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5th EDITION

EMPLOYEE BENEFITS GUIDE

A Comprehensive Guide for Indiana Employers

**Ogletree
Deakins**

Employers & Lawyers. Working Together

Employee Benefits Guide

A Comprehensive Guide for Indiana Employers

Fifth Edition

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September 21, 2020

Dear Reader:

The Employee Benefits and Executive Compensation Group of Ogletree Deakins Nash Smoak & Stewart (“Ogletree Deakins”) proudly joins the Indiana Chamber of Commerce to provide Indiana employers with this fifth edition of the Employee Benefits Guide.

Employee benefits continue to be a heavily regulated and increasingly complex topic for employers to navigate. With new regulations come new opportunities for tax-favored benefit plan design options that help companies attract and retain employees with cutting-edge benefits. Unfortunately, the rules also provide additional compliance burdens and legal exposure for employers.

Our employee benefits lawyers work with companies across the nation to design benefit plans, address compliance problems, and assist with claims issues. This book will help you understand the different types of benefit plans that employers commonly offer, as well as the legal obligations attached to those plans.

This book includes:

- Legal outlines and descriptions of new legislation
- Discussion of tax advantages and funding options using a “pro” and “con” identification process
- Identification of trends and ideas emerging in the workplace
- Detailed compliance charts

Among several other legal updates, this fifth edition includes discussion of new legislation applicable to retirement plans and addresses issues that have arisen in the wake of the implementation of the Patient Protection and Affordable Care Act. We have also included several updates to the complex tax rules that apply to fringe benefits offered by employers.

September 21, 2020

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Please visit our web site at www.ogletreedeakins.com where you can subscribe to our Employee Benefits Blog free of charge and receive weekly emails with our insights about the most recent developments affecting employee benefits, compensation, and human resources. To learn more about the services our professionals provide, please check out our website or feel free to contact us at any time.

Sincerely,

Ogletree, Deakins, Nash, Smoak & Stewart, P.C.



Stephanie Alden Smithey

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Employee Benefits and Executive Compensation, Mergers and Acquisitions, RIF/WARN



Kevin practices ERISA and employee benefits with an emphasis on qualified retirement plans, nonqualified deferred compensation, and severance plans/arrangements. He distills complex and archaic employee benefits problems into practical, useful advice that leads to best-in-class solutions for clients.

The majority of Kevin's practice focuses on executive compensation. He advises public and private employers (tax-exempt and for-profit) on nonqualified deferred compensation, excess plans, top hat plans, change in control arrangements, short and long-term and retention bonus plans/arrangements to comply with ERISA and Code Sections 83, 162(m), 280G, 409A, 457, 4960, and 4999. Kevin has substantial experience with Code Section 409A's document and operational corrections programs. Kevin prepares equity plan documents and awards and associated participant communications, and advises on tax and employment aspects of incentive stock options, nonqualified stock options, stock appreciation rights, restricted stock, restricted stock units and performance-based awards.

Kevin also specializes in the benefit and compensation aspects of employee severance plans/arrangements, early voluntary retirement windows, and reductions-in-force. He advises on plan design and structure, ERISA implications (including ERISA coverage and pension plan avoidance), and Code Section 409A (and 457(f)) compliance or avoidance for such plans/arrangements.

Kevin advises clients on matters that maintain retirement plan qualification, avoid maladministration, and correct document and operational failures. He prepares retirement plan correction submissions under the IRS's EPCRS program and the DOL's VFCP and DFVCP programs, and assists clients with IRS and DOL audits advocating on their behalf. He has significant experience with employee benefits in corporation transactions, including, performing pre-closing due diligence, drafting employee benefit portions of asset and stock purchase agreements, and addressing post-transaction integration issues, including retirement plan mergers, terminations, and spin-offs. He also leverages his significant experience with annual retirement coverage and nondiscrimination testing to eliminate plan inefficiencies while maximizing client value in maintaining retirement plans.

Kevin is a Shareholder in Ogletree's Indianapolis office. Prior to joining Ogletree, Kevin practiced employee benefits at law firms in Cincinnati, Ohio and Denver, Colorado, and, during law school, he worked at the United States Senate Budget Committee where he advised legislative analysts on complex tax issues.

Admitted to Practice:

Indiana
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Ohio

Matthew Hoffman

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Matt Hoffman joined the Indianapolis office of Ogletree Deakins in 2019 in the Employee Benefits and Executive Compensation practice group. He assists clients with ERISA compliance matters, focusing on qualified plans. He graduated in 2019 from the University of Florida Levin College of Law with a Master of Laws in Taxation. He is a 2018 graduate of Brigham Young University's J. Rueben Clark Law School. As a JD student, Mr. Hoffman clerked with Senator Hatch's Judiciary Committee Staff. Mr. Hoffman received his Bachelor Degree in Business Management at Brigham Young University.



Jessica Kuester

Of Counsel || [Indianapolis](#)

Jessica Kuester practices in the area of employee benefits. She has experience representing employers in a wide variety of compliance areas, including health plans and retirement plans. She advises employers on compliance with the Affordable Care Act, HIPAA, COBRA, and ERISA. With extensive experience in drafting health plan documents, Jessica has designed compliant 125 cafeteria plans, HIPAA programs, and "wrap" health plan documents. She has also provided HIPAA training for employers' workforces.

Jessica also works with employers to keep their retirement plans in compliance with relevant laws, with experience in both defined benefit and defined contribution plans. She assists clients with IRS and DOL audits, as well as internal compliance audits and plan corrections.



Paralegal Bio



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Practice Areas:

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Ms. Lucas has worked continuously as an Employee Benefits Paralegal since 1988. She devotes her focus to all aspects of employee benefits law. The majority of her experience has involved health and welfare plans, assisting in plan design, compliance, and administrative issues associated with such plans.

Her primary focus is on welfare benefit plans, including drafting plan documents (health plans, cafeteria plans, consumer directed health plans, and fringe benefit plans) and summary plan descriptions, drafting and reviewing administrative compliance documents including compliance with COBRA, HIPAA, FMLA, USERRA laws, assisting with compliance with health-related laws including the Affordable Care Act, and assisting clients with general compliance issues with these plans. In addition, she assists attorneys throughout the firm with benefit plan filings with the Internal Revenue Service and the Department of Labor, as well as researching client legal compliance and tax issues.

Professional Associations:

- Indiana Benefits Conference (Past Board member, 2009-2012); Member
- Indiana Paralegal Association
- American Bar Association
- Worldwide Employee Benefits Network (Past Board member, 1990-1992)

Ann Carr Mackey

Of Counsel || [Indianapolis](#)

Ms. Mackey has practiced law for over 35 years. Early in her career she was a criminal attorney, litigator, environmental attorney, estate planning attorney and divorce attorney. For more than 20 years, she has specialized in employee benefits. Since the Affordable Care Act was enacted in the spring of 2010, Ms. Mackey has played a key role helping employers comply with the requirements of Health Care Reform. She is co-chair of Ogletree Deakins' Health Care Reform Subgroup.

As an employee benefits lawyer, Ms. Mackey has advised large and small employers regarding the design and operation of their benefit plans, defended employers in IRS and DOL audits, cured plan defects, and assisted with benefits due diligence in acquisitions and divestitures. She advises companies on the design and operation of company-owned or leased primary care medical clinics.

Because of her broad legal background, Ms. Mackey is uniquely positioned to help employers evaluate and manage risks arising from the design and operation of their benefit plans.

Ms. Mackey is a frequent speaker on benefit topics, in particular the employer mandate and other requirements of Health Care Reform.



Paralegal Bio

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Employee Benefits

Ms. Mounts has worked continuously as an employee benefits paralegal since 1988, and prior to working in employee benefits, she worked for two years as a general corporate paralegal.

Her primary focus is qualified employee benefit plans, including drafting plan documents, drafting summary plan descriptions and administrative forms, preparing IRS determination letter applications for qualified plans, assisting with benefits issues involved in mergers and acquisitions, reviewing and assisting with the preparation of qualified domestic relations orders, and researching and assisting employers with legal issues surrounding plan administration and corrections of plan failures under IRS programs. She is proficient in Word, Excel, PowerPoint, and RIA Checkpoint.

In 2009, the IRS introduced a federal program to allow retirement plan professionals to earn the designation of Enrolled Retirement Plan Agent ("ERPA"). Tracy was among the first in the country, as well as the first person in Indiana, to earn the ERPA designation by passing a comprehensive ERPA Special Enrollment Examination relating to retirement plan matters. To maintain this ERPA designation, she continues to meet extensive annual continuing legal education requirements. The ERPA designation enables Tracy to represent clients and communicate directly with the IRS with respect to specific tax matters, including the IRS determination letter application and retirement plan corrections programs.

Tracy has had the opportunity to speak on several retirement plan administration and correction topics. As an active member of the Indiana Benefits Conference since 1994, Tracy served on its Board for several years and as its Chair for the 2007-2008 membership year.

Professional Certification: Enrolled Retirement Plan Agent (ERPA)

Professional Associations:

- Indiana State Paralegal
- American Bar Association
- NALA (National Association of Legal Assistants)
- NFPA (National Federation of Paralegal Associations)
- Indiana Benefits Conference

Elizabeth W. O'Gara

Of Counsel || [Indianapolis](#)

Ms. O'Gara works with private, not-for-profit, publicly traded, and governmental employers with the plan design and implementation of qualified retirement plans, including 401(k) plans, profit sharing plans, money purchase pension plans, and employee stock ownership plans (ESOPs). This includes the analysis of clients' existing retirement plans to determine the best options to meet employer objectives and the drafting of plan documents.

She advises clients and their human resources, payroll, and accounting employees regarding the establishment of procedures for day-to-day data collection for the administration of employee benefit plans. Additionally, she works in conjunction with accountants, lawyers, and consultants in structuring and drafting a wide range of documents relating to employee benefit plans and their operation. Ms. O'Gara negotiates and drafts service provider agreements, including agreements with fiduciaries, valuation firms, and third party administrators.

Ms. O'Gara performs compliance assessments of clients' employee benefit plans, identifies potential issues and concerns, and determines the best methods to correct compliance problems, including correction of errors under the Employee Plans Compliance Resolution System (EPCRS).



Catherine R. Reese

Shareholder || [Indianapolis](#)

Ms. Reese concentrates her practice in employee benefits. She works with employers to design, establish and administer qualified retirement plans (defined contribution, defined benefit, cash balance), welfare benefit plans, and nonqualified deferred compensation plans.

She assists clients in complying with statutory and regulatory requirements for reporting and disclosure, testing, and corrections for benefit plans, as well as assisting with IRS, DOL and PBGC filings, audits, and queries. Ms. Reese also works on benefits issues involved in business transactions including due diligence, termination, spin-off, and merger of existing benefit plans, and design and implementation of new plans. She helps to educate plan fiduciaries about fiduciary duties, settlor functions, prohibited transactions, and procedural prudence. In addition, she prepares and reviews nonqualified deferred compensation agreements including executive employment and severance agreements, incentive programs, and top hat plans.

Ms. Reese works with public and private employers, both for-profit and not-for-profit, of varying size.





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Practice Areas:

Employee Benefits and Executive Compensation, Healthcare, Cybersecurity and Privacy, Technology



Mr. Riga concentrates his practice in the areas of privacy and security, employee benefits, and healthcare matters, with clients in the healthcare, technology, retail, and manufacturing industries.

Privacy and Security

Mr. Riga counsels clients on a variety of data privacy and information security compliance issues regarding healthcare, employment and other company data. Work with clients includes:

- Analyzing regulatory compliance under state, federal and international standards, including HIPAA privacy and security rules, FMLA and ADA confidentiality, GDPR, and the CCPA
- Developing data privacy and information security programs, including internal and external corporate policy preparation and review
- Workforce training
- Counseling clients during and after security incidents and breach events, evaluating scope, applicable law, and methods to mitigate harm
- Representing clients in governmental investigations

Employee Benefits

Mr. Riga's benefits practice includes work with both qualified retirement plans and health and welfare plans. Services include:

- Counseling on compliance under tax law, ERISA, the Affordable Care Act and HIPAA
- Preparation of plan documents and supporting documents
- Benefit communication counseling
- Conducting due diligence related to benefit plan issues for mergers and acquisitions

Health Care

Mr. Riga represents a number of clients in the health care industry, providing services regarding:

- HIPAA compliance advice
- Privacy policy and security program design
- Workplace training
- Breach incident evaluation and mitigation

Mr. Riga received his J.D. from the Indiana University School of Law – Indianapolis in 2006. Originally from Los Angeles, California, Mr. Riga earned an undergraduate degree in English and History from Ball State University.

Admitted to Practice:

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Stephanie A. Smithey

Shareholder || [Indianapolis](#)

As Chair of our Employee Benefits and Executive Compensation practice group, Ms. Smithey devotes her practice to all aspects of employee benefits law. She represents clients with respect to qualified retirement plans and health and welfare plans, assisting them with a variety of plan design, compliance, and administration issues for all types of pension, health and welfare benefit plans.

Ms. Smithey advises her clients as to ERISA, MPPAA, HIPAA, COBRA, PPACA, the Internal Revenue Code, as well as other federal and state laws applicable to employee benefit plans and plan sponsors. She assists clients with IRS and DOL audits, as well as internal compliance audits and plan corrections. She regularly counsels clients as to the scope of their fiduciary duties and how they may seek to limit fiduciary exposure. Ms. Smithey frequently assists health plans in complying with the health care reform laws as well as the HIPAA privacy security rules and provides in-house training for employers and other plan personnel.

In addition to counseling clients as to how to comply with the many laws that apply to their employee benefit plans, Ms. Smithey advises them how to handle benefit plan-related disputes in an effort to avoid litigation. In this context, she has counseled employers, insurers, third party administrators, trustees, and other plan fiduciaries.

Ms. Smithey has served on the Board of Directors for the Indiana Benefits Council, and held positions of Chair, Vice Chair, Past Chair. For 2013 – 2020, Ms. Smithey was selected by *Best Lawyers* for ERISA/Employee Benefits in Indiana.

Ms. Smithey worked with the Indiana Chamber of Commerce to publish the 4th Edition of the Employee Benefits Guide. In addition, she co-authored the *Indiana Employer's Guide to Workplace Wellness* for the Wellness Council of Indiana. In 2017, Ms. Smithey was honored with the Indiana Chamber's Samuel C. Schlosser Indiana Chamber Volunteer of the Year award.

Ms. Smithey is honored to serve on the Board of Directors of Girl Scouts of Central Indiana.



About Ogletree Deakins Employee Benefits and Executive Compensation Group

Ogletree Deakins is a nationally recognized labor and employment firm that represents private and public employers. The firm is continually expanding its geographic reach and, at the time of this printing, has 53 offices in 31 U.S. states, the District of Columbia, the U.S. Virgin Islands, Canada, Mexico and Europe.

Ogletree Deakins has one of the largest teams of employee benefits and executive compensation practitioners in the United States. The large and growing Employee Benefits Practice Group consists of more than 60 lawyers and three paralegals who focus exclusively on employee benefits, executive compensation, payroll tax, and fringe benefit matters. Our goal is to provide practical advice that allows the company's benefit strategy to work in harmony with its overall personnel, financial and business objectives.

Employers nationwide have come to depend on Ogletree Deakins for their employee benefits regulatory and compliance advice, both on a day-to-day basis and for unique projects involving corporate restructuring, acquisitions, Section 409A-compliant executive compensation arrangements, and benefits plan redesign.

Our highly trained employee benefits practitioners advise clients regarding the full array of retirement plans and welfare plans, sponsored by employers in the private, not-for-profit, and public sectors. These include tax-qualified retirement plans, executive compensation arrangements, welfare and fringe benefits programs, incentive and other bonus arrangements, cafeteria plans, severance pay plans, stock option and other equity-based compensation plans, and defined contribution/consumer-directed health plans implementing cost-containment strategies, such as health savings account plans or health reimbursement arrangements.

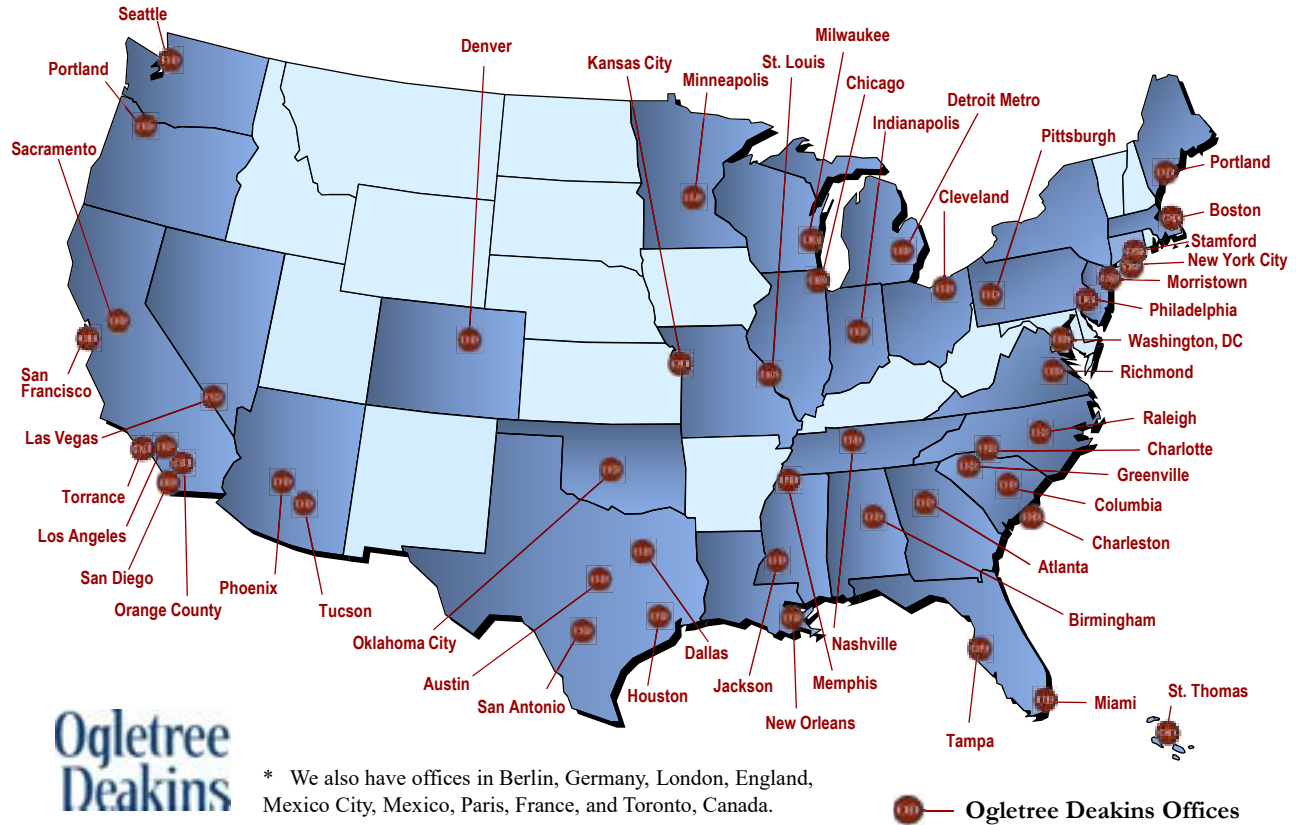
We have helped clients with benefits arrangements for employees during international assignments, planning and implementation of early retirement and severance programs, the benefits aspects of mergers and acquisitions, and negotiating and drafting executive consulting and phased retirement arrangements. We also advise clients on such matters as health insurance portability, privacy, and non-discrimination requirements, continuation coverage rules, reporting and disclosure obligations to the Department of Labor, the Internal Revenue Service and the Pension Benefit Guaranty Corporation, retirement and welfare plan non-discrimination requirements, and fiduciary compliance.

Our employee benefits attorneys routinely assist clients in dealings with government agencies regarding plan operations, including advanced approvals of qualified plans (ranging from simple to often complex designs), exemptions from various regulatory requirements, rulings on disputed questions, and audits. In this capacity we have successfully represented clients in audits or civil investigations conducted by the Internal Revenue Service, the Department of Labor, the Pension Benefit Guaranty Corporation, the Office of Civil Rights, and the Justice Department.

In addition, our talented team of ERISA litigators has defended employee benefits lawsuits across the country, including claims for benefits and fiduciary breach involving individuals and class plaintiffs.

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Preface

In order for employers to remain competitive in today's employment market, it is important that they provide a well-planned benefits package that will put them above the competition. There are many responsibilities and requirements with which employers must understand and comply. In order to assist Indiana employers in their compliance efforts and in creating the ultimate benefits package, the Indiana Chamber and the law firm Ogletree Deakins are proud to bring you the fifth edition of the *Employee Benefits Guide: A Comprehensive Guide for Indiana Employers*.

The purpose of this handbook is to provide employers with practical, concise and easy-to-understand assistance. Attorneys from Ogletree Deakins have graciously lent their time and expertise in revising this fifth edition. This handbook includes current, comprehensive explanations of employee benefits, employers' rights and responsibilities, and forms and filing requirements in language that is easy to understand.

We hope that you will utilize this handbook to create or enhance your employee benefits system. Indiana Chamber members can receive free advice on issues they may face concerning this topic or any other employee/labor-related issue. If you have an issue that you can't answer, or if you just want a second opinion and you are a member of the Indiana Chamber of Commerce, call the Chamber's HR helpline at (317) 264-3167. We will be happy to assist you.



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Michelle Kavanaugh has been active in the field of human resources for more than 20 years, focusing on employee relations, training and recruiting. Michelle has led human resources functions for both privately and publicly held companies in health care and financial industries. She has five years of experience managing the human resources side of mergers and acquisitions, including cultural assimilation as well as redeployment of staff.

She currently serves as director of human resources at the Indiana Chamber of Commerce. She is an active member of the Society for Human Resource Management (SHRM), IndySHRM and works with Indiana Dual Career Network.

Michelle holds a B.S. in management from Indiana Wesleyan University and is a certified Senior Professional in Human Resources (SPHR) and SHRM-SCP.

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Chapter 1

Introduction

This book addresses employee benefit issues affecting Indiana employers. Although many employers strive to offer a dynamic employee benefits package that will help to recruit and retain productive employees, these companies also struggle to keep up with the ever-increasing and evolving body of federal regulation of employer-sponsored benefit plans. The goal of this book is to educate employers about key employee benefits issues, alternatives and legal requirements. This book will also assist employers in reviewing their current benefit offerings and devising a strategy for providing current and prospective employees with benefit packages tailored to meet the employer's goals and to satisfy the employees' needs.

Employers of all sizes take an active role in the creation of employee benefit programs designed to attract and retain talented employees. Employers may use this book to help identify cutting-edge benefit alternatives and learn about any legal requirements that may apply. This book is intended to promote awareness of the multitude of federal and state regulations that may apply to Indiana employers and their emerging businesses. This guide also explores the tax advantages many types of employee benefit programs provide to employers and employees, as well as some new ways that employers may consider shifting some benefit costs to employees.

Organization of This Book

This book is organized by categories of employee benefits. It includes chapters on the following topics, among others:

- Medical, dental and vision benefits (Chapter 2)
- Life, disability and other insured benefits (Chapter 3)
- Retirement benefits (Chapter 5)
- Stock benefits (Chapter 6)
- Worker's compensation benefits (Chapter 7)
- Time-off and severance benefits (Chapter 8)
- Nontaxable fringe benefits (Chapter 10)

Each of these chapters includes a description of the types of benefits employers may offer, various options for designing a benefit program, and applicable legal requirements, compliance obligations and tax considerations associated with such benefits.

This book also includes information on the privacy and security laws that impact certain employee health benefit plans, plus discussions of plan administration and fiduciary conduct for employers that sponsor 401(k) and other pension plans. Discussions of federal health care reform laws are included in Chapters 2 and 4. Rules regarding deferred compensation appear in Chapters 5 and 6.

What Is ERISA?

As you begin to use this book, you will immediately note that employee benefits are treated differently from a legal perspective depending upon whether they are subject to the Employee Retirement Income Security Act of 1974 (ERISA) and whether they are offered to employees through an employee benefit plan. Understanding these distinctions will allow you to use this book effectively to assist you when establishing and maintaining employee benefit plans in compliance with federal law.

Categories of ERISA Benefits

There is no limit as to the types of benefits that employers may provide to employees; however, an understanding of the various categories of employee benefits will enable employers to appreciate the legal and tax ramifications of offering employees different types of benefits. Generally, for the purposes of this book, we will separate all employee benefits into two broad categories: those that are subject to ERISA, and those that are not.

ERISA is federal legislation that governs the provision of pension and welfare benefits to employees by employers. Pension benefits may include any benefits that defer income until retirement or separation from service. These benefit programs may take the form of 401(k) plans, traditional pension plans, employee stock ownership plans and other forms of deferred compensation. Welfare benefits include any benefits designed to provide any of the following to employees and their beneficiaries, through insurance or otherwise:

- Medical, surgical or hospital benefits
- Benefits in the event of sickness, accident, disability, death or unemployment
- Vacation benefits
- Apprenticeship or other training programs
- Daycare centers
- Scholarship funds
- Prepaid legal services

All of these benefits are subject to ERISA, which generally means that employers providing such benefits must comply with strict reporting and disclosure requirements and fiduciary standards.

Note: Some “welfare” benefits are exempt from ERISA’s requirements to the extent that they are unfunded payroll practices, as discussed later in this chapter.

In the case of pension benefits, employers also must meet stringent participation, vesting, funding and accrual rules. Among other things, these rules require employers to communicate their benefit programs to their employees in easily understood language. In addition, ERISA imposes certain fiduciary duties upon individuals who exercise control over plan assets, holding plan administrators and others to the level of care of a “knowledgeable expert.” ERISA requires employers to act in the sole interests of the plan participants and beneficiaries when they make decisions regarding plan benefits. A full discussion of these fiduciary standards appears in Appendix B.

Note: Some deferred compensation programs are exempt from ERISA's requirements to the extent that they are "top hat" plans providing benefits only to a select group of highly paid employees, as discussed later in Chapters 5 and 6.

This book discusses the various types of pension benefits and the complex legal requirements that govern the provision of pension benefits to employees in Chapter 5, "Retirement Benefits," and Chapter 6, "Employer Stock: Equity-based Compensation Plans." Because of the wide variety of welfare benefits available, the book divides discussion of these popular benefits among several chapters, including:

- Chapter 2, "Health Benefit Plans: Medical, Dental and Vision Coverage";
- Chapter 3, "Life Insurance, Disability Insurance and Other Insured Benefits";
- Chapter 4, "Section 125 'Cafeteria' Plans"; and
- Chapter 8, "Time-off and Severance Benefits."

What Is an ERISA Plan?

After determining whether the benefits at hand are subject to ERISA (i.e., are the benefits provided either pension or welfare benefits as described above?), an employer must consider whether to provide these benefits to employees through an ERISA plan. ERISA applies to the benefits only if they are offered through an employee benefit plan. Courts have developed useful tests for determining whether an employer has established an employee benefit plan that is subject to ERISA. Generally, courts within the United States Court of Appeals for the Seventh Circuit (which covers Indiana, Illinois and Wisconsin) determine whether an ERISA plan exists by asking the following two questions:

1. From the surrounding circumstances, could a reasonable person ascertain the intended benefits, the intended beneficiaries, the source of funding for the benefits, and the procedure for receiving the benefits?
2. Does the payment of benefits require an ongoing administrative scheme and entail some level of administration by the employer to process claims and pay out benefits on an ongoing basis?

In most instances, employers who provide qualified retirement or health benefits to a group of employees will have established an ERISA plan. Some offerings of insurance may not be subject to ERISA, however, and occasional one-time cash payments to employees upon employment termination may sometimes escape the application of ERISA. Similarly, ERISA will not apply to certain group or group-type insurance programs offered by an insurer under which no contributions are made by the employer, participation is voluntary, the sole function of the employer is to permit the insurer to publicize the program, and the employer receives no consideration (in the form of cash or otherwise) in connection with the program.

The determination of whether an ERISA plan exists is ultimately extremely fact-sensitive, causing many employers to improperly assume that insurance premiums or severance payments simply may be paid from the company's general assets without worrying about ERISA compliance. This approach may result in substantial penalties for failure to comply with ERISA if, in fact, the employer inadvertently created an ERISA plan.

Other Benefits

By contrast, many employers also provide their employees with some benefits that are not subject to ERISA. Those benefits may include some items that are considered to be “payroll practices,” such as the payment of an employee’s normal compensation:

- for work performed, including overtime pay, shift premiums, holiday premiums and weekend premiums;
- out of the employer’s general assets for time when the employee was physically or mentally unable to work, such as short-term disability or “loss of time” benefits; and
- out of the employer’s general assets for time when the employee, although physically and mentally able to work, performed no work, such as vacation or holiday pay and pay for absence while on military training or leave, jury duty, sabbatical or educational leave.

In addition, there are various other benefits and practices that are not subject to ERISA, including the following:

- Certain on-premises facilities, such as dining facilities and first-aid centers
- Holiday gifts
- Sales to employees of employer products
- Remembrance funds
- Strike funds
- Various industry advancement programs where there are no participants
- Certain nonfunded scholarship programs (e.g., nonfunded tuition assistance programs under which payments are made solely from the general assets of the employer)

Although not subject to ERISA, some of these benefits are viewed as “fringe benefits” by the IRS and are subject to detailed legal requirements in order to obtain favorable tax treatment. Fringe benefits are discussed in more detail in Chapter 10, “Nontaxable Fringe Benefits.” Employers will also want to peruse Chapter 11, “Quality of Life Benefits,” for a preview of some nontraditional benefits that many employers provide in an effort to enhance the quality of life of their employees.

Mandated Benefits

Although most of the benefits discussed in this book are optional and offered only if an employer chooses to provide them to employees, others are mandatory. For example, any employer with more than 50 employees must comply with the Family and Medical Leave Act (FMLA), as discussed in Chapter 8, “Time-off and Severance Benefits.” Similarly, any employer with more than 20 employees that offers a group health plan must offer continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1989 (COBRA). Certain other mandated benefits are discussed in detail in Chapter 2, “Health Benefit Plans: Medical, Dental and Vision Coverage,” and employers sponsoring group health plans will want to review the compliance requirements in Chapter 12, “HIPAA Privacy and Security for Small Health Plans.”

Worker’s compensation insurance completes the package of benefits most employers provide. Chapter 7, “Worker’s Compensation,” will help you become familiar with the requirements of the Indiana Worker’s Compensation Act, which generally applies to all employers in the state.

Using This Book

You may use this book to familiarize yourself with those benefits to which ERISA may apply, to become aware of the compliance obligations imposed upon plans that are subject to ERISA, and to assist in identifying the objectives that ultimately will enable you to design and properly administer an employee benefit program. In order to do so, it may be easiest to proceed as follows:

- Review the descriptions of the various types of employee benefits contained in each of the following chapters and determine what benefits your company currently offers to its employees, and what benefits the company would like to offer employees in the future. For example, one employer may want to provide employees with a health plan, as well as life and disability insurance. Another employer may want to provide employees with a pension benefit and a health plan. Yet another employer may want to develop a multifaceted employee benefit package offering a full range of pension, health, welfare and fringe benefit programs.
- With the help of service providers, the next step is to make several decisions regarding the design of the benefits the company will offer to employees, including, for example, coverage levels, managed care options, contribution levels and vesting schedules. This book will help employers begin thinking about those design decisions.
- Iron out the details for administering the benefits your company intends to offer. In order to do so, you will need to work with the appropriate service providers. This may include attorneys, insurance agents, third-party administrators, actuaries, accountants, investment advisors, bank trust departments and plan record keepers, among others, depending on the types of plans the employer intends to offer. For example, Chapter 2, “Health Benefit Plans: Medical, Dental and Vision Coverage,” will help you determine the types of service providers needed for those benefits.
- Once the company has identified those benefits it is interested in providing, determine what steps are necessary to implement those benefit programs. To the extent that those benefits are subject to ERISA, employers will need to reflect the terms of the benefit programs in formal legal documents known as “plan documents.” These formal documents are required for all plans subject to ERISA.
- Once the legal documents are in place, communicate the terms of the benefit programs to employees in writing. Again, ERISA contains detailed provisions requiring the disclosure of the terms of benefit programs to employees in common, understandable language and for reporting such programs to the government. Employers who develop a strategy for communicating their benefit programs that includes an accurate and usable summary booklet create awareness and understanding of their benefit programs so that employees can utilize and appreciate them fully.
- If an employer already has employee benefit programs in place, this book allows the employer to conduct a self-audit of those programs and to verify that all plans are up to date regarding legal requirements and compliance obligations. In addition, this book may help identify new ideas for revitalizing, modernizing and communicating an existing employee benefit package.

Attracting and retaining skilled, dedicated workers requires companies to offer a competitive employee-focused benefit package and to make sure employees understand the benefits provided. If structured properly, many employee benefits may be provided to employees on a tax-free or tax-deferred basis, and the employer will receive a corresponding tax deduction. The mission of this book is to provide Indiana employers with a road map to achieve their strategic goals with respect to employee benefits.

Chapter 2

Health Benefit Plans: Medical, Dental and Vision Coverage

For more than 50 years, most Americans with health insurance benefits have received those benefits through their employers. For several decades, the provision of employer-sponsored health insurance went largely unregulated. Over the last 30 years, company health plans have faced an increasing array of federal legislation. The passage of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act in 2010 (collectively referred to as the “Affordable Care Act” or “Health Care Reform”), along with the issuance of thousands of pages of regulatory and interpretive guidance and comprehensive reform of the nation’s health care system, resulted in new obligations on individuals, insurers and employers. It also creates new markets for employees to obtain health care coverage for themselves and their families.

Health plans have become perhaps the single most important benefit to employees. Individuals frequently make employment decisions because of their understanding of their current health plan access. In addition, when provided in compliance with the Internal Revenue Code (the “Code”), health benefit costs provide an additional deduction for employers without increasing the taxable income of employees.

The Affordable Care Act (ACA) originally included individual and employer coverage mandates that imposed penalties for failing to offer or enroll in health plan coverage, but subsequent legislation eliminated the individual mandate. As of this book’s publication date, the employer mandate remains. Many large employers are subject to an assessment if they do not provide their full-time employees with affordable, minimum value health care coverage, making the design and coverage of adequate coverage critical for employers to avoid significant tax penalties.

Over the past several decades, employers have provided health benefits via a variety of vehicles, including insurance contracts, health maintenance organizations (HMOs) and self-insured plans. Funding options have emerged with an account-based approach. Health care reimbursement accounts (HRAs) and health savings accounts (HSAs) are discussed in this chapter. Another option for funding health benefits is medical flexible spending accounts (FSAs), available through Section 125 “cafeteria” plans, which are discussed in detail in Chapter 4.

Health plans are subject to an array of laws, through Health Care Reform and a variety of other state and federal mandates.

This chapter describes various health care coverage delivery systems and discusses the major federal legal requirements employers need to know about when providing a health plan to their employees. It also provides employers with an introduction to additional changes on the horizon for employer-sponsored health plans as Health Care Reform is gradually implemented.

ERISA Requirements

As mentioned in Chapter 1, employer-provided health benefit plans are subject to portions of the Employee Retirement Income Security Act (ERISA). ERISA requires plan administrators to comply with strict reporting and disclosure requirements. (See Appendix A for a detailed description of the compliance obligations that generally apply to ERISA plans.) In general, ERISA requires the following for health plans:

- The terms of the health plan must be reflected in a formal, written plan document.
- The plan must be summarized in an easy-to-understand format and distributed to employees in the form of a summary plan description.
- Participants must be informed of plan changes via a summary of material modifications.
- The plan must file an annual report known as a Form 5500 with the U.S. Department of Labor. (See Appendix F for an example of this form.)
- Individuals who handle plan assets or exercise discretion as to plan administration must adhere to ERISA's fiduciary duties. (See Appendix B for a summary of these duties.)
- Detailed claims processing rules must be followed. (See Appendix G for a chart reflecting the rules applicable to health benefit claims.)

When establishing a health plan, the employer should take an active role in the development of plan documents that accurately reflect the terms of the benefits that the employer intends to provide. Although there are several provisions that should be included in the plan documents in order to comply with legal requirements and some minimum coverage requirements mandated by the Affordable Care Act (as discussed in more detail below), the terms of the coverage provided are largely up to the discretion of the employer. The nature and detail of the ERISA plan documents will depend upon the funding mechanism for the plan and the benefits provided.

Internal Revenue Code Requirements

Generally, absent a specific tax rule, the value of the benefits provided by an employer to an employee, including the value of health care services, is taxable to an employee just like any other income. The Code excludes from an employee's income, however, any employer contributions for health coverage under an accident or health plan (e.g., premiums for health coverage), as well as amounts paid to an employee directly or indirectly to provide reimbursement for medical expenses incurred by the employee or the employee's dependents (e.g., payments for medical services). These exclusions from income mean that the employee does not pay taxes on employer-provided health care.

For purposes of obtaining this favorable tax treatment, medical expenses include expenses for the diagnosis, treatment or prevention of disease, or treatment for the purpose of affecting a structure or function of the body, including dental and vision care and mental health treatment. Transportation expenses reimbursed by an employer are also excluded from income if they are incurred primarily for, and essential to, medical care.

In addition, favorable tax treatment is conditioned upon the benefits being provided in a nondiscriminatory manner. This means that employers cannot favor highly compensated employees by providing them with better or different benefits without triggering tax consequences, either in the form of imputed taxable income to the highly paid workers of the value of self-funded coverage provided, or in the case of discriminatory insurance coverage, possible excise taxes imposed on the employer. This issue is discussed in more detail below.

Employers may offer health benefits through:

- commercial accident and health insurance policies marketed by insurance companies and health maintenance organizations;
- an employer self-insured health plan that pays benefits from an employer's general assets; or
- a trust set up for the purpose of funding employee health claims.

The Internal Revenue Code defines a self-insured medical reimbursement plan as a plan of an employer to reimburse employees for medical expenses where there is no policy of accident and health insurance.

Plan Administration

Employers that provide benefits through self-insured health plans typically contract with a third-party administrator to process benefit claims and participant enrollments and otherwise administer the plan on a day-to-day basis. Insured products usually offer these administrative services as a part of a package. In addition, employers that maintain self-insured plans often reduce their risk of incurring significant health claims by purchasing stop-loss insurance to cover claims beyond the employer's chosen risk threshold. For example, an employer may choose to self-fund claims below \$75,000 for each individual employee, but it may buy insurance to cover individual claims that exceed \$75,000. It may also reinsure claims that exceed an identified aggregate threshold.

Nondiscrimination

Health plans are subject to the Code's nondiscrimination provisions and may not discriminate in favor of highly compensated employees with regard to eligibility for plan coverage or with regard to the actual benefits provided. These provisions are designed to protect lower-paid workers and generally would prevent a company from establishing a plan that only benefits highly paid executives.

Self-funded Plans

Generally, any employee who is one of the five highest-paid officers, a shareholder who owns more than 10% in value of the stock of the employer, or among the highest-paid 25% of all employees is considered to be "highly compensated" in this context. The Code sets forth detailed tests to gauge whether a self-insured health plan discriminates in favor of highly compensated employees and who those employees are. However, notwithstanding the nondiscrimination requirements, a self-insured plan may exclude the following individuals without triggering nondiscrimination concerns under the Code:

- Employees who have not completed three years of service
- Employees who have not reached age 25
- Part-time or seasonal employees
- Employees covered by a collective bargaining agreement
- Nonresident aliens earning no income from sources within the United States

If a self-insured plan is found to discriminate in favor of highly compensated employees, reimbursements made to highly compensated employees are considered income to those employees and are taxable as wages. Furthermore, the employer can incur tax liability for failing to withhold employment taxes on such amounts.

Insured Plans

Health Care Reform amended the Internal Revenue Code to apply nondiscrimination rules to fully insured plans. As a result, the law states employers may not base participation in an insured health plan on employee compensation or exclude lower-paid employees from those plans without triggering an excise tax. Enforcement of this provision remains pending at the time of this writing, so employers will want to consider the risks of any fully insured discriminatory plan they offer. It is anticipated that plans in effect as of March 23, 2010 (when the first of the Health Care Reform laws was enacted) may be entitled to “grandfathered” status, but without guidance to date, there is nothing that spells out that protection. Employers that maintain discriminatory fully insured plans should be aware that simple changes to those plans may trigger the loss of any “grandfathered” status under other Health Care Reform rules that provide similar relief, and a loss of status can trigger the excise tax. Violations of this provision will result in an excise tax on employers of \$100 per day, calculated on each employee who is not eligible for the special discriminatory insurance coverage.

This is not to say, however, that employers may engage in other types of prohibited discrimination in their health plans. For example, health plans are subject to Title VII of the Civil Rights Act of 1964 and may not discriminate among employees on the basis of gender, race, national origin, ethnicity or religion. In addition, the Age Discrimination in Employment Act (ADEA) and the Americans with Disabilities Act (ADA) prohibit discrimination in benefits based on a person’s age or disabled status. Other federal laws, such as the Health Insurance Portability and Accountability Act (HIPAA) and the Genetic Information Nondiscrimination Act (GINA), prohibit health plans from discriminating based upon health status, genetic information and family medical history.

Retiree Health Benefits

Some employers choose to provide health benefits to retirees of the company in addition to current employees. Although most general provisions regarding employer-sponsored health benefit plans discussed throughout this chapter apply equally to retiree health benefit plans, there are additional legal considerations affecting retiree health benefits. For example, retiree health plan documents should clearly state the intended duration of the benefit. In other words, unless the employer clearly states that the benefit will terminate at a specific time, there is the risk that a court would conclude that the employer intended to provide the benefit to the retiree for life. Careful drafting of any documents providing for retiree health benefits is essential to avoid unintended liability.

Also, employers offering retiree medical benefits must observe special accounting standards that require employers to report their future liability for retiree health coverage. In addition, these costs must be reported on the plan’s annual report, which includes a full disclosure of the plan’s liability, including any liability for post-retirement benefits, based upon audited financial statements.

Special issues arise for retiree coverage under Health Care Reform. Although the rules do not apply to stand-alone retiree-only plans, Health Care Reform mandates will apply to retiree coverage offered as a part of a larger plan that also covers active employees.

Prescription Drug Coverage and Medicare Part D

The Medicare Part D prescription drug benefit, enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, became available starting January 1, 2006. This benefit provides prescription drug coverage under Medicare to individuals who are 65 and older and to individuals

who are eligible for Medicare because of disability or end-stage renal disease. This law potentially affects all employers who provide prescription drug coverage under a group health plan, even if only active employees are covered.

All employers that sponsor health plans providing prescription drug benefits to individuals covered by Medicare must provide an annual notice to Medicare-eligible Part D participants stating whether the plan's prescription drug coverage is "creditable" for Medicare Part D purposes. The notice also must be provided to newly eligible Medicare beneficiaries who participate in the plan. The employer must advise the Centers for Medicare and Medicaid Services (CMS) – the federal agency responsible for administering Part D – every year if its coverage is creditable by making an online disclosure to CMS. Model notices are available from the CMS at www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html. The annual notice must be given by October 15 of each year. Employers may avoid the process of determining which participants (employees and dependents) are covered or are becoming covered by Medicare by simply providing the notice to everyone.

Medicare-eligible individuals will use their employer's notice to decide whether to enroll in the Medicare Part D prescription drug benefit or to continue receiving prescription drug coverage through their employer-sponsored plan. Medicare will impose penalties on individuals who enroll late in the Part D prescription drug benefit; these penalties are similar to the penalties for enrolling late in Medicare Part B. The penalty is waived if Part D coverage was not elected because the person had creditable drug coverage through an employer-sponsored plan.

Employers may need to engage an actuary to certify whether group health plan coverage is creditable. Actuarial certification is not needed if the prescription drug coverage meets the following criteria:

- The coverage applies to both brand-name and generic prescriptions.
- The coverage provides reasonable access to retail providers and, optionally, mail-order coverage.
- The coverage is designed to pay on average at least 60% of participants' drug expenses.
- The coverage satisfies one of the following conditions:
 - The prescription drug coverage has no annual drug maximum or an annual drug maximum of at least \$25,000.
 - The coverage has an actuarial expectation that the amount payable by the plan will be at least \$2,000 per year per Medicare-eligible individual.
 - For entities that have integrated health coverage, the integrated health plan has no more than a \$250 deductible per year, has no annual benefit maximum or a maximum annual benefit payable by the plan of at least \$25,000, and has not less than a \$1 million lifetime combined benefit maximum.

For employers who offer coverage to Medicare-entitled retirees, this Medicare coverage originally offered opportunities to reduce health care costs. An employer who covers these retirees had the options to continue "creditable" prescription drug coverage under the group health plan and apply for a tax-free employer subsidy; however, the federal tax deduction for that subsidy was eliminated with the passage of Health Care Reform.

Employers may continue to offer prescription drug coverage that is not "creditable." The employer could not qualify for the subsidy when it was available, and Medicare-eligible individuals often drop the employer-sponsored non-creditable coverage and enroll in Medicare Part D as soon as they are eligible in order to avoid paying a higher Part D premium as a result of late enrollment.

Chapter 2

Employers may arrange with a prescription drug vendor to provide a benefit that is actuarially equivalent to Part D (“base coverage”) or better than Part D (“enhanced coverage”). Without the government subsidy, however, there is less of an incentive to the parties, without the opportunity to negotiate sharing of some or all of the subsidy.

Employers may amend their group health plan to supplement Part D coverage. Due to the complexity of Part D coverage, this may be administratively challenging. This approach requires the employer to advise participants that the plan’s coverage is not creditable.

The employer may discontinue drug coverage under the plan (and perhaps pay part or all of the Part D premium). This relieves the employer of the creditable coverage notice requirements. The employer also may decide to become a private prescription drug plan sponsor.

Structuring a Health Plan

Traditional insurance companies, managed care organizations, and self-insured plans offer different vehicles for funding health benefits. These options offer varying levels of provider choice and cost. Employers may turn to employee benefits attorneys, health care consultants, insurance brokers or third-party administrators to help them sort out the various health benefit options available. The following sections provide descriptions of three traditional health benefit funding options. Those options are:

1. indemnity plans;
2. preferred provider organizations; and
3. health maintenance organizations.

Some employers offer more than one of these options in their health plans, and permutations of these three basic models can be crafted. Later in this chapter is a detailed discussion of health plan funding options known as “defined contribution health care” or “account-based health care,” and a discussion of the viability of these options after Health Care Reform.

For purposes of this discussion, the term “payer” will be used to describe the entity that actually pays a health care provider for services, whether that entity is a self-insured employer or an insurance company with which an employer has contracted to provide health benefits.

Traditional Indemnity Plans

Traditional indemnity or fee-for-service plans generally provide employees with the ability to go to any health care provider they choose without incurring any decrease in the level of benefits paid from the health plan. However, these plans also are generally the costliest option for employers providing health care benefits. In a traditional indemnity plan, the employee may obtain treatment from the health care provider of his or her choice, and the plan will reimburse the provider on a fee-for-service basis. The responsibility for payment typically lies directly with the payer, not the health care provider. If the payer is an insurance company, it will reduce its risk of high costs by charging the employer higher premiums. Although traditional indemnity plans have few, if any, of the cost control features of managed care, today’s indemnity plans often introduce some element of managed care, such as a gatekeeper function (see “Health Maintenance Organizations” on the next page), pretreatment certification, second opinions or case management.

Preferred Provider Organizations (PPOs)

PPOs contain many of the same features of traditional indemnity plans with a significant exception: enrollees are given a financial incentive (e.g., lower copayments or deductibles) to receive care from a physician who is a member of the plan's network of providers. A PPO contracts with a network of providers who agree to provide health care services at reduced rates. This arrangement allows the payer to pass some of its risk of high health care costs on to providers who agree to charge lower fees in exchange for the possibility of receiving an increased patient base from the PPO. A PPO arrangement usually benefits the employer through lower premiums (if insured) or lower direct health care reimbursements (if self-insured). Employees benefit from this arrangement through lower deductibles or copayments when using a network provider. Over the past several years, many large networks have developed, frequently providing employees with many viable provider options – even for specialty needs in rural areas. Moreover, in many PPO plans, employees still may choose to use non-network providers; however, if they do, in exchange, the employees typically incur higher copayments or deductibles or other increased cost-sharing.

Health Maintenance Organizations (HMOs)

An HMO is an entity that seeks to manage the cost of health care through alternative payment schemes and intensive utilization review. Payment for services through an HMO is often made on a “capitated” basis. In other words, health care providers are not paid for medical services they render. Instead, an employer pays the HMO and/or the HMO pays its providers a predetermined amount for each HMO enrollee, regardless of whether an enrollee actually receives services from the HMO. The HMO and its providers incur the risk that the capitation fees they receive will not exceed the actual cost of health care services provided to enrollees. Sometimes HMOs compensate providers on a fee-for-service basis with a system that encourages the providers to reduce health care costs. Under this system, the HMO withholds a portion of providers' fees and providers receive the withheld amounts only if certain utilization goals are realized. If health care costs exceed the goals, the providers forfeit the amounts withheld.

In order to achieve the cost goals or to stay within the bounds of the capitation fees, HMOs employ a number of cost-controlling tools. A typical HMO restricts enrollees to providers who agree to accept the HMO's payment scheme and abide by the HMO's cost-cutting policies. Access to specialists is usually controlled by primary care providers (PCPs), such as family practitioners, internists and, increasingly, gynecologists, who act as “gatekeepers” to ensure that higher levels of care are actually necessary. HMOs also may require patients to obtain second opinions prior to certain treatments, may mandate pretreatment authorizations, may engage in concurrent case management during a treatment process, and may audit post-treatment billings to determine whether appropriate billing has occurred.

Mandated Benefits

A variety of state and federal laws may apply to employer-sponsored health plans and affect who must be included in the health plan and what benefits must be provided. The next several sections of this chapter describe those federal mandates.

Although this chapter discusses the mandated benefits that federal law imposes, in some instances Indiana law imposes benefit mandates. In most cases, employer-provided health benefit plans do not need to comply with state statutes that regulate employee health benefits because ERISA generally overrides state laws that relate to employee benefit plans. However, insurance policies (such as those used to fund a fully

insured health plan) must comply with state insurance laws, although this obligation falls upon the insurance company rather than the employer. In addition, certain multiple employer welfare arrangements (MEWAs) must comply with ERISA and all applicable state laws that are not inconsistent with ERISA. A discussion of state insurance law and/or laws that are applicable to MEWAs doing business in Indiana is beyond the scope of this book.

Patient Protection and Affordable Care Act of 2010

The Affordable Care Act (ACA) is a comprehensive set of federal laws intended to reform the nation's health care delivery and insurance system. There are three main provisions that formed the backbone of Health Care Reform for the employer-sponsored health coverage system:

1. Individual mandate
2. Employer mandate
3. Insurance exchanges

In 2017, the Tax Cuts and Jobs Act eliminated any tax penalty for violating the individual mandate effective January 1, 2019. As a result, the employer mandate and the insurance exchanges are the main surviving components of the ACA 10 years after passage.

The individual mandate was the requirement that individuals must either purchase minimum essential health care coverage for themselves and their families or pay a tax penalty. In 2012, the United States Supreme Court ruled that the individual mandate was a constitutional exercise of the Congressional power to levy taxes on individuals. At the time of this writing, other provisions of the ACA continue to be challenged in litigation. Of note, although the individual mandate effectively has been repealed at the federal level, several states have implemented state mandates that maintain an individual coverage requirement in those states. At this time, Indiana does not impose a mandate on individuals to purchase health insurance.

The employer mandate is the requirement for large employers to provide their full-time employees with an opportunity to enroll in affordable, minimum value coverage or pay a tax penalty. This mandate, which has been in place since 2015, is often referred to as the "play or pay" provision. For purposes of this mandate, a large employer is one that has at least 50 full-time equivalent employees. This determination is made on a controlled group basis, meaning that employers with sufficient common ownership to be treated as a single employer for ERISA purposes are treated as a single employer for purposes of determining whether they are subject to the play or pay mandate. For this purpose, employers should count all employees working at least 30 hours per week, and for remaining employees, the employer should aggregate all hours worked and divide by 120 to compute the number of full-time equivalent employees they have.

