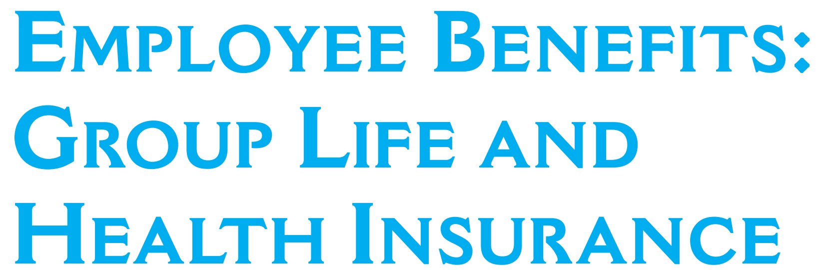
CHAPTER

16

Employee Benefits: Group Life and Health Insurance



"Most health plans give you the best deal when you see a doctor who has a contract with your health plan. Visiting an 'in-network' provider usually means you will have lower out-of-pocket costs."

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Learning Objectives

After studying this chapter, you should be able to

- Explain the basic underwriting principles followed in group insurance.
- Describe the basic characteristics of group term life insurance plans.
- Describe the major characteristics of the following managed care plans:
  - Health maintenance organizations (HMOs)
  - Preferred provider organizations (PPOs)
  - Point-of-service plans (POS)
- Understand how the Affordable Care Act affects group medical expense insurance.
- Explain the basic characteristics of consumer-directed health plans.
- Explain the basic characteristics of group dental insurance plans.
- Describe the important characteristics of group short-term and group long-term disability-income plans.

Employee benefits play an important role in the personal risk management programs of workers and their families. The various benefits provide considerable economic security to employees and their families. The benefits are also important in calculating total employee compensation. Employer-sponsored benefits generally can increase the total wage package by 20 to 40 percent. For example, Jake, age 26, is a history major who recently graduated from a small liberal arts college in the Midwest. He interviewed for a job with a nonprofit charitable organization. The director stated that the charity sponsors a number of employee benefit plans, which include group life and health insurance, a 401(k) plan, paid holidays, and vacation. When added to the starting salary, the total wage package became more appealing, and Jake accepted the job offer.

This chapter is the first of two chapters dealing with employee benefit plans. In this chapter, we limit our discussion largely to group life insurance and group health insurance plans. Retirement plans are covered in Chapter 17. Important topics discussed in this chapter include group underwriting principles, group life insurance, group medical expense insurance, group dental insurance, group disability-income plans, and the impact of the Affordable Care Act on group health insurance coverages. The chapter concludes with a discussion of cafeteria plans.

MEANING OF EMPLOYEE BENEFITS

Employee benefits *are employer-sponsored benefits, other than wages, that enhance the economic security of individuals and families and are partly or fully paid for by employers*. These benefits include group life insurance, group medical expense and dental insurance plans, group short-term and long-term disability plans, paid holidays and vacations, paid family and medical leaves, wellness programs, employee assistance programs, educational assistance, employee discounts, and numerous other benefits. Employee benefits also include the employer contributions to Social Security and Medicare, state unemployment compensation programs, workers' compensation, and temporary disability insurance. However, it is beyond the scope of this chapter to analyze all employee benefits in detail. Instead, we focus our attention largely on group life insurance and group health insurance plans, which are important areas of coverage for employees.

FUNDAMENTALS OF GROUP INSURANCE

Group insurance is based on certain fundamental principles. The following section discusses (1) the major differences between group and individual insurance, (2) basic group underwriting principles, and (3) eligibility requirements for group insurance benefits.

Differences between Group Insurance and Individual Insurance

Group insurance differs from individual insurance in several respects. *A distinct characteristic is the coverage of many persons under one contract*. A **master contract** is formed between the group policyholder and insurer for the benefit of the individual members. In most plans, the group policyholder and the insurer are the only two parties to the contract. Employees are not a party to the contract; instead, they receive a certificate of insurance that shows they are insured and the benefits provided.

A second characteristic is that group insurance usually costs less than comparable insurance purchased individually. Employers usually pay part or all of the cost, which reduces or eliminates premium payments by the employees. In addition, administrative and marketing expenses are reduced as a result of mass distribution methods.

A third characteristic is that individual evidence of insurability is usually not required. Group selection of risks is emphasized, not individual selection. The insurer is concerned with the insurability of the group as a whole rather than with the insurability of any single member within the group.

Finally, **experience rating** *is used in group insurance plans.* If the group is sufficiently large, the actual loss experience of the group is a major factor in determining the premiums charged.

Basic Underwriting Principles

Group insurers follow certain fundamental underwriting principles so that the loss experience of the group overall is favorable. Basic underwriting principles include the following:[1]

- Insurance incidental to the group
- Flow of persons through the group
- Automatic determination of benefits
- Minimum participation requirements
- Efficient administration

Insurance Incidental to the Group The group should not be formed solely for the purpose of obtaining insurance. If the group were formed for the specific purpose of obtaining insurance, a disproportionate number of unhealthy persons would join the group to obtain low-cost insurance, and the loss experience would be unfavorable.

Flow of Persons through the Group Ideally, in group life and health insurance, there should be a flow of younger persons into the group and a flow of older persons out of the group. Without a flow of younger persons into the group, the average age of the group will increase, and premium rates will likewise increase. Higher premiums may cause some younger and healthier members to drop out of the plan, while the older and unhealthy members will still remain, which would lead to still higher losses and increased rates.

Automatic Determination of Benefits Ideally, benefits should be automatically determined to prevent adverse selection against the insurer by participating employees. If unhealthy employees were permitted to select unlimited amounts of specific benefits, the result would be a disproportionate amount of insurance on impaired lives. However, there is some deviation from this principle today in so-called cafeteria plans, which allow participants to select among a package of benefits. This results in some adverse selection against the insurer, which can be taken into consideration in experience rating.

Minimum Participation Requirements A minimum percentage of the eligible employees must participate in the plan. If the plan is **noncontributory**, the employer pays the entire premium, and 100 percent of the eligible employees are covered. If the plan is **contributory**, the employee pays part or all of the cost and a large proportion of the eligible employees must elect to participate in the plan. In a contributory plan, it may be difficult to get 100 percent participation, so a lower percentage such as 50 to 75 percent is typically required.

There are two reasons for the minimum participation requirement. First, if a large proportion of eligible employees participate, adverse selection is reduced because the possibility of insuring a large proportion of unhealthy lives is reduced. Second, if a high proportion of eligible members participate, the expense rate per insured member or per unit of insurance can be reduced.

Efficient Administration The group plan should be efficiently administered. Premiums are collected from the employees by payroll deduction, which reduces the insurer's administrative expenses and keeps participation in the plan high.

Eligibility Requirements in Group Insurance

Insurers typically require that certain eligibility requirements must be satisfied before the insurance is in force. The eligibility requirements generally are designed to reduce adverse selection against the insurer.

Eligible Groups Eligible groups are determined by insurance company policy and state law. Such groups

include individual employer groups, multiple-employer groups, labor unions, creditor-debtor groups, and miscellaneous groups, such as fraternities, sororities, and alumni groups.

Group insurers require the group to be a certain size before the group is insured. Traditionally, this size was 10 members, but some insurers now insure groups with as few as 2 or 3 members. There are two reasons for a minimum-size requirement. First, the insurer has some protection against insuring a group that consists largely of substandard individuals, so that the financial impact of one impaired life on the loss experience of the group is reduced. Second, certain fixed expenses must be met regardless of the size of the group. The larger the group, the broader the base over which these expenses can be spread, and the lower the expense rate per unit of insurance.

Eligibility Requirements Before employees can participate in a group insurance plan, they must meet certain eligibility requirements, including the following:

- Be a full-time employee
- Satisfy a probationary period (if any)
- Apply for insurance during the eligibility period
- Be actively at work when insurance becomes effective

Employers generally require the workers to be employed full time before they can participate in the plan. A *full-time worker* is one who works the required number of hours established by the employer as a normal work week, which is at least 30 hours. However, some group plans today permit part-time workers (20 to 29 hours weekly) to be covered.

Some group plans require new employees to satisfy a short **probationary period** *(waiting period)*, which generally is a period of 1 to 3 months, before they can participate in the plan. The purpose is to screen out employees who work for the firm only a short time. It is costly to insure workers and maintain records when there is considerable labor turnover.

If the plan is contributory, employees must request coverage during their eligibility period. The **eligibility period** is a short period of time—such as 31 days from the date of hire—during which time eligible employees can sign up for the insurance without furnishing evidence of insurability. In group term insurance plans, you can obtain coverage after the eligibility period expires by furnishing evidence of insurability, such as filling out a health questionnaire. However, the Affordable Care Act prohibits evidence of insurability as a condition of eligibility in individual and group medical expense plans. If an employee fails to sign up for group medical expense insurance during his or her eligibility period, he or she may have to wait until the next open enrollment period to obtain coverage. However, some qualifying events may occur that allows an employee to qualify for a special enrollment period. Qualifying events include (1) a change in family size (birth of a child, adoption, marriage, divorce); (2) turning age 26; (3) early retirement; (4) permanent move to a new area; (5) and loss of health insurance coverage because of termination of employment, reduction of hours, death of a spouse, or discontinuation of an employer-based policy.

Finally, most group insurance plans contain an actively-at-work provision. With certain exceptions, if the employee is absent from work on the day the insurance becomes effective because of sickness, accident, or other reasons, coverage is not in force. Coverage starts when the employee returns to work.

GROUP LIFE INSURANCE

Group life insurance is a popular and relatively inexpensive employee benefit. In 2013, group life insurance accounted for 41 percent of the face amount of life insurance in force. Group life insurance plans today have the following characteristics:

- *Group life insurance coverages*. Group life insurance plans typically provide *yearly term insurance coverage* to participating employees. Term insurance provides low-cost protection to employees during their working years, especially to younger employees. Different coverage amounts are available. First, group life plans provide a *basic amount* of term life insurance to all eligible employees based on earnings, position, a flat amount for all, or some combination. Evidence of insurability is not required. For example, the basic amount of group term insurance on covered employees can be some multiple of earnings or salary, such as one to three times salary.

  Second, group plans also make available *supplemental term insurance*, which allows

eligible employees to purchase additional life insurance up to certain limits with no evidence of insurability. Evidence of insurability is required for higher amounts. This is a voluntary coverage paid entirely by the employee.

Third, most plans offer group *accidental death and dismemberment (AD&D) benefits*, which pay additional benefits if the employee dies in an accident or incurs certain types of bodily injury. The full AD&D benefit, called the *principal sum*, is paid if the employee dies in an accident. A percentage of the principal sum is paid for certain dismemberments, such as one-half the principal sum for the loss of a hand, foot, or eye because of accidental bodily injury.

Finally, group plans generally make available other types of life insurance and annuity products on a voluntary basis, such as whole life insurance, universal life insurance, voluntary accidental death and dismemberment insurance, and fixed and variable annuities. The employees pay the entire premium by payroll deduction.

- *Noncontributory and contributory plans.* In a *noncontributory plan*, the employer pays the entire cost. In a *contributory plan*, both the employer and employee contribute to the plan. For example, the employer may pay one-third of the monthly premiums, and the employees pay two-thirds.
- *Probationary period and eligibility period.* As stated earlier, some plans require employees to satisfy a *probationary period (waiting period)* before they can participate in the plan, which generally is a period of 1 to 3 months before eligible employees can participate in the plan. After the probationary period (if any) expires, eligible employees can participate in the plan. If the plan is contributory, eligible employees must elect coverage either before or during their eligibility period. As stated earlier, an eligibility period is a short period of time—typically 31 days—during which eligible employees can elect coverage without providing evidence of insurability.
- *Experience rating.* **Experience rating** is commonly used in group insurance plans. If the group is sufficiently large, the actual loss experience of the group is a major factor in determining the premiums charged. If the loss experience is unfavorable, premiums can be increased by experience rating.
- *Insurance on spouse and dependent children.* Most plans allow a modest amount of life insurance to be written on an employee's spouse and dependent children. Because of state law and tax considerations, the amount of dependent life insurance is relatively low.
- *Conversion of term insurance.* If employees leave the group because of termination of employment or retirement, they can convert their term insurance to an individual cash value policy within 31 days with no evidence of insurability. Some plans have a **portable term insurance** option that allows employees to continue their life insurance protection to some stated age with no evidence of insurability even though they are no longer employed by the company or are eligible for group insurance with their employers.
- *Credit life insurance.* Commercial banks and other lending institutions also have group term life insurance plans that provide for the cancellation of outstanding debt if the borrower dies. The lending institution is both the policyholder and beneficiary. The unpaid balance of the loan is paid to the creditor at the debtor's death. Many consumer experts and financial planners do not recommend the purchase of credit life insurance because of excessive rates. Although the states regulate credit life insurance rates, many debtors are overcharged for their protection.

GROUP MEDICAL EXPENSE INSURANCE

Group medical expense insurance is an employee benefit that pays the cost of hospital care, physicians' and surgeons' fees, prescription drugs, and related medical expenses. These plans are extremely important in providing economic security to employees and their families. Most insured workers today obtain their coverage through employer-sponsored medical expense plans.

Group medical expense coverage is available from several providers, including the following:

- Commercial insurers
- Blue Cross and Blue Shield plans

- Managed care organizations (some of which are offered by commercial insurers and Blue Cross Blue Shield plans)
- Self-insured employer plans (some of which are administered by commercial insurers and Blue Cross Blue Shield plans)

Commercial Insurers

Commercial life and health insurers sell both individual and group medical expense plans. Some property and casualty insurers also issue various types of health insurance. Most individuals and families insured by commercial insurers are covered under group plans. A Congressional Budget Office (CBO) study of individual, small group, and large group insurers showed that health insurance is highly concentrated. *In each of the three market segments, the three largest insurers had at least 80 percent of the total enrollment in at least 37 states.* In more than half of these states, a single insurer accounted for more than half of the total enrollees.[2] When a small number of insurers dominate the market, this may indicate a less-competitive market and could affect the consumers' choice of health insurance plans and their premiums.[3] In addition, the American Medical Association believes individual physicians are usually at a competitive disadvantage in negotiating rates with health insurers, because almost half of the physicians work in practices with fewer than five physicians.[4]

Blue Cross and Blue Shield Plans

Blue Cross and Blue Shield (BCBS) plans initially were separate legal entities. Blue Cross covered hospital bills and related expenses, and Blue Shield covered physicians' and surgeons' fees and related medical expenses. However, most plans today combine Blue Cross and Blue Shield benefits into a single entity. When plans are separate, they normally act in consort to provide coverage. Initially, BCBS plans paid benefits expressed in terms of services (e.g., a certain number of days in the hospital were covered). Today, however, BCBS plans typically pay benefits expressed in dollar amounts the same way that commercial insurers do. In most cases, there is little practical distinction between the Blues and commercial insurers.

In the majority of states, Blue Cross and Blue Shield plans are nonprofit organizations that receive favorable tax treatment and are regulated under special legislation. However, to raise capital and become more competitive, many Blue Cross and Blue Shield plans have converted to a for-profit status, with stockholders and a board of directors. In addition, many nonprofit plans own for-profit affiliates.

Managed Care Organizations

Managed care organizations are another source of group medical expense benefits. These organizations generally are for-profit organizations that offer managed care plans to employers. **Managed care** is a generic term for medical expense benefits provided to covered employees in a cost-effective manner. There is great emphasis on controlling costs, and the medical care provided by physicians is carefully monitored. Managed care is discussed in greater detail later in the chapter.

Self-Insured Plans by Employers

Many employers self-insure part or all of the benefits provided to their employees. **Self-insurance** (also called **self-funding**) means that the employer pays part or all of the cost of providing health insurance to the employees. In 2014, 81 percent of covered workers at larger firms, and 15 percent of covered workers at small firms, were enrolled in plans that were partially or completely self-funded.[5]

Many self-insured plans also have stop-loss insurance in force. *Stop-loss insurance means that a commercial insurer will pay claims that exceed a certain dollar amount overall, or for a particular participant.* A self-insured employer generally can predict its normal losses within specified parameters, but a stop-loss agreement provides protection against unusual spikes in losses that could severely damage the financial position of an employer.

