Employee Benefits Report

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Qualified vs. Nonqualified Plans?

Are you looking to reward a few highly compensated employees? Are you unwilling to take on a lot of extra benefits paperwork and administrative costs? A nonqualified retirement plan could meet the needs of your organization and your employees.

A qualified retirement plan must meet the requirements of Internal Revenue Code Section 401(a) and the Employee Retirement Income Security Act (ERISA) for coverage, participation, funding, vesting and reporting. In return, employers and participants enjoy certain tax advantages.

Meeting these requirements takes diligence, time and paperwork. Qualified plans cannot discriminate in favor of highly compensated employees. They must cover at least 70 percent of non-highly compensated employees, and employers must generally offer them to all full-time employees on the same terms. Any time an employer makes a contribution, it must make contributions on behalf of all participants. Some plans require employers to make annual contributions whether or not the company is profitable. Qualified plans require extensive reporting and, depending on how they are structured, you might have to perform complicated nondiscrimination tests.

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New California Legislation

As of January 1, 2012, SB 299 and AB 592 require that all employers with five or more employees provide pregnant employees the same level of insurance benefits during their pregnancy-related leaves as they were provided prior to taking the leave. Employers can always offer more leave or greater benefits, but under these new additions to the law, in no event may an employer maintain health benefits for less than the four-month period required by FEHA.

For larger employers covered under FMLA, these new pregnancy disability leave laws apply to all employees, regardless of tenure with the employer. Therefore, a pregnant employee could have

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Tax advantages

Despite the administrative burdens, qualified plans offer valuable tax advantages for both the employer and participating employees. Employers can take a current tax deduction for all qualified plan contributions, while employee accounts grow tax-free until the time of distribution. Qualified plans also have further protections under ERISA, the Employee Retirement Income Security Act of 1974. This federal law requires accountability of plan fiduciaries and gives participants the right to sue for benefits and breaches of fiduciary duty. Employer contributions to qualified plans are held in trust until the employee is entitled to receive them, an arrangement that helps assure employees that the money will actually be there when they retire.

Nonqualified deferred compensation (NQDC) plans are employer-sponsored retirement plans designed to benefit a select group of executive or key employees. If the plan is properly structured, the employer can include only those employees it chooses — without having to abide by the anti-discrimination, participation or vesting rules that qualified plans must follow. NQDC plans may be formal or informal, and they need not be in writing.

NQDC plans typically fall into four categories. **Salary reduction arrangements** allow participants to defer receipt of a portion of their salary. **Bonus deferral plans** resemble salary reduction arrangements, except participants can use them to defer receipt of bonuses. In both these types of plans, participants elect to defer a portion of their compensation.

Employers who want to contribute to an NQDC can select from a **top-hat plan** or an **excess benefit plan**.

Also known as supplemental executive retirement plans, or SERPs, **top-hat plans** benefit a select group of management or highly compensated employees, while **excess benefit plans** provide benefits solely to employees whose benefits under the employer's qualified plan are limited by IRC Section 415. NQDC plans maintained by governmental and tax-exempt employers, referred to as 457 plans, are subject to a special set of rules.

Although non-qualified plans are subject to fewer government regulations, they receive fewer tax benefits. Any earnings in the plan are taxable to the employer and taxable to the employee when distributed as benefits. However, the employer can take a tax deduction at the time of distribution. And since non-qualified plan contributions are not held in a separate trust, employees receive no guarantee that benefits will be there when they retire — and any assets set aside for future payouts are subject to claims by the employer's creditors.

NQDC plans are either funded or unfunded, though most are intended to be unfunded because of the tax advantages unfunded plans afford participants. Under an unfunded arrangement, the employee has only the employer's "mere promise to pay" the deferred compensation benefits in the future, and the promise is not secured in any way. The employer may keep track of the benefit in a bookkeeping account, or it may choose to invest in annuities, securities or insurance to help fulfill its promise to pay the employee. The employer may transfer benefit amounts to a trust; however, funds remain part of the employer's general assets, subject to the claims of creditors if the employer becomes insolvent. If amounts are set aside from the employer's creditors for the exclusive benefit of the employee, the employee may have currently includible compensation.

The accompanying chart summarizes the key differences between qualified and nonqualified retirement plans. If you'd like to supplement your qualified plan with a nonqualified plan, please contact us for assistance and information. ■

just started working with your company and already qualify for up to four months of leave and health insurance benefits during that leave. This is more expansive than employer obligations under FMLA, which require an employee to complete at least one year of employment and 1,250 hours of work within that year to be eligible for the benefit.

