

TEN EMPLOYEE BENEFITS TASKS TO DO NOW ¹

Employment Roundtable

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I. INTRODUCTION

Every fall you start to see the words “year end:” year end clearance sales, year end gardening tips or year end tax planning strategies. For businesses, fall is when forward-thinking managers start to consider the coming year and what needs to occur before it begins. This year, that things-to-do list should include several items regarding employee benefit plans. New laws and regulations, court decisions, changing economic circumstances and several other factors require employers to consider how those changes might affect their company, their employees and their plans. Some of the items on a company’s year-end things to do list are discussed below.

A. Find All of Your Company’s Deferred Compensation Plans

Internal Revenue Code Section 409A comprehensively regulates – and imposes drastic penalties for non-compliance – deferred compensation plans. “Deferred compensation” is the legally binding right in one year to compensation not paid until a future year. Many compensatory arrangements not traditionally thought of as deferred compensation fit within this definition, including stock options, phantom plans, employment or severance agreements and other common incentive compensation arrangements. Even employment offer letters including promises of bonuses or severance payments can constitute “deferred compensation” under the statute. The statute is not limited to compensation paid to employees. It also regulates compensation paid to directors, owners, independent contractors and anyone providing services to the business.

Failing to comply with §409A can accelerate taxation of several years’ worth of deferred compensation into a single year and subject it to income tax, interest and a 20% penalty tax. Although the recipient, not the company, pays the income tax, interest and penalty, the IRS may impose the tax due to the mere *presence* of a non-compliant arrangement. That means current executives, employees, Board members or consultants may have substantial income tax liabilities for payments that they have never received.

¹ This memorandum contains a summary of information obtained from laws, regulations, court cases, administrative rulings, and legal publications and should not be viewed or relied upon as legal advice. Ater Wynne LLP urges readers of this memorandum to consult legal counsel regarding specific legal issues and factual circumstances.

For example, a company presents an individual with an offer letter. The offer letter promises the individual that upon signing the offer letter, among other things the company will pay her a bonus equal to five percent of the company's profits in the coming year, will pay for a golf club membership and reimburse any moving expenses incurred in relocating. All of these items are "deferred compensation" subject to the statute unless an exception applies. If an exception is not available, section 409A offers a complex way to comply by making "deferral elections" by certain deadlines that specify specific payment dates at allowable times in the future.

Because of the breadth of the statute, a full discussion of its terms, helpful exceptions and ways to comply is beyond this brief introduction and summary. However, section 409A came with some fairly generous transition rules that expire at the end of this year. To take advantage of those rules, companies should take the following actions immediately:

- Identify all agreements and arrangements that might be "deferred compensation." Written employment or severance agreements, non-written policies or procedures may all include deferred compensation.
- Analyze whether the time and form of payment complies with section 409A, or whether exceptions are available. Outside counsel may be better able to do this quickly and efficiently.
- If necessary, change deferral and payment provisions to comply, considering the IRS guidance.
- Make deferral elections for 2009 compensation subject to §409A and document 2008 elections, if necessary, before the end of the year.
- Review stock option and stock appreciation right grants to determine if exercise price is at least fair market value, and if not, consider corrective actions.
- Consider on-going compliance with section 409A and what processes require change.

B. Conduct a Benefit Plan Review

After you've done a thing the same way for two years, look it over carefully. After five years, look at it with suspicion. And after ten years, throw it away and start all over. ~Alfred Edward Perlman, American Industrialist

Periodically, we take our vehicles in to get checked out and tuned up. Things that no longer work so well get repaired or replaced, and the vehicle's performance increases and it becomes more efficient. Similarly, an employer's objectives, benefit plan costs, workforce and tax laws change over time. Simply because something made sense a decade ago is not a good reason to continue doing the same thing now. Periodically, employers should check out and tune up their benefit plans.

In conducting the check up, keep in mind the five big-picture reasons for offering employee benefit plans in the first place:

- It allows the employer to distinguish itself from its competitors in attracting and retaining desired employees
- It encourages (and rewards) higher levels of employee performance
- It aligns employee performance with the employer's strategic goals
- It minimizes company cash outlays, accelerates company income tax deductions and defers employee income tax obligations, and
- It provides a higher perceived value to the employee than it costs the employer.

Like any other check-up, begin with some questions about your company's current benefit plans:

- Do our company's benefit plans have gaps or overlaps in coverage?
- Have our company objectives changed since we originally established our benefit plans?
- Do we anticipate or have we experienced any acquisitions, mergers or spin-offs?
- Have our employee demographics or population changed? What affect does this have on our employee benefit plans?
- Can our benefit program help the company or our employees save on their income taxes?
- Are new plan design features, administration practices or new products available to provide better benefits or help reduce benefit plan costs?
- Do our current benefit programs provide the best value to the company and our employees?
- Do our employees understand and appreciate their benefits?
- Do our employees know the full cost of the benefits they receive? Is the value they place on those benefits more than, less than or equal to the cost of providing them?
- Do our benefit providers offer appropriate services? Is the cost reasonable?
- Do our benefit providers coordinate with each other? With us?
- Do our employees want or need benefits we do not provide? Are there benefits we provide which our employees do not want or need?
- How do our benefit programs compare with our hiring competitors or within our industry?

C. Review the Service Providers for your Company's Employee Benefit Plans

If a business provides benefits to its employees, there are two consequences. First, the benefit plan is subject to ERISA, and second, someone (usually the company or one of its officers) is now a fiduciary of the plan. The obligations of a fiduciary to the participants and beneficiaries of a plan “are the highest known to the law.”² ERISA §404(a)(1) states:

“A fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries . . . with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.”