The tax penalty is assessed according to a two-tier structure. If the employer does not provide an opportunity to enroll in coverage to substantially all of its full-time employees and their dependents, and at least one employee purchases subsidized coverage through an insurance exchange, the employer will be assessed a penalty (on a monthly basis) in an amount equivalent to \$2,000 per year, as adjusted for inflation, per full-time employee after subtracting the company's pro rata share of the first 30 employees across its controlled group. For 2020, the adjusted annual equivalent is \$2,570.

If the employer provides an opportunity to enroll in a health plan but that plan is either not affordable to the employee or does not provide minimum value, and an employee declines that coverage and purchases subsidized coverage on an insurance exchange, the employer will be assessed a penalty (on a monthly

basis) in an amount equivalent to \$3,000 per year, as adjusted for inflation, for that employee. For 2020, the adjusted annual equivalent is \$3,860. Coverage will be deemed to provide minimum value if the plan provides payment for at least 60% of the covered health costs. There are several methods that an employer may demonstrate that its plan provides minimum value, including through use of an online calculator, completion of a checklist, or by obtaining an actuarial opinion.

Coverage is affordable if the employee's cost of self-only coverage does not exceed 9.5% of the employee's household income, adjusted annually. For 2020, the adjusted limit is 9.78%. Initially, coverage is deemed to be affordable for an employee if the employee's cost of self-only coverage does not exceed 9.5% of the employee's W-2 income, rate of pay, or the federal poverty level. In any event, the penalty incurred by the employer for failing to offer affordable, minimum value coverage cannot exceed the penalty the employer would have incurred if it had not offered coverage at all.

The second surviving prong of Health Care Reform is its insurance exchanges. The law requires each state to establish a health insurance purchasing exchange that will be open to individuals and small employers. If any state declines to do so, the federal government creates the exchange for that state. These exchanges are also called "insurance marketplaces" or simply, "the Marketplace."

Individuals can purchase coverage on an exchange to meet their individual mandate, and in the case of low-income individuals, may receive subsidized coverage. For employed individuals who do not have employer-sponsored coverage available to them, or who do not have affordable, minimum value employer-sponsored coverage available to them, purchase of subsidized coverage on an exchange will trigger a "play or pay" penalty for their employer.

ACA Methods for Identifying Full-Time Employees

In order to avoid paying a penalty under the employer mandate, a large employer must provide substantially all of its full-time employees the opportunity to enroll in affordable coverage that provides minimum value. For this purpose, a full-time employee is an employee who works an average of 30 hours per week, measured monthly using the threshold of 130 hours per month. The employer may impose a waiting period for that employee to enroll in coverage of no more than 90 days before the employer will be subject to a potential penalty.

Guidance has provided employers with a mechanism for identifying individual employees who must be treated as "full-time" employees for purposes of the employer mandate. This mechanism applies to employees who work on a part-time, variable hour or seasonal basis. For employees who are not hired with the expectation of working an average of 30 hours per week, or for employees who are hired for a particular season, employers may determine whether the employee meets the 30-hour-average standard over a period of time known as a "measuring period" or look-back period.

Guidance permits employers to look back over a period of no fewer than three and no more than 12 months and assess whether the variable-hour or seasonal employee worked on average 30 hours per week. In order to take advantage of this mechanism, the employer must then provide coverage to any employee meeting the full-time standard for a stability period that is at least as long as the measuring period. The employer is permitted to take a short period of time, not more than 90 days, after the look-back period, to assess whether coverage must be offered.

ACA Mandates and Grandfathered Status

Beginning in 2011, the Affordable Care Act introduced many, many additional provisions intended to overhaul the health care reform delivery system. Several benefit coverage mandates applied to all new or changed plans, including the following:

- No annual limits or lifetime limits on essential health benefits
- No pre-existing condition limits
- Coverage of adult children until age 26
- Limits on rescinding coverage retroactively
- 90-day limit on waiting periods
- Limits on deductibles and out-of-pocket maximums
- Cap on employee contributions to health flexible spending accounts
- Auto-enrollment for health plans in the future

Certain plans that were in effect upon passage of the first of the Health Care Reform laws on March 23, 2010, were exempt from some – but not all – of these mandates. These plans became known as “grandfathered” plans. Additional rules apply to all plans that are not “grandfathered” plans. As a result, plans that remain grandfathered are not subject to certain requirements, but new plans are. These requirements are as follows:

- Additional claims procedures and external review requirements
- Full coverage of preventive care with no cost-sharing
- Coverage of patients participating in clinical trials
- Patient protections, such as the ability to designate one’s own primary care provider and pediatrician, access to OB/GYN and emergency services

Detailed rules govern what changes to a plan will cause a loss of grandfathered status, triggering the application of the remainder of the health care reform mandates. The following changes can cause the loss of grandfathered status:

- **Elimination of Benefits:** The employer eliminates all or substantially all benefits to diagnose or treat a particular condition.
- **Increase in Percentage of Cost Sharing:** Any increase, measured from March 23, 2010, in a percentage cost-sharing requirement (such as individual’s coinsurance).
- **Increase in a Fixed-Amount Cost Sharing Other than Copayment:** Any increase in a fixed-amount cost-sharing requirement (other than a copayment – e.g., a deductible or out-of-pocket limit) determined as of the effective date of the increase, if the total percentage increase measured from March 23, 2010 exceeds the maximum percentage increase (i.e., medical inflation plus 15%).
- **Increase in a Fixed-Amount Copayment:** Any increase in a fixed-amount copayment, determined as of the effective date of the increase, if the total increase measured from March 23, 2010 exceeds the greater of:
 - \$5 multiplied by the rate of medical inflation plus \$5; or
 - medical inflation plus 15% (determined by expressing the total increase as a copayment percentage).

- **Decrease in Contribution Rate by Employers and Unions – Contribution Rate Based on Cost of Coverage:** A decrease in the employer's or union's contribution rate based on the cost of coverage (i.e., amount of employer or union contributions, minus employee contributions for self-funded plans, compared to the total cost of coverage calculated at the COBRA rate, expressed as a percentage) toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5% below the contribution rate for the coverage period that includes March 23, 2010.
- **Decrease in Contribution Rate by Employers and Unions – Contribution Rate Based on Formula:** A decrease in employer's or union's contribution rate based on a formula (i.e., the formula in place on March 23, 2010, such as contributions based on hours worked) toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5% below the contribution rate for the coverage period that includes March 23, 2010.

ACA Notices and Fees

Health Care Reform also implemented several new notice, reporting, and periodic fee requirements. New mini-SPDs, known as "Summaries of Benefits and Coverage," were required beginning with the first open enrollment periods after September 23, 2012. Employers must provide a "Notice of Exchanges" for new employees within 14 days of hire. Employers must report on the Form W-2 the value of health coverage provided to employees. A per capita fee is required for all plan sponsors and insurers to fund "patient centered outcomes research." Initially, this fee is \$1 per covered person. For plan years ending from October 1, 2019 to September 30, 2020, the fee is \$2.54 per covered life

A great amount of detail beyond the scope this book is contained at www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is a federal law that provides protection to employees who receive health benefits through their employers and who subsequently change jobs. HIPAA applies to most group health plans; however, some benefits excepted from HIPAA include coverage for accident and/or disability income only; worker's compensation insurance; coverage for on-site medical claims; and limited scope dental, vision or long-term care benefits if provided under a separate policy, certificate or contract, or not an as integral part of the health plan.

Special Enrollment Rights Under HIPAA

HIPAA also created mandatory special enrollment rights in health plans. The special enrollment requirement allows current employees to enroll their dependents (and sometimes themselves) in a health plan upon the occurrence of certain events without waiting until the traditional annual open enrollment period. In addition to any other enrollment period offered under a plan (such as enrollment upon employment or annual open enrollment), enrollment in the plan must be allowed under the following circumstances:

- If an employee or dependent initially declined health plan coverage because he or she was covered by alternative coverage and the employee stated in writing at the time he or she declined the coverage that the alternative coverage was the reason for declining enrollment, then the

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health plan must allow a special enrollment for the employee or dependent if:

- the alternative coverage was COBRA coverage and it was exhausted;
 - the alternative coverage was terminated as a result of the employee's loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or reaching a lifetime benefit limit); or
 - employer contributions toward such coverage were terminated.
- If a health plan provides dependent coverage, a special enrollment period must be made available to an employee's new dependent if that person became a dependent as a result of marriage, birth, adoption or placement for adoption. The employee must request enrollment within 30 days of the event giving rise to the special enrollment period. In the case of birth or placement for adoption, the coverage must become effective as of the date of birth or placement for adoption. In the case of marriage, the coverage must become effective no later than the first day of the month following the date the completed request for enrollment is received. If the employee is not already enrolled, he or she must enroll at the same time as the new dependent.
 - A special enrollment period also must be made available to employees and dependents who are eligible for, but not enrolled in, a health plan to enroll in the plan upon losing eligibility for coverage under a state Medicaid or Children's Health Insurance Program (CHIP) program, or becoming eligible for state premium assistance under either Medicaid or CHIP.

If the individual requests a special enrollment within 30 days of the enrollment event (60 days for Medicaid or CHIP enrollment events), the employer must make all health plan benefit options available to the employee and his or her dependents.

HIPAA's provisions also prevent discrimination in health plans based on a participant's health status. A health plan may not establish rules for eligibility or premium payment based on "health status-related factors" such as medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. Health Care Reform also prohibits discrimination in health coverage based upon health status.

Electronic Claims, Privacy and Security

Beginning in 2003, regulations first issued pursuant to HIPAA's administrative simplification provisions require the implementation of policies and procedures to simplify electronic claims processes and to protect the privacy and security of health information.

1. First, HIPAA requires the national standardization of certain electronic transactions, such as claims for payment from health care payers and enrollment in health plans.
2. Second, HIPAA requires health plans to implement policies to:
 - protect the privacy of participants' health information;
 - afford participants' rights to request all health information held by the plan;
 - demand an accounting of all of the plan's uses of their health information; and
 - amend any misleading or incorrect health information held by the plan.
3. Third, health plans must employ encryption, passwords, contingency plans and other mechanisms to protect the physical and electronic security of health information and the computer hardware on which it is stored and transmitted.

These regulations were most recently updated in January of 2013, requiring all health plans subject to HIPAA to update their HIPAA privacy and security policies and procedures. See Chapter 12 for a detailed discussion of the HIPAA privacy and security rules that apply to most health plans, as well as provisions that apply in the event of a breach of unsecured protected health information.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) is a federal law that seeks to cover gaps in health coverage for individuals who lose coverage and are not able to immediately replace it. COBRA requires employers who offer group health coverage and who have more than 20 employees to offer certain individuals the option to continue their health coverage for a limited amount of time after qualifying events that would otherwise result in a loss of coverage.

Individuals who are eligible for COBRA coverage are called “qualified beneficiaries” and may include employees, an employee’s spouse or the employee’s children, as long as they were covered by the employer’s group health plan on the day before a “qualifying event” occurs. A qualifying event is an event that would cause a qualified beneficiary to lose coverage under a health plan. The following table sets forth the COBRA qualifying events and the period of COBRA coverage available to qualified beneficiaries upon the occurrence of each event.

Qualified Event	Period of Coverage
For a qualified beneficiary employee:	
Voluntary or involuntary termination of employment for reasons other than gross misconduct	18 months (can be increased by 11 months if someone in the family is disabled within the first 60 days of COBRA coverage)
Reduction in the number of hours of employment	18 months (can be increased by 11 months if someone in the family is disabled within the first 60 days of COBRA coverage)
For a qualified beneficiary spouse or child:	
Voluntary or involuntary termination of the covered employee’s employment for any reason other than gross misconduct	18 months (can be increased by 11 months if someone in the family is disabled within the first 60 days of COBRA coverage)
Reduction in the hours worked by the covered employee	18 months (can be increased by 11 months if someone in the family is disabled within the first 60 days of COBRA coverage)
Covered employee becoming entitled to Medicare	36 months
Divorce or legal separation from the covered employee	36 months
Death of the covered employee	36 months
Loss of “dependent child” status under the plan rules	36 months

COBRA requires sponsors of group health plans to provide notice to employees and their dependents of their COBRA rights. An initial notice of COBRA rights must be provided to employees and their spouses at the time of their initial enrollment in the health plan. Within 30 days of the occurrence of an employee’s death, termination, reduced hours of employment or entitlement to Medicare, an employer must notify the health plan administrator (which might be the health insurance company or the self-insured plan’s third-

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party administrator) of the event. Similarly, an employee must notify the health plan's administrator of the occurrence of a divorce or legal separation or a child ceasing to be covered as a dependent under the plan rules. This notice must be provided within 60 days after the latest of:

- the date the event occurs;
- the date the qualified beneficiary would lose coverage due to such qualifying event; or
- the date the qualified beneficiary is notified of his or her notice obligations.

Within 14 days after receiving such notice from an employer or employee, the plan administrator must provide notice to qualified beneficiaries of their rights to elect COBRA. In addition, if a qualified beneficiary is not entitled to receive COBRA coverage, he or she must be notified of this and must be provided with an explanation as to why he or she is not entitled to COBRA. Model notices were recently revised to include additional statements regarding the interaction of Medicare and COBRA coverage. These can be found online at www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra. Several new class action lawsuits have been filed against employers in recent years, claiming the content of the notice was insufficient to put individuals on notice of their COBRA coverage rights. Employers should take time to confirm that the COBRA notices provided to their employees, former employees and their family members are complete and accurate. Using the Department of Labor's model notice language provides an employer's COBRA notice will be deemed to be compliant with COBRA notice requirements, and that approach may well provide the best defense against an allegation that a notice is insufficient.

Qualified beneficiaries must be offered coverage that, as of the time the coverage is being provided, is identical to the coverage provided to similarly situated beneficiaries under the plan. If coverage is modified under the plan for any group of similarly situated beneficiaries, the coverage must also be modified in the same manner for all individuals who are COBRA-qualified beneficiaries under the plan.

Each qualified beneficiary has an independent right to elect COBRA coverage; however, the employee or the employee's spouse may elect COBRA coverage on behalf of a minor dependent child. Qualified beneficiaries must be given a period to elect COBRA coverage that is no less than 60 days from the later of the coverage loss date or the date the COBRA election notice is provided. Employers may charge qualified beneficiaries 100% of the cost of COBRA continuation coverage, plus an additional 2% administrative charge. In other words, if an employer usually pays all or a part of employer health coverage, the employer is not required to continue to pay such costs for the period of COBRA continuation coverage. If COBRA continuation coverage is extended to 29 months because of a finding of disability, premiums for the additional 11 months may be increased to 150% of premium. Initial premium payments must be made within 45 days after the date of the COBRA election and must cover the period of coverage from the date of the COBRA election retroactive to the date of the loss of coverage. Further premiums are due as required by the plan, but the plan must provide for a minimum 30-day grace period for payments.

COBRA coverage may be canceled under any of the following circumstances:

- Premiums are not paid on a timely basis.
- The employer ceases to maintain any group health plan.
- After the COBRA election, coverage is obtained with another employer group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the beneficiary. (However, if the other group health coverage is obtained before the COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.)
- After the COBRA election, a beneficiary becomes entitled to Medicare benefits.

Uniformed Services Employment and Re-employment Rights Act (USERRA)

USERRA protects the employment rights of individuals in the uniformed services (the armed forces, Army National Guard, Air National Guard, etc.). In general, USERRA provides for re-employment after a period of uniformed service. (See Chapter 8, “Time-off and Severance Benefits,” for more details regarding USERRA’s re-employment rights.) In addition, USERRA protects an individual’s rights to benefits under an employer’s retirement and health plans during and after a period of uniformed service.

During a period of uniformed service, the individual performing service and his or her dependents are entitled to elect continuation coverage under an employer’s health plan. This continuation coverage is very similar to COBRA continuation coverage. The coverage for the person and his or her dependents must be available for at least a 24-month period beginning on either the date on which the person’s absence begins or the day after the date on which the person fails to apply for or return to a position of employment following a period of uniformed service.

If an employee elects USERRA continuation coverage, the employer may charge the employee up to 102% of premium under the plan; however, in the case of a person who performs uniformed service for fewer than 31 days, the employer may only charge the person up to the person’s usual share, if any, for health plan coverage. If an individual’s health plan coverage was discontinued because of his or her uniformed service, no exclusion or waiting period may be imposed on the person or his or her dependents in connection with the reinstatement of the coverage upon the person’s re-employment – even if the plan usually imposes one.

Employers must provide employees with notice of their rights, benefits and obligations under USERRA. This requirement may be satisfied by posting the U. S. Department of Labor’s model notice in the workplace in the location where employee notices are customarily posted. This notice is available from the U. S. Department of Labor’s web site at www.dol.gov/vets/programs/userra/USERRA_Private.pdf.

Mental Health Parity Act

The Mental Health Parity Act of 1996 sought to achieve equality between benefits provided for medical/surgical conditions and those provided for mental conditions. The act did not require health plans to provide coverage for mental health benefits; however, if a plan provided mental health benefits, it could not provide for greater annual or lifetime benefit limitations for medical/surgical benefits than those allowed for mental health benefits. In other words, a plan could not impose a lifetime aggregate benefit limitation of \$1 million on medical/surgical benefits but only a \$50,000 lifetime aggregate benefit limit on mental health benefits. A plan could combine medical/surgical and mental health benefits under one cap or have separate, equal caps for each type of benefit.

Although the Mental Health Parity Act sought equality among the types of benefits provided, the act did not explicitly prevent plans from imposing other restrictions on mental health benefits, such as limiting the number of mental health inpatient days or outpatient sessions that the plan will cover. Furthermore, the act did not limit other terms and conditions that a plan could impose on mental health benefits, such as cost-sharing provisions (imposing higher copayments, deductibles, etc.), medical necessity restrictions, prior authorization for treatment requirements and mandatory primary care physicians’ referrals.

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In response to these loopholes in the original law, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was enacted. The MHPAEA expanded the requirements of the original law, requiring health plans that provide coverage for mental health and/or substance use disorder benefits to provide those benefits at the same level as benefits for medical and surgical claims. Beginning generally in 2010, the MHPAEA extend the parity required by the original act to also include substance use/abuse treatments. It also required parity in treatment limitations, such as the number of office visits coverage or days of inpatient treatment coverage, and financial limitations, such as deductibles and copayments.

Newborns' and Mothers' Health Protection Act of 1996 (Newborns' Act)

Like the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act of 1996 does not *require* that health plans provide any benefit; however, if a health plan chooses to cover maternity benefits (and other legal requirements such as Title VII of the Civil Rights Act of 1964 may require a plan to do so), the act states that a health plan may not restrict benefits for a hospital stay in connection with childbirth to fewer than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48- or 96-hour period begins at the time of delivery. A participant's attending provider may decide, after consultation with the participant, that an earlier discharge is appropriate.

Also under this act, a group health plan may not do any of the following:

- Deny eligibility to a mother or a newborn child to avoid the requirements of the Newborns' Act
- Provide incentives to mothers to encourage them to accept less than the minimum protections of the Newborns' Act
- Penalize or otherwise reduce or limit the reimbursement to an attending provider because the provider rendered care in accordance with the terms of the Newborns' Act
- Provide incentives to an attending provider to induce the provider to provide care that is inconsistent with the Newborns' Act
- Restrict benefits for any portion of a period within a hospital length of stay required under the Newborns' Act in a manner that is less favorable than the benefits provided for any preceding portion of such stay

Women's Health and Cancer Rights Act of 1998 (WHCRA)

If a group health plan offers mastectomy benefits, the WHCRA requires the plan to provide coverage for the following:

- Reconstructive surgery on the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications for all stages of the mastectomy, including lymphedemas

The WHCRA also included several notice requirements for group health plans. All group health plans were required to provide notice of WHCRA rights to all participants by January 1, 1999. Since then, plans have been required to provide notice of WHCRA rights to new participants upon enrollment in the plan and to all participants annually thereafter.

Temporary Coronavirus Coverage Mandate

Effective March 18, 2020 and for the period of the national health emergency declared due to the coronavirus pandemic, Congress has mandated health plan coverage of diagnostic testing for the novel coronavirus and associated office visit, urgent care or emergency room charges required to determine eligibility for testing. Plans must provide this coverage without imposing any cost-sharing requirements (such as deductibles, copayments, and coinsurance) or prior authorization or other medical management requirements. Regulatory guidance indicates that the coverage mandate is limited to testing that is medically appropriate for the covered person, as determined by the individual's attending health care provider in accordance with accepted standards of current medical practice.

Defined Contribution Health Plans

Over the past several years, a hot topic in health benefit planning has been “defined contribution” health care, often referred to as consumer-driven health care or account-based health care. Employers that take a defined contribution or consumer-driven approach to health benefits decide at the front end what amount they will spend on employees for the year. For example, under a traditional self-funded health benefit plan, if an employer spends, on average, \$5,000 per year per employee on health care, some employees receive more of that than others. In a defined contribution system, the employer decides in advance how much to spend on each employee and then provides the employees with that specified amount of money. The employees are then responsible for spending that money on medical care. This type of system allows employers to better control their costs and removes employers from the business of purchasing or providing insurance.

There are different ways to achieve a defined contribution approach to health care. One mechanism is for employers to make funds available to employees to purchase health insurance coverage in the individual market. The money remains tax advantaged, as long as it is used solely to purchase health insurance. Alternatively, employees could use that money to purchase health insurance coverage through joint purchasing arrangements with other employees or buying groups rather than through individual insurance policies. Entities such as fraternal organizations, universities, churches, associations, credit unions, labor unions and professional organizations frequently provide access to this type of coverage.

A defined contribution health care program lowers employer administrative costs because the employer is no longer managing a health care plan. Employees can customize their insurance to their needs and resources and purchase a product that is accountable directly to them. Their coverage is guaranteed renewable, and therefore permanent, as well as portable, at least in theory.

One type of IRS-approved defined contribution health plan is known as a health care reimbursement arrangement (HRA). Under such a program, employers fund accounts for their employees. The accounts may be used to pay for either medical expenses or health insurance premiums. The accounts are used to reimburse the employee up to a maximum dollar amount usually per calendar year, and amounts not used during the year may be carried over to future years. In addition to using these funds to pay insurance premiums, the ability to carry unused amounts over to future years is a key difference between these programs and flexible spending accounts (FSAs), which are described in Chapter 4. Another important distinction is that a health care reimbursement arrangement is funded solely by the employer while a medical flexible spending account is typically funded with pre-tax employee money through a salary reduction. See Appendix H for a more detailed comparison of these accounts.

Debit cards may allow employers to offer added convenience and faster payments to employees who participate in medical reimbursement programs. The Internal Revenue Service allows employers to issue debit cards to employees who participate in programs such as FSAs (discussed in Chapter 4) and HRAs. Instead of submitting receipts for medical expenses and waiting days or weeks to be reimbursed, employees can just swipe their FSA or HRA debit card at the doctor's office or pharmacy and their provider is paid immediately: no further paperwork is needed. Debit cards can streamline costs associated with administering health care reimbursement programs. However, debit card programs must comply with IRS procedures to allow reimbursements to remain tax-free.

High-Deductible Health Plan (HDHP) and Health Savings Account (HSA) Combinations

Another form of defined contribution health care is the health savings account (HSA). HSAs are IRA-like accounts used to save for qualified medical expenses and are only available if a person is either covered by a high-deductible health plan (HDHP) or is not covered by health insurance. HSAs were created at the end of 2003 as the next phase of "consumer-driven health care." The plans are consumer-driven because the participant bears the cost of all medical expenses until the HDHP's deductible is met. In theory, participants in these plans will be more prudent consumers, ask more questions and generally be more informed about their care because their own accounts will be responsible for the first dollar of services, instead of the health plan.

There are many technical rules associated with participation in an HSA. (A more detailed examination of HSAs appears in Appendix H.) One prerequisite for eligibility states that a person may participate in an HSA only if he or she is either covered by an HDHP or not covered by any health plan. If a person participates in a plan that pays the first dollar of coverage (this includes a FSA), the person will be ineligible to participate in an HSA.

An HDHP is a health plan that has a minimum deductible for individual coverage and for family coverage (indexed for inflation, \$1,400 and \$2,800 respectively for 2020). The participant generally is responsible for health costs up to the deductible and the HDHP covers a portion of medical expenses after the deductible is met. Participants must meet the annual deductible before the plan pays benefits. A participant's eligibility to contribute to an HSA will be determined on a monthly basis. The maximum amount an individual may contribute to an HSA is \$3,550 (for 2020). The maximum amount a family may contribute to an HSA is \$7,100 (for 2020). Both individuals and employers may make contributions.

Tax benefits help to make HSAs attractive health care funding options for consumers. HSA contributions are tax deductible. Individual participants may deduct their contributions when determining their gross income. Employers may deduct contributions and exclude them from the employee's income, and those contributions are not subject to withholding for FICA or FUTA tax.

The HSA balance remaining at year-end can roll over to subsequent years, and the individual may invest the balance in a variety of investment vehicles. Earnings on the contributions are tax-deferred. Any distributions made for qualified medical expenses are not taxed. Distributions made for other purposes will be subject to income tax and a 10% penalty tax until participants reach age 65, when they may receive HSA distributions for nonmedical expenses and will only have to pay ordinary income tax on the distribution, without the 10% penalty. (Again, see Appendix H for a detailed comparison of HSAs, HRAs, and FSAs.)

Despite guidance that reconciled this defined contribution approach with the tax code, other potential regulatory obstacles remain, including those related to ERISA, COBRA and HIPAA. In some instances, a defined contribution system may create a welfare benefit plan subject to ERISA's reporting, disclosure and fiduciary requirements.

Health Care Reform cast doubts on the continued viability of certain defined contributions plan designs. For example, in some instances, guidance has been issued offering some limited relief to health reimbursement arrangements. In other cases, the guidance makes clear that a stand-alone health reimbursement arrangement will continue to be subject to the ACA rules. After ACA, employers considering adopting a defined contribution approach to employee health benefits had to carefully consider any potential legal issues that may impact these programs.

More recently, new guidance has breathed life back into defined contributions plan designs that seek to establish stand-alone health reimbursement arrangements for the reimbursement of individual coverage. Starting in 2020, employers are able to pay for out-of-pocket expenses, premiums for Medicare, or individual policies purchased through or outside an ACA Marketplace as their sole health plan options for specified classes or their entire workforce, if the arrangement meet certain design requirements. Provision of an individual coverage health reimbursement arrangement can qualify as a valid offer of coverage for purposes of the employer mandate.

Conclusion

In order to establish a health plan for its employees, an employer first must determine what types of benefits it intends to provide (e.g., medical, dental, vision or some combination thereof) and then identify the appropriate structure(s) and funding vehicle(s) for providing those benefits. Once these general goals and parameters are established, the employer can work with legal counsel and other consultants to draft appropriate plan documents, identify a method of plan administration, ensure compliance with all applicable legislative mandates, obtain appropriate stop-loss insurance and fiduciary insurance and develop employee communication pieces to launch the plan. Employers must consider whether it is providing the opportunity to enroll in coverage that provides minimum value and will be affordable for its full-time employees to avoid triggering penalties under the ACA. Even before Health Care Reform, health coverage was one of the most expensive benefits for employers to provide and, therefore, one of the most valuable to employees. Although defined contribution funding approaches can achieve cost savings for some employers, all employers must take care to design these programs within the parameters of the laws. Employers who provide health coverage will want to take steps to clearly explain the plan options and their value to their employees, and to enroll as many employees as possible in their plans to prevent employees from purchasing subsidized coverage from an insurance exchange and thereby further driving up the employer's costs of coverage.

Chapter 3

Life Insurance, Disability Insurance and Other Insured Benefits

Chapter 2 explored various types of health benefit plans that employers may provide to their employees, focusing on traditional (self-funded and fully insured) mechanisms for funding medical, dental and vision benefits programs, as well as account-based funding approaches. This chapter focuses on other types of non-pension benefits that employers may provide to employees. Typically, although not always, these benefits are provided through a contract of insurance where the risk of loss is shifted from the plan to the insurance company. As mentioned in Chapter 1, the definition of an ERISA employee welfare benefit plan includes not only medical, surgical and hospital benefits, but also those benefits provided in the event of an employee's sickness, accident, disability or death. Employers may fund any of these common employee benefits through group insurance policies.

Generally, an insured benefit program provided through a group insurance contract between an employer and an insurance company constitutes an employee welfare benefit plan that is subject to ERISA and governed by federal law. In addition, the underlying insurance policy is also subject to regulation by the state. In Indiana, the Department of Insurance regulates the provision of insurance, and the Indiana Insurance Code provides detailed requirements that insurance companies must meet to become and remain licensed to offer insurance in the state. A discussion of the state insurance regulations that are applicable to insurance companies doing business in Indiana is beyond the scope of this book.

Common Types of Life Insurance

Several common types of life insurance are discussed in this chapter. These include term life insurance, whole life insurance, universal life insurance, group term life insurance, accidental death and dismemberment insurance, and dependent life insurance, as well as a number of other types of death benefits.

Term Life Insurance

Term life insurance is coverage intended to continue for a limited period of time (a "term"), usually ranging from one year to 20 years, or to a particular age (for example, to age 65). Generally, little or no policy reserves are maintained. As a result, if death occurs while the policy is in force, only the policy face amount will be paid. Coverage is typically nonparticipating, meaning that the policy owner earns no dividends or interest.

Whole Life Insurance

Whole life insurance provides coverage intended to continue throughout the insured person's entire life, and it features a level premium amount. The premium rate level exceeds the amount needed to fund the policyholder's early years of coverage, and the excess earns interest to supplement future premiums, which are insufficient to fund coverage during the policyholder's later years. This reserving of premiums creates a

fund within the policy that is nonforfeitable and commonly referred to as the policy's "cash value" or "cash surrender value." In the event that the policyholder no longer desires to keep the coverage in force, this amount is payable upon surrender and cancellation of the policy. Whole life insurance is sometimes also referred to as "ordinary" or "traditional" life insurance.

Universal Life Insurance

Universal life insurance developed in response to proponents of a "buy term insurance and invest the difference" strategy of funding death benefits. The primary feature is the payment of a certain minimum premium amount, which is then used to purchase a term insurance policy providing the desired amount of death benefit, with the balance of the premium going into a side accumulation fund that is invested in various instruments providing earnings at more competitive rates of return than those offered through more traditional or "whole" life insurance. The premium amounts paid can be increased so that more money is invested, or they can be decreased once the policy's reserves permit it. Additional premiums may be required if the investment fund does not perform well enough to sustain the policy's insurance cost.

Group Term Life Insurance

Group term life insurance generally provides employees with term life insurance, usually at a lower rate than the individual employees could obtain on their own. Most employee groups, regardless of size, can qualify for and have easy access to this common type of insurance coverage. Groups as small as two employees can usually obtain group term life insurance coverage. Often, however, these smaller employers will have to pay most (if not all) of the applicable premiums in order to keep participation in the program at or above the insurance company's minimum threshold for coverage (usually 70% of the eligible group). Group term policies also have certain limited tax advantages, as discussed in the following sections.

Tax Issues/Plan Design Options for Group Term Life Insurance

Premiums paid by employers for up to \$50,000 of group term life insurance coverage are deductible as a business expense by the employer (and not treated as income to the employee) as long as the plan satisfies the requirements contained in Internal Revenue Code Section 79.

In general, Code Section 79 requires the insurance to cover a bona fide "group" and requires the benefits to be provided in a nondiscriminatory manner. The plan providing group term life insurance benefits may not discriminate in favor of "key employees" with respect to either their eligibility to participate in the plan or the amount of benefit provided. In general, a "key employee" is any employee who, at any time during the plan year, is in at least one of the following classifications:

- An officer with annual compensation above a certain indexed level
- A 5% owner of the employer
- A 1% owner of the employer with annual compensation from the employer in excess of \$150,000

As long as the amount of coverage being provided bears a uniform relationship to the employee's compensation or is based upon reasonable compensation brackets, the plan will satisfy the "amount of benefit" nondiscrimination requirement. Tying coverage amounts to job classifications, however, may be far more likely to result in failure of these nondiscrimination tests.

Life Insurance, Disability Insurance and Other Insured Benefits

The eligibility nondiscrimination requirement is a little more complex. A plan will meet this requirement if at least one of the following conditions holds true:

- The plan benefits 70% or more of all employees
- At least 85% of the employees who are participants are not key employees
- The plan benefits employees who qualify under a classification that does not discriminate in favor of key employees
- The requirements of Code Section 125 are met (in the case of group term life insurance offered through a “cafeteria” plan)

Failure to satisfy the nondiscrimination requirements will cause the higher of the actual premiums or a uniform premium amount (known as the Table I premiums) to be taxable to the key employees. These brackets are shown below.

Table I, Internal Revenue Code Section 79 Uniform Premium for \$1,000 of Group Term Life Insurance Protection (Effective July 1, 1999)	
5-year bracket*	Cost per \$1,000 of protection for one month
Under 25	\$0.05
25 to 29	\$0.06
30 to 34	\$0.08
35 to 39	\$0.09
40 to 44	\$0.10
45 to 49	\$0.15
50 to 54	\$0.23
55 to 59	\$0.43
60 to 64	\$0.66
65 to 69	\$1.27
70 and above	\$2.06

**Age is determined based upon the insured individual's age as of the last day of the taxable year.*

Benefit coverage amounts provided in excess of \$50,000 will result in imputed taxable income for the affected employees, in accordance with the premium rate brackets provided under Table I of Code Section 79.

Employers who provide group term life insurance coverage in excess of \$50,000 to any employee must calculate the amount of income to impute to such employee, adjust that amount for any employee contributions, make proper withholdings and report the resulting income on the employee's annual W-2 form. In the event of the employee's death, however, the policy proceeds are not subject to federal or state income taxes, although they may be subject to federal or state estate taxes.

Common Features of Group Life Insurance Contracts

Group life insurance plans often provide reduced coverage amounts based upon the employee's age. For example, a typical reduction formula might call for a 35% reduction in coverage at age 65, another 15% reduction of the original (pre-age 65) amount of coverage at age 70, and another 10% reduction at age 75. These reduction formulas vary from one insurance carrier to another. Any such reductions for employees must be based on sound actuarial principles to reflect the higher cost of coverage based on age in order to avoid violating the Age Discrimination in Employment Act (ADEA).

Most group life insurance plans include an accelerated death benefit feature, which permits the payment of some or all of the death benefit for qualified long-term care services on behalf of a chronically ill or terminally ill employee. Another common feature is a provision for the waiver of premiums on any group life insurance coverage provided to an individual who has become totally and permanently disabled. (Typically, this feature becomes effective only after a waiting period.) Such waivers usually will remain in force as long as the disability continues, even if the underlying group contract is canceled. Employers should consider such added features when designing their group term plans.

Finally, most group life insurance contracts contain a right of conversion. Conversion rights guarantee the insured individual's right to continue insurance coverage under an individual policy when he or she ceases to be eligible for coverage under the group policy. This conversion coverage is available without the need for a medical examination or other proof of good health, at rates identical to those charged to other individuals of like age and gender. (It should be noted that COBRA continuation coverage requirements, which require continued health coverage in certain circumstances at the employee's cost and are discussed in detail in Chapter 2, do not generally apply to group life insurance benefits. Therefore, in most cases the only way for employees to continue group life coverage following a termination of employment is to purchase a conversion policy or to negotiate ongoing coverage in an employment contract or severance agreement. However, some states have laws that provide COBRA-like continuation rights for life insurance benefits in some cases.)

Designating and Changing Beneficiaries

In order to participate in a group life insurance plan, each employee must complete and sign an enrollment form. The enrollment form requires the employee to name a beneficiary who will receive the life insurance policy proceeds upon the employee's death. Generally, employees can name any person, place or thing as beneficiary. As opposed to individual life insurance, group insurance does not demand that the named beneficiary have an "insurable interest" in the employee. Employees are prohibited, however, from naming their employer as the beneficiary. In some instances, employees seeking to name minor children as their beneficiaries may want to consider establishing a trust to accept insurance proceeds for the benefit of the minor children and may want to consult with an estate-planning attorney.

Employees may revoke and change a beneficiary designation in accordance with procedures set forth in the insurance policy. Generally, in Indiana a beneficiary change will not be effective unless it is in writing, is signed by the insured and is made in strict compliance with the policy terms. Employers and employees should retain copies of any enrollment forms and changes of beneficiary filed with the insurance carrier. Employees should be encouraged to periodically review their beneficiary designations in order to keep up with changed life circumstances, such as divorce, death of a named beneficiary or addition of new beneficiaries.

Employer Obligations

It is the employer's obligation to pay the applicable insurance premiums on a timely basis. In addition, the employer will want to carefully review the certificate of coverage provided by the insurance company to make sure that the proper groups of employees are covered. The employer will need to add new employees to and delete former employees from the contract on a regular and timely basis. Some insurance contracts may distinguish between benefits provided for employees who are not working due to a disability or for former employees who are retired. Employers must communicate such changes in status to the insurance carriers where applicable. For plans in which benefits are determined by salary, insurance carriers will need to be notified of salary changes, and employers should review monthly billing statements to verify that the correct coverage amounts are reflected.

Employers have the ultimate obligation to communicate the terms of the life insurance coverage program to their employees. When offered through an ERISA plan, group term life insurance becomes subject to ERISA's reporting and disclosure requirements. (See Appendix A.) Therefore, employers are required to provide written summary plan descriptions to employees, and employers will be subject to ERISA's fiduciary standards in all communications regarding the terms of the coverage. (See Appendix B.) Particularly in the context of time-sensitive matters such as filing a death benefit claim or exercising conversion rights, timely and accurate communications with employees are crucial.

Compliance with ERISA

In order to establish a fully insured group term life insurance plan, a sponsoring employer must enter into a master contract with an insurance company. Individual "certificates of coverage," which frequently take the form of small booklets, are issued to employees. These certificates provide the detailed terms of the coverage. The insurance contract, along with the certificates of coverage and any other insurance documents, will become the ERISA "plan documents" if there are no other designated plan documents.

Insurance companies – not employers – often prepare the policy and contract documents. As a result, these documents usually comply with state insurance laws but rarely incorporate the required ERISA language. Therefore, it is often advisable to prepare a separate formal plan document or a supplement reflecting the terms of the program, incorporating the insurance contract documents by reference, and including the required ERISA provisions.

Similarly, the certificates of coverage issued by insurance companies frequently do not include the ERISA rights language that employers must distribute in the form of a summary plan description. Employers should distribute the certificates of coverage to employees when they enroll for coverage and in compliance with ERISA's rules for summary plan descriptions (see Appendix A). However, before doing so, they may want to consider adding additional pages or incorporating the certificate into a formal wrap-around summary plan description document in order to be in compliance with the law.

A common approach many employers take is to prepare an ERISA "wrap" or umbrella plan through which several benefit options are offered. One plan may provide a number of different benefits, such as life insurance and long-term disability benefits, as well as health benefit options. The wrap approach allows employers to meet ERISA's reporting and disclosure obligations with one plan document, one summary plan description (SPD) and one Form 5500 annual report.

Filing a Claim

Each insurance company develops its own forms and procedures for filing a claim for life insurance benefits upon an employee's death, so employees and employers will want to read the policy provisions and any additional instructions from the insurance company and follow them carefully. Usually, the employer must verify the employee's dates of employment as well as the benefit amount on the claim form. The named beneficiary (or his or her legal representative) will complete and sign the remainder of the claim form and provide an original, certified copy of the death certificate. In some cases (such as in cases where the death was caused by an accidental injury), the attending physician must complete a portion of the claim form.

The employer should include other appropriate attachments (e.g., payroll records, obituary notices) before sending the claim to the insurance company's claims department. Under normal circumstances, life insurance claims are processed and paid within three to six weeks.

Accidental Death and Dismemberment Insurance

Accidental death and dismemberment (AD&D) insurance coverage is a separate policy of accident insurance that provides for the payment of a lump-sum benefit in the event of an employee's accidental death or accidental loss of a principal body part or parts. This type of insurance developed out of the general presumption that, during an employee's working life, his or her risk of death or permanent disability is far more likely to be the result of an accidental injury than an illness.

AD&D coverage is usually sold as a "rider" to a group term life insurance policy, and its benefits are often a multiple of the face amount of the basic life insurance coverage provided. AD&D coverage typically ceases at retirement, even if the underlying group life insurance continues during retirement. For claims involving accidental death or loss of two or more principal body parts (e.g., both hands, both legs, sight in both eyes), the benefit payable is often equal to the life insurance face amount. If the dismemberment loss is one body part, the benefit payable is typically one-half of the life insurance face amount. Some policies offer benefits for partial dismemberment losses and loss of hearing. Coverage may be limited to nonoccupational accidents.

Losses resulting from intentional, self-inflicted injuries or suicide attempts generally are not covered, provided the risk of death and/or dismemberment was reasonably foreseeable. Because this determination can be very fact sensitive, AD&D claims generally take longer to process than typical life insurance claims and may require more information (such as autopsy results).

Dependent Life Insurance

Dependent life insurance coverage is another type of protection often added as a "rider" to a group term life insurance policy. The benefit amounts are usually fixed by class of dependent. For example, the spouse's benefit is frequently 50% of the group life insurance face amount for the employee and each eligible child's benefit is 25% of the group life insurance face amount. Premiums are typically fixed, regardless of the age of the dependent or the number of dependents covered. In some cases, a minimum amount of coverage (\$500, perhaps) is extended to children 14 days to six months of age, after which the child becomes eligible for the regular dependent child benefit amount.

Employer-paid dependent life insurance coverage is considered a taxable fringe benefit unless the amount of coverage provided is less than \$2,000 per insured dependent. If taxable, the amount of income imputed

to the employee on an annual basis is determined in accordance with the premium rates set forth in Code Section 79, Table I, included earlier in this chapter. As discussed in Chapter 4, dependent life insurance coverage cannot be included under a Section 125 “cafeteria” plan.

Other Types of Death Benefits

Other types of employer-provided death benefits include travel accident insurance, split-dollar/reverse split-dollar life insurance, group universal life insurance, group supplemental life insurance, voluntary group life insurance and post-retirement life insurance.

Travel Accident Insurance

This type of policy provides a fixed benefit covering an employee’s death that occurs while traveling on company business. The policy usually only covers certain classes of employees. The coverage may be broadened to cover travel time before and after business events.

Split-Dollar/Reverse Split-Dollar Life Insurance Plans

“Split-dollar” insurance is a program where both the employer and employee share in the benefits provided by an individual whole life insurance policy purchased on the life of the employee. The employer typically pays all premiums (the premiums are not tax deductible). The employee may pay the cost of the “pure term insurance.” If the employer elects to pay the entire premium, the employee will be taxed on the value of the “pure insurance” benefit. Although the structure of a split-dollar program can take one of several forms, the primary attraction common to these programs is that the employer will receive a refund of premiums paid from the policy proceeds at either the employee’s death or at roll-out (termination of the split-dollar agreement), and the employee or estate will receive the remaining value of the policy. Sometimes the employee retains all rights of policy ownership and the split-dollar agreement provides for repayment to the employer of premiums paid. This form is known as the “collateral assignment method.” If the employee terminates employment or dies, the split-dollar agreement typically requires the employee to repay the employer for premiums paid by the employer, and the employee can pay future premiums to keep the insurance in force, or, in the case of death of the employee, the remaining policy proceeds are paid to the designated beneficiary or estate. The other approach is for the employer to own the policy and endorse over the death benefits and other rights in excess of the repayment of the employer’s premiums to the employee; this is the so-called “endorsement method.” IRS rules have made both approaches less valuable by requiring the programs either to be treated as a loan of the premium with imputed interest taxable to the employee or to tax the employee on the value of the policy above repayment of the premiums due the employer.

Reverse split-dollar arrangements, on the other hand, reverse these traditional roles: The employer receives the death benefit and the employee retains title to the policy’s accumulated cash surrender value. Any death benefits (less the employee’s contributions) are payable to the employer and can be used to offset the costs associated with finding and training a replacement worker. If the employee terminates employment, the employee still has the opportunity to “buy out” the employer’s interest and retain the insurance coverage. Although these arrangements were originally used as a means to provide tax-deferred, deferred compensation to employees, the IRS has called into question some of the more aggressive programs being marketed by the insurance industry. Employers should seek independent counsel to evaluate the merits of any traditional split-dollar or reverse split-dollar programs being proposed.

Group Universal Life Plans

Group universal life plans provide for individually controlled universal life insurance contracts that are issued and underwritten on a group basis. As a result, although there is some loss of flexibility, the basic features of a universal life policy (i.e., a separate term insurance benefit and side accumulation fund) remain. Due to the group feature of the program, policy administrative costs are generally lower than for comparable individual coverage.

Supplemental Group Life Insurance

This form of insurance consists primarily of group term life insurance coverage that is 100% employee paid and supplements an existing company-sponsored group term life insurance plan. It is intended to provide additional life insurance coverage for employees with increased needs and it can be provided on a simplified-issue basis. Coverage is generally available in multiples of earnings and it may require evidence of good health before being approved. This supplemental insurance frequently accompanies a group term life program that limits the employer-provided coverage to \$50,000 per eligible employee (i.e., the amount that employers may provide on a tax-free basis).

Voluntary Group Life Insurance

Voluntary group life insurance is similar to the supplemental life insurance described above; however, voluntary group life insurance is employee-paid coverage generally consisting of either a preset amount of coverage for an employee and/or his or her dependents or as multiples of earnings. Five-year age brackets usually band premiums, and often individuals may continue the coverage following termination from the group.

Post-Retirement Life Insurance

There are a number of ways of providing for continuation of group life insurance coverage after retirement, including group term life insurance, retired lives reserve plans, group permanent life insurance, deferred paid-up life insurance, and "guaranteed issue" life insurance plans. As one might expect, each of these methods has associated with it differing costs, tax treatment rules, and reporting requirements. Employers considering implementing a post-retirement life insurance program will need to consult with appropriate insurance, tax and legal advisors.

Group Disability Insurance

According to the Social Security Administration, nearly one in five workers will experience a disabling medical condition lasting at least five years between the ages of 35 and 65. Group disability income insurance is designed to provide employees who become unable to perform the tasks of their job due to illness or accident with at least a partial replacement of their lost earnings. Group disability benefits are generally based on a percentage of the affected worker's normal rate of pay, with a maximum benefit limit. Depending on the duration of benefit payments, the insurance contract may characterize the coverage as either short-term or long-term in nature.

Because both benefit eligibility and duration are tied to an individual's physical or mental condition at the time, group disability plans are subject to a number of anti-discrimination laws including the Americans with

Disabilities Act (ADA), the Age Discrimination in Employment Act (ADEA) and the Civil Rights Act. These legal requirements impact both the design and the underwriting of group disability insurance plans.

Although either the employer or the employees may pay all or a portion of the premiums, the method of premium payment determines the tax treatment of both the premiums and any benefits ultimately received. If the employee pays 100% of the premium with after-tax dollars or elects to include in taxable income the value of the employer-paid premium, then any benefits received will be excluded from the employee's gross income. Conversely, if the employer pays all of the premium and it is not taxed to the employee, any benefits paid will be subject to Social Security and Medicare taxes, as well as federal (and possibly state) income tax. IRS guidance permits employers to offer employees a choice of these two funding approaches in some limited circumstances. This election approach allows employees to control whether disability benefits will be taxable, but only if the election is made prior to the beginning of the plan year for which the election applied.

If the employer and employee share the premium payments, more complicated rules apply. A pro rata proportion of benefits received that are attributable to employer contributions will be subject to income taxation to the employee. As discussed in more detail in Chapter 4, any disability premiums paid on a pre-tax basis through a Code Section 125 "cafeteria" plan will render the benefit payments taxable.

Short-Term Disability Plans

Although many employers pay short-term disability benefits from the company's general assets, others purchase group short-term disability insurance to pay short-term disability benefits. As the name suggests, short-term disability insurance is designed to provide wage-replacement coverage for a short period of time. Typically, employees must satisfy a benefit waiting period of one or two weeks after their disability commences before benefits become payable. After benefits accrue, coverage generally continues for no more than 13 or 26 weeks. The percentage of earnings replaced is usually fairly high, generally between 60% and 70%, but typically there is a maximum benefit limit that impacts more highly compensated employees, reducing their amount of wage replacement to perhaps 40% or 50%. Disability insurance covers only non-occupational disabilities because worker's compensation insurance would compensate employees for any job-related injuries. (See Chapter 7 for a more thorough discussion of worker's compensation insurance arrangements.)

Because the maximum benefit duration for short-term disability coverage is relatively short, these types of plans have few coverage exclusions. Benefits most often are payable weekly, with partial-week benefits paid where appropriate. Due to the short waiting period and benefit duration and because most insurance carriers take a few weeks to process a claim, it is critical for both the employer and the employee to react quickly, completing and submitting the necessary documentation for filing a claim. An employee's attending physician must also complete all required paperwork, and a disability benefit claimant generally must be under the direct care of a physician throughout the term of the disability to remain eligible for benefits.

Although a simple wage-continuation plan paid from the company's general assets will eliminate the delay that usually accompanies an insured benefit claim as well as the administrative expenses associated with maintaining an insured program, even the simplest of short-term disability programs requires some level of administration. Even though these unfunded payroll practices generally are not subject to ERISA, employers who develop an insured short-term disability benefit program should have a written description of the program and communicate it to employees in an employee handbook or otherwise. Reducing the terms of the program to writing clarifies the nature of the benefit, the procedure for making a claim and how eligibility determinations will be made.

Long-Term Disability Plans

In contrast to short-term disability coverage, long-term disability benefits do not commence until the employee has satisfied a relatively long waiting period (usually three to six months), which often corresponds with the duration of any short-term disability payments. These programs are generally insured programs because of the potential large and long-term liabilities that arise from a disability. However, many larger employers have found that self-insuring these benefits (either with or without a voluntary employee benefit association trust, also known as a VEBA, to fund the benefit payments) can be more cost-effective. Employers usually coordinate this waiting period with the period of coverage under their short-term disability program.

Once benefits begin, disability payments usually continue for a long period of time, frequently until the disabled worker returns to work or reaches normal Social Security retirement age. Generally, long-term disability coverage replaces a lower percentage of earnings than short-term disability coverage, typically between 50% and 60% of gross pay, due to the longer payout period and as a means of encouraging the disabled employee to return to work.

Employers who provide long-term disability benefits for their workforces tend to pay 100% of the associated premiums; however, as discussed above, the resulting benefits payments will become taxable income to the employee. Considering that disability benefits tend to provide a fraction of pre-disability income, some employees may prefer to pay their own premiums on an after-tax basis to avoid the future taxation of any benefits payable upon disability.

Long-term disability plans usually distinguish between two categories of disabilities:

1. Those that render an individual incapable of performing his or her own regular occupation
2. Those that render an individual incapable of performing any occupation for wage or profit

Individuals who are incapable of performing their own regular occupation typically qualify for benefits during an initial period of disability, often two years in length. Thereafter, in order to continue to qualify for benefits, individuals often must be incapable of performing any occupation. To offset the potential negative impact of this distinction, a policy may include a longer period during which benefits are payable as long as the employee cannot perform his or her own occupation, and/or it can include provisions for the payment of benefits during any "partial disability" or "rehabilitative employment" period.

Partial disability benefits provide for the payment of a reduced benefit when an employee is capable of performing most, if not all, of the duties of his or her regular occupation, but only on a part-time basis. In such cases, the regular monthly benefit is usually reduced by some percentage of the employee's part-time earnings. Similarly, rehabilitative employment benefits allow a disabled worker to become involved in other work for which he or she might reasonably be qualified and then offset the monthly benefit amount by some percentage of those earnings.

