have already been posed to the IRS concerning this requirement. Comments are requested on the proper responses to those questions, as well as other issues associated with this limitation on waiting periods.

Employers that are likely to be affected by these "shared responsibility" or 90-day waiting period provisions of the ACA may wish to submit comments to the IRS. The Notice describes three different methods for doing so. Any such comments are due by June 17, 2011. *(Back to top)*

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FURTHER DELAY OF CERTAIN ACA-REQUIRED INTERNAL REVIEW PROCEDURES

As explained in our August 2010 article, "interim final regulations" issued under the Affordable Care Act (ACA) will require group health plans (other than those that are "grandfathered") to comply with a number of internal claims and appeals procedures that go beyond those previously required under ERISA. Although these new requirements are generally effective for plan years beginning on or after September 23, 2010, the Department of Labor (DOL) granted a limited extension of this compliance deadline in late 2010. Then in March of this year, the compliance deadline was *further* extended for certain of these requirements.

The ACA made the following changes to ERISA's claims and appeals procedures:

1. The types of "adverse benefit determinations" for which the internal claims and appeals procedures are available must include any "rescission" of coverage.
2. Notice of any denial of an "urgent care claim" must be provided within 24 hours, rather than 72 hours.
3. Plans must provide claimants with any new or additional evidence considered, relied upon, or generated in connection with the claim, as well as any new or additional rationale for a denial at the initial appeals stage, and a reasonable opportunity for the claimant to respond to the new evidence or rationale.
4. Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual (such as a claims adjudicator or medical expert) must not be based on the likelihood that the individual will support the denial of benefits.
5. Notices must be provided in a culturally and linguistically appropriate manner.
6. Notices to claimants must include the following additional content:
   a. Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
   b. In the case of any claim *denial*, the denial code and its corresponding meaning, as well as a description of the plan's standard (if any) that was used in denying the claim;
   c. A description of available internal appeals and external review processes, including information on how to initiate an appeal; and
   d. The availability of, and contact information for, an applicable state office of health insurance consumer assistance or ombudsman.
7. If a plan fails to *strictly* adhere to all of these requirements, a claimant is

deemed to have exhausted the plan's internal claims and appeals procedures – regardless of whether the plan has "substantially complied" with the requirements. This will allow the claimant to initiate any available external review process or remedies available under ERISA or state law.

All of these new rules were originally set to take effect for plan years beginning on or after September 23, 2010. However, in Technical Release 2010-02, the DOL granted an enforcement grace period until July 1, 2011, for *some* of the above standards. As explained in our October 2010 article, that enforcement grace period applied to standard #2, above (the timeframe for making urgent care decisions), standard #5 (providing notices in a culturally and linguistically appropriate manner), standard #6 (additional content in benefit determination notices), and standard #7 (strict compliance). In that Technical Release, the DOL announced that it would not take any enforcement action against a group health plan that was working in good faith to implement these standards.

The enforcement grace period has now been even *further* extended, but with a few modifications. Technical Release 2011-01 extends the enforcement grace period in two different respects. First, it extends *until plan years starting on or after Jan. 1, 2012*, the enforcement grace period for standard #2 (24-hour urgent care claim decisions), standard #5 (culturally and linguistically appropriate notices), standard #6(a) (*only* with respect to diagnosis and treatment codes), and standard #7 (strict compliance). This Technical Release also eliminates the requirement that plans be working in good faith to implement these standards.

Second, it extends *until plan years starting on or after July 1, 2011*, the rest of the additional disclosure requirements set forth in standard #6 (*i.e., other than* the diagnosis and treatment codes). Note that for non-calendar year plans, this compliance date could be earlier than January 1, 2012.

