Employee Benefits Report

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Understanding Retirement Plan Fees and Expenses

ERISA (the Employee Retirement Income Security Act), the federal law governing private-sector retirement plans, requires those responsible for managing retirement plans to carry out their responsibilities prudently and solely in the interest of the plan's participants and beneficiaries. Called "fiduciaries," these individuals also have a responsibility to ensure that the services provided to their plan are necessary and their cost is reasonable.

Why Consider Fees?

Fees and expenses can have a substantial cumulative effect on plan participants' retirement savings. Therefore, understanding and evaluating the fees and expenses associated with retirement plans are an important part of a fiduciary's responsibility.

A variety of plan fees and expenses may affect your organization's retirement plan. They generally fall into three categories: **administration fees, investment fees** and **individual service fees.**

Plan Administration Fees. These fees cover the plan's day-to-day operating expenses, such as recordkeeping, accounting, legal and trustee services. This can also in-

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This Just In…

Disclosure deadline: Administrators of "participant-directed individual account plans," such as 401(k)s, have until August 30 to make required fee and investment option disclosures to plan participants and beneficiaries. If your organization sponsors such a plan, your service provider should have provided your administrator with the necessary information by July 1.

The U.S. Department of Labor promulgated the rule, which establishes uniform, basic disclosures and requires administrators to provide investment-related information in a form that allows participants to easily compare a plan's investment alternatives. It protects administrators from liability for the completeness and accuracy of information they provide to participants if the

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clude the cost of providing additional services to participants, such as educational seminars, retirement planning software, investment advice, electronic access to plan information, daily valuation and online transactions.

Some plans deduct the costs of administrative services directly from investment returns. When administrative costs are billed separately, they may be borne, in whole or in part, by the employer or charged directly against the assets of the plan. In the case of a 401(k), profit sharing, or other similar plan with individual accounts, administrative fees are either allocated among individual accounts in proportion to each account balance (a "pro rata" charge) or passed through as a flat fee against each participant's account (a "per capita" charge). Generally the more services provided, the higher the fees.

Investment Fees. By far the component of plan fees and expenses is associated with managing plan investments. Fees for investment management and other related services generally are assessed as a percentage of assets invested. Employers should pay attention to these fees. They are paid in the form of an indirect charge against the participant's account or the plan because they are deducted directly from investment returns. Net total return is the return after these fees have been deducted. For this reason, these fees, which are not specifically identified on statements of investments, may not be immediately apparent to employers.

Individual Service Fees. In addition to overall administrative expenses, a plan may charge fees to the accounts of those participants who take advantage of a particular plan feature. For example, a participant may have to pay fees for taking a loan from the plan or for executing participant investment directions.

Fees Associated with the Investment Choices

Apart from administration fees, a plan may charge two basic types of fees in connection with plan investments or investment options made available to participants and beneficiaries. These fees, which can be referred to by different terms, include:

- Sales charges (also known as loads or commissions). These are basically transaction costs for buying and selling shares. They may be computed in different ways, depending on the particular investment product.
- Management fees (also known as investment advisory fees or account maintenance fees). These are ongoing charges for managing the assets of the investment fund. They are generally stated as a percentage of the amount of assets invested in the fund.

Funds that are "actively managed" (i.e., funds with an investment adviser who actively researches, monitors and trades the holdings of the fund) generally have higher fees than funds that are "passively managed." The higher fees are associated with the more active management provided and increased sales charges from the higher level of trading activity. While actively managed funds seek to provide higher returns than the market, neither active management nor higher fees necessarily guarantee higher returns.

Funds that are "passively managed" generally have lower management fees. Passively managed funds seek to obtain the investment results of an established market index, such as the Standard and Poor's 500, by duplicating the holdings included in the index. Thus, passively managed funds require little research and less trading activity.

Fees and expenses are one of several factors to consider when you select and monitor plan service providers and investments. The level and quality of service and investment risk and return will also affect your decisions. For more information on setting up and administering an employee retirement plan, please contact us.

plan administrator reasonably and in good faith relies upon information provided by a service provider.

Administrators of calendar- year plans must provide the initial annual disclosure no later than August 30, 2012. The first quarterly statement must then be furnished no later than November 14, 2012.

The rule does not apply to plans involving individual retirement accounts or individual retirement annuities, such as SIMPLE IRAs.

For more information on your disclosure responsibilities, please see the fact sheet at www.dol.gov/ebsa/newsroom/fsparticipantfeerule.html or contact us.

Covering the Disability Income Gap

Employer group disability income plans offer tremendous tax advantages to both employer and employee. The employer can deduct premiums as a business expense, and they do not count toward the employee's taxable income. However, group disability plans usually do not provide enough coverage for upper management and highly compensated employees. Here's how to provide for these employees' additional coverage needs.