Many employers also have administrative services only (ASO) contracts with organizations that do not assume any risk but provide services such as plan design, claims processing, actuarial support, and record keeping. Many employers are not efficient at providing the services related to their plans so they contract such services out to a commercial insurer or a "third-party administrator." Employers self-insure

their medical expense plans for several reasons, including the following:

- Under the Employee Retirement Income Security Act of 1974 (ERISA), self-insured plans generally are not subject to state regulation. Thus, a national employer does not have to comply with laws in 51 jurisdictions.
- Costs may be reduced (or increase less rapidly) because of savings in state premium taxes, commissions, and the insurer's profit.
- The employer retains part or all of the funds needed to pay claims and earns interest until the claims are paid.
- Self-insured plans are exempt from state laws that require insured plans to offer certain state-mandated benefits.

MANAGED CARE PLANS

Group medical expense plans have changed dramatically over time. Older plans typically were **indemnity plans** (also called **fee-for-service plans**) that have largely disappeared and currently account for less than 1 percent of all covered employees in group medical expense plans. Under indemnity plans, physicians were paid the usual, customary, and reasonable fee for each covered service as determined by the local market; employees had considerable freedom in selecting physicians and other healthcare providers; and cost containment was not heavily stressed.

Today, the vast majority of covered employees are in managed care plans. Under managed care plans, the employee's choice of physicians and hospitals may be limited to a network of certain healthcare providers; cost control and reduction are heavily emphasized; utilization review is done at all levels; the quality of the care provided by physicians is carefully monitored and evaluated; healthcare providers may share in the financial results through incentive payment programs that meet budgeted costs and utilization levels; and preventive care and healthy lifestyles are emphasized.

There are several types of managed care plans. The most important include the following:

- Health maintenance organizations (HMOs)
- Preferred provider organizations (PPOs)
- Point-of-service (POS) plans

Health Maintenance Organizations (HMOs)

A **health maintenance organization (HMO)** is an organized system of healthcare that provides comprehensive medical services to its members on a prepaid basis. Basic characteristics include the following:

- *Organized healthcare plan.* Health maintenance organizations (HMOs) have the responsibility of organizing and delivering comprehensive health services to their members. HMOs negotiate rates and enter into agreements with hospitals and physicians to provide medical services, hire ancillary personnel, and have general managerial control over the various medical services provided.
- *Broad, comprehensive medical services.* Health maintenance organizations provide broad, comprehensive health services to their members. Covered services typically include hospital care, surgeons' and physicians' fees, maternity care, laboratory and X-ray services, outpatient services, special-duty nursing, and numerous other medical services. Office visits to HMO physicians are also covered, either in full or at a nominal charge for each visit.
- *Restrictions on the choice of healthcare providers.* Typically, HMOs limit the choice of physicians and other healthcare providers to providers that are part of the HMO network. Key points include the following: (1) when you join an HMO, you select a primary care physician for your basic healthcare needs; (2) your primary care physician must approve and make a referral for you to see a specialist; (3) care received from healthcare providers outside of the network generally is not covered except in an emergency; and (4) because HMOs operate in specific geographical areas, there is limited coverage for treatment received outside the area. Most HMOs generally provide only emergency medical treatment outside the geographical area of the HMO.
- *Payment of fixed premiums and cost-sharing provisions.* Health maintenance organization members typically pay a fixed prepaid fee (usually paid monthly) for the medical care provided. However, many HMOs also have cost-sharing provisions. In previous years, HMOs did not emphasize deductibles or coinsurance to any great extent. In recent years, however, employers have been faced with sizeable premium increases.

To hold down costs, many HMOs now require enrollees to meet an annual deductible. Many also impose an inpatient deductible or copayment charge for a hospital stay. Employees, too, have copayments for certain services, such as $30 for an office visit or $10 for a generic drug.

- *Heavy emphasis on controlling cost.* Health maintenance organizations place heavy emphasis on controlling costs. There are different methods for controlling cost. First, a *modified fee-for-service method* is commonly used to compensate physicians and other providers.[6] Typically, HMOs enter into contracts with physicians, hospitals, and other healthcare providers to provide covered medical services based on negotiated fees, which typically are discounted fees. Providers are free to set their own fees. However, the maximum amount paid for a covered procedure is based on a negotiated fee schedule, which lists the maximum amount paid for each covered service. Hospitals in the network generally are paid a negotiated fee for each day a plan member is hospitalized regardless of the hospital's actual cost. Second, some HMOs reimburse physicians or medical groups based on a **capitation fee**, which is a fixed annual amount for each plan member regardless of the number of medical services provided. Third, some employers, especially smaller employers, have banded together to form *purchasing cooperatives* to obtain more favorable prices from healthcare providers. Finally, HMOs typically emphasize *preventive care and healthy lifestyles*, which also hold down costs in the long run.

  Other techniques for holding down costs include (1) precertification and approval for nonemergency admission into a hospital as an inpatient; (2) outpatient surgery for certain types of surgery; and (3) referral to a specialist by a gatekeeper physician. A **gatekeeper physician** is a primary care physician who determines whether medical care or tests from a specialist is necessary.

Types of HMOs There are several types of HMOs:

- *Staff model.* Under a staff model, physicians are employees of the HMO and are paid a salary and possibly an incentive bonus to hold down costs. The HMO may own its own hospitals, laboratories, or pharmaceutical firms, or enter into contracts with other providers for such services.
- *Group model.* Under a group model, physicians are employees of a group practice that has a contract with the HMO to provide medical services to HMO members. The HMO may pay the group of physicians a monthly or annual capitation fee for each member. As stated earlier, a capitation fee is a fixed amount for each member regardless of the number of services provided. In return, the group agrees to provide all covered services to members during the year. The group model typically has a closed panel of physicians that requires HMO members to use physicians affiliated with the HMO.
- *Network model.* Under a network model, the HMO contracts with two or more independent group practices to provide medical services to covered members. The HMO pays a fixed monthly fee for each member to the medical group.
- *Individual practice association plan.* A final type of HMO is an **individual practice association (IPA) plan**. An IPA is an open panel of physicians who work out of their own offices and treat patients on a fee-for-service basis. However, the individual physicians agree to treat HMO members at reduced fees, either by a capitation fee for each member or by a reduced fee for each HMO patient treated. In addition, to encourage cost containment, IPAs may have risk-sharing agreements with the participating physicians, and payments are reduced if the plan experience is poor. A bonus is paid if the plan experience is better than expected.

Preferred Provider Organizations (PPOs)

Another type of managed care plan is a preferred provider organization. A **preferred provider organization (PPO)** *is a plan that contracts with healthcare providers to provide certain medical services to the plan members at discounted fees*. To encourage patients to use PPO providers, deductibles and coinsurance charges are reduced.

Do not confuse PPOs with HMOs. There are important differences between them.[7] First, PPO providers typically do not provide medical care on a

fixed prepaid basis, but are paid on a fee-for-service basis as their services are used. However, the fees charged are negotiated fees that are typically below the provider's regular fee.

Second, unlike HMOs, patients are not required to use a preferred provider but have freedom of choice to select any physician, hospital, or provider when care is needed. However, patients have a financial incentive to use a preferred provider because of lower deductible and coinsurance charges if the provider is in the PPO network.

Third, if the healthcare provider's actual charge exceeds the negotiated fee, the provider absorbs the excess amount. In such cases, savings to the patient are substantial. For example, assume that a surgeon who participates in a PPO charges a regular fee of $5,000 for a knee operation. If the negotiated fee is $3,000, the patient does not pay the additional $2,000. The surgeon absorbs this amount.

Finally, PPOs generally do not have a gatekeeper physician, and employees do not have to get permission from a primary care physician to see a specialist. In contrast, to control costs, HMOs generally require members to obtain permission from their primary care physician to see a specialist. Patients in a PPO, however, can visit a specialist directly without first getting approval from the primary care physician.

Preferred provider organizations (PPOs) have the major advantage of controlling healthcare costs because provider fees are negotiated at a discount. PPOs also help physicians build up their practices. Patients also benefit because they pay substantially less for their medical care.

Point-of-Service (POS) Plans

A **point-of-service (POS) plan** is a managed care plan that combines the basic characteristics of an HMO and a PPO, but members have the option to select care outside the network. Key points are the following: (1) the POS plan establishes a network of preferred providers; (2) POS members select a primary care physician to provide for their basic healthcare needs; (3) at the time medical care is needed (point of service), a plan member has the option to elect care within the network or go outside the network. *If patients receive care from network providers, they pay substantially lower out-of-pocket expenses. However, if patients elect to receive care outside the network, they must pay substantially higher deductibles and coinsurance charges.*

You might have some difficulty in distinguishing between PPO plans and POS plans because they are very similar. However, there are two major differences between them. First, PPO plans generally do not require you to select a primary care physician when you enroll; POS plans normally require you to select a primary care physician who acts as a "gatekeeper" for all levels of care provided within the network. Second, in a PPO, you can see a specialist directly without first getting approval from a primary care physician; however, some POS plans may require you to inform the gatekeeper physician if you intend to go outside the network, so that the gatekeeper physician can recommend specialists within the network to hold down costs. However, you are still free to receive care outside the network, but your out-of-pocket costs will be substantially higher.

Point-of-service plans have the major advantage of preserving freedom of choice for policyholders by allowing coverage outside the network; such plans eliminate the fear that policyholders cannot see a physician or specialist of their choice. The major disadvantage is the substantially higher cost for deductibles, coinsurance, and other charges for care received outside the network.

AFFORDABLE CARE ACT AND GROUP MEDICAL EXPENSE INSURANCE

Most provisions of the Affordable Care Act that affect group medical expense plans are now in effect. Although these provisions have already been discussed in Chapter 15, certain provisions are repeated here because of their importance and direct impact on group medical expense plans. These provisions include the following:

- *Certain insurance practices prohibited.* The Affordable Care Act (ACA) prohibits insurers from engaging in certain practices harmful to insurance consumers. Prohibited practices include the following:
  - Applicants for medical expense insurance have guaranteed issue and availability of

coverage and cannot be turned down or rated up regardless of their health and medical condition.
  - Insurers are prohibited from denying claims or excluding coverage for preexisting conditions.
  - Insurers are prohibited from imposing lifetime and annual limits on benefits.
  - Insurers are prohibited from retroactively rescinding insurance policies because of unintentional errors on the application except in cases of fraud or intentional misrepresentation of a material fact.
  - Adult children are allowed to remain on their parents' policies until age 26.
  - Certain routine and preventive services are not subject to cost-sharing provisions.

- *Employer-shared responsibility*. This provision is another name for an employer mandate, which requires large business firms to offer health insurance or pay penalties. Beginning in 2015, business firms with 100 or more full-time equivalent employees must either offer health insurance coverage or pay a penalty of $2,000 annually for each full-time worker if at least one employee is receiving a tax credit and coverage through the Health Insurance Marketplace. The health insurance offered must meet the *essential health benefits* requirements discussed in Chapter 15 and pay at least 60 percent of the benefit costs; otherwise, employers face additional penalties.
- In 2016, this mandate will require business firms with 50 or more full-time equivalent employees to offer health insurance to employees or pay a penalty if at least one employee is receiving a tax credit and coverage through the Health Insurance Marketplace.
- *Small employer tax credits*. Tax credits are available to small employers that have fewer than 25 full-time equivalent employees and pay average annual wages of less than $50,000. A tax credit of up to 50 percent of the employer's contribution is available if the employer contributes at least 50 percent of total premium costs. The tax credit is available for only 2 consecutive years.
- *SHOP Marketplace program for small business firms*. In 2015, the Small Business Health Options Program (SHOP) Marketplace program opened, which helps small firms provide health insurance to their employees. The **SHOP Marketplace program** enables small firms to offer high-quality health insurance and dental coverage to employees and provides flexibility, choice, and convenience of online application and account management. Insight 16.1 discusses the basic characteristics of this important program in greater detail.
- *Required minimum medical loss ratio*. Insurers must meet a minimum medical loss ratio of 80 percent for plans in the individual and small group markets and 85 percent in the large group markets. Rebates must be paid to enrollees if the loss ratios are not met.

  A *loss ratio* is the percentage of each premium dollar paid for covered medical services and for activities improving the quality of care. For example, if an insurer in a small group plan pays 80 cents out of each premium dollar to pay for its customers' medical claims and activities that improve the quality of care, the insurer has a medical loss ratio of 80 percent. The remaining 20 cents of each premium dollar is accounted for by expenses and profits. As stated earlier, the Affordable Care Act sets minimum medical loss ratios for different markets, as do some state laws.
- *Grandfathered plans*. Grandfathered plans are individual plans and employer-sponsored group plans that existed on March 23, 2010 and have not made any prohibited changes. Grandfathered plans generally can remain the same and are subject only to certain provisions of the Affordable Care Act. These provisions have already been discussed in Chapter 15, and additional treatment is not needed here.
- *Flexible spending account limits*. Contributions to a flexible spending account for unreimbursed medical expenses, such as deductibles, coinsurance, copayments, and certain other expenses, are limited to $2,550 yearly (2015 limit).
- *Out-of-network claim payments for emergency room visits*. Claim payments for emergency room visits outside the network must be the same payment amount as the amount paid for a visit to an emergency room inside the network. A requirement for prior approval of a visit to an emergency room is prohibited.

INSIGHT 16.1

Basic Characteristics of the Small Business Health Options (SHOP) Marketplace Program

The SHOP Marketplace is an online program and is available to employers with 50 or fewer full-time equivalent employees. It has the following basic characteristics:

- The employer determines the number of plans offered and the dollar amount the firm will contribute toward employee premiums. The employer determines whether to offer coverage to dependents (some states require coverage). The employer also determines the length of the open enrollment period for the employees and the waiting period before new employees can enroll.
- The employer can enroll in the SHOP program during any month or time of the year. There is no restricted enrollment period when an employer can start offering a SHOP plan.
- In all states, the employer can offer one health plan to the employees. In some states, the employer can determine the benefit category (such as bronze or silver) and allow the employees to select the health plan in that category.
- Firms with fewer than 25 employees may qualify for the small business healthcare tax credit, which is available only for plans purchased through the SHOP Marketplace.

To use the SHOP Marketplace, employers must meet certain eligibility requirements. The major eligibility requirements are summarized as follows:

- As stated earlier, the firm must have fewer than 50 full-time equivalent employees.
- Coverage must be offered to all full-time employees (those working 30 or more hours each week on average). Coverage of part-time workers (29 hours or less weekly) is not required.
- In most states, at least 70 percent of the full-time employees must enroll in the SHOP plan.
- Employers who enroll in SHOP coverage between November 15 and December 15 each year can offer SHOP coverage without meeting the 70 percent requirement. This provision provides greater flexibility to employers because many small employers may be unable to meet the 70 percent requirement.
- Employers must have an office or work site within the SHOP's service area.

- *Uniform coverage documents*. Health plans must describe the coverage in a uniform format and give it to participants upon enrollment and renewal. The document must include definitions and examples.
- *Cadillac tax on high-value policies*. In 2018, a stiff 40 percent excise tax will be levied on insurers and plan administrators for high-cost health insurance plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage. The tax applies to the amount of premium in excess of the threshold.
- *Employer W-2 reporting obligations*. Employers must disclose the aggregate value of plan benefits on W-2 forms to employees. The amount reported is not taxable to the employee but is designed to be informational and provide greater transparency on the cost of healthcare.

KEY FEATURES OF GROUP MEDICAL EXPENSE INSURANCE

Employers have a choice of dozens of group medical expense plans with various deductibles, coinsurance percentages, copayment amounts, and premiums. New group medical expense plans sold today generally have the following features:

- *Comprehensive benefits*. New plans provide comprehensive benefits to covered employees with no lifetime limits or annual limits on benefits. The benefits provided typically meet or exceed the essential health benefits requirement under the ACA. Typical benefits include coverage for primary care physicians, surgeons, specialists, chiropractors, and other providers; inpatient hospital costs, outpatient diagnostic tests, outpatient surgery, emergency room fees, prescription drugs, maternity and baby benefits, mental illness and substance abuse, and numerous other benefits.