It is important to remember that Technical Release 2011-01 does *not* extend the compliance deadline for standards # 1, 3 or 4. Likewise, the enforcement grace period does not change the effective date for complying with the new *external* review processes required under the ACA. That requirement continues to be effective as of the first plan year beginning on or after September 23, 2010. However, the DOL did indicate in a footnote to Technical Release 2011-01 that the scope of the federal external review process (*i.e.,* for self-funded plans) is still under review and may be addressed in future guidance. *(Back to top)*

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MISPLACED ENROLLMENT FORM CREATES ERISA LIABILITY FOR SPONSOR

A small, Oklahoma-based employer recently learned that inattention to 401(k) plan governance can create costly corporate liability. It also learned that retaining the responsibility for collecting plan participants' investment election forms, and then forwarding them to the plan's recordkeeper, may not be advisable.

The case *(Womack v. Orchids Paper Products Co. 401(k) Savings Plan* (N.D. Okla. Feb. 15, 2011)) involved facts that are not unusual for many plan sponsors. Orchids sponsored a 401(k) plan for its 150 employees. When Orchids decided to change recordkeepers from Principal to Fidelity, employees were asked to submit new investment election and beneficiary designation forms. The accounts of those who failed to affirmatively make new investment elections were invested in the plan's qualified default investment alternative. Employees were given the option of submitting their new paperwork directly to Fidelity or to the employer's accounts receivable clerk, who would then forward the investment forms to Fidelity. The company retained the beneficiary designation forms in employee personnel files.

Carolyn Womack elected to submit her investment election and beneficiary designation forms to the company's accounts receivable clerk. Unfortunately, however, the clerk noticed only the beneficiary designation form (which was on top of the investment election form). She therefore failed to send Ms. Womack's investment election form to Fidelity. The predictable result was that Ms. Womack's new investment directions were not implemented, and her account suffered approximately $100,000 in losses. She then sued for breach of fiduciary duty under ERISA. Ultimately, she prevailed, as the court granted her motion for summary judgment.

On a superficial level, one might glean from this *Womack* decision the lesson that employers should be cautious when retaining certain responsibilities related to plan investments – particularly when those responsibilities can be assigned to others, such as the plan's recordkeeper. Had Orchids not given its employees the option of returning their investment election forms to its accounts receivable clerk, any liability for failing to implement those elections would have rested with Fidelity. That is certainly valuable information. But to stop there would be to miss an even more important lesson.

In this case, Ms. Womack sued the plan itself, the plan sponsor (Orchids), and two of the sponsor's senior executives. She sued the executives because the plan document authorized them to carry out certain fiduciary functions on the sponsor's behalf. Those executives had designated the company's accounts receivable clerk as the individual to whom participants

could return their investment election forms. (Ms. Womack did not sue the accounts receivable clerk who misplaced her investment election form.) She sued Orchids because the plan document designated Orchids as the plan administrator and named fiduciary. It is in this designation that the most important lesson from *Womack* lies.

The court dismissed the claim against the plan, because a plan is not a "fiduciary" under ERISA. Considering the claims against the executives, the court determined that, though they were fiduciaries of the plan, they did not breach any of the fiduciary duties they owed to the plan's participants. Acting as fiduciaries, they had merely delegated certain responsibilities to the accounts receivable clerk. The court found no evidence that their delegation of responsibilities, or their monitoring of the clerk thereafter, was imprudent. Thus, three of the four defendants were absolved of liability.

Orchids itself, however, was found liable for breach of fiduciary duty based on the acts and omissions of its accounts receivable clerk. Even though the clerk was performing what arguably should have been characterized as merely "ministerial" – and not fiduciary – functions, the court found that she was doing so as an agent of Orchids. And because the plan document named Orchids as a fiduciary, the court attributed fiduciary status to the clerk's actions: "The Court holds that Orchids – by and through [the clerk] – was functioning in its capacity as a fiduciary when performing the omission giving rise to the alleged breach."