Consumer-Driven Health Plans Promote Health While Saving Money

Many employers are switching to consumer-driven health plans (CDHPs) because they give employees incentives to control costs and improve their own health. Do they accomplish those goals? The evidence in favor of CDHPs is growing.

In a recently released survey, the Employee Benefit Research Institute (EBRI) found that individuals with CDHPs were more likely to engage in cost-conscious decision making than those with traditional plans. These cost-conscious behaviors included checking whether their plan would cover care, talking to their doctor about prescription options and costs, developing a budget to manage healthcare expenses, using online cost-tracking tools provided by their health plan and checking the price of a service before getting care.

Many human resource professionals would agree that consumer-driven plans increase employee engagement in their own health. A 2011 study by the Society for Human Resource Management (SHRM) found that HR professionals whose organizations offered account-based CDHPs were more likely to strongly or somewhat agree that offering a CDHP helped engage employees in their own health and wellness, at 77 percent versus 56 percent for the control group.

And health insurer Cigna recently announced that employees enrolled in its CDHP saved an average of $9,700 over five years as compared to individuals who remained enrolled in a traditional health plan. According to Cigna, "Cost reductions were achieved without employers shifting out-of-pocket health expenses to their employees," and the CDHP enrollees received higher levels of care.

For the purposes of its survey, the EBRI defined a CDHP as a high-deductible health plan (HDHP) paired with a tax-advantaged payment account. The most common type of tax-advantaged savings accounts are health savings accounts (HSAs) and health reimbursement arrangements (HRAs).

HSAs

If you want your employees to have an HSA, they must have a qualifying HDHP. For calendar year 2012, a qualifying "high-deductible health plan" must have an annual deductible of at least $1,200 for self-only coverage or $2,400 for family coverage (no changes from 2011). Annual out-of-pocket expenses (deductibles, co-payments and other amounts, excluding premiums) cannot exceed $6,050 for self-

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only coverage or $12,100 for family coverage.

Individuals covered by an HDHP can have no additional health coverage. This means that HSA participants cannot have a medical FSA (flexible spending account), unless it is limited to services not included in a medical plan, such as dental or vision expenses. You must also be under age 65 and not entitled to Medicare to have an HSA.

Employers can contribute to employees' HSAs; however, to avoid excise taxes, they must make "comparable" contributions for all "comparable" employees. Comparable contributions must either be the same dollar amount or the same percentage of the annual deductible limit under the employees' HDHP. Participating employees are considered comparable if they have the same category of coverage (self-only or family coverage) and the same category of employment (part-time, full-time, or former employees). For purposes of making contributions to HSAs of non-highly compensated employees, highly compensated employees shall not be treated as comparable participating employees.

For 2012, total contributions to an individual's HSA (from employer and employee) cannot exceed $3,100 for an individual with self-only coverage and $6,250 for family coverage under an HDHP.

HRAs

For employees who do not qualify for an HSA, you can establish an HRA, or health reimbursement arrangement. An HRA must be funded solely by an employer. Employers can use HRAs as a tax-advantaged benefit, to reimburse employees for qualified medical expenses. Employers determine the maximum dollar amount for a coverage period.

An HRA may be offered with other health plans, including FSAs. They can cover current and former employees, spouses and dependents of those employees (with limits), children under age 27 at the end of the tax year, and spouses and dependents of deceased employees.

As with an HSA, HRAs have tax advantages for both employers and employees, and amounts unused in one year can be carried forward, if the employer so structures the plan. But unlike HSAs, HRAs are generally subject to COBRA continuation coverage requirements.

Consumer-driven plans can help employers keep their employee medical costs under control. Of course, that comes with some risk, particularly for lower-paid employees, who are less likely to have funds available to pay an unexpected medical expense. A study by the National Bureau of Economic Research showed that half of all Americans would have a hard time coping with a $2,000 expense, such as a medical copayment. For employees likely to need expensive medical care in the near future, a consumer-driven plan might not be the best option. We can help you determine the plan that offers the best balance of coverage and cost for your employees. For more information, please contact us.

Critical Illness Insurance: Filling the Benefits Gap

Two important trends are converging and affecting employers' health benefit programs. As medical technologies and treatments improve, more people are surviving once-fatal forms of cancer, heart disease and other conditions. Many employers have responded to rising costs by increasing their employees' share of costs. This can leave many employees with staggering healthcare expenses — even if they have medical benefits. The answer? Supplemental health benefits.