In other words, acting as a fiduciary means your actions are compared to experts in that field and must satisfy some very high standards. And failing to meet those standards is expensive: the fiduciary has *personal* liability for breaches of his/her fiduciary responsibility to plan participants. Participants may sue *any* fiduciary to the plan for damages caused by such breaches. The U.S. Dept. of Labor (“DOL”) may also enter the action, or file its own action. The DOL may also assess a civil penalty of twenty percent of the amount it recovers and impose additional penalties, including criminal penalties.³ The IRS has some jurisdiction over these plans and may assess its own penalties and excise taxes, in addition to the DOL penalties.⁴

Because the liability is personal, the fiduciary is responsible to use personal assets (or insurance proceeds) to make good any losses to the plan resulting from the breach, or restore any profits made through the use of the plan assets by the fiduciary. A court may also impose any other remedies it deems appropriate, including removal of the fiduciary.

Thus, fiduciaries should be very careful with the decisions they make. The selection, retention or termination of service providers and vendors to the plan are all fiduciary decisions. The Employee Benefits Security Administration, the part of the DOL that enforces ERISA, provides a list of 12 items that a plan fiduciary should consider when selecting and subsequently monitoring a service provider⁵:

1. Consider what services you need for your plan – legal, accounting, trustee/custodial, recordkeeping, investment management, investment education or advice.
2. Ask service providers about their services, experience with employee benefit plans, fees and expenses, customer references or other information relating to the quality of their services and customer satisfaction with such services.

² *Donovan v. Bierwirth*, 680 F.2d 263, 272 (2nd Cir. 1982).

³ ERISA §501, 502(a)(2), (1)(1).

⁴ See, e.g., Internal Revenue Code section 4975.

⁵ <http://www.dol.gov/ebsa/newsroom/fs052505.html>, as visited October 6, 2008.

3. Present each prospective service provider identical and complete information regarding the needs of your plan. You may want to get formal bids from those providers that seem best suited to your needs.
4. You may also wish to consider service providers or alliances of providers who provide multiple services (e.g., custodial trustee, investment management, education, or advice, and recordkeeping) for a single fee. These arrangements are often called “bundled services.”
5. Ask each prospective provider to be specific about which services are covered for the estimated fees and which are not. Compare the information you receive, including fees and expenses to be charged by the various providers for similar services. Note that plan fiduciaries are not always required to pick the least costly provider. Cost is only one factor to be considered in selecting a service provider. More information on pension plan fees and expenses can be found in *Understanding Retirement Plan Fees and Expenses and the 401(k) Fee Disclosure Form*, located at www.dol.gov/ebsa.
6. If the service provider will handle plan assets, check to make sure that the provider has a fidelity bond (a type of insurance that protects the plan against loss resulting from fraudulent or dishonest acts).
7. If a service provider must be licensed (attorneys, accountants, investment managers or advisors), check with state or federal licensing authorities to confirm the provider has an up-to-date license and whether there are any complaints pending against the provider.
8. Make sure you understand the terms of any agreements or contracts you sign with service providers and the fees and expenses associated with the contracts. In particular, understand what obligations both you and the service provider have under the agreement and whether the fees and expenses to be charged to you and plan participants are reasonable in light of the services to be provided.
9. Prepare a written record of the process you followed in reviewing potential service providers and the reasons for your selection of a particular provider. This record may be helpful in answering any future questions that may arise concerning your selection.
10. Receive a commitment from your service provider to regularly provide you with information regarding the services it provides.
11. Periodically review the performance of your service providers to ensure that they are providing the services in a manner and at a cost consistent with the agreements.
12. Review plan participant comments or any complaints about the services and periodically ask whether there have been any changes in the information you

received from the service provider prior to hiring (e.g. does the provider continue to maintain any required state or Federal licenses).

Plan fiduciaries should consider these suggestions as they decide which services to provide directly and which services to outsource. Periodic reviews of the plan, its needs and what providers may be appropriate is required to fulfill fiduciary requirements, and can often uncover unnecessary functions or lower cost alternatives. Documenting the arrangement with a written services agreement is always beneficial. However, using the form provided by the service provider without legal review is not recommended. Many include waivers or limitations of liability or damages that may be recovered by the service provider.

D. Review the Enrollment Process for New Hires

Many employers have either started or are just about to start their annual benefits plan open enrollment. While the existing employee enrollment process is going on is a good time to look at the process used for enrolling newly hired employees. This review may also suggest plan design changes. For example, if the 401(k) plan requires completion of three months of service should the health plan do likewise? Should enrollment information and meetings occur once or more often, depending on initial eligibility criteria for the various benefit plan offered, to avoid overwhelming new employees?

Think through new-hire benefits enrollment

New hire enrollments can occur at any time of the year. It is therefore more difficult to use an established routine, increasing the chance of improper communications, providing incorrect election forms or related forms processing errors. New employees must take several steps must to take full advantage of the retirement, health and welfare benefits available to them and to make informed choices.

Determine benefit eligibility

The first step in enrolling a new employee is to determine which benefits they are eligible for. This will usually depend on the employee's job classification – full-time or part-time, hourly or salaried, rank-and-file or executive. Employee status can also affect available benefit choices, required contributions, and coverage start dates. Think about who does this and how and when it is done.

Prepare the enrollment information package

In addition to the appropriate forms for enrolling in available benefit plans, the following information should be included in all new-hire enrollment packages:

- **Pre-tax choices.** If you offer a cafeteria-type plan, advise new employees of the benefits and limitations associated with making pre-tax contributions to benefit plans or to dependent care and health flexible spending accounts.
- **Tax consequences.** Communicate the federal and state tax implications of benefit plans to the new employee. For example, the value of employer-paid life

insurance may be taxable to the employee. Employer-paid disability coverage may cause disability benefit payments to be taxable. And employer contributions to health savings accounts or certain other benefit plans may be exempt from federal income tax but not state income tax.