In an effort to control costs and prevent overutilization, long-term disability insurance carriers have developed many sophisticated programs for rehabilitating and/or retraining workers so they can return to productive employment as soon as possible.

Long-term disability policies typically provide that any benefits payable to a disabled individual will be reduced or "offset" by any benefits received from other sources because of the same disabling condition, including Social Security disability benefits, worker's compensation or other occupational disease benefits, pensions, and any other group disability insurance benefits.

A long-term disability claim should be filed as soon as it appears likely that the disabling condition will

outlast the benefit waiting period. As is the case with short-term disability benefits, a long-term disability claimant must be under a doctor's direct, continuous care in order to qualify for benefits.

Other Insurance Programs

Voluntary Insurance Programs

For groups of almost any size, there are a variety of voluntary, employee-pay-all insurance programs available from several different insurance carrier sources. These programs include the following:

- Voluntary dental plans
- Voluntary universal life plans
- Voluntary term life plans
- Voluntary disability plans
- Voluntary vision plans
- Supplemental medical plans that provide for fixed per diem payments when the insured is hospitalized and/or for limited reimbursement for medical expenses that are not covered under a base policy (such as routine care or hearing aids)
- Disease-specific plans that cover unreimbursed costs associated with treatment of a particular medical condition (cancer, for example) or pay a set, per diem amount up to the selected policy maximum

All of these programs have the advantage of letting the employer provide this coverage without increasing its benefits costs. In addition, to the extent that the cost of these types of coverage may be paid with pre-tax premium conversion in a Code Section 125 "cafeteria" plan, employees may realize significant tax savings as well. (See Chapter 4 for more details regarding the availability of this option.)

On the other hand, even voluntary insurance programs involve some administrative effort and expenses on the employer's part, and employers must take into consideration the additional level of administration involved in deciding whether to offer these voluntary benefits to employees, as well as how valuable and utilized these benefits will be.

Warning: Employers must be cautious when offering voluntary insurance coverage to employees, as any endorsement or sponsorship of the voluntary coverage can cause the coverage to be an ERISA plan. If the employer promotes, endorses, sponsors, or obtains a favorable group rate for employees for the voluntary coverage, ERISA may apply to the benefit and required establishment of an ERISA plan document and compliance with ERISA's reporting, disclosure, claims, and fiduciary provisions.

Group Long-Term Care Insurance

As a part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Internal Revenue Code was amended to extend certain tax incentives to employers offering group long-term care insurance coverage to their employees. These incentives allow employers to deduct their share of long-term care

Chapter 3

insurance premiums paid on behalf of employees as an ordinary business expense, provided the insurance is offered through a “qualified” long-term care plan.

Long-term care premiums are not taxable to the employees when paid. In addition, the Internal Revenue Code states that benefits provided by qualified long-term care policies are nontaxable to employees except for per diem reimbursements in excess of the limit for the tax year. This inflation-adjusted limit is \$380 for 2020.

In order to be “qualified,” a long-term care contract must provide insurance only for long-term care, must be guaranteed renewable and must not cover expenses that are reimbursable under Title 18 of the Social Security Act. The contract also may not include a cash surrender value or permit its use for collateral. It must provide for premium refunds and other distributions applied to reduce future premiums or increase benefits. Long-term care insurance contracts are also subject to consumer protection notices.

Although these plans currently are not widespread and states’ efforts to regulate these arrangements are gaining momentum, there are a variety of insurance policies available to employers to provide long-term care benefits. Group policies frequently include coverage for the following:

- Nursing home care
- Skilled home care
- Adult daycare
- Hospice care
- Case/care management
- Unskilled home health care

In addition, other coverage options may include respite care, physical and/or speech therapy, and alternative medical care. Employers considering offering long-term care benefits to employees will want to review the latest options for structuring these benefits with an attorney, insurance broker, or other employee benefits consultant.

In 2010, as part of the Affordable Care Act, the Community Living Assistance Services and Supports (CLASS) Act sought to establish a national voluntary long-term care insurance program. In October of 2011, the federal government determined that this program was financially unsustainable and stopped its implementation.

Obtaining and Replacing Insurance Contracts

Whenever an employer first seeks to obtain a group insurance contract or attempts to find an appropriate replacement policy, there are several issues that should be considered. An employer applying for group life insurance for the first time will need to submit a complete census listing of eligible employees and their work locations, age, gender and benefit class/level of earnings. This is because group life insurance is underwritten and priced according to the group’s physical location (or locations), industry type, age and gender makeup of its eligible workforce and concentration of risk.

Example: If 30% of the coverage population is made up of the oldest classification of workers, then premium rates will reflect this higher concentration of risk.

Life Insurance, Disability Insurance and Other Insured Benefits

Similarly, employers applying for either short- or long-term disability insurance for the first time will need to submit a complete census listing of eligible employees, including their age, sex, amount of covered earnings, job classification and location. As with group life insurance, disability insurance is underwritten and priced according to this data. Employers should take an active role in determining the length of the plan's waiting period, its maximum benefit period, the definition of "earnings" and the maximum benefit amount payable (as well as the percentage of earnings payable) for the coverage they sponsor.

Employers who intend to replace one insurance carrier with another should consider the following questions:

- Is the replacement coverage guaranteed renewable?
- For how long are premium rates guaranteed?
- Will the insurer waive any "actively at work" eligibility requirements for employees who are currently out on disability?
- Are there any disabled employees enrolled for coverage who have not yet satisfied the waiver of premium waiting period? If so, will the replacement coverage pick up these individuals?
- Are the coverage, benefit classes and reduction schedule comparable or identical to those being replaced?
- If the benefits are collectively bargained, does the union have to be notified about or agree to the change in insurance carrier and/or any resulting contract differences?

Employers that consider changing disability insurance carriers should consider the same issues that confront employers that are changing life insurance carriers, with particular attention to whether there are former employees who are currently receiving long-term disability benefits and whether the new insurance company will cover those individuals on the replacement policy. Employers should consider whether these issues justify engaging legal counsel to supplement the advice of any agent who may be selling the new insurance product.

Chapter 4

Section 125 “Cafeteria” Plans

Section 125 of the Internal Revenue Code permits employers to establish employee benefit plans known as “flexible benefit” plans or “cafeteria” plans. These plans offer employees a choice between taxable income and certain nontaxable or “qualified” benefits. Employees who participate in a Section 125 plan may choose from one benefit option or a variety of benefit offerings in lieu of receiving cash compensation or other taxable benefits. The qualified benefits options may include benefits funded through premium conversion arrangements, as well as flexible spending accounts, discussed in greater detail in the following sections.

Qualified Benefits

Generally, a Section 125 plan may include the following qualified benefits:

- Group medical coverage
- Group dental coverage
- Prescription drug coverage
- Vision coverage
- Medical flexible spending accounts
- Dependent care reimbursement accounts
- Accidental death and dismemberment coverage
- Group term life insurance coverage (for employees only)
- Long-term and short-term disability coverage
- Vacation days or pay
- Wellness benefits
- Personal accident insurance
- Certain retiree medical benefits
- Contributions to a health savings account
- Adoption assistance benefits

These benefits may be provided through insurance policies or the employer may self-fund them.

Another qualified benefit that employers may include as an option in a Section 125 plan is to allow employees to make elective contributions to a 401(k) plan. A 401(k) plan is a type of retirement savings plan in which employees have the option of receiving compensation in cash or deferring their earnings into a trust fund until they retire. These plans are discussed in greater detail in Chapter 5.

Certain benefits may not be included within a Section 125 plan, including group term dependent life coverage, educational assistance benefits, medical savings accounts, long-term care insurance, elective contributions to a 403(b) plan, and employee fringe benefits such as employee discounts, eating facilities

and other de minimis fringe benefits. (These fringe benefits are discussed in more detail in Chapter 10 and Chapter 11.)

The key feature of a Section 125 plan is that it allows participants to choose to receive either “cash” or qualified benefits such as those benefits listed above. A Section 125 plan may satisfy the “cash” option requirement by offering a benefit that is a “cash equivalent.” Importantly, to be considered a cash equivalent benefit, the option must not defer the receipt of compensation. For example, benefit options payable with after-tax dollars would satisfy this requirement.

Funding Features

Flexible benefit plans may be funded through one or more structural features. One common feature is the premium conversion. Premium conversion allows employees to reduce compensation to pay the employee’s share of benefit costs with pre-tax dollars. Upon the signing of a salary reduction agreement, in lieu of receiving cash compensation, an employee directs his or her employer to withhold from his or her salary certain costs associated with a benefit that the employee has selected. The amounts withheld to pay for the benefit avoid Social Security tax (FICA), federal unemployment tax (FUTA) and state income tax. For example, the employee’s share of any “premiums” associated with insured or self-funded group medical and dental coverage is frequently funded in this manner. In most instances, the benefits received by the employees are also tax free; however, certain benefits such as disability benefits will become taxable when paid to the employee if those benefits were purchased with pre-tax dollars. (See Chapter 3 for discussion of the taxation of long-term disability benefits.)

Flexible Spending Accounts

Flexible spending accounts (FSAs) are accounts set aside for the reimbursement of certain eligible medical and dependent care expenses. These accounts may be funded through salary reduction agreements, employer contributions, other “dollars” made available from benefit “tradeoffs,” or any combination of these methods. Amounts contributed to an FSA via salary reduction contributions become nontaxable income, as with premium conversion; however, employees generally must use these accounts for expenses incurred in the year that the salary is deferred or the balance of the money in the accounts will be forfeited. Employers may design a plan to allow a small amount of money to carry over into the next year, with any leftover funds beyond the carryover amount being forfeited. Alternatively, employers may design a plan to allow a short grace period after the year ends to incur and submit flexible spending account claims, as discussed in more detail later in the chapter. Both a carryover feature and a grace period feature are optional: employers do not have to implement either one. Plans cannot use both a carryover feature and a grace period feature.

An election to make a contribution to a flexible spending account generally must remain in effect for an entire plan year. There are some limited circumstances in which midyear election changes are permissible, as discussed later in the chapter. In addition to the restrictions on election changes, these accounts are subject to strict claims substantiation requirements. The IRS allows for electronic reimbursement of certain claims from medical flexible spending accounts via debit cards.

There are two types of flexible spending accounts that may be included within a Section 125 plan: medical flexible spending accounts and dependent care reimbursement accounts. A medical flexible spending account, or health FSA, allows employees to use pre-tax dollars to pay for unreimbursed “qualifying medical expenses.” The plan document will usually specify a limit on the amount an employee may contribute

to the health FSA. In 2013 and later years, the Internal Revenue Code limits employee contributions to a health FSA to \$2,500 per calendar year. This amount is indexed for inflation each year. As of 2020, the limit on health FSA contributions was \$2,750. A dependent care reimbursement account allows employees to use pre-tax dollars to pay for eligible childcare expenses, and the Internal Revenue Code generally limits contributions to this account to \$5,000 per calendar year. With each of these accounts, the amount of available reimbursement must be predetermined by the employee and set aside during the applicable year.

Although the employee typically will lose any unused amounts at the end of the year, most plans allow a run-out period following the end of the plan year during which the employee may submit claims for expenses incurred during the plan year.

In addition, the Internal Revenue Service permits the reimbursement of expenses incurred after the end of the plan year in plans that have implemented either a grace period or a carryover. In 2005, the IRS issued guidance allowing employers to offer employees a short grace period to incur expenses under medical flexible spending accounts and dependent care reimbursement accounts after the plan year ends. The grace period may last no longer than two and one-half months after the end of the immediately preceding plan year (March 15 for calendar year cafeteria plans).¹ In other words, qualified benefits (such as medical expenses in a medical flexible spending account) incurred during the grace period may be reimbursed from unused flexible spending account amounts remaining at the end of the immediately preceding plan year. Employers may take advantage of this rule immediately by amending their cafeteria plans to adopt a grace period, although employers will want first to review administrative issues with their cafeteria plan administrator.

In 2013, the Internal Revenue Service issued guidance allowing employers to offer a carryover of unused health FSA funds to the next plan year. Under this guidance, a small amount of unused health FSA amounts that remain at the end of the plan year may be carried over to the next plan year. For plan years that began in 2019 and earlier, the maximum amount that could be carried over to the next plan year was \$500. For plan years that began in 2020 or later, the maximum amount was increased to 20% of the maximum employee contribution amount. For example, the maximum employee contribution amount in 2020 was \$2,750. This means that the maximum carryover amount from the 2020 plan year to the 2021 plan year was \$550 (i.e., 20% of \$2,750). Because the maximum carryover amount is now tied to the maximum employee contribution amount, and that amount increases periodically, the maximum carryover amount will also increase periodically. Employers may take advantage of the carryover rule by amending their cafeteria plans to adopt a carryover provision.

Note: Employers cannot include both a grace period and a carryover provision. Internal Revenue Service rules specifically prohibit employers from having both. Employers may choose to implement either a grace period, a carryover provision, or neither.

Federal regulations provide that the full amount of money that the employee has elected to defer into a medical flexible spending account during a plan year must be made available to that employee on the first day of the plan year, even if the full amount has not yet been withheld from the employee’s compensation. This means that an employee who elects to contribute \$2,000 to a health FSA during 2020 is eligible for the full \$2,000 in reimbursement from the medical FSA on January 1, 2020, even before the employee has

¹ In 2020, the Internal Revenue Service provided for a limited extended grace period for certain plans due to the novel coronavirus pandemic. The extended grace period applied only to plan years or grace periods that ended in 2020. A health FSA or dependent care reimbursement account could have extended the grace period until December 31, 2020. Note that this was a one-time, limited extension that applied in 2020 only.

made his or her first contribution for the year. This rule does not apply to dependent care accounts, so the employer may limit the funds available for reimbursement from a dependent care account to that amount that has been withheld from the employee's pay and is credited to the employee's dependent care reimbursement account at the time of a reimbursement claim. This rule also does not apply to health care reimbursement arrangements (HRAs), which are employer-funded accounts that employees may use to pay for medical expenses or health insurance premiums. These accounts are explained in more detail in the defined contribution health plan discussion in Chapter 2.

Plan Design Options

A Section 125 plan may offer benefits in one of a variety of formats. Some plans will include a premium conversion option with or without flexible spending accounts. A traditional Section 125 plan will allow employees to select among a few prescribed benefit combinations. The plan may or may not allow employees to "opt out" or waive benefits. The plan may include combinations of self-funded and fully insured options, and the plan may require employees to bear the increased cost associated with "upgrading" a particular benefit. This increase may be funded through a salary reduction/premium conversion arrangement as described above. Typically, in a traditional Section 125 plan, employee choice is limited to the pre-established plan options, and the employer has little control over which options are selected. For example, an employee may have three health plan options: an HMO, a PPO, or a high deductible health plan (HDHP). The HMO may be a low-cost option, with a modest increase in the employee contribution required for participation in the HDHP, and a higher premium required for the PPO option.

Another approach in designing a Section 125 plan is to designate certain benefits as "core" benefits, creating a core benefit package that is provided at no cost to employees and adding various upgrades for which employees must bear the cost. Again, the employer may include both self-funded and fully insured options and may fund employee contributions through salary reduction agreements, employer contributions, opt-out dollars or any combination of these. Some employers use actual dollars; others give benefits credits or use a dollar "banking" approach. Most experts view this plan design as more responsive to employee needs than a traditional plan because it ensures that all employees receive a core or minimum benefit at no cost to themselves. The employer chooses that minimum benefit, and the employee is free to select upgrades as needed on an individualized basis. In response to the employer mandate in the Health Care Reform law, employers may want to consider designating as the core option a plan designed to provide affordable, minimum essential coverage, as discussed in Chapter 2.

The most versatile and flexible approach is a "full-flex" plan that allows employees to use benefit dollars to select from among a broad menu of benefit options, tailoring their benefit package to their individual needs. There is a greater level of administrative complexity associated with such plans, which are generally used only by larger employers because of the difficulty in controlling costs when providing a variety of benefit options to small groups of employees.

Flexible Spending Accounts, Health Savings Accounts and Plan Design

It is important to be aware of the coordination issues involving flexible spending accounts and health savings accounts (HSAs) described in Chapter 2. A prerequisite to using an HSA is that the individual must be covered by a high-deductible health plan and may not have other health coverage. If the individual is

also covered by a medical flexible spending account that reimburses medical expenses that are not covered by the high-deductible health plan, the individual will not be eligible to participate in the HSA. However, there are limited circumstances in which a person who is eligible to participate in an HSA may also participate in a medical flexible spending account.

An employer may offer a limited-purpose flexible spending account without affecting the eligibility of people wishing to participate in an HSA. This type of FSA will reimburse only for vision expenses, dental expenses and/or preventive care benefits. (However, after 2010 the Health Care Reform law mandated first dollar coverage for preventive care for all non-grandfathered plans, so the latter design is now rare.) Alternately, an employer may offer a post-deductible health FSA that reimburses for medical expenses only after the minimum annual deductible of the HDHP is satisfied. These types of limited-purpose FSAs will not prevent a person from being eligible for an HSA. (See Appendix H for more comparisons between FSAs and HSAs.)

Cafeteria Plan Document

The written plan document for a Section 125 “cafeteria” plan should include, at minimum, the following information written in plain English:

- A description of the benefits options provided
- A description of the periods of coverage that apply to each benefit provided
- The plan’s eligibility rules
- The plan’s rules regarding coverage, including a description of when coverage elections may be changed and when new elections may be made
- The method of making plan contributions, as well as any minimum and maximum contributions permitted
- The year on which the plan operates
- Claims administration provisions that inform participants how to make a claim for benefits and how to appeal any denied claims
- Who the plan administrator is
- Limits on FSA contributions
- Election change rules (discussed below)
- Any grace period or carryover provisions
- If coordinating with an HSA, the limitations on the scope of FSA reimbursements

The terms of a Section 125 plan must be reflected in a written plan document that is executed prior to the initial contribution. ERISA applies to health FSAs offered through Section 125 plans. Therefore, additional provisions that apply to health plans (such as COBRA and HIPAA privacy rules) should be included.

When administering a plan with health FSAs, the plan administrator is subject to ERISA’s fiduciary requirements. (See Appendix B.) In addition, the Section 125 plan must comply with ERISA’s annual reporting and disclosure requirements, which generally require the distribution of a summary plan description to plan participants, as well as summaries of material modifications when the plan is amended and the filing of an annual report (Form 5500) with the Department of Labor in some cases. (See Appendix A for more information regarding the reporting and disclosure obligations and Appendix F for details about Form 5500.)

Election Changes

Generally, employees make their benefits elections for the following year during an annual “open enrollment” period. As mentioned above, in order to gain the tax advantages associated with a Section 125 plan, employee coverage elections generally must remain in place for the full period of coverage, usually the full plan year. There are exceptions to this rule, however, and those exceptions arise when the employee experiences a change in his or her status or a significant cost or coverage change. Depending on the plan terms, the rules governing these changes may add some complexity to cafeteria plan administration.

The following events may justify a change in an employee’s current election under a Section 125 plan (if the plan permits such a change) and should be described in any open enrollment information given to employees:

- Change in marital status, including marriage, divorce or death of a spouse
- Addition to the family, including the birth, death, adoption or placement for adoption of a child
- Change in employment status for the employee, spouse or tax dependent, including the termination or commencement of employment, switching from full- to part-time status or vice versa, strike or lockout, commencement of or return from an unpaid leave of absence or a change in one’s work location, that results in the gain or loss of coverage
- Change in the plan’s eligibility rules that results in the gain or loss of coverage for an employee, spouse or tax dependent
- Employee, spouse or tax dependent becoming entitled to Medicare or Medicaid
- Employee’s tax dependent satisfies (or ceases to satisfy) the plan’s eligibility rules, including coverage changes compelled by a qualified medical child support order
- Change in residence for the employee, spouse or tax dependent
- Judgment, decree or order

Any of the events listed above may justify an election change under a Section 125 plan, but only if the requested change is because of, and consistent with, the corresponding events and if the plan permits such an election change. For example, an employee may change his or her election following the birth or adoption of a child to add dependent coverage for the child. Similarly, if an employee becomes divorced from his or her spouse, the employee may change his or her election to drop health coverage for the spouse for the remainder of the plan year. Otherwise, employees are limited in their ability to change their plan benefit elections. For example, a merger or acquisition will not automatically trigger a change in employment status that will justify a change in an employee’s election under a Section 125 plan. The key fact will be whether new coverage is made available to the employee or whether prior coverage terminates as a result of the merger or acquisition. Although an employee’s termination of employment is a change in status that may justify an election change under the plan, certain election changes would not be consistent with that event.

This “consistency rule” applies unless the election change seeks only to increase the amount of employee’s pre-tax premium conversion for group health coverage in order to cover the increased costs of coverage offered pursuant to COBRA, which is limited continuation coverage that employers generally must offer employees and dependents who otherwise would lose coverage following certain qualifying events. A full description of this coverage, as well as the requirements of COBRA, is set forth in greater detail in Chapter 2.

A plan may also permit participants to change their elections due to significant cost or coverage changes. The rules permit a plan to automatically implement a corresponding change to a participant’s election if employees’ payments for the qualified benefits are increased or decreased due to a change in the cost of the qualified benefits. A plan may also allow a participant to voluntarily make an election change due to significant cost changes for a benefit package option.

Coverage changes may also justify a participant’s election change mid-year. The rules recognize a broad array of coverage changes. For example, a participant may experience any of the following events:

- A significant reduction of coverage without a complete loss of coverage
- A significant reduction in coverage that results in a loss of coverage
- An addition or improvement of a benefit package option
- A change in coverage under another employer plan

The Health Care Reform law added additional situations in which a plan may permit a participant’s election change. Under these rules, if a participant experiences a reduction in hours (even if eligibility under the plan is not lost) or a participant signs up for coverage under an Exchange, then the plan can permit an election change if the participant certifies that he or she will obtain alternate coverage.

The election change rules apply differently to certain types of benefits. Not all of the election change rules described above apply to health FSAs. For example, health FSA elections generally cannot be changed based on coverage changes. On the other hand, the election change rules generally apply more broadly to dependent care reimbursement accounts. In addition, employee elections to contribute to an HSA can be changed on a monthly basis.

Finally, in 2020 the Internal Revenue Service issued special election change rules related to the global novel coronavirus pandemic. These rules allow plans to permit participants to make mid-year election changes to the medical plan, health FSA, and dependent care reimbursement account without experiencing any of the events listed above. These special election change rules apply in 2020 only. Plans must be amended by December 31, 2021 to take advantage of these rules.

Special Enrollment Rights

The enrollment rules of pre-tax premium conversion for health benefits and medical FSAs in a Section 125 plan should coordinate with the HIPAA requirement (also discussed in more detail in Chapter 2) that recognizes certain “special enrollment rights” of participants. Events prompting these special enrollment rights include the loss of other coverage, the acquisition of a new dependent, eligibility for state premium assistance programs, and the loss of Medicaid or CHIP coverage. For example, if an employee or his or her dependents decline coverage in the group medical plan because they had other coverage, and if they lose that other coverage for certain specified reasons, then the plan must allow them to enroll within 30 days of the loss of the other coverage (60 days for Medicaid or CHIP coverage). The plan may deny an employee special enrollment if the plan required the employee to give a written statement at the time of his or her eligibility for enrollment regarding the reason for declining coverage under the plan and the employee failed to provide this statement.

If an employee acquires a new dependent through marriage, birth, adoption or placement for adoption, the plan must allow the employee and/or his or her dependents to enroll in the plan within 30 days of the marriage, birth, adoption or placement for adoption. The medical coverage due to birth, adoption or

placement for adoption must be effective as of the birth, adoption or placement, and coverage for a new spouse must be effective by the first day of the month after the request for enrollment. HIPAA's special enrollment rules apply to all group health plans and require plans to notify employees of the plan's special enrollment rules during each open enrollment period and at the time of enrollment of any new enrollee.

FMLA and Other Leaves of Absence

Special rules also apply to employees who take a leave of absence that qualifies under the Family and Medical Leave Act (FMLA). When applicable, the FMLA allows employees to take a leave of absence for up to 12 weeks following certain events, which are discussed in Chapter 8. Although employers may provide that part or all of an FMLA leave as paid leave, the FMLA does not require employers to pay employees during an FMLA leave. Therefore, during an unpaid FMLA leave, employees may revoke an existing election for coverage under a Section 125 plan. Upon the employee's return to work following the leave, the employee may reinstate coverage under the Section 125 plan for the remainder of the plan year, regardless of whether the employee terminated the coverage voluntarily or simply failed to timely pay premiums during the leave. Employees who choose to continue coverage during an FMLA leave must be allowed to pay required premiums prior to the leave, during the leave or at the end of the leave without losing coverage.

Similarly, under the Uniformed Services Employment and Re-employment Rights Act (USERRA), a Section 125 plan must allow an employee to continue participating, even when on an unpaid leave due to certain military service. See Chapter 8 for more detail regarding the requirements of USERRA.

Compliance with State Law

Indiana law imposes certain restrictions upon an employer's ability to withhold amounts from an employee's pay. Indiana law requires that any payroll reduction agreement between an employee and an employer be in writing and be revocable at any time. A Section 125 plan administrator will want to develop a payroll reduction agreement that complies with the requirements of Indiana law and allows the employee to revoke his or her election at any time. If an employee revokes his or her payroll reduction election at a time other than as authorized by the plan, the Section 125 plan document should provide that the employee's participation in the Section 125 plan ceases.

Application of COBRA to Medical Flexible Spending Accounts

Generally, health FSAs in Section 125 plans are viewed as group health plans subject to COBRA; however, guidance from the Internal Revenue Service provides an exception. This exception recognizes that COBRA continuation of a health FSA usually is not useful to an individual. As a result, two rules generally will apply:

1. In the year of the COBRA qualifying event, if the maximum benefit available for the remainder of the year from the medical flexible spending account is less than or equal to the COBRA premium that would be payable, COBRA coverage does not have to be offered.
2. In subsequent years, if the COBRA premium for an entire year of coverage is more than the maximum benefit for the year, COBRA does not have to be offered.

Because the COBRA premium charged may be as much as 102% of the total premium, it will rarely make sense for a COBRA beneficiary to pay the COBRA premium to obtain a benefit that is worth less, particularly because the individual is no longer employed and has no income from which to withhold the contribution on a pre-tax basis. These rules apply to most health FSAs that are offered through a Section 125 plan.

Nondiscrimination

A Section 125 plan generally may not discriminate in favor of highly compensated employees with respect to eligibility to participate in the plan, required contributions or benefits provided. The plan must give all participants an equal opportunity to select nontaxable benefits and the actual selection of benefits must not be discriminatory. If a plan fails to satisfy any of three detailed nondiscrimination tests that apply to Section 125 plans, the highly compensated employees who are benefited must include in their gross income the value of the benefits that could have been elected on a tax-free basis if the plan had been nondiscriminatory. Clear communication of the advantages of participating in a Section 125 plan – particularly the potential tax advantages to the employee (discussed below) – will be crucial to increasing the participation of non-highly compensated employees and avoiding discrimination.

For small employers with 100 or fewer employees, the Affordable Care Act added “simple cafeteria plans.” Under a simple cafeteria plan, if an employer meets certain eligibility and contribution rules, the plan is treated as passing the nondiscrimination rules of not only Section 125 but also component benefits such as health plans, dependent care reimbursement accounts and life insurance.

Tax Advantages

One of the primary reasons to offer employees benefits via a cafeteria plan is to allow them to purchase nontaxable benefits with pre-tax dollars. Some employers may also include benefits in their cafeteria plans that may be purchased only with after-tax dollars. Similarly, there are some benefits that will become taxable when received by the employee if the benefit was purchased with pre-tax dollars. Employers nonetheless may desire to offer benefits falling into these latter two categories in order to maximize employee choice. The following is a summary of the tax issues that are unique to the various benefits that may be offered under a cafeteria plan.

The most common type of benefits found in cafeteria plans are group medical, dental, prescription drug and vision benefits coverage. Not coincidentally, these benefits all receive the most favored tax status available. Employees may use pre-tax dollars to pay premiums associated with these benefits, and benefits received by the employees and their dependents will be excludable from income.

Example: Assume the employee’s taxable income for 2020 is \$35,000. The employee elects to have \$300 of pay per month used under the plan to pay for health coverage costs for the year. As a result, the employee’s taxable income is reduced by \$3,600 to \$31,400. Assuming that the employee’s marginal tax rate is 27% (including federal, state and local income taxes), the employee would reduce or save the amount he or she would otherwise pay in income taxes by \$972 (27% of \$3,600) and the amount he or she would otherwise pay in Social Security taxes by \$275.40 (the 7.65% Social Security rate times \$3,600) by participating in the pre-tax portion of the plan. This is a savings of \$1,247.40.

With No Flexible Benefit Plan Election		Election Under the Section 125 Plan
\$35,000.00	Annual Pay	\$35,000.00
-NA	Pre-tax Contributions	-\$3,600.00
\$35,000.00	Taxable Pay	\$31,400.00
-\$9450.00	Withholdings (27%)	-\$ 8,478.00
-\$2,677.50	Social Security (7.65%)	-\$ 2,402.10
-\$3,600.00	After-tax Contributions	-NA
\$19,272.50	Take-home Pay	\$20,519.90

In other words, the employee will have \$1,247.40 more in take-home pay if the employee pays his or her medical plan premium on a pre-tax basis through the Section 125 plan.

Amounts directed to flexible spending accounts, including both medical and dependent care reimbursement accounts, are also pre-tax dollars. In the example used above, assume the employee also elects to have \$2,000 of his or her annual pay contributed to a dependent care reimbursement account. As a result, the employee's annual income would be reduced by an additional \$2,000 to \$18,519.90. The employee would reduce his or her income tax by an additional \$540 (27% times \$2,000) and the amount he or she pays in Social Security taxes by \$153 (7.65% times \$2,000) by participating in the dependent care reimbursement account. The employee's \$2,000 contribution to a flexible spending account would save an additional \$693 in taxes for the year.

Employers may want to consider communicating these tax advantages to employees with a worksheet that allows them to calculate their actual tax savings based upon the various benefit elections available to them.

Qualifying Medical Expenses

The scope of medical expenses that may be reimbursed from a health FSA is quite broad. Employees may receive reimbursement for any unreimbursed qualifying medical expenses, which generally include items that are considered medical care under the Code and are not otherwise reimbursed or covered by insurance. Examples of qualifying medical expenses could include hearing aids, birth control pills, coinsurance and deductible amounts, custodial care, and amounts in excess of maximum limits under a company health plan. Since 2020, qualifying medical expenses also includes over-the-counter medications and menstrual products. These expenses generally could be incurred by the employee, a spouse, or individuals who qualify as the employee's tax dependents. Expenses that would not qualify for reimbursement from a health FSA include charges that exceed reasonable and customary guidelines, certain cosmetic surgery, premiums for health coverage, travel expenses, health club fees, vitamins, and long-term care services. (See Appendix C for a list of qualifying medical expenses.)

Qualified Dependent Care Expenses

Reimbursement from a dependent care reimbursement account is available as long as certain criteria are met. To qualify as dependent care expenses, the expenses must be for the care of a “qualified person” or relate to household expenses, and they must be incurred to enable the employee or the employee’s spouse to work. A “qualifying person” would include an employee’s dependent who is under the age of 13 or an employee’s tax dependent or spouse who is physically or mentally incapable of caring for himself or herself. The Code contains detailed criteria regarding who may qualify as a tax dependent for various reasons, so employers will want to consult with counsel in designing these criteria.

Additionally, the employee will not be entitled to reimbursement unless both the employee and his or her spouse work. For purposes of this rule, however, the spouse will be deemed to work if he or she is a full-time student or is mentally or physically unable to care for himself or herself.

Expenses will not be reimbursed as dependent care expenses unless their main purpose is to assure the qualifying person’s well-being and protection. Not all benefits provided for a qualifying person will be considered to be for his or her well-being and protection. Examples of expenses that are not reimbursable dependent care expenses include the following:

- Services not required by employment, such as baby-sitters for leisure activity
- Overnight camps
- Care provided by a person the employee claims as a dependent on his or her federal income tax return
- Amounts paid for food, clothing or education
- Transportation expenses for a dependent care provider
- Care when the employee is on vacation, holiday or sick leave

The care may include expenses for other benefits that are incidental to and inseparably a part of the care. For example, the full amount paid to a nursery school in which a child is enrolled is a reimbursable dependent care expense, even though the school also furnishes lunch and educational services. However, educational expenses incurred for a child in the first grade or higher are not eligible dependent care expenses. On the other hand, childcare provided by a housekeeper whose services include childcare and house cleaning are covered.

Special rules apply to childcare centers. A childcare center is a center that provides dependent care for more than six individuals who do not live at the center on a regular basis during the year and that receives a fee for providing the services. Such centers must comply with all applicable state and local laws and regulations in order for such expenses to be reimbursable.

Insured Benefits

Employer contributions for accidental death and dismemberment coverage are excluded from the employee’s gross income, as are any benefits that become payable. Similarly, benefits paid under a personal accident insurance policy will be nontaxable, as long as the benefits are computed with reference to the nature of the injury rather than the period of absence from work. Unlike life insurance, accident insurance for spouses and dependents may be included in a cafeteria plan, not just insurance for employees.

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Disability coverage, however, is not treated as favorably. If an employer chooses to offer long-term or short-term disability coverage through a Section 125 plan and either pays a portion of the premium or allows premium payment on a pre-tax basis, any benefit received will be taxable when received by the employee. Therefore, many employers offer employee-paid disability coverage only on an employee-paid, after-tax basis, making the disability benefits nontaxable.

Employer contributions for employee term life insurance for up to \$50,000 of coverage are excludable from the employee's gross income. Although additional amounts may be provided or offered to employees, tax consequences should be considered. The first \$2,000 of spousal coverage is not included in the employee's gross income; however, it is impermissible to include that benefit in a cafeteria plan.

Vacation Pay

Although frequently included in a cafeteria plan, vacation pay is a taxable benefit. The value of any unused vacation time at the end of each year must either be forfeited or paid to the employee before year-end and is subject to appropriate withholding.

Retiree Benefits

Although retirees may participate in a Section 125 plan with active employees, there are limits on their ability to participate due to the nature of their relationship with the company. Although there are ways to use a cafeteria plan to create a meaningful benefit for retirees, such as offering a Medicare supplement plan, legal requirements prevent retirees from using salary reduction contributions beyond the plan year in which they retire. Therefore, any ongoing benefit offered to retirees through a cafeteria plan must be carefully considered and structured to avoid inadvertently creating an additional pension benefit.

Adoption Assistance Benefits

The Small Business Job Protection Act of 1996 added provisions to the Internal Revenue Code establishing favorable tax treatment for individuals who adopt children. Parents who adopt children may exclude from their income certain amounts paid by their employers for expenses incurred in connection with the adoption. The Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) increased the limitation amount and made the exclusion permanent.

In order for the employee to exclude these expenses, they must be paid pursuant to an adoption assistance program. An adoption assistance program is a separate written plan of benefits that provides adoption assistance exclusively to employees. Employers must provide employees with reasonable notice of the availability and terms of the program, and the plan may not discriminate in favor of highly compensated employees when providing adoption assistance benefits. Not more than 5% of benefits paid may benefit shareholders owning 5% or more of the company.

Although the program need not be funded, adoption assistance is a qualified benefit under a Section 125 plan. It should be noted that there is currently a federal tax credit for qualified adoption assistance that would provide some employees with more tax savings than an exclusion from income. Adding these benefits to a cafeteria plan, however, allows employers to assist employees with the adoption of stepchildren or with surrogate parenting arrangements, even though these expenses are excluded from the tax credit available

for adoption expenses. Moreover, providing adoption assistance through a Section 125 plan may provide employees with needed resources to pursue an adoption that otherwise might not have gone forward. There are detailed rules and provisions that apply to adoption assistance programs in order to include them in a cafeteria plan and receive favorable tax treatment.

Identifying Your Objectives

Before designing a cafeteria plan for its employees, an employer will want to identify its objectives. The following is a list of common goals from a flexible benefit perspective:

- Offering competitive benefits
- Improving benefits
- Maintaining company costs at current levels
- Reducing company costs
- Recruiting/retaining key personnel
- Gaining tax advantages
- Rewarding key executives
- Improving employee involvement in benefit decisions
- Establishing equity in benefits among employees
- Increasing employee choice

After identifying goals, the employer can design a cafeteria plan to meet those goals. For example, if the employer’s primary goals are to improve employee involvement and increase employee choice without increasing the company’s spending, the employer may develop a strategy that includes the following:

- Offering employees several benefit plan options, including some “no-cost” or “employee-pay-all” options, such as voluntary insured dental or vision benefits
- Devising a “bank” or “credit” system that may allow employees to choose some benefits and “opt out” of others while implementing cost-control and/or cost-shifting measures that may include increasing employee contributions, deductibles and copayments, or applying those features to a broader array of plan expenses
- Including “cost management” approaches, such as outpatient reviews, second surgical opinions, utilization reviews and large case management in any self-funded health plan option
- Coordinating a limited-purpose FSA with an HSA and high-deductible health plan

After designing a cafeteria plan to meet the employer’s specific strategy, an employer should embark on an employee education campaign designed to communicate the various options to employees. Employees who understand how to use these benefit offerings will appreciate their ability to choose the options that suit them best.

Conclusion

There is no limit to the number of benefits options that an employer may provide its employees. Offering those benefit options through a Section 125 plan not only allows employees to maximize their tax savings,

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but it also encourages employee choice in their benefit package. Even the simplest of plans, composed of a premium conversion arrangement, will facilitate significant tax savings to employees, with little additional cost to the employer. Employers who provide employees with clear information about their available choices and the value of those choices, including comparisons of potential tax savings, can maximize the positive impact of the benefit packages they offer.

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Retirement Benefits

An employer might consider providing retirement benefits to its employees in an effort to attract new employees, retain current employees, target particular key employees or generally increase employee morale and performance. Employers may provide retirement income to their employees through a number of different vehicles. Typically, however, retirement benefits are provided through either a “qualified” or a “nonqualified” retirement plan. This chapter explains the differences between these types of plans, discusses various types of qualified and nonqualified retirement plans, and examines the factors that an employer should consider in selecting an appropriate plan for providing retirement income to its employees, officers and working owners.

Qualified Retirement Plans

A qualified retirement plan receives favorable tax treatment because it complies with certain special requirements under the Internal Revenue Code (“the Code”). The basic tax advantages of a qualified retirement plan are as follows:

- The sponsoring employer receives a current tax deduction for amounts contributed to the plan, even though the employees generally do not pay taxes on those amounts when they are contributed to the plan.
- Generally, employees are not taxed on contributions until the contributions are actually paid to the employees at retirement (when the employees’ tax rates are presumably lower).
- Employees are not taxed on earnings on their retirement plan investments until the earnings are paid to the employees at retirement.
- Income taxes on certain types of distributions to employees, their surviving spouses and non-spouse beneficiaries may be deferred by rolling over the distribution to an IRA or another qualified plan.
- Qualified retirement plans are required to hold both employer and employee contributions in trust accounts. Plan administrators and others who handle plan assets are subject to strict legal requirements, or fiduciary duties, with respect to their handling of those funds. (See Appendix B for a summary of those duties.) The accumulated retirement funds of these plans are protected from creditors of both the employer and the employee (with some exceptions) and may provide limited ancillary benefits on death, disability or termination of employment.

In order to gain the tax advantages of qualified status, a retirement plan must satisfy a host of strict and complex requirements under the Code and ERISA. These include requirements relating to participation, coverage, funding, vesting, administration, reporting and disclosure, as well as the fiduciary duties referenced above. Additionally, qualified retirement plans are subject to a number of other federal laws, all of which can make establishing and administering a qualified retirement plan complex and expensive. Through the use of qualified service providers, however, employers can successfully establish and maintain a variety of qualified plans for their employees.

Types of Qualified Retirement Plans

Generally, all qualified retirement plans are one of two types: either a defined benefit plan or a defined contribution plan. Both types of qualified retirement plans are discussed in the following sections.

Defined Benefit Plans

Defined benefit plans provide retirement benefits that are determined under a definite formula, usually based upon the employee's compensation and the number of years of service the employee has completed with the company when he or she retires. The benefit provided at retirement is determined according to the terms of the plan, without regard to the amount of contributions made to the plan or the investment experience of plan assets. In other words, the amount of an employee's retirement benefit is predetermined. The longer an employee works, the larger the retirement benefit will be under a defined benefit plan. Therefore, such plans tend to primarily benefit older, longer-service workers.

Generally, defined benefit plans are funded entirely by the employer. The employer makes contributions to the plan in an amount determined by an actuary to be sufficient to fund the plan and to meet the employer's benefit obligations. The employer bears the risk of poor investment performance but will also benefit from favorable investment returns. The Pension Benefit Guaranty Corporation (PBGC), a federal pension insurance agency to which employers must pay premiums, insures benefits under a defined benefit plan.

Types of defined benefit plans include unit benefit plans, flat benefit plans, and cash balance plans. They are defined as follows:

- **Unit benefit plans** recognize an employee's length of service with an employer by providing benefits that are expressed as a percentage of the employee's average compensation multiplied by years of service with the employer (e.g., 1% of final average pay times years of service).
- **Flat benefit plans**, or fixed benefit plans, express benefits as a flat dollar amount (e.g., \$300 per month) or as a set percentage of the employee's final compensation at retirement (e.g., 25% of final pay).
- **Cash balance plans** have an individual account feature, like a defined contribution plan. Under this type of plan, each participant has a hypothetical cash balance account and receives hypothetical service credits (usually a percentage of compensation) and interest credits (at either a standard or variable rate). Upon termination of employment, a participant generally receives his or her cash balance account in a lump-sum payment.

Defined Contribution Plans

A defined contribution plan is a retirement plan that provides for an individual account for each participant. Benefits are based solely upon amounts contributed to the account, after adjustment for expenses, gains, losses and (sometimes) forfeitures from accounts of other participants. The employer makes contributions to each participant's account in an amount determined by a formula. The employer invests the participant's account as provided under the plan or as directed by the participant.

Unlike in a defined benefit plan, the retirement benefits payable from a defined contribution plan are not predetermined by the plan document. Instead, the contributions made to the plan are preset. Because the benefit is based solely on the value of a participant's account, the investment risk is borne entirely by

participants. Nonetheless, an employer must prudently invest plan assets or provide prudent investment choices to participants. Otherwise, the employer may be liable to participants for a breach of fiduciary duty. Plan benefits payable from a defined contribution plan are not insured by the PBGC.

A defined contribution plan is generally an attractive retirement plan option for a small employer with a relatively young, highly paid workforce because it is generally less costly to administer and easier to communicate to employees than a defined benefit plan. It is also an attractive retirement plan option for larger employers that want control over their retirement plan liabilities. Employers must make the contributions to the plan that they promise to make, but they do not guarantee that an employee will receive any minimum benefit. Employers can shift the risk of investment losses to participants by giving participants the authority to direct the investment of their accounts. This is especially attractive to employers when the investment markets are volatile. Also, the ability to roll account balances into another defined contribution plan or an individual retirement account if a job change occurs is very attractive to employees.

As with defined benefit plans, there are several types of defined contribution plans. These are discussed in the following sections.

401(k) Plans

Probably the most popular type of qualified retirement plan, a 401(k) plan allows employees to elect to receive all of their compensation from their employer or to have some of their compensation contributed to the plan. A 401(k) election may be in the form of a salary reduction agreement, under which an employee agrees to reduce current compensation by a certain amount (usually a percentage of compensation) or agree to forego a salary increase and have the increase contributed to the plan. Generally, the amounts contributed to the plan, as well as earnings on those contributions, are not taxed to the employees until distributed from the plan. However, 401(k) plans may also permit employees to defer current compensation on an after-tax basis (i.e., Roth 401(k) contributions). By paying taxes on the compensation and then contributing the compensation to the 401(k) plan, the earnings on the contributions grow on a tax-free basis, and if distributions are made in accordance with the Roth 401(k) provisions (i.e., at least five years after the first Roth contribution was made and after reaching age 59½, at death or due to a disability), the distributions will not be taxed either. Generally, elective contributions, both pre-tax and Roth contributions are limited to \$19,500 (in 2020). If a participant turns age 50 or older during the year, the participant may contribute an additional \$6,500 to the plan in “catch-up” contributions. The contribution limits may be modified annually by IRS cost-of-living adjustments.

A 401(k) plan may also permit other types of employer contributions, including matching contributions, profit-sharing contributions (also known as non-elective contributions) and other discretionary contributions. Total contributions during a year are limited to \$57,000 in 2020, subject to IRS cost-of-living adjustments. Many 401(k) plans grant employees who participate in the plan the ability to direct their own investments.

See Chapter 13 for a discussion of administrative issues affecting 401(k) plans and how employers may ease those burdens.

Profit-Sharing Plans

A profit-sharing plan provides for employee participation in the employer’s profits, although neither current nor accumulated profits are required for an employer to contribute to a profit-sharing plan. Typically, employer contributions are entirely discretionary and vary from year to year or are fixed at a percentage of compensation if, for instance, the employer’s profits exceed a certain level. In a qualified plan, however,

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such contributions must be substantial and recurring and must be allocated to each participant's account according to a defined formula. A profit-sharing plan can be designed to allocate employer contributions based on both age and compensation if an employer wants to favor older, higher-paid employees.

Money Purchase Plans

In a money purchase plan, the employer makes mandatory contributions, usually based solely on each participant's compensation. The employer's obligation to fund this type of plan distinguishes it from most profit-sharing plans, where contributions are discretionary. Retirement benefits in a money purchase plan are based on the benefit that the money in a participant's account will purchase at the time of retirement.

Target Benefit Plans

A target benefit plan is similar to a money purchase plan, except that employer contributions are not determined based solely on participant compensation. Instead, the plan identifies a target retirement benefit for participants. An actuary then determines how much the employer must contribute to the plan in order to fund the target benefit. The employer's contribution is the amount needed to accumulate (at an assumed rate of interest) a fund sufficient to pay a projected retirement benefit (e.g., 40% of compensation). The definite benefit formula of a target benefit plan makes it similar to a defined benefit plan. However, once contributions to a target benefit plan are made, the plan's actual investment experience will determine the participants' benefits payable at retirement, which may be higher or lower than the projected target benefit.

Thrift or Savings Plans

A thrift or savings plan can be in the form of either a money purchase pension plan or a profit-sharing plan. Employer contributions in a thrift or savings plan are based on mandatory contributions by employees and are made on a matching basis (e.g., 50% of the contributions made by the employees). The plan may also permit additional discretionary employer contributions and voluntary employee contributions.

Stock Bonus Plans

A stock bonus plan is similar to a profit-sharing plan except that employer contributions are made to the plan in shares of the company's stock. Although a plan may permit cash distributions, a participant has the right to a distribution in shares of stock. If the employer securities are not readily tradable, the plan may give participants the right to require the employer to repurchase the shares. See Chapter 6 for a thorough discussion of various uses of employer stock in employee benefits planning.

Employee Stock Ownership Plans

An employee stock ownership plan (ESOP) is a special type of defined contribution plan that is described in greater detail in Chapter 6.

Simplified Employee Pensions (SEPs)

A SEP is an IRA established for an employee by the employer, to which the employer makes tax-deductible contributions. In the past, SEPs were attractive to employers seeking to minimize the cost of maintaining a retirement plan, limit their contributions to the plan, simplify reporting obligations and reduce their fiduciary responsibility. These simplified plans are subject to certain participation rules, however, and benefits under

a SEP must be fully vested. Changes in the law prevent the establishment of salary reduction SEPs after 1996. Instead, small employers may want to consider a SIMPLE plan, described in detail below, which has effectively replaced the SEP in recent years.

Savings Incentive Match Plans for Employees (SIMPLE Plans)

A SIMPLE plan, available to businesses with 100 or fewer employees, allows employees to make elective contributions and requires employers to make limited matching or non-elective contributions. A SIMPLE plan may be structured as a SIMPLE IRA or a SIMPLE 401(k) plan. Generally, an employer contributing to a SIMPLE plan may not maintain any other qualified retirement plan, and elective contributions must be limited to \$13,500 in 2020 for participants under 50 and \$16,500 for participants over 50 (as adjusted for inflation). All contributions must be fully vested. These plans are attractive to many smaller employers because they are not subject to the strict, complex nondiscrimination rules generally applicable to qualified retirement plans. In addition, simplified reporting requirements apply to these plans. As a result, employers may establish and maintain these plans and obtain the same tax advantages associated with other qualified plans, but at a lower cost and administrative burden.

Section 403(b) Plans/Tax-Sheltered Annuities/Tax-Deferred Annuities

A 403(b) plan, which is also known as a tax-sheltered annuity or a tax-deferred annuity, is a special type of retirement arrangement available only to employees of tax-exempt organizations described in Code Section 501(c)(3), namely certain religious, charitable or scientific organizations, or public educational systems. This type of plan is usually funded with an annuity contract purchased by the employer on behalf of its employees from an insurance company. Employees can exclude from gross income, within limits (\$19,500 in 2020), the amounts contributed toward the purchase of the annuity contract. Employee contributions are most commonly made through a salary reduction agreement and must be fully vested. They can be pre-tax or after-tax (Roth). An employer can make matching contributions or non-elective contributions to a 403(b), but the contributions must be nondiscriminatory. As under a qualified retirement plan, contributions and the earnings in the annuity contract are taxable income to employees when distributed, unless the distribution is rolled over to another plan. Section 403(b) plans are subject to their own complex rules under the Code (many of which mirror the requirements for qualified retirement plans), and they may also be subject to certain requirements of ERISA.

IRAs: Individual Retirement Accounts/Individual Retirement Annuities

An IRA is a personal retirement plan to which an individual may make annual contributions. IRAs provide a simple and direct method for employees to contribute to their retirement savings through payroll deduction. As long as the employee (rather than the employer) decides whether, when and how much to contribute to the IRA, this program is generally not viewed as a retirement plan and is not subject to federal retirement plan requirements. (For 2020, employees may contribute up to the lesser of: 1) \$6,000, plus catch-up contributions of up to \$1,000 for those age 50 or older; or 2) the employee's taxable compensation for the year.)

An employee may maintain an IRA in addition to participating in a qualified retirement plan or a 403(b) plan; however, contributions made to an IRA by an active participant in one of these other plans may be entirely or partially nondeductible, depending on the individual's adjusted gross income. IRAs may be in the form of an individual retirement account or an individual retirement annuity (a contract purchased from an insurance company).

There are other types of accounts to which individuals may contribute, including Roth IRAs and Coverdell Education Savings Accounts (formerly known as Education IRAs). Roth IRAs allow individuals to make contributions on an after-tax basis and to defer tax on the earnings until the time of distribution. Coverdell ESAs are also after-tax contributions, although deposits grow tax-free and distributions are tax-free if used for educational purposes. Coverdell ESAs limit contributions to \$2,000 annually per beneficiary.

An employer may establish IRAs for its employees and their nonworking spouses and may discriminate in favor of highly compensated employees in doing so. Contributions to an IRA are deductible by the employer and are subject to Social Security and unemployment taxes (FICA and FUTA).

Nonqualified Retirement Plans

Nonqualified retirement plans do not satisfy the special qualification requirements of the Code and therefore do not provide employers or employees with the same tax advantages that qualified retirement plans offer. Consequently, contributions by an employer to a nonqualified retirement plan are not deductible by the employer until they are included in an employee's income. If the nonqualified retirement plan is unfunded (i.e., paid out of the employer's general assets at the time of retirement), an employee is not taxed until the benefits are distributed to the employee.

On the other hand, if a nonqualified retirement plan is funded (i.e., paid into a trust for the benefit of the employee), the employee is generally taxed on the benefit in the first year that his or her rights are transferable or are not subject to a substantial risk of forfeiture. As a result of these rules, the same employer contribution to a nonqualified retirement plan will produce a smaller retirement benefit than it would produce under a qualified retirement plan.