Although we might question some of the court's analysis, the outcome almost certainly would have been different had the plan's governance structure been more carefully considered. We have repeatedly cautioned that giving the employer/plan sponsor a formal "fiduciary" role in the plan document can create unintended fiduciary liability under ERISA. As the *Womack* court's analysis demonstrates, when the plan sponsor is a named fiduciary, the acts or omissions of any of the sponsor's employees – even low-level clerks – can create fiduciary liability. Had the Orchids plan merely named either an administrative committee or the two executives as the plan's administrator and named fiduciary, Orchids most likely would have avoided liability.

The *Womack* case therefore holds at least three lessons for employers:

- Even small employers can be sued for large amounts under ERISA;
- Retaining the responsibility for collecting investment forms can be risky; and
- Thoughtful plan governance can prevent unforeseen corporate liability.

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FEE DISCLOSURE: A THREE-RING CIRCUS FOR PLAN FIDUCIARIES AND SERVICE PROVIDERS!

Employers sponsoring ERISA-covered, participant-directed, individual account plans (such as 401(k) or 403(b) plans) are constantly reminded of their fiduciary duties. In recent years, almost any discussion of these duties has included the issue of fees that are charged to participants' accounts (or that otherwise affect a participant's account balance). Fiduciaries are being told that they must (i) know what fees are being charged to or paid from plan assets, (ii) understand what those fees are for, (iii) make sure that the fees paid are reasonable in relation to the services provided, (iv) disclose certain fees to plan participants, and (v) report certain fees to the government. But where are all of these requirements coming from? And why is there so much more focus on fees than there was 10 years ago?

The Department of Labor ("DOL") is the federal agency charged with interpreting and implementing the Employee Retirement Income Security Act ("ERISA"), the 1974 legislation designed to protect the interests of participants and beneficiaries in employer-sponsored benefit plans, including tax-favored retirement plans. In recent years, both the DOL and members of Congress have become increasingly concerned about the effect that high fees can have on participant account balances in ERISA-covered retirement plans, particularly over the duration of the "accumulation phase" (the period during which participants are contributing to, rather than making withdrawals from, their retirement accounts).

The DOL has determined that, in many cases, neither the plan sponsor nor participants are fully aware of the actual "cost" of the plan's investments or the services provided to the plan. The DOL has also noted that, as revenue sharing has became more common, many plan sponsors and participants mistakenly believe that certain services are "free," when in fact the true costs of those services are hidden within the "expense ratio" associated with mutual funds or the "mortality and expense" fees charged on annuities and other insurance products offered as plan investment options.

In an effort to address this problem, the DOL has focused on three specific aspects of fee disclosure (although not necessarily in this order): (i) to plan fiduciaries by service providers and investment providers, (ii) to participants by plan fiduciaries, and (iii) to the government and the public by plan administrators (as a part of the Form 5500 annual reporting process). The result has been something of a three-ring circus. Unfortunately, fiduciaries and service providers would be well-advised to keep an eye on all three rings.

Ring #1: Disclosures to the Government and the Public

Because the last of the DOL's three fee initiatives (increased disclosure of fees on Form 5500 annual reports) is already fully implemented, the action in that ring is now well underway. Beginning with the 2009 plan year, "large" plan sponsors (those with over 100 participants) have been required to disclose additional information about fees paid to service providers on Schedule C to Form 5500. Under these rules, a plan sponsor must report the identity of, and the amount paid to, any service provider that received (from plan assets) at least $5,000 in direct or indirect compensation for services provided to the plan, or due to that provider's position with respect to the plan (*e.g.,* for serving as a trustee or administrator). For certain types of service providers, this $5,000 threshold is reduced to $1,000.

Although the requirement to complete and file a Schedule C falls on the plan administrator (which is often the plan sponsor), service providers are required, under ERISA, to provide plan administrators with the information needed to complete the annual report. In addition, service providers often provide "signature-ready" Forms 5500 for the plans they serve. Therefore, much of the burden of the Schedule C reporting requirement has been shouldered by service providers.