- **Dependents, domestic partners or same-sex spouses.** If the company provides dependent, domestic partner, same-sex spouse or similar coverage, explain the coverage available for the employees' dependents, and who the plan(s) consider a "dependent." Advise employees who are enrolling dependents, a domestic partner or same-sex spouse of the relevant federal and state tax and legal implications and what verifications (if any) are required. (see section E below).
- **Enrollment deadlines.** Provide clear instructions about when and how to return which enrollment forms. Explain the consequences (for example, no coverage, default coverage) if enrollment materials are not timely returned to the correct place.
- **Beneficiary designations.** If any plans provide death benefits, ensure that the employee receives beneficiary designation forms and information. An insurer often has to approve designations, especially complex ones. The employee should be instructed to consult with a qualified adviser regarding any complex designations.
- **Evidence of insurability.** Any evidence-of-insurability requirements should be communicated to newly eligible employees for any life or disability insurance. (Most group health plans are not permitted to require evidence of insurability.)
- **Required group health plan notices.** Group health plans must provide employees with several required notices. Public employers that have opted out of complying with HIPAA portability and other federal mandates are required to provide only the Medicare notice.
- **HIPAA portability special enrollment notice.** Advise employees that if they or a family member decline group health plan coverage when first eligible, they may enroll later upon providing proof of loss of other coverage for certain specified reasons. For plans with dependent coverage, employees must be allowed to enroll later if they gain a dependent.
- **Information about HIPAA portability pre-existing condition exclusions.** If the plan includes a pre-existing condition restriction, new participants must be notified of the exclusion and the right to demonstrate creditable coverage to reduce the exclusion period.
- **Women's Health and Cancer Rights Act notice.** Newly covered employees (not spouses or dependents) must receive a WHCRA notice describing the availability of federally mandated breast reconstructive surgery benefits. Note that employees must also receive the notice annually.

- **Medicare creditable coverage notices.** If your plan covers prescription drugs, you must give creditable coverage notices to any Medicare Part D-eligible participants. Anyone enrolled in Medicare A or B, even as secondary coverage, must be told whether the employer's drug coverage is at least as good as Part D and therefore creditable. To be sure new hires properly receive this notice, you should include it in their enrollment package.

Provide information to vendors and insurers

Once the new hire returns any required enrollment materials, you must send the forms and documentation to the relevant insurance carriers or other service providers on a timely basis. Failure to timely send enrollment forms to insurers can lead to employer liability for incurred claims. You will need to have an administrative procedure for accepting certificates of creditable coverage and forwarding them to the vendor administering medical claims payments and the pre-existing condition restriction.

Distribute post-enrollment communications

It would be nice if the initial packet finished the job. However, you now need to distribute the following notices and other materials to a new hire who has enrolled in a benefit plan:

- **Summary Plan Descriptions.** For ERISA plans, participants must receive an SPD that describes the material provisions of the benefit program within 90 days after participation begins.
- **General COBRA notice.** ERISA plans and public employers must provide the general COBRA notice to employees and their spouses within 90 days of first enrolling in a group health plan.
- **HIPAA privacy notice.** Employees must receive a privacy notice when they enroll in a group health plan.
- **HIPAA portability pre-existing condition notice.** If the group health plan includes a pre-existing condition restriction, new enrollees must be notified if the plan determines that a pre-existing condition exclusion period applies to the employee or a covered family member.

Complete internal administration tasks

To complete the process, you must submit the new hire's benefits elections to the payroll department, calculate imputed income where necessary for non-tax exempt dependents and group term life insurance coverage, and file any required waiver of coverage forms returned by employees who do not enroll in coverage.

E. IDENTIFY DEPENDENTS FOR EMPLOYEE BENEFIT PURPOSES

The Internal Revenue Code includes several tax-free employer benefits for "dependents" of employees. Two common examples are employer-paid health benefits covering dependents and

dependent care assistance plans. Until recently, each benefit had different criteria for identifying who was a “dependent,” usually based on the relationship of the individual to the employee, their age and residency. In 2004 Congress amended the federal tax code to add a uniform definition of “dependent” intended to simplify eligibility for the various benefits.

Under the new definition, employee benefits are tax-free only if they are provided to the employee’s “qualifying child” or “qualifying relative.” A qualifying child

- Is the employee’s son, daughter, stepchild, sibling, stepsibling, or descendent of any of these individuals (e.g., a grandchild, niece or nephew). Adopted or foster children are also included.
- Has the same principal residence as the employee for more than one-half of the taxable year. Special rules apply for divorced or legally separated parents. Temporary absences for education, military service, vacation or illness are not treated as absences for purposes of the residency test.
- Is under age 19 at the end of the year, or is under age 24 if a full-time student, or is totally and permanently disabled and beginning in 2009 is also unmarried and younger than the employee.
- Does not provide more than more than one-half of their own support for that taxable year.

A qualifying relative:

- Is not a qualifying child of the employee or any other taxpayer.
- Is the employee’s child or child’s descendent, sibling (including half-sibling) or sibling’s child, parent or their ancestor, aunt, uncle, in-law or any member of the employee’s household having the same residence as employee other than a spouse for that taxable year.
- Has gross income less than \$3,500 for 2008 (amount adjusted annually). However, for purposes of the plans discussed below this requirement is not applicable.
- Receives over one-half their support from the employee.