Nonqualified plans do offer distinct advantages, however. For example, a nonqualified retirement plan does not have to comply with the coverage and nondiscrimination rules of the Code. There are no limits on benefits or contributions, and most reporting and disclosure requirements of the Code and ERISA do not apply if the plan is limited to a select group of management or highly compensation employees and the employer submits a one-time statement to the Department of Labor known as a "top hat" plan statement. For these reasons, many employers establish nonqualified retirement plans to supplement the retirement benefits that are payable to executives and other key employees under a qualified retirement plan.

Many nonqualified retirement plans are subject to Section 409A of the Internal Revenue Code. That provision imposes significant limitations on the design and operation of these plans. Code Section 409A broadly defines a "nonqualified deferred compensation plan" as any plan or arrangement, other than a qualified plan or Section 403(b) plan that provides that compensation earned in one year will or may be paid during a subsequent year. The law imposes significant tax penalties on all nonqualified deferred compensation plans and arrangements that do not comply with Section 409A. The penalties include current income tax on deferred compensation as soon as it vests (regardless of when it will be distributed, thus potentially creating phantom taxable income), an additional 20% tax on all amounts deferred, and an underpayment penalty.

Code Section 409A requires participants to make some critical decisions before the beginning of the year in which deferred compensation is earned (that is, by December 31, 2020 for compensation that will be earned in 2021). First, participants must decide *when* they wish to receive a distribution of the deferred compensation, unless the written plan dictates the timing of the distribution. Whether elected by the employer

or the employee, distributions may be made only upon the following six specific distribution events:

1. Termination of employment
2. Death
3. Disability
4. Unforeseeable emergency
5. A change in control of the company
6. Upon a specific date that is determined before the compensation is earned

Second, before the beginning of the year in which deferred compensation is earned, participants must decide the form in which they wish to receive the distribution, unless the written plan dictates the form. For example, for compensation that will be earned in 2021, if the written plan allows distributions to be made in one lump-sum payment or in several installment payments, as elected by the participant, the participant must make this election before the end of 2020. The written plan may limit the time or form of payment further, so participants may not be able to elect all these distribution events or may not be able to elect the form of distribution. Code Section 409A strictly limits a participant's ability to later change their election, and it strictly prohibits any acceleration of the elected distribution.

Finally, if the plan allows participants to elect to defer compensation (as opposed to the employer making its own contributions to the plan), participants must decide how much they will defer into a nonqualified plan during the next calendar year before the beginning of the year. This election can be changed during the year only in very limited circumstances such as an unforeseeable emergency.

Code Section 409A imposes several additional rules on deferred compensation, and these restrictions apply to a variety of nonqualified plans. Among the most common of these plans are excess benefit plans and top hat plans, which are described below. Code Section 409A also applies to some of the equity-based compensation plans discussed in Chapter 6.

Excess Benefit Plans

Excess benefit plans are maintained solely for the purpose of providing benefits for certain employees in excess of limitations on contributions and benefits imposed by the Code with respect to qualified retirement plans. If unfunded, these plans are not subject to ERISA.

Top Hat Plans

A top hat plan is an unfunded plan maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees. Although a top hat plan must be funded from the general assets of the employer (which remain subject to all claims of the employer's creditors), the plan's assets may be held in trust (commonly known as a "rabbi trust") whose assets will be subject to the general creditors of the employer if the employer becomes insolvent. While top hat plans are exempt from the participation, funding, vesting and fiduciary duty requirements of ERISA, they are subject to abbreviated reporting and disclosure requirements, and the ERISA claims procedures.

To be a top hat plan, the employer must file a top hat plan statement with the Department of Labor (DOL), generally not later than 120 days after establishing the plan, and must make plan documents available to the DOL upon request.

Factors to Consider in Selecting a Retirement Plan

In designing a retirement program for employees, an employer will want to identify those employees whom it hopes to benefit. Selection of a plan structure to meet its goals and focused, individualized design of various plan features will allow the employer to establish a plan that provides the optimum benefits to the desired individuals while minimizing benefits to other individuals at the lowest cost to the employer. For example, if the employer desires to benefit only a business owner and key employees, a qualified plan that requires substantial contributions to the majority of employees will not achieve that goal, and the plan's costs likely will exceed the cost of a simpler plan structure designed to meet the employer's specific needs.

Some factors that should be considered in selecting a retirement plan include the following:

- The category or categories of employees the employer wishes to benefit (e.g., owners employed in the business, key employees or rank-and-file employees)
- Desired objectives in establishing the program (e.g., improving performance, reducing employee turnover or recruiting essential employees from competitors)
- The target group's needs and other sources of income (e.g., income from Social Security, worker's compensation or military benefits)
- The employer's objectives: maximizing benefits, tax-deductible contributions or flexibility with regard to annual contributions
- The employer's ability to make contributions and cover costs of plan administration (e.g., an employer with a weak cash position or fluctuating profits should consider a profit-sharing plan, which affords significant flexibility in contributions, and not a defined benefit plan, which entails a commitment to fund the plan)
- The age of the individuals in the target group, (e.g., to maximize benefits payable at retirement for older, long-service workers, the employer might consider a defined benefit plan, while a younger workforce might better benefit from using a defined contribution plan)

Once the employer has determined the most suitable retirement plan vehicle, consideration must be given to the actual plan provisions (e.g., eligibility requirements, contribution or benefit formulas, vesting, investment provisions, method of benefit payments, hardship withdrawals, loans from the plan and other terms).

Many service providers offer standardized master and prototype plan documents or volume submitter plan documents that have been pre-approved by the IRS. Although these are only available for certain types of plans and only permit certain plan provisions, employers may adopt one of these plan documents as an alternative to drafting an individually designed plan document. These plan documents contain a number of choices to suit the employer's purpose and may be less expensive than individually designed plan documents that are tailored to accommodate the employer's specific needs.

Operating a Retirement Plan

The plan administrator is responsible for administering a retirement plan. Unless an individual or a group of individuals is designated as the plan administrator, this role will automatically be assigned to the plan sponsor, which is the employer. If a plan is subject to ERISA, the plan administrator must provide, without charge, certain documentation to plan participants, including a summary plan description (SPD), summary

of material modifications (SMM) made to the plan, and a summary annual report of plan operation. Upon request, other documents must be furnished to participants at a reasonable charge.

Service Providers

In administering various aspects of the plan, the plan administrator may delegate certain functions to third-party service providers, including those listed in the following sections.

Accountant

An accountant will prepare statements of plan assets, audit the plan's books and records, and prepare reports to government agencies.

Actuary

An actuary will determine the amount needed to fund a defined benefit plan and certain types of defined contribution plans (such as target benefit plans) and will certify the amount of tax-deductible contributions the employer must make to the plan. The actuary may also calculate benefits owed to participants.

Attorney

An attorney will consult with the employer regarding plan design issues and draft the legal documents establishing the plan. An attorney will also review plan forms and administrative practices for compliance with the requirements of the Code and ERISA. For individually designed qualified plans, an attorney will coordinate submission of the plan document to the IRS for a determination as to the qualified status of the plan document.

Record Keeper

A record keeper will be responsible for enrolling eligible employees, allocating contributions amongst the participants, providing status reports, processing loans and distributions and performing other functions.

Trustee

A trustee will hold the legal title to the plan assets and manage the investment of the plan assets, unless investment responsibility has been delegated to an investment manager.

Other Providers

Depending upon the employer's experience and needs, other service providers may also provide additional valuable services to the employer and plan administrator, such as banks, custodians, consultants, investment managers and advisers and insurance companies.

In selecting providers for a retirement plan, a plan sponsor should weigh each vendor's fees, capabilities and experience. The sponsor should also ensure that the vendor has the ability and willingness to respond promptly to changing legal rules and regulations, to permit the employer to outsource burdensome administrative functions, to keep administrative expenses at a reasonable level and to accept appropriate

fiduciary liability. Selection of vendors will have a direct impact on the degree of liability borne by plan fiduciaries (as discussed later in this chapter) and on employee relations to the extent that the service provider communicates directly with employees.

Reporting to Governmental Agencies

Once a retirement plan is established, the plan administrator is responsible for filing certain information returns, reports and statements with agencies that administer federal retirement plan laws. Most of these filing requirements have specific deadlines, with monetary penalties if the deadlines are not met. See Appendix A for a general description of the compliance obligations imposed upon qualified retirement plans and Appendix F for information pertaining to Form 5500. Note that this filing must be done electronically through the EFAST system, and this form is frequently updated. The form and instructions may be obtained each year from the Department of Labor at www.efast.dol.gov or the IRS web site at www.irs.gov/Forms-&Pubs. In general, the required filings demonstrate the plan's compliance with the Code and ERISA and should be filed in accordance with the prescribed rules and deadlines. There is a significant penalty for late filings, so plan administrators that fail to timely file should consider filing through the Department of Labor's Delinquent Filer Voluntary Compliance Program. Information regarding that program may be accessed at www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/dfvcp.pdf.

Amendment and Termination of a Qualified Retirement Plan

Changing legal, economic and other circumstances may prompt an employer to amend or terminate a retirement plan. It is important that the legal documents establishing the plan grant the plan sponsor the discretion to amend or terminate the plan and set forth a procedure for doing so. As with other aspects of retirement plan compliance, there are specific rules that govern the termination of retirement plans, and those rules vary depending upon whether the plan is a defined benefit plan or a defined contribution plan.

Fiduciary Responsibilities

Under ERISA, a person who exercises any discretionary authority or control over management of a plan or management of the assets of a plan, or who renders investment advice for a fee is a fiduciary of the plan. For example, the plan administrator is always a plan fiduciary, and certain third-party service providers to whom the plan administrator has delegated plan duties may also be fiduciaries.

ERISA imposes rigid duties upon fiduciaries. (See Appendix B for a summary of those duties.) Plan fiduciaries must act solely in the interest of the plan's participants and beneficiaries, and for the exclusive purpose of providing benefits to the plan's participants and beneficiaries and paying reasonable expenses of plan administration. They must also act prudently and in a manner consistent with the plan's documents. A fiduciary must fully and accurately respond to all inquiries by participants and beneficiaries, and a fiduciary must diversify the investment of the plan's assets.

Fiduciaries can be sued by participants, beneficiaries and the Department of Labor for not adequately fulfilling their fiduciary responsibilities. A fiduciary may be held personally liable for any losses to the plan resulting from a breach of fiduciary duty, and any profits obtained by the fiduciary through the use of plan

assets must be paid into the plan. A court may also remove a fiduciary and may award attorneys' fees and costs to the prevailing party in a breach of fiduciary duty legal action. Fiduciaries should, therefore, always document their decision-making process and the reasons for the decisions they make, so that they may demonstrate the prudence of their actions if later challenged.

Certain dealings between fiduciaries and others are prohibited. These prohibited transactions involve plan fiduciaries and either "parties in interest" (under ERISA) or "disqualified persons" (under the Code). "Parties in interest" and "disqualified persons" generally include any plan fiduciary, plan attorney, employee of the plan, a plan service provider, a sponsoring employer, a 50% owner of the employer, or a relative of any of the above individuals. For example, all of the following are prohibited transactions, even if they benefit plan participants and beneficiaries:

- Sale of property by the employer to the plan, or by the plan to the employer
- Extension of credit by the plan to the employer
- The furnishing of goods or services by the plan to a fiduciary
- The transfer of plan assets to a fiduciary
- The acquisition by the plan of employer securities or property in excess of the limits set by law

The Code and ERISA impose penalties on the "disqualified person" or "party in interest" in the event of a prohibited transaction, and they require the disgorgement of profits earned from the prohibited transaction.

Fiduciary Insurance

ERISA allows a plan to purchase insurance to protect the plan from a breach of fiduciary duty. The insurer must have recourse against the fiduciaries in the event of a fiduciary breach. Most insurance companies offering fiduciary insurance will also provide a rider that provides insurance to the individual fiduciaries in the event of a fiduciary breach. The employer or the fiduciary must purchase this rider from their own assets. They may not use plan assets to purchase this rider.

Factors to Consider in Selecting and Monitoring Service Providers

Administration of a retirement plan is complex and, consequently, many plan sponsors choose to outsource much of the plan's day-to-day operations. This can lead to an "out of sight, out of mind" situation. It is, therefore, important to remember that selection and retention of service providers is a fiduciary act for which fiduciaries are personally liable. A fiduciary has a fiduciary obligation to select providers prudently and to monitor the actions of the providers. The fiduciary has ultimate authority and responsibility for the actions or inactions of the service providers. (See Appendix B for a summary of ERISA's fiduciary requirements.) In most cases, the employer is the fiduciary who must diligently select and periodically monitor the people who provide services to the plan.

Common service providers who must be carefully selected and monitored include all of those listed previously, as well as others such as third-party administrators, brokers, registered investment advisors, consultants and insurance companies.

When acting in a fiduciary capacity, a company or individual must engage in a prudent process. In other words, a fiduciary's ultimate decision is less important than the prudence of the steps the fiduciary takes to

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reach the decision. For this reason, the ideal way to select a service provider is through a formal request for proposal (RFP) process. The RFP process begins with the committee or the fiduciaries identifying the things that are most important in the provider selection process. A written document is submitted to each prospective provider. This document establishes the parameters of the services to be provided and ensures that all service providers are answering the same questions in similar formats. This procedure also helps establish written criteria for future monitoring of the selected provider.

A company should establish formal procedures for identifying who is responsible for monitoring service providers and for coordinating the process. This job would include maintenance of the written criteria, as well as determination of the frequency of the evaluation, the parties involved, and any information needed in advance. The person charged with monitoring should preserve all written documentation of the evaluation meetings, including formal notes from the meetings and details of the decisions made during the meetings.

When reviewing retirement plan service providers, fiduciaries should consider the following general categories of information:

- **Company information:** Financial stability, overall reputation in the market, outsourcing arrangements, recent restructurings or changes in philosophy
- **Staffing:** Hierarchy of staff, turnover, backup and support structures
- **Plan sponsor services:** Technology, special services, responsiveness, overall support
- **Participant services:** Processing turnaround times, technology, overall support
- **Plan administration:** Compliance testing, government reporting, other administration
- **Investment options:** Compliance with investment policy statement, managed accounts, investment advice
- **Fees:** Complete disclosure, reasonableness
- **Service contract:** Reflects services agreed upon, expiration date clearly stated, reasonable termination provisions

Of course, these are general categories. It is important that each plan sponsor establish specific details regarding the services that are critical to success of the operation of the plan. The sponsor should review the criteria and update it at least annually. Ongoing monitoring and documentation is an essential component of the “procedural prudence” required by plan fiduciaries. Similarly, an annual review of the written investment policy statement is advisable. In fact, an annual service provider review could be completed at the same time the committee is reviewing investments.

To assist plan sponsors in assessing the reasonableness of their contracts with service providers, and specifically to compare fees paid to plan service providers, the Department of Labor adopted rules requiring certain service providers to disclose to plans any direct or indirect compensation received for providing services to a retirement plan. These disclosures must be made annually to plan fiduciaries and must include a great deal of required information, including disclosure of conflicts of interests.

It is sometimes difficult to determine whether advice received from plan consultants or advisors is objective, particularly advice with respect to the investment of plan assets. The Department of Labor and the Securities and Exchange Commission (SEC) released questions to assist plan fiduciaries in evaluating the recommendations of plan advisors. These questions are designed to help identify any conflicts of interest or other arrangements that might compromise an advisor’s objectivity. The questions are available on the DOL’s web site. “Selecting and Monitoring Pension Consultants – Tips for Plan Fiduciaries” can be found at www.dol.gov/sites/dolgov/files/EBSA/about-ebbsa/our-activities/resource-center/fact-sheets/

selecting-and-monitoring-pension-consultants.pdf, and “Tips for Selecting and Monitoring Service Providers for Your Employee Benefit Plan” is available at www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/fact-sheets/tips-for-selecting-and-monitoring-service-providers.pdf. The SEC publication “Selecting and Monitoring Pension Consultants: Tips for Plan Fiduciaries” is reprinted in Appendix I.

Conclusion

The range of retirement plan alternatives is extensive. Although selecting an appropriate retirement income vehicle requires a certain degree of sophistication, a professional adviser can help employers identify specific needs and goals and match a retirement plan structure to those objectives. This chapter is an initial step in building the employer’s understanding of retirement planning, as well as of some of the administrative and compliance obligations that accompany the decision to provide retirement benefits to employees. Employers may want to consult the IRS web site (www.irs.gov), an excellent resource for employers making this choice, as it contains a series of articles on choosing a retirement plan.

Chapter 6

Employer Stock: Equity-Based Compensation Plans

The public is often bombarded by stories of individuals becoming millionaires from exercise of stock options or granting of restricted stock or restricted stock units, and the sale of employer stock when their employer decides to “go public.” Indeed, equity-based compensation is often glamorized in movies and television shows. For start-up companies, offering stock options and other equity-based incentives may be the only way to adequately compensate employees until the business becomes more established. Although the concept of stock options and other equity-based incentive programs has been around for a very long time, the demand for these programs is greater than ever. Every employee wants a piece of the action and hopes to become the next employee millionaire.

By contrast, the employees of Enron watched as the value of their retirement savings disintegrated along with the plummeting price of the company’s stock following the now notorious corporate accounting scandals that brought down the company in 2001. Many Enron employees who had accumulated more than \$1 million in company stock lost their employee-millionaire status in a heartbeat. Although much of the employee-owned Enron stock was held in qualified pension plans (such as those discussed in Chapter 5), this chapter generally explores other types of equity-based incentive plans available for privately held, for-profit employers. It discusses several broad-based employee ownership models (for example, employee stock purchase plans and employee stock ownership plans) that encourage employees and employers, through tax incentives, to expand the number of employee-owners. In addition, this chapter explains the uses of options, restricted stock grants and performance awards.

Note: This chapter is limited to arrangements that ultimately grant the employee access to ownership of the employer. As a result, this chapter does not address certain “synthetic equity” arrangements (such as phantom stock and stock appreciation rights and, sometimes, restricted stock units), which award the value of stock or equity to the employee in cash without relinquishing any actual ownership in the company. Although such arrangements are an effective way to provide ownership-like incentives to employees, they are beyond the scope of this chapter.

Under Internal Revenue Code Section 409A, many restrictions are placed on the design and administration of nonqualified deferred compensation plans. Certain equity-based compensation plans may be subject to Code Section 409A, depending on how they are designed. As a general rule, although tax-favored qualified plans are not subject to the Code Section 409A, nonqualified equity-based plans that have the effect of deferring compensation are subject to the Code Section 409A requirements, with certain exceptions noted below. See Chapter 5 for a more extensive discussion of the requirements of Code Section 409A.

Terms Used in This Chapter

In order to better understand the concepts discussed in this chapter, it is first necessary to develop a

deeper understanding of two critical terms: equity and stock.

- **Equity:** Equity is an ownership interest in a corporation, and more specifically for employer-sponsored plans, an ownership interest in an employer. For corporations, this “ownership” is expressed in terms of ownership of shares of stock; however, employee ownership is not limited exclusively to employees of corporations. Other forms of business entities, such as partnerships and limited liability companies, may also issue equity to their employees in the form of partnership interests or membership interests.
- **Stock:** Strictly speaking, stock is an ownership interest in a corporation. This chapter, however, refers to all forms of equity as “stock.” Because this is a general discussion, the compensation programs discussed below are limited to certain legal entities (such as corporations) in some instances, which are highlighted. Employers will want to consult legal counsel before implementing any of the programs described in this chapter to ensure the desired result and the intended tax consequences.

General Considerations for Equity-Based Compensation Plans

A variety of equity-based compensation plans are available to employers, and each plan has specific advantages, disadvantages and design considerations associated with it, as illustrated later in this chapter. Before considering one or more particular plans, however, an employer should first be aware of the securities laws considerations and other general design considerations detailed below.

Securities Laws Considerations

When considering whether to award employees equity or synthetic equity opportunities, employers must consider state and federal securities laws. As a general matter, and in an effort to avoid personal liability, the employer must disclose sufficient information regarding the risks associated with such an investment, as well as all other material information that a reasonable investor would want to have prior to making such an investment. This disclosure must comply with the anti-fraud protections of federal and state securities laws. In addition to complying with the anti-fraud provisions, such securities may have to be registered with state or federal securities law agencies unless an exemption from registration applies. As a result, legal advice should be sought as it relates to the securities law aspects of such programs prior to implementation.

A common exemption for equity-based programs for employees from federal securities registration requirements is found under Rule 701 of the Securities Act of 1933. Under Rule 701, federal securities registration is not required if equity plan participants are provided a copy of the equity plan and award agreement and total sales (granting options or vesting restricted stock are considered sales for this purpose) of the stock at issue during a 12-month period do not exceed the greater of:

- \$1 million;
- 15% of the company’s total assets; or
- 15% of all outstanding securities of that class.

An important note is that state securities laws apply independently of the federal securities law. Section 23-19-2-2(21) of the Indiana Code exempts from state securities registration requirements securities transactions under employees’ stock purchase, savings, option, profit-sharing, pension, or similar employees’

benefit plan. This exemption applies to any securities, plan interests, and guarantees under a compensation benefit plan or compensation contract. The exemption also applies to securities, plan interests, and guarantees contained in a record, established by the issuer of the securities or interests for the participation of its employees. For this purpose, the issuer includes its parents, its majority-owned subsidiaries, or the majority-owned subsidiaries of the issuer's parent, for the participation of their employees.

Other Design Considerations

Whenever employer stock of a closely held company is distributed among employees, the employer should ensure its rights to secure the return of the stock in the event that the relationship with the employee terminates. There are a number of ways to address this issue. Some employers attach transfer restrictions to the stock; others retain the right of first refusal; others modify the repurchase price depending on the manner of the employee's termination of employment. Moreover, and as a condition to participating in such programs, employers should consider using confidentiality, nonsolicitation, and noncompetition agreements (as appropriate) to secure the proper degree of loyalty from employees before relinquishing ownership in the company to them.

Equity-Based Compensation Arrangements

As noted above, employer equity-based compensation arrangements involve the issuing of equity in a company to employees. The following sections detail several types of these arrangements, as well as their associated considerations, advantages and disadvantages.

Incentive Stock Option Plans

An incentive stock option (ISO), also known as a statutory stock option or a qualified stock option, is a contract granted exclusively to employees (i.e., non-employees cannot be granted ISOs) that provides them the option to purchase stock at a price fixed at the date of grant, regardless of the value of the stock at the time the option is exercised. Only corporations and other entities that are taxed as corporations (e.g., limited liability companies and S corporations that have made a permitted election with the Internal Revenue Service to be treated as a corporation for federal income tax purposes) may issue or grant ISOs to employees and receive the favorable tax benefits of an ISO (discussed below).

ISOs are exempt from Code Section 409A.

Requirements/Design Considerations

General

To qualify as an ISO, an option must satisfy several tax law requirements. The option must be granted pursuant to a written plan that states the aggregate number of ISOs that may be issued and identifies the employees or class of employees eligible to receive options. The granting corporation's shareholders must approve the option plan under which ISOs are granted within 12 months before or after the date the ISO is granted. The option itself must be granted within 10 years of the date the plan is adopted or of the date the shareholders approve the plan, whichever is earlier. In addition, the option cannot be exercised more than 10 years from the date the option is granted.

Option Price Considerations

The ISO price may not be less than the fair market value (FMV) of the stock at the time the option is granted. For a publicly traded company, FMV can be determined as the first or last selling price on the grant date or the mean between the highest and lowest quoted selling prices on the grant date. If there were no publicly traded sales on the on grant date but there were sales on dates within a reasonable period before the grant date, the FMV can be determined by taking a weighted average of the means between the highest and lowest sales on the nearest date before the grant date with sales or the weighted average of the means for the 30, 60 or 90 days immediately preceding the grant date. In a closely held business (not publicly traded), there is generally no market for the shares and thus it is difficult to determine the FMV of the stock at the date of grant. In these instances, the board of directors must make a good-faith determination of the FMV of the company which can be set by a qualified appraiser or can be based on relevant facts and circumstances. Relevant facts and circumstances include, to the extent applicable, some or all of the following factors:

- The value of the company's tangible and intangible assets
- The present value of anticipated future cash flows of the company
- The market value of the stock or other equity interests of similar companies and other entities engaged in trades or businesses substantially similar to those engaged in by the company whose value can be readily determined through non-discretionary objective means
- Recent arm's length transactions involving the sale or transfer of the company's stock
- Other relevant factors, such as control premiums or discounts for lack of marketability

The aggregate FMV of the stock for which options may be granted to an employee in any calendar year in which the options are first exercisable may not exceed \$100,000, determined as of the date of the option grant. If the value of the stock exceeds \$100,000, the excess will not be considered an ISO.

Exercise Considerations

The option must be exercisable by only the employee during his or her lifetime. The employee must receive the option during his or her employment and generally must exercise it no later than three months after the termination of his or her employment with the granting employer. The three-year period is extended if the employee becomes totally disabled. "In that case, the employee would have one year after termination of employment to exercise the option. If the employee dies, the employee's heirs have until the option expires to exercise the option. The option must not be exercisable after 10 years from the date it is granted. The employee must hold stock acquired pursuant to the option for at least two years after the date of the option grant and at least one year after the stock is acquired through the exercise of the option. Any disposition of the stock before the holding period is satisfied results in a "disqualifying disposition" that causes the employee to lose the favorable tax treatment associated with the ISO (discussed below). The only exceptions to the holding period requirements are in the case of the death or insolvency of the employee.

Additional Limitations for 10% Shareholders

If an employee owns more than 10% of the combined voting power of the employer, the ISO rules require that the option price be at least 110% of the fair market value of the stock subject to the option at the date of grant. Also, the option by its terms must not be exercisable after five years from the date of grant.

Vesting Periods

Although neither required nor prohibited, many ISO plans require that a vesting period be satisfied before the option may be exercised. Such periods generally range from a minimum number of months to several years of continued service after the option is issued. Upon the expiration of the vesting period, all of the options may become exercisable, or the options may become exercisable over a period of time. For example, 20% of the options issued may become exercisable on each of the first five anniversaries of the date of the grant; however, there are no adverse tax consequences whether vested immediately or over a period of years.

Advantages and Disadvantages

No Employee Coverage Requirements

The ISO rules do not contain employee coverage requirements. Therefore, the employer's ISO plan may cover as many or as few employees as the employer desires.

Cash Outlay Required

The employee must generally come up with the necessary cash to exercise the option, which may limit the desirability of the option. Because of this, cashless exercises should be considered (e.g., surrendering other employee-owned shares for the exercise price). If the employee surrenders ISO shares in a cashless exercise, the employee will not satisfy the stock holding period and will have a "disqualifying disposition." Furthermore, if the employer lends money to an employee to purchase the stock, perhaps to avoid cash flow difficulties, the loan may result in imputed income to the employee if the interest rate is below the applicable federal rate. With the passage of the Sarbanes-Oxley Act of 2002, however, public companies are generally prohibited from making loans (for this purpose or any other) to directors and executive officers.

Tax Treatment to Employees (Capital Gains)

An ISO may provide favorable income tax treatment for an employee if the employee does not dispose of the shares before fulfilling the holding period requirements described previously. Specifically, ordinary income is not recognized upon the grant or exercise of the option if the exercise occurs during the employee's employment or within three months after termination (subject to the exceptions noted above). If the employee retains the stock for the requisite holding period, he or she is taxed (usually at capital gains rates) at the time of the eventual disposition of the shares on the difference between the amount realized on the sale and his or her adjusted basis in the stock. Additionally, the exercise of the option may subject the employee to alternative minimum tax.

Tax Treatment to Employer

The employer will not be able to claim a deduction unless the employee disposes of the stock fewer than two years after the date of the option grant or less than one year after receiving the stock, in which case the employer will receive a deduction equal to the amount of ordinary income realized by the employee. The employer's deduction will equal the amount of ordinary income reported by the employee.

Nonqualified Stock Option Plans

The term “nonqualified stock option” (NQSO), also referred to as a nonstatutory option, refers to stock options that do not comply with the tax requirements for ISOs and therefore do not receive the same favorable tax treatment. On the other hand, an NQSO allows significant flexibility in pricing, time of exercise, employment status and other matters not available to ISOs. Normally, employers grant NQSOs to employees at or above the value of the stock at the time of grant, although this feature is not required. Some companies used to offer discounted stock options in which the employer intends the exercise price to be substantially below the value of the stock at the time of grant. Currently, if a company offers discounted stock options, then the options will be subject to the rules under Code Section 409A and may result in immediate taxation. (See Chapter 5 for a more extensive discussion of this law.) Additionally, unlike ISOs, NQSOs can be granted to non-employees, such as service providers and consultants.

Requirements/Design Considerations

General

NQSOs do not have qualification requirements because they receive no special tax treatment; however, NQSOs should be issued pursuant to a written plan or agreement to assure appropriate documentation.

Vesting Periods

Like ISOs, most NQSO plans require individuals to satisfy a vesting period before the option may be exercised, but this feature is not required. (See the ISO discussion earlier in the chapter.)

Exercise Considerations

Nonqualified stock options generally expire upon termination of employment for reasons other than retirement, death or disability. Non-publicly traded corporations generally may provide for an indefinite period of option exercise, although many plans provide that unexercised options will expire after a specified period following their issuance.

Advantages and Disadvantages

Exercise Price

Unlike ISOs, NQSOs are not limited in amount or exercise price. The employer has flexibility in structuring NQSOs without regard to the ISO requirements outlined in the tax laws.

The employer incurs no cash expense and receives a tax deduction when the grantee exercises the option. If stock options are granted with an exercise price below fair market value at the time of the grant, the NQSOs will be considered deferred compensation and will be subject to the additional detailed requirements of Code Section 409A, which are discussed in Chapter 5, and may cause immediate taxation to the employee. However, if options are granted with an exercise price at or above fair market value and participants are not permitted to defer any of the amounts received upon exercise, the options will not be subject to Code Section 409A. That said, care must be taken to avoid unintentionally creating an arrangement that constitutes deferred compensation within the meaning of Code Section 409A.

Cash Outlay Required

Absent a cashless exercise (discussed above under the ISO summary), the employee must generally come up with the necessary cash to exercise the option. Furthermore, if the employer lends money to the employee to purchase the stock, the loan may result in imputed income to the employee. Again, the Sarbanes-Oxley Act of 2002 generally prevents public companies from making loans to directors and executive officers for any reason.

Tax Treatment to Employees (Ordinary Income)

In general, neither the grant nor the vesting of an NQSO ordinarily will result in recognition of taxable income for the employee. Upon exercise of the option, the employee is taxed at ordinary income (as opposed to capital gains) rates on the difference between the stock's FMV on the date of exercise and the option price (i.e., the amount paid for the stock). However, if the stock transferred under the NQSO is subject to a substantial risk of forfeiture and is not freely transferable, the employee will not be taxed until his or her rights in the stock are substantially vested (which occurs when either the transferability or the forfeitability restrictions lapse). Any subsequent appreciation in the shares following the date of exercise should be taxed at capital gains rates upon later disposition of the shares.

Tax Treatment to Employer

The employer generally is entitled to a business expense deduction in an amount equal to the ordinary income realized by the employee. This deduction is allowed at the same time the employee recognizes the income (i.e., at the time of exercise).

Performance Share Plans

In a performance share plan (PSP), shares of stock are awarded to key management employees based on the performance of the employer, a particular division or the individual employee. The performance is usually measured over some fixed period of one year or up to three to five years and is gauged with respect to specific company goals. Examples of company goals include a specific increase in earnings per share of the employer's stock, a specific increase in earnings or shareholders' equity, the achievement of cost savings or an increase in a division's earnings. At the end of the performance period and upon attainment of the goals, the employer distributes the award.

Requirements/Design Considerations

General

Like NQSOs, PSPs do not have qualification requirements because they receive no special tax treatment. Again, however, a written plan or agreement is advisable.

Flexibility

The employer generally retains complete discretion in establishing award criteria for performance shares. However, care must be taken to avoid unintentionally creating an arrangement that constitutes deferred compensation within the meaning of Code Section 409A, discussed in Chapter 5. If the employer distributes the award by the 15th day of the third month after the end of the year in which the amount is no longer

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subject to a substantial risk of forfeiture, a PSP will not be subject to the rules under Code Section 409A. However, it is critical that the employer distribute the award within this time period, because the award will be subject to Code Section 409A if it is distributed later than two-and-a-half months after the end of the performance period.

Advantages and Disadvantages

Ease of Administration

The administration of a PSP is relatively simple and inexpensive and can be tailored to the employer's needs and business plans. Unlike an ISO, a PSP does not involve any holding period or percentage ownership restrictions.

No Cash Outlay

Unlike ISOs and NQSOs, PSPs typically do not require cash investments by the grantee, which eliminates risk and the need for financing arrangements.

Tax Treatment to Employees (Ordinary Income)

The FMV of the stock on the date of transfer is included in the grantee's W-2 income; therefore, the grantee is subject to ordinary income tax (as opposed to capital gains tax) on that amount. Subsequent appreciation in the value of the shares awarded under the PSP should be taxed at capital gains rates upon later disposition of the shares.

Tax Treatment to Employer

The employer generally is entitled to a business expense deduction in an amount equal to the ordinary income realized by the grantee.

Restricted Stock Plans

Unlike a PSP, a restricted stock plan (RSP) awards the stock up-front but restricts the actual ownership of the shares based on the establishment of certain objectives, satisfaction of which vests the ownership of the shares in the grantee. The grantee's right to ownership in some or all of the shares of stock is generally contingent upon the grantee's continued employment by the employer for a specified period after the grant or satisfaction of an employer or grantee's performance metric, or both. For example, the restricted stock vests in the grantee upon the employer's attainment of a specified level of earnings. The restricted shares are subject to forfeiture if the conditions are not met. Occasionally, vested shares may also be subject to repurchase upon the occurrence of certain events specified in the plan.

Requirements/Design Considerations

General

Like NQSOs and PSPs, RSPs have no special qualification requirements because no special tax consequences are associated with such plans, although a written plan or agreement is advisable. Shares

granted under a restricted stock plan are considered a property transfer and not a deferral of compensation. Therefore, this type of plan generally will not be subject to the rules of Code Section 409A. (See Chapter 5 for a more extensive discussion of this law.)

Flexibility

Like NQSOs and PSPs, the employer retains complete discretion in establishing the restrictions associated with the grant of restricted shares.

Advantages and Disadvantages

Grantee Has Certain Shareholder Rights

The holder of restricted stock may enjoy certain benefits of ownership as of the date of grant (e.g., dividends, voting rights and appreciation potential).

Tax Treatment to Employees (Ordinary Income)

As a general rule, the grantee is taxed when the rights to the stock become substantially vested — in other words, either transferable or not subject to a substantial risk of forfeiture. Upon vesting, the grantee must include in gross income the excess of the FMV of the stock over the amount paid (if any) for the stock. If the grantee expects the value of the stock to increase over the period in which the stock is restricted, an election can be made whereby the grantee can elect to include the value of stock in income in the year of grant (as opposed to the year in which the restrictions lapse). Any subsequent appreciation will be taxed at capital gains rates upon later disposition of the shares. The IRS has adopted a model election form for individuals to use in making an election to include the value of the stock in income.

Tax Treatment to Employer

The employer generally is entitled to a business expense deduction in an amount equal to the ordinary income realized by the grantee.

Value in Declining Value Situations

If the employer's stock declines in value, the restricted stock will retain some value, while stock options may have no present value in such situations.

Tax-Favored Employee Stock Purchase Plans

A tax-favored employee stock purchase plan (ESPP) is a right granted by the sponsoring employer to employees to purchase shares of the employer's stock at fixed intervals and at a price per share of not less than 85% of the fair market value of the stock. The payment for the stock is often accomplished via regular payroll deductions, and the stock acquired is typically not otherwise restricted. If the ESPP is designed to comply with the requirements of the Internal Revenue Code, the amount of the discount in the purchase price (not exceeding 15%) will not be taxed to the employee at the time of purchase.

Only corporations and other entities that are taxed as corporations (e.g., limited liability companies and S corporations that have made a permitted election with the Internal Revenue service to be treated as a

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corporation for federal income tax purposes) may issue or grant options under ESPPs to employees and receive the favorable tax benefits of an ISO (discussed below).

Requirements/Design Considerations

General

Unlike NQSOs, PSPs and RSPs, a tax-favored ESPP is subject to the tax law requirements for tax-favored stock purchase plans and therefore must comply with certain employee coverage and other requirements. In general, in order to qualify for favorable tax benefits (i.e., to avoid the tax on the discount), the ESPP must meet the following criteria:

- It must generally be offered to all employees of the employer
- It must be approved by the shareholders of the granting corporation
- It must not discriminate among eligible employees (i.e., all employees eligible under the ESPP must be treated similarly)
- It must comply with the maximum terms and an annual maximum grant limitation, and the options must be nontransferable

Because ESPPs receive tax-favored treatment, they are excluded from complying with the rules of Code Section 409A.

Flexibility

Due to specific requirements applicable to ESPPs, employers have little discretion in terms of offering such benefits, which by statute are designed to be broad-based.

Advantages and Disadvantages

Cash Outflow Generally Required

Like an ISO and an NQSO, participating in an ESPP may cause cash flow difficulties for an employee; however, by withholding amounts from paychecks, the employee may pre-fund the eventual acquisition of shares.

Tax Treatment to Employees (Ordinary Income)

If the employee holds the stock acquired pursuant to the option for at least two years after the date of the option grant or at least one year after the stock is acquired through the exercise of the option, any discount in the purchase price (up to 15%) will not be taxed as of the date of exercise and will instead be deferred until the stock is later sold. All subsequent appreciation in the shares should be taxed at capital gains rates upon later disposition of the shares; however, any disposition of the stock before the holding period is satisfied results in a “disqualifying disposition,” which causes the employee to lose the right to defer income tax, resulting in current taxation on the amount of the discount.

Tax Treatment to Employer

The employer generally is entitled to a business expense deduction in an amount equal to the ordinary income, if any, realized by the grantee resulting from a disqualifying disposition.

Nonqualified Employee Stock Purchase Plans

A nonqualified employee stock purchase plan (NESPP) is a right granted by the sponsoring employer to employees to purchase shares of the employer's stock at fixed intervals. The payment for the stock is often accomplished via regular payroll deductions, and the stock acquired is typically not otherwise restricted.

Requirements/Design Considerations

General

Like NQSOs, PSPs and RSPs, an NESPP is not subject to the tax law requirements for qualified stock purchase plans, so it need not comply with any employee coverage requirements. Therefore, an NESPP can cover as many or as few employees as an employer desires. The employer may also impose certain conditions that employees have to fulfill to gain the right to purchase or retain stock.

Flexibility

Like RSPs and PSPs, the employer retains complete discretion in establishing the restrictions associated with an NESPP and the related purchase of such shares. The exercise price may be equal to or below the fair market value of the stock, although this approach may unintentionally create an arrangement that constitutes deferred compensation within the meaning of Code Section 409A. If the exercise price of the shares is at the fair market value of the stock upon the grant date, there will be no deferral of income, and therefore the shares will not be subject to the rules of Code Section 409A. However, if the shares are offered at a discount (the exercise price of the shares is below the fair market value of the stock at the date of acquisition), then the shares will be subject to the rules under Code Section 409A, and may result in immediate taxation. (See Chapter 5 for a more extensive discussion of this law.)

The shares covered by the NESPP may be common or second-class stock (which may be convertible to common shares upon satisfaction of performance criteria). The amount of stock covered by the NESPP is not limited.

Advantages and Disadvantages

Cash Outflow Generally Required

Like an ISO and an NQSO, participating in an NESPP may cause cash flow difficulties for an employee. However, by withholding amounts from paychecks, an employee may pre-fund the eventual acquisition of shares.

Tax Treatment to Employees (Ordinary Income)

If the employer sets the stock purchase price at FMV, the employee may defer tax recognition until he or she disposes of the stock; however, if the purchase price is less than the FMV, the employee will recognize

ordinary income on the difference. All subsequent appreciation in the shares should be taxed at capital gains rates upon later disposition of the shares.

Tax Treatment to Employer

The employer generally is entitled to a business expense deduction in an amount equal to the ordinary income realized by the grantee (if any).

Employee Stock Ownership Plans

Unlike a stock option plan, an employee stock ownership plan (ESOP) is a tax-qualified retirement plan governed by the Code and ERISA, and it is designed to invest primarily in employer securities (such as employer stock). Unlike other tax-qualified retirement plans (such as 401(k) plans), ESOPs contain a number of additional tax advantages designed to encourage employee ownership. For instance, with respect to shareholders of C corporations, an ESOP can acquire outstanding shares from an existing shareholder and, as long as the ESOP owns at least 30% of the corporation after the acquisition by the ESOP, the selling shareholder(s) can defer income taxes on any gain on the sale if the proceeds are invested in qualified replacement property within a fixed time period.

Entities that are not considered corporations for federal income tax purposes cannot sponsor ESOPs. As of the date of this writing, it remains unclear whether a noncorporate entity (such as a partnership or a limited liability company) that has elected to be taxed as a corporation for federal income tax purposes can sponsor an ESOP, although the IRS has privately ruled that limited liability companies in the same control group with a parent company sponsoring an ESOP may participate in the ESOP.

In addition, ESOPs can generally borrow money to finance the acquisition of company stock. Due to certain favorable deduction rules, the corporation may be able to deduct the principal payments (in addition to the interest payments) on the loan. Moreover, certain special rules apply to ESOPs sponsored by S corporations. Generally, a corporation is eligible for "S" status if it has only one class of shares and 100 or fewer shareholders, all of whom are U.S. citizens. For instance, if an ESOP acquires 100% of the outstanding shares of an S corporation, the corporation can essentially escape federal income taxes since all income from the corporation will pass through to the tax-exempt ESOP trust. However, special rules designed to limit ESOPs of S corporations apply to extend ESOP participation more broadly to benefit rank-and-file employees as well as owners. Limits on "synthetic equity" arrangements may apply to executives of a company that is an S corporation with an ESOP.

Requirements/Design Considerations

ESOPs can be complex to set up and administer. In addition, they must comply with a number of tax-qualification requirements set forth in the Internal Revenue Code. For instance, an ESOP must:

- be designed to avoid discrimination in favor of highly compensated employees;
- comply with certain coverage requirements; and
- adhere to certain participation, eligibility, and vesting requirements.

Additionally, ESOPs sponsored by privately held companies will need to engage the services of an independent valuation firm to value the corporation's stock on an annual basis.

Advantages and Disadvantages

Cash Outflow Generally Not Required

Unlike options and employee stock purchase plans, an ESOP typically is funded entirely with employer contributions. Thus, the employee is not required to contribute to the ESOP. An ESOP may add a cash or deferred arrangement to the ESOP, creating what is known as a KSOP, but the ESOP portion of this tax-qualified retirement plan remains funded entirely with employer contributions.

Tax Treatment to Employees (Ordinary Income Deferred)

If the ESOP satisfies the requirements of the federal pension laws, employees are not taxed on the value of the common shares held on their behalf under the ESOP until they later receive distributions from the ESOP.

Because ESOPs are tax-qualified plans, they are excluded from compliance with Code Section 409A.

Tax Treatment to Employer

Unlike the equity-based compensation techniques noted previously, an ESOP contains added tax advantages whereby the employer can take deductions for contributions to the ESOP even though employees do not include such amounts in income until distributions are later made from the ESOP. Employers may deduct dividends paid on employer securities held by the ESOP if the dividends are, at the election of ESOP participants or beneficiaries, paid to the plan and then reinvested in qualifying employer securities. This deduction is available if the ESOP participant has also elected to receive the dividend in cash.

Other Advantages of ESOPs

The ESOP creates a “fair value” market for closely held corporation shares without the need to sell the whole corporation. Further, the ESOP often creates a financial “partner” for acquiring a corporation. Therefore, ESOPs and ESOP loan transactions can be used in estate and business succession planning, management buyouts and business acquisitions.

The use of ESOP debt and/or the contribution of corporation shares to an ESOP generates tax deductions and thereby can improve cash flow. Corporation shares acquired through an ESOP loan transaction are purchased with pre-tax dollars, with both principal and interest payments generally deductible by the corporation. In addition, ESOP loan transactions may have advantages over non-ESOP loans because of the ESOP’s tax advantages (e.g., the lender should recognize the borrower’s cash-flow advantage in the pretax repayment of principal).

Individual shareholders who sell shares to a C corporation ESOP may defer or completely avoid any taxable gain on the sale of their shares. This mechanism presents significant planning opportunities and advantages in estate and business succession planning. In addition, an ESOP can form a key component of the corporation’s overall productivity by providing the incentive of ownership in the corporation, as well as a retirement program. For an S corporation ESOP, the corporation’s earnings pass through to the ESOP free of federal income tax. The actual earnings may be retained by the corporation to fund growth, pay more competitive salaries or meet other business needs.

Additional Potential Disadvantages of an ESOP

Under an ESOP loan transaction, the corporation is obligated to make annual contributions to the ESOP and typically assumes a direct loan obligation to a commercial lender. These obligations affect cash flow and are reported as a liability on the corporation's financial statements. In addition, the corporation has a contingent obligation to repurchase shares held by the ESOP at the future fair market value of the shares, some of which is unknown because repurchase obligations can arise when an employee terminates employment.

ESOPs are subject to complex legal requirements and generally involve significant administrative costs, including fees for trustees, accountants, appraisers and attorneys. Further, the failure to comply with these legal requirements exposes ESOP fiduciaries, selling shareholders and the corporation to potentially substantial liabilities.

The ESOP also creates a new class of shareholders to whom the corporation's officers and directors owe corporate fiduciary duties, and the voting rights and ownership of existing shareholders may be diluted. Further, the ESOP's investment primarily in corporation shares represents a more volatile and risky investment than normally associated with retirement plans. The Department of Labor has scrutinized ESOPs on audit because of perceived abuses.

Conclusion

Employers generally have broad discretion to determine:

- which employees are eligible to participate in an equity-based compensation program;
- the price employees must pay, if any, to participate in the program;
- the applicability of a vesting schedule; and
- the treatment of stock shares upon termination of employment, death or disability.

Because the federal government attaches tax advantages to these programs, however, the employer's discretion in designing such a program is limited by the plan qualification requirements applicable to employee stock ownership plans and tax-favored employee stock purchase plans, as well as the Code Section 409A requirements for many other forms of deferred compensation. It is important to consider these legal requirements, as well as the administrative restrictions regarding deferrals and distribution decisions in nonqualified equity-based compensation plans.

Because these programs can be complicated to explain to employees, employers must communicate detailed information in an understandable format to allow employees to balance the potential risks and rewards involved in investing in equity-based compensation.

Chapter 7

Worker's Compensation

Many employers overlook worker's compensation benefits when they evaluate their total benefits package, possibly because worker's compensation programs are mandated by state statute. However, worker's compensation provides substantial benefits to employees who suffer work injuries. The prudent employer will make sure that employees appreciate the value and cost of the worker's compensation program and will coordinate worker's compensation payments with the other elements of the benefits package.

When employees suffer work-related injuries, they are entitled to receive worker's compensation benefits from their employer. The coverage an employer must provide for worker's compensation may take the form of a fully insured benefit, a partially insured benefit or a self-funded benefit.

The modern worker's compensation system evolved from an idea originally developed during the Industrial Revolution. With an increasing number of serious work-related injuries, employees had little chance of prevailing in suits against their employers, who could argue that the employee had "assumed the risk" of the injury or contributed to the accident with his or her own negligence.

In response, a "no fault" theory of recovery emerged, resulting in a legal trade-off between employers and employees. Employers accepted automatic liability for their workers' work-related injuries, and in return, employees received specified, limited benefits and were barred from bringing suit against their employers. The goal of the worker's compensation system is to ensure that workers receive the medical treatment and disability benefits they need immediately following a work-related injury and eventually return to work.

This chapter presents a general discussion of Indiana's worker's compensation system; however, almost every state has a similar law providing benefits for injured employees. Worker's compensation in Indiana is governed by the Indiana Worker's Compensation Act ("the Act"). The Act prescribes the benefits to which injured employees are entitled and the way the Act is to be administered by the Worker's Compensation Board ("the Board"). Only the Board, not any state court, has jurisdiction over the administration of the Act and the power to determine what benefits are payable under the Act.

Applicability

The Act applies to nearly all employers and employees in the state of Indiana. "Employer" generally means any person or entity that uses the services of another for pay. In Indiana, the Act applies to any employer that has at least one employee.

An "employee" is virtually anyone who enters into a contract of employment with another; however, railroad workers and certain municipal workers are not covered by the Act. Also, limited coverage is provided for unpaid student workers participating in school-to-work programs, as well as volunteer workers performing work for public entities. The Act does not apply to casual laborers, farm and agricultural workers, nor domestic service workers unless their employer waives the exemption from coverage. Defining who falls into these rare exceptions is often a complicated legal question.

Providing Coverage

Employers must secure their worker's compensation obligation by either purchasing a worker's compensation insurance policy or obtaining a certificate of self-insurance from the Board. Most employers choose to purchase an insurance policy. Worker's compensation insurance policies vary little from one insurance company to another because the terms and benefits are dictated by the Act. Insurance premiums generally are based on payroll and classification of the employees. Also, an employer's experience of injuries is taken into account when calculating the premium. The Act provides that insurance policies may offer deductibles. If an employer purchases a policy with a provision for a deductible, then the insurer must pay the employee the full amount of the benefit to which the employee is entitled, and the employer must reimburse the insurer for the applicable deductible amount.

By contrast, those employers who desire to "self-fund" their worker's compensation obligation must apply to the Board to obtain a certificate of self-insurance. The Board requires employers to provide evidence of financial solidity and post a bond sufficient to secure the employer's worker's compensation obligation.

The Act provides penalties for employers that do not purchase worker's compensation insurance or obtain a certificate of insurance from the Board, including awarding double compensation to injured employees. In extreme cases, the Board may impose criminal penalties and order an employer to cease business until compliance with the Act's insurance requirements is obtained.

Reporting Injuries

The Act requires employers or their carriers to file an Employer's Report of Injury (Form 34401) whenever an injury results in an employee missing more than one day of work, or whenever an employee alleges such an injury, even if the employer disagrees. The Report of Injury must be filed within seven days of the occurrence or of the employer's knowledge of the injury. A sample copy of Form 34401 is located on the following page. This form can be accessed online through the Indiana Worker's Compensation Board web site at www.in.gov/wcb/2339.htm.

Remedies Under the Act

The Act is the employee's exclusive remedy against the employer for personal injury or death by accident arising out of and in the course of employment. This means that, generally speaking, an employee may not sue an employer for work-related injuries. The Act prescribes three basic benefits to which an injured employee is entitled:

1. Medical services and supplies
2. Temporary or permanent disability (in the case of inability to work)
3. Permanent partial impairment (in the case of loss of function)

If an employee dies as a result of a work-related injury, the Act also prescribes death benefits for the employee's dependents. Medical services and disability, impairment and death benefits are all discussed in depth in the following sections.



INDIANA WORKER'S COMPENSATION FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R10 / 1-02)

Please return completed form electronically by an approved EDI process.