- *Calendar-year deductible*. Group plans typically have a **calendar-year deductible** that must be satisfied before benefits are paid. The deductible can be either an individual deductible or **family deductible** in which covered medical expenses of family members can be applied to the deductible. The majority of PPOs typically have calendar-year deductibles. In many PPO plans, the annual deductible is at least $1,000, especially for smaller firms. Family deductibles are substantially higher.
- ***Coinsurance requirements***. Medical expense plans have coinsurance requirements in which the employee must pay a certain percentage of covered expenses in excess of the annual deductible up to some maximum annual limit, such as 20 percent, 25 percent or 30 percent. The coinsurance percentage is substantially higher if care is received outside the network, such as 40 or 50 percent.
- *Copayments*. Most covered workers in HMOs, PPOs, and POS plans face copayments for certain expenses, such as an office visit to a primary care physician or specialist, or purchase of a prescription drug.
- *Out-of-pocket maximum limits*. Plans also have **out-of-pocket maximum limits**, which place annual limits on amounts paid out-of-pocket each year, such as $3,000 for individual coverage and $6,000 for family coverage. The plans specify the medical expenses that can be counted toward meeting the annual limit. Not all medical expenses can be applied to the annual limit. The majority of plans allow deductibles and coinsurance amounts to be counted (but not premiums).
- *No cost sharing for certain preventive services*. Certain routine and preventive services are not subject to cost-sharing provisions (deductibles, coinsurance, and copayments). If care is received from a network provider, there is 100 percent reimbursement. If care is received outside the network, the cost is subject to substantially higher deductible and coinsurance charges. Examples of preventive services include mammograms and pap smears; immunizations, such as flu shots and vaccinations for children; screening for colorectal cancer; cardiac stress tests; and hearing and vision exams.
- *Noncovered services*. All group medical expense plans have exclusions and limitations on certain services. Depending on the plan, excluded services can include (1) services for injury or sickness arising out of and in the course of employment (covered under workers compensation); (2) services for illness or injury sustained while performing military service; (3) charges that exceed reasonable and customary charges; (4) services considered to be experimental or investigative; (5) cosmetic surgery; (6) eyeglasses and hearing aids; and (7) services, drugs, and supplies considered not to be cost-effective when compared to standard alternatives.

CONSUMER-DIRECTED HEALTH PLANS

Consumer-directed health plans are becoming increasingly popular with both employers and employees in the group medical expense market. A **consumer-directed health plan (CDHP)** *is a generic term for a plan that combines a high-deductible health plan with a health savings account (HSA) or health reimbursement arrangement (HRA)*. These plans are designed to make employees more sensitive to healthcare costs, to provide a financial incentive to avoid unnecessary care, and to seek out low-cost providers.

High-Deductible Health Plans

A **high-deductible health plan** is a medical expense plan with an annual deductible that is substantially higher than deductibles in traditional medical expense plans. A high deductible plan that meets certain federal requirements for a qualified **health savings account (HSA)** is called an *HSA-qualified high-deductible health plan (HDHP)*. To receive favorable tax treatment, the account holder must meet the following requirements: (1) be covered under a qualified high-deductible plan, (2) have no other first-dollar medical coverage (certain exceptions apply), (3) not be enrolled in Medicare, and (4) not claimed as a dependent on another person's tax return.

In addition, the high-deductible plan must meet certain requirements. Dollar amounts are indexed for inflation. For 2015, the minimum annual deductible must be at least $1,300 for individual coverage

and $2,600 for family coverage. The employer, employee, or both can contribute to the HSA account; however, HSA contributions cannot exceed $3,350 for individual coverage and $6,650 for family coverage.

The plan may also contain a coinsurance requirement. Many high-deductible plans pay 100 percent of covered medical expenses in excess of the deductible. However, other high-deductible plans have a coinsurance requirement that applies to covered charges in excess of the deductible. The coinsurance percentage is typically 20 or 30 percent of covered expenses in excess of the deductible up to some maximum annual out-of-pocket limit. The coinsurance percentage is significantly higher if care is received outside the network. Certain basic preventive services, however, are not subject to cost-sharing provisions. For 2015, maximum out-of-pocket expenses (deductible, copayments, other amounts, but not premiums) cannot exceed $6,450 for individual coverage and $12,900 for family coverage.

A qualified HSA plan has substantial tax advantages. Employer contributions to an HSA are not taxable as income to the employees; employee contributions are made with before-tax dollars; investment earnings accumulate income-tax free; and distributions from the HSA account are free from taxation if used to pay for qualified medical expenses.

Health Reimbursement Arrangements

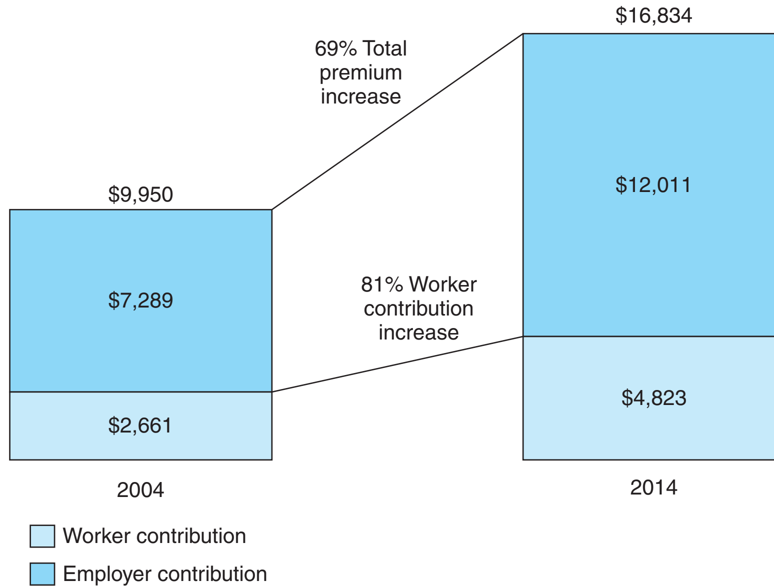
A high-deductible plan can also be combined with a health reimbursement account. *A* **health reimbursement arrangement (HRA)** *is an employer-funded plan with favorable tax advantages that reimburse employees for medical expenses not covered by the employer's standard insurance plan.* These HRAs are 100 percent employer-funded and controlled. The employer specifies the out-of-pocket expenses that are covered. For example, an HRA can reimburse covered employees for deductibles, coinsurance, copayments, and services not covered under the employer's plan. The employer receives a tax deduction for the amounts contributed, and the contributions are not taxable as income to the employees. Amounts in the employee's account at the end of the year can be rolled over to the next year.

RECENT DEVELOPMENTS IN EMPLOYER-SPONSORED HEALTH PLANS

Most of the recent developments in employer-sponsored health plans focus on holding down rising costs to employers. The Kaiser Family Foundation conducts an annual survey of employer-sponsored group health plans. The 2014 report included the following:[8]

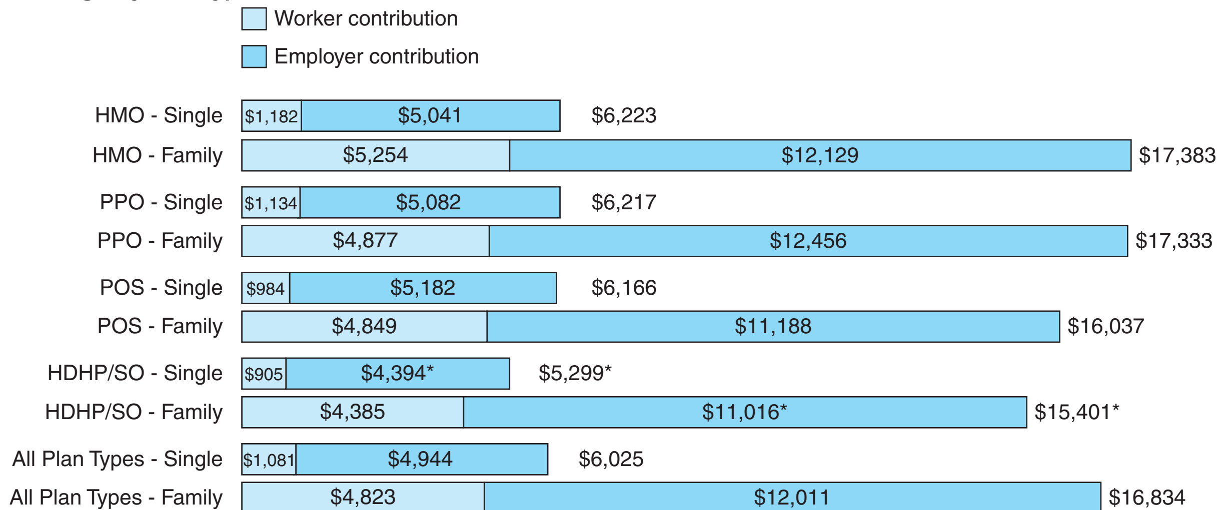
- *Continued escalation in health insurance premiums.* Group health insurance premiums continue to rise. In 2014, average annual premiums for employer-sponsored health plans reached $16,834 for family coverage (see Exhibit 16.1) and $6,025 for single coverage (see last item, Exhibit 16.2). The rise in premiums has substantially exceeded the growth in workers' wages and general inflation over the past 10 years. As a result, the financial burden of rising premiums on workers has been increasingly painful.
- *Higher deductibles for employees.* In response to rising costs, employers continue to shift costs to their employees by higher cost-sharing provisions. In addition to higher premiums, a growing number of employees face significantly higher annual deductibles in their employers' plans. In 2014, the average annual deductible for single coverage was $1,217, up from $826 in 2009. *Overall, for single coverage, 61 percent of covered workers in small firms are in plans with an annual deductible of at least $1,000, compared to 32 percent in larger firms. At smaller firms, more than one in three covered workers have annual deductibles of at least $2,000.*[9]
- *Dominance of PPOs.* Preferred provider organizations continue to dominate group health insurance markets. In 2014, 58 percent of covered workers were enrolled in PPOs. In contrast, HMO coverage continues to decline.[10]
- *Growth of high-deductible health plans with a savings option (HDHP-SO).* In 2014, 20 percent of covered workers in employer-sponsored health plans were enrolled in HDHP-SO plans, up sharply from 4 percent in 2006. However, enrollments have leveled off recently. These plans have a deductible of at least $1,000 for single coverage and $2,000 for family coverage. High-deductible plans combined with a Health Reimbursement

EXHIBIT 16.1
Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2004–2014



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2004–2014, Exhibit A. Reprinted with permission of Henry J. Kaiser Family Foundation.

EXHIBIT 16.2
Average Annual Firm Worker Premium Contributions and Total Premium for Covered Workers for Single and Family Coverage, by Plan Type, 2014



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2004–2014, Exhibit B. Reprinted with permission of Henry J. Kaiser Family Foundation.

Arrangement (HRA) are referred to as HDHP/HRA plans. These plans are appealing to both employers and employees. Employers have an effective tool for controlling healthcare costs, and employees pay lower premiums. There is also some evidence that high-deductible plans are effective in holding down healthcare costs for employers. However, some critics believe the quality of healthcare may be threatened. Because of a high deductible, some employees may postpone needed medical treatment or the purchase of life-enhancing prescription drugs.

- *Decline in medical coverage for early retirees over time.* Coverage for workers who want to retire early has declined substantially over time. In 2014, only 25 percent of large employers offered health insurance coverage to retirees under age 65, down from 35 percent in 2004.
- *Tiered or high-performance networks.* To hold down cost, some plans have established tiered or high-performance networks in which healthcare providers are grouped into tiers based on the quality and cost of medical care provided. The objective is to encourage covered employees to receive care from low-cost providers that provide high-quality care. *This is done either by restricting the network to efficient providers or by having different copayment or coinsurance charges for different tiers in the network.* According to the Kaiser Family Foundation, 19 percent of the firms offering coverage in 2014 included a tiered or high-performance provider network in their largest health plan.[11]
- *Tiered pricing for prescription drugs.* To hold down increases in prescription drug costs, many employers have also adopted a tiered pricing system for prescription drugs. The vast majority of employees now face a three-tier or four-tier pricing system for prescription drugs. Copayment charges vary depending on the drug used. In 2014, the average copayment for first-tier drugs (generic drugs) was $11. For second-tier drugs (brand-name drugs listed on a formulary) the average copayment was $31. A formulary is a list of approved medications that can be prescribed in a particular health insurance policy.

  For third-tier drugs (brand-name drugs not on the formulary), the average copayment was $53; and for fourth-tier drugs (specialty drugs), the average copayment was $83.[12] Fourth-tier drugs generally are costly specialty drugs, such as life style drugs or biologics.
- *Wellness benefits.* Many employers have designed voluntary wellness programs for their employees. These include weight-loss programs, gym membership discounts, onsite exercise facilities, smoking cessation programs, nutrition programs, newsletters, websites that encourage healthy living, and similar programs. Many large employers provide financial incentives to their employees to encourage them to participate in health management or wellness programs. Beginning in 2014, the Affordable Care Act allows employers to give a wellness discount of up to 30 percent of the premiums paid by an employee.
- *Health risk assessments.* Large employers increasingly are using health risk assessments to learn about their employees' health habits. As an incentive to complete the questionnaire, employers may provide financial incentives to employees, such as waiving copayment charges. A *health risk assessment (HRA)* is an evaluation of the employee's health status based on information provided by the employee, such as health history and current medical condition. The HRAs identify employees who might benefit from disease management programs, such as counseling and preventive services for asthma, diabetes, heart disease, and other diseases.
- *Onsite health clinics.* Many large employers (1,000 employees or more) have onsite health clinics for employees at one or more locations. Employees can receive treatment for nonoccupational diseases or injury at these locations. Employers with onsite facilities believe it is less expensive to provide onsite coverage for routine medical expenses rather than through traditional healthcare channels.
- *Tighter eligibility requirements for spousal coverage.* To hold down costs, an increasing number of employers are now adopting tighter eligibility requirements for coverage of working spouses. Working spouses may be totally excluded if they have access to health insurance through their own employer or must pay a spousal surcharge to be covered under the employee's plan. Some experts believe that almost half of the medium- and

large-sized companies will include this provision in their group plans by the end of 2015.

GROUP MEDICAL EXPENSE CONTRACTUAL PROVISIONS

Group medical expense insurance plans contain numerous contractual provisions that can have a significant financial impact on the insured. Three important provisions deal with (1) coordination of benefits, and (2) continuation of group health insurance, and (3) preexisting conditions.

Coordination of Benefits

Group medical insurance plans typically contain a **coordination-of-benefits provision**, which specifies the order of payment when an insured is covered under two or more group health insurance plans. Total recovery under all plans is limited to 100 percent of covered expenses. The purpose is to prevent overinsurance and duplication of benefits if an insured is covered by more than one health plan.

The coordination-of-benefit provisions in most group plans are based on rules developed by the National Association of Insurance Commissioners (NAIC). These rules are complex and are beyond the scope of this text to discuss in detail. The following summarizes the major provisions based on the NAIC rules.

- *Coverage as an employee is usually primary to coverage as a dependent*. For example, Karen and Chris Swift both work, and each is insured as a dependent under the other's group medical insurance plan. If Karen incurs covered medical expenses, her plan pays first. She then submits any unreimbursed expenses (such as the deductible and coinsurance payments) to Chris's insurer for payment. No more than 100 percent of the eligible medical expenses are paid under both plans.
- With respect to dependent children, if the parents are married or are not separated, *the plan of the parent whose birthday occurs first during the year is primary; the plan of the parent with the later birthday is secondary*. For example, if Karen's birthday is in January and Chris's birthday is in July, Karen's plan would pay first if their son is hospitalized. Chris's plan would be secondary.
- If the parents of dependent children are not married, or are separated (regardless of whether they have ever been married), or are divorced, and there is no court decree specifying who is responsible for the child's healthcare expenses, the following rules apply:

  —The plan of the parent who is awarded custody pays first.
  —The plan of the stepparent who is the spouse of the parent awarded custody pays second.
  —The plan of the parent without custody pays third.
  —The plan of the stepparent who is the spouse of the parent without custody pays last.

Continuation of Group Health Insurance

Employees sometimes lose their group health insurance for a variety of reasons called "qualifying events." If you lose your coverage, you and your covered dependents can elect to remain in your employer's group health insurance plan for a limited period under the Consolidated Omnibus Budget Reconciliation Act of 1985 (also known as COBRA). The **COBRA law** applies to firms with 20 or more employees. *A qualifying event includes termination of employment for any reason (except gross misconduct), divorce or legal separation, death of the employee, and attainment of a maximum age by dependent children*. If you lose your job or no longer work the required number of hours, you and your covered dependents can elect to remain in your employer's plan for as long as 18 months. If the you die or become divorced or legally separated or have a child who is no longer eligible for coverage, your covered dependents have the right to remain in the group plan for up to 3 years. If you elect to remain in your employer's plan under COBRA, you must pay 102 percent of the group insurance rate.