The basic group disability income policy acts as a safety net for your employees when a disability keeps them out of work. A basic policy probably provides enough coverage for rank-and-file employees, but its structure can create a major coverage gap for higher-income employees.

Most group policies replace 50 to 60 percent of pre-disability income—enough to help cover basic expenses while out of work, but not enough to create a disincentive to returning to work. In addition, policies have a maximum monthly benefit. Depending on the insurer, your industry, location and the size of your group, that maximum could be as low as $3,000 or $4,000 for smaller groups, and range from $7,000 to $15,000 for larger groups. If you have executives, salespeople and others earning more than $300,000 per year, this level of basic group plan won't even replace 60 percent of their pre-disability earnings.

The policy's definition of earnings could create another stumbling block to adequate income replacement. Most group policies pay a benefit equal to a percentage of the employee's "basic monthly earnings." This usually includes gross salary but may exclude commissions and bonuses. For salespeople and executives with significant commission and bonus income, this could result in a serious income shortfall in the event of a disability.

To remedy this problem, a number of insurers have developed supplemental group disability plans, popularly known as disability buy-ups. These plans allow highly compensated employees to combine the employer's basic group coverage with another plan to receive a higher monthly benefit in event of disability.

You can structure a buy-up plan in several ways:

Employer-paid plans: In an employer-paid plan, the employer pays all premiums, which it can deduct as an ordinary business expense. Premiums do not count toward the employee's taxable income, but he/she will have to pay income tax on any benefits received.

An executive buy-up plan often involves two tiers of coverage: a guaranteed issue policy and a modified guaranteed issue policy. If your group of highly compensated employees is large enough, your insurer might be willing to write a guaranteed issue policy, which means the insurer asks no medical questions and provides a group policy at standard rates. This ensures that even executives with health problems will be able to obtain coverage.

For the second tier of coverage, a modified guaranteed issue plan, the insurer will ask some simple medical questions to make its coverage decision. It may decline to cover an individual, exclude coverage for a pre-existing condition or charge extra premium.

In some buy-up plans, the employer "carves out" coverage for highly compensated employees, providing them with the basic group

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plan and then supplementing it with individual disability income policies. Insurers typically individually underwrite individual disability income plans, but may make individual policies available on a guaranteed-issue basis for larger groups. Individual plans also offer better rate guarantees and portability than group policies. Unlike with employee-paid individual policies, however, any benefits received under an employer-paid policy will be taxable income.

Employer-sponsored (voluntary) plan: The most popular approach to supplemental disability coverage, voluntary plans, require the employer merely to act as plan sponsor, allowing the insurer to directly solicit employees. Employees who elect coverage pay 100 percent of premium. If the employer has a Section 125 (cafeteria) plan, employees can pay premiums with pre-tax dollars; any benefits received will be taxable. Employees can also opt to pay premiums with after-tax dollars and receive policy benefits tax-free.

Hybrid plan: In a hybrid plan, the employer pays premiums on supplemental coverage for a select group of employees. Employers can deduct premiums as a business expense, but covered employees must pay income taxes on benefits. Other employees can buy the supplemental coverage on a voluntary basis.

Gross-up plans for key employees: For higher-paid key employees, having the employer pay the premiums makes any benefits received taxable. Since it may be difficult to get an insurer to replace enough of the highly compensated employee's pre-disability pay, this employee would not want to lose benefits to taxes. To avoid this, the employer can gross-up the employee's pay by the amount of the premium, and have the employee pay the premium with after-tax dollars, making the benefits tax-free. In this arrangement, the employee pays the tax only on the amount of the pay increase, and receives any benefits tax-free.

Negotiating Buy-Up Benefits

To start your search for a buy-up plan, first determine the number of highly compensated employees you want it to cover. The size of the eligible group (both number and percentage of eligible employees), along with plan features, will affect your costs. If your benefits budget can handle an employer-paid or hybrid plan, you will reward your highly compensated employees and help guarantee their financial health. If you cannot commit to an employer-paid plan, a voluntary plan could still give highly compensated employees a valuable benefit by giving them access to a guaranteed issue or modified issue plan with the convenience of payroll deduction payments.

For more assistance in structuring a disability income plan to fit the needs of all your employees, please contact us. ■

How to Spot and Stop FMLA Abuse

The Family and Medical Leave Act (FMLA) has helped organizations establish a family-friendly environment. On the other hand, it has introduced administrative cost and worries, chief among them FMLA abuse.

The FMLA generally requires covered employers to provide up to 12 weeks of unpaid, job-protected leave in any 12-month period for the birth or adoption of a child; to care for a sick child, parent or spouse; or when an employee has a serious health condition. The law applies to your organization if it employs 50 or more employees within a 75-mile radius for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year. An individual working for an organization subject to the FMLA qualifies for FMLA leave if he/she has worked a minimum of 1,250 hours in the preceding year.