FOR WORKER'S COMPENSATION BOARD USE ONLY

Jurisdiction	Jurisdiction claim number	Process date
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PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION									
Social Security number	Date of birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Occupation / Job title				NCCI class code		
Name (last, first, middle)		Marital status <input type="checkbox"/> Unmarried <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown		Date hired	State of hire	Employee status			
Address (number and street, city, state, ZIP code)				Hrs / Day	Days / Wk	Avg Wg / Wk	<input type="checkbox"/> Paid Day of Injury <input type="checkbox"/> Salary Continued		
Telephone number (include area)		Number of dependents		Wage Per \$ <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year <input type="checkbox"/> Other					
EMPLOYER INFORMATION									
Name of employer		Employer ID#		SIC code		Insured report number			
Address of employer (number and street, city, state, ZIP code)		Location number		Employer's location address (if different)					
		Telephone number							
		Carrier / Administrator claim number		OSHA log number		Report purpose code			
Actual location of accident / exposure (if not on employer's premises)									
CARRIER / CLAIMS ADMINISTRATOR INFORMATION									
Name of claims administrator		Carrier federal ID number		Check if appropriate <input type="checkbox"/> Self Insurance					
Address of claims administrator (number and street, city, state, ZIP code)		<input type="checkbox"/> Insurance Carrier <input type="checkbox"/> Third Party Admin.		Policy / Self-insured number					
Telephone number				Policy period From To					
Name of agent		Code number							
OCCURRENCE / TREATMENT INFORMATION									
Date of Inj. / Exp.	Time of occurrence <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Cannot be determined		Date employer notified	Type of injury / exposure				Type code	
Last work date	Time workday began		Date disability began	Part of body				Part code	
RTW date	Date of death	Injury / Exposure occurred on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of contact				Telephone number	
Department or location where accident / exposure occurred				All equipment, materials, or chemicals involved in accident					
Specific activity engaged in during accident / exposure				Work process employee engaged in during accident / exposure					
How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.									
								Cause of injury code	
Name of physician / health care provider									
Hospital or offsite treatment (name and address)								INITIAL TREATMENT <input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinic / Hospital <input type="checkbox"/> Emergency Care <input type="checkbox"/> Hospitalized > 24 Hours <input type="checkbox"/> Future Major Medical / Lost Time Anticipated	
Name of witness		Telephone number		Date administrator notified					
Date prepared	Name of preparer		Title	Telephone number					

An employer's failure to report an occupational injury or illness may result in a \$50 fine (IC 22-3-4-13).

Medical Services

After an injury occurs but before the effects of the injury become permanent and quiescent, the employer must furnish the employee with medical services, free of charge. These services include the following:

- An attending physician for treatment of injuries
- Surgical, hospital and nursing services and supplies as the physician or the Board deem necessary
- Certain limited travel, food and lodging expenses if the medical services are provided outside the county of employment
- Reimbursement of lost wages should the travel to or from the place of treatment cause a loss of working time

Benefits for medical treatment are payable until the effects of the injury are determined to be permanent and quiescent. Thereafter, the Board may order additional medical benefits on account of change in condition or to limit the impairment, within time periods specified by the Act.

In Indiana, the employer has the right to select the attending physician and direct the treatment. An employee's refusal to accept the medical services and supplies provided bars compensation that otherwise would be payable, and it suspends the employee's right to pursue the worker's compensation claim during the period of refusal. An employer must provide the employee notice of the effect of such refusal by sending the employee the Board's Report of Claim Status (Form 38911). A sample copy of this form can be found on the following page and obtained at www.in.gov/wcb/2339.htm.

The employer is not obligated to pay for treatment provided by unauthorized medical providers unless one of the following three cases following applies:

1. The employer refuses to provide treatment
2. An emergency exists
3. The Board finds a good reason to obligate the employer

If disputes arise over an employee's injury or care, the employer may wish to request that the employee submit to a medical examination. The physician will then provide a report on the medical examination that describes the patient's medical history, the physician's diagnosis, the opinion of the cause of the injury, the opinion of the disability and/or impairment, the extent to which the employee is disabled or impaired, and the physician's signature. This information can be used to guide the employee's medical care, or it may be put in evidence if litigation results. The employee's right to compensation will be suspended if the employee refuses to submit to the examination. Again, the employer must give notice to the employee on the Board's Form 38911, advising of the consequences of such refusal. The employer must pay for the employee's travel to and from the examination, including meals, lodging, mileage and lost wages.

A medical provider may not attempt to collect payment for services for a work-related injury from an employee. It is the responsibility of the employer or its worker's compensation carrier to pay for the services and, if it does not, the provider's remedy lies with the Worker's Compensation Board. The Act provides penalties for providers who wrongfully attempt to collect payment from injured employees.



**REPORT OF TEMPORARY TOTAL DISABILITY (TTD) /
TEMPORARY PARTIAL DISABILITY (TPD) TERMINATION**
State Form 38911 (RS / 1-14)

INDIANA WORKER'S COMPENSATION BOARD
402 West Washington Street, Room W196
Indianapolis, IN 46204
Telephone: (317) 232-3808
www.in.gov/wcb

* Your Social Security number is being requested by this state agency in accordance with IC 22-3-4-13; disclosure is voluntary, and you will not be penalized for refusal.

INSTRUCTIONS: 1. You must report all compensation payments on this prescribed form. (IC 22-3-3-7)
2. Mail to the Worker's Compensation Board at the above address.

Date of injury (month, day, year)		Accident number	
CLAIM INFORMATION			
Name of employer		Federal identification number	Telephone number ()
Address of employer (number and street, city, state, and ZIP code)			
Name of insurer		Insurer claim number	
Address of insurer (number and street, city, state, and ZIP code)			
Name of adjuster / case manager		Telephone number ()	E-mail address
Name of employee		Employee Social Security number *	
Address of employee (number and street, city, state, and ZIP code)			
Telephone number ()		E-mail address	
BENEFIT TERMINATION / REDUCTION (check all that apply)			
<input type="checkbox"/> In accordance with IC 22-3-3-7 (c), TTD/TPD benefits have been terminated due to the following (check all that apply): <input type="checkbox"/> The employee has returned to ANY employment; <input type="checkbox"/> The employee has died; <input type="checkbox"/> The employee has refused to accept suitable employment under Section 11 (IC 22-3-3-11); <input type="checkbox"/> The employee has refused to undergo a medical examination under Section 6 (IC 22-3-3-6); <input type="checkbox"/> The employee has received five hundred (500) weeks of TTD benefits or has been paid the maximum compensation allowed under IC 22-3-3-22; <input type="checkbox"/> The employee is unable or unavailable to work for reasons unrelated to the compensable injury. <input type="checkbox"/> Other (IF CHECKED, MEDICAL DOCUMENTATION MUST BE SERVED ON INJURED PARTY.) <input type="checkbox"/> TTD benefits shall be terminated and Temporary Partial Disability (TPD) begun because employee has been released to part time work suitable to employee's disability. <input type="checkbox"/> Employer intends to terminate TTD/TPD benefits on _____ (must be at least four (4) days after mailing or two (2) days after personal service) because: <input type="checkbox"/> Treating physician has released employee to full time light duty work and employer has appropriate light duty work available. <input type="checkbox"/> Treating physician finds employee has reached MMI and/or employee is released to full time work (check one): <input type="checkbox"/> With restrictions <input type="checkbox"/> Without restrictions			
Explanation			
COMPENSATION PAYMENTS			
Average weekly wage \$	Number of weeks paid	Weekly rate \$	Start date of payments (month, day, year) End date (month, day, year)
Total amount paid \$	Check one: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent		Reason(s) for ending payments
EMPLOYEE'S OBJECTION TO TERMINATION OF TTD BENEFITS			
If the employee disagrees with the proposed benefit termination, the employee must complete, sign and return a copy of this notice to the Worker's Compensation Board and the employer within seven (7) days after receipt. This notice can also be filed via the Dispute Termination of Benefits link on the Board's website.			
Please check all that apply: <input type="checkbox"/> Employee disagrees with the termination / reduction of benefits. <input type="checkbox"/> Employee requires further medical care. <input type="checkbox"/> Employee believes an independent medical examination (IME) may be helpful to resolve this dispute.			
Explanation			
EMPLOYER CERTIFICATION / RECEIPT OF EMPLOYEE / DEPENDENT			
Employer and employee must sign below to certify service or acknowledge receipt of this notice. I certify that the foregoing is true and that a copy of the relevant medical documentation is attached.			
Signature of employer		Date of service (month, day, year)	
Printed name		By (check one): <input type="checkbox"/> US Mail <input type="checkbox"/> Personal service	
Signature of employee		Date received (month, day, year)	
Printed name		By (check one): <input type="checkbox"/> US Mail <input type="checkbox"/> Personal service	

Temporary Disability

If a work-related injury prevents an employee from performing the job he or she was performing at the time of the injury, the employee is entitled to temporary disability benefits. Temporary total disability (TTD) is payable if the employee is totally unable to work during the healing period. Once the effects of the injury become permanent, TTD terminates. The amount due for TTD is 66-2/3% of the employee's average weekly wage, up to a statutory maximum. TTD payments become payable on the eighth day of disability. Compensation for the first seven days of an employee's temporary total disability is payable only if the disability continues for over 21 days. Within 30 days from the date of injury, the employer or the employer's worker's compensation carrier must tender to the employee, or (in the event of death) to the employee's dependent, a properly prepared agreement to compensation, along with all compensation due. Once signed by the employer and employee, the agreement to compensation is filed with the Board for approval. The Board's approval of the agreement is a binding adjudication that the injury is governed by the terms of the Act.

TTD is payable throughout an employee's entire period of temporary total disability, up to 500 weeks. If an employee suffers an injury that causes a disability that extends beyond 500 weeks, the employee may be entitled to apply to the Second Injury Fund for additional benefits. The Second Injury Fund is administered by the Board and is funded by contributions from employers and insurance carriers.

If the employer or the employer's insurance carrier denies a claim, the employer or carrier is required to notify the Board and the employee in writing on a form prescribed by the Board not later than 30 days after the employer's knowledge of the claimed injury. If a determination of liability cannot be made within 30 days, the Board may approve an additional 30 days upon written request of the employer or the employer's insurance carrier that sets forth the reasons that the determination could not be made (such as lack of medical documentation) within 30 days and states the facts or circumstances that are necessary to determine liability within the additional 30 days.

When TTD payments are terminated by the employer or the employer's carrier, the employer or its carrier should provide the employee with written notice on a prescribed form – that is, a Board Form 38911 – of its intent to terminate TTD benefits. TTD may be terminated for a number of reasons. For example, the employee may return to any employment, die, refuse to submit to a medical examination, unjustifiably refuse suitable work procured by the employer, or be unable or unavailable to work for reasons unrelated to the injury. If the employer believes that TTD should terminate because the injury has healed (i.e., the effects of the injury have reached a state of permanence and quiescence), the employee has a right to request that the Board require an independent medical examination. This examination is performed at the employer's expense, and the independent physician provides an opinion regarding whether more treatment for the injury is necessary.

Temporary partial disability (TPD), on the other hand, occurs when the injured worker can work, but not at his or her former wage. For example, TPD occurs when an employee can only work a lower-rated job or cannot work as many hours after the injury. If a work-related injury results in temporary partial disability, the employee is entitled to a weekly compensation equal to 66-2/3% of the difference between his or her pre-injury average weekly wage and the weekly wage at which he or she is actually employed after the injury, for a period not to exceed 300 weeks. As with TTD, once the effects of the injury become permanent and quiescent, temporary partial disability ends.

Many employers have implemented return-to-work programs to reduce their worker's compensation costs. Temporarily disabled employees with restrictions are returned to work in limited-duty positions. It is not

unusual for the employer to pay TTD for a period of time while the worker is totally disabled, and then to pay TPD while the employee performs light-duty work, until the employee's injury reaches the point of permanence and quiescence.

Permanent Partial Impairment

After the effects of an injury reach a state of permanence and quiescence, the treating physician will determine whether the injury resulted in permanent partial impairment (PPI). An injury results in PPI if the employee suffers some permanent loss of function of a body part. The Act provides a detailed schedule of injuries that assigns a certain number of degrees of impairment for each specific body part. The amount of compensation to which an employee is entitled varies based on the number of degrees and the value of each degree as set by the Indiana legislature for the date of injury. While compensation for smaller impairments is often paid in a lump sum, the Act provides that compensation for permanent impairment is paid out on a weekly basis at 66-2/3% of the average weekly wage.

Death Benefits

If a work-related injury results in the death of an employee, the employee's eligible dependents are entitled to up to 500 weeks of compensation payable at 66-2/3% of the employee's average weekly wage. The employer and/or worker's compensation carrier is also obligated to pay any medical benefits and up to \$10,000 for burial expenses.

For purposes of establishing dependency, the Act distinguishes between presumptive dependents and dependents-in-fact. Presumptive dependents include:

- any current spouse;
- unmarried children under the age of 21 who were living with the employee at the time of the employee's death;
- unmarried children under the age of 21 who were not living with the employee at the employee's time of death but for whom the employee has a legal support obligation; and
- children older than 21 who have never been married, are mentally or physically handicapped, or are keeping house for the employee and not otherwise gainfully employed.

Presumptive dependents are entitled to compensation on behalf of the employee to the complete exclusion of all other dependents. An award of death benefits is divided equally among all presumptive dependents.

A dependent-in-fact is a person related by blood and "actually dependent" (totally or partially) upon the employee. Such a dependent will be entitled to benefits only if there are no presumptive dependents at the time of the employee's death. Certain events, such as marriage and emancipation, can change dependency status. Therefore, it is important to regularly revisit a dependent's situation to determine whether the dependent remains eligible for compensation.

Calculating Compensation

When calculating the payments due to an employee under the Worker's Compensation Act, it is vital to consider the employee's weekly wage as well as any applicable maximum compensation levels and bars to payment.

Average Weekly Wage

Average weekly wage is defined as the earnings of the injured employee in the employment in which he or she was working at the time of the injury for 52 weeks immediately preceding the date of injury, divided by 52 (or the number of weeks or parts of weeks actually worked). In the event that this calculation does not provide a reasonable result (as, for example, with very new employees), the Act provides that the wages of another employee performing a similar job may be used. The Act provides minimum and maximum average weekly wage caps that vary according to the date of injury. It is very important to consult the Act to determine whether the maximum applies so that there is no excess payment of compensation.

Maximum Compensation

For purposes of the Act, temporary total disability, temporary partial disability, and permanent partial impairment payments are considered compensation. The Act provides a maximum for all compensation to which an employee is entitled based on the date of injury. For example, for injuries occurring on or after July 1, 2016, the maximum an employee may receive for temporary total disability, temporary partial disability and permanent partial impairment combined is \$390,000. Again, it is very important to consult the Act to determine what cap applies.

Further, the Act provides that the maximum amount of time that disability compensation may be paid to an employee may not exceed 500 weeks, and an award of permanent total disability may not be less than \$75,000. The maximum caps do not apply to medical benefits; the employer is obligated to pay for all necessary medical treatment until the injury reaches a state of permanence and quiescence.

Bars to Compensation

The Act provides that no compensation is allowed for injury or death due to an employee's knowingly self-inflicted injury, intoxication, commission of an offense, knowing failure to use a safety appliance, knowing failure to obey a reasonable written or printed rule of the employer that had been posted in a conspicuous position, or knowing failure to perform any statutory duty. The Act further provides that the burden of proof for these defenses is on the employer. It is important to recognize that the employer, in order to prevail, must prove that misbehavior on the part of the employee caused the injury.

Initiating a Claim

Unless the employer has actual knowledge of a workplace injury, the employee must give his or her employer written notice of the injury as soon as practicable. If such notice is not given within 30 days, no worker's compensation will be payable until the notice is given or actual knowledge of the injury is obtained. The lack of notice or knowledge of the injury will not bar the payment of compensation unless the employer is prejudiced by such lack of notice or knowledge. In most cases, compensation and medical benefits are simply paid by the employer or its compensation carrier without any litigation; however, if a dispute develops regarding the claim, either party (but typically the employee) may file an application requesting a hearing before the Worker's Compensation Board.

Hearing Procedure

The Worker's Compensation Board is composed of seven members: one chairman and six single hearing members, each of whom is assigned to a certain geographical area. Although as many as 90% of all worker's compensation claims are paid without dispute, there are several issues that may be contested in an ordinary worker's compensation claim. For example, it may not be clear that the injury was caused by the employment or occurred while the employee was in the course of employment. Other widely litigated issues relate to the actual benefits provided. If there is a dispute, either party may file an application for adjustment of claim and ask for a hearing, although the vast majority of applications are filed by employees. Hearings before the Board are similar to civil trials, except they are more informal and there is no jury. Any party who is dissatisfied with a single hearing member's decision may file a petition for full Board review. The full Board usually hears oral argument. Evidence not admitted before the single hearing member will not be admitted before the full Board without a very good reason. Parties may appeal the decision of the full Board to the Indiana Court of Appeals within 30 days of the decision and may request that the Indiana Supreme Court review a decision of the Court of Appeals.

Third-Party Liability

Acceptance of worker's compensation by an employee or his or her dependents will not bar the employee or dependents from pursuing a claim against another party, other than the employer or a person in the same employ, who may be liable for the employee's injury. If the employee recovers from such third party, the employer or the employer's worker's compensation carrier will have a lien upon the amounts paid by the third party to the employee. The amount of the employer's or the employer's worker's compensation carrier's lien is the amount the employer/carrier actually paid to the employee, subject to a number of limitations. The lien is subject to reduction for the employer's pro rata share of costs, expenses and attorneys' fees that the employee incurs to pursue legal action against the third party. The attorneys' fee is generally 33% of the employer's recovery, after subtraction of the employer's share of expenses, if a lawsuit is required. When the third-party case is settled, the employer's or carrier's obligation to pay worker's compensation benefits ends. However, if the claimant's third-party recovery is worth less than the worker's compensation claim (e.g., if there is serious injury but the third party is essentially judgment proof), the claimant has the option of assigning the judgment to the employer and continuing to receive worker's compensation benefits. The lien is also reduced if the employee's recovery is reduced because of comparative fault or because the judgment is uncollectible, for example.

If the employee fails to pursue the third party within two years of his or her right to bring the action, the employer/carrier may pursue the third-party claim. The employer/carrier has one year from the date the employee's right to bring the action expired to initiate legal action against the third party.

Contractors

Any person who contracts with another for work over \$1,000 must obtain certification from the Worker's Compensation Board that the subcontractor has provided worker's compensation coverage for the subcontractor's employees. If the contractor fails to obtain this certificate, it will be liable for injuries to employees of the subcontractor.

Independent Contractors Working in the Construction Trades

The Act does not require independent contractors to carry worker's compensation insurance on themselves. However, independent contractors in the construction trades must obtain a certificate of exemption from the Indiana Department of Revenue, and anyone hiring the independent contractor must obtain a copy of the certificate. Otherwise, a dispute may develop as to whether the worker was, in fact, an independent contractor or actually an employee, and the person hiring the worker may be liable to pay worker's compensation.

Note that this exception applies only to the individual contractor doing the work, not to any employee he or she may have. The construction contractor must have worker's compensation coverage for all employees.

Limitations

Generally, employees must file any claims for worker's compensation within two years of the accident date, and in the event of death, a beneficiary must file any claim within two years of the employee's death. This period may be extended for radiation exposure, silicosis and asbestos-related diseases. If the injury was accepted as a compensable one but a dispute develops, the application must generally be filed within two years of the last date for which compensation (disability or impairment benefit) was paid, although in some cases the limit is one year.

Chapter 8

Time-Off and Severance Benefits

Most Indiana employers routinely grant a variety of time-off benefits to their employees. In fact, most employers allow their employees to take time off for vacations, holidays, family or medical/maternity leave, personal or sick leave, bereavement leave, jury duty and military service. Other than the Family and Medical Leave Act (FMLA), however, there are relatively few legal obligations requiring employers to grant time-off benefits in Indiana. Nonetheless, employers need to be aware of various public policy, re-employment and compensation issues that can accompany these time-off benefits. Because of these associated issues, employers should have clear, published guidelines and policies that outline their treatment of time-off benefits, and they should communicate those policies to their employees. Additionally, employers should have easy-to-understand forms that can be used for the purposes of requesting, approving and documenting employees' actual time off.

Family and Medical Leave

The Family and Medical Leave Act (FMLA) requires certain employers to provide job-protected leave of up to 12 weeks for eligible employees who need to care for a newborn or newly adopted child, who need to care for a family member with a serious health condition, or who suffer from their own serious health condition. FMLA leave is also available for eligible employees who need time to address issues that arise when a family member is deployed for military service in a foreign country. In addition, up to 26 weeks of FMLA leave is available to employees who need to care for servicemembers who incur serious illness or injury while on active duty in the Armed Forces.

Employees may take FMLA leave on either a continuous or an intermittent basis. The FMLA was enacted to provide limited job security for employees who need to take time off from work because they suffer from serious health conditions or who need to care for family members with serious health conditions. The FMLA was extended to include military family leave beginning in 2009.

The FMLA applies to all employers that employ 50 or more employees for 20 or more calendar workweeks in the current or preceding calendar year. An employee is considered eligible for FMLA leave if he or she meets all of the following criteria:

- He or she has been employed by the employer for at least 12 months (which need not be consecutive)
- He or she has been employed by the employer for at least 1,250 hours of service during the 12-month period immediately preceding the date the leave commences
- He or she is employed at a worksite where 50 or more employees are employed by the employer within 75 miles of that worksite

The FMLA provides leave for eligible employees for up to 12 workweeks in any designated 12-month period or rolling 12-month period measured backward from the date an employee uses FMLA leave due to the following events:

- Birth and care of a newborn child

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- Placement and care of a child for foster care or adoption
- Serious health condition of the employee's family member (spouse, child or parent)
- Employee's own serious health condition

Eligible employees who are the spouse, son, daughter, or parent of a military member may take up to 12 weeks of FMLA leave during any 12-month period to address the most common issues that arise when a military member is deployed to a foreign country. For example, an employee may take FMLA leave to attend military-sponsored functions, make appropriate financial and legal arrangements, and arrange for alternative childcare. This qualifying exigency leave applies to families of members of both active duty and reserve servicemembers.

An eligible employee can take up to 26 weeks of FMLA leave to care for a servicemember who is the employee's spouse, child, parent, or next of kin who is undergoing medical treatment, recuperation, or therapy due to a serious illness or injury incurred or aggravated while serving in the Armed Forces (including the National Guard). Employees can also take leave to care for a spouse, child, parent or next of kin who is a veteran with a serious illness or injury that was incurred or aggravated in the line of duty while on active duty in the Armed Forces and that manifested itself before or after the servicemember became a veteran. The veteran must have been a member of the Armed Forces at any time during the five-year period preceding the date of the serious illness or injury for which they are receiving medical treatment, recuperation or therapy.

In addition to the FMLA leave described above, employers should be aware that the Americans with Disabilities Act of 1990 (ADA) in certain circumstances may require an employer to grant additional leave if such leave would be a reasonable accommodation for a qualified individual with a disability.

Under the FMLA, employers have responsibility for determining and designating whether an employee is eligible for FMLA leave. In fact, an employer must evaluate whether an employee is eligible for FMLA leave and whether the reason for the requested leave is covered under the FMLA. An employee does not have to expressly request FMLA leave for an employer's obligations to be triggered. Furthermore, the employer must designate whether the leave is paid or unpaid. The employer must provide the employee with written notice detailing the specific expectations and obligations of the employee and the potential consequences of the employee's failure to meet these obligations. This written notice should include an explanation of the employee's obligations under the employer's benefit plans.

COVID-19 Leave Provisions

In response to the COVID-19 pandemic, the Families First Coronavirus Response Act (FFCRA) created two new types of paid leave: the Emergency Paid Sick Leave Act (EPSLA) and the Emergency Family Medical and Leave Expansion Act (EFMLEA). EPSLA and EFMLEA apply through December 31, 2020 for specific reasons related to the pandemic.

EPSLA and EFMLEA apply to private employers with fewer than 500 employees. Most federal government employees are covered by EPSLA, but not by EFMLEA. Small businesses (fewer than 50 employees) may qualify for exemption from some requirements of EPSLA and EFMLEA if the leave requirements would jeopardize the viability of the business as a going concern.

EPSLA provides for either:

- two weeks (up to 80 hours) of paid sick leave at the employee's regular rate of pay where the employee is unable to work because the employee is quarantined (pursuant to federal, state or local government order or advice of a health care provider), and/or experiencing COVID-19 symptoms and seeking a medical diagnosis; or
- two weeks (up to 80 hours) of paid sick leave at two-thirds the employee's regular rate of pay because the employee is unable to work due to a bona fide need to care for an individual subject to quarantine (pursuant to federal, state or local government order or advice of a health care provider), or to care for a child (under 18 years of age) whose school or childcare provider is closed or unavailable for reasons related to COVID-19, and/or the employee is experiencing a substantially similar condition as specified by the Department of Health and Human Services (HHS).

EFMLEA provides for up to an additional 10 weeks of paid expanded family and medical leave at two-thirds the employee's regular rate of pay where an employee, who has been employed for at least 30 calendar days, is unable to work due to a bona fide need for leave to care for a child whose school or childcare provider is closed or unavailable for reasons related to COVID-19. Combined EFMLEA and FMLA leave is limited to 12 weeks per year.

All employees of covered employers qualify for up to two weeks of leave under EPSLA if the employee is unable to work (or unable to telework) due to a need for leave because the employee is:

1. is subject to a government quarantine or isolation order related to COVID-19;
2. has been advised by a health care provider to self-quarantine related to COVID-19;
3. is experiencing COVID-19 symptoms and is seeking a medical diagnosis;
4. is caring for an individual subject to an order described in (1) or self-quarantine as described in (2);
5. is caring for a child whose school or place of care is closed (or childcare provider is unavailable) for reasons related to COVID-19; or
6. is experiencing any other substantially similar condition specified by HHS.

For leaves due to quarantine or isolation orders or advice, or due to the employee's own COVID-19 symptoms, the employee is entitled to pay at either their regular rate or the applicable minimum wage, whichever is higher, up to \$511 per day and \$5,110 in the aggregate (over a two-week period). For leaves taken to care for someone else (e.g., a child whose school or place of care is closed, or an individual who is subject to quarantine or isolation), an employee is entitled to pay at two-thirds their regular rate or two-thirds the applicable minimum wage, whichever is higher, up to \$200 per day, capped at \$2,000 in the aggregate over a two-week period and \$12,000 in the aggregate over a 12-week period.

Maternity Leave

Time off for maternity leave is subject to the provisions of the FMLA. The Pregnancy Discrimination Act (PDA) amended Title VII of the Civil Rights Act to clarify that pregnancy discrimination is prohibited as sex discrimination. While a full discussion of employment discrimination is beyond the scope of this book, the Indiana Chamber publishes its *Employment Law Handbook*, available for purchase at www.indianachamber.com/publications, among numerous other employment law and human resources titles.

Vacation and Sick Pay

Generally, an employer has no legal obligation to grant any paid vacation and/or sick days to employees. Obviously, most employers elect to grant their employees a certain number of paid days off per year, often depending on the length of an employee's service. An issue of contention for employers in Indiana is whether terminated employees are entitled to receive accrued but unused vacation and/or sick pay upon their dismissal from employment.

Indiana courts have fashioned a rule that entitles terminated employees to a pro rata share of earned vacation pay to the time of termination unless an agreement or published policy to the contrary exists. Under Indiana law, vacation pay is a form of deferred wage and is subject to the provisions of the Indiana Wage Payment Act. Therefore, an employee is entitled to his or her accrued but unused vacation pay upon termination, unless a written policy exists to the contrary, because it is a form of deferred wage. At least one Indiana court has extended the treatment of vacation pay to sick pay. The court determined that the sick pay was a form of deferred wage analogous to vacation pay because the employer's policy called for the payment of unused sick days upon termination. Accordingly, employers should have written vacation and sick pay policies that set forth whether employees receive payment for their unused vacation and sick days upon the termination of their employment.

Holidays

While Indiana law does not require employers to grant employees time off for holidays, most employers designate the holidays that they observe. For example, the state of Indiana observes the following holidays during which time most state employees do not work:

- New Year's Day: January 1
- Martin Luther King, Jr.'s Birthday: The third Monday in January
- Good Friday: A movable feast day
- Memorial Day: The last Monday in May
- Independence Day: July 4
- Labor Day: The first Monday in September
- Columbus Day: The second Monday in October
- Election Day: The day of any general, municipal or primary election
- Veterans Day: November 11
- Thanksgiving Day: The fourth Thursday in November
- Abraham Lincoln's Birthday: Previously celebrated February 12, but more recently celebrated the Friday after Thanksgiving Day.
- Christmas Day: December 25
- George Washington's Birthday: Previously celebrated the third Monday in February, but more recently celebrated on Christmas Eve.

When any of these holidays falls on Sunday, the following Monday is the legal holiday observed by the state. When any of these holidays falls on Saturday, the preceding Friday is the legal holiday observed by the state.

Jury Duty

Under both Indiana and federal law, an employer may not dismiss an employee, deprive the employee of any employment benefits or threaten an employee with dismissal because the employee has jury duty. While an Indiana employer is not required to provide paid leave for jury duty, the employer may not require or ask an employee to use his or her annual leave, vacation leave or sick leave for time spent on jury duty.

Military Duty

Under Indiana law, an employer must allow an employee to attend drill or other duty of the Indiana National Guard. The employer may grant the employee a leave of absence, in addition to the employee's regular vacation period, for the total number of days that the employee is on state active duty. This leave of absence may be with or without loss of time or pay at the discretion of the employer. After a leave of absence for military training, an employer must restore the employee to his or her previous position or a substantially similar position with equal status and pay.

Indiana employers with 50 or more employees are also required to provide military family leave of up to 10 days for an eligible employee whose spouse, child, grand parent or sibling is ordered to active duty. To be eligible for Indiana military family leave, the employee must have worked for the employer for 12 months and have worked for 1,500 hours during the 12-month period immediately preceding the day leave begins. Unless military orders are issued less than 30 days before the leave date, the employee is required to give the employer written notice at least 30 days prior to the leave date. Military family leave can be unpaid; however, the employee can substitute any available paid leave, except medical or sick leave, for unpaid leave. An employee who takes military family leave must be permitted to continue health benefits at the employee's expense during the leave.

If an employee is leaving full-time employment to serve in the United States military, the employee may have re-employment and benefits continuation rights under the federal Uniformed Services Employment and Re-employment Rights Act (USERRA). Essentially, USERRA mandates that an employer may not deny employment, re-employment or any employment benefit to a member of the United States military on the basis of the individual's membership in the United States military; that is, the individual's membership in the military cannot be a "motivating factor" for an employer's adverse employment decision.

Any employee whose absence from a position of employment is because of service in the United States military must be entitled to the re-employment rights and benefits afforded by USERRA, provided certain criteria are satisfied. Among other things, the employee must give advance written or verbal notice of such military service, if reasonably possible, and if the length of service exceeds five years, the employee will not have the right to be re-employed. These general guaranteed job reinstatement rights will apply unless the job was for a brief, nonrecurrent period and the employee had no reasonable expectation it would continue.

In general, employees must be rehired to the positions they would have obtained, with reasonable efforts by the employer to train employees for a new position. More specifically, if an employee's military service was at least 91 days, the employee must be rehired to a position of like pay, status and seniority. The period of time allowed for the employee to reapply for his or her prior job is based on the period of service. If the employee is hospitalized or convalescing, the employee generally has an additional two years to reapply. Prior to re-employment and following periods of military service of 31 days or more, an employer may require reasonable documentation of the leave and of honorable discharge. Rehire rights apply only for those individuals who were honorably discharged.

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Upon rehire, the employer cannot fire the employee without cause for a limited period of time if the employee's military leave was longer than 30 days. If the leave was shorter than 30 days, the employee may be terminated without cause at any time.

With respect to benefits, USERRA generally provides that employees entering military service must be extended all rights and benefits not determined by seniority that are generally provided to employees on leave or furlough. The obligation to continue these benefits continues indefinitely, although employees can be required to pay the employee portion of any "funded" benefit.

Pension plans must give credit to employees for eligibility, vesting and benefit accrual purposes for periods of military service if they are re-employed after such service. In other words, plans may not treat periods of military service as a "break in service." For defined contribution plans, returning employees have three times the period of service (not to exceed five years) to make up any missed pre- and after-tax contributions. In addition, the employer and plan must provide any "missed" matching contributions, the employer and the plan must provide any missed profit-sharing or money purchase contributions, and the "missed" profit-sharing or money purchase contributions must be based on what compensation would have been for the employee if he or she had not taken the military leave. If the military leave was longer than 90 days, the employer may require documentation before allowing retroactive pension contributions to be made.

If an employee dies while on military leave, any rights under a qualified retirement plan must be determined as if the employee returned to active employment prior to his or her death and died while actively employed. This may result in accelerated vesting or survivor benefits.

With respect to health plans, the plan administrator must offer continuation coverage that is similar to COBRA to the employee and his or her dependents, even though the employee and his or her dependents are covered by CHAMPUS (health coverage for members of the military and their dependents) if the employee is called to serve at least 31 days. To be entitled to continuation coverage from the employer's plan, employees and their dependents must have been covered at the time military service began. The health plan must offer continuation coverage for at least 24 months at no more than 102% of the full premium cost. However, if the employee's military service is for fewer than 31 days, the employee can be charged no more than what active employees are charged for their health benefit costs. Upon an employee's return from military service, the employee and dependents must be covered by the health plan without respect to any waiting periods or pre-existing condition exclusions, except for any illnesses or injuries determined by the U.S. Secretary of Veterans Affairs to be incurred or aggravated by the employee's military service.

Severance Pay

Often, employers will provide their employees with some type of benefits upon their termination from employment. These benefits, known as severance pay, are usually paid in cash, and they may include other benefits such as outplacement services and continued health coverage at no or reduced cost for a stated period of time. Employers will want to give special attention to any severance benefits they decide to offer employees, because these benefits are frequently subject to ERISA's compliance obligations. Severance pay is not, however, subject to the requirements of the Indiana Wage Payment Act.

Severance benefits, depending on administrative complexity and ongoing employer obligations, may or may not be subject to ERISA. If subject to ERISA, such benefits may be classified as either a welfare plan or pension plan. Welfare plans include programs designed to pay benefits resulting from an employee's termination of employment. Pension plans include benefit programs that defer income to periods extending to the termination of employment or beyond. In devising a severance program, however, employers will

want to avoid creating a pension plan, which will be subject to ERISA's rigid participation, vesting and funding requirements.

Fortunately, there is significant guidance on how to structure a program that the U.S. Department of Labor will not treat as a pension plan, as long as these arrangements meet the following criteria:

- Payments are not contingent upon the employee's retirement or normal retirement age.
- The total amount of the severance payments do not exceed twice the employee's annual compensation during the year preceding his or her termination.
- All payments are completed within 24 months of the employee's termination (unless the employee is terminated in connection with a limited program of terminations, in which case the payments must be completed within the later of 24 months after the employee's termination of service or 24 months after the employee reaches normal retirement age).

Although compliance with this "safe harbor" allows employers to avoid inadvertently creating a pension plan by paying employee benefits upon termination of employment, severance benefits may be a welfare plan subject to ERISA that must comply with ERISA's written plan document, reporting and disclosure requirements. The standard for determining whether an employer has created a severance plan that is subject to ERISA is the same standard set forth in Chapter 1 of this book for assessing whether an ERISA plan is in place. This standard depends on two factors:

1. Whether the payment of benefits requires an ongoing administration scheme by the employer
2. Whether, from the surrounding circumstances, a reasonable person could ascertain the intended benefits, beneficiaries, source of financing and procedure for receiving the benefits

This "test" developed from various court cases in which participants challenged their employers' failure to pay severance benefits, and it requires a fact-specific inquiry. Application of this standard has sometimes produced surprising results, including some cases finding that severance plans subject to ERISA exist even where an employer has simply made cash severance payments to one individual out of the company's general assets. Generally, the type of severance arrangements that are least likely to be subject to ERISA are those involving a single, lump-sum payment to several terminated employees following a plant closure or other one-time corporate event.

Any benefit paid upon an employee's termination of employment may be viewed as a severance benefit, regardless of whether the termination resulted from a plant shutdown or the closure of a division necessitating widespread layoffs, or whether the payment was made to a single employee who voluntarily quit. This conclusion may be true even if the severance arrangement is an informal, unwritten policy. In fact, to the extent that a court were to determine that an unwritten practice of providing severance exists and forms the basis for concluding that an ERISA plan exists, that "practice" may be subject to ERISA as well.

Generally, severance payments should be designed to comply with or be exempt from Code Section 409A, as such payments may be considered deferred compensation subject to the restrictions of Internal Revenue Code Section 409A, discussed in more detail in Chapter 5.

Penalties for Failure to Have a Written Plan Document

ERISA provides for certain penalties that will apply if an employer establishes any welfare plan that is subject to ERISA but fails to comply with ERISA's requirements. Severance plans are particularly at risk of such penalties, because employers frequently provide severance benefits out of general assets without realizing that they inadvertently may have created an ERISA plan.

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ERISA requires that plan administrators provide participants and beneficiaries with certain plan documents upon request. Failure to do so may result in both civil and criminal penalties. The civil penalties are subject to annual adjustments. Currently, the failure to provide plan documents upon request may result in a civil penalty of as much as \$159 per day, not to exceed \$1,594 per request. Willful violations of ERISA's reporting and disclosure rules can result in a maximum fine to an individual of \$100,000 (or \$500,000 if the violator is other than an individual), or imprisonment for not more than 10 years, or both. Additional penalties and excise taxes may apply if a fiduciary breach is involved.

Most employers that provide severance payments without treating them as an ERISA plan do not file a Form 5500 Annual Report with the Department of Labor with regard to those severance payments. (See Appendix F for a sample of Form 5500.) If the payments rise to the level of an ERISA plan, an annual filing may be required. The penalties associated with the failure to file a Form 5500 currently include civil penalties of up to \$1,100 per day, as well as the potential criminal penalties mentioned above.

Benefits of Having a Written Plan Document

Any employer providing severance on a regular and consistent basis may want to consider developing a written plan document that complies with ERISA. This approach may be advisable for several reasons, including the following:

- A written plan document is required if the severance arrangement is subject to ERISA.
- The absence of a written plan may restrict the company's ability to amend or terminate the plan at will.
- A written plan can effectively reserve the company-wide discretion to determine what severance benefits, if any, will be payable upon any of several specified events.
- A written plan document may provide specific eligibility criteria and grant the company considerable latitude in interpreting the facts to decide whether such criteria are met.
- Having a written plan document that grants the plan administrator the discretion to make eligibility determinations and to interpret plan terms will strengthen the company's position when forced to defend any lawsuit regarding severance benefits.

If the company does not intend to pay severance benefits in the future, employee handbooks and other ERISA plan documents should clearly state that employees will not be entitled to any severance pay. Clear and accurate written documents, along with careful communications with employees, will help avoid lawsuits based upon alleged unwritten practices or verbal promises.

Severance Agreements and Releases

Frequently, employers provide severance benefits to terminated employees in return for an executed severance agreement that contains a full release of any claims against the employer. Such releases will also generally include confidentiality and noncompete provisions, which are subject to detailed legal requirements beyond the scope of this book. Courts will normally only enforce a severance agreement when the employee receives something of value to which he or she would not otherwise have been entitled. Additionally, the Older Workers Benefit Protection Act, which amended the Age Discrimination in Employment Act, provides that employees who are age 40 or over must be allowed at least 21 days to consider a release of potential claims against an employer (extended to 45 days in the event of a group layoff or reduction-in-force

program) and seven days to revoke such a release once it is signed. This requirement will dictate additional provisions in any severance agreement provided to an individual who is age 40 or older.

Conclusion

Employers will want to be aware of the detailed legal requirements for all time-off benefits and devise policies that meet those requirements. Some employers may choose to be more generous than the law requires in providing time-off benefits by providing paid leave in some instances, for example. All employers should clearly communicate each of these policies to their workforce to increase understanding and appreciation of these valuable benefits.

Chapter 9

Nontraditional Work Scheduling Options: Part-Time, Flextime and Telecommuting Arrangements

Building on a trend that began in the late 1990s, employers are using nontraditional work options to help employees find a better work-life balance and to help themselves find and keep quality employees. Work scheduling options like telecommuting, flex time and part-time scheduling give employees more autonomy to control when, where and how they get their work done.

Telecommuting is defined as an employment arrangement between an employer and employees in which the employees perform a portion of their normally scheduled work from an agreed-upon alternative worksite. Telecommuting allows an employee to work either at home or in a telecommuting center or mobile office. According to a 2016 National Study of Employers (NSE) by the Families and Work Institute/Society for Human Resource Management, 66% of employers surveyed offered a telecommuting option. The NSE survey included 920 employers with 50 or more employees.²

Flextime is an approach to work scheduling that allows employees to vary their work hours to accommodate personal needs and preferences within certain limitations. Indeed, flextime scheduling allows certain employees to schedule their own hours of work as long as their employer can count on certain minimum staffing levels at specified times. Within these parameters, flextime takes many forms. For example, employees may vary their starting times, they may vary the length of the workday, or they may vary the length of both the workday and the workweek. The 2016 NSE survey found 81% of employers surveyed offered some type of flextime or part-time option.

Part-time work is exactly what it sounds like: an arrangement that permits employees to work a fewer number of hours during a workweek. Part-time arrangements are often created in situations in which employees have established job-sharing opportunities.

Advantages and Disadvantages of Nontraditional Work Scheduling Options

Employers and employees can reap many benefits from nontraditional work scheduling options. These alternatives help accommodate working parents and employees caring for their elderly parents by giving them time during a regular workweek to attend to personal, childcare or eldercare issues. These options can also save a great deal of time for employees by alleviating commuting and traffic problems. Furthermore, they can increase employee productivity and morale while decreasing stress and absenteeism. For example, employees who feel poorly may be able to work from home, with the added benefit that they're less likely to make others in the workplace ill.

² This study can be found at www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/pages/national-study-of-employers.aspx.

Nontraditional work scheduling options can decrease the real estate, parking and overhead costs to an employer. Nontraditional arrangements may also facilitate business continuity in the event the weather or technical outages prevent employees from getting to the office. In addition, they may help an employer increase diversity and inclusion by accommodating caregivers, disabled individuals, and those who need flexibility for religious observances. Most importantly, these alternative work scheduling options can be helpful in recruiting new talent and increasing retention of valuable employees.

Although many employers and employees benefit from nontraditional work scheduling options, there are also a number of potential drawbacks to these options. For example, a lack of continuity may arise between employees and employers. Supervisors may find it difficult to monitor the actions and performance of the individuals they supervise. Off-site use of employer-provided computer equipment creates potential insurance issues with respect to lost or stolen equipment, as well as potential tax issues. Off-site mechanical breakdowns may cause serious delays that jeopardize the completion of important job tasks. Employers also need to be certain that security protocols are sufficient to protect sensitive data that is used or maintained off-site or transmitted to or from an off-site location. Key individuals may be unavailable at certain times because of their unusual schedules, and employers may be understaffed. Additionally, the non-labor costs of longer hours of operation and additional off-site equipment may increase with these scheduling options.

Legal Implications of Nontraditional Work Scheduling Options

Although it is important for employers to consider the potential benefits and disadvantages of the aforementioned scheduling alternatives, it is also important for employers to understand how the law treats such options. Flextime, part-time and telecommuting arrangements raise many legal issues. These issues may be related to the Americans with Disabilities Act of 1990 (ADA) and the Family and Medical Leave Act of 1993 (FMLA), as well as wage and hour, worker's compensation, confidentiality and privacy, intellectual property, employee theft, general anti-discrimination and general liability laws, all of which are discussed in the following sections. In addition to these labor and employment law issues, telecommuting arrangements may create a state tax withholding obligation for the employer in the employee's home state. To help avoid potential liability under these laws, including potential state tax liability, employers should implement and communicate clear policies and guidelines regarding any nontraditional work scheduling arrangements offered.

Americans with Disabilities Act of 1990 (ADA), ADA Amendments Act of 2008 (ADAAA)

The ADA, as amended by the ADAAA, requires an employer to make reasonable accommodations to qualified individuals with disabilities as defined under the ADA as long as the accommodation does not cause an undue hardship to the employer. The ADA defines "reasonable accommodations" to include part-time or modified work schedules. Accordingly, employers must be aware that a qualified employee with a disability may be entitled to work part-time or on a flextime basis unless this would cause the employer an undue hardship. Additionally, employees may seek telecommuting arrangements as a form of reasonable accommodation. Although allowing an employee to work from home is not specifically addressed by the text of the ADA, both the EEOC and several courts have taken the position that where work is performed is another policy that may have to be modified for some jobs. Obviously, there are many jobs that simply cannot be performed from home; nevertheless, an employer must make an individualized assessment as to whether telecommuting would be a reasonable accommodation.

Wage and Hour Laws

An employer is responsible for recording and paying a non-exempt employee for actual time worked as well as for retaining such time records for the employee. Of course, this becomes more difficult when the employee is not at the workplace. Accordingly, employers should only enter into alternative scheduling arrangements (particularly telecommuting) with those employees whom it feels will act responsibly in reporting actual time worked. Telecommuting employees should be required to track and record their actual work time on a daily basis and report such time weekly. The employer's policies and guidelines should require prior approval before overtime is worked.

If the employee is an exempt employee under the Fair Labor Standards Act (FLSA), the employer should be careful not to inadvertently transform a telecommuter's exempt status to non-exempt. The employer should make sure that the exempt telecommuter's job responsibilities continue to include the same independence and decision-making authority that the employee had prior to the telecommuting arrangement. Furthermore, the employer should ensure that the employee's salary is not subject to reduction because of variation in the quality or the quantity of the work performed. Under the FLSA, an exempt employee's salary may be reduced if he or she switches to a part-time schedule, but a part-time employee must still be paid the required minimum salary to qualify for exempt status.

At-Will Employment Status

Employers also need to ensure that the telecommuting agreement cannot be construed as altering an employee's at-will status. Language should be included that states that participation in the telecommuting agreement is voluntary and can be terminated by either party at any time, with or without cause. The telecommuting agreement should further state that the agreement is not an employment agreement and that all terms and conditions of the employee's employment with the company remain the same (including the employee's salary, pension, benefits and insurance).

Worker's Compensation

As discussed in Chapter 7, the Indiana Worker's Compensation Act provides that a covered employer must pay and a covered employee must accept compensation as provided by the Act for personal injury or death by accident arising out of and in the course of employment. This law also applies to part-time employees when their employment is in the usual course of the trade, business, occupation or profession of their employer. Telecommuting, on the other hand, may increase the employer's exposure to worker's compensation issues because the employer is unable to supervise the alternative workplace. Telecommuting will challenge the employer's investigation and determination of injuries occurring within the scope of employment, which would be covered by worker's compensation. Moreover, the employer must place more reliance on the telecommuter to keep the designated work area safe and to report accidents accurately in situations where there are no witnesses or supervisors present.

Consequently, an employer should establish clear guidelines in its telecommuting policy requiring the employee to maintain a clean, safe and dedicated workspace and specifying procedures for immediately reporting injuries. An employer may want to include a clause that allows a supervisor or other representative of the company to inspect the work area throughout the term of the telecommuting agreement to ensure compliance.

Family and Medical Leave Act of 1993 (FMLA)

The Family and Medical Leave Act (FMLA), which is discussed in more detail in Chapter 8, allows eligible employees to take leave from work for family or medical reasons. The FMLA allows up to 12 weeks of leave during any 12-month period (up to 26 weeks of leave to care for a servicemember with a serious illness or injury). Employees (both full-time and part-time) are eligible for FMLA leave if they have worked at least 1,250 hours during the 12 months prior to commencing the leave. Consequently, employers need to be vigilant in tracking the number of hours worked by part-time employees.

Insurance and Liability

An employer should review its insurance policies to determine whether equipment used by a telecommuter in his or her home is covered in the event of a loss. The employer may also want to consider requiring the telecommuter to show proof of coverage for such loss under a homeowner's or renter's insurance policy. An employer's common general liability insurance generally covers bodily injury and property damage claims, including losses arising out of personal injury. If the telecommuter is using employer-provided equipment, it should be covered by first-party property insurance or an off-premises endorsement.

Furthermore, a telecommuter's use of his or her home for business purposes may change the status of individuals visiting the property from social guests to business invitees, thereby creating potential liability for both the employer and the employee. For example, a telecommuter may attempt to seek reimbursement for accidents occurring on the employee's premises; however, early court decisions on this subject have dismissed personal injury claims against employers by noting that the telecommuter's home was still residential rather than commercial.

Accordingly, an employer's telecommuting agreement and policy manual should set forth clear terms for insurance coverage. The employer may require the employee to show proof of insurance coverage before accepting a telecommuting agreement. The documents should further state that the employer is not liable for any injuries or damages to persons or property sustained by family members or third parties and that all business meetings should be held at the workplace.

Confidentiality and Privacy

A telecommuter may necessarily have access to confidential computer files, trade secret information and copies of confidential documents in his or her home. In order to protect this material, the employer's telecommuting agreement should require confidentiality of the documents and security measures that must be taken (e.g., keeping the files locked and out of sight of third parties) to ensure maintenance of the desired level of confidentiality. The agreement should also state that, upon a telecommuter's termination of employment, the employee is responsible for returning all employer documents (including documents that may be stored on the employee's personal computer if the employer did not provide the employee with equipment) and that the employee is prevented from future access to the employer's confidential materials.

The telecommuter's use of email, voicemail and the internet raises concerns regarding abuses of these services. For example, improper use of these services could result in claims of defamation, retaliation, sexual harassment and/or discrimination against the employer and the individual. In the traditional workplace, employers often monitor these services; however, it is important for employers to be aware that state and federal laws (e.g., the Electronic Communications Privacy Act of 1968) regulate the intentional interception of electronic communications. The courts have generally held that an employer has the right to monitor

email and voicemail if the employee has consented to such monitoring; the employee would therefore not have a reasonable expectation of privacy in the communication.

The employer's ability to monitor these services nonetheless raises litigation concerns. Saved email and voicemail communications may provide a plaintiff with a "smoking gun" in harassment, discrimination and product liability claims. Employees tend to communicate more freely with these services, because they have the misconception that these communications disappear when email or voicemail is erased. Furthermore, litigation document requests that include electronic communications would potentially encompass workstations of telecommuters (if they contain files or communications responsive to the request).

Copyright and Trade Secrets

Some employers should consider including guidance with respect to intellectual property in their telecommuting policies and procedures. Employers should expressly require employees to assign any rights to intellectual property developed during employment (including time in which the employee is telecommuting) and related to the business of the company. Employers will thereby eliminate an employee's ownership claim to an invention that the employee created while telecommuting (alleging that it was developed on the employee's "own time").

The lack of on-site supervision and control associated with telecommuting presents greater challenges to an employer faced with verifying an employee's use of employer resources to develop an invention, whether the invention or work was created during work hours, and the relationship of the invention or work to the employer's business. Accordingly, an employer should monitor the use of its equipment and the work performed by the telecommuter.

The use of electronic information systems and networks "off-site" also presents problems for companies attempting to protect trade secrets and confidential information. Employees have the ability to access, reproduce and distribute an employer's proprietary information, data and resources. An employer should implement security on both its internal and external network systems in order to prevent the disclosure of confidential information, either inadvertently or otherwise. Measures should be taken to protect computer equipment used off-site from viruses, hackers and other security problems. Employees should be instructed on the proper retention and storage of company information and data so as to prevent unauthorized access. If the telecommuter is not given a company computer to use, the employer should also be concerned with how it will obtain access to any company proprietary data that is stored where the company may be denied access. Accordingly, the employer should include language in the telecommuting agreement that allows it access to obtain company property upon the termination of the telecommuter's employment.

Miscellaneous Legal Issues

In general, ERISA provides that an employee who works more than 1,000 hours a year must be given the opportunity to participate in any retirement plan that the employer offers. Under ERISA, therefore, company-sponsored retirement plans should allow part-time employees working approximately 20 hours per week to participate.

Not surprisingly, the coverage of the federal anti-discrimination statutes (Title VII, ADEA and ADA) does not change merely because employees work nontraditional schedules. Employers utilizing these nontraditional work schedules need to grant or deny these options to employees in a nondiscriminatory manner. For example, some plaintiffs have asserted that they have been assigned part-time schedules and reduced hours

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because of age, sex, race or disability status. Therefore, reducing the hours of an employee's job to part time can potentially raise an inference of discrimination, just as making part-time schedules available to select groups of employees may do the same.