How the definition affects employee benefits depends on the type of benefit and the individual involved. For example, same sex marriages, civil unions, or domestic partnerships may exist under state law, but federal income tax law does not recognize those individuals as “spouses.” To receive income tax-free benefits under federal law, such individuals must qualify as the taxpayer’s “qualifying relative.” The impact of the new definition on common types of employee benefits is illustrated below.

Health Insurance

Persons that meet the definitions of qualifying child or qualifying relative may continue to receive tax-free employer-provided health benefits, if the health plan document's eligibility provision so provides. Note the difference in residence requirements between the two definitions: six months for a qualifying child, a full year for qualifying relative. A child that spends a significant portion of the year with the non-employee parent or other relatives may not be a "qualifying child."

Dependent Care Assistance Plan (DCAP) and Health Savings Accounts

DCAP eligibility is similar to health insurance. Thus, a domestic partner or an elderly parent of the employee that meets the 50% support test and resides with the employee may be a dependent, and the DCAP benefits used to pay for in-home care expenses for them are not taxable to the employee. Health Savings Accounts (an IRA-like arrangement paired with a high deductible health insurance plan that allows individuals or their employer to make pre-tax contributions and receive tax-free distributions to pay for medical expenses for themselves and their dependents) use the same rules as DCAPs.

Hardship Distributions From 401(k) or Nonqualified Deferred Compensation Plans

Many 401(k) and nonqualified deferred compensation plans allow participants to make in-service hardship withdrawals (called "unforeseen emergencies" in nonqualified plans) if the participant meets certain circumstances. New IRS regulations also allow such hardship distributions for non-spouse dependents if the dependent receive more than 50% of their support from the employee and meets the residency and other tests.

Other Affected Plans

Several other types of employee benefit plans may provide benefits to the employee's dependents. Flexible Spending Accounts (FSA), tuition reimbursement plans and long-term care plans all typically provide for dependent eligibility. Once again, the statutes regulating the various benefits usually refer to 'dependents' as defined in IRC §152.

Action Steps

Employers should review their benefit plan document to identify how they describe "dependent," and ensure the definition matches the employer's objective. Employers will need to decide who they want to receive plan benefits and proceed accordingly, after understanding the tax consequences of the decision. Some employers may use (or their insurer requires) an affidavit to establish an individual's eligibility as a qualifying relative. Health plans that currently offer same-sex partner, domestic partner or civil union benefits should review their certification processes for designating dependents for health benefit purposes. Employers may also need to revise the explanatory and enrollment material used to describe the benefits, eligible dependents and income tax consequences.

All benefit plans may continue covering individuals that do not meet the new definition of dependent. However, those individuals must also satisfy the definition of qualified child or

qualified relative for the benefit to be exempt from federal income tax. Otherwise, the employer creates a taxable benefit, triggering administrative withholding and reporting complications. If the employer wants to retain the tax-free nature of the benefit, the employer may need to amend the plan document and the related employee communications (SPDs, enrollment forms, etc.) and administrative procedures.

Another reason to consider reviewing who is a dependent is to ensure that only eligible dependents are covered by the plan. This is important for two reasons: first, because ERISA requires the plan be administered in accordance with its terms, and second, it is expensive covering dependents and most employers prefer to not cover any more than they have to. With ever-escalating health care costs, covering only those truly eligible for benefits may reduce the cost of health coverage for the employer.

F. Implement New Reporting Procedures for Incentive Stock Options

For some time the Internal Revenue Code has required corporations to provide written statements to employees regarding transfers of stock pursuant to an option or purchased under an ESPP by January 31. In 2006, Congress amended the Code to require the employer to also submit information returns to the IRS regarding the transfers beginning in 2007. However, because the IRS did not have regulations, forms or processes in place, in late 2007 the IRS waived the requirement for the 2007 calendar year (meaning no IRS reporting in early 2008).

The IRS recently published Proposed Regulations on the IRS filing process. The Proposed Regulations describe the content and form used to satisfy the filing requirement. New IRS form 3921, Exercise of an Incentive Stock Option and IRS form 3922, Transfer of Stock Acquired Through an Employee Stock Purchase Plan are used to provide this information to employees *and are filed with the IRS*. They are not yet available on the IRS web site.

Although the Regulations are effective as of January 1, 2007, they indicate that companies are not required to comply with the return filing requirements for transfers occurring during 2007 and 2008. So the first filing deadline under the new process will be January 31, 2010, for transactions occurring during 2009. The Proposed Regulations allow companies to continue relying on the current version of the regulations for transfers occurring through the end of 2008, meaning the reports issued to individuals in January 2009 (for 2008 transactions) are unchanged and are not reported to the IRS.

For option exercises occurring after 2008, the report must be provided to the individual using IRS form 3921, which is also filed with the IRS, and which will require the following information to complete for each exercise:

- Name, address and employer identification number of the company transferring the stock (and the same information for the issuer of the stock, if different)
- Name, address and taxpayer identification number of the employee
- The grant date

- The exercise price per share (instead of the total cost of the shares acquired, as required by the current regulations)
- Exercise date
- Fair market value of the stock on the exercise date
- Number of shares of stock transferred pursuant to the exercise of the option

For purchases under an ESPP after 2008, the written report to the employee is done using IRS form 3922 that will require:

- Name, address and employer identification number of the company (and the same information for the issuer of the stock, if different)
- Name, address and taxpayer identification number of the employee
- Grant date (i.e., the enrollment date – not required under the current regulations)
- Fair market value of the stock on the date of grant/enrollment (not required under the current regulations)
- Purchase price per share (not required under the current regulations)
- Date of exercise/purchase (not required under the current regulations)
- Fair market value of the stock on the date of exercise/purchase (not required under the current regulations)
- Date of transfer of legal title to the stock
- Number of shares transferred

Although these are proposed regulations, we expect them to be finalized later this year with little if any modification. Since transactions occurring during 2009 will be subject to the new rules, employers need to consider how to modify current processes now in order to compile the required information necessary to complete the IRS forms in early 2010.