Although the other two disclosure initiatives have not yet been fully implemented, they are scheduled to take effect in the very near future. Accordingly, plan fiduciaries and service providers will now want to pay closer attention to the other two rings of the circus.

Ring #2: Disclosures by Service Providers to Plan Fiduciaries

The DOL has already issued both proposed and "interim final" regulations setting forth new standards for disclosure of fees by service providers. These rules were promulgated under Section 408(b)(2) of ERISA, which (oddly enough) is one of the "prohibited transaction" rules. Under Section 408(b)(2), it is a "prohibited transaction" for a plan fiduciary to enter into a contract with a service provider unless the contract is a "reasonable" contract or arrangement. That is, the plan may not pay more than "reasonable" compensation for the services rendered to the plan and its participants.

The interim final Section 408(b)(2) regulations provide that, effective January 1, 2012, a contract between a plan and a service provider will be deemed to be an "unreasonable" contract unless the service provider discloses (in advance) certain information about the services that will be provided to the plan, along with the direct *and indirect* compensation the service provider will receive in exchange for providing those services. These regulations reflect the DOL's belief that a responsible plan fiduciary cannot determine the reasonableness of an arrangement (or the reasonableness of the fees paid for services to the plan) unless

the service provider fully discloses the fees it will receive – either directly from the plan or indirectly from other parties related to the plan – for the services it is promising to provide.

Failure to satisfy these Section 408(b)(2) service-provider fee disclosure requirements (once they become effective) will have consequences for both the service provider *and* the responsible plan fiduciary. The parties will be deemed to have entered into a prohibited transaction, under both ERISA and the Internal Revenue Code. This would constitute a breach of fiduciary duty by the plan fiduciary (which could subject the fiduciary to civil penalties and personal liability for losses associated with that breach), and would also subject the service provider to a 15% excise tax. Therefore, both service providers and plan fiduciaries have a vested interest in satisfying the fee disclosure requirements of Section 408(b)(2).

Service providers and plan fiduciaries are currently awaiting "final" DOL regulations detailing exactly what information must be disclosed, as well as how and when that information must be provided to the responsible plan fiduciary. We understand that those regulations will soon be sent to the Office of Management and Budget for final review, meaning that they should be issued within the next few months. If they are not issued soon, however, it may be difficult for service providers to fully comply by the (currently proposed) effective date of January 1, 2012.

Ring #3: Disclosures by Plan Fiduciaries to Participants

The third initiative in this three-ring, fee-disclosure circus will require plan fiduciaries to disclose certain information about fees (including the fees associated with investment options) to plan participants. This is essentially an expansion of the fiduciary responsibility rules found in Section 404 of ERISA. The DOL has issued both proposed and final regulations setting forth the types of fee information that must be disclosed to participants, and those regulations are scheduled to become effective for plan years beginning on or after November 1, 2011 (i.e., January 1, 2012, for calendar-year plans).

Under the final regulations, fiduciaries of participant-directed, individual-account plans must notify participants – when they first become eligible to participate in the plan and annually thereafter – of the fees associated with both (i) the operation and administration of the plan (such as recordkeeping fees, loan origination fees, or QDRO review fees), and (ii) the investment options available under the plan. In addition, these regulations will require quarterly disclosure of any fees that have actually been charged to a participant's account during the previous quarter. Although these disclosures are technically the responsibility of a plan fiduciary, many fiduciaries will be looking

to their investment providers and/or service providers to help them satisfy these fee disclosure requirements.

Once the participant fee disclosure regulations become effective, many of the disclosures that are now required only if a plan intends to satisfy the requirements of ERISA Section 404(c) (which limits the liability of plan fiduciaries when participants exercise control over the investment of their accounts) will now apply to *any* plan that allows participants to direct the investment of their accounts.

After the Big-Top Comes Down: What Does It All Mean?

So what effect will all these disclosures have on plan sponsors and participants? Only time will tell. The DOL *hopes* that the service-provider fee disclosure rules will give plan fiduciaries the information they need to make more informed (*i.e.,* prudent) decisions when purchasing plan services and selecting investment providers.