State Payroll Taxes Withholding

Telecommuting can trigger unique payroll tax issues for employers as well. Generally, state unemployment tax and state income tax, collectively known as payroll taxes, are withheld from wages of employees from the state where the work is performed. A telecommuting arrangement allowing an employee to work either at home or in a telecommuting center or mobile office may create a business presence (known as nexus) for their employers that are not residents of the employee's home state or the state where the telecommuting center or mobile office is located. If there is sufficient nexus between the nonresident employer and the employee, telecommuting center or mobile office's home state, that employer may be required to withhold state payroll taxes from the wages of their employee. In other words, for an Indiana employer with employees who live in Ohio, Michigan, Illinois or Kentucky and normally cross over into Indiana to come to work, if those employees begin working from home, the employer may be deemed to have a business presence in that other state and be required to withhold state payroll taxes from the employees wages for that other state.

Whenever the employer has employees working at home or off-site from another state, the employer should examine the state tax laws of the home state to determine if there is a withholding obligation due to the telecommuting arrangement. Some states may provide nexus relief for telecommuting arrangements that are required because of a health crisis such as the COVID-19 pandemic. If an employer determines that it has a state withholding requirement but fails to comply, the employer may be subject to penalties and interest for failure to withhold payroll taxes.

Conclusion

Today, employers have the option of letting employees adopt any of a number of nontraditional work schedules, including part-time, flextime and telecommuting arrangements. While these options may present an employer with certain benefits, they may also expose the employer to a variety of potential problems. Thus, before allowing employees to adopt nontraditional work schedules, an employer should carefully review the points presented in the checklist on the following pages.

Nontraditional Work Scheduling Checklist

The following is a checklist of potential actions that employers should consider when drafting policies and guidelines concerning nontraditional work scheduling agreements.

- _____ Make sure the agreement is not an employment agreement and the employee retains at-will status.
- _____ Make sure the agreement does not alter the employee's terms or conditions of employment.
- _____ Include a statement that nontraditional work scheduling is not a benefit, and employees are not entitled to such an arrangement.
- _____ Be sure to state the duration of the agreement.
- _____ Spell out the employer's and the employee's right to terminate the arrangement and return the employee to the original work schedule.
- _____ Include a description of the employee's job duties/responsibilities.
- _____ State the hours that the employee is required to work off site and/or on site. The employer and employee should agree upon a set of core office hours during the day in which supervisors and coworkers can communicate with the employee.
- _____ Determine the employee's frequency and method of reporting to his or her supervisor.
- _____ Set forth the events, meetings and hours that the employee is required to be present.
- _____ Specify the requirement that all meetings take place at the office rather than at telecommuter's home.
- _____ State that overtime must be approved in advance (for non-exempt employees).
- _____ Specify that participation and the employee's performance are subject to review, subject to renewal and may be terminated at any time. Specify any applicable time frames.
- _____ State whether the employer will provide office equipment, the type of equipment that will be provided (if applicable) and whether the employee will be reimbursed for office supplies.

Nontraditional Work Scheduling Checklist (continued)

- _____ State that company equipment is strictly for business use and remains company property that must be returned upon termination of the agreement.
- _____ If the company does not provide equipment, clarify that the employer retains the right to reclaim all company information from the employee's premises (including access to the employee's computer on which company information or documents may be stored).
- _____ State that the employee is responsible for any tax consequences of the arrangement.
- _____ State that the employee is responsible for retaining proper insurance and providing proof thereof.
- _____ State that a safe work environment is the employee's responsibility.
- _____ State that all work injuries occurring off site should be reported immediately.
- _____ Include a company disclaimer of liability for loss, theft or damage to company-provided equipment and for property damage/personal injuries.
- _____ Warn that company information should be kept confidential and that company procedures for doing such should be followed.
- _____ Explain that the employer is indemnified for any negligent acts committed by the employee.
- _____ Explain that the employer has the right to inspect the home worksite during business hours.
- _____ Determine whether employer has a state payroll withholding tax obligation for any other states due to telecommuting arrangement.

The employer may also want to restate its harassment policy in these scheduling arrangements and the guidelines it will use in selecting candidates for the arrangements. Employers may want to consult this checklist when considering offering a nontraditional scheduling opportunity to an employee or group of employees as it develops the parameters of part-time, flextime or telecommuting employment relationships.

Chapter 10

Nontaxable Fringe Benefits

Many employers provide employees with various “fringe” benefits. These benefits are provided to employees free of charge and, if certain requirements are met, are not subject to income tax. This chapter discusses the general requirements that must be satisfied in order for an employer to exclude the value of certain fringe benefits from an employee’s gross income under Internal Revenue Code Section 132 (“the Code”). The Tax Cuts and Jobs Act of 2017 (TCJA) eliminated or suspended exclusions for some fringe benefits. In addition, this chapter identifies certain exclusions and other special rules with respect to withholding and nondiscrimination.

In general, the Code provides that an individual’s gross income includes all income from whatever source derived, including the value of any fringe benefits that an employee receives from his or her employer. An exception to this general rule provides that gross income shall not include any fringe benefit that qualifies as one of the following:

- No-additional-cost service
- Qualified employee discount
- Working condition fringe benefit
- De minimis fringe benefit
- Qualified transportation fringe benefit
- Qualified moving expense reimbursement (Note that the TCJA suspended this exclusion for tax years 2018-2025.)
- Qualified retirement planning service
- Qualified military base realignment and closure payment

The Code defines each of these terms, as discussed in more detail in this chapter. In addition, the Code excludes from an employee’s gross income any other fringe benefit as to which the Code grants special tax treatment.

No-Additional-Cost Services

A no-additional-cost service is defined as a service provided to an employee for which the employer does not incur “substantial additional cost.” The Code traditionally excludes the value of these services from an employee’s gross income based on the theory that the employee is using excess capacity of the employer that would otherwise go unused. Examples of costs determined to be “not substantial” for purposes of this exclusion include the costs of fuel and in-flight meals provided to airline employees under no-cost or low-cost space-available travel.

For a service to qualify for this exclusion, it must be offered to customers in the ordinary course of the line of business of the employer in which the employee performs substantial services. For example, an employer that owns both an airline and a hotel chain is generally prevented from offering free hotel accommodations to its airline employees unless the airline employees also provide substantial services with respect to hotel

operations. Also, if an employer sells its products or services primarily to employees rather than customers, the line of business requirement is not met, and the exclusion will not apply.

Special definitions of the terms “employee,” “employer” and “line of business,” as well as special nondiscrimination rules, are included in the regulations. A special rule also applies with respect to reciprocal agreements under which certain services provided to employees of other employers may be excluded.

Qualified Employee Discounts

An employee discount is the excess of the price at which property or services are offered by an employer for sale to its customers over the price at which such property or services are offered to an employee. “Qualified” employee discounts—with the exception of discounts on real property, investment property and property or services that are not offered for sale to customers in the ordinary line of business of the employer—are excluded from an employee’s gross income. For services, a qualified employee discount cannot exceed 20% of the price at which the service is offered to customers. For products or merchandise, a qualified employee discount cannot exceed the employer’s gross profit percentage. Gross profit percentage is determined separately for each line of business of the employer and is generally defined, using a representative time period, as the excess of the aggregate sales price of products sold to non-employee customers over the aggregate cost of such property, divided by the aggregate sales price. Detailed nondiscrimination rules apply, as do rules regarding how to determine the aggregate sales price, the effect of quantity discounts offered by the employer, and the employer’s applicable line of business. If an employee discount exceeds the applicable limitation, the excess discount is included in the employee’s income unless it is excludable under another Code provision.

Working Condition Fringe Benefits

The Code provides that an employer may exclude the value of a working condition fringe benefit from an employee’s gross income. A “working condition fringe benefit” is a property or service that is provided to an employee for free, if the employee could have deducted any payment for such property or service as an ordinary and necessary business expense (or depreciated the payment if the item was a capital expenditure).

In general, an employee’s ability to deduct or depreciate the value of such property or service based on personal circumstances is not determinative for purposes of excluding its value as a working condition fringe benefit. Instead, it is the character of the property or services (i.e., whether it is eligible for deduction or depreciation) that determines its excludability from the employee’s gross income. In addition, if a payment for property or services would be an allowable deduction for an employee’s trade or business (other than the employee’s trade or business of being an employee of the employer), the employee cannot exclude the payment as a working condition fringe benefit. For example, if a company pays the travel expenses for one of its executives to attend a board meeting of another company as a director of that other company, the company could not exclude the expenses from the executive’s gross income as a working condition fringe benefit because the expenses are not incurred in connection with the trade or business of the first company. However, if a business relationship exists between the companies such that the executive attends the board meeting in his capacity as an employee of the first company, the executive would be able to exclude the cost of the travel expenses as a working condition fringe benefit.

If a benefit provided to an employee satisfies the requirements set forth above, the employer generally can exclude the value of such benefit from the employee’s gross income. Additional requirements that must be satisfied with respect to certain working condition fringe benefits are set forth in the following sections.

Employer-Provided Transportation

As a general rule, an employer may exclude the value of a company vehicle (including company cars, trucks and other land transportation provided to an employee) from the employee's gross income to the extent that the vehicle is used for business purposes. Incidental personal use of a company-provided vehicle, not including commuting expenses related to travel between an employee's residence and the business location, is generally excluded as a de minimis fringe benefit, as discussed later in this chapter. An employer who provides a vehicle to an employee may include the full value of the vehicle on an employee's W-2 or only include the employee's personal use of the vehicle on the employee's W-2. An employee may be able to deduct from income the value of the business use of the provided vehicle from the full value included in the employee's W-2. However, if the employee's personal use of an employer-provided vehicle is significant, the exclusion from income of the value of the business use of the vehicle requires detailed recordkeeping, which generally mandates a contemporaneous allocation between business-use miles and personal-use miles.

Special valuation rules may simplify allocation and accounting with respect to the personal use of an employer-provided vehicle. For example, if an employer requires reimbursement from an employee for the personal use of a company-provided vehicle and if the employer and employee both use the special valuation rules for determining the value of the benefit and the amount of reimbursement, an employer may be entitled to exclude the entire value of the benefit from the employee's gross income. Special detailed rules also apply in the event that an employee is required to use a company-provided vehicle for commuting purposes.

There are additional rules that apply to certain types of employer-provided vehicles. If the mode of transportation is a qualified non-personal-use vehicle, including fire engines, clearly marked police vehicles, school buses and ambulances, an employee can exclude the value of the vehicle from gross income as a working condition fringe benefit without having to substantiate the business use. If an employee uses an employer-provided airplane, an employee does not realize income when the aircraft is used in the discharge of employment duties because this is a working condition. However, any personal use of an employer's airplane usually will be taxable to the employee, subject to special rules and requirements.

Employer-Provided Cell Phones

The value of an employer-provided cell phone can be excluded from an employee's taxable income as a working condition fringe benefit if the cell phone is provided primarily for noncompensatory business reasons. If the employer provides the cell phone primarily for noncompensatory business reasons, the employee's personal use of the cell phone is also excludable as a de minimis benefit. A cell phone is provided for a noncompensatory business purpose if there are substantial business reasons for providing the cell phone. Examples of substantial business reasons include the following:

- The employer's need to contact the employee at all times for work-related emergencies
- The employer's requirement that the employee be available to speak with clients at times when the employee is away from the office
- The employee's need to talk with clients at times outside the employee's normal workday because the clients are located in other time zones

An employer-provided cell phone must be included in the employee's taxable income if not provided primarily for noncompensatory business reasons. For example, an employer-provided cell phone is included

in the employee's wages if it is provided to promote goodwill, boost morale, attract a prospective employee or provide additional compensation to an employee.

Office Decor and Administrative Support

Employers generally may exclude the value of attractive or well-appointed office facilities and other administrative items from an employee's gross income as a working condition fringe benefit. The value of such items often can be excluded as a de minimis fringe benefit as well. Because of the potential for abuse, the Internal Revenue Service monitors such exclusions closely. For example, the IRS has ruled that a "tool allowance" paid pursuant to a union contract where the company furnished company tools and equipment to employees who wanted them was taxable income to the employees.

Employer-Provided Home Computer Equipment

Many employers provide portable computers and other related equipment to employees in order to enable employees to work from home. The TCJA provided that the IRS will treat the employee's use of employer-provided computer equipment for reasons related to the employer's trade or business as a working condition fringe benefit, the value of which is excludable from the taxable wages. Any personal use of the employer-provided computer equipment will be treated as a de minimis fringe benefit, excludable from the employee's taxable wages. The employer should be clear that the property must be returned to the employer when no longer used by the employee for primarily business purposes.

Professional Memberships, Dues and Publications

Generally, an employer may exclude the costs related to attendance at professional meetings and training sessions, memberships in professional organizations, and publications in trade literature from an employee's gross income as working condition fringe benefits. In contrast, employers generally cannot exclude social or country club dues or dues to any other organization whose principal purpose, based on its activities, is to conduct entertainment activities for members or their guests or to provide members or their guests with access to entertainment facilities.

Educational Assistance

An employer may exclude the value of certain job-related employer-provided educational assistance from an employee's gross income as a working condition fringe benefit to the extent that such amounts exceed the dollar limitations applicable to educational assistance plans. Educational assistance plans are discussed in greater detail in Chapter 11.

Expenditures for education can be considered a non-taxable working condition fringe benefit only if the education:

- maintains or improves skills needed in the employee's job; or
- is required by the employer or by law for the employee to keep his or her present salary, status or job.

Even if the education meets one of the tests above, it will not qualify as a working condition fringe benefit if it is needed to meet minimum educational requirements for the employee's current position or to qualify the employee for a new trade or business.

Security Arrangements

Employers may exclude from income the value of employer-provided home or office security arrangements for the benefit of an employee or the employee's spouse and dependents. Special rules apply with respect to the use of employer vehicles or airplanes to provide security while traveling. These rules generally require that the employer establish both of the following:

- A genuine, business-related security concern
- A 24-hour security program that meets detailed requirements set forth in the regulations

Additional special rules apply with respect to the amount and valuation of such expenses that may be excluded from the employee's gross income. Security arrangements may only be excluded from income if a bona fide business-oriented security concern exists.

Consumer Product Testing Programs

Detailed rules apply with respect to products provided to an employee pursuant to a consumer product testing program. These rules generally permit the value of such products to be excluded from an employee's gross income if each of the six general requirements set forth below is satisfied:

1. Consumer testing and evaluation is an ordinary and necessary business expense of the employer and the costs of such a program are reasonable with respect to its benefits
2. Business reasons necessitate that the testing be performed away from the employer's business premises
3. The employer must furnish the product to the employee for purposes of testing and evaluation and must not furnish it exclusively to highly compensated employees unless a business reason exists for only providing the product or service to a specific group of employees
4. The employee must return the product to the employer at the conclusion of the evaluation period, which must be a reasonable length of time with respect to the product being tested
5. The employer must limit the employee's use of the product in order to significantly reduce the value of any personal benefit to the employee
6. The employee must submit detailed reports with respect to testing and evaluation, and the employer must compile and analyze these reports within a reasonable amount of time

Travel and Entertainment Reimbursements

Generally, an employer may exclude from the employee's gross income the full amount of an employee's travel and entertainment expenses without regard to the employer's ability to deduct expenses of this type. The TJCA eliminated some deductions for entertainment expenses as a business expense for employers. Reimbursed business lunches are still deductible business expenses at 50% but entertainment experiences provided to clients and customers are no longer deductible. Entertainment for the benefit of employees, such as office holiday parties or company picnics, unless limited to highly compensated employees, is still a 100% deductible expense. Notwithstanding the employer's deductibility of the travel and entertainment expenses, the exclusion from an employee's gross income is available to the extent that such expenses are:

- actually paid or incurred by the employee;
- sufficiently documented; and
- provided to the employee pursuant to an "accountable" reimbursement plan.

Spouse and Dependent Travel

Generally, payment by an employer of the costs related to travel by a spouse, dependent or friend with an employee on a business trip results in income to the employee unless:

- the accompanying person is also an employee of the same employer;
- the accompanying person's travel is for a genuine business purpose; or
- the travel expenses would otherwise be deductible by the accompanying person.

Outplacement Services

Outplacement services include programs that are designed to assist employees in finding other employment in connection with termination from the employer's services, such as career counseling, seminars and use of office equipment. Generally, an employer can exclude the value of outplacement services from an employee's gross income as a working condition fringe benefit, provided that:

- the employer derives a "substantial business benefit" from providing the services; and
- the employee is not offered a choice to receive cash payments in lieu of outplacement services.

A "substantial business benefit" may include promoting a positive corporate image, maintaining corporate morale, decreasing the likelihood of wrongful termination suits, fostering a positive work atmosphere and attracting quality employees.

Cash Payments

Cash payments from an employer to an employee (e.g., per diem "allowances") do not qualify as working condition fringe benefits unless the employer requires the employee to:

- use the payment for expenditures that are otherwise deductible as a business expense or a depreciation expense to the employee;
- confirm that the payments are actually used for such expenses (according to rules that are similar to employee business expense reporting requirements); and
- return any unused portion of the payment to the employer.

Excluded Benefits

Under the regulations, flexible spending accounts and physical examination programs do not qualify as working condition fringe benefits. (Note that a flexible spending account refers to an agreement, written or oral, between an employer and an employee whereby a certain level of unspecified non-cash benefits with a predetermined cash value are made available to the employee over a predetermined time period.) However, such programs may be excluded from an employee's gross income under other Code provisions. (For a discussion of flexible spending accounts, see Chapter 4 regarding Section 125 "cafeteria" plans.)

De Minimis Fringe Benefits

Generally, property or services provided to an employee may qualify as de minimis fringe benefits and can be excluded from the employee's income if the fair market value of the property or services is so small

that accounting for the property or services would be unreasonable or administratively impractical. The frequency with which such benefits are provided with respect to each employee (as well as to the employer's entire workforce, if it is administratively impracticable to consider each employee) needs to be considered. In making such a determination, the regulations also require that the property itself be the benefit, not cash to purchase such property. An employer's provision of cash (e.g., for theater tickets that would otherwise be de minimis fringe benefits) for purchase of the benefit will not be excludable as a de minimis fringe benefit. Special rules have been established with respect to specific benefits, some of which are discussed below.

Office Equipment and Support Staff

A special rule applies with respect to copy machines: If an employer restricts use of the equipment so that at least 85% is for business purposes, personal use in excess of 85% may be excluded from employees' income as a de minimis fringe benefit. Presumably, similar use criteria would apply for other office equipment, such as telephones, dictating equipment, calculators, computers (although some rules exist with respect to computers) and occasional utilization of office support staff, although such criteria are not currently contained in the Code or applicable regulations.

Meal Allowances and Taxi Fares

Generally, meals and taxi fares must be reasonable in amount and satisfy the following requirements in order to be excludable from the employee's gross income:

- The meals, meal money or taxi fare must be provided on an "occasional" basis (which is not defined in the Code)
- The meals, meal money or taxi fare must be provided to enable the employee to work overtime

A common issue with respect to such benefits is whether an employer provides such benefits on more than an "occasional" basis. The amount of this kind of benefit cannot be calculated based on extra hours worked.

Meals provided on the employer's business premises can be excluded from the employee's taxable wages if provided for the employer's convenience. To demonstrate the employer's convenience, an employer must have a substantially noncompensatory business reason for providing the meals. For example, meals can be excluded if provided during working hours so an employee is available for emergency calls during the meal period or if provided on-site for an employee who cannot be expected to eat elsewhere because the nature of his or her job restricts the employee to a short meal period (such as 30 or 45 minutes) or because there are insufficient eating facilities near the place of employment. Meals furnished to a restaurant or other food service employee during, or immediately before or after, the employee's working hours are furnished for the convenience of the employer and can be excluded. In addition to demonstrating a substantially noncompensatory business reason, the IRS requires employers to maintain recordkeeping to substantiate the employee meal expenses.

Commuting

If an otherwise excludable taxi trip involves commuting or is provided to a "control employee," complex special rules apply that may require including the value of the benefit in the employee's gross income. Generally, a private sector "control employee" is defined as one of the following:

- A director

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- An officer or board member whose compensation exceeds \$50,000 (subject to cost-of-living adjustments, i.e., \$115,000 in 2020)
- An employee whose compensation exceeds \$100,000 (subject to cost-of-living adjustments, i.e., \$230,000 in 2020)
- An owner of 1% or greater

There is a different method for this determination when dealing with government employees.

Office Social Functions

Although an employee does not realize gross income from the benefit of attending an occasional office function, such as an office holiday party, a company picnic or a staff meeting, an employer generally may deduct such expenses.

Gifts and Awards

Traditional gifts of low value (property other than cash) on holidays, birthdays or similar occasions (e.g., a Thanksgiving turkey) generally are treated as de minimis fringe benefits. Gifts based on employee achievement for either length of service or safety achievements are not de minimis fringe benefits and are governed by other sections of the Code.

Theater or Sports Tickets

Generally, theater or sports tickets are excluded from an employee's gross income if they are granted occasionally. Season tickets to either theatrical or sporting events, however, generally are not excluded because of the increased frequency of the benefit.

Employer-Provided Health or Athletic Facilities

Costs related to minor facilities for employee comfort, health and well-being (e.g., medical or first-aid facilities) are excluded from an employee's gross income. Use of an on-premises gym or other athletic facility by an employee or retiree, or their spouse or dependent children, can also be excluded if substantially all use of the facility is by employees, retirees, spouses and dependents.

Qualified Transportation Fringe Benefits

Subject to the maximum amounts identified below, the Code generally permits an employer to exclude from an employee's gross income qualified transportation fringe benefits including the following:

- The value of transportation in a commuter highway vehicle in connection with travel between the employee's residence and place of employment (e.g., van pooling)
- Transit passes
- Qualified parking

The aggregate amount excludable for the first two categories above is limited to \$270 per month (in 2020). An employer may also exclude up to \$270 per month for qualified parking expenses paid or incurred on behalf of an employee. Any amount spent in excess of these limitations is not excludable as either a working condition fringe benefit or a de minimis fringe benefit.

An employer may offer its employees the option of electing cash compensation in lieu of a qualified transportation fringe benefit and generally can provide such benefits either directly or pursuant to a reimbursement program (provided that the employer verifies that the employee has, in fact, incurred such expenses). An employer may not provide these benefits under a cash advance program.

The Code defines a “commuter highway vehicle” as a vehicle operated by or for an employer that seats at least six adults (in addition to the driver) where at least 80% of the mileage is reasonably expected to be used for transporting employees from their residence to the workplace (using at least one-half of the adult seating capacity of the vehicle). The value of transportation provided to an employee in such a vehicle is determined under one of several detailed methods provided in the regulations. A “transit pass” is defined as any pass, token, fare card, voucher or similar item that entitles a person to transportation if such transportation is either on mass transit facilities or provided by a person for hire in a vehicle that seats at least six adults in addition to the driver.

For an employee, the aggregate value that may be excluded from that person’s gross income for commuting in an employer-provided commuter highway vehicle and for transit passes is limited to \$270 per month beginning in 2020. If the aggregate benefits paid or incurred on behalf of an employee exceed \$270, only the excess is included in the employee’s gross income.

Generally, the tax treatment of the working condition fringe benefits for an independent contractor is similar to the tax treatment for employees. However, an employer may only provide qualified transportation fringe benefits to individuals who are currently employees of the employer.

“Qualified parking” is defined as parking provided to an employee that is either on or near the business premises of the employer or at a location from which the employee can commute to work (including commuting by carpool, commuter highway vehicle, mass transit facilities or transportation provided by any person in the business of transporting persons for compensation or hire). Parking on or near property used by the employee for residential purposes is not qualified parking.

Qualified Retirement Planning Services

An employer that provides qualified retirement planning services to an employee and his or her spouse can exclude the value of such services from the employee’s income. The term “qualified retirement planning services” means any retirement planning advice or information provided to an employee and his or her spouse by an employer maintaining a qualified plan. A qualified plan includes a 401(k) plan, governmental plans, certain annuity contracts, SEPs and SIMPLE retirement accounts. Services that qualify for exclusion include advice or information regarding retirement planning in general and how an employer’s plan may complement an employee’s overall retirement income plan. General financial services that may be related to retirement planning, such as accounting, tax preparation and legal services, are not excludable. Detailed nondiscrimination requirements apply. (See the discussion regarding nondiscrimination rules set forth later in the chapter).

Qualified Military Base Realignment and Closure Payments

Payments made by an employer to compensate military personnel and certain civilian employees for a reduction in the fair market value of their homes resulting from a military base closure or realignment generally are excludable from an employee's gross income, within certain limitations. This exclusion only applies to payments made after November 11, 2003 that are disbursed pursuant to the Department of Defense Homeowners Assistance Program.

Other Rules Regarding Fringe Benefits

No matter what form they take, all fringe benefits are subject to certain additional rules. Several rules of particular importance relate to withholding and nondiscrimination.

Withholding

All fringe benefits that are not expressly excluded from an employee's gross income are subject to income tax withholding and employment taxes under the Federal Insurance Contributions Act (FICA) and Federal Unemployment Tax Act (FUTA). For withholding and tax deposit purposes, an employer may elect to treat most non-cash fringe benefits as paid on a pay period, quarter, semiannual annual or other basis, as long as benefits are treated as paid no less frequently than annually and all benefits provided in a calendar year are treated as paid no later than December 31 of that calendar year. In addition, the Code (as well as related regulations and administrative pronouncements) generally permits employers to withhold from fringe benefit income at either the employee's regular withholding rate or the special 25% flat rate (37% for payments to an individual exceeding \$1 million during the year) applicable to supplemental wages (e.g., bonuses and other extraordinary payments).

Nondiscrimination Rules

To be excludable from income, certain benefits are subject to special nondiscrimination rules, which generally require that an employer not provide such benefits exclusively to highly compensated employees. When nondiscrimination rules apply, employers must either offer the benefits to all employees or offer them to each member of a group that is both a reasonable and nondiscriminatory classification of employees.

Nondiscrimination rules generally apply with respect to exclusions for no-additional-cost services, qualified employee discounts and qualified retirement planning services. Working condition fringe benefits, de minimis fringe benefits, qualified transportation fringe benefits and qualified moving expense reimbursements generally are not subject to nondiscrimination rules, with the exception of consumer product testing programs and employer-provided cafeterias and dining rooms.

Definitions

Many terms relating to the tax treatment of fringe benefits are specially defined under the Code and related regulations. Some of these are set forth below.

Recipient

A “recipient” is the person who performs the services for which the fringe benefit is furnished. Recipients need not be employees and generally include partners, directors and independent contractors. The term generally does not include shareholders.

Employee

The regulations provide a special definition of employee, which adopts neither common law nor state law definitions and which varies in scope with the particular fringe benefit provided. In addition to current employees, the definition generally includes former employees separated by reason of retirement or disability and their respective surviving spouses.

Spouses and dependent children are treated as employees for purposes of no-additional-cost services, qualified employee discounts, employer athletic facilities and qualified employer security expenditures (but not for most other working condition fringe benefits). For the most part, parents are not treated as employees, except under a special rule with respect to no-additional-cost services provided to parents of airline company employees. A former employee who is retired or left on disability, a widow or widower of an individual who died while an employee or while retired or who left on disability, or certain leased employees are considered employees for purposes of no-additional-cost services.

If a partner performs services for a partnership, the partner generally is treated as an employee except for purposes of the qualified transportation fringe benefit exclusion.

In general, independent contractors are entitled to exclude de minimis fringe benefits and most working condition fringe benefits.

Corporate directors generally may exclude working condition fringe benefits (including parking provided other than as qualified transportation) and de minimis fringe benefits. However, directors are not entitled to the working condition fringe benefit exclusion for qualified consumer product testing.

A volunteer who performs services for a tax-exempt organization or governmental entity generally is entitled to an exclusion for working condition fringe benefits if the value of the fringe benefits provided to the volunteer is substantially less than the value of the services provided by the volunteer. Special rules apply to volunteers in organizations other than those previously mentioned.

Employer

The term “employer” generally includes corporations that are members of a “controlled group” and unincorporated trades or businesses of a partnership, LLC or proprietorship that are under “common control” as those terms are specifically defined in the regulations.

Line of Business

Detailed and extensive regulations apply with respect to line of business limitations (e.g., for no-additional-cost services and qualified employee discounts). In general, these benefits must be of the same type as the goods or services ordinarily offered by the employer, but special rules and exceptions apply.

Conclusion

Unless properly excluded from an employee's gross income, an employer must include in the employee's gross income the fair market value of a fringe benefit that is in excess of the amount (if any) paid by an employee for that benefit. These guidelines are intended for general purposes, only to assist employers who are considering whether to extend certain fringe benefits to their employees. Both employer and employee taxpayers are urged to consult their personal tax return preparers and other legal advisors with respect to their personal circumstances and the tax treatment of the fringe benefits discussed herein.

Chapter 11

Quality of Life Benefits

Frequently, employers are looking for new ways to enhance an already rich benefit package in order to attract and retain valued employees. Particularly in highly competitive employment markets, employers are developing and offering nontraditional benefits often aimed at improving their employees' quality of life. These benefits go beyond the standard employee cafeterias, amusement park passes and movie tickets, taking the form of more imaginative benefits such as childcare facilities, gym memberships, in-office massages, concierge services and family counseling. During times of low unemployment, unique employee benefits may explain why some employers keep employee turnover rates in the single digits. Even during more difficult economic times, these benefits go a long way in establishing a company's culture and demonstrating the value employers place on creating and maintaining a satisfied workforce – in some cases without a significant cost to the employer. The purpose of this chapter is to provide employers with some ideas for creative ways to enhance their traditional employee benefit offerings.

Increase Voluntary Benefits

One of the simplest and least expensive ways for employers to improve the variety of benefits offered is to increase voluntary benefit options for employees. In addition to some of the voluntary benefit options discussed in Chapter 3 and Chapter 4, employers may consider extending the following voluntary benefits on a fully insured, employee-pay-all basis:

- Long-term care insurance
- Homeowner's or automobile insurance
- Prepaid legal insurance
- Property and casualty insurance
- Critical illness or hospital indemnity insurance
- Pet health insurance

Although employees must pay the premiums associated with these benefits with after-tax dollars, they may do so through payroll deduction. In addition, they will receive the advantage of a lower group premium rate. By evaluating, selecting and communicating with employees regarding vendors of these insured programs, employers provide a valuable service to employees in addition to the benefit itself.

Family-Friendly Workplace

One concept that is gaining popularity is the "family-friendly" workplace. Employers may strive to achieve a reputation of providing a family-friendly workplace by enhancing some of their existing benefit programs. For example, an employer might increase the medical benefits payable for the birth of a child by eliminating employees' out-of-pocket expenses or increasing the number of days of a hospital stay that the health plan will cover. Another way an employer might enhance an existing program would be to provide for maternity or paternity leave beyond the 12-week minimum required by the FMLA or to provide that some or all of the leave be paid leave.

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Other ideas for achieving a family-friendly work environment include the following concepts:

- On-site childcare facilities
- Flextime for employees of all ages, particularly those going on or returning from maternity, paternity or other FMLA leave and those phasing into retirement
- Providing highchairs in the employee cafeteria
- Nanny locator services
- Adoption benefits (which can be provided tax-free and are discussed in detail in Chapter 4)
- Family counseling
- Childcare and elder care assistance, including plans to allow employees to pay expenses on a pre-tax basis, as well as back-up care, emergency care and sick care services for days when an employee's normal arrangements are not available.

Nursing Mothers

Employers are required to provide reasonable break times for an employee to express breast milk for her nursing child. Employers are also required to provide a private place, other than a toilet stall, that is shielded from view and free from intrusion from coworkers or the public where an employee can express breast milk. To the extent possible, the employer must also provide a refrigerator or other cold storage place for keeping milk that has been expressed or allow the employee to provide a portable cold storage device for keeping expressed milk cold until the end of the employee's work day.

These provisions are required for all Indiana private employers with 25 or more employees. Private employers with fewer than 25 employees are not subject to the requirement if compliance would impose an undue hardship. Governmental employers are required to reasonably comply with the requirements list above. In addition, for governmental employees, break times for expressing milk must be paid breaks, though they can run concurrently with other paid breaks, if possible.

Domestic Partner Benefits

Some employers have extended health, death and survivor benefits to same-sex and/or opposite-sex partners of their employees. Even though these benefits are increasingly common among very large employers, employers that choose to provide domestic partner benefits must develop detailed eligibility standards and carefully communicate the terms of the program. In addition, in many instances these benefits are not available on a tax-free basis and any premiums paid for these benefits must be paid with after-tax dollars, so employers will want to work closely with their legal and tax advisors to be sure to properly address all tax issues, including imputing income to employees for the value of benefits paid on behalf of any partner who is not the employee's tax dependent.

Focus on Wellness

Enhancing existing employee plans may provide a simple way to promote the health and wellness of employees. Benefits designed to help employees maintain a healthy lifestyle are gaining in popularity. These

wellness benefits may include the following:

- On-site fitness centers or personal trainers
- On-site, near-site, and shared-site health clinics
- On-site flu shots
- Subsidized health club memberships and exercise programs
- Stress management
- Nutrition counseling
- Health risk screenings
- Yoga classes
- In-office massages
- Basketball courts/gym rental
- Intramural sports teams
- Health plan premium discount programs
- Programs designed to encourage cessation of tobacco use

There are numerous legal requirements governing workplace wellness programs. Those requirements vary depending upon whether the program is an employment practice or a health plan. Any program linked to an employee group health plan, such as a premium discount or penalty, will be governed as an ERISA group health plan and subject to a variety of detailed requirements under ERISA, COBRA, HIPAA, GINA, the ADA, and the Affordable Care Act. Special rules apply to any program that links a health coverage discount or penalty to achieving any healthy status or performing any physical activity, most notably connected to tobacco or nicotine use. Special care must be taken when designing or implementing these types of programs.

For employers offering on-site health clinics, near-site or shared-site clinics, there are a variety of compliance rules to note. Assuming these clinics provide medical care services beyond first aid or emergency assistance, the clinic is both a medical provider subject to applicable state laws and an ERISA group health plan, subject to requirements under ERISA, COBRA, and HIPAA. In addition, if the employer sponsors a high deductible health plan (discussed in more detail in Chapter 2), it is important to note that any medical care provided at the employer-sponsored clinic other than preventive care should be subject to the regular deductible and co-pay requirements. Otherwise, if the employer provides non-preventive care at no cost, the clinic coverage will be deemed to be “other” health coverage that makes the employee ineligible to contribute to a health savings account.

Another trend that is gaining popularity is the integration of alternative health care coverage into health plans. Employers are increasingly covering chiropractic and other “alternative” treatments in response to employee requests. Employers wishing to promote the image of a healthy, vibrant workforce may consider including these types of benefits within their overall benefit plan structure.

Tuition Assistance

Employers can enhance their employee benefit package by offering benefits designed to encourage employees to further their education. As discussed in Chapter 10, the Internal Revenue Code currently allows employees to exclude from their taxable income job-related, employer-provided educational

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assistance as a working condition fringe benefit. In addition, employers can provide educational assistance to their employees on a tax-free basis under a qualified educational assistance program.

If an employer provides tuition assistance benefits in the form of a qualified educational assistance program, an employee may exclude up to \$5,250 per year of such benefits from his or her taxable income. Educational expenses that qualify for this exclusion include tuition, books, laboratory fees, supplies and equipment. Tools or supplies that an employee retains after completion of the course are not excludable, nor are meals, lodging or transportation. Educational assistance does not include courses involving sports, games or hobbies. The educational expense exclusion from gross income applies to reimbursement for educational expenses associated with undergraduate- and graduate-level courses, as well as courses taken in pursuit of a law, business, medical or other advanced degree. Although courses reimbursed under a qualified educational assistance program are not required to be job-related to qualify for tax-free treatment, an employer can design a more restrictive program that includes (or excludes) specific fields of study or types of courses.

Employers offering these benefits will want to be aware of special legal requirements that must be met for a program to be tax qualified, including a written plan document, notification to employees, and nondiscriminatory eligibility provisions. A qualified educational assistance program need not be funded, but it cannot provide employees with a choice between educational assistance and other pay. In addition, payments to certain shareholders and owners and their spouses and dependents are limited.

For a short period of time, it may be possible for employers to help employees pay some portion of their employee's student loan debt on a tax-free basis. For 2020 only, the CARES Act allows employers to use an educational assistance program to pay up to \$5,250 toward an employee's qualified education loans in 2020 and the payment can be excluded from an employee's income. Employers interested in offering these benefits should consider establishing an educational assistance program or expanding existing programs.

Financial Education

Beyond tuition assistance for formal education, many employers are providing their employees with financial education. Such education, frequently offered in connection with a company-sponsored 401(k) plan that allows participants to direct the investment of their funds, often goes beyond traditional investment principles. Financial education may be tailored to the needs of individuals or small employee groups and include personal financial planning, instruction as to Medicare and Social Security benefits, and tax and estate planning.

Personal Time

Some benefits are designed to do nothing more than increase the efficiency of an employee's use of personal time. For example, although some employers discourage employees from using the internet at work for personal shopping, others have embraced this technology, recognizing that employees may perform personal tasks in a fraction of the time, leaving more productive work time.

Some employers have instituted web-based benefits application and administration with the same goals in mind. Employees may quickly submit health claims online, reducing time spent completing and copying forms. Other on-site personal services such as hairdressers or barbers, dry cleaning pick-up, massages, manicures and personal bankers, to name a few, save employees much valued personal time, allowing them to ultimately increase their efficiency during working and nonworking hours.

Conclusion

To the extent that any of the aforementioned quality of life benefits are subject to ERISA (as discussed in Chapter 1), the benefits may be offered as part of an existing plan or program. To the extent any of the non-ERISA benefits would qualify for favorable tax treatment as a fringe benefit (as discussed in Chapter 10), the employee would not have to include the value of the benefit in his or her gross income, and the employer may be able to take a corresponding tax deduction for the value of the benefit. Although many of these benefits may qualify as de minimis fringe benefits, some may not fall within the legal parameters discussed in Chapter 10 and may result in some additional tax consequences for the employee. Employers considering offering benefits of these types should consult with a tax advisor with respect to the specific benefit.

Benefits designed to promote an active lifestyle, healthy family life, ongoing educational advancement and productive personal time are just a few ways employers can use their employee benefit offerings to improve the quality of life of their employees. Implementing these programs along with a well-rounded program of medical, retirement and other benefits discussed throughout this book demonstrates a recognized and valued commitment to employees.

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HIPAA Privacy and Security for Small Health Plans

When Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996, it included sections focused on fostering efficiencies through the standardization of electronic transactions between members of the health care industry. Known as HIPAA's administrative simplification provisions, these rules seek to create a uniform system for electronic transfers of information among health care providers, insurance companies and health benefit plans. As HIPAA's standardization principles developed, concern arose about the privacy and security of the individually identifiable health information that is transmitted and used by players in the health care industry on a daily basis. Privacy advocates pushed for national protection for individually identifiable health information. As a result, three sets of final regulations were implemented that apply to those players, including most health benefit plans. These regulations are commonly known as the HIPAA Privacy Regulations, Security Regulations, and Standard Transaction Regulations. Both plans and business associates (described below) must adopt administrative, technical and physical safeguards to ensure the confidentiality, integrity and availability of PHI. This chapter will focus on the requirements of the Privacy Regulations for small health plans, with a few comments on the Security Regulations.

The Privacy Regulations, finalized in August 2002, provide procedures for protecting the privacy of health information used and maintained by certain health plans and health care providers, among others. This chapter will help employers who sponsor small health plans understand these regulations.

This chapter will also discuss the impact of the Health Information Technology for Economic and Clinical Health Act (HITECH Act), which in 2009 added new requirements, including breach notification rules, as well as the final Omnibus regulations issued by HHS in January 2013 that implemented changes in the privacy rule under the HITECH Act. The HITECH Act also expanded government penalties for those who fail to comply with HIPAA and added new periodic audit requirements. As a result, the federal government established an audit program in 2011 and now audits health plans and medical providers for compliance with HIPAA's privacy and security regulations and the HITECH Act. The final regulations furthermore made significant changes to the breach notification requirements under the HITECH Act and expanded the definition of business associates and their obligations with respect to privacy.

Small Health Plans

Since April 14, 2004, small health plans have been required to comply with the Privacy Regulations. A small health plan is a health plan with annual receipts of \$5 million or less. It is generally accepted that, for insured employer-sponsored group health plans, the \$5 million benchmark is measured by annual premiums paid to the insurance company in the last full fiscal year. For self-insured employer-sponsored group health plans, the \$5 million benchmark is measured by the amount the self-insured health plan paid in claims during the last full fiscal year.

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Self-administered plans with fewer than 50 participants are not subject to the Privacy Regulations. Employers who contract with a third party to administer their health benefit programs will not be able to take advantage of this exception, however, even if the plan has fewer than 50 participants.

Health plans include any insured or self-funded program that provides benefits for medical care, including medical, dental, vision, prescription drug and long-term care benefits. Medical flexible spending accounts provided through an Internal Revenue Code Section 125 plan (discussed in Chapter 4) are subject to these rules, as are certain employee assistance programs. Short- and long-term disability plans generally are not.

General Privacy Provisions

The Privacy Regulations control the way health plans use and disclose an individual's protected health information (PHI). Generally, PHI is information created or received by a health plan. The information must relate to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual. Finally, to be PHI, the information must also identify the individual, or there must be a reasonable basis to believe the information can be used to identify the individual. PHI includes demographic information collected about the individual.

PHI does not include information held by an employer regarding whether a participant is enrolled in a group health plan. The same information, once held by a group health plan or health insurance provider, is PHI. The Privacy Regulations allow a group health plan, or its health insurance issuer or HMO, to disclose to the plan sponsor information regarding whether the individual is participating in the group health plan or is enrolled or disenrolled from the health insurance issuer or HMO offered by the plan. No special amendments or provisions need to be made to the health plan document for this information to be given to the plan sponsor.

Health plans may use an individual's PHI without the individual's consent for treatment purposes, for payment purposes and for health care operations, as defined below:

- Treatment is the provision, coordination or management of health care and related services by one or more health care providers and includes the coordination or management of health care by a health care provider with a third party.
- Payment purposes are activities undertaken by a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan. It also describes activities undertaken by a health plan to obtain or provide reimbursement for the provision of health care. These activities include, among other things, determining coverage, improving methods of payment, adjudication of health benefit claims, risk adjusting, billing, claims management, medical data processing, medical necessity reviews and precertification.
- Health care operations include conducting quality assessment; conducting personnel evaluations; performing underwriting (except with genetic information, which is prohibited), premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance; and conducting business planning and development.

Other Uses for PHI

If a health plan wants to use PHI for purposes other than treatment, payment or health care operations,

it generally must obtain an explicit written authorization from the participant. Some common uses in which specific authorization would be required include disclosures for:

- to the employer for employment functions (such as for drug testing);
- to the spouse or parent of an adult child;
- the sale of PHI; and
- the use of PHI in marketing.

For example, if an employer wanted to use PHI from its health plan to administer its disability program or its Family and Medical Leave Act (FMLA) policy, it would need an authorization from the participant to do so. Furthermore, a plan may require such an authorization in order for the individual to enroll in the plan or become eligible for benefits. The plan may only require such an authorization, however, if it does so prior to an individual's enrollment and only if the authorization is for the purpose of the health plan's eligibility, enrollment, underwriting or risk-rating determinations relating to that individual. The authorization must not seek the use or disclosure of psychotherapy notes. The Privacy Regulations set forth very specific elements that an authorization must contain in order to be valid.

The Privacy Regulations set forth a number of "public policy exceptions," however, that allow a health plan to disclose PHI for limited purposes without a written authorization from the individual to whom the PHI relates. Those exceptions recognize the need to use and disclose PHI to serve important public policy purposes, such as public health activities, compliance with worker's compensation or other laws, reporting abuse, responding to subpoenas, cooperating with law enforcement and averting threats to health or safety.

Minimum Necessary Standard

Subject to a few exceptions, a health plan must ensure that it uses, discloses or requests only limited data sets or, if limited data sets will not work, the minimum necessary PHI to accomplish the intended purposes of the use, disclosure or request. A limited data set is a set of data that is stripped of nearly all identifying information, such as names, addresses, identification numbers and dates.

The "minimum necessary" standard applies to uses and disclosures of PHI for payment or health care operations purposes. It does not apply to disclosures to or requests by a medical provider for treatment purposes or when the use or disclosure is pursuant to the individual's authorization, is to the individual himself or herself or is required by law.

Administrative Requirements

The Privacy Regulations require health plans to take a number of administrative steps to ensure that PHI is used and disclosed properly. These steps include the following:

- Designating an internal privacy official
- Providing privacy training to employees
- Implementing physical, administrative and technical safeguards to protect participants' privacy
- Accepting complaints from individuals about the uses and disclosures of their PHI
- Refraining from intimidating or committing retaliatory acts against individuals who exercise their privacy rights

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- Creating mechanisms to ensure appropriate sanctioning of workforce members who fail to comply with privacy policies and procedures
- Mitigating harmful effects of wrongful uses or disclosures
- Refraining from requiring individuals to waive rights guaranteed by the Privacy Regulations
- Drafting written policies and procedures addressing the privacy of PHI
- Documenting such policies and procedures
- Limiting disclosures of PHI to the minimum necessary to accomplish the intended purpose, as discussed above
- Notifying appropriate parties impacted by a breach of unsecured PHI

Most health plans must take all of these steps. However, if a health plan is funded through a commercial insurance policy and the employer/plan sponsor does not receive any PHI from the insurance company, then the plan only needs to ensure that it refrains from intimidating or committing retaliatory acts against individuals who exercise their privacy rights. Such a plan also may not make individuals waive their privacy rights. Otherwise, an insured group health plan that does not receive PHI from its insurance company does not need to take any other of the foregoing administrative steps. Furthermore, such a group health plan does not need to maintain and distribute its own notice of privacy practices (see “Individual Rights” below); however, the insurance company that funds the plan must distribute its notice of privacy practices to plan participants.

Individual Rights

Health plans must afford individuals certain rights with respect to their PHI. Specifically, they must do the following:

- A health plan must provide individuals with a mechanism to request the plan to restrict its uses and disclosures of the individual’s PHI for treatment, payment and health care operations, although the plan is not generally required to grant such requests.
- A health plan must provide individuals with the ability to request that the plan communicate with them at alternative locations or through alternative means (e.g., sending explanations of benefits to an office address instead of a home address).
- Individuals must be provided with the right to access, inspect and copy the PHI that a plan maintains about them in formal records. Plans must generally grant these requests with few exceptions and must usually do so within 30 days of a request. The HITECH Act requires health plans provide electronic PHI to individuals in the same format it is maintained by the plan and to transmit a copy of PHI directly to another designated individual.
- Individuals must be provided with the opportunity to ask that their PHI be amended if they believe it is inaccurate or misleading. While plans may deny an individual’s request to amend, very complicated procedures govern this right.
- Upon an individual’s request, a health plan must give an individual a list of the disclosures the plan has made to other entities of the individual’s PHI. Currently, this right is subject to significant limitations because disclosures made for treatment, payment and health care operations (among others) do not need to be listed for an individual. Under the HITECH Act and regulations proposed under it, electronic PHI would be subject to a separate reporting requirement. The rules proposed in 2011 would require the health plan to provide a separate report to the individual, listing any

instances in which the health plan had used or shared the individual's electronic PHI. Industry resistance to this burdensome new reporting obligation has resulted in delayed implementation of this rule. As of publication, the government has yet to issue a final rule.

In addition to these rights, individuals have the right to receive a plan's notice of privacy practices (NPP). The NPP is a document that the plan distributes to participants that describes how the plan may use and disclose health information. The NPP must also describe the rights set forth in this section, including a description of the types of uses and disclosures requiring an authorization, a statement that individuals will be notified of a break of unsecured PHI, etc. A health plan's obligation to provide a notice of privacy practices depends on the level of health information it handles. A self-funded health plan must provide a notice of privacy practices to participants. A small health plan must provide the notice, and any material changes to that notice, according to the following schedule:

- No later than April 14, 2004, to each individual enrolled in the health plan
- Thereafter, at the time of enrollment to individuals who are new enrollees in the health plan
- Within 60 days of a material revision to the notice (if the notice is not posted on a web site) by sending a copy of the notice to the individuals then covered by the plan
- No later than the effective date of a material revision to the notice and in its next annual mailing to individuals then covered by the plan (if the notice is posted on a web site).

In addition, no less frequently than every three years, the health plan must distribute the notice or notify individuals in the plan of the availability of the notice and how to obtain the notice.

A fully insured group health plan that does create or receive PHI must maintain an NPP. In contrast, a fully insured group health plan that does not create or receive PHI does not need to maintain or distribute an NPP (although the insurance company will distribute one to participants).

Breach Notification

Under the HITECH Act and its associated regulations, a health plan must promptly notify affected individuals, the government, and sometimes the media when the plan experiences a breach of unsecured PHI. A breach is the unauthorized acquisition, access, use or disclosure of unsecured PHI in a way that violates the Privacy Regulations and compromises the PHI's security or privacy and does not demonstrate that there is a low probability that the PHI has been compromised. To demonstrate that there is, in fact, a "low probability" that PHI has been compromised, a plan must perform a risk assessment that analyzes the nature and extent of the PHI involved, the authorized person who used the PHI or to whom the disclosure was made, whether the PHI was actually acquired or viewed, and the extent to which the risk to the PHI has been mitigated. In addition, there is a presumption that an impermissible use or disclosure of PHI is a breach subject to the HIPAA rules on breach notifications. To secure PHI and protect against breach notice obligations, a plan may either encrypt PHI (if electronic PHI) or destroy the PHI.

Under HIPAA, a plan has at most 60 days to inform an individual of the breach. The plan must send a notice to each person whose PHI the plan believes was used or shared. If there are 500 or more people involved in a breach, the plan must also notify the government and media within 60 days after the end of the calendar year in which the breaches were discovered. Breach notifications under HIPAA also may be subject to state breach notification laws, and plans should make sure notices are made in a manner consistent with applicable state requirements, such as those for recipients, timing, and content.

Business Associates' Use of PHI

Not only must a health plan abide by the Privacy Regulations, but it must also require its business associates to protect the privacy of PHI. A “business associate” is an individual or entity who creates, receives, maintains or transmits PHI on behalf of the plan. Such functions include claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities, billing, benefit and practice management and repricing. In addition, business associates also include entities or individuals that provide legal, actuarial, accounting, consulting, data aggregation, administrative or financial services to a health plan, if the provision of the services requires the disclosure of PHI.

Health plans must enter into business associate agreements with these entities to ensure that the business associates protect PHI in the same manner that the health plans must protect the PHI, including following the terms of the business associate agreement. The Privacy Regulations set forth a number of provisions that must be included in these business associate agreements. Third-party administrators, pharmacy benefit managers, billing services, medical equipment repair services, utilization review agents, attorneys, actuaries, brokers and consultants are typical business associates. However, members of the plan’s workforce, health insurers funding the plan’s benefits, and stop-loss insurers reimbursing the plan are generally not business associates. Plans should carefully review their business associate agreements to ensure that they contain provisions that will protect the plan if a business associate misuses health information. These recommended provisions may include indemnification, injunctive relief and strong termination provisions.

All business associates must comply with the Privacy and Security Regulations when they use or share PHI.

Disclosure of PHI from Health Plans to Group Health Plan Sponsors

Health plans must exercise caution when disclosing PHI to employers that sponsor group health plans. Disclosures to the plan sponsor generally may be made only when the plan sponsor is performing some administrative function on behalf of the plan. To determine whether a disclosure to a plan sponsor is proper, it is important to distinguish the roles that an employer/sponsor might play in relation to the group health plan.