G. Conduct Welfare Plan Discrimination Tests

Employers choose how to structure compensation packages for their employees. Usually that choice includes some fringe benefits. Employer-sponsored benefits are a useful tool in attracting and retaining a workforce and can offer an employer a competitive advantage. However, an employer must satisfy statutory criteria in order to maintain the tax-free nature of the benefit. Usually, those statutes impose non-discrimination tests. As a result, the employer's ability to restrict the benefit to a favored group may be limited by the outcome of discrimination tests.

Initially, some issues are common to all tests: they tend to compare one group of employees to another, usually based on compensation levels, status or ownership. Each type of benefit plan test has a disfavored group, but may define the group using different names such as “highly compensated employee” or “highly compensated individual” or use different criteria to select the group’s members. So, an individual in a disfavored group for one plan may not be in the disfavored group for a different plan.

Testing occurs at two levels. First, each component plan will have specific tests it must pass. Then any cafeteria plan containing those non-discriminatory component plans must pass the tests applicable to it. A summary of the tests applicable for each type of plan is below.

Medical, Dental and Vision Plans

Fully insured health plans are not subject to specific nondiscrimination testing. Instead, they are only indirectly subject to nondiscrimination rules through the tests applied to the cafeteria plan. Self-insured health plans are subject to substantial additional testing.

Short-term and Long-term Disability Plans

These plans are also not subject to specific nondiscrimination testing, whether insured or self-insured and likewise are only indirectly subject to the testing of the cafeteria plan.

Health Flexible Spending Account (FSA)

The FSA is subject to two tests: the Eligibility Test and the Benefits Test. Both tests compare “Highly Compensated Individuals” (HCI) with non-HCIs. An HCI is one of the five highest paid officers, a shareholder owning *more* than ten percent of the value of the company’s stock, or among the highest paid 25% of all non-excludable employees.

The Eligibility Test has three alternatives; the Benefits Test has a single test with two parts. The Eligibility Test alternatives compare participation by HCIs and non-HCIs. If at least 70% of all employees are “participating,” (i.e., making salary deferrals into the plan) the plan passes. The other two forms of the test are more complex but again compare HCI and non-HCI participation rates.

The Benefits Test looks to the FSA document and its operation. The document cannot provide benefits for HCIs that non-HCIs cannot receive. For example, a FSA plan that allows HCIs to contribute \$2,000 but non-HCIs only \$1,000, or allowed HCIs reimbursement of expenses denied to non-HCIs is facially discriminatory. Discrimination in operation is a facts and circumstances test. Examples might be offering reimbursement of certain expenses only during periods when an HCI incurs the expense or applying a lower claims substantiation standard for HCIs than non-HCIs.

Failure to pass both tests causes benefits from the plan paid to HCIs to become taxable.

Group Term Life Insurance

This benefit is also subject to an Eligibility Test and a Benefits Test. However, the disfavored employees are called “key employees” (“Keys”). Keys are employees that satisfied any of the following tests on any day of the year: (i) an officer having annual compensation more than \$150,000 (adjusted annually); (ii) owns more than five percent of the outstanding stock or voting power of the employer; or (iii) owns more than one percent of the employer and has compensation of more than \$150,000.

A group term life insurance plan is discriminatory if it discriminates in favor of Keys as to eligibility to participate. The plan is discriminatory unless it passes one of four versions of the Eligibility Test, including the cafeteria plan eligibility test discussed below. All four versions of the test compare the eligibility of participation by Key and non-Key employees. The benefits test compares the benefits available under the plan to Key and non-Key employees. A common safe harbor method of passing this test is limiting the allowable benefit to a uniform percentage of the employee’s compensation. Failing to pass the test results in the Keys’ benefit becoming taxable income.

Dependent Care Account (DCAP)

DCAPs are subject to four different discrimination tests: Eligibility, Contributions and Benefits, 5% Owners Concentration and Average Benefits Tests. All but the 5% Owner test involve Highly Compensated Employees and their dependents (“HCEs”) and non-HCEs. An HCE is an employee that owned more than 5% of the employer during the current or preceding year *or* earned more than a specified amount of compensation during the prior year (for 2008, the amount is \$105,000). The 5% Owner test considers employees or their family members that own more than 5% of the employer. Failing to pass all four tests results in the DCAP benefits becoming taxable income to the HCEs.

Cafeteria Plans

Once the component plans pass the various nondiscrimination tests applicable to them, the cafeteria plan as a whole is tested. The cafeteria arrangement as a whole must demonstrate nondiscrimination by passing an Eligibility Test, Contributions and Benefits Test and a Key Employee Concentration Test. The first two tests focus on “Highly Compensated Participants” or “Highly Compensated Individuals.” Both mean the same group: an officer; a shareholder owning more than 5% of the voting power or value of all classes of stock of the employer; highly compensated; or a spouse or dependent of an individual described above.

The Eligibility test has three parts (the employment, entry and nondiscrimination classification tests). The Contribution and Benefits test considers benefit availability and utilization, and provides a safe harbor for certain plans. The Key Employee test requires the Key employees to receive no more than 25% of the nontaxable benefits provided to all plan participants. If any test fails, benefits to the disfavored group associated with the failed test (either Key employees or highly compensated”) become taxable.