For example, a "bundled" service provider may have formerly sold its services to plan sponsors by claiming that it will provide "free" recordkeeping and year-end testing and reporting services, so long as the plan chooses the provider's "proprietary" investment options (or an array of investment options that provide significant "revenue sharing" to the provider). Now, that same provider must disclose not only the amount of direct compensation it receives from the plan, but also the amount of revenue it expects to receive from third parties (such as the mutual funds selected as investment options under the plan).

In addition, under the separate participant fee disclosure rules, participants must be advised that, even if there are no fees explicitly assessed against their accounts for "recordkeeping" or "administration," a portion of the "investment management" fee (or "expense ratio") attributable to the plan's investment options is actually being paid to the plan's recordkeeper or other service provider to compensate them for providing those services.

This additional information should, in theory, allow participants to make more informed investment decisions with respect to the options available under the plan. Unfortunately, it could also lead to increased litigation by participants who feel that their plan fiduciaries are not prudently managing the plan's fees and expenses. Again, only time will tell, so stay tuned! *(Back to top)*

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WELLNESS PROGRAM CLEARS ADA HURDLE

In a recent decision, a Florida federal trial court waded into an area of the law that has generated substantial concern among employers wishing to implement wellness programs that include both a carrot *and* a stick. The result was surprisingly good news for those employers.

This decision (in *Seff v. Broward County*) arose from Broward County's imposition of a monetary penalty ($20 per bi-weekly pay period) on any participant in the County's health plan who refused to complete a health risk assessment (HRA) and undergo a biometric screening (including a finger-stick blood test to measure glucose and cholesterol levels). Citing the Americans with Disabilities Act (ADA) prohibition on involuntary medical examinations or disability-related inquiries, an employee who was assessed the penalty filed a class action lawsuit against the County.

This case first drew national attention in December of 2010, when the court certified the lawsuit as a class action. In its April 2011 decision, however, the court dismissed all of the ADA claims against the County. In so ruling, the court relied on an ADA "safe harbor" for "bona fide benefit plans that are based on underwriting risks, classifying risks, or administering such risks … ."

What makes this *Seff* decision interesting is that it might be something of a "game changer" in this area of the law. Until now, any ADA discussion of a wellness program has focused on whether the program is "voluntary." This was due to a "voluntary wellness program" exception to the ADA prohibition noted above. Under this line of analysis, the key question is whether a wellness program imposes a "penalty" on employees who *decline* to participate (making it "involuntary"), or merely "rewards" those employees who *agree* to participate ("voluntary").

Certainly, this was the analysis presented by the staff of the Equal Employment Opportunity Commission ("EEOC") in a 2009 letter addressed to an unnamed county (but sponsoring a wellness program that sounded suspiciously like Broward County's). According to this letter, any wellness program that includes a medical exam or disability-related inquiry must be "voluntary," and any penalty for not participating in the program makes it "involuntary." It's hard to argue with that logic.

But what the EEOC staff *failed* to address was the entirely separate ADA safe harbor relied upon by the *Seff* Court. Under the ADA's statutory framework, this "bona fide benefit plan" safe harbor applies not only to the substantive terms of a health plan (a context in which numerous courts have applied it to reject ADA challenges), but also the ADA prohibition on involuntary medical exams and disability-related

inquiries that are not "job-related and consistent with business necessity."

Broward County did not even try to argue that its wellness program was job-related or consistent with business necessity, perhaps because the EEOC's 2009 letter had specifically rejected such a characterization. Hence its need to find some other ADA defense. But rather than arguing that its wellness program was "voluntary" (probably a *losing* argument, in view of the monetary penalty – over $500 per year – imposed for not participating), the County relied on the bona fide benefit plan safe harbor.