Because the terminated employee must pay the entire cost, there is no contribution from the employers, and the resulting monthly premium is relatively high. As a result, many employees who quit their jobs or are laid off or fired do not exercise their COBRA option.

As an alternative to COBRA, under the Affordable Care Act, if you leave your job for any reason and lose your job-based health insurance coverage, you may qualify for a special enrollment period. This means you can enroll in a Health Insurance Marketplace plan outside the open enrollment period. You usually have 60 days from the day you lose your health insurance to enroll in a Marketplace plan. As a result, depending on your income and household size, you may qualify for premium tax credits and lower deductibles, copayments, and other out-of-pocket costs. Some low-income persons may enroll in a Marketplace plan and end up paying relatively small premiums.

Preexisting Conditions

In 1996, Congress enacted the **Health Insurance Portability and Accountability Act (HIPAA)**, which placed restrictions on the right of insurers and employers to deny or limit coverage for preexisting conditions. Under HIPAA, employer-sponsored group health insurance plans could not exclude or limit coverage for a preexisting condition for more than 12 months (18 months for late enrollees). A **preexisting condition** *is defined as a medical condition diagnosed or treated during the previous 6 months*. After the initial 12-month period expires, no new preexisting condition period may be imposed on workers who maintained continuous coverage with no more than a 63-day gap in coverage, even if the workers changed jobs or healthcare plans.

In addition, insurers and employers must give credit for previous coverage of less than 12 months with respect to any preexisting condition exclusion found in the new health plan. For example, a worker with a preexisting condition who was previously insured for 8 months under a group plan when he or she changed jobs faced an additional exclusion of only 4 months, rather than the normal 12 months.

The Affordable Care Act has substantially changed the preexisting condition provisions under HIPAA just discussed. As stated earlier, insurers are prohibited from denying claims or inserting exclusions for preexisting conditions in individual and group medical expense policies. As a result, employees changing jobs generally do not have to fear a delay in coverage under a new group medical expense plan because of a preexisting condition.

GROUP DENTAL INSURANCE

Group dental insurance helps pay the cost of normal dental care and also covers damage to teeth from an accident. Dental insurance has the principal advantage of helping employees meet the costs of regular dental care. It also encourages insureds to see their dentists on a regular basis, thereby preventing or detecting dental problems before they become serious.

Benefits

Employers have a choice of dental plans with various benefits, deductibles, and coinsurance requirements. Group dental insurance plans typically cover a wide variety of dental services, including X-rays, cleaning, fillings, extractions, inlays, bridgework and dentures, oral surgery, root canals, and orthodontia. In some plans, orthodontia benefits are excluded. A small number of plans are indemnity plans (also called fee-for-service plans). Dentists are reimbursed on the basis of their reasonable and customary charges subject to any limitations on benefits stated in the plan. However, the majority of dental plans today are managed care plans, such as PPO dental plans or HMO dental plans. In particular, PPO dental plans are becoming increasingly popular with both employers and employees. Under these plans, dentists are reimbursed for covered services based on negotiated fees.

Calendar-Year Deductible

A covered employee must satisfy an individual deductible each calendar year. If the employee elects family coverage, a family deductible must be met. However, the plan may permit family members to combine their covered expenses to meet the required deductible amount. To promote loss prevention and encourage routine dental care, the deductible may not apply to certain diagnostic and preventive services, such as two oral examinations each year, teeth cleaning, and dental X-rays.

Coinsurance

After the calendar deductible is met, the employee must meet a coinsurance requirement and pay a certain percentage of charges in excess of the deductible. Dental services are typically grouped into different levels, with varying coinsurance requirements. To

encourage regular visits to a dentist, some plans do not impose any coinsurance requirement for one or two routine dental examinations each year. However, fillings and oral surgery may be paid only at a rate of 80 percent, whereas the cost of orthodontia or dentures may be paid at a lower rate of 50 percent.

The following is an example of the classification of benefits and the reimbursement levels:[13]

- Type I. Diagnostic and preventive services: 100 percent
- Type II. Basic services, including anesthesia and basic restoration: 75 percent
- Type III. Major restoration, including endodontic, oral surgery, periodontics, and prosthodontics: 50 percent
- Type IV. Orthodontics: 50 percent

Calendar-Year Maximum Benefits

In addition to deductibles and coinsurance, most plans have a maximum limit on benefits paid during the calendar year, such as $1,000, or $2,000. After maximum benefits are paid, additional dental services are not covered for the remainder of the calendar year.

Noncovered Services

To control costs, certain dental services are not covered. Excluded services may include services provided primarily for cosmetic purposes; services considered to be investigative or not medically necessary; injectable drugs or drugs dispensed in a provider's office; services provided with respect to congenital malformations (e.g., missing teeth); and replacement of third molars with prostheses.

Predetermination-of-Benefits Provision

A *predetermination-of-benefits provision* is also used to control costs. Although this provision is usually not mandatory, it provides useful information to both the dentist and patient on the amount that will be paid. Under this provision, if the cost of dental treatment exceeds a certain amount, such as $300, the dentist submits a plan of treatment to the insurer. The insurer reviews the treatment plan and determines the amount that will be paid. The employee is informed of the cost then makes a decision on whether to proceed with the proposed plan.

GROUP DISABILITY-INCOME INSURANCE

Group disability-income insurance pays weekly or monthly cash payments to employees who are disabled from accidents or sickness. There are two basic types of plans: (1) short-term plans and (2) long-term plans.

Short-Term Plans

Many employers have short-term plans that pay disability benefits for relatively short periods that generally range from 13 weeks to 52 weeks. The benefits are based on earnings and typically replace 50 to 66.7 percent of normal earnings up to some maximum weekly or monthly limit.

The majority of short-term plans pay benefits for a maximum period of 13 or 26 weeks. In addition, most plans have a short elimination period of 1 to 7 days for sickness, whereas accidents are typically covered from the first day of disability. Some plans have elimination periods that apply to both accidents and sickness.

Most short-term plans cover only **nonoccupational disability**, which means that an accident or sickness must occur off the job. *Disability is usually defined in terms of the worker's own occupation. You are considered totally disabled if you are unable to perform each and every duty of your regular occupation.* Short-term plans generally do not cover partial disability; you must be totally disabled to qualify. However, a few plans provide partial disability benefits to participants.

Long-Term Plans

Many employers also have long-term plans that pay benefits for longer periods, typically ranging from 2 years to age 65. Some long-term plans have extended the benefit period to age 67 for younger workers who may have to meet a higher retirement age for full unreduced Social Security benefits. The percent of earnings replaced generally ranges from 50 to 80 percent of gross salary; a 60 replacement rate, however, is widely used.

A dual definition of disability is typically used to determine whether a worker is totally disabled. *For the first 2 years, you are considered disabled if*

you are unable to perform all of the material duties of your own occupation. After 2 years, you are still considered disabled if you are unable to work in any occupation for which you are reasonably fitted by education, training, and experience. In addition, in contrast to short-term plans, long-term plans typically cover both occupational and nonoccupational disability.

The disability-income benefits are usually paid monthly, and the maximum monthly benefits are substantially higher than the benefits paid by short-term plans. Most plans commonly pay maximum monthly benefits of $3,000, $4,000, 5,000, or some higher amount. A waiting period of 3 months or 6 months is typically required before the benefits are payable.

To reduce malingering and moral hazard, other disability-income benefits are taken into consideration. If the disabled worker is also receiving Social Security or workers compensation benefits, the long-term disability benefit is reduced accordingly. However, many plans limit the reduction only to the amount of the initial Social Security disability benefit. Thus, if Social Security disability benefits are increased because of increases in the cost of living, the long-term disability-income benefit is not reduced further.

Some long-term plans have additional supplemental benefits. Under the *cost-of-living adjustment,* benefits paid to disabled employees are adjusted annually for increases in the cost of living. However, there may be a maximum limit on the percentage increase in benefits.

Under the *pension accrual benefit,* the plan makes a pension contribution so that the disabled employee's pension benefit remains intact. For example, if both Carlos and his employer contribute 6 percent of his salary into a retirement plan, and Carlos becomes disabled, the plan would pay an amount equal to 12 percent of his monthly salary into the company's retirement plan for as long as he remains disabled. Thus, Carlos would still receive retirement benefits at the normal retirement age.

Finally, if the disabled worker dies, the plan may pay monthly *survivor income benefits* to an eligible surviving spouse or children for a limited period—such as 2 years—following the disabled worker's death.

CAFETERIA PLANS

The final part of this chapter deals with cafeteria plans. **Cafeteria plans** *allow employees to select those employee benefits that best meet their specific needs.* Instead of a single benefits package that applies to all employees, cafeteria plans allow employees to select among the various group life, medical expense, disability, dental, and other plans that are offered. Cafeteria plans also allow employers to introduce new benefits to meet the specific needs of certain employees.

Cafeteria plans take several forms. The most common are (1) full choice plans, (2) premium conversion plans, and (3) flexible spending accounts. Although these categories are not mutually exclusive, cafeteria plans share certain common characteristics.

- *Full choice plans.* These plans are also called *full flex plans*. This type of plan allows employees to select a full range of benefits. There is typically a core plan that offers a basic core of benefits to all participating employees. In addition, there may be a second layer of optional benefits from which employees can choose. The employer gives each employee a certain number of dollars or credits that can be spent on the different benefits or taken as cash. If taken as cash, the employer's credits are taxed as income to the employee.
- *Premium conversion plans.* Many cafeteria plans are premium conversion plans, which is a generic name for a plan that allows employees to make their premium contributions for plan benefits with before-tax dollars. Premium-conversion plans are commonly used for group health and dental insurance. Employees elect to reduce their salaries, and the salary reduction is used to pay for plan benefits. In effect, employee premium contributions are paid with before-tax dollars.
- *Flexible spending accounts.* Cafeteria plans typically make available flexible spending accounts to group insurance participants. A **flexible spending account** *permits employees to pay for certain unreimbursed medical expenses with before-tax dollars.* In 2015, the maximum employee contribution to a flexible spending account is $2,550, which is indexed for inflation and may change from year to year. Under a flexible spending account, the employee agrees to a salary reduction, which is used to pay for certain expenses

permitted by the Internal Revenue Code with before-tax dollars. These expenses include unreimbursed medical and dental expenses, plan deductibles, coinsurance charges, eyeglasses, hearing aids, cosmetic surgery, and other expenses not covered under a typical group plan. Any unused amounts in the flexible spending account at the end of the year are forfeited to the employer. However, to avoid forfeiture, the plan can provide for either a grace period or a carryover.

1. *Grace period*. A grace period of up to $2\frac{1}{2}$ months after the plan year ends can be provided. Qualified medical expenses incurred during that time can be paid from any unused amounts in the account at the end of the previous year. Employers are not permitted to refund any part of the remaining balance to the employees.
2. *Carryover.* Up to $500 of unused amounts left over at the end the plan year can be used to pay for qualified medical expenses incurred during the following plan year. The plan may specify a lower dollar amount as the maximum carryover amount. However, if the plan permits a carryover, any unused amounts in excess of the carryover amount are forfeited. The carryover does not affect the maximum amount of salary reduction contributions that employees can make.

Many employers provide debit cards that employees can use to pay for unreimbursed expenses out of their account balances. The debit card allows employees to be reimbursed immediately for their uncovered out-of-pocket expenses. Finally, if the cafeteria plan meets certain requirements specified in the Internal Revenue Code, the employer's credits are not currently taxable to the employee.

Cafeteria plans have certain advantages, including the following:

- Employees can select those benefits that best meet their specific needs.
- Employees generally pay their share of the cost of benefits with before-tax dollars. As a result, take-home pay declines by less than the reduction in salary.
- Employers can more easily control rising employee benefit costs. For example, an employer may limit the number of benefit dollars or credits given to each employee or offer the employees a medical expense plan with a higher deductible.

Cafeteria plans also have certain disadvantages, including the following:

- The employer may incur higher initial development and administrative costs in establishing and managing a cafeteria plan rather than a traditional employee benefits plan.
- Administrative complexity is increased. The employee benefits manager must have knowledge of the details of a large number of plans and must be able to answer the specific questions of employees concerning these plans.

Case Application

Megan is president of an accounting firm that has 10 employees. The only employee benefit provided by the firm is a paid 2-week vacation for employees with one or more years of service. The firm's profits have substantially increased, and Megan would like to provide some additional benefits to the employees. Megan needs advice concerning the types of benefits to provide. Assume you are an employee benefits consultant. Based on the following considerations, answer the following questions:

a. Megan would like to provide health insurance benefits to the employees. Describe briefly the major types of managed care plans that she might consider.

b. Assume that Megan is considering both a preferred provider organization (PPO) and a health maintenance organization plan (HMO). Explain the major differences between these two plans to Megan.

c. Are there any other group health insurance benefits that Megan might consider? Explain your answer.

d. Megan is concerned that rising healthcare costs may result in an increased financial burden to the firm. Describe a group healthcare plan that Megan might consider to deal with the problem of rising healthcare costs.

SUMMARY

- Group insurance provides benefits to a number of persons under a single master contract. Low-cost protection is provided because the employer pays part or all of the premiums. Evidence of insurability is usually not required. Larger groups are subject to experience rating, by which the group's loss experience determines the premiums charged.
- Certain underwriting principles are followed in group insurance to obtain favorable loss experience:

  Insurance should be incidental to the group.

  There should be a flow of persons through the group.

  Ideally, the benefits should be determined by some formula that precludes individual selection of benefit amounts.

  A minimum percentage of eligible employees should participate in the plan.

  There should be simple and efficient administration of the plan.

- Most groups today are eligible for group insurance benefits. However, employees must meet certain eligibility requirements:

  Is a full-time employee.

  Has satisfied a probationary period (required in some plans).

  Has applied for insurance during the eligibility period.

  Is actively at work when the insurance becomes effective.

- Group life insurance typically provides *yearly term insurance coverage* to participating employees. Different coverage amounts are available. A *basic amount* of term life insurance is provided to all eligible employees based on earnings, position, a flat amount for all, or some combination. Evidence of insurability is not required. Group plans also make available *supplemental term insurance*, which allows eligible employees to purchase additional life insurance up to certain limits with no evidence of insurability. Higher limits require evidence of insurability.
- Most group life insurance plans also offer group *accidental death and dismemberment (AD&D) benefits*, which pay additional benefits if the employee dies in an accident or incurs certain types of bodily injury.
- Group plans generally make available other types of life insurance and annuity products on a voluntary basis, such as whole life insurance, universal life insurance, voluntary accidental death and dismemberment insurance, and fixed and variable annuities.
- Group medical expense plans are available from a number of sources, including the following:

  Commercial insurers

  Blue Cross and Blue Shield

  Health maintenance organizations (HMOs)

  Self-insured plans by employers

- Managed care is a generic name for a medical expense plan that provides necessary medical care in a cost-effective manner. Major types of managed care plans are HMOs, PPOs, and POS plans.
- A health maintenance organization (HMO) is a managed care plan that provides broad, comprehensive services to its members for a fixed, prepaid fee. A typical HMO has the following characteristics:

  Organized plan to deliver health services to the members

  Broad, comprehensive health services

  Restrictions on the choice of healthcare providers

  Payment of fixed premiums and cost-sharing provisions

  Heavy emphasis on controlling costs

- A preferred provider organization (PPO) is a plan that contracts with healthcare providers to provide certain medical services to its members at discounted fees. Members pay lower deductibles and coinsurance charges if preferred providers are used.
- A point-of-service (POS) plan is a managed care plan that allows members to receive medical care outside the network of preferred providers. However, the patient must pay substantially higher deductible and coinsurance charges.
- Group medical expense plans have a number of common characteristics: payment of comprehensive benefits, calendar-year deductible, coinsurance requirements, copayments, no cost sharing for preventive services, and exclusions or limitations of certain services.
- The Affordable Care Act will have a significant impact on group medical expense plans. The ACA will be phased in from 2010 through 2018. However, most provisions that affect group medical expense plans are now in effect.