Recommendations

As you can see, to maintain the tax-free nature of these benefits requires some effort. Employers should review with their benefit plan administrators the results of each test. The Service Agreements with the vendors should require the vendor to perform the tests annually and to provide written summaries of the results to you for review. If tests are not run and the IRS audits the company, the IRS may reclassify the benefits as taxable, requiring the highly compensated employees, shareowner-employees or others to include those potentially substantial amounts in income. The IRS audit window is at least three years before the current year, and the inclusion of these amounts may have spill over effects such as triggering AMT, golden parachute payment limits, under-reporting penalties or excise taxes and interest.

H. Update Your Cafeteria Plan to Comply with New Regulations

Employers sponsoring a Cafeteria plan should examine the plan considering new cafeteria plan regulations effective January 1, 2009. When it proposed the new regulations, the IRS withdrew the previous version. That left the new proposals as the only definitive guidance on most of the fundamental features of cafeteria plans.

The new proposed regulations are for the most part to be effective for plan years beginning on or after January 1, 2009. Employers may rely on the proposed regulations pending the issuance of final regulations.

The new regulations' significant provisions include:

Written Plan Document. A cafeteria plan must have a written plan document that includes:

- the benefits available;
- the plan's eligibility provisions;
- an explicit prohibition that prevents participation by non-common law employees;
- procedures for making elections between benefits;
- procedures for making salary reduction contributions;
- a stated maximum contribution per employee; and
- the plan year.

Nondiscrimination Requirements. As discussed above, cafeteria plans cannot favor highly compensated employees with respect to eligibility, contributions or benefits. A key employee discrimination test also applies. The new proposed regulations clarify terms and establish a framework for performing the tests.

Flexible Spending Accounts. Notable changes include:

- *Advance Payment for Orthodontia Work.* Orthodontists often require up-front payment for services provided over a period that extends beyond the current plan year. Under the previous regulations, it was not clear whether the plan could reimburse payment for services not yet provided. The new regulations directly address this and provide that such expenses are eligible for reimbursement.
- *Dependent Care Expenses incurred After Termination.* Dependent Care FSAs can reimburse qualified dependent care expenses incurred after employment ceases.
- *Uniform Coverage Rule.* Health FSAs do not violate the rule that the maximum reimbursement amount be available on the first day of the plan year by making reimbursements payable on a monthly or shorter interval, or by setting a “reasonable minimum amount” for reimbursements (not more than \$500).
- *New Adoption Assistance FSA.* The new regulations introduce a third type of FSA, for adoption assistance. Adoption assistance FSAs must satisfy the tax code requirements for adoption assistance programs (i.e., the FSA may be used only to reimburse expenses that an employer could pay on an employee’s behalf on a tax-favored basis).
- *Experience Related Gains.* A consequence of the use-or-lose rule is that FSAs may end up with a surplus at the end of the plan year. The new proposed regulations clarify that employers can retain these experience gains for their own use if they choose.

The proposed regulations establish a higher, more detailed standard for an arrangement to qualify as a cafeteria plan. The regulations are not final – and it is not known precisely how or when they will be finalized. However, they indicate a clear direction the IRS is heading. As the only existing regulatory guidance regarding the fundamental features of cafeteria plans, employers should strongly consider conforming their plan document and plan administration practices to the proposed regulations. As mentioned above, employers may rely on the proposed regulations.

I. EVALUATE YOUR INVESTMENT POLICY STATEMENT

As mentioned above, plan fiduciaries are expected to meet a very high standard of conduct and performance. To avoid personal liability for failing to do so, every fiduciary needs to know their responsibilities and carry them out under ERISA’s guidelines. ERISA requires that every employee benefit plan “provide a procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan and the requirements of this title.”⁶

ERISA, the DOL regulations and the cases that interpret them impose a duty on fiduciaries to prudently select and then periodically monitor the plan investments. ERISA defines fiduciary compliance in terms of “procedural prudence.” To determine whether a fiduciary fulfilled its

⁶ ERISA §402(b)(1).

duty, procedural prudence looks at the procedure used in selecting and monitoring the investment option, not its performance:

“[ERISA’s] test of prudence ... is one of conduct, and not a test of the result of performance of the investment. The focus of the inquiry is how the fiduciary acted in his selection of the investment, and not whether his investments succeeded or failed.”⁷

The first step in using a prudent procedure is to have a procedure. It might be possible for investment fiduciaries to follow an unwritten procedure, . However, any unwritten procedure will be difficult to articulate if questioned. And, if the fiduciaries’ actions are questioned, it is be unlikely that all of the plan fiduciaries will have consistent understandings of what that unwritten policy is. Also, documenting compliance with an undocumented policy sounds somewhat difficult. If investment fiduciaries aspire to procedural prudence in the selection and monitoring of plan investments, a logical -- and prudent -- place to start is with a written IPS.

Like any other important document, an IPS should be carefully drafted by an attorney familiar with employee benefits issues, working with the fiduciaries and their investment consultants. A well-drafted IPS should provide guidelines for the investment fiduciaries, but leave the decisions to their judgment, and not mechanically require removing funds for failure to meet those guidelines. This flexibility will minimize the risk of generating claims of a breach of fiduciary duty for a failure to follow the terms of the IPS.