The court analyzed the County's wellness program and found that it met the safe-harbor requirements. That is, the program was a "term" of the County's health plan (because only health plan enrollees were eligible for the program, and the program was administered by the plan's insurer). Moreover, the program was "based on underwriting, classifying, and administering risks because its ultimate goal is to sponsor insurance plans that maintain or lower its participant's [*sic*] premiums."

So how far does this *Seff* decision reach? Clearly, wellness programs must continue to be analyzed under both the Genetic Information Nondiscrimination Act (GINA) (*e.g.,* does an HRA ask for family medical history?) *and* the nondiscrimination provisions of the Health Insurance Portability and Accountability Act (HIPAA) (does the program offer an alternative route to any premium discount that is otherwise conditioned on satisfying a particular health status?). But does this decision *at least* give wellness programs a free pass under the ADA? We don't think so, for several reasons.

First, this was only a trial court decision. It could be reversed on appeal. And in the meantime, the decision is not binding on any court outside of south Florida.

Second, this wellness program was closely tied to the County's health plan, making it easy for the court to characterize the program as a "term" of that bona fide benefit plan. A more free-standing program – such as one covering *all* employees, or not administered by a health plan's insurer – might not be considered part of a health plan. (Whether such a free-standing wellness program could itself constitute a bona fide benefit plan is another unresolved question.)

Third, the ADA safe harbor for bona fide benefit plans is subject to its *own* exception for employer actions that are "a subterfuge to evade the purposes" of the ADA. Other courts – or the EEOC – might place greater weight on this "subterfuge" analysis.

Finally, Broward County's wellness program contained various safeguards that might have colored the court's ADA analysis. The program was administered by an outside insurer, and the County did

not receive any employee's personal information (only aggregated data). Any employee who was identified as having one of five specific "disease states" was given an opportunity to participate in a free disease management coaching program (but was not *required* to do so). After this coaching, such an employee would be eligible to receive certain medications at no additional cost. Finally, even those employees who declined to participate in the wellness program remained eligible for coverage under the County's health plan.

A wellness program failing to incorporate these types of safeguards might not be viewed as a "bona fide benefit plan." Or it could be viewed as a "subterfuge to evade the purposes" of the ADA. Either characterization would result in the program falling outside of the ADA safe harbor relied upon by the *Seff* court.

Clearly, wellness programs are here to stay. And employers who are dissatisfied with the low level of employee participation achieved through "rewards" are increasingly turning to "penalties" for *non*-participation. This recent decision suggests that, notwithstanding the EEOC's announced position, such an approach might be consistent with the ADA.

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IRS PROVIDES GUIDANCE ON SCOPE OF "UNFORESEEABLE EMERGENCY"

Most sponsors of Section 401(k) plans are familiar with the IRS standards for allowing active employees to withdraw their elective deferrals on account of "financial hardship." The same hardship withdrawal standards apply to Section 403(b) deferrals. However, far more stringent in-service withdrawal standards apply to nonqualified deferred compensation arrangements that are subject to Code Section 409A. These "unforeseeable emergency" standards apply to Section 457(b) plans, as well. In its Revenue Ruling 2010-27, the IRS has helped to define the scope of these unforeseeable emergency standards.

Actually, this is an area in which the IRS has long had guidance. Regulations issued under Section 457 spelled out specific standards for allowing in-service withdrawals due to unforeseeable emergencies. Those standards were then incorporated into a model amendment issued as part of Revenue Procedure 2004-56. According to this latest guidance, Section 5.10 of that model amendment provides for "unforeseeable emergency" withdrawals in all of the circumstances permitted under the Section 457 regulations.

In general, the standard for allowing a withdrawal on account of a participant's unforeseeable emergency requires that the participant experience a severe financial hardship due to one of the following events:

- An illness or accident of the participant, the participant's spouse, or the participant's tax dependent;
- The loss of the participant's property due to casualty;
- The need to pay for funeral expenses of the participant's spouse or tax dependent; or
- ***"Other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the participant."***

The highlighted phrase prompts the most questions in this area. That is, how "similar" must the circumstances be to any of the listed events in order to allow an active employee to obtain an in-service withdrawal from either a 457(b) plan or a nonqualified deferred compensation arrangement?