- A consumer-directed health plan (CDHP) is a generic term for a plan that combines a high-deductible health plan with a health savings account (HSA) or health reimbursement arrangement (HRA). These plans are designed to make employees more sensitive to healthcare costs, to provide a financial incentive to avoid unnecessary care, and to seek out low-cost providers.
- Under the Affordable Care Act (ACA), group medical expense plans are prohibited from excluding or limiting coverage for preexisting conditions or imposing lifetime limits or annual limits on benefits.
- Group medical expense plans typically contain a coordination-of-benefits provision, which specifies the order of payment when an insured is covered under two or more group medical expense plans. Total recovery under all plans is limited to 100 percent of covered expenses.
- Under the COBRA law, if a qualifying event occurs that results in a loss of coverage, employees and covered dependents can elect to remain in the employer's health insurance plan for a limited period.
- Under the ACA, if you left your job for any reason and lose your job-based health insurance coverage, you may qualify for a special enrollment period, which means you can enroll in a Health Insurance Marketplace plan outside the open enrollment period.
- Group dental insurance plans typically cover a wide variety of dental services. Dental services are typically grouped into different levels with varying coinsurance requirements. In many plans, coinsurance does not apply to diagnostic and preventive services, such as cleaning of teeth, or the coinsurance percentage is lower.
- Many employers provide disability-income benefits to covered employees. There are two basic types of plans:

  Short-term disability-income plans

  Long-term disability-income plans
- Cafeteria plans allow employees to select those benefits that best meet their specific needs. Flexible spending accounts in a cafeteria plan allow employees to pay for the benefits with before-tax dollars.

KEY CONCEPTS AND TERMS

Blue Cross and Blue Shield plans (351)
Cafeteria plans (364)
Calendar-year deductible (357)
Capitation fee (353)
COBRA law (361)
Coinsurance requirements (357)
Consumer-directed health plans (CDHP) (357)
Contributory plan (348)
Coordination-of-benefits provision (361)
Eligibility period (349)
Employee benefits (347)
Experience rating (348)
Family deductible (357)
Fee-for-service plans (352)
Flexible spending account (364)
Gatekeeper physician (353)
Group dental insurance (362)
Group disability-income insurance (363)
Group medical expense insurance (350)
Health Insurance Portability and Accountability Act (HIPAA) (362)
Health maintenance organization (HMO) (352)
Health reimbursement arrangement (HRA) (358)
Health savings account (HSA) (357)
High-deductible health plan (HDHP) (357)
Indemnity plans (352)
Individual practice association (IPA) plan (353)
Managed care (351)
Master contract (347)
Noncontributory plan (348)
Nonoccupational disability (363)
Out-of-pocket maximum limits (357)
Point-of-service (POS) plan (354)
Portable term insurance (350)
Preexisting condition (362)
Preferred provider organization (PPO) (353)
Probationary period (349)
Self-insurance (self-funding) (351)
SHOP Marketplace program (355)

REVIEW QUESTIONS

1. Describe the basic underwriting principles followed in group insurance.
2. Explain the typical eligibility requirements that employees must meet in group insurance plans.
3. a. Describe the major characteristics of Blue Cross and Blue Shield plans.
   b. Explain the reasons employers self-insure (self-fund) their group medical expense plans?
4. Briefly explain the basic characteristics of the following types of managed care plans:
   a. Health maintenance organizations (HMOs)
   b. Preferred provider organizations (PPOs)
   c. Point-of-service (POS) plans

5. What are some of the reasons for having a minimum participation requirement before a group is eligible for insurance?
6. What is the purpose of stop-loss insurance that is used with self-insured group medical expense plans?
7. What are the characteristics of a health maintenance organization (HMO)?
8. Briefly explain the basic characteristics of group dental insurance plans.
9. Compare between short-term plans and long-term plans with respect to each of following:
   a. The coverage
   b. The elimination period
   c. The length of benefit period
   d. The amount of disability income benefits
10. Describe the basic characteristics of cafeteria plans in an employee benefits program.

APPLICATION QUESTIONS

1. Margo, age 35, was severely injured in an auto accident. She is covered under her employer's preferred provider organization (PPO) plan. The plan has a $1,000 calendar-year deductible, 80/20 percent coinsurance, and an annual out-of-pocket maximum limit of $3,000. As a result of the accident, Margo incurred the following medical expenses:

Cost of ambulance to the hospital	$500
Hospital bill for a 3-day stay	$24,000
Surgery for broken leg	$5,000
Prescription drugs outside the hospital	$300
Physical therapy for the broken leg	$1,200

   In addition, Margo could not work for 1 month and lost $4,000 in earnings.
   a. Based on this information, how much will Margo collect for her injury if she receives medical care from healthcare providers who are part of the PPO network? (Assume that all charges shown are the allowable or approved charges by the insurer and all providers are in the PPO network.)
   b. Assume that Margo's broken leg does not heal properly, and she needs another surgical operation. Margo would like a different surgeon with an outstanding professional reputation to perform the operation. The surgeon is not a member of the PPO network. Will Margo's plan pay for the surgery? Explain your answer.
2. Doug, age 40, is the owner of a small firm that sells window blinds and cleans carpets. The company provides health insurance for seven employees. The wife of one employee has breast cancer and has incurred substantial medical bills, which resulted in a 40 percent increase in health insurance premiums for the company. Doug is not certain that the company can continue to provide health insurance for the employees because of the substantial increase in premiums. Explain the provision in the Affordable Care Act that will enable Doug to provide affordable health insurance to his employees.
3. Malcolm, age 57, works only part-time and has no health insurance. The cartilage in both his knees is severely eroded from osteoarthritis, which causes severe pain during his daily activities. As a result, Malcolm requires major surgery and a total knee replacement for both knees. Explain one or more provisions in the Affordable Care Act that will enable Malcolm to obtain health insurance.
4. Maria, age 28, and Mike, age 30, are married and have a 1-year-old son. Maria is covered under her employer's group medical expense plan as an employee. She is also covered under Mike's plan as a dependent. The son is covered under both plans as a dependent. Maria's birthday is January 10, and Mike's birthday is November 15. Both plans have the same coordination-of-benefits provision.
   a. If Maria is hospitalized, which plan is primary? Which plan is excess?
   b. If the son is hospitalized, which plan is primary? Which plan is excess?
   c. Assume that the couple gets a divorce, and Maria is awarded custody of her son. A court decree states that Mike must provide health insurance on his son. If the son is hospitalized after the divorce, which plan is primary? Which plan is excess?
5. Many employers have both group short-term and long-term disability-income plans. Compare short-term plans with long-term plans with respect to each of the following:
   a. Definition of disability under the plan
   b. Elimination period
   c. Length of the benefit period
   d. Offsets if other disability-income benefits are received

INTERNET RESOURCES

- **America's Health Insurance Plans (AHIP)** is a national trade association that represents companies that provide health insurance coverage to more than 200 million Americans. The site provides considerable information on healthcare issues in the United States. Visit the site at
ahip.org

- **Blue Cross and Blue Shield** plans are nonprofit corporations that provide medical, hospital, and surgical benefits to plan members in specific geographical areas. The various plans account for a substantial portion of the group health insurance market. Visit the site at
bcbs.com

- **Centers for Disease Control and Prevention (CDC)** is the leading federal agency for protecting the health and safety of people in the United States and abroad. The organization provides credible statistics to enhance health decisions and to promote good health. The CDC serves as the national focus for disease prevention and control, environmental health, and educational activities to improve health. Visit the site at
cdc.gov/nchs

- **Employee Benefit Research Institute (EBRI)** focuses solely on analyzing employee benefits. There is no attempt to lobby or promote policy positions. EBRI stands alone in employee benefits research as an independent, nonprofit, and nonpartisan organization. It conducts research studies without spin or an underlying agenda. As such, EBRI information is considered the gold standard by many private analysts and decision makers, government policymakers, the media, and the public. Visit this important site at
ebri.org

- **HealthCare.gov** is the official website of the federal government that provides detailed information on the Affordable Care Act (ACA) and its implementation. The site provides a convenient source of information concerning ACA provisions. Visit the site at
healthcare.gov

- **Healthgrades.com** uses a star system to rate hundreds of hospitals based on specific procedures. The stars range from a high of 5 to a low of 1. Hospitals that have fewer complications for a specific procedure receive a higher grade. Information on physicians and nursing homes is also available. Visit the site at
healthgrades.com/quality/hospital-ratings-awards

- **International Foundation of Employee Benefit Plans** is a nonprofit educational organization that provides programs, publications, and research studies to individuals in the employee benefits field. The organization cosponsors the Certified Employee Benefit Specialist (CEBS) program. Visit the site at
ifebp.org

- **National Committee for Quality Assurance (NCQA)** provides information to employers and consumers on the quality of their healthcare plans. The organization issues a report card on the quality of care provided and has an accreditation program for healthcare plans. Visit the site at
ncqa.org

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3. Ibid.
4. Emily Berry, "Few Physicians Can Avoid Dominant Health Insurers," amednews.com, February 21, 2011.
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13. Ronald L. Huling, "Dental Plan Design," in Jerry S. Rosenbloom (Ed.), *The Handbook of Employee Benefits,* 7th ed. (New York: McGraw-Hill, 2011), p. 326.

Students may take a self-administered test on this chapter at

www.pearsonglobaleditions.com/Rejda

CHAPTER

17

Employee Benefits: Retirement Plans

"Retirement at age 65 is ridiculous. When I was 65, I still had pimples."

George Burns

"When some fellers decide to retire, nobody knows the difference."

Kin Hubbard

Learning Objectives

After studying this chapter, you should be able to

- Explain the basic features of private retirement plans, including:
  - Minimum age and service requirements
  - Retirement ages
  - Vesting rules
- Distinguish between defined-contribution and defined-benefit retirement plans.
- Describe the basic characteristics of Section 401(k) plans.
- Explain the major features of profit-sharing plans.
- Identify the major features of SIMPLE retirement plans for small employers.

Brandon, age 27, is a marketing analyst who is employed by a large national retail firm. The company recently installed a new 401(k) plan that replaced an older defined-benefit pension plan that the company plans to phase out. Eligible employees are automatically enrolled in the new plan. Brandon has several questions, including the amount he can contribute, the amount contributed by the firm, the retirement age, and investment options. He also wants to know if he will receive the employer's contributions if he should leave the company.

Like Brandon, many employees are bewildered by the complexities of private retirement plans. This chapter deals with the questions that he and others may have concerning the characteristics of 401(k) plans and other qualified retirement plans. Although private retirement plans are complicated, they are extremely important in maintaining your economic security during retirement. When added to Social Security benefits and to your personal savings, the additional benefits from your retirement plan will enable you to attain a higher standard of living during retirement.

In this chapter, we discuss the fundamentals of private retirement plans. The first part of the chapter discusses the fundamentals of private retirement plans, which include eligibility requirements, retirement ages, and vesting rules. The second part explains the major types of retirement plans, which include defined-benefit and defined-contribution plans, 401(k) plans, profit-sharing plans, and retirement plans for the self-employed. The final part focuses on several current problems and issues in tax-deferred retirement plans.

FUNDAMENTALS OF PRIVATE RETIREMENT PLANS

Millions of workers participate in private retirement plans. These plans have an enormous social and economic impact on the nation. Retirement benefits increase the economic security of both individuals and families during retirement. Retirement contributions are also an important source of capital funds to the financial markets. These funds are invested in new plants, machinery, equipment, housing developments, shopping centers, and other worthwhile economic investments.

Federal legislation and the Internal Revenue Code have had a great influence on the design and growth of private retirement plans. The **Employee Retirement Income Security Act of 1974 (ERISA)** established minimum pension standards to protect the rights of covered workers. The **Pension Protection Act of 2006** increased the funding obligations of employers, made permanent the higher contribution limits that were scheduled to expire at the end of 2010, and encouraged automatic enrollment of employees in Section 401(k) plans and defined-contribution plans. More recently, federal legislation has been introduced to address the perceived gap between the retirement preparation of women compared to their male counterparts.

The Internal Revenue Service (IRS) also exerts a significant influence on private retirement plans. The IRS continuously issues new rules and regulations that affect plan design and growth of private retirement plans. The following discussion is based on current IRS requirements at the time of this writing.[1]

Favorable Income Tax Treatment

Private retirement plans that meet certain Internal Revenue Service (IRS) requirements are called **qualified plans** and receive favorable income tax treatment.

Both employers and employees enjoy favorable tax advantages, which include the following:

- Employer contributions are income-tax deductible up to certain limits as an ordinary business expense. Employers can also deduct plan expenses if paid directly.
- Employer contributions are not considered taxable income to the employees and are not taxed until the employee retires or receives the funds.
- Investment earnings on plan assets accumulate on a tax-deferred basis and are not currently taxable to plan participants. Distributions from the plan can be rolled over on a tax-deferred basis to another qualified retirement plan or individual retirement account (IRA). IRA distributions, however, must start at age 70½.
- If set up properly, employees can voluntarily reduce their salaries and make a contribution to a qualified plan with *before-tax* dollars, which reduces taxable wages. The savings in taxes over the years are sizeable.

Minimum Coverage Requirements

A qualified plan must benefit workers in general and not only **highly compensated employees.**[2] A retirement plan must meet certain minimum coverage tests to prevent discrimination in favor of highly compensated employees. The coverage tests are complex and beyond the scope of the text to discuss in detail. Only one test is described here. A retirement plan satisfies the minimum coverage requirement if it meets the **ratio percentage test**. Under this test, the percentage of nonhighly compensated employees covered under the plan must be at least 70 percent of the percentage of highly compensated employees who are covered. For example, for the current plan year, the retirement plan for the Swift Corporation covers 90 percent of the highly compensated employees and 63 percent of the nonhighly compensated employees. The ratio percentage is 70 percent (63 percent ÷ 90 percent), and the plan meets the ratio percentage test.

The minimum coverage tests typically come into play when an employer establishes a retirement plan for employees in one location (e.g., the Philadelphia office) but not in another location (e.g., the Boston office). The coverage tests are also important if an employer establishes a retirement plan for some workers based on the job classification but not location.

Minimum Age and Service Requirements

Most pension plans have a **minimum age and service requirement** that must be met before employees can participate in the plan. *Under present law, all eligible employees who have attained age 21 and have completed 1 year of service must be allowed to participate in the plan.* The plan can require 2 years of service, however, if there is 100 percent immediate vesting (discussed later) upon entry into the plan.

For purposes of determining eligibility, a worker who works at least 1,000 hours during an initial 12-month period after being hired earns 1 year of service. An hour of service is any hour the employee works or for which he or she is entitled to be paid.

Retirement Ages

A typical pension plan has three retirement ages:

- Normal retirement age
- Early retirement age
- Deferred retirement age

Normal Retirement Age The **normal retirement age** is the age that a worker can retire and receive full, unreduced pension benefits. Age 65 is the normal retirement age in most plans. However, as a result of an amendment to the Age Discrimination in Employment Act, most employees cannot be forced to retire at some stated mandatory retirement age. To remain qualified, with certain exceptions, private pension plans cannot impose a mandatory retirement age.

Early Retirement Age An **early retirement age** is the earliest age that workers can retire and receive a retirement benefit. The majority of employees currently retire before age 65. For example, a typical plan may permit a worker with 10 years of service to retire at age 55.

In a defined-benefit plan (discussed later), the retirement benefit is actuarially reduced for early retirement. The actuarial reduction is necessary for three reasons: (1) the worker's full benefit will not have accrued by the early retirement date; (2) the retirement benefit is paid over a longer period of time; and (3) early retirement benefits are paid to some workers who would have died before reaching the normal retirement age.

Deferred Retirement Age The **deferred retirement age** is any age beyond the normal retirement age.

Some older employees continue working beyond the normal retirement age. However, under current law with certain exceptions, workers can defer retiring with no maximum age limit as long as they can do their jobs. Employees who continue working beyond the normal retirement age continue to accrue benefits under the plan.

Vesting Provisions

Vesting *refers to the employee's right to the employer's contributions or benefits attributable to the contributions if employment terminates prior to retirement.* The employee is always entitled to the contributions he or she makes to the plan if employment terminates prior to retirement. However, the right to the employer's contributions, or benefits attributable to the contributions, depends on the extent to which vesting has been attained.