Although an IPS should be unique to the plan using it, most IPS include:

- A framework for investment decision-making and clearly define the responsibilities and authority of each party involved in the investment program. It will discuss how often the investment fiduciaries will meet to review plan investments, and how they make decisions and communicate with plan participants, other fiduciaries and service providers. The IPS should offer a documented fiduciary audit trail for any investment-related decision.
- The broad array of fund offerings or investment classes and how they are selected. It should detail how individual fund options are selected and monitored on an ongoing basis. Common key quantitative factors include: net-of-fees returns relative to appropriate benchmarks; risk metrics on both an absolute and a benchmark-relative basis and a rolling return period analysis. Key qualitative factors include: the portfolio manager’s tenure; the stability of the organization; the depth of investment resources; and the fund’s physical location. Many studies conclude these qualitative assessments are often a better predictor of investment results than past performance.
- How the fiduciaries will monitor the investment’s ongoing performance. Plan fiduciaries should do this at least annually, and probably quarterly. Those responsible for the plan need a good understanding of the overall economic and general market conditions. Take, for instance, the current volatility caused by the

⁷ *Donovan v. Cunningham*, 716 F.2d 1455, 1467 (5th Cir. 1983).

problems with certain financial stocks. It would be impossible to evaluate an equity manager without understanding what is happening in this part of the market.

- Making sure the fund's management has not undergone major changes, and the fund is still in an appropriate class (i.e., "style drift"). Analyze the extent to which investment policies have been carried out and how they have affected the actual results.
- Looking carefully at the plan's investment-related vendor contracts and service agreements to make sure the fiduciaries are getting what they pay for. The first step is to ensure that they are receiving full disclosure of all fee arrangements.

Finally, there is an important practical reason for having an IPS--an IPS is evidence of a carefully considered and executed investment strategy, that should, over the long term, provide superior investment results for all of the participants, including those who serve as investment fiduciaries.

J. CONSIDER NEW ENROLLMENT AND INVESTMENT PROVISIONS

The Pension Protection Act of 2006 included a number of significant changes to how participants are enrolled in retirement plans and how fiduciaries can help those participants make sound investment decisions. Congress enacted these laws in response to data showing about one-third of employees eligible for 401(k) type plans do not participate in them. Studies suggested that automatically enrolling eligible employees would reduce that number to less than ten percent.⁸

However, that created a fiduciary risk issue: since the participants had not affirmatively selected investment options, plan fiduciaries would have liability for the investment selections that they made on behalf of the automatically enrolled participants. So Congress addressed both problems: it removed legal impediments to automatic enrollment, provided incentives for adopting it and added fiduciary relief for those doing so.

Eligible Automatic Contribution Arrangement (EACA)

An automatic contribution arrangement provides that unless the eligible employee affirmatively elects otherwise, they are enrolled in the plan and a default initial deferral election applies. An affirmative election would generally require the participant to elect a deferral amount, including a zero election.

The employer can extend the automatic contribution arrangement to current participants that have already elected not to defer or defer less than the initial default percentage. The employer must provide each eligible employee with an opportunity to make or change their deferral election at least once during each plan year.

⁸ Fact Sheet, U.S. Dept. of Labor, *Regulation Relating to Qualified Default Investment Alternatives in Participant-Directed Individual Account Plans* (October 2007).

The initial default election begins when the employee is first automatically enrolled. The employer may choose to provide for an annual step up provision to increase the deferral percentage each succeeding year. The employer must apply the initial default election uniformly to all eligible employees. However, the plan may vary the deferral amount based on the number of years an eligible employee has participated in the automatic contribution arrangement.

Under an EACA, the employer must provide a notice to each employee subject to the automatic contribution arrangement. The employee must receive the notice a reasonable period before becoming eligible for the plan to allow the participant time to make an alternative deferral election. In addition, the employer must provide a notice before the beginning of each subsequent plan year. Under an EACA, automatic contributions must be invested in a Qualified Default Investment Alternative (QDIA).

The employer is permitted, but not required, to include a permissible withdrawal provision for contributions made pursuant to an EACA. A participant may request to receive a distribution equal to the amount of default elective deferral contributions plus applicable gains and losses. Employer matching contributions attributable to the default elective deferral contribution are forfeited.

The EACA must be in effect as of the first day of the plan year. However, an EACA may add the permissible withdrawal option during the plan year if applied prospectively to automatically enrolled participants and is reflected in the participant notice.

An additional benefit of adopting an EACA is making corrective ADP distributions up to six months after the end of the plan year and avoiding the 10% excise tax, instead of 2½ months.

Qualified Automatic Contribution Arrangement (QACA)

A QACA combines an automatic contribution arrangement with a safe harbor contribution to satisfy the required annual ADP and ACP testing. In addition, such a plan meets the top heavy requirements if the only contributions are the deferrals and the safe harbor contributions. The QACA requirements are:

- The initial minimum qualified default percentage is between 3% and 10%. After the initial period, an automatic step up provision increases the deferral percentage by 1% for each of the next three plan years.
- The minimum qualified percentage is at least 4%, 5% and 6% in third, fourth, fifth, and subsequent years, respectively. The automatic step up provision is not necessary if the initial default percentage is at least 6%.
- An employer matching contribution of 100% of the first 1% of deferrals and 50% of the next 5%, or a 3% non-elective contribution regardless of whether the participant defers.
- Full vesting no later than completing two years of vesting service.

- The plan provides an annual notice to participants informing them of their rights, ability to make changes, and provides a reasonable period to make any changes. This includes the participant's right to elect not to have elective deferral contributions made or to elect a different percentage of compensation, and how contributions will be invested in the absence of any investment decision by the participant. The notice must be provided at least 30 days, but no more than 90 days, before the beginning of each plan year. For a plan with immediate eligibility, the timing requirement would be satisfied if the employee is provided the notice on the first day of employment.