Both the regulations and the model amendment list examples of circumstances that are *deemed* to be "similar" for this purpose. These include the imminent foreclosure on, or eviction from, a participant's primary residence, or the need to pay for medical expenses, including non-refunded deductibles, and the cost of prescription medications. The examples specifically *rule out* withdrawals to purchase a home or to pay college tuition, on the ground that these events are not "unforeseeable."

The latest guidance makes clear, however, that these examples are not intended to be exhaustive. Rather, other factual circumstances may be sufficiently "similar" to the listed events to constitute an unforeseeable emergency. Based on the factual scenarios outlined in Revenue Ruling 2010-27, such circumstances might include the following:

- The need to repair a participant's principal residence due to significant water damage (assuming this damage is not covered by insurance and arises as a result of events beyond the participant's control), even though the damage may not be the result of a natural disaster; or
- The need to pay for the funeral expenses of a participant's adult child, even though the child is no longer a tax dependent of the participant.

On the other hand, this latest guidance also makes clear that certain circumstances do *not* constitute an unforeseeable emergency for this purpose. The example given in the Ruling involves a participant who requests an unforeseeable emergency withdrawal to pay accumulated credit card debt.

Because that debt was not itself due to any circumstances that were extraordinary and unforeseeable and that arose as a result of events beyond the participant's control, the IRS ruled that an in-service withdrawal could not be allowed. In other words, the IRS looks to the nature of the event that gave rise to the credit card debt, and not the fact that the accumulated debt may now be so large as to constitute an emergency from the participant's standpoint.

The upshot of this latest guidance is that any plan sponsor who is faced with a request for an unforeseeable emergency withdrawal should ask for proper documentation of the underlying debt. Absent such documentation, the request for a withdrawal should be denied. *(Back to top)*

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FORM 8955-SSA REPLACES SCHEDULE SSA

The Internal Revenue Service has announced that a new Form 8955-SSA ("Annual Registration Statement Identifying Separated Participants with Deferred Vested Benefits") has replaced Schedule SSA to the Form 5500.

Under Section 6057(a) of the Internal Revenue Code, a plan administrator must report certain information regarding plan participants who separated from service with deferred vested benefits. In the past, this reporting requirement was satisfied by submitting a Schedule SSA ("Annual Registration Statement for Deferred Vested Participants") along with a plan's Form 5500. However, Schedule SSA was eliminated from the Form 5500 package

beginning with the 2009 plan year. This was done to comply with the Department of Labor's electronic filing procedures (known as "EFAST2").

According to IRS Announcement 2011-21, the IRS and the Social Security Administration have jointly developed a Form 8955-SSA to satisfy the Section 6057(a) reporting requirement for plan years beginning on or after January 1, 2009. A draft of the Form 8955-SSA for use with the 2009 plan year has just been issued, and a 2010 version should be available later this year.

Generally, Form 8955-SSA must be filed with the IRS by the last day of the seventh month following the last day of the plan year (plus extensions). As with the Form 5500, Plan administrators may obtain an extension of time to file a Form 8955-SSA by filing a Form 5558. However, in order to give plan administrators additional time to complete and file Forms 8955-SSA for the 2009 and 2010 plan years, the IRS has extended the due date for both filings to the later of (1) the due date that would otherwise apply to the 2010 Form 8955-SSA, or (2) August 1, 2011.

The IRS has also developed a voluntary electronic system for filing a Form 8955-SSA. This electronic filing system will be operational once the Form 8955-SSA has been finalized.

The IRS will accept any Schedules SSA that were submitted for the 2009 or 2010 plan years if the filings were received by April 20, 2011. After that date, however, a Schedule SSA will no longer satisfy the Section 6057(a) reporting requirement.

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