Employer Functions

Without written authorization, an employer may not use PHI obtained from a health plan to perform an employer function. This rule applies even if the employer sponsors and/or administers the health plan. Employer functions include the following:

- Hiring employees
- Terminating employees
- Disciplining employees
- Administering other employee benefit plans (e.g., disability plans, FMLA leaves, worker’s compensation programs)
- Administering or ordering drug screens for employees
- Obtaining return-to-work authorizations

Plan Sponsor Functions

When an employer is performing certain plan sponsor functions, it may receive and use only summary health information from a group health plan. Summary health information is information from which most personal identifiers have been removed that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the plan sponsor has provided health benefits under its group health plan. Plan sponsor functions include the following:

- Obtaining premium bids from health plans for providing health insurance coverage (including stop-loss insurance coverage)
- Modifying, amending or terminating a group health plan

Plan Administration Functions

An employer may receive and use PHI from a group health plan in order to perform plan administrator functions. However, the employer first must amend the health plan to address the Privacy Regulations and provide the health plan with a certification that it will comply with those protective provisions. Plan administration functions are as follows:

- Treatment
- Claims payment and activities
- Health care operations

Plan administration functions do not include administration functions for other benefit plans, such as an employer's disability or life insurance program. In addition, enrollment functions performed by the plan sponsor on behalf of its employees are not administrative functions and are not subject to these rules.

The plan may disclose PHI to the plan sponsor (other than the information discussed earlier in this chapter) if the plan sponsor requires the information for purposes of administering a group health plan but only if the plan document is amended to do the following:

- Describe the permitted uses and disclosures of PHI
- Specify that disclosure is permitted only upon receipt of a certification from the plan sponsor that the plan documents have been amended and the plan sponsor has agreed to certain conditions regarding the use and disclosure of PHI
- Provide adequate firewalls to identify the employees or classes of employees who will have access to PHI, restrict access solely to the employees identified and only for the functions performed on behalf of the group health plan, and provide a mechanism for resolving issues of noncompliance

In addition, the plan sponsor must execute a certification in which it agrees to all of the following:

- Not to use or further disclose the information other than as permitted or required by the plan document or by law
- To ensure that any agents or subcontractors to whom it provides PHI received from the plan agree to the same restrictions and conditions that apply to the plan sponsor
- Not to use or disclose the information for employment-related actions or decisions in connection with any other benefit plan of the sponsor
- To report to the plan any unauthorized use or disclosure
- To make information available as required by law

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- To make information available to provide an accounting of its disclosures
- To make its internal practices, books and records relating to uses and disclosures of PHI available to the U.S. Secretary of Health and Human Services for determining the health plan's compliance with the Privacy Regulations
- To return or destroy all PHI received from the plan when the purpose for the plan sponsor's use is over
- To ensure adequate separation of the plan and plan sponsor for these purposes

Security Regulations

In addition to privacy requirements, HIPAA also mandated security requirements for certain types of PHI. While the Privacy Regulations dictate how a health plan may use and disclose PHI, the Security Regulations establish how a health plan must keep the information secure.

The Security Regulations describe those administrative, physical and technical safeguards designed to protect the confidentiality, integrity and availability of a subset of PHI known as electronic protected health information or EPHI. EPHI includes protected health information that is used, maintained or transmitted in an electronic media format, including on or over computer hard drives, magnetic tapes or disks, optical disks, the internet, extranets, leased lines, dial-up lines, private networks and floppy disks. EPHI does not include information contained in facsimiles, telephone transmissions, voice mail or video teleconferencing.

The Security Regulations require employers that administer group health plans to implement basic safeguards to protect EPHI from unauthorized access, alteration, deletion and transmission. Specifically, the Security Regulations require plans to do the following:

- Ensure the confidentiality, integrity and availability of all EPHI the plan creates, receives, maintains or transmits
- Protect against any reasonably anticipated threats or hazards to the security or integrity of such information
- Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required by the Privacy Rule
- Ensure compliance by their workforce

To ensure the security of EPHI, the Security Regulations require protections in three general categories: administrative safeguards, physical safeguards and technical safeguards, each of which is discussed below. The Regulations break each of these categories down into various "standards" that must be achieved.

The administrative safeguards category of the Security Regulations details how employers must manage the selection, development, implementation and maintenance of security measures to protect EPHI and the conduct of the employer's workforce in relation to the protection of EPHI. An employer must conduct a risk assessment and determine those risk management strategies will address the risks identified. For this purpose, the employer must implement various specified administrative safeguards, such as establishing a security management process, with assigned security responsibilities, workforce management including sanctioning for rule violations, information access management, security awareness and training, security incident procedures, a contingency plan, security evaluations and security provisions in business associate agreements.

The second general category of compliance required by the Security Regulations is physical safeguards.

Physical safeguards must protect an employer's electronic information systems and related buildings and equipment from natural and environmental hazards and unauthorized intrusion. The required physical safeguards include safeguards for facility access controls, workstation use, workstation security and device and media controls.

The final category of safeguards for EPHI under the Security Regulations is technical safeguards. These safeguards relate to the technology that protects EPHI and controls access to it. These safeguards address access control, audit controls, encryption, integrity, person or entity authentication and transmission security.

For plans to meet these standards, the Security Regulations impose both required and addressable implementation specifications. If an implementation specification is required, a plan must implement it to achieve compliance with the standard to which it relates. If the implementation specification is addressable, a plan must assess whether the implementation specification is a reasonable and appropriate way for the plan to meet the standard given the plan's environment.

Additional Requirements for Group Health Plans

The Security Regulations have additional requirements for group health plans that are similar to those under the Privacy Regulations. Except when EPHI disclosed to a plan sponsor is summary health information or enrollment or disenrollment information, group health plan documents must provide that the plan sponsor will reasonably and appropriately safeguard EPHI created, received, maintained or transmitted to or by the plan sponsor on behalf of the group health plan. The plan documents of the group health plan must be amended to incorporate provisions to require the plan sponsor to:

- implement reasonable and appropriate safeguards to protect the confidentiality, integrity and availability of the EPHI that it creates, receives, maintains or transmits on behalf of the group health plan;
- ensure that the adequate separation is supported by reasonable and appropriate security measures;
- ensure that any agents, including subcontractors, to whom it provides this information agree to implement reasonable and appropriate safeguards to protect the information; and
- report to the group health plan any security incident of which it becomes aware.

The Security Regulations represent the minimum steps necessary for adequate protection of EPHI and are required to be implemented by all health plans. Plans are required to implement written security policies and procedures that are reasonably designed taking into account the size and type of activities of the plan that relate to the EPHI used. The security requirements are technically flexible, allowing an employer to take into account its size, complexity and capabilities; its technical infrastructure, hardware and software security capabilities; the costs of security measures; and the probability and criticality of potential risks to EPHI.

Conclusion

The creation of documents containing appropriate HIPAA provisions and procedures alone will not make a health plan HIPAA compliant. HIPAA compliance is an ongoing process that requires a thorough understanding of the Privacy and Security Regulations, the careful analysis of a health plan's uses and disclosures of health information, the documentation and consistent enforcement of strong, specific policies and procedures, and the training of employees. Each health plan must analyze its own uses and disclosures

of health information, tailor any sample forms or policies it obtains and create additional policies that are specific to the health plan, train its workforce, and apply its policies on a daily basis. Compliance with HIPAA privacy and security requirements is far more than reducing policies and procedures to paper – it is a change in the manner in which a health plan thinks about, approaches, protects and limits the uses and disclosures of health information.

Privacy Regulations Compliance Checklist

Health plans may use the following checklist as a guideline to work toward compliance with the HIPAA Privacy Regulations:

- **Designate a Privacy Official.** A privacy official must develop and implement all required written policies and receive complaints regarding wrongful use of health information. Ideally, a privacy official might have a background in human resources, compensation and/or employee benefits, or auditing, law or operations. The choice of a privacy official will send a strong message to the health plan's employees about how seriously the plan takes its privacy obligations.
- **Assemble a HIPAA Team.** Most health plans will require the input of a number of departments and stakeholders when identifying the uses and disclosures of PHI, developing forms and policies and implementing HIPAA. Individuals from the following areas are candidates for the HIPAA team: human resources, legal, benefits administration, billing, information technology, training and risk management.
- **Read the Privacy Regulations.** There is no substitute for reading the Privacy Regulations. The Regulations are the final word when it comes to compliance. It is essential that the privacy official and those people working closely with the privacy official read the Regulations and keep them as a constant guide.
- **Determine Uses and Disclosures of PHI.** The health plan must determine how it uses PHI internally and to whom and for what reasons it discloses PHI externally. This analysis should be approached in various ways to ensure that potential uses and disclosures are not overlooked.
- **Review Existing Policies Relating to Privacy to Determine Gaps.** Many health plans already carefully observe the privacy of PHI and have policies in place to properly use and disclose PHI. Those policies should be reviewed to determine whether they meet the standards in the Privacy Regulations.
- **Develop Privacy Policies and Forms.** Health plans must develop written policies and forms to implement the Privacy Regulations into the day-to-day practices of the health plan. There is no "magic" number of policies and forms that will make a health plan HIPAA compliant. Each health plan must carefully review its own uses and disclosures of PHI and develop the appropriate policies and forms.
- **Train Employees.** Health plans must train individuals who work for or on behalf of the plan about the plan's privacy obligations. The health plan must determine which employees to train and the content of the training. Employees must be provided training that is appropriate to the exposure they have to PHI. The health plan must also determine how employees will be trained. The Privacy Regulations do not prescribe a specific means of training employees.

Privacy Regulations Compliance Checklist

(continued)

- _____ **Amend Plan Documents and Communicate with Participants.** All plan documents must be amended consistent with the plan's privacy policies and the Privacy Regulations. All applicable notices must be issued to plan participants.
- _____ **Enter into/Review/Update Agreements with Business Associates.** Health plans must carefully inventory and identify all potential Business Associates and must amend their agreements, or enter into new agreements with these Business Associates, clearly delineating the health plan's privacy policies and the expectations that the health plans have of their Business Associates with respect to maintaining the privacy of PHI.
- _____ **Consider Risk Management/Liability Shifting Mechanisms.** Health plan administration should also think about different ways in which they can manage and mitigate risk and liability. For instance, a plan may want to take the following actions:
 - Consult with its insurance broker to determine whether existing policies (e.g., general liability, medical malpractice, directors' and officers' coverage) will provide coverage for privacy breaches
 - Ensure that business associate agreements and general confidentiality agreements with non-business associates contain strong indemnification language
 - Develop strong and consistent procedures for addressing unauthorized uses and disclosures by business associates and employees
 - Reduce or avoid direct use of PHI, if possible, particularly if the health plan is a group health plan funded through commercial insurance or a self-funded group health plan administered by a third-party administrator
- _____ **Monitor and Report Compliance.** Health plans must monitor their employees' and business associates' compliance with the Privacy Regulations. This requirement will mandate that the plan maintain a log of certain disclosures, gathered internally and from its business associates, as well as a record of authorizations and written or verbal agreements. Health plans must monitor for, identify, and document breaches through a risk assessment and provide notice of breaches.
- _____ **Comply with Any Applicable State Law.** Health plans will be responsible for ensuring that they comply with any state privacy laws that are not preempted by the Privacy Regulations, especially those that are more stringent than the Privacy Regulations.

Chapter 13

Redesigning Your 401(k) Plan to Ease Administration

Although 401(k) plans have become the most popular type of retirement plan provided by companies to their employees, these plans often require significant time and expense to administer. Administrative errors are common, costly and frustrating for employers and employees alike. Several basic design decisions can avoid some of the most common administrative problems encountered in 401(k) plans. Employers who understand these choices may simplify plan administration considerably without significantly compromising the value of the benefit provided. This chapter discusses several design changes an employer can make to ease 401(k) plan administration.

Discontinue Plan Annuities

Some plans permit plan participants to receive their benefit in a lump sum, installment payments and/or an annuity. Annuities can be paid out over a stated number of years or for life. Payment options in the form of a life annuity have complex notice and explanation requirements. IRS regulations allow employers to eliminate or restrict annuity options in a 401(k) plan without violating the “anti-cutback” rules of the Internal Revenue Code if the plan includes a lump-sum distribution option that is otherwise equal in value to the annuity option that is eliminated or restricted. An employer may put this change into effect immediately but must provide participants with notice of the change through an updated summary plan description (SPD).

Note: Plan sponsors may not remove annuity options from money purchase plans (see Chapter 5) or eliminate the options with respect to any plan assets that are transferred into a 401(k) plan from a defined benefit pension plan.

Eliminate Plan Loans

Although generally popular among participants, 401(k) plan loans can create many administrative problems for employers, including the need to do the following:

- Adopt and maintain a loan policy and application forms and set-up procedures, including periodically setting a reasonable interest rate for loans
- Administer repayments and coordinate with payroll so that the loan is amortized and paid off over a permissible time period
- Pursue payments (or initiate defaults and offsets) from participants who terminate employment, file bankruptcy or fail to make payments during an unpaid leave of absence
- Reconcile records and loan balances when plans merge due to acquisitions and sales of companies/divisions

Loans are not subject to the anti-cutback rules previously discussed, so they can be eliminated by plan amendment. Participants should be notified of this change through an updated SPD.

Avoid Nondiscrimination Testing

An employer may eliminate the need for nondiscrimination testing in a 401(k) plan by adopting a “safe harbor” plan formula. A safe harbor 401(k) plan automatically satisfies the Code’s nondiscrimination tests for employee pre-tax elective deferrals and employer matching contributions. This approach allows all employees to save at their personal maximum level for retirement on a pre-tax basis and eliminates the administrative costs and headaches employers otherwise experience with the annual nondiscrimination testing required for 401(k) plans. Safe harbor plan designs also eliminate the problems that arise if the nondiscrimination tests are not passed (e.g., payback of excess contributions to highly compensated employees [HCEs]). As a result, HCEs can defer the maximum allowable pre-tax elective contributions – \$19,500 in 2020 – without testing, and regardless how much the non-highly compensated employees (non-HCEs) choose to defer into the plan. (Generally, HCEs are 5% owners and employees with pay over \$130,000 in 2020.)

A safe harbor 401(k) plan must meet one of the following contribution options for the entire plan year:

- **Safe Harbor Option 1:** The employer must make contributions of at least 3% of pay for each non-HCE who is eligible to participate in the plan, regardless whether the employee makes any pre-tax elective contributions to the plan.
- **Safe Harbor Option 2:** The employer must make matching contributions for each non-HCE that match the employee’s pre-tax contributions dollar for dollar up to 3% of the employee’s pay, plus 50 cents on the dollar for the employee’s pre-tax contributions over 3% of the employee’s pay, up to 5% of the employee’s pay.
- **Safe Harbor Option 3:** The employer must make matching contributions for non-HCEs at least equal to the maximum that could be made under Option 2. For example, the employer could match the employee’s pre-tax contributions dollar for dollar up to 4% of pay.
- **Safe Harbor Alternative:** In addition to the safe harbor options listed above, implementing automatic enrollment in a 401(k) plan can eliminate the need for nondiscrimination testing. To satisfy this alternative, pre-tax elective contributions equal to 3% of pay are automatically contributed for each newly eligible non-HCE who does not make an affirmative election regarding contributions. This automatic contribution percentage increases by 1% each year until it reaches at least 6% of pay, or until the employee makes an affirmative election. In addition, the employer must make either the contributions described in Option 1, or a matching contribution that is similar to but less than the matching contributions described in Options 2 and 3. This employer contribution matches the employee’s pre-tax contributions dollar for dollar up to 1% of pay, and then 50 cents on the dollar on the employee’s next 5% of pay, or is at least equal to this amount (e.g., dollar for dollar up to 3.5% of pay).

Employer contributions are required under all three options and the safe harbor alternative, even if the non-HCE terminates employment during the year or works fewer than 1,000 hours during the year. The mandatory employer safe harbor contributions must be fully vested at all times, and they must be subject to the same withdrawal restrictions as employee pre-tax contributions, i.e., they can be withdrawn only in the event of attaining age 59½, death, disability or other termination of service. They are not available for hardship distributions. Under Options 2 and 3 and the safe harbor alternative, the matching contribution

rate for HCEs cannot exceed the matching rate for non-HCEs, and it cannot increase as the employee's rate of pre-tax elective contributions increases. Under all four options, HCEs may (but are not required to) receive the same contribution as non-HCEs.

For Options 2 and 3 as well as the safe harbor alternative, eligible employees must receive a written, understandable notice describing the material provisions of a safe harbor 401(k) plan. The notice generally must be given 30 to 90 days before the start of a new plan year or the start-up of a new safe harbor 401(k) plan. The notice generally must describe the plan eligibility and contribution rules, but it may refer to explanations in the plan's SPD for some purposes. This annual notice is not required for Option 1.

Generally, safe harbor plan designs must be adopted before the beginning of a plan year. They cannot be adopted during the year. However, an employer adopting Option 1 can wait until as late as 30 days prior to the last day of the year to decide whether it is going to make the safe harbor 3% contribution. Plan sponsors are allowed to switch to a safe harbor 401(k) plan with nonelective contributions any time prior to the last day of the following year if the amendment provides for a nonelective contribution of 4% instead of 3%.

Simplify the Hardship Withdrawal Procedures

A 401(k) plan may allow an employee to withdraw pre-tax contributions if the employee experiences a financial hardship. IRS regulations impose three requirements for an employee to obtain a hardship withdrawal from a 401(k) plan:

- **Requirement 1:** The amount withdrawn cannot exceed the financial hardship but can include the amounts necessary to pay income taxes and penalties on the withdrawal.
- **Requirement 2:** The financial hardship must represent an "immediate and heavy financial need."
- **Requirement 3:** The distribution must be necessary to satisfy the need.

The plan administrator must enforce all three requirements before distributing elective deferrals from 401(k) plans. In order to understand how these provisions may be simplified, one must look at all three requirements for a hardship withdrawal, even though the IRS "safe harbor" actually only addresses the second of these requirements.

For Requirement 1, the amount withdrawn cannot exceed the financial hardship. There is no safe harbor for this requirement. Therefore, for example, if the hardship is a \$1,000 medical expense not covered by insurance, the employee should present the \$1,000 medical bill and certify to the employer that the financial hardship amount is \$1,000.

For Requirement 2, the financial hardship must represent an "immediate and heavy financial need." The IRS regulations state that the administrator can make this determination on a "facts and circumstances" basis (meaning the employee states the facts involved with the financial hardship and the administrator makes a determination), or the financial hardship is "deemed" an "immediate and heavy financial need" if it arises from any one of seven specific circumstances, including:

1. non-covered medical care for a family member;
2. purchase of a principal home for the participant;
3. qualifying educational expenses of a family member;
4. to prevent eviction of the participant from his or her home;

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5. payment of family burial or funeral expenses;
6. repair of casualty (e.g., hurricane) damage to the employee's principal residence; or
7. losses attributable to a federally declared disaster (for taxable years 2018 through 2025).

In addition, employers may permit hardship withdrawals if events 1, 3 or 5 above affect a person whom the participant has named as his or her primary 401(k) plan beneficiary. These hardship circumstances are "safe harbor" reasons for hardship withdrawals, and most plans limit withdrawals to these safe harbor hardship categories.

For Requirement 3, the distribution must be necessary to satisfy the financial need. Under the IRS regulations, a participant must meet two requirements to establish that a hardship distribution is necessary:

1. The participant must first obtain any other currently available distributions under the plan and any other deferred compensation plan maintained by the employer; and
2. The participant must represent in writing (including by electronic medium) that they have insufficient cash or other liquid assets reasonably available to satisfy the financial need.

The plan administrator can rely on the participant's written representation that the withdrawal is necessary to meet the need unless the administrator knows the facts to be different than those certified by the participant. There is no requirement that the administrator make an independent investigation of the facts.

The IRS regulations permit plans to impose additional conditions for establishing that a hardship distribution is necessary. For example, a plan could – but is not required to – force participants to take available participant loans before the taking a hardship distribution. However, the IRS regulations now prohibit a plan from requiring a suspension of deferrals as a condition of receiving a hardship distribution. While additional conditions may be considered useful if the employer wishes to discourage hardship distributions, adding conditions will increase the complexity of administering hardship distribution requests.

Note that it is not required to offer a hardship withdrawal option under a 401(k) plan. An employer could choose to avoid or eliminate this option. Hardship distributions are not subject to the anti-cutback rules previously discussed, so they can be eliminated by plan amendment. Participants should be notified of this change through an updated SPD.

Adopt a "Safe Harbor" Definition of Compensation

Plan compensation definitions generally can include or exclude any form of compensation paid by the employer. Plan definitions often exclude such items as bonuses, moving expenses, overtime pay, taxable stock options or commissions. Compensation definitions that do not meet a safe harbor definition, however, must be tested each year to demonstrate that the plan's definition does not discriminate in favor of HCEs. In addition, special inclusions/exclusions are more prone to administrative errors. Often a disconnect occurs between the plan administrator (usually the human resources department) and the payroll administrator, resulting in incorrect reporting of compensation to the plan, inaccurate calculation of plan benefits, and inaccurate non-discrimination testing. One way to simplify this very complex problem is to adopt a safe harbor definition of compensation for plan purposes. The three basic safe harbor definitions include the following.

1. **W-2 Compensation:** Generally defined to include "gross" wages subject to federal income tax withholding; specifically includes (or "adds back") employee pre-tax elective deferrals to cafeteria plans and 401(k) plans. Employer-paid expense reimbursements, fringe benefits and moving

expenses are not part of W-2 compensation to the extent they are not taxed to the employee (i.e., not part of gross income).

2. **Code Section 415 Compensation:** Generally defined as an employee's earned income, wages, salaries, fees and other amounts received (without regard to whether an amount is paid in cash) for personal services actually rendered in the course of employment with the employer maintaining the plan, to the extent that the amounts are includible in gross income (including such amounts as overtime, commissions, tips, bonuses, taxable fringe benefits and taxable expense reimbursements). Unlike the W-2 definition, this definition generally excludes distributions from nonqualified deferred compensation plans, amounts realized from the exercise of a non-statutory stock option or when restricted stock (or property) held by the employee becomes freely transferable or is no longer subject to forfeiture. This definition also includes pre-tax elective deferrals under 401(k) plans and cafeteria plans.
3. **Code Section 3401(a) Compensation:** Generally defined as "wages" subject to payroll tax withholding, without regard to any rules that limit these amounts based on the nature or location of the employment or the services performed (such as certain agricultural labor exceptions). Like the other definitions, this compensation definition also excludes non-taxable expense reimbursements, non-taxable moving expenses and non-taxable fringe benefits, and includes the amount of any employee pre-tax elective deferrals under 401(k) plans and cafeteria plans. Unlike the other definitions, it excludes taxable group term life insurance greater than \$50,000.

Note: Some companies believe "plan compensation" is more administratively simple if it is each employee's "base pay" before adjustments for bonuses, reimbursed expenses and other such items. This approach does have advantages, but this definition does not satisfy the safe harbor requirements, and so it must be tested annually to ensure it does not discriminate in favor of HCEs.

Simplify Entry Dates

Instead of letting new employees begin participating each payroll period throughout the year when they first meet the age and service eligibility requirements, another way to simplify 401(k) plan administration is to require all new employees to start participating on one of two dates during the year - the first day of the plan year (e.g., January 1), or on the first day of the seventh month of the plan year (e.g., July 1). Fewer plan entry dates generally means less administrative work, simpler recordkeeping and less potential for administrative errors. This structure meets the IRS requirements that plan participation must begin no later than the earlier of (1) the first day of the plan year after the employee has met the age and service requirements, or (2) six months after the employee has met the age and service requirements. Alternatively, a plan can have one annual entry date if it provides that new employees are not eligible to participate until the January 1 that follows their hire date.

Pay-Out Qualified Domestic Relations Orders

Administration of 401(k) accounts becomes more complex when a participant becomes divorced and the former spouse retains an interest in the plan. A qualified domestic relations order (QDRO) generally is a court order requiring payment of plan benefits to the former spouse upon the divorce of an employee.

QDRO assets that remain in the employer's plan are subject to ongoing potential claims and notice requirements and are often the cause of significant administrative headaches. Generally, a QDRO requires the administrator to segregate the former spouse's interest into an account in the former spouse's name and permits the former spouse to separately direct the investment of the segregated account.

To simplify this problem, employers may amend the 401(k) plan to provide that a former spouse may take an immediate distribution of his or her separate account even if the employee is not eligible for a distribution. The plan provisions and QDRO procedures should clearly state that the non-employee spouse's interest in the plan is immediately available for distribution upon approval of the QDRO by the plan. This approach often encourages the former spouse's attorney to design the QDRO to call for immediate payment.

Many companies now have "model" QDROs for their plans that they forward to counsel for the divorcing employee and non-employee spouse. These models generally provide for immediate payout and tend to result in better-drafted court orders that are more likely to satisfy the detailed requirements for a QDRO and that are easier for the plan to administer.

Reduce Small Benefit Cash-Outs to \$1,000

Most 401(k) plans provide that a terminated employee will receive an automatic cash-out of the employee's account if it has a value under \$5,000 (excluding rollover contributions into the plan) unless the participant timely elects otherwise. However, plan administrators must roll over accounts in excess of \$1,000 (including for this purpose any rollover contributions into the person's account) to an individual retirement account (IRA) rather than cashing out the small account if the participant does not make their own distribution election. This procedure requires the employer to enter into a detailed contract with an IRA provider and issue special notices to the terminated employee. A simpler approach is to reduce the small benefit cash-out threshold from \$5,000 to \$1,000, eliminating the need for the automatic rollover to IRAs when participants fail to make their own distribution elections for their accounts.

Stop Counting Hours of Service

Most 401(k) plans require employees to complete a minimum number of hours of service (not in excess of 1,000 hours) for purposes of eligibility and/or vesting. Regulations permit plan administrators to use equivalencies instead of counting actual hours. The equivalencies can be based on working time or payroll periods (e.g., 870 hours worked are treated as equivalent to 1,000 hours paid), regular time (e.g., 750 regular or non-overtime hours are equivalent to 1,000 hours) or periods of employment (e.g., 10 hours of service per day, 45 hours of service per week, 95 hours of service per semimonthly payroll period or 190 hours of service per month). This approach permits the plan to designate a set number of hours that will be credited to the employee on a daily, weekly or monthly basis and can eliminate the need to track actual hours, which can be complex and time consuming process that is prone to error.

Conclusion

There are many steps an employer can take to make 401(k) plan administration simpler. Adopting some or all of these plan design decisions will eliminate errors and reduce the time and administrative costs associated with operating the plan. An employer may adopt these features in a new plan or implement these changes to an existing plan with an amendment to the current plan documents.

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ERISA's Compliance Obligations for Pension and Welfare Benefit Plans

Pension Plans

Item	Description	Due Date, Disclosure, Etc.
ANNUAL REPORTS (See ERISA §103 regarding annual report requirements.)	<u>Form 5500 and Schedules – Annual Return/Report of Employee Benefit Plans</u> : For plans with fewer than 100 participants at the beginning of the plan year, a simplified filing may be required. See Form 5500 instructions for plans exempt from filing requirements and for other special rules.	Plan administrator must file with U.S. Department of Labor (DOL) no later than the last day of the 7th month after the close of each plan year. A one-time extension of up to 2½ months may be granted for filing this annual return if Form 5558 (Application for Extension of Time) is filed in sufficient time for DOL to consider and act on it before the regular due date of the annual return. The plan administrator must make the latest annual report available for examination by any participant or beneficiary in the principal office of the plan administrator. ¹ A copy of the latest annual report must be furnished to participants and beneficiaries upon written request. ²
ANNUAL REGISTRATION STATEMENT IDENTIFYING SEPARATED PARTICIPANTS WITH DEFERRED VESTED BENEFITS	Form 8955-SSA replaced the Form 5500 Schedule SSA: For plans with deferred vested participants.	Plan administrator must file with the IRS by the last day of the 7th month after the close of any plan year (plus extensions, as described above) for which a Form 8955-SSA is required to be filed to report deferred vested participants.

1. The plan administrator must also make copies of any instruments under which the plan was established or is operated available for examination by any plan participant or beneficiary in the principal office of the plan administrator and in such other places necessary to make all pertinent information available to all participants.

2. The plan administrator, upon written request of any participant or beneficiary, must also furnish to such participant or beneficiary a copy of any terminal report or any instrument under which the plan is established or is operated. The plan administrator may make a reasonable charge to cover the cost of furnishing these documents. The plan administrator shall also furnish to the Department of Labor, upon request, any documents relating to the plan.

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<p>SUMMARY ANNUAL REPORT (See ERISA §104 and §2520.104b-10.)</p>	<p>Summary of the latest annual report (not required for PBGC covered defined benefit plans).</p>	<p>The summary annual report must be furnished to each participant and each beneficiary receiving benefits within 9 months after the close of each plan year unless the filing date for the annual report is extended, in which case the disclosure date is 2 months after the due date for filing the Form 5500 (with the approved extension). For plans with fewer than 100 participants, in lieu of furnishing the summary annual report, simplified notice requirements may apply</p>
<p>NONDISCRIMINATION TESTING Nondiscriminatory contributions or benefits test</p>	<p><u>Annual Code §401(a)(4) test</u> required if plan does not use a design-based safe harbor. Tests contributions or benefits provided under the plan to make certain that the plan does not discriminate in favor of highly compensated employees.</p>	
<p>Actual deferral percentage (ADP) test</p>	<p><u>Annual Code §401(k) test</u> required for defined contribution plans allowing pre-tax or Roth elective deferral contributions, unless the plan is a safe harbor 401(k) plan that meets certain contribution and notice requirements. Actual deferral percentage calculated and compared for highly compensated and non-highly compensated employees.</p>	<p>If the plan does not pass the ADP test and excess contributions plus allocable income are to be distributed to highly compensated employees to correct, distributions must be completed not later than 12 months after the end of the plan year. The employer will be subject to a 10% penalty if the excess contributions are not distributed within 2½ months following the end of the plan year. If the excess contributions are to be recharacterized to correct, the recharacterizations must be completed no later than 2½ months after the end of the plan year. A plan may make non-elective contributions to non-highly compensated employees, in lieu of refunding contributions to highly compensated employees, to correct the actual deferral percentage.</p>

ERISA's Compliance Obligations for Pension and Welfare Benefit Plans

Actual contribution percentage (ACP) test	Annual Code §401(m) test required for defined contribution or defined benefit plans allowing employee after-tax contributions and defined contribution plans with matching contributions unless the plan is a safe harbor 401(k) plan that meets certain contribution and notice requirements.	<p>If the plan does not pass the ACP test and excess aggregate contributions plus allocable income are to be distributed to highly compensated employees to correct, distributions must be completed no later than 12 months after the end of the plan year. Only after-tax contributions and vested matching contributions can be distributed. Nonvested matching contributions can be forfeited. The employer will be subject to a 10% penalty if the excess aggregate contributions are not distributed (or forfeited if nonvested) within 2½ months following the end of the plan year. Alternatively, if the plan is not a safe harbor plan, elective deferrals of non-highly compensated employees that are not needed to satisfy the ADP test can be treated as matching contributions for purposes of the ACP test.</p> <p>A plan may correct the actual contribution percentage by making non-elective contributions to non-highly compensated employees, in lieu of refunding contributions to highly compensated employees (or forfeiting if nonvested).</p>
Minimum coverage test	<p>Code §410(b) requires that a plan do one of the following:</p> <ol style="list-style-type: none"> 1. Benefit a percentage of non-highly compensated employees that is at least 70% of the percentage of highly compensated employees benefiting under the plan 2. Benefit a classification of employees that does not discriminate in favor of highly compensated employees; here, the average benefit provided to non-highly compensated employees under all of the employer's qualified plans must be at least 70% of the average benefit provided to highly compensated employees under all of the employer's qualified plans 	<p>The Code §410(b) minimum coverage test must be satisfied under one of the following test options:</p> <ol style="list-style-type: none"> (a) Daily testing option: Must be satisfied on each day of the plan year (b) Quarterly testing option: Must be satisfied on at least one day of each quarter of the plan year (c) Annual testing option: Must be satisfied as of the last day of the plan year. This testing option is required for §401(k) and §401(m) plans and in applying average benefits testing (d) Snapshot testing option: Must be satisfied on a single representative "snapshot" day during the plan year (e) For plans that do not experience significant changes, testing may be as infrequent as once every 3 years

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Minimum participation test	<u>Code §401(a)(26)</u> requires that a defined benefit plan cover at least the lesser of (i) 50 employees or (ii) the greater of (a) 40% of all employees of the employer or (b) 2 employees (1 employee if there is only 1 employee).	The Code §401(a)(26) requirement must be satisfied every day of the plan year; however, under a simplified testing method, the plan is treated as satisfying Code §401(a)(26) if it meets the requirements at least one representative day of the plan year. A special exemption from Code §401(a)(26) may apply for a defined benefit that has frozen participation so that no new participants can join, but existing participant continue to accrue benefits.
Limit compensation taken into account for plan purposes	<u>Code §401(a)(17)</u> caps the amount of compensation that can be taken into account to determine contributions or benefits.	The annual compensation limit is adjusted for cost of living each year.
Test limit on elective deferrals	<u>Code §402(g)</u> limits the total amount of pre-tax and Roth elective deferrals made by an individual during a calendar year. <u>Code §414(v)</u> limits the amount of catch-up contributions that can be made by participants who are age 50 or older by the end of the calendar year.	If deferrals in excess of the Code §402(g) or §414(v) limits must be distributed by the following April 15 to avoid double taxation. The employer must monitor deferrals made under its plans. The participant must notify the employer if the limits are exceeded due to deferrals made by the participant to plans of another employer during the calendar year.
Test limits on contribution or benefits	<u>Annual Code §415</u> testing is required for each participant under a qualified retirement plan. In some instances, excess annual additions to a defined contribution plan can be distributed, reallocated to other participants or used to offset employer contributions.	It is preferable to monitor during the plan year and prevent excess annual additions from going into the plan. Employer deductions for plan contributions are not permitted for amounts in excess of the Code §415 limits; therefore, they should be determined prior to funding the plan.
Top-heavy costs	Code §416 testing is required annually to determine whether minimum contributions or benefits are required for non-key employees, unless the plan is a safe harbor 401(k) plan that meets certain contribution and notice requirements.	To be deducted by the employer for the preceding plan year for which the contribution is made; the contribution must be made not later than the due date of the employer's return, including extensions. The determination of top-heavy status should be made early enough to facilitate contributions by this date.
ADMINISTRATIVE FORMS	Some or all of the following administrative forms must be provided by the plan administrator (or record keeper), depending on features of the plan.	
Salary reduction forms	Written elections from participants regarding pre-tax, Roth and after-tax contributions to be withheld from paychecks for contribution to a pension plan.	Must be received from participants before issuance of the first paycheck from which the amount is to be deducted. Consider compliance with applicable state laws.

ERISA's Compliance Obligations for Pension and Welfare Benefit Plans

Plan loan forms	Should include information demonstrating that the loan is made in compliance with certain requirements regarding loan amount, repayment terms, and amortization in order to be exempt from truth-in-lending disclosure requirements.	Must be received from participants at the time a loan is requested and processed.
Written explanations of preretirement survivor annuity provided under plans subject to minimum funding standards and under profit-sharing plans subject to survivor annuity requirements	Plan administrator must provide this information to participants and beneficiaries.	<p>Generally due by the later of the following, either:</p> <p>(a) the period beginning with the first day of the plan year in which the participant reaches age 32 and ending with the close of the plan year preceding the plan year in which the participant reaches age 35; or</p> <p>(b) the date one year after the individual becomes a participant if he or she is hired after age 35.</p> <p>This election must be made within the period beginning on the first day of the plan year in which the participant attains age 35 and ending with the participant's death. In some situations, the participant may make this election before reaching age 35. If the participant terminates employment before age 35, the plan must notify him or her within one year of separation from service.</p>
Written explanation of joint and survivor annuity provided under plans subject to minimum funding standards and under profit-sharing plans, but only to participants subject to survivor annuity requirements	Plan administrator must provide this information to participants	Written notice should be given no less than 30 days and no more than 180 days prior to annuity starting date. Waiver of waiting period permissible (with spousal consent) if distribution is made within 7 days of written notice. Election must be no sooner than 180 days before annuity starting date. Retroactive payments permissible if the participant has at least 30 days to elect after notice.
Notice explaining rollover, withholding and tax rules that apply to "eligible rollover distributions"	Plan administrator must provide this notice to participants and beneficiaries.	<p>Due no less than 30 days and no more than 180 days before the distribution is made.</p> <p>Participants can waive the 30-day waiting period if all of the following hold true:</p> <p>(a) The participant is given at least 30 days after receiving the notice to make a decision to directly roll over the payment</p> <p>(b) The plan administrator clearly lets the participant know that he or she has at least 30 days in which to make a decision</p> <p>(c) The participant's spouse does not have to consent to the distribution</p>

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Notice of the right to elect not to have federal income tax withheld from distributions other than "eligible rollover distributions"	Plan administrator must provide this notice to participants and beneficiaries taking distributions.	<p>For periodic payments, notice is due no earlier than 6 months before and no later than with the first payment. Notice must thereafter be given of the right to make or revoke any existing election once each calendar year at approximately the same time.</p> <p>For nonperiodic payment, notice is due no earlier than 6 months before the distribution but within reasonable time for the payee to make a decision and notify the payor of election choice before distribution is made.</p> <p>Note: U.S. citizens living abroad with no permanent address in the U.S. cannot elect out of federal tax withholding. Special rules may apply for nonresident aliens.</p>
Form 1099-R	Statement for receipt of distribution from retirement plan.	Must be furnished to recipient of any distribution from the plan made during the calendar year by January 31 of the year following the year of distribution. Must be furnished to Internal Revenue Service by February 28 (paper) and March 31 (electronic) of the year following the year of distribution.
Notice of domestic relations order pending qualification	Plan administrator must provide to participants and all alternate payees.	Due promptly upon receipt of domestic relations order and upon determination that the order is or is not qualified.
PENSION BENEFIT GUARANTY CORPORATION ANNUAL FILINGS Estimated premium payment form	<u>PBGC Form 1-ES</u> – Estimated Premium Payment Form required for defined benefit plans with 500 or more participants on the preceding years' PBGC Form 1.	Must be filed with the PBGC, together with the flat rate portion of the PBGC premium, by the end of the second month of the plan year. If all the information for PBGC Form 1 is known at that time, Form 1 should be filed instead of Form 1-ES.
Annual premium payment form	<u>PBGC Form 1</u> – Annual Premium Payment Form reports premium for defined benefit plans for current plan year based on the number of participants at the end of the prior year. Also, used to reconcile PBGC Form 1-ES. <u>Schedule A</u> accompanies the variable rate portion of the PBGC premium for defined benefit plans.	<p>Must be filed with the PBGC, together with the applicable premium amount, 9½ months after the beginning of the plan year. There are special rules for the first and second plan years of a new plan.</p> <p>Must be filed with the PBGC with PBGC Form 1.</p>

ERISA's Compliance Obligations for Pension and Welfare Benefit Plans

Notice of reportable event	<p>Report to PBGC of certain significant plan events, e.g., decrease in participants, failure to make required minimum funding payment, inability to pay benefits when due, distribution to a substantial owner, change in controlled group, liquidation, extraordinary dividend or stock redemption, transfer of benefit liabilities, application for minimum funding waiver, loan default, insolvency or similar settlement.</p> <p>In addition, a Form 200 must be filed within 10 days of a payment due date when unpaid employer contributions (including interest) exceed \$1 million.</p>	In most cases, reporting is due 30 days after the event occurs. However, in certain cases involving nonpublic companies with large underfunding, advance notice of certain events must be given to PBGC.
Annual Funding Notice	Notice of whether a defined benefit plan is 100% funded and, if not, the actual funded percentage, together with detailed plan information regarding participants, assets and liabilities of the plan, funding policy, asset allocation, and more.	Generally due within 120 days of the end of the plan year; however, plans with fewer than 100 participants must furnish by the due date for filing annual Form 5500.
Notice of benefit restrictions	Notice of benefit restrictions which apply when the funding level of a defined benefit plan is less than 80%.	Generally due within 30 days after the plan is subject to a benefit restriction.
PBGC notice of underfunding	Annual financial and actuarial information required for large single employer defined benefit plans that generally have more than \$50 million in unfunded vested benefits.	Due on or before the 105th day after the end of the filer's fiscal year (or calendar year, if control group members have different fiscal years).
ERISA BOND/ FIDUCIARY INSURANCE (See ERISA §412.)	<p>ERISA bond required for fiduciaries who handle funds or other property under the plan. There are exceptions for some corporate fiduciaries. The amount of the bond must be at least 10% of the funds handled and not less than \$1,000 or more than \$500,000.</p> <p>Consider purchasing fiduciary liability insurance.</p>	Amount of bond required is established at the beginning of each plan year.
INVESTMENT POLICY STATEMENT	Written statement providing fiduciaries responsible for plan investments (including investment managers) with guidelines or general instructions concerning types or categories of investment management decisions, which may include proxy voting.	Should be monitored and reviewed at least annually.

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PERIODIC BENEFIT STATEMENT	To any participant or beneficiary, on the basis of the latest available information, a description of the total benefits accrued and the nonforfeitable benefits, if any, that have accrued, or the earliest date on which benefits will become nonforfeitable.	Frequency of which plan administrator must provide notice is based on type of plan: (i) participant-directed defined contribution plan due quarterly; (ii) non-directed defined contribution plan due annually; and (iii) defined benefit plan due every three years (or may provide annual notice indicating how statement may be obtained).
STATEMENTS OF DEFERRED VESTED BENEFITS	To each participant who has separated from service with a deferred vested benefit, a description of this benefit and any benefit that is forfeitable if the participant dies before a certain date.	Plan administrator must provide to such participants on or before the day by which Form 8955-SSA must be filed.
SEPARATE LINE OF BUSINESS NOTICE (See Code §1.414(r)-4.)	Form 5310-A notifying the IRS that the employer intends to test on a qualified separate line of business basis, if applicable.	Must be filed with the IRS not later than the 15th day of the 10th month following the plan year for which qualified separate line of business testing will be used. Once notice has been filed, it will apply for all subsequent years until the employer notifies the IRS that the qualified separate line of business status has been revoked, modified or amended. Such notice of change is also filed on Form 5310-A under the same time requirements as the initial notice.
NOTICE OF DENIAL OF CLAIM (See ERISA §2560.503-1.)	To participants and beneficiaries who submit claims that are denied.	Plan administrator (or the insurance company, insurance service or other similar organization, if 29 C.F.R. §2560.503-1(c) applies, relating to insured welfare or pension plans) must provide response to claimants (participants and beneficiaries) within 90 days after receipt of a claim for benefits. A claimant must be given at least 60 days to appeal a claim. If denial is appealed, an appropriate named fiduciary must furnish decision on review, generally within 60 days. Note: Special rules apply for certain health and disability plans. See Appendix G.

ERISA's Compliance Obligations for Pension and Welfare Benefit Plans

<p>ELECTION TO REMAIN UNDER PRIOR VESTING SCHEDULE</p>	<p>Plan administrator must communicate this information to participants whenever there is a change to the current vesting schedule.</p>	<p>A participant meeting the 3-year service requirement may elect to remain under the pre-amendment vesting schedule. This election must be made during a period which begins no later than the date the plan amendment changing the schedule is adopted and ends no earlier than the latest of the following:</p> <ul style="list-style-type: none"> (a) 60 days after the day amendment is adopted (b) 60 days after amendment becomes effective (c) 60 days after the participant is issued written notice of amendment by employer or plan administrator
<p>SUMMARY PLAN DESCRIPTION (SPD)</p> <p>(See ERISA §2520.102-3 regarding contents of SPD and §2520.104b-2 regarding obligation to furnish SPD.)</p>	<p>To each participant and beneficiary receiving benefits under the plan, providing a summary of plan provisions.</p>	<p>SPD includes such information as: name and type of plan; plan's requirements regarding eligibility; description of benefits and when participants have a right to those benefits; statement that the plan is maintained pursuant to a collective bargaining agreement, if applicable; statement about whether the plan is covered by termination insurance from the Pension Benefit Guaranty Corporation; source of contributions to the plan and the methods used to calculate the amount of contributions; provisions governing termination of the plan; procedures regarding claims for benefits and remedies for disputing denied claims; statement of rights available to plan participants under ERISA.</p> <p>New employees must receive a copy of their plan sponsor's latest Summary Plan Description within 90 days after becoming covered by the plan. Plan sponsors are not required to file the Summary Plan Description with the Department of Labor (DOL), although they are required to provide it to DOL upon request.</p>

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UPDATED SPD	To each participant and beneficiary receiving benefits under the plan, providing an updated summary of plan provisions.	Must distribute to participants and beneficiaries receiving benefits under the plan within 210 days after the end of the plan year that is 5 years after the date of the most recent SPD if there have been any plan amendments, and 10 years after the date of the most recent SPD if there have been no plan amendments. The plan administrator must make the latest updated SPD available for examination by any participant or beneficiary in the principal office of the plan administrator. A copy of the latest updated SPD must be furnished to participants and beneficiaries no later than 30 days after written request. ²
SUMMARY OF MATERIAL PLAN MODIFICATIONS (SMM) (See ERISA §2520.104b-3.)	To each participant and each beneficiary receiving benefits under the plan after any material modifications have been made to the plan in a manner calculated to be understood by the average plan participant.	Must distribute to participants and beneficiaries receiving benefits under the plan within 210 days after the end of the plan year in which the plan modifications were adopted (within 60 days after adoption if modifications involve material benefit reductions). All SMMs must be included with SPD furnished to participants and beneficiaries receiving benefits under the plan, if not incorporated into that SPD. The plan administrator must make the SMM available for examination by any participant or beneficiary in the principal office of the plan administrator. A copy of the SMM must be furnished to participants and beneficiaries upon written request. ²
401(k) SAFE HARBOR NOTICE	Plan administrator must provide a notice to all eligible employees for each plan year that a 401(k) plan will be a safe harbor 401(k) plan.	Must distribute to all eligible employees under the plan at least 30 and not more than 90 days before the applicable plan year. A newly eligible employee must also receive the notice no more than 90 days before the employee becomes eligible and no later than the date the employee becomes eligible to participate in the plan. The SECURE Act eliminated the safe harbor notice requirement for nonelective safe harbor plans.
PARTICIPANT FEE DISCLOSURE	Plan administrator must provide plan expense and fee information and information for each investment option available under the plan.	Must provide annual general disclosure and quarterly specific disclosure with actual administrative and individual expenses charged to the participant or beneficiary account on an individual rather than a plan-wide basis.

ERISA's Compliance Obligations for Pension and Welfare Benefit Plans

NOTICE OF SIGNIFICANT REDUCTION IN RATE OF FUTURE ACCRUALS (ERISA 204(h) NOTICE)	When future benefit accruals will be significantly reduced by a plan amendment, the plan administrator must provide a written notice to each plan participant, alternate payee under a QDRO and employee organization representing participants. This notice must include a description of the amendment and its effective date.	After amendment is signed and at least 45 days before the amendment's effective date; however, in some circumstances a 15-day advance notice may be provided.
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Welfare Benefit Plans

Item	Description	Due Date, Disclosure, Etc.
ANNUAL REPORTS³	<u>Form 5500 and Schedules:</u> As described above. See Form 5500 instructions for plans exempt from filing requirements (e.g., some insured health plans with under 100 participants) and for other special rules. Required for flexible benefit plans with medical flexible spending accounts.	As described above.
SUMMARY ANNUAL REPORT⁴	As described above.	As described above, except that the summary annual report need not be furnished to beneficiaries.

3. A welfare plan that (i) covers fewer than 100 participants at the beginning of the plan year, (ii) is unfunded and/or provides benefits exclusively through insurance contracts or HMOs, where premiums are paid by the employer from its general assets or partly from its general assets and partly from employee contributions (provided that contributions by participants are forwarded by the employer within 3 months of receipt) and (iii) for insured plans, provides that refunds are returned to participants within 3 months of receipt by the employer and provides that contributing participants are informed of plan provisions regarding refunds, is not required to (i) file with the Department of Labor the annual report or any terminal report, (ii) furnish participants with a copy of the summary annual report, (iii) furnish participants and beneficiaries, on written request, with a copy of the SPD, the updated SPD, the SMM, the annual report or any terminal report or (iv) make copies of the SPD, the updated SPD, the SMM or the annual report available for examination by participants and beneficiaries.

4. A welfare plan for a select group of employees under 29 CFR 2520.104-24 is not required to provide a summary annual report to participants.

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NONDISCRIMINATION TESTS	<p>Nondiscrimination tests required by the following Code Sections must be performed for any plan maintained by the employer to which the Code Section applies:</p> <ul style="list-style-type: none"> • Code §79 group term life insurance • Code §105(h) self-insured medical reimbursement • Code §120 legal services plan (currently expired) • Code §125 cafeteria plan • Code §127 tuition reimbursement program • Code §129 dependent care assistance program • Code §132 fringe benefit plan • Code §501(c)(9) and 505 VEBAs 	These tests must be completed each plan year to determine whether benefits provided can be excluded from the participant's taxable income.
ADMINISTRATIVE FORMS Salary reduction forms	Written elections from participants regarding pre-tax and after-tax premiums or contributions to be withheld from paychecks.	Must be received from participants before issuance of the first paycheck from which the amount is to be deducted. Consider compliance with state laws.
Notice of medical child support order pending qualification	Plan administrator must provide this notice to participants and alternate recipients regarding receipt and qualification determination on a MCSO directing the plan to provide health insurance coverage to a participant's noncustodial children.	Administrator, upon receipt of MCSO, must promptly issue notice (including plan's procedures for determining its qualified status). Administrator must also issue separate notice as to whether the MCSO is qualified within a reasonable time after its receipt.
FMLA forms	See below.	
COBRA forms	See below.	
SEPARATE LINE OF BUSINESS NOTICE/DEPENDENT CARE ASSISTANCE BENEFITS	Form 5310-A notifying the IRS that the employer intends to test dependent care assistance on a qualified separate line of business basis.	As described above. Single Form 5310-A will cover pension and dependent care programs.
SPECIAL ENROLLMENT RIGHTS NOTICE (See ERISA §701 and HIPAA regulations.)	Written notice of the health plans provisions concerning special enrollment rights, including the right to enroll within 30 days of the loss of other coverage or of marriage, birth of a child, adoption, or placement for adoption, or within 60 days of termination of Medicaid or CHIP coverage or eligibility for assistance under Medicaid or CHIP.	At or before the time an employee is offered opportunity to enroll in health plan.

ERISA's Compliance Obligations for Pension and Welfare Benefit Plans

EVIDENCE OF CREDITABLE COVERAGE OTHER THAN CERTIFICATE (See ERISA §706 and HIPAA regulations.)	Form used for individual who is not using a certificate of creditable coverage.	Form goes to any participant who wants to submit evidence of prior creditable health coverage (that is not a certificate). Should be sent as soon as possible after learning that the individual wants to submit alternate evidence.
REQUEST FOR UPDATED DEPENDENT INFORMATION (See ERISA §706 and HIPAA regulations.)	Disclosure of dependent information (e.g., name, age).	Should be sent annually to all participants; can be part of enrollment information.
HIPAA NOTICE OF PRIVACY PRACTICES (See HIPAA administrative simplification provisions)		Should be sent within 90 days following a participant's enrollment in the health plan and within 60 days of a material revision to the notice to individuals then covered by the health plan. Also, participants should be notified once every 3 years of availability of notice.
SUMMARY PLAN DESCRIPTION (SPD)³	As described above.	Should be provided as described above, except that the SPD need not be furnished to beneficiaries. Summary of material reductions in covered services or benefits under a health plan must be provided generally within 60 days of the adoption of a material reduction (usually provided through a SMM or updated SPD).
UPDATED SPD³	As described above.	Should be provided as described above, except that the updated SPD need not be furnished to beneficiaries. Summary of material reductions in covered services or benefits under a health plan must be provided generally within 60 days of the adoption of a material reduction (usually provided through SMM or updated SPD).
SUMMARY OF MATERIAL PLAN MODIFICATIONS (SMM)³	As described above.	Should be provided as described above, except that the SMM need not be furnished to beneficiaries. Summary of material reductions in covered services or benefits under a health plan must be provided generally within 60 days of the adoption of a material reduction (usually provided through SMM or updated SPD).