The traditional safe harbor requirements also apply to a QACA, including:

- The QACA must be adopted before the first day of the plan year and remain in effect for the entire plan year. An exception applies for a newly established 401(k) plan, or a profit sharing plan adding a 401(k) component, which requires the first plan year to be at least three months.
- QACA matching contributions may be calculated using compensation paid during either the full plan year or each payroll period.
- Any additional discretionary match cannot exceed 4% of an employee's compensation. The employer must not match more than the first 6% of deferrals (QACA safe harbor match and additional match combined). For the allocation of additional discretionary match, a last day and/or hours requirement cannot apply.
- Additional non-elective contributions to the plan are allowed and may require a last day and/or hours condition for allocation purposes.
- QACA contributions are not available for in-service withdrawals prior to age 59½ or as a hardship withdrawal at any time.

The automatic contribution arrangement must be applied uniformly to all eligible employees. A plan does not fail to meet this requirement if the percentage varies due to the exceptions previously described for an EACA. An employer utilizing a QACA may also elect to meet the requirements of an EACA. This would allow permissible withdrawals within 90 days following the first elective contribution under the automatic contribution arrangement.

Qualified Default Investment Alternative

As mentioned above, plan fiduciaries are responsible for the investment of plan assets unless a participant makes their own investment decisions (and the plan complies with a number of additional requirements). The new statute and regulations release them from liability for investing QACA or EACA (and certain other participants) if the fund satisfies the regulation's requirements for a Qualified Default Investment Alternative ("QDIA"). In order to qualify as a QDIA, plans must meet six conditions.

1. Assets Must Be Invested in a QDIA. Any default investments must be invested on behalf of participants to a QDIA. A QDIA is one of four specific categories of investment alternatives:

- A fund with a blend of equity and fixed income investments that considers the individual's age, retirement date or life expectancy (for example, a life-cycle or target-retirement fund);
- An investment service that allocates participant contributions among existing plan investment options to provide an asset mix that also takes into account the individual's age and retirement date, such as a professionally managed account;
- An investment product with a mix of equity or fixed income investments that takes into account the characteristics of a group of employees as a whole, such as a balanced fund; or
- A capital preservation product, such as a money market fund, but only for the first 120 days of participation in the plan.

A QDIA must be managed by a registered investment manager, a mutual fund family or bank trust department or a named fiduciary under the plan, in the case of large plan sponsors with an in-house investment management service.

2. Participants Must Have Had Opportunity to Direct the Investment. The participant must have had the opportunity to direct the investment of the funds but failed to do so. Upon this failure to direct, the fiduciary may utilize the QDIA process.

3. Transfers Out of QDIA Must be Available at Least Quarterly Without Financial Penalty. Participants in a QDIA must be allowed to transfer QDIA funds to any other available investment alternative with the same frequency provided to non-QDIA investments. Transfers must be permitted at least quarterly. No restrictions, fees or expenses (other than fees charged on an ongoing basis, such as investment management, 12b-1 fees and administrative-type fees) may be imposed on transferring assets from the QDIA for the first 90 days of a participant's investment in the QDIA.

Fees and expenses charged after 90 days cannot be any greater for QDIA participants than those applied to participants who make affirmative investment elections. Once a participant makes an affirmative election to transfer any assets in a QDIA to another investment vehicle, the participant is considered to have made an affirmative election to leave the remainder of the assets in the QDIA. The participant is then no longer deemed to be invested in a QDIA.

4. Provide Initial and Annual Notice. Participants must receive notice of the QDIA at designated times. The plan must provide an initial notice at least 30 days before the date of initial eligibility or before the first QDIA investment. It can be provided on or before the date of plan eligibility as long as plan participants are allowed 90 days to make a "permitted withdrawal" from the default account. Subsequent annual notices must be sent within a reasonable period of time of at least 30 days in advance of each subsequent plan year.

The notice cannot be included within a summary plan description. However, notices can be sent with other documents such as quarterly statements or annual enrollment notices. In addition, plans that already have to provide automatic enrollment notices or 401(k) safe harbor notices can combine these notices with the annual QDIA notice. The notice can be provided electronically.

The notice generally must describe: (a) the circumstances under which the individual's plan assets may be invested in a QDIA; (b) the QDIA option and how it operates; (c) the right of the participants whose assets are invested in a QDIA to direct the investment of those assets to any other investment alternative; and (d) how the participants can obtain investment information concerning the other investment alternatives available under the plan.

5. Provide Investment Materials (e.g., Prospectuses). The fiduciary must provide material relating to a participant's investment in a QDIA. For example, a prospectus or proxy voting materials may be required and can be sent directly from the provider to the participant. This requirement is similar to that already imposed on ERISA 404(c) plans.

6. Offering A Broad Range of Investment Alternatives. The final condition is that participants must have the opportunity to invest in a broad range of investment alternatives. This range should achieve a diverse portfolio with risk and return characteristics typically appropriate for the participant. Again, most participant-directed plans already attempt to comply with this standard.

The QDIA rules are not the only way for fiduciaries to satisfy their responsibilities regarding the investment of assets on behalf of a participant who fails to give investment directions. Plan fiduciaries "must engage in an objective, thorough, and analytical process that involves consideration of the quality of competing providers and investment products, as appropriate" and "must carefully consider investment fees and expenses" when choosing a QDIA.

II. CONCLUSIONS

One nice thing about working with employee benefits is each year is a new opportunity to make good things better. Engaging in year end processes give you a change to make a meaningful contribution to the success of your employer, the financial security of your employees and your job easier. Periodically taking a step back to think about why we do what we do is always productive and beneficial. Even if the result is keeping the status quo, you now know that things are the way they should be and have evidence to support that opinion.