Defined-Benefit Plans Qualified defined-benefit plans must meet one of the following **minimum vesting standards**:

- *Five-year cliff vesting*. Under this rule, the employee must be 100 percent vested after 5 years of service.
- *Three- to seven-year graded vesting*. Under this rule, the rate of vesting must meet or exceed the following minimum standard:

Years of Service	*Percentage Vested*
3	20%
4	40
5	60
6	80
7	100

Defined-Contributions Plans Employer contributions to a qualified defined-contribution or profit-sharing plan must vest at a faster rate than defined-benefit plans. Faster vesting is designed to encourage greater participation by lower- and middle-income employees.

Defined-contribution retirement and profit-sharing plans must meet one of the following minimum vesting schedules:

- *Three-year cliff vesting*. Employer contributions must be 100 percent vested after 3 years.
- *Two- to six-year graded vesting*. Employer contributions must meet or exceed the following vesting schedule:

Years of Service	*Percentage Vested*
1	0%
2	20
3	40
4	60
5	80
6	100

From the employer's viewpoint, the basic purpose of vesting is to reduce labor turnover. Employees have an incentive to remain with the firm until a vested status has been attained. In a defined-benefit plan, if employees terminate their employment before full vesting is attained, the forfeitures generally are used to reduce the employer's future pension contributions. However, in a defined-contribution plan, forfeitures can either be reallocated to the accounts of the remaining participants or used to reduce future employer contributions.

Another important reason for vesting is to avoid the expense of administering benefits for short-term employees. This is especially true for defined-benefit plans where complex (and therefore expensive) actuarial calculations must be made annually.

Early Distribution Penalty

A 10 percent penalty tax applies to funds withdrawn from a qualified plan before age 59½. The 10 percent penalty tax applies to the amount included in gross income. However, there are exceptions to this rule. The early distribution penalty does not apply in the following circumstances:

- After the participant reaches age 59½
- Permissive withdrawals from a plan with automatic enrollment features
- Corrective distributions of excess contributions, excess aggregate contributions, and excess deferrals
- After death of the participant
- Total and permanent disability of the participant
- Distributions to an alternate payee under a qualified domestic relations order

- Series of substantially equal payments beginning after separation from service, and paid at least annually over the employee's life expectancy, or over the joint lives or joint life expectancy of the employee and designated beneficiary
- Dividend pass through from an ESOP
- Distributions to an employee after attaining age 55 and separation from service
- Distributions to an employee for medical care up to the amount allowable as a medical expense deduction
- Distributions because of an IRS levy
- Certain distributions to qualified military reservists called to active duty

Minimum Distribution Requirements

Pension contributions cannot remain in the plan indefinitely. Plan distributions must start no later than April 1 of the calendar year following the year in which the individual attains age 70½. However, participants older than 70½ who are still working can delay receiving minimum distributions from a qualified retirement plan. The required beginning date of a participant who is still employed after age 70½ is April 1 of the calendar year that follows the calendar year in which he or she retires. *The preceding rule does not apply to individual retirement accounts (IRAs) and certain other qualified plans*. Finally, the minimum distribution rules do not apply to Roth IRAs.

Integration with Social Security

Many qualified retirement plans are integrated with Social Security. The primary purpose of integration is to recognize that employers pay half of the social security payroll tax and that Social Security benefits should be taken into consideration in the calculation of private retirement benefits. As a result, pension costs can be reduced. A second purpose is that integration permits employers to increase the pension contributions for highly compensated employees with earnings above the integration level without violating the antidiscrimination rules that prohibit employers from discriminating in favor of highly paid employees.

The integration level can be any amount up to the maximum taxable Social Security wage base for the plan year. The integration level can be set lower, but this generally reduces the maximum excess contribution. The IRS has prescribed complex integration rules (called *permitted disparity rules*) that limit the employer's contributions made on behalf of highly compensated employees. It is beyond the scope of the text to discuss these rules in detail. However, the rules are designed to limit the pension contributions the employer can make on behalf of highly compensated employees with earnings above the integration level. For example, assume that a money purchase plan has a contribution rate of 6 percent of compensation up to and including the Social Security taxable wage base ($118,500 for 2015) and 11.5 percent of compensation in excess of the taxable wage base. In this case, the excess contribution percentage does not exceed the permitted disparity limits.[3]

TYPES OF QUALIFIED RETIREMENT PLANS

A wide variety of qualified retirement plans are available today to meet the specific needs of employers. There are two basic types of qualified retirement plans: (1) defined-benefit plans and (2) defined-contribution plans. Different rules apply to each type of plan. Qualified retirement plans include the following:

- Defined-benefit plans
- Defined-contribution plans
  - Money purchase plan
  - Section 401(k) plan
  - Section 403(b) plan
  - Profit-sharing plan
  - Retirement plans for the self-employed (Keogh plans)
  - Simplified employee pension (SEP)
  - SIMPLE IRA plan

DEFINED-BENEFIT PLANS

Traditional Defined-Benefits Plans

From a historical perspective, employers typically established defined-benefit plans that paid guaranteed benefits to retired workers. In a **defined-benefit plan,** *the retirement benefit is known in advance, but the contributions will vary depending on the amount needed to fund the desired benefit*. For example, assume that James, age 50, is entitled to a retirement

benefit at the normal retirement age equal to 50 percent of average pay for the highest three consecutive years of earnings. An actuary then determines the amount that must be contributed to produce the desired benefit.

In a defined-benefit plan, the benefit amount can be based on **career-average earnings**, which is an average of the worker's earnings while participating in the plan, or it can be based on **final average pay**, which generally is an average of the worker's earnings over a 3- to 5-year period just prior to retirement.

When a new defined-benefit pension plan is installed, some older workers may be close to retirement. To pay more adequate retirement benefits, defined-benefit plans may give credit for service with the firm prior to the installation of the plan. The **past-service credits** provide additional pension benefits. The actual amount paid, however, will depend on the benefit formula used to determine benefits.

Limits on Benefits

Defined-benefit plans have annual limits on pension benefits that can be funded. For 2015, under a defined-benefit plan, the maximum annual benefit is limited to 100 percent of the worker's average compensation for the three highest consecutive years of compensation, or $215,000, whichever is lower. This latter figure is indexed for inflation.

There is also a maximum limit on the annual compensation that can be counted in determining benefits. For 2015, the maximum annual compensation that can be counted in the benefit formula is $265,000 (indexed for inflation).

Defined-Benefit Formulas

Retirement benefits in defined-benefit plans are based on formulas that, combined with Social Security, will generally replace 50 to 60 percent of the worker's gross earnings prior to retirement. They include the following:

- *Unit-benefit formula*. Under this formula, both earnings and years of service are considered. For example, the plan may pay a retirement benefit equal to 1 percent of the worker's final average pay multiplied by the number of years of service. Thus, a worker with a final average monthly salary of $4,000 and 30 years of service would receive a monthly retirement benefit of $1,200.
- *Flat percentage of annual earnings*. Under this formula, the retirement benefit is a fixed percentage of the worker's earnings, such as 25 to 50 percent. The benefit may be based on career-average earnings or on an average of final pay. This formula sometimes lowers the amount provided if the employee does not have the required amount of service. For example, a plan may provide benefits equal to 50 percent of average final pay if the employee has 30 years of service. However, if the employee has only 20 years of service, the benefit is actuarially reduced.
- *Flat dollar amount for each year of service*. Under this formula, a flat dollar amount is paid for each year of credited service. For example, the plan may pay $40 monthly at the normal retirement age for each year of credited service. If the employee has 30 years of credited service, the monthly pension is $1,200. This formula is not widely used except in union-negotiated retirement plans.
- *Flat dollar amount for all employees*. This formula is sometimes used in collective bargaining plans by which a flat dollar amount is paid to all employees regardless of their earnings or years of service. For example, the plan may pay $800 per month to each worker who retires.

Years of service are extremely important in determining the total pension benefit. Frequent job changes and withdrawal from the labor force for extended periods can significantly reduce the size of the pension benefit. This is especially true for women who often have prolonged breaks in employment due to family considerations.

Pension Benefit Guaranty Corporation

Participants in defined-benefit plans are protected against the loss of pension benefits up to certain limits if the pension plan should terminate. The **Pension Benefit Guaranty Corporation (PBGC)** is a federal corporation that guarantees the payment of vested or nonforfeitable benefits up to certain limits if a private defined-benefit pension plan is terminated. A formula is used to determine maximum PBGC benefits. The formula provides lower limits for employees who start receiving benefits

before age 65 and higher limits for workers older than 65. For single employer plans terminated in 2015, the maximum monthly PBGC benefit to workers age 65 for a straight-life annuity (no survivor benefits) is $5,011.36. For workers receiving PBGC benefits at age 55, the maximum monthly benefit is $2,255.11. And for workers age 75 when the plan is terminated, the maximum monthly PBGC benefit is $15,234.53. The maximum monthly payment is lower for workers who elect survivor benefits for their beneficiaries.

Advantages of Defined-Benefit Plans

Defined-benefit plans provide guaranteed retirement benefits and certain additional advantages. First, the retirement benefits reflect more accurately the effects of inflation because they are usually based on a final-pay formula. Second, the plans are usually noncontributory, which means that only the employer contributes to the plan. Third, the investment risk falls directly on the employer and not on the employees. Finally, defined-benefit plans favor workers who enter the plan at older ages because the employer must contribute a relatively larger amount for older workers than for younger workers.

Disadvantages of Defined-Benefit Plans

Defined-benefit plans have declined in relative importance over the years. Because of actuarial considerations, defined-benefit plans are more complex and expensive to administer than defined-contribution plans. Also, some defined-benefit plans have large unfunded past-service liabilities that are expensive to fund. Because of cost and complexity, many corporations have frozen or have terminated their defined-benefit plans. As a substitute, many companies have replaced their defined-benefit plan with a defined-contribution plan, which is less costly and easier to administer.

Cash-Balance Plans

To reduce pension costs, many employers have converted their traditional defined-benefit plans to a cash-balance plan. A **cash-balance plan** *is a defined-benefit plan in which the benefits are defined in terms of a hypothetical account balance; actual retirement benefits will depend on the value of the participant's account at retirement.*

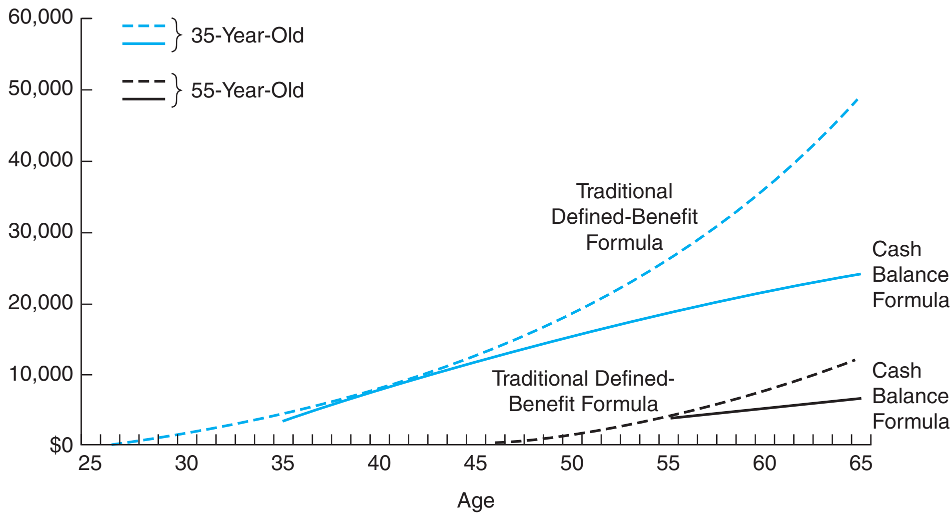
In a typical cash-balance plan, the employer establishes "hypothetical accounts" for plan participants. The accounts are hypothetical because the contributions and interest credits are bookkeeping credits. Actual contributions are not allocated to the participants' accounts, and the accounts do not reflect actual investment gains or losses. The investment credits are also hypothetical and are based on an interest rate stated in the plan or on some external index.

Each year, the participants' accounts are credited with (1) a *pay credit,* such as 4 percent of compensation and (2) an *interest credit,* such as 5 percent on the account balance. The interest credit can be based on a fixed rate or on a variable rate pegged to some index, such as a 1-year Treasury bill rate. Investment gains and losses on the plan's assets do not directly affect the benefits promised to the participants. Thus, the employer bears the investment risks and realizes any investment gains. For example, assume that the employer makes a contribution of 4 percent of pay each year to the participants' accounts. If James earns $50,000 annually, his "account" is credited with $2,000. Each year, his account balance will be credited with a stated interest rate, such as 5 percent. At retirement, James can elect to receive a life annuity that will pay him a life income. Instead of an annuity, the cash-balance plan may allow him to elect a lump-sum payment equal to the account balance, which can then be rolled over into an IRA.

Many employers have converted traditional defined-benefit plans into cash-balance plans in an effort to hold down pension costs. Also, younger workers benefit because they can understand the plan better; benefits accrue at a faster pace than under a traditional defined-benefit plan; and the benefits are portable for workers who leave before retirement age.

On the downside, however, critics argue that the switch to a cash-balance plan can reduce expected benefits for older workers by 20 to 40 percent. When the conversion occurs, plan benefits are "frozen," which means that earned benefits do not continue to grow. However, under a defined-benefit plan, a large part of the initial retirement benefit is earned during the last 3 to 5 years prior to retirement. When benefits are frozen, the worker's pension grows only from the annual interest and wage credits under the cash-balance plan. As a result, the initial retirement benefit for an older worker is substantially less than if the defined-benefit formula had remained in place. This can be illustrated by Exhibit 17.1, which shows that

EXHIBIT 17.1
How Conversion to a Cash-Balance Plan Potentially Lowers Annuity Benefits



Note: Model results are based on the assumption of $40,000 salary and 10-year tenure at conversion for both the 35-year-old and the 55-year-old worker at conversion.
Source: United States General Accounting Office, *Private Pensions, Implication of Conversion to Cash Balance Plans*, GAO/HEHS-00-185 (September 2000), Figure 4, p. 26

a worker, age 55, at the time of conversion may receive lower benefits under a cash-balance formula as compared to a younger worker, age 35.

DEFINED-CONTRIBUTION PLANS

Most newly installed qualified retirement plans are defined-contribution plans. In a **defined-contribution plan**, *the contribution rate is fixed, but the actual retirement benefit varies*. For example, both the employer and employee may each contribute 6 percent of the employee's pay into the plan. The actual retirement benefit, however, depends on the age of entry into the plan, the contribution rate, the types of investments and investment returns, and the age of retirement. As such, retirement benefits can only be estimated.

Money Purchase Plan

One type of defined-contribution plan is a money purchase plan. *A* **money purchase plan** *is a plan in which each participant has an individual account, and the employer's contribution is a fixed percentage of the participant's compensation*. For example, the money purchase formula may specify an annual contribution by the employer of 10 percent of base pay into the plan. If the plan is contributory, both the employee and employer may contribute at the same rate, such as 5 percent, or the plan may specify a higher employer contribution rate, such as 6 percent for the employer and 4 percent for the employee.

Each employee has an individual account, and the retirement contributions and investment income are credited to the account. The employee receives periodic statements that show the account value and investment income and contributions credited to the account. Amounts forfeited by employees who terminate their employment before they attain full vesting are used to reduce future employer contributions or are reallocated to the accounts of the remaining employees.

Limits on Contributions

Defined-contribution plans have annual limits on the amounts that can be contributed into the plan. For 2015, under a defined-contribution plan, the

maximum annual addition that can be credited to an employee's account is 100 percent of compensation, or $53,000, whichever is lower. Workers age 50 and older can make an additional catch-up contribution of $6,000. Annual additions include both employer and employee contributions and any forfeitures allocated to the employee's account.

There is also a maximum limit on the annual compensation that can be counted in determining the amount that can be contributed each year. For 2015, the maximum annual compensation that can be counted in the benefit formula is $265,000 (indexed for inflation).

Defined-contribution plans are widely used by business firms today. One financial advantage to the firm is that past-service credits are not granted for service prior to the plan's inception date, which reduces the employer's cost. Defined-contribution plans are also widely used by nonprofit organizations and state and local governments, where pension costs must be budgeted as a percentage of payroll.