The Advantages of Critical Illness Coverage

A critical illness policy pays a lump sum benefit if a plan participant is diagnosed with a serious health condition, such as cancer, heart attack or stroke. Illnesses covered under the policies vary, but can include Alzheimer's, paralysis, coma, multiple sclerosis and loss of hearing. These policies pay a lump sum upon diagnosis, which the insured can use for any expense — co-payments, travel costs, experimental treatments or even to replace wages of a family member leaving work to provide support.

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Maximum benefits under critical illness policies typically average around $25,000, with premiums costing about $300 to $500 annually, depending on the health, gender, age and location of the insured. Higher-end policies covering a dozen or more conditions generally pay benefits of more than $100,000 and cost about $1,500 to $2,000 a year.

Most critical illness policies are written on a voluntary basis, or entirely employee-paid, although an employer may choose to offset part of the cost. Most policies qualify under Section 125 plans, so workers using payroll deductions can allocate pre-tax dollars to pay premiums.

Critical illness policies are generally portable. In addition, equal benefit amounts are available for each family member when the employee buys family coverage. Some insurers offer a "return of premium" feature. If the insured dies of something that's not covered by the policy—say, a car accident or a very rare disease—the provider will give back all of the premiums, minus any benefits already paid.

Eligibility and enrollment. Employees usually must complete a detailed medical questionnaire as part of the critical illness insurance enrollment process. Applicants might be denied coverage if they already have a covered illness or if several direct relatives have had one. Policies under $100,000 generally don't require a medical exam. Some plans require waiting periods of 30 days or even several months before coverage begins. Some have a "survival period," a period of time after initial diagnosis that the insured must survive before the policy will pay.

Limitations. Most policies have age limitations. Many insurers won't issue new policies after ages 59 or 65, although the age cutoffs vary by insurer. After the cutoff age, many policies reduce the lump-sum payout by half, but don't reduce the premiums. In other words, if a policyholder has a stroke at age 75, she might only get half the benefit. Many critical illness policies also have fixed dollar limits, paying a maximum amount for individual services or limiting total benefits for a single illness to a fixed amount, such as $5,000 or $10,000.

Some financial advisors and consumer advocates claim that aggressive marketing by insurers might be scaring some individuals into purchasing coverage unnecessarily. They believe consumers would be better off devoting the premium dollars to savings, investments, or even to fitness programs to help reduce the risk of illness. In many cases, comprehensive health and disability coverage might be enough protection. However, since most employees do not have an adequate emergency fund, critical illness can provide valuable protection when the need arises.

It's a good idea to educate employees about their options regarding traditional health and disability insurance to ensure they make an informed decision about the need for supplemental benefits. Coordinating proposed benefits before adding critical care insurance can help avoid duplication of coverage.

Critical illness insurance might hold special appeal for employees who are caring for children or aging parents. By lessening the financial blow of a serious illness, the employee can focus on recovery, rather than the added stress of staggering medical expenses. Supplemental benefits can boost employee morale and foster loyalty—both of which enhance productivity. For more information about the right critical illness or other supplemental benefit policies for your employees, please contact us.

Requirements of a Qualified Retirement Plan

A qualified retirement plan offers tax advantages to both the employer and employee; however, they pose more compliance challenges than nonqualified plans. The IRS's "list of some of the more important retirement plan requirements" appears below. Note that the IRS also says, "Your plan may have other operational requirements that need to be monitored." We can help your organization set up and administer your retirement plan; please contact us for more information.

1. Minimum Participation Requirements
2. Operate in Accordance with Plan
3. No Cutback by Plan Amendment
4. 401(k) ADP and Distribution Requirement
5. Matching/Employee Contribution ACP Test
6. Elective Deferral Test
7. 415 Maximum Contribution/Benefit Limit
8. 401(a)(17) Maximum Compensation Limit
9. Top-Heavy Requirements
10. Minimum Vesting Requirements
11. Minimum Distribution Requirements
12. Consent for Distribution Requirement
13. Joint and Survivor Annuity Requirements
14. Direct Rollover Requirements
15. Assignment or Alienation Prohibition
16. Nondiscrimination Requirements
17. Coverage Requirements
18. 401(a)(26) Participation Requirement
19. Funding Requirements
20. Exclusive Benefit Requirement
21. Reporting and Disclosure

For details, please see the IRS website at or contact us for more details. ■

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