Problems arise most frequently when employees take intermittent leave. When is that leave legitimate and when is it not? Forty-two percent of human resource professionals surveyed said the potential for or suspicion of abuse by employees causes "extreme difficulty" in administering intermittent FMLA leave, according to a study by WorldatWork, a Scottsdale, Ariz.-based human resource association.

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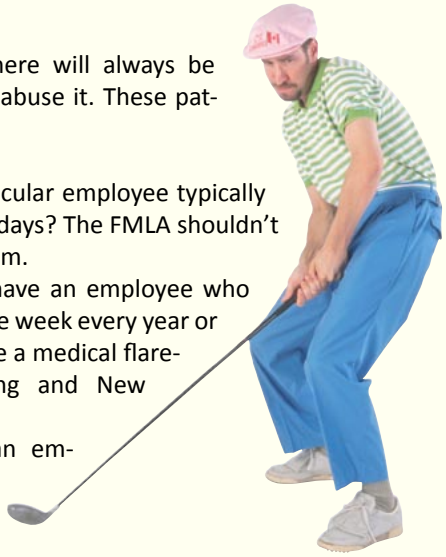
Be an Abuse Detective

As with any program, there will always be some employees who try to abuse it. These patterns could indicate abuse:



- The Weekender. Is a particular employee typically absent on Mondays or Fridays? The FMLA shouldn't be a long weekend program.
- The Vacationer. Do you have an employee who takes FMLA leave the same week every year or who always seems to have a medical flare-up between Thanksgiving and New Years?
- The Accountant. Does an employee have exactly 12 weeks' worth of health problems every year?
- The Sleepyhead. Do employees use FMLA requests to save them from violating attendance policies?

An Ounce of Prevention

What can you do if you suspect FMLA abuse? You certainly want to be cautious before accusing an employee of fraud or misuse of FMLA leave, but you can create an environment where abuse becomes more difficult, according to Matthew E. Johnson, an attorney with the labor law firm of Halleland, Lewis, Nilan & Johnson. Here's how:

- Adopt a written policy that clearly defines FMLA policies and prohibits employees from engaging in certain conduct while on FMLA leave.
- Request a second medical opinion concerning the employee's condition, as permitted by FMLA regulations.
- Have employees acknowledge in writing that they have received the policy.
- Let it be known that you're willing to question the employee with the goal of obtaining an admission of wrongdoing, or as an alternative, obtaining information (that doesn't violate HIPAA regulations) from private investigators or outside sources.
- Make it clear that FMLA time runs concurrently with sick leave, vacation, paid time off, short-term disability or workers' comp, for example. This may deter some who don't really need the leave.
- Brief employees on the consequences of ignoring FMLA deadlines and requirements.

Despite these warnings, most employees use FMLA benefits properly. The law has achieved its goal of creating a structure in which employees feel comfortable taking time off without fear of losing their job. Before the law's adoption, employees might have been reluctant to take time off out of concern for losing their job or having the leave held against them.

For more information on complying with the FMLA and other employment laws and regulations, please contact us.

Supreme Court Rules on Affordable Care Act

In June, the U.S. Supreme Court upheld the constitutionality of two contentious provisions of the Affordable Care Act (ACA) in the case National Federation of Independent Business et al. v. Sibelius, Secretary of Health and Human Services, et al. The decision paves the way for continued implementation of the law.

The ACA's "individual mandate" requires most Americans to maintain "minimum essential" health insurance or pay a "shared responsibility payment" to the federal government. Opponents argued that compelling individuals to buy something unconstitutionally expanded Congress's power to regulate commerce. However, the court determined that the "shared responsibility payment" is a tax and therefore within Congress' authority.

The Act also requires state Medicaid programs to cover adults with incomes up to 133 percent of the federal poverty level by 2014; many states have more limited coverage. It allows the Secretary of Health and Human Services to penalize states that choose not to expand Medicaid by taking away Medicaid funding. The court's majority found that witholding funds was incompatible with the Constitution's Spending Clause, but nothing prohibited the federal government from offering states funds for Medicaid expansion.

Most plan administrators, trustees and organizational representatives surveyed by the International Foundation of Employee Benefit Plans in late June reported they would "definitely" or "very likely" provide health coverage in 2014, when health insurance exchanges created by the ACA are scheduled to go into effect.

As for their opinion of the decision, organizational representatives in the public sector, which stands to benefit the most, showed the most satisfaction with 59 percent satisfied. The multi-employer (49 percent) and single employer/corporation (33 percent) sectors had lesser degrees of satisfaction with the Supreme Court's ruling. Interestingly, organizations in states that have already implemented health insurance exchanges are generally more satisfied with the Supreme Court's decision (47 percent, versus 35 percent of respondents in states that haven't implemented). They are also more prepared with current provisions (47 percent to 36 percent) and more likely to continue coverage in 2014 (56 percent to 42 percent). ■

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