However, from the employee's perspective, a defined-contribution plan has several disadvantages. Retirement benefits can only be estimated, and the benefit formula may produce an inadequate benefit if the worker enters the plan at an advanced age. In addition, some employees do not understand the factors to consider in choosing a particular investment, such as a stock fund, bond fund, money market fund, and other investment options. Finally, investment losses fall directly on participating employees. In the severe 2007–2009 economic downswing, the economy experienced a massive financial meltdown and brutal stock market crash that substantially reduced the life savings of most workers in defined-contribution plans.

SECTION 401(K) PLAN

Another important defined-contribution plan is a Section 401(k) plan. *A* **Section 401(k) plan** *is a qualified cash or deferred arrangement (CODA) that allows eligible employees the option of receiving funds as taxable compensation or putting funds into the plan on a tax-deferred basis*. Employer contributions are deductible in the year they are made and are not currently taxable as income to plan participants.

A Section 401(k) plan can be a qualified profit-sharing plan, savings or thrift plan, or stock bonus plan. A plan can be established that includes either employer and employee contributions or employee contributions alone.

In a typical plan, both the employer and employees contribute, and the employer matches part or all of the employee's contributions. For example, for each dollar contributed by the employee, the employer may contribute 25 or 50 cents, or some higher amount.

Most plans allow the employees to determine how the funds are invested. Employees typically have a choice of investments, such as a common stock mutual fund, bond fund, fixed-income fund, and numerous other funds. Many employees, however, make some common mistakes when they invest their 401(k) contributions, which ultimately reduce the amounts accumulated for retirement (see Insight 17.1).

Annual Limit on Elective Deferrals

Eligible employees can voluntarily elect to have their salaries reduced if they participate in a Section 401(k) plan. The salary reduction is technically called an *elective deferral*. The amount of salary deferred is then invested in the employer's Section 401(k) plan. The amounts deferred accumulate free of current income taxes until the funds are withdrawn. However, Social Security taxes must be paid on the contributions to the plan. The funds are taxed as ordinary income when withdrawals are made. See Insight 17.1 for some common 401(k) mistakes.

For 2015, the maximum limit on elective deferrals in a Section 401(k) plan is $18,000 for workers under age 50. Workers who are age 50 or older before the end of the plan year can make an additional catch-up contribution of $6,000. The maximum dollar limits are indexed for inflation in increments of $500.

Actual Deferral Percentage Test

To prevent discrimination in favor of highly compensated employees in a Section 401(k) plan, an **actual deferral percentage (ADP) test** must be satisfied. That is, the actual percentage of salary deferred for highly compensated employees is subject to certain limitations. In general, the eligible employees are divided into two groups: (1) highly compensated employees and (2) other eligible employees. The percentage of salary deferred for each employee is totaled and then averaged to get an ADP for each group. The ADPs of both

INSIGHT 17.1

Six Common 401(k) Mistakes

For the vast majority of people, having a 401(k) retirement plan is essential to their future financial health. As a matter of fact, a 401(k) is so vital to a comfortable retirement that possibly the most important thing for most people who are eligible to invest in such plans is to know what mistakes they should avoid making. Listed here are six of the most common 401(k) mistakes that people make. Don't repeat them in your investment program.

- ***The first (and possibly worst) mistake:*** *investing in volatile securities (such as stocks), then selling in a panic if their prices decline.* In other words, the worst mistake is for a novice to make an investment that is suitable only for sophisticated investors. Stocks can be great investments—for those who are experienced in the stock market and are equipped with the proper risk tolerance.
- ***The second (and also quite expensive) mistake:*** *not taking advantage of a 401(k) plan when one is available.* Many millions of eligible Americans have not elected to participate in their employer-sponsored plans. This represents a golden opportunity to procure help in building a substantial retirement fund, an opportunity that daily slips further away from those that may need it the most. Studies have shown that the well-to-do are as likely to participate in salary-deferral plans as the less well-to-do, who would probably benefit more.
- ***The third mistake:*** *not taking advantage of employers' contributions.* Many companies match their employees' contributions up to a certain amount. For instance, if the employee contributes 3 percent of his or her salary to the 401(k) plan, the employer may match that contribution by adding an extra 1.5 percent to the employee's account. That's an immediate *fifty percent* return on the invested money, and it's free! Not to mention the fact that the matching funds compound right along with the employee's contributions. Yet many people don't even put the minimum amount of money into their 401(k) plans that would be matched by their employers.
- ***Mistake number four:*** *not putting away more money.* Studies have found that only about one-third of active participants contributed the maximum annual amounts (the maximum amount can change yearly in line with inflation). The least that a savvy employee should contribute is the amount that will be matched by his or her employer's contribution. Again, it's senseless to turn down free money.
- ***The fifth mistake:*** *not putting enough money into the stock market.* Yes, mistake number one warned of investing in the stock market. It's volatile; it can rise and fall with alarming quickness. It can drop in value and remain down for extended periods of time. Yet, over the years, the stock market has rewarded investors more generously than fixed-income investments (bonds), cash equivalents (such as money market funds), precious metals, antiques and collectibles, and most other investments. To be invested exclusively in the safest assets available will only serve to guarantee that the employee will earn much lower returns than if his or her portfolio were properly allocated to include at least some riskier investment options.
- ***And, mistake number six:*** *putting too much money into the employer's stock.* Actually, the real mistake here is not being fully *diversified*—not having enough money in a variety of different investments. The company may be a fantastic place to work; fair, generous, and a home away from home. It may be a thriving enterprise, making huge profits; the stock may even be selling for less than it should. Regardless, it's still a bad idea—and goes against one of the first tenets of prudent investing—to have one stock dominating the investing portfolio, even if that stock can be bought cheaply.

SOURCE: Adaptation of "Six Common 401(k) Mistakes," Financial Web at finweb.com. Reprinted with permission from Internet Brands.

groups are then compared. For example, if the nonhighly compensated group has an ADP of 6 percent, the maximum ADP for the highly compensated group is limited to 8 percent for favorable tax treatment.[4]

Limitations on Distributions

As noted earlier, a 10 percent penalty tax applies to an early distribution of funds before age 59½ with certain exceptions that were discussed earlier.

The plan may also permit the withdrawal of funds for a hardship. The IRS recognizes the following as a hardship withdrawal:

- Payments to prevent eviction or foreclosure on your home
- Certain nonreimbursable medical expenses
- Purchase of a primary residence
- Payments for post-secondary education expenses
- Burial or funeral expenses

- Certain expenses incurred for the repair or damage to the employee's principal residence, which would qualify as a deductible casualty expense

The 10 percent penalty tax still applies to a hardship withdrawal. However, Section 401(k) plans typically have a *loan provision* that allows funds to be borrowed without a tax penalty.

Despite the substantial tax penalties for a premature distribution, many employees often use their 401(k) funds and other retirement funds for purposes other than retirement, such as spending the funds outright, paying off debts, or buying a home. Employees who take money out of their retirement plans early will receive a substantially lower amount of income during retirement. As a result, they may be exposed to serious economic insecurity during retirement.

Roth 401(k) Plan

Employers have the option of allowing employees to invest in a Roth 401(k) plan. In a traditional 401(k) plan, you make contributions with before-tax dollars, and distributions are taxed as ordinary income. In a **Roth 401(k) plan**, *you make contributions with after-tax dollars, and qualified distributions at retirement are received income-tax free*. Investment earnings also accumulate on a tax-free basis. Distributions from the Roth 401(k) are income-tax free if you are at least age 59½ and the account is held for at least 5 years. However, with certain exceptions, there is a 10 percent tax penalty under both plans if you withdraw funds before age 59½.

There are no income limitations. Employees at all income levels can contribute to a Roth 401(k). For 2015, if you are under age 50, you can contribute a maximum of $18,000 into the plan. If you are age 50 or older, you can contribute an additional $6,000. You can split the contributions between a traditional 401(k) and a Roth 401(k), but your contributions to both accounts cannot exceed the maximum annual limits. If your employer makes a matching contribution, it is made with before-tax money and must go into the traditional 401(k) plan.

Another advantage is that funds in a Roth 401(k) can be rolled over into a Roth IRA, which has no minimum distribution requirements at age 70½. As a result, larger sums can be bequeathed to heirs on a tax-free basis.

Individual 401(k) Retirement Plan

An individual 401(k) retirement plan provides attractive tax advantages to self-employed individuals. The **individual 401(k) retirement plan** (also called a *solo 401(k) plan*) is a plan that combines a profit-sharing plan with a 401(k) plan. The plan is limited to self-employed individuals or business owners with no employees other than a spouse, which include sole proprietors, partnerships, corporations, and "S" corporations. Taxable income is reduced by contributions into the plan, and investment income accumulates income-tax free. For 2015, an individual 401(k) plan allows a maximum annual contribution of 25 percent of compensation (20 percent of net self-employment income for the business owner) into the plan. In addition, for 2015, the business owner can elect a salary deferral up to $18,000, which also reduces taxable income. Older workers age 50 and over can make an additional catch-up contribution of $6,000. However, for 2015, total profit-sharing contributions and salary deferral for an individual under age 50 cannot exceed $53,000. The tax savings are substantial.

As an example, Daniel, age 40, is a finance professor who has self-employment income from part-time consulting and book royalties. In 2015, after deducting allowable expenses and one-half of the Social Security payroll tax, Daniel has a net income of $50,000. He can elect a maximum salary deferral of $18,000. He can also contribute 20 percent or $10,000 into his individual 401(k) plan. As a result, his taxable income from consulting is reduced from $50,000 to $22,000. Daniel has tax sheltered 56 percent of his net earnings.

SECTION 403(B) PLAN

Section 403(b) plans are retirement plans designed for employees of public educational systems and tax-exempt organizations, such as hospitals, nonprofit groups, and churches. These plans are also known as **tax-sheltered annuities (TSAs)**. Under the plan, eligible employees voluntarily elect to reduce their salaries by a fixed amount. The salary reduction is called an *elective deferral,* which is then invested in the 403(b) plan. Employers may make a matching contribution, such as 50 cents for each dollar contributed by the employee by salary reduction. For example, if Kathy earns $3,000 monthly and elects to defer $300 monthly, only $2,700 is subject to income taxes. The $300 salary reduction plus any employer contributions are then invested in the 403(b) plan.

A 403(b) plan can be funded by purchasing an annuity from an insurance company or by investing in mutual funds. If an annuity is used, the employer must purchase the annuity, and the employee's rights under the contract must be nonforfeitable. *Nonforfeitable* means that the amounts contributed by the employer cannot be taken away from the employee. Employee salary reductions are always nonforfeitable. In addition, the annuity must be nontransferable. *Nontransferable* means the annuity contract cannot be sold, assigned, or pledged as collateral for a loan.

Current law places a maximum annual dollar limit on elective deferrals under a 403(b) plan. For 2015, the maximum limit on elective deferrals for workers under age 50 is $18,000. Employees age 50 and older can make an additional catch-up contribution of $6,000. The limits are adjusted for increases in the cost-of-living.

Finally, employers have the option of allowing employees to invest in a **Roth 403(b) plan**. A Roth 403(b) plan is similar to the Roth 401(k) plan discussed earlier. Contributions to the plan are made with after-tax dollars; investment earnings accumulate on a tax-free basis; and qualified distributions at retirement are received income-tax free.

PROFIT-SHARING PLANS

Many employers have profit-sharing plans to provide retirement income to eligible employees. A **profit-sharing plan** *is a defined-contribution plan in which the employer's contributions are typically based on the firm's profits*. However, there is no requirement that the employer must actually earn a profit to contribute to the plan.

Employers establish profit-sharing plans for several reasons. Eligible employees are encouraged to work more efficiently; the employer's cost is not affected by the age or number of employees; and there is greater flexibility in employer contributions. If there are no profits, there may be no contributions.

The profit-sharing contributions can be discretionary—based on an amount determined annually by the board of directors—or they can be based on a formula, such as a certain percentage of profits above a certain level. There are annual limits, however, on the amount that can be contributed into an employee's profit-sharing account. Employer contributions to a profit-sharing plan are limited to 25 percent of compensation paid or accrued during the taxable year to employees or their beneficiaries under the plan. For 2015, in determining the deduction limit, the amount of annual compensation to any one employee that can be considered is limited to $265,000.

The profit-sharing funds are typically distributed to the employees at retirement, death, disability, or termination of employment (only the vested portion), or after a fixed number of years (at least 2 years). Amounts forfeited by employees who leave the company before they attain full vesting are reallocated to the accounts of the remaining participants.

A 10 percent tax penalty applies to a distribution to a participant younger than age 59½. To avoid the tax penalty, many plans have loan provisions that permit employees to borrow from their accounts.

RETIREMENT PLANS FOR THE SELF-EMPLOYED (KEOGH PLANS)

Retirement plans for self-employed were formerly called *Keogh Plans* to reflect the law that first allowed unincorporated business firms to sponsor qualified retirement plans. Since the law no longer makes a distinction between corporate sponsors and other plan sponsors, this term is seldom used today. With certain exceptions, the same rules that apply to qualified corporate pension plans now apply to **retirement plans for the self-employed** (**Keogh plans**). The contributions to the plan are income-tax deductible up to certain limits; the investment income accumulates on a tax-deferred basis; and the amounts deposited and the investment earnings are not taxed until the funds are distributed.

SIMPLIFIED EMPLOYEE PENSION (SEP)

A **simplified employee pension** (**SEP**) is a retirement plan in which the employer establishes and contributes to an IRA for each eligible employee; however, the annual contribution limits are substantially higher than a traditional IRA. These plans are available to any size business as well as to the self-employed. Simplified employee pension plans are popular with smaller employers because they are easy to set up and operate; they have low administrative costs; the amount of required paperwork is minimal; SEPs do not have the start-up costs and operating costs of conventional retirement plans; and there are no annual filing requirements for employers.

Eligible Employees

A SEP plan must cover all qualifying employees who are at least age 21, have worked for the employer in at least 3 of the immediately preceding 5 years, and have received at least $600 (indexed limit for 2015) from the employer in compensation during the tax year.

SEP Contribution Limits

For a **SEP IRA**, the employer establishes and contributes to it for each eligible employee. The employer must contribute equally for all eligible employees. For 2015, the maximum annual tax-deductible employer contribution to a SEP plan is limited to 25 percent of the employee's compensation, or $53,000, whichever is less. A SEP plan is funded only by employer contributions. Employees cannot contribute because SEPs permit only employer contributions. There is always 100 percent full and immediate vesting of all employer contributions, or employees have ownership of all SEP funds.

SIMPLE IRA PLAN

A Savings Incentive Match Plan for Employees (SIMPLE) is a **SIMPLE retirement plan** that allows employees and employers to contribute to a traditional IRA established for the employees. Such plans are limited to employers that employ 100 or fewer eligible employees and do not maintain another qualified plan. Under a SIMPLE IRA plan, smaller employers are exempt from most nondiscrimination and administrative rules that apply to qualified plans.

Eligible Employees

All employees who have earned at least $5,000 from the employer during any two previous years (whether or not consecutive) and who are reasonably expected to earn at least $5,000 during the current year must be allowed to participate in a SIMPLE IRA plan. Self-employed individuals can also participate.

Employee Contributions

For 2015, eligible employees can elect to make before-tax contributions to an IRA of up to $12,500. Participants age 50 and older in 2015 can elect an additional catch-up contribution of $3,000.

Employer Contributions

Employers can choose between two options and can switch options each year if certain notification requirements are met:

- *Matching contribution.* The employer matches the employee's contributions on a dollar-for-dollar basis up to 3 percent of the employee's compensation, or
- *Nonelective contribution.* The employer must contribute 2 percent of compensation for each eligible employee who has earned at least $5,000 for 2015. (For 2015, the maximum compensation for determining contributions is $265,000.) The contribution must be made regardless of whether the employee participates or not.
  - *Example 1: Audrey earns $50,000 annually and contributes 5 percent of compensation ($2,500) to a SIMPLE IRA. The employer's matching contribution is $1,500 (3% of $50,000), or a total contribution of $4,000.*
  - *Example 2: Joel's annual compensation is $40,000. Even if Joel does not contribute this year, the employer must make a contribution of $800 (2% of $40,000).*

All contributions go into an IRA account and are fully and immediately vested. Withdrawals of funds by participants under age 59½ are subject to a 10 percent tax penalty with certain exceptions. However, withdrawals during the first two years of participation are subject to a stiff 25 percent tax penalty.

SAVER'S CREDIT

To encourage low- to moderate-income earners to save for retirement, a tax credit called a *Saver's Credit* (Retirement Savings Contributions Credit) is available. Unlike tax deductions that reduce the amount of taxable income, *tax credits reduce the actual amount of tax owed on a dollar-for-dollar basis up to some maximum limit*. You are eligible for the tax credit if you are age 18 or older, not a full-time student, and not claimed as a dependent on another person's tax return.

The tax credit is a percentage of your contributions to a traditional or Roth IRA, 401(k), SIMPLE IRA, 403(b), 501(c), and certain other employer-sponsored retirement plans. Depending on your adjusted gross income (AGI), the credit is 50 percent, 20

percent, or 10 percent of your IRA or retirement contributions up to $2,000 annually ($4,000 if married filing jointly). For 2015, the credit rates and adjusted gross income limits are as follows:

2015 Saver's Credit

Credit Rate	*Married Filing Jointly*	*Head of Household*	*All Other Filers*
50% of your contribution	AGI not more than $36,500	AGI not more than $27,375	AGI not more than $18,250
20% of your contribution	$36,501–$39,500	$27,376–$29,625	$18,251–$19,750
10% of your contribution	$39,501–$61,000	$29,626–$45,750	$19,751–$30,500
0% of your contribution	more than $61,000	more than $45,750	more than $30,500

For example, Ann-Marie is married and earned $30,000 in 2015. Her husband was unemployed in 2015 and did not have any reported earnings. Ann-Marie contributed $1,000 to her traditional IRA in 2015. After deducting her IRA contribution, the adjusted gross income shown on her joint tax return is $29,000. Jane can claim a 50 percent tax credit ($500) for her $1,000 IRA contribution.

FUNDING AGENCY AND FUNDING INSTRUMENTS

An employer must select a funding agency when a pension plan is established. A **funding agency** *is a financial institution that provides for the accumulation or administration of the funds that will be used to pay pension benefits*. If the funding agency is a commercial bank or individual trustee, the plan is called a *trust-fund plan*. If the funding agency is a life insurer, the plan is called an *insured plan*. If both funding agencies are used, the plan is called a *split-funded combination plan*.

The employer must also select a funding instrument to fund the pension plan. A **funding instrument** *is a trust agreement or insurance contract that states the terms under which the funding agency will accumulate, administer, and disburse the pension funds*. Funding instruments that are widely used today include the following:[5]

- Trust-fund plan
- Separate investment account
- Guaranteed investment contract (GIC)

Trust-Fund Plan

Most private pension plan assets are invested in trust-fund plans. Under a **trust-fund plan**, all contributions are deposited with a trustee who invests the funds according to the trust agreement between the employer and trustee. The trustee can be a commercial bank or individual trustee. Annuities are not purchased when the employees retire, and the pension benefits are paid directly out of the fund. The trustee does not guarantee the adequacy of the fund. In addition, there are no guarantees of principal and interest rates when a defined-benefit plan is used. A consulting actuary periodically determines the adequacy of the fund.

Separate Investment Account

A separate investment account is a group pension product with a life insurance company. Under a **separate investment account**, the plan administrator can invest in one or more of the separate accounts offered by the insurer. A separate account is an account by which assets in the separate account are segregated from the insurer's general investment account that backs its fixed policies and are not subject to claims by the insurer's creditors. Funds in a separate account can be invested in stock funds, bond funds, and other types of investments. Separate accounts are popular because they permit the plan administrator to invest in a wide variety of investments, including common stocks.

Guaranteed Investment Contract

A **guaranteed investment contract (GIC)** is an arrangement in which the insurer guarantees the interest rate for a number of years on a lump-sum deposit. The insurer also guarantees the principal against loss. Guaranteed investment contracts are popular with employers because of interest rate guarantees and protection against the loss of principal. Guaranteed investment contracts are sometimes used to fund the fixed-income option in a defined-contribution retirement plan, such as a 401(k) plan. In addition, most guaranteed investment contracts

make annuity options available at retirement, but employers are not required to use these options.

PROBLEMS AND ISSUES IN TAX-DEFERRED RETIREMENT PLANS

Although tax-deferred retirement plans have great potential in reducing economic insecurity during retirement, several serious problems must be resolved. They include the following:[6]

- *Inadequate 401(k) and IRA account balances*. The majority of households nearing retirement have 401(k) plans or IRAs to supplement their OASDI retirement benefits. Most participants, however, have inadequate assets in their accounts for a comfortable retirement. *According to the 2013 Survey of Consumer Finances by the Federal Reserve, working households near retirement (ages 55 to 64) had median combined 401(k) and IRA assets of only $111,000.*[7] This amount is inadequate for most workers to maintain their present standard of living during retirement.

  Another study by the Center for Retirement Research at Boston College concluded that roughly half of today's working households will be unable to maintain their present standard of living during retirement because of insufficient financial assets and inadequate retirement income.[8]
- *Incomplete coverage of the labor force*. Coverage of the labor force is incomplete. *In March 2014, 65 percent of private industry employees had access to retirement benefits, and only 48 percent actually participated in the plans.*[9] Inadequate participation is due to several factors. First, wages paid to low- and middle-income workers have been stagnant or have declined in real terms over the past 20 years; as a result, many workers believe they cannot afford to contribute to a retirement plan because of insufficient earnings. Second, retirement plans are expensive, and many small firms cannot afford them. Third, membership in labor unions, which historically have bargained aggressively for pensions, has declined significantly over time. Fourth, to reduce labor costs, an increasing number of firms employ part-time employees and independent contractors who generally are ineligible to participate. Finally, employment in the services industry has increased substantially over time; service firms generally are financially weaker and less inclined to install retirement plans than larger manufacturing firms.
- *Lower benefits for women*. Women are more likely to receive lower retirement benefits than men. *According to the Employee Benefit Research Institute (EBRI), in 2010, the median annual retirement benefit from employment-based pension plans and retirement annuities for people age 65 and over was $15,000 for males and only $8,400 for females.*[10] Pension payments are lower because women enter and leave the labor force more frequently than men because of family obligations. As a result, pension contributions and benefits are lower. Also, women generally are paid less than men, which results in lower pension benefits. Finally, women are more likely to work in part-time jobs where employer-sponsored pension plans may not be available.
- *Limited protection against inflation*. Most participants in employer-sponsored retirement plans are in defined-contribution plans where the benefit amount depends on the value of the employee's account at retirement. Most retired workers do not annuitize their account balances in the form of lifetime income from an insurer but invest the funds on their own. Many retired workers are risk adverse and invest a large part of their retirement assets in fixed income investments, which provide only limited protection against inflation. Likewise, if a fixed immediate annuity is purchased, the annuity typically pays fixed benefits, which also does not provide an inflation hedge unless an option that indexes benefits to inflation is available. If the index option is elected, initial payments are significantly lower than a traditional fixed-income annuity, typically 25 to 30 percent lower. Finally, some retired workers receive benefits from defined-benefit pension plans, and most defined-benefit plans do not adjust benefits annually for inflation. As such, the real purchasing power of the benefits declines over time.
- *Leakages from 401(k) plans and IRA plans*. Leakages of cash assets from 401(k) plans and individual retirement accounts aggravate the problem of insufficient retirement assets

for many workers. Two important leakages are (1) lump-sum distributions when workers change jobs and (2) workers who receive distributions after age 59½ but still continue working until age 62 or some older retirement age. The leakage amount is significant. *According to the Center for Retirement Research, estimated leakages from 401(k) plans and IRA plans reduce retirement assets by at least 20 percent because of current distribution rules.*[11]

Millions of workers change jobs each year and often receive lump-sum distributions from their employers' retirement plans. Part or all of the distributions are spent rather than saved for retirement. Many workers used part or all of the funds for consumption needs, home purchases, paying down debt, starting a business, education expenses, or expenses in changing jobs. Spending a lump-sum distribution reduces economic security during retirement because the cash is spent, and retirement benefits, if any, are lower. There are also substantial tax penalties for premature distributions before age 59½. A lump-sum distribution is taxed as ordinary income, and, with certain exceptions, a 10 percent penalty tax also applies. Finally, the benefits of compound interest on a tax-deferred basis are lost.

In addition, some older workers beyond age 59½ make withdrawals from their IRA plans prior to their actual retirement at some later date. In such cases, the 10 percent tax penalty for a premature distribution does not apply. Also, some retirement experts believe it is easier to make withdrawals from IRA plans than from 401(k) plans.[12] First, IRA withdrawals are not subject to any mandatory withholding tax at the time the transaction occurs; IRA withdrawals can be made any time without any explanation; and IRA sponsors generally do not discourage withdrawals prior to the age of retirement.

- *Investment mistakes that jeopardize economic security*. Three mistakes are worth noting. First, many eligible workers do not participate in their employers' plans, or if they do, they contribute less than the maximum allowed; as a result, employees who do not participate are passing up "free money" from the matching contributions of employers. Second, many older workers near retirement are too heavily invested in common stock, which can result in substantial losses during market declines. An EBRI study showed that older workers (ages 56 to 65) experienced losses of 25 percent or more in their 401(k) plans in 2008 when the stock market declined sharply. *One in four participants, ages 56 to 65, had more than 90 percent of their account balances invested in equities*.[13] Finally, some employees continue to invest heavily in company stock, which can result in significant losses if the company experiences financial problems.

Case Application

Richard, age 40, is the owner of Auto Repair, Inc. In addition to Richard, the company has five employees. Richard wants to establish a retirement plan for his employees. He is considering two plans: a *Section 401(k) plan* and a *SEP-IRA*. Assume you are a financial planner and Richard asks for your advice. Answer the following questions.

a. Explain to Richard the advantages and disadvantages of each plan.

b. Assume that Auto Repair establishes a 401(k) plan. Employees can elect a salary deferral of up to 6 percent of compensation but not to exceed $18,000 (2015 limit for participants under age 50). The company makes a matching contribution of 50 cents for each dollar contributed. Pete, age 25, is a mechanic who has decided to defer only 3 percent of his wages because of substantial personal expenses. What advice would you give to Pete?

c. Sue, age 28, is the company's office manager and earns $35,000. She has worked for the company for 3 years. Can Richard exclude her from participating in the 401(k) plan to hold down retirement contributions? Explain your answer.

SUMMARY

- Qualified retirement plans receive favorable income-tax treatment. Employer contributions are tax-deductible and not considered taxable income to the employees; investment earnings accumulate income-tax free; and pension benefits attributable to the employer's contributions are not taxed until the employee retires or receives the funds.
- Under the tax law, qualified pension plans must meet certain **minimum coverage requirements**, which are designed to reduce discrimination in favor of highly compensated employees.
- All employees who are at least age 21 and have 1 year of service must be allowed to participate in a qualified retirement plan.
- A retirement plan has a normal retirement age, an early retirement age, and a deferred retirement age. Most employees cannot be forced to retire at some mandatory retirement age. Benefits generally continue to accrue for employees who work beyond the normal retirement age.
- The benefits in a defined-benefit plan are typically based on the following benefit formulas:
  - – Unit-benefit formula
  - – Flat percentage of annual earnings
  - – Flat dollar amount for each year of service
  - – Flat dollar amount for all employees
- Vesting refers to the employee's right to the employer's contributions or benefits attributable to the contributions if employment terminates prior to retirement. Qualified retirement plans must meet certain minimum vesting standards.
- A *defined-benefit plan* is a retirement plan in which the retirement benefit is known in advance, but the contributions vary depending on the amount needed to fund the desired benefit.
- For 2015, the maximum annual benefit is limited to 100 percent of the worker's average compensation for the three highest consecutive years of compensation, or $215,000, whichever is lower.
- A *cash-balance plan* is a defined-benefit plan in which the benefits are defined in terms of a hypothetical account balance. The participant's account is credited with a pay credit and an interest credit. Actual retirement benefits will depend on the value of the participant's account at retirement.
- A *defined-contribution plan* is a retirement plan in which the contribution rate is fixed, but the actual retirement benefit varies depending on the age of entry into the plan, contribution rate, investment returns, and age of retirement. For 2015, the maximum annual addition that can be credited to an employee's account is 100 percent of compensation, or $53,000, whichever is lower.
- A *money purchase plan* is a defined-contribution plan in which each participant has an individual account, and the employer's contribution is a fixed percentage of the participant's compensation.
- A *Section 401(k) plan* is a qualified cash or deferred arrangement (CODA) that allows eligible employees the option of putting money into the plan or receiving the funds as cash. The employee typically agrees to a salary reduction, which reduces the employee's taxable income. For 2015, the maximum salary reduction is limited to $18,000 for participants under age 50. Participants age 50 and older can make a catch-up contribution of $6,000. These limits are indexed for inflation. The contributions deposited in the plan accumulate income-tax free until the funds are withdrawn.
- A *Section 403(b) plan* is a retirement plan for employees of public schools and tax-exempt organizations. This plan is also called a *tax-sheltered annuity*. Eligible employees can voluntarily elect to reduce their salaries by a fixed amount, which is then invested in the plan. For 2015, the maximum elective deferral for workers under age 50 is $18,000. Participants age 50 and older can make a catch-up contribution of $6,000.
- A *profit-sharing plan* is a defined-contribution plan in which the employer's contributions are typically based on the firm's profits.
- A self-employed individual can establish a *Keogh plan* and receive favorable federal income-tax treatment. The contributions to the plan are income-tax deductible, and the investment income accumulates on a tax-deferred basis.
- A *simplified employee pension (SEP)* is a retirement plan in which the employer contributes to an individual retirement account (IRA) established for each eligible employee. For 2015, the maximum annual tax-deductible employer contribution to a SEP-IRA is limited to 25 percent of the employee's compensation, or $53,000, whichever is less. There is full and immediate vesting of all employer contributions under the plan.
- A SIMPLE IRA plan (Savings Incentive Match Plan for Employees) is a retirement plan that allows employees

and employers to contribute to a traditional IRA established for the employees. The employer has the option of either matching the employee's contributions on a dollar-for-dollar basis up to 3 percent of compensation, or making a nonelective contribution of 2 percent of compensation for all eligible employees.

- The major types of funding instruments to fund a pension plan include the following:
  - Trust-fund plan
  - Separate investment account
  - Guaranteed investment contract (GIC)
- Tax-deferred retirement plans have a number of current problems and issues, which include the following:
  - Inadequate 401(k) and IRA account balances
  - Incomplete coverage of the labor force
  - Lower benefits for women
  - Limited protection against inflation
  - Leakages from 401(k) and IRA plans
  - Investment mistakes that jeopardize economic security

KEY CONCEPTS AND TERMS

Actual deferral percentage (ADP) test (379)
Career-average earnings (376)
Cash-balance plan (377)
Deferred retirement age (373)
Defined-benefit plan (375)
Defined-contribution plan (378)
Early retirement age (373)
Employee Retirement Income Security Act of 1974 (ERISA) (372)
Final average pay (376)
Funding agency (384)
Funding instrument (384)
Guaranteed investment contract (GIC) (384)
Highly compensated employees (373)
Individual 401(k) retirement plan (381)
Minimum age and service requirement (373)
Minimum coverage requirements (387)
Minimum vesting standards (374)
Money purchase plan (378)
Normal retirement age (373)
Past-service credits (376)
Pension Benefit Guaranty Corporation (PBGC) (376)
Pension Protection Act of 2006 (372)
Profit-sharing plan (382)
Qualified plan (372)
Ratio percentage (373)
Retirement plans for the self-employed (Keogh plans) (382)
Roth 401(k) plan (381)
Roth 403(b) plan (382)
Section 401(k) plan (379)
Section 403(b) plan (381)
Separate investment account (384)
SEP-IRA (383)
SIMPLE retirement plan (383)
Simplified employee pension (SEP) (382)
Tax-sheltered annuities (TSAs) (381)
Trust-fund plans (384)
Vesting (374)

REVIEW QUESTIONS

1. a. What are the federal income-tax advantages to employers in a qualified retirement plan?
   b. What are the federal income-tax advantages to employees in a qualified retirement plan?
2. A qualified retirement plan must meet certain minimum coverage requirements to receive favorable income-tax treatment. Explain the ratio percentage test.
3. Explain the following retirement ages in a typical qualified retirement plan:
   a. Early retirement age
   b. Normal retirement age
   c