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ACA EXCHANGE-RELATED NOTICE TO EMPLOYEES	Provides notice of: 1) the existence of a health care marketplace exchange; 2) access to premium tax credit in certain circumstances; and 3) the loss of employer contributions to the employee's health plan if the employee chooses coverage through an exchange.	Distributed upon hire (i.e., within 14 days of the start date). Electronic disclosure is permitted if the employee has regular access to computer as part of job or if employee affirmatively consents.
COBRA FORMS (See Code §4980B and regulations.) Notice of rights to continued group health coverage (General COBRA Notice)	Form explaining COBRA rights.	Must distribute notice of COBRA rights to covered employees and their covered spouses within 90 days after commencement of coverage (or when individual experiences a qualifying event and is entitled to COBRA election, if sooner). Group health plans can satisfy this requirement by including the general notice in the plan's SPD and giving the SPD to the employee and to the spouse within this time limit.
Notice of qualifying event relating to continued group health coverage	Form in which employer notifies qualified beneficiaries of certain qualifying events.	Employer must provide notice to plan administrator within 30 days after an employee's death, termination of employment, reduction in hours, Medicare entitlement, or bankruptcy proceedings of employer. Plan administrator must then notify employee or his or her spouse of COBRA rights within 14 days of notification by the employer.
Notice of qualifying event relating to continued group health coverage	Form in which employee notifies employer of certain qualifying events.	Employee must provide notice to plan administrator within 60 days after divorce, legal separation or a child's becoming ineligible under the plan. Plan administrator must then notify spouse or dependent of COBRA rights within 14 days after notification by the employee.
Notice of unavailability of COBRA	Notice explaining the reason for denying the COBRA request.	To qualified beneficiaries within 14 days after notification of the qualifying event.
Notice of early termination of COBRA coverage	Notice describing the date coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage, such as a right to convert to an individual policy.	As soon as practicable after determining that coverage will terminate.

ERISA's Compliance Obligations for Pension and Welfare Benefit Plans

FAMILY AND MEDICAL LEAVE ACT (FMLA) NOTICE	<p>Covered employer (50 or more employees for each working day during 20 or more workweeks in the current or preceding calendar year) must post a notice describing FMLA provisions; the text of the notice is prescribed by regulations. Employer must also provide notice to the employee in the event of FMLA leave and other certifications. Employer must furnish additional information regarding FMLA to employees through a handbook or other written guidance.</p>	<p>Notice must be posted in conspicuous place(s) at all times. Written guidance must be provided to all employees through handbook or other means. The employer must provide specific details and notice forms to employees who provide notice of the need for FMLA leave.</p>
NEWBORNS' AND MOTHERS HEALTH PROTECTION ACT (See ERISA §711.)	<p>Notice of rights concerning maternity benefits.</p>	<p>Should be provided upon first day of eligibility for health plan; can be part of SPD if distribution of SPD made on first day of employment.</p>
WOMEN'S HEALTH AND CANCER RIGHTS ACT	<p>Notice of required benefits for mastectomy-related reconstructive surgery, prostheses, and treatment of physical complications of mastectomy.</p>	<p>Must be given to the following:</p> <ul style="list-style-type: none"> (a) Any individual who enrolls in the health plan during the year. Should be distributed on first day of employment; can be done via SPD if it is distributed at enrollment and notice is in SPD. (b) All COBRA beneficiaries. Should be distributed as part of COBRA packet upon qualifying event and on an annual basis to all COBRA beneficiaries as part of open enrollment for COBRA beneficiaries. (c) To health plan participants and beneficiaries. Should be distributed annually and could be distributed as part of annual enrollment materials. <p>A single notice may be sent to participants and beneficiaries living at the same mailing address. However, if a beneficiary has a different mailing address than the participant, separate notice should be sent to that beneficiary.</p>

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MEDICARE PART D: CREDITABLE OR NON- CREDITABLE COVERAGE NOTICE	<p>Disclosure by entities providing prescription drug coverage, as to whether its Medicare Part D coverage is creditable or non-creditable and effect on delayed enrollment.</p>	<p>Provide (i) annually by October 15 each year; (ii) within 12 months prior to an individual's initial enrollment period for Part D; (iii) within 12 months prior to the effective date of coverage for any Part D-eligible individual who enrolls in the employer's prescription drug coverage; (iv) when the plan no longer provides any drug coverage or when the coverage is no longer creditable; and (v) upon request provide as soon as practicable and no later than 30 days after the request is made. Sending the notice to all plan participants (regardless of whether Medicare eligible) annually <u>and</u> as part of new enrollee materials satisfies requirements (i), (ii) and (iii) above.</p>
MEDICARE PART D: DISCLOSURE TO CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)	<p>Online disclosure to CMS provides details to CMS of plan's prescription drug benefits. Participants in a "creditable" plan may not receive credit for participation and be subject to Part D enrollment penalties.</p>	<p>Must be filed online: (i) annually within 60 days following the beginning of the plan year and (ii) within 30 days after a termination or a plan change that modifies the creditable status of a plan.</p>

ERISA's Compliance Obligations for Pension and Welfare Benefit Plans

SUMMARY OF BENEFIT COVERAGE (SBC), INCLUDING UNIFORM GLOSSARY	Provides summary description of health plan benefits and coverage provisions and a uniform glossary of health plan definitions provided by the DOL.	<p>Must be given:</p> <ul style="list-style-type: none">(a) Annually to participants during open enrollment(b) At initial enrollment but no later than the first date participant is eligible to enroll(c) At special enrollment within 30 days after special enrollment(d) Within 60 days if a health plan makes a material modification that affects the SBC(e) As soon as possible upon request but no later than 7 business days following request <p>The SBC must be provided on request in a non-English language to individuals who reside in counties identified by the Census Bureau as having 10% or more of their population literate only in the same non-English language. An SBC furnished to residents of those counties must include a statement in the applicable non-English language advising participants of the availability of the language service. The current required additional languages are Spanish, Chinese, Tagalog, and Navajo.</p>
W-2 REPORTING OF EMPLOYER COVERAGE	Reflects the aggregate cost of health plan benefits and coverage provisions, as well as any employer contributions to an employee's HSA.	Reflected annually on issuance of W-2.

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ACA CODE SECTION 6055 REPORTING AND DISCLOSURE	<p>IRS – Specific employee information, plan sponsor information, and months of enrollment and entitlement to benefits.</p> <p>Participants – Information on the reporting entity and information reported to the IRS on the employee, spouse and dependents.</p>	<p>IRS (1094-C/1095-C) – On or before February 28 of the year following the year of report (if filed via paper) or March 31 of the year following the year of report (if filed electronically).</p> <p>Relief for fully insured GHP (2020 only): The IRS will not assess a penalty for failure to furnish to individuals Forms 1095-B for 2019 in cases in which:</p> <ul style="list-style-type: none">• the reporting entity posts a notice prominently on its web site stating that individuals may receive a copy of their 2019 Form 1095-B upon request, accompanied by an email address and a physical address to which a request may be sent, as well as a telephone number that individuals can use to contact the reporting entity with any questions; and• the reporting entity furnishes a 2019 Form 1095-B to any individual upon request within 30 days of the date the request is received. <p>Participant’s notice (1095-B and 1095-C) – On or before January 31 of the year following the year of report.</p>
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ERISA's Compliance Obligations for Pension and Welfare Benefit Plans

ACA CODE SECTION 6056 REPORTING AND DISCLOSURE	<p>IRS – Detailed information on employee relating to minimum value coverage offered and provided, months covered, etc., and certification of eligibility of employee.</p> <p>Participants – Individual statements to full-time employees (either form filed with IRS or substitute statement.</p>	<p>IRS (1094-C/1095-C) – On or before February 28 of the year following the year of report (if filed via paper) or March 31 of the year following the year of report (if filed electronically).</p> <p>Relief for fully insured GHP (2020 only): The IRS will not assess a penalty for failure to furnish to individuals Forms 1095-B for 2019 in cases in which:</p> <ul style="list-style-type: none"> • the reporting entity posts a notice prominently on its web site stating that individuals may receive a copy of their 2019 Form 1095-B upon request, accompanied by an email address and a physical address to which a request may be sent, as well as a telephone number that individuals can use to contact the reporting entity with any questions; and • the reporting entity furnishes a 2019 Form 1095-B to any individual upon request within 30 days of the date the request is received. <p>Participants (1094-C) – On or before January 31 of the year following the year of report.</p>
PCORI FEE (IRS FORM 720)	<p>Fee on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans to help fund the Patient-Centered Outcomes Research Institute, based on the average number of lives covered under the policy or plan.</p>	<p>Each July 31 until the fee expires in 2029.</p>
NOTICE OF STATE PREMIUM ASSISTANCE SUBSIDIES (CHIPRA)	<p>Provides notice of coordination of coverage under an employer health plan with state Medicaid and CHIP.</p>	<p>Annually by first day of each plan year. May be provided concurrently with (i) furnishing of materials relating to health plan eligibility (ii) materials provided to the employee during open enrollment election process, or (iii) furnishing the SPD</p>
EXCHANGE-RELATED NOTICES TO EMPLOYEES	<p>Provides notice of: 1) the existence of an exchange; 2) access to premium tax credit in certain circumstances; and 3) the loss of employer contributions to the employee's health plan if the employee chooses coverage through an exchange.</p>	<p>Must be given upon hire (i.e., within 14 days of start date).</p>

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ERISA BOND/ FIDUCIARY INSURANCE	As described above.	As described above.
NOTICE OF CLAIM DENIAL	Information regarding benefit claim determinations. Adverse benefit determination must include required disclosures (e.g., the specific reason[s] for the denial of a claim, reference to the specific plan provisions on which the benefit determination is based, and a description of the plan's appeal procedures).	<p>The SPD has to describe claims procedures, procedures for obtaining prior approval for a benefit, and all related time frames.</p> <p>Time for distributing notices varies depending on type of plan and type of benefit claim involved.</p> <p>Plan administrator (or insurance company, insurance service or other similar organization if 29 C.F.R. §2560.503-1(c) applies, relating to insured welfare or pension plans) must provide response to claimants (participants and beneficiaries) within 90 days after receipt of a claim for benefits. A claimant must be given at least 60 days to appeal a claim; if denial is appealed, an appropriate named fiduciary must furnish decision on review, generally within 60 days. Note: Special rules apply for certain health and disability plans. See Appendix G.</p>
ACA NOTICE OF RESCISSION	Under ACA, coverage can only be rescinded (retroactively terminated) for fraud or intentional misrepresentation.	Must provide at least 30 calendar days advance notice to an individual before coverage may be rescinded (retroactively terminated).
USERRA NOTICE	Notice of military rights, benefits and obligations.	<p>Employers must post Department of Labor's model notice where notices are customarily posted for employees.</p> <p>There are no prescribed methods for developing or distributing the notice, but employers can combine a USERRA continuation coverage notice and election form with its COBRA continuation coverage notice and election form. A best practice is also to include notice of such rights in the SPD.</p>

ERISA's Compliance Obligations for Pension and Welfare Benefit Plans

WELLNESS PROGRAM DISCLOSURE	Notice if individual must meet a health-related standard (e.g., BMI, non-smoker) to receive a reward. The notice must disclose the availability of a reasonable alternative standard (or possibility of waiver of the otherwise applicable standard).	Disclose in all plan materials describing the terms of the program the availability of any reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) provided under the program; however, if plan materials merely mention that a program is available, without describing its terms, this disclosure is not required.
WRITTEN PARTICIPANT REQUEST FOR DOCUMENTS		Required response within 30 days of request.

Appendix B

ERISA's Fiduciary Duties

What are ERISA's fiduciary duties?

ERISA provides that an employee benefit plan fiduciary must discharge his or her duties with respect to the plan in accordance with the following principles: (1) the fiduciary must act in accordance with the written plan documents unless such action would not be consistent ERISA; (2) the fiduciary must act solely in the interests of plan participants and beneficiaries; (3) the fiduciary must act for the exclusive purpose of providing benefits to plan participants and beneficiaries and defraying reasonable plan expenses; (4) the fiduciary must act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person 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; and (5) the fiduciary must diversify the investments of the plan so as to minimize the risk of losses unless it is clearly prudent not to do so.

To whom do those duties apply?

Anyone can be an ERISA fiduciary. A person becomes a fiduciary with respect to an employee benefit plan to the extent that the person exercises or has the authority to exercise any discretionary authority or control over the management or administration of an employee benefit plan or the management or disposition of the plan's assets. A person also becomes a fiduciary with respect to an employee benefit plan to the extent the person renders investment advice for direct or indirect compensation.

What activities typically will make a person an ERISA fiduciary with respect to an employee benefit plan?

A person will typically be a fiduciary if he or she engages in any activity relating to the management, investment or administration of the plan or plan assets, including the following examples: appointing other plan fiduciaries, delegating responsibility to or allocating duties among other plan fiduciaries, selecting and monitoring plan investment vehicles, acquiring or disposing of plan assets or interpreting plan provisions.

What activities typically will NOT make a person an ERISA fiduciary?

Purely administrative activities, such as calculating benefits, processing claims and maintaining records, typically will not render a person a plan fiduciary. The U.S. Department of Labor has said that the following administrative functions are not fiduciary activities: applying rules to determine eligibility for participation or benefits; calculating service and compensation for benefits purposes; preparing employee communication materials; maintaining participants' service and employment records; preparing reports required by government agencies; making recommendations with respect to plan administration; explaining plan benefits, rights and options to plan participants; collecting contributions and applying them as specified in the plan documents; preparing reports covering participants' benefits; processing claims; and calculating

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benefits. It should be noted, however, that courts have imposed liability upon plan fiduciaries and non-fiduciaries in a variety of circumstances involving traditionally nonfiduciary activities when participants have relied to their detriment upon inaccurate or incomplete communications from plan representatives and service providers.

Can service providers be held liable for fiduciary breaches?

Yes. Service providers can be held liable for breach of fiduciary duty. They can also be held liable for knowing participation in the breach of fiduciary duty of another fiduciary.

What plans are subject to these fiduciary rules?

These rules apply to all ERISA plans, including both welfare and pension plans.

Who enforces these rules?

These rules are enforced by the U. S. Department of Labor, the Internal Revenue Service and plan participants and beneficiaries.

Can a fiduciary be held personally liable for violating these duties?

Yes. If a fiduciary breaches his or her duties imposed by ERISA, he or she is personally liable to make the plan whole for any losses resulting from the breach. The fiduciary must also restore to the plan any profits that he or she made through the use of plan assets. Generally, this is true even if the person is unaware that he or she is a fiduciary or is unaware that he or she is violating ERISA's fiduciary duty requirements.

Can a fiduciary be held personally liable for violations of these duties made by another fiduciary of the plan (a "co-fiduciary")?

Yes. A fiduciary is liable for breach of duty by a co-fiduciary if he or she knowingly participates in or conceals a co-fiduciary's breach or enables the co-fiduciary's breach by failing to act prudently and in the interest of plan participants. A fiduciary is also liable if he or she knows of a co-fiduciary's breach and fails to make reasonable efforts to fix the breach. A co-fiduciary could include third-party service providers who take on a fiduciary role with respect to the plan or any other person who has authority and control over the plan and its assets.

What are 404(c) plans? Do they protect fiduciaries from liability?

404(c) plans are retirement plans that allow participants to direct the investment of their own accounts. If these plans meet the detailed requirements of Section 404(c) of ERISA, they provide the plan fiduciaries some limited protection. A common example of a 404(c) plan is a 401(k) plan that allows participants to select their investments from a menu of investment options chosen by the plan administrator. Such an arrangement may shield fiduciaries from liability for poor investment results if it meets the 404(c) requirements and the participant makes an affirmative investment election. However, the selection of the investment

options available for participants to choose among and the ongoing monitoring of those options are still fiduciary functions. Even if a fiduciary satisfies all the requirements under ERISA section 404(c) to shift liability and responsibility to the individual participants for investment decisions, the fiduciary could still lose 404(c) protection if he or she takes or fails to take certain actions. Therefore, it is important to realize that 404(c) plans offer only limited protection from fiduciary liability. Failure to comply with 404(c) may subject the plan fiduciary to liability for poor investment selections by the participant.

How can a fiduciary limit his or her potential legal exposure under ERISA?

The best way for a fiduciary to limit his or her potential legal exposure is to not be a fiduciary. If that is not an option, some basic methods to reduce fiduciary exposure include the following:

- Purchase fiduciary liability insurance.
- Obtain indemnification from your employer.
- Limit the scope of your fiduciary duties by allocating specific plan duties among other plan fiduciaries.
- Properly delegate duties to others; this requires both proper selection of the party to whom the duty is delegated and proper monitoring of that party's performance.
- Perform your duties well.
- Establish and follow a "prudent process." A "prudent process," if properly established and adhered to, shields the fiduciary from liability regardless of the results achieved. In other words, if a fiduciary follows a proper, prudent course of action, he or she will not be liable for fiduciary violations even if undesirable investment returns result. Why? Because although the Department of Labor has raised its scrutiny of fiduciary actions, neither the DOL nor the courts have imposed a "mind reading" requirement on plan fiduciaries. If a plan fiduciary takes actions that are designed and intended to carry out his or her fiduciary duties pursuant to ERISA's fiduciary standards, he or she will not be liable even if the results of those actions are investment losses. Key elements of a "prudent process" with respect to investment decisions include the following:
 - Describing the vendor selection process in writing
 - Developing and implementing a written investment policy statement
 - Maintaining a "due diligence" file documenting your selection, evaluation and monitoring process
 - Documenting your authority, your duties, your role, your decision-making process, your decisions and your actions

Appendix C

Qualifying Medical Expenses

Under Internal Revenue Code Section 213, “qualifying medical expenses” include amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, as well as amounts paid for the purpose of affecting any structure or function of the body. Whether a deduction is allowed for any particular expense will depend on whether the expense was essential and primary to the taxpayer’s (or his or her dependent’s) medical care. The following charts reflect some of the items for which the IRS has and has not allowed a qualifying medical expense deduction, as well as some “gray” areas. Because of the extremely fact-specific nature of this determination, taxpayers should consult with a legal or tax advisor regarding the deductibility of any expenses under Code Section 213.

Note: The charts included on the following pages are for illustration purposes only and should not be relied upon as legal or tax advice.

Appendix C

Deduction Allowed		
Abortion	Handicapped accommodations for one's home	Osteopaths
Acupuncture	Health insurance for self-employed individuals (limited)	OTC drugs and medicines
Ambulance services	Hearing aids	Oxygen and equipment
Artificial teeth and limbs	Hospital services	Prescription drugs
Birth control prescribed by doctor	Insulin	Psychiatric care
Blind aids (e.g., special equipment, cost of Braille books)	Legal expense necessary to authorize treatment for mental illness	Radial keratotomy
Chiropractors	Medical care insurance premiums	Remedial reading
Crutches	Medical expense for child before placement for adoption	Smoking cessation programs
Dental Treatment	Menstrual care products	Special food/beverages to treat specific illness, unless taken as a substitute for food normally consumed
Drug and alcohol addiction treatment	Nursing home	Special instruction, training or equipment for the deaf
Elective sterilization	Nursing services	Surgical, hospital and transportation costs for organ donors
Eyeglasses and/or contacts	Obstetrical expenses	Therapy
Fertility treatments	Occupational therapy	Weight reduction program if prescribed for special medical condition
Group home for intellectually and developmentally disabled child	Operations	Wheelchairs
Guide dog or other service animal (expenses to acquire, train and maintain)	Optometrists	X-rays

Deduction Not Allowed		
Auto insurance – medical expense payments	Handyman expenses	Nonprescribed weight loss methods
Babysitting and childcare	Health club dues	Nutritional supplements
Ear piercing	Housekeeper	Religious counseling
Electrolysis	Illegal operations and treatments	Tattoos
Fallout shelter	Lessons (e.g., dance, swimming) only for improvement of general health	Toothpaste
Funeral expenses	Marriage counseling	Vacation
Hair transplant	Maternity clothes	Wellness

Deduction Sometimes Allowed Depending on the Facts		
Air conditioning	Moving expense	Special school for disabled
Cosmetic surgery	Over-the-counter drugs	Transportation and lodging (for patient and accompanying person)
Domestic help	Psychoanalysis	Tuition for special-needs program
Long term care	Residence in a sanitarium or rest home	

Appendix D

Chronological List of Major Federal Employee Benefits Legislation Since ERISA

- Employee Retirement Income Security Act of 1974 (ERISA)
- Revenue Act of 1978
- Multiemployer Pension Plan Amendments Act of 1980 (MPPAA)
- Economic Recovery Tax Act of 1981
- Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)
- Deficit Reduction Act of 1984 (DEFRA)
- Retirement Equity Act of 1984 (REA)
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- Tax Reform Act of 1986 (TRA '86)
- Age Discrimination in Employment Amendments of 1986 (ADEA)
- Omnibus Budget Reconciliation Act of 1986 (OBRA '86)
- Omnibus Budget Reconciliation Act of 1987 (OBRA '87)
- Technical and Miscellaneous Revenue Act of 1988 (TAMRA)
- Retiree Benefits Bankruptcy Protection Act of 1988
- Omnibus Budget Reconciliation Act of 1989 (OBRA '89)
- Omnibus Budget Reconciliation Act of 1990 (OBRA '90)
- Americans with Disabilities Act of 1990 (ADA)
- Older Workers Benefit Protection Act of 1990 (OWBPA)
- Unemployment Compensation Amendments of 1992 (UCA)
- Family and Medical Leave Act of 1993 (FMLA)
- Omnibus Budget Reconciliation Act of 1993 (OBRA '93)
- Uruguay Round Agreements Act of 1994 (URAA) [implemented GATT, or the Uruguay Round General Agreement on Tariffs and Trade]
- Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)
- Retirement Protection Act of 1994 (RPA '94)
- Small Business Job Protection Act of 1996 (SBJPA)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Mental Health Parity Act of 1996 (MHPA)

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- Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)
- Taxpayer Relief Act of 1997 (TRA '97)
- Women's Health and Cancer Rights Act of 1998 (WHCRA)
- Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA)
- Trade Act of 2002
- Sarbanes-Oxley Act of 2002
- Job Creation and Worker Assistance Act of 2002 (JCWAA)
- Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA)
- Veterans Benefits Improvement Act of 2004
- Pension Funding Equity Act of 2004 (PFEA)
- Pension Protection Act of 2006 (PPA)
- Heroes Earnings Assistance and Relief Tax Act of 2008 (HEART Act)
- Worker, Retiree, and Employer Recovery Act of 2008 (WRERA)
- Genetic Information Non-discrimination Act of 2008 (GINA)
- Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
- Michelle's Law
- Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)
- American Recovery and Reinvestment Act of 2009 (ARRA)
- Patient Protection and Affordable Care Act of 2010 (ACA)
- Moving Ahead for Progress in the 21st Century Act (MAP-21)
- Cooperative and Small Employer Charity Pension Flexibility Act (CSEC Act)
- Multiemployer Pension Reform Act of 2014 (MPRA)
- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- 21st Century Cures Act
- Tax Cut and Jobs Act of 2017 (TCJA)
- Bipartisan Budget Act of 2018 (BBA2018)
- Continuing Appropriations Act, 2020, and Health Extenders Act of 2019
- Setting Every Community Up for Retirement Enhancement Act of 2019 (SECURE Act)
- Families First Coronavirus Response Act (FFCRA)
- Coronavirus Aid, Relief, and Economic Security Act (CARES Act)

Appendix E

Useful Employee Benefit Web Sites

Ogletree Deakins	www.ogletreedeakins.com
Indiana Chamber of Commerce	www.indianachamber.com
Internal Revenue Service (IRS)	www.irs.gov
Department of Labor (DOL)	www.dol.gov
Employee Benefits Security Administration (EBSA)	www.dol.gov/ebsa
International Foundation of Employee Benefit Plans	www.ifebp.org
Benefits Link	www.benefitslink.com
Indiana Worker's Compensation Board	www.in.gov/wcb/
Employee Benefit Research Institute	www.ebri.org
Form 5500 Information	www.efast.dol.gov , https://5500search.dol.gov , or www.irs.gov/formspubs
Bureau of Labor Statistics	www.bls.gov
Health and Human Services (HHS)	www.hhs.gov
Centers for Medicare and Medicaid Services (CMS)	www.cms.hhs.gov
Medicare	www.medicare.gov
Pension Benefit Guaranty Corporation (PBGC)	www.pbgc.gov
Securities and Exchange Commission	www.sec.gov
Social Security Administration (SSA)	www.ssa.gov
Indiana Government Web Portal	www.in.gov
HIPAA Administrative Simplification	www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA
Coronavirus (COVID-19) Information	www.ogletree.com or www.coronavirus.gov

Appendix F

Form 5500

The U.S. Department of Labor, Internal Revenue Service, and the Pension Benefit Guaranty Corporation jointly developed the Form 5500 Series so employee benefit plans could utilize the Form 5500 Series forms to satisfy annual reporting requirements under Title I and Title IV of ERISA and under the Internal Revenue Code. Forms and guidance can be found online at www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/form-5500.

The electronic filing system, eFast, is online at www.efast.dol.gov.

Appendix G

ERISA's Time Limits for Health Claims (for Health Plans with One Level of Appeal)

Appendix G

TYPE OF CLAIM	PERIOD FOR CLAIM REVIEWER TO DECIDE INITIAL CLAIM (If no additional information is needed; whether adverse or not)	EXTENSION OF TIME FOR DETERMINING INITIAL CLAIM	PERIOD FOR CLAIM REVIEWER TO NOTIFY CLAIMANT	PERIOD FOR CLAIM REVIEWER TO NOTIFY CLAIMANT OF CLAIMANT'S FAILURE TO FOLLOW PROPER PROCEDURES
Urgent Care Claim	No later than 72 hours after receipt of the claim by the plan	None	No later than 24 hours after receipt of the incomplete claim by the plan	No later than 24 hours after receipt of the improper claim by the plan
Pre-Service Claim	No later than 15 days after receipt of the claim by the plan	One 15-day extension is allowed if it is (i) due to matters beyond the plan's control and (ii) the claim reviewer notifies the claimant before the end of the initial 15-day period of such extension and of the date the claim reviewer expects to render a decision. If the extension is due to the claimant's failure to submit necessary information, the reviewer's notice will describe the required information. Note: The plan <u>may</u> or <u>may not</u> allow an extension due to the claimant's failure to provide needed information.	N/A	No later than 5 days after receipt of the improper claim by the plan
Post-Service Claim	No later than 30 days after receipt of the claim by the plan	One 15-day extension is allowed if it is (i) due to matters beyond the plan's control and (ii) the claim reviewer notifies the claimant before the end of the initial 30-day period of such extension and of the date the claim reviewer expects to render a decision. If the extension is due to the claimant's failure to submit necessary information, the reviewer's notice will describe the required information. Note: The plan <u>may</u> or <u>may not</u> allow an extension due to the claimant's failure to provide needed information.	N/A	N/A

ERISA's Time Limits for Health Claims (for Health Plans with One Level of Appeal)

TYPE OF CLAIM	PERIOD FOR CLAIMANT TO THEN PROVIDE NEEDED INFORMATION (If extension allowed by claim reviewer)	PERIOD FOR CLAIM REVIEWER TO DECIDE CLAIM AFTER REQUESTING ADDITIONAL INFORMATION AND NOTIFYING CLAIMANT (If applicable)	PERIOD FOR CLAIMANT TO FILE APPEAL	PERIOD FOR PLAN ADMINISTRATOR TO RESPOND
Urgent Care Claim	Not less than 48 hours after receipt of notice from claim reviewer	No later than 48 hours after earlier of (i) claim reviewer's receipt of additional information from the claimant or (ii) end of the period given to the claimant to provide additional information (48 hours)	180 days after receipt of denial by claimant	72 hours after receipt of appeal by plan administrator
Pre-Service Claim	At least 45 days after receipt of notice from the claim reviewer Note: The claim reviewer <u>may</u> or <u>may not</u> request needed information from claimant.	No later than 15 days after earlier of (i) claim reviewer's receipt of additional information from the claimant, if requested, or (ii) end of the period given to the claimant to provide additional information (45 days)	180 days after receipt of denial by claimant	30 days after receipt of appeal by plan administrator
Post-Service Claim	At least 45 days after receipt of notice from the claim reviewer Note: The claim reviewer <u>may</u> or <u>may not</u> request needed information from claimant.	No later than 15 days after earlier of (i) claim reviewer's receipt of additional information from the claimant, if requested, or (ii) end of the period given to the claimant to provide additional information (45 days)	180 days after receipt of denial by claimant	60 days after receipt of appeal by plan administrator

Appendix H

FSA, HRA, and HSA: Comparison of Health Funding Arrangements

	FSA	HRA	HSA
Who is eligible?	The employer establishes eligibility standards. These standards must meet Internal Revenue Code ("Code") rules for nondiscrimination.	The employer establishes eligibility standards. These standards must meet Internal Revenue Code ("Code") rules for nondiscrimination.	Federal law (not the employer) establishes eligibility standards. Any individual who is covered under a high-deductible health plan (HDHP) as of the first day of the month is an "eligible individual" and may be allowed a tax deduction for contributions made to an HSA. However, the individual may not be covered by any other health plan that is not an HDHP. In addition, the individual may not have coverage by another health plan for any benefit the HDHP covers
	No statutory restrictions on Medicare-eligible individuals.	No statutory restrictions on Medicare-eligible individuals.	Eligible individuals may not be Medicare-eligible (generally age 65 or older) or claimed as a dependent on another person's tax return.
	There are no restrictions on the types of health coverage that eligible individuals may have.	There are no restrictions on the types of health coverage that eligible individuals may have.	<p>Eligible individuals may have separate coverage for accidents, disability, dental and vision care or long-term care. In addition, the following "permitted insurance" coverage will not make an individual ineligible for an HSA: all insurance where substantially all of the coverage provided relates to liabilities from worker's compensation laws, torts or property ownership (e.g., auto insurance); insurance for a specified disease or illness; or insurance paying a fixed amount per day of hospitalization.</p> <p>EAPs, disease management programs and wellness programs that do not provide significant medical care or treatment are allowed.</p> <p>Beginning in 2020, telehealth services are allowed.</p> <p>Free or reduced cost health care through an on-site clinic may affect HSA eligibility.</p> <p>Discount cards are allowed.</p> <p>An individual who is covered by an FSA and/or an HRA that pays or reimburses all medical expenses that are not covered by the HDHP will not be eligible to participate in an HSA. However, an individual may still be covered under an HSA and/or an FSA under limited circumstances. See "Can/must the account coordinate with another medical plan, cafeteria plan or flexible spending account?" below.</p>

Appendix H

	FSA	HRA	HSA
What are the non-discrimination requirements?	Nondiscrimination requirements under Internal Revenue Code Sections 125 and 105(h) prohibit an employer from discriminating in favor of highly compensated employees.	The nondiscrimination rules applicable to self-insured HRAs are the same rules applicable to self-insured medical expense reimbursement plans. These rules prohibit an employer from discriminating in favor of highly compensated individuals with regard to eligibility to participate and benefits provided under the plan.	<p>If an employer makes contributions to an employee's account, the employer must make comparable contributions on behalf of all "comparable participating employees" during the same period. This comparability rule is applied separately to part-time employees (employees who work fewer than 30 hours per week).</p> <p>If an employer fails to follow the comparability rule, the employer is subject to an excise tax equal to 35% of the aggregate amount contributed by the employer to HSAs for that period.</p> <p>Note 1: Rollovers from other HSAs or Archer MSAs are not subject to this requirement.</p> <p>Note 2: The comparability rules do not apply if contributions are made through a cafeteria plan. In that case, the more flexible cafeteria plan nondiscrimination rules will apply.</p>
What is an HDHP (high-deductible health plan)?	An FSA may be used with any kind of health plan, whether or not it is an HDHP. In addition, employers who do not wish to provide underlying health insurance but who wish to assist employees with paying for some health expenses may consider contributing to an FSA.	An HRA may be used with any kind of health plan, whether or not it is an HDHP. In addition, employers who do not wish to provide underlying health insurance but who wish to assist employees with paying for some health expenses may consider contributing to an HRA. Note, however, that there are many rules that apply to HRAs that are not integrated with employer-sponsored coverage.	<p>An HDHP is a plan that (i) for single coverage, has an annual deductible not less than \$1,400 (2020) with total out-of-pocket expenses no greater than \$6,900 (2020), or (ii) for family coverage, has an annual deductible not less than \$2,800 (2020) with total out-of-pocket expenses of no more than \$13,800 (2020). A plan will still be an HDHP if preventive care is not subject to the deductible.</p> <p>Note 1: Limits are indexed.</p> <p>Note 2: Deductibles and out-of-pocket limits may be higher for out-of-network providers.</p> <p>Note 3: Separate deductibles (e.g., for prescription drug benefits) will not count against out-of-pocket limit.</p> <p>Note 4: Plan may provide no deductible for preventive care. Preventive care can include periodic health exams, prenatal and well-child care, immunizations, smoking cessation, obesity weight loss programs, screening services, preventive prescription drugs (if asymptomatic) and procedures done as a part of preventive care, as well as preventive care as defined under health care reform.</p>
Does the account have to be funded?	No. FSAs can be funded or unfunded.	No. HRAs can be funded or unfunded.	Yes. HSAs must be funded.

FSAs, HRAs, and HSAs: Comparison of Health Funding Arrangements

	FSA	HRA	HSA
Must there be a trust?	A separate trust is not required. An employee's account may only be a bookkeeping account, or it may be a funded account. Reimbursements may be paid from the employer's general assets or from the funded account.	A separate trust is not required. An employee's account may only be a bookkeeping account, or it may be a funded account. Reimbursements may be paid from the employer's general assets or from the funded account.	<p>A health savings account means a trust created in the United States as an HSA for the exclusive purpose of paying the qualified medical expenses of the individual.</p> <p>The trust must be a written document that meets the following criteria:</p> <ul style="list-style-type: none"> • Established in the name of the beneficiary • Belongs to the beneficiary personally (not the employer) • The beneficiary must be fully vested in the account balance • Contributions must be in cash (except for rollover contributions) and not exceed 100% of the deductible limit • Investments may not be made in life insurance contracts • The assets may not be commingled with other property
Who can be trustee?	No trustee is required.	No trustee is required.	The trust must be maintained by a qualified HSA custodian (e.g., bank, life insurance company or approved non-bank custodian).
Who may administer the account?	The employer may administer the FSA. The employer may also delegate administration to a third-party administrator.	The employer may administer the HRA. The employer may also delegate administration to a third-party administrator.	<p>An HSA may be administered by any insurance company, bank or any other person approved by the IRS to administer IRAs or Archer MSAs.</p> <p>Note: The HSA does not have to be administered by the same entity that provides the HDHP.</p>
Who invests the account?	Accounts are generally not funded (reimbursements generally come from the employer's general assets), but if funded, the employer would likely control the investments.	Accounts are generally not funded (reimbursements generally come from the employer's general assets), but if funded, the employer would likely control the investments.	The employees determine who invests their account. The employer can establish a program but cannot force an employee to use that program.

Appendix H

	FSA	HRA	HSA
What “medical expenses” can the account be used for?	<p>The account can be used for the following:</p> <ul style="list-style-type: none"> • Amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease • Amounts paid for the purpose of affecting any structure or function of the body • Expenses incurred for the transportation primarily for and essential to medical care • As of 2020, over-the-counter drugs and menstrual products 	<p>The account can be used for the following:</p> <ul style="list-style-type: none"> • Amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease • Amounts paid for the purpose of affecting any structure or function of the body • Expenses incurred for the transportation primarily for and essential to medical care • Expenses for qualified long-term care services for any qualified long term care insurance contract • As of 2020, over-the-counter drugs and menstrual products 	<p>Same as an HRA.</p>
Can the account be used for health insurance premiums?	No.	Yes. The HRA may pay insurance premiums covering medical care both before and after employment.	HSA funds may be used before age 65 to pay for premiums only in very limited circumstances (e.g., COBRA, a qualified long-term care insurance contract or premiums while on unemployment). HSA funds may be used to pay for premiums for individuals age 65 and over for any insurance other than Medicare supplemental insurance (e.g., may be used for Medicare Part B premiums and employer retiree health insurance but not to pay Medigap premium).
How can accounts/distributions be used?	FSAs may only be used for reimbursement of qualified medical expenses.	HRAs may only be used for reimbursement of qualified medical expenses.	Funds in an HSA may be used for any purpose. If funds are not used for qualified medical expenses, taxes and a 10% penalty will apply. However, if the account beneficiary is age 65 or older, dead or disabled, no penalty will apply.

FSAs, HRAs, and HSAs: Comparison of Health Funding Arrangements

	FSA	HRA	HSA
Who can make contributions?	Employee and employer (but usually only the employee). Contributions are made through a cafeteria (125) plan.	Employer only. Contributions may not be made through a cafeteria (125) plan.	Employer, employee and/or anyone else on behalf of account beneficiary may make cash contributions. Contributions may be made through a cafeteria (125) plan.
When can contributions be made?	Contributions must be made in substantially equal installments over the course of the plan year.	Contributions can be made during the plan year as designed by the employer.	Contributions may be made at any time during the tax year and up to the time that the eligible individual's tax return is due for the relevant year (without extensions). However, contributions can only be made for months in which an individual is eligible.
Can/must the account coordinate with another medical plan, cafeteria plan or flexible spending account?	No other plan is required. Note 1: FSAs are often tied to the employer's health care plan. Note 2: FSAs can coordinate with HRAs.	No other plan is required. Note 1: HRAs are often tied to the employer's health care plan. Complex rules apply when HRAs are not integrated with the employer's health care plan. Note 2: HRAs can coordinate with FSAs; however, contributions may not be made through a cafeteria (125) plan.	Eligible individuals must have an HDHP (which can include a self-insured plan). An individual who is covered by an FSA and/or HRA that pays or reimburses all medical expenses not covered by the HDHP will not be eligible to participate in an HSA. This is true if the individual is covered by a health FSA/HRA of his or her spouse. (See also, "Who is Eligible?") However, eligible individuals may have an HRA and/or an FSA under limited circumstances. Limited Purpose Health FSA/HRA: An individual may have an HSA (assuming the existence of an HDHP) if covered by an FSA and/or HRA that only pays or reimburses vision and dental expenses (regardless of whether the minimum annual deductible of the HDHP has been satisfied) and/or preventive care benefits without losing eligibility status for an HSA. Post-Deductible Health FSA/HRA: An individual may have an HSA if covered by an FSA/HRA that pays or reimburses medical expenses (including the individual's co-insurance responsibility for expenses above the deductible of the HDHP) after the minimum annual deductible of the HDHP has been satisfied. The deductible under the FSA/HRA does not have to be same as for the HDHP, but a lower deductible under an FSA/HRA will affect the limit on an HSA.

Appendix H

	FSA	HRA	HSA
Can/must the account coordinate with another medical plan, cafeteria plan or flexible spending account? (continued)			<p>Suspended HRA: An individual who is otherwise eligible for a HSA will not lose his/her eligibility if he/she receives employer contributions to an HRA but elects prior to the beginning of the HRA coverage period to forego the payment or reimbursement of medical expenses incurred during that coverage period. The HRA may be used for expenses related to permitted insurance, permitted coverage and preventive care during the time period he/she has foregone payment, and for reimbursement of other medical expenses incurred after the suspended coverage period ends.</p> <p>Retirement HRA: An individual will remain eligible for an HSA if he/she is covered by an HRA that only reimburses medical expenses incurred after he/she retires.</p> <p>Note: HSA contributions may be made through a cafeteria (125) plan.</p>
Can employees take their account with them when they leave employment? (Are the accounts portable?)	<p>No, but employers generally allow accounts to be used for expenses incurred before the end of employment. In addition, FSAs are subject to COBRA.</p>	<p>No, but reimbursement for medical (and other permitted) expenses of the former employee is permitted (e.g., to fund retiree health benefits). In addition, HRAs are subject to COBRA.</p>	<p>Yes. The HSA belongs to the individual owner/account beneficiary.</p>

FSAs, HRAs, and HSAs: Comparison of Health Funding Arrangements

	FSA	HRA	HSA
Can account balances be carried over to the next taxable year?	Yes, but only if an employer chooses to allow a 2½-month grace period at the end of the plan year or a carryover. If the plan uses a grace period, unused account balances are forfeited at end of the grace period. If the plan uses a carryover, the maximum amount that can be carried over to the next plan year is 20% of the maximum employee contribution amount (for 2020, the maximum employee contribution amount is \$2,750, so the maximum carryover amount from 2020 to 2021 is \$550). Otherwise, unused account balances are forfeited at the end of the taxable year.	Yes, if the employer designs the HRA to permit carryovers.	Yes.
What are the contribution limits, if any?	Beginning in 2013, \$2,500 per employee per taxable year (as indexed). For 2020, the maximum contribution amount was \$2,750. Employers may impose a lower limit. In addition, nondiscrimination rules designed to ensure that benefits do not discriminate in favor of highly compensated employees may require limits. Generally, nonelective employer contributions (e.g., matching or seed contributions, flex credits, or after-tax contributions) do not count against the limit.	None under the Code. Employers may impose limits. In addition, nondiscrimination rules designed to ensure that benefits do not discriminate in favor of highly compensated employees may require limits.	Total contributions (regardless of source) are limited to \$3,550 (2020) for individual coverage or \$7,100 (2020) for family coverage. Note 1: Limits are indexed. A Medicare-eligible individual (generally age 65) may not make any contributions. Contributions made to an Archer MSA during the same taxable year must be added to HSA contributions to determine contribution limitations.
Are catch-up contributions permitted?	No.	No.	Yes, \$1,000 for ages 55-65.
Are contribution limits coordinated with anything else?	No.	No.	Maximum contributions are reduced by any Archer MSA contributions made in the same year.
What are the penalties for excess contributions?	If excess contributions are not returned to the employee and reported as wages for federal withholding and tax purposes, cafeteria plan could lose tax-advantaged status.	None, since there are no statutory limits.	If excess contributions are not returned to the account beneficiary by the account beneficiary's tax return due date, a 6% excise tax penalty will be imposed.

Appendix H

	FSA	HRA	HSA
Are rollovers permitted? If so, how are rollovers treated with regard to the contribution limitations?	No.	No.	Rollovers from HSAs, Archer MSAs, and qualified HSA funding distributions from IRAs are permitted. HSA and Archer MSA rollovers are not subject to the annual contribution limitation. Rollovers are not permitted from flexible spending accounts or HRAs.
Are contributions deductible/excludable from an employee's income?	<p>Yes. Employee contributions generally come through elective deferrals in a cafeteria (125) plan and are considered employer contributions to employer-provided coverage under an accident or health plan and are excludable from gross income.</p> <p>Employer contributions are treated as employer-provided coverage under an accident or health plan and are excludable from gross income.</p>	<p>No employee contributions are permitted.</p> <p>Employer contributions are treated as employer-provided coverage under an accident or health plan and are excludable from gross income.</p>	<p>Yes. Employee contributions are deductible in computing gross income without regard to itemized deduction limitations. However, no deduction is allowed for a HSA contribution to anyone who can be claimed as a dependent by another taxpayer for the past year.</p> <p>Employer contributions are treated as employer-provided coverage under an accident or health plan and are excludable from gross income.</p>
Are contributions subject to income withholding taxes?	No.	No.	Employer contributions are not subject to withholding taxes if it is reasonable to believe that contributions will be excludable from an employee's income. Employee contributions are subject to withholding but may not be if made through a cafeteria plan.
For FICA-covered positions, are the employer contributions subject to FICA? Are employer contributions subject to other payroll taxes, such as Medicare tax?	No.	No.	No, unless it's not reasonable to assume that contributions will be excludable from employee's income.

FSAs, HRAs, and HSAs: Comparison of Health Funding Arrangements

	FSA	HRA	HSA
For FICA-covered positions, are the employee contributions subject to FICA? Are employee contributions subject to other payroll taxes, such as Medicare tax?	No.	Not applicable because employee contributions are not permitted.	Yes, but they may be exempt from FICA and payroll taxes if HSA contributions are made by salary reductions through a cafeteria plan.
Does the employer have to substantiate expenses?	Yes. Substantiation of expenses is required.	Yes. Substantiation of expenses is required.	No. The employee may need to substantiate to the IRS if requested to justify deductions.
Are payments/reimbursements deductible/excludible from income?	Yes. Since reimbursements may only be used for the account holder, spouse or dependents, reimbursements are generally excludible from income.	Yes. Since reimbursements may only be used for the account holder, spouse or dependents, reimbursements are generally excludible from income.	Yes, if used to reimburse medical expenses for the account beneficiary, spouse or dependents (if not covered by another plan). HSAs can be used to make payments for other expenses, but distributions will be subject to normal income taxes plus a 10% penalty. There is no 10% penalty for any payment after age 65 or in event of death or disability.
What are the reporting requirements?	None, assuming contributions are eligible for tax-favorable treatment (i.e., participants have not used contributions for ineligible expenses or received contributions for ineligible dependents).	Generally none, assuming contributions are eligible for tax-favorable treatment (i.e., participants have not used contributions for ineligible expenses or received contributions for ineligible dependents). Qualified Small Employer HRAs must report the total amount of the QSEHRA benefit on Form W-2 in Box 12.	The employer is required to report contributions on the employee's Form W-2. The trustee is required to report distributions on Form 1099-SA. Form 8889 is required to be filed with the employee's tax return to report contributions (including excess contributions) to and distributions from an HSA.
Is COBRA coverage required to be provided?	Yes.	Yes.	No.

Appendix H

	FSA	HRA	HSA
What happens in the case of death or divorce?	Divorced/surviving spouse and dependents will likely be eligible for COBRA coverage to spend down account.	Divorced/surviving spouse and dependents will likely be eligible for COBRA coverage to spend down account.	<p>Death: If beneficiary is spouse, HSA retains its character, and surviving spouse is considered account beneficiary. If beneficiary is not spouse, then HSA ceases and fair market value is includible in beneficiary's income.</p> <p>Divorce: Interest in a HSA may be transferred to divorced spouse and is not a taxable transfer. Transferred interest is still considered to be an HSA.</p> <p>Note: HSAs are not subject to COBRA.</p>
Can an employer restrict eligibility to receive employer contributions based on nonstatutory obligations (e.g., submitting eligibility data on a monthly basis)?	Employers generally do not fund, but if they do, same as HRA.	<p>Yes.</p> <p>The eligibility requirements must be included in the plan document and communicated to employees.</p>	<p>Yes, if the employer provides contributions through a written plan document.</p> <p>Same as HRA.</p>

Appendix I

Selecting and Monitoring Pension Consultants: Tips for Plan Fiduciaries

Note: This information is reprinted from the U.S. Securities and Exchange Commission web site and may be accessed at www.sec.gov/investor/pubs/sponsortips.htm.

The Employee Retirement Income Security Act (ERISA) requires that fiduciaries of employee benefit plans administer and manage their plans prudently and in the interest of the plan's participants and beneficiaries. In carrying out these responsibilities, plan fiduciaries often rely heavily on pension consultants and other professionals for help. Findings included in a report by the staff of the U.S. Securities and Exchange Commission released in May 2005, however, raise serious questions concerning whether some pension consultants are fully disclosing potential conflicts of interest that may affect the objectivity of the advice they are providing to their pension plan clients.

Under the Investment Advisers Act of 1940 ("Advisers Act"), an investment adviser providing consulting services has a fiduciary duty to provide disinterested advice and disclose any material conflicts of interest to clients. In this context, SEC staff examined the practices of advisers that provide pension consulting services to plan sponsors and trustees. These consulting services included assisting in determining the plan's investment objectives and restrictions, allocating plan assets, selecting money managers, choosing mutual fund options, tracking investment performance and selecting other service providers. Many of the consultants also offered, directly or through an affiliate or subsidiary, products and services to money managers. Additionally, many of the consultants also offered, directly or through an affiliate or subsidiary, brokerage and money management services, often marketed to plans as a package of "bundled" services. The SEC examination staff concluded in its report that the business alliances among pension consultants and money managers can give rise to serious potential conflicts of interest under the Advisers Act that need to be monitored and disclosed to plan fiduciaries.

To encourage the disclosure and review of more and better information about potential conflicts of interest, the Department of Labor and the SEC have developed the following set of questions to assist plan fiduciaries in evaluating the objectivity of the recommendations provided, or to be provided, by a pension consultant.

1. Are you registered with the SEC or a state securities regulator as an investment adviser? If so, have you provided me with all the disclosures required under those laws (including Part II of Form ADV)?

You can check yourself – and view Part I of the firm's Form ADV – by searching the SEC's Investment Adviser Public Disclosure web site. Your investment adviser must furnish you with a copy of Part II of Form ADV. At present, the IAPD database contains Forms ADV only for investment adviser firms that register

Appendix I

electronically using the Investment Adviser Registration Depository. In the future, the database will expand to encompass all registered investment advisers – individuals as well as firms – in every state. If you can't locate an investment adviser in IAPD, be sure to contact your state securities regulator or the SEC's Public Reference Branch.

2. Do you or a related company have relationships with money managers that you recommend, consider for recommendation or otherwise mention to the plan for our consideration? If so, could you describe those relationships?

When pension consultants have alliances or financial or other relationships with money managers or other service providers, the potential for material conflicts of interest increases, depending on the extent of the relationships. Knowing what relationships, if any, your pension consultant has with money managers may help you assess the objectivity of the advice the consultant provides.

3. Do you or a related company receive any payments from money managers you recommend, consider for recommendation or otherwise mention to the plan for our consideration? If so, what is the extent of these payments in relation to your other income (revenue)?

Payments from money managers to pension consultants could create material conflicts of interest. You may wish to assess the extent of potential conflicts.

4. Do you have any policies or procedures to address conflicts of interest or to prevent these payments or relationships from being considered when you provide advice to your clients?

Probing how the consultant addresses these potential conflicts may help you determine whether the consultant is right for your plan.

5. If you allow plans to pay your consulting fees using the plan's brokerage commissions, do you monitor the amount of commissions paid and alert plans when consulting fees have been paid in full? If not, how can a plan make sure it does not overpay its consulting fees?

You may wish to avoid any payment arrangements that could cause the plan to pay more than it should in pension consultant fees.

6. If you allow plans to pay your consulting fees using the plan's brokerage commissions, what steps do you take to ensure that the plan receives best execution for its securities trades?

Where and how brokerage orders are executed can impact the overall costs of the transaction, including the price the plan pays for the securities it purchases.

7. Do you have any arrangements with broker-dealers under which you or a related company will benefit if money managers place trades for their clients with such broker-dealers?

As noted above, you may wish to explore the consultant's relationships with other service providers to weigh the extent of any potential conflicts of interest.

8. If you are hired, will you acknowledge in writing that you have a fiduciary obligation as an investment adviser to the plan while providing the consulting services we are seeking?

All investment advisers (whether registered with the SEC or not) owe their advisory clients a fiduciary duty. Among other things, this means that advisers must disclose to their clients information about material conflicts of interest.

9. Do you consider yourself a fiduciary under ERISA with respect to the recommendations you provide the plan?

If the consultant is a fiduciary under ERISA and receives fees from third parties as a result of his or her recommendations, a prohibited transaction under ERISA occurs unless the fees are used for the benefit of the plan (e.g., offset against the consulting fees charged the plan) or there is a relevant statutory or class exemption permitting the receipt of such fees.

10. What percentage of your plan clients utilize money managers, investment funds, brokerage services or other service providers from whom you receive fees?

The answer may help in evaluating the objectivity of the recommendations or the fiduciary status of the consultant under ERISA.

For more information on the SEC staff's findings, please read Staff Report Concerning Examinations of Select Pension Consultants. Plan trustees, pension consultants and other service providers can learn about their fiduciary responsibilities under the Employee Retirement Income Security Act (ERISA) by visiting the web site of the Department of Labor. Pension consultants who have questions concerning their obligations under the Investment Advisers Act of 1940 should either consult with an attorney who specializes in the federal securities laws or contact the staff of the SEC's Division of Investment Management.

This information is reprinted from the U.S. Securities and Exchange Commission web site and may be accessed at www.sec.gov/investor/pubs/sponsortips.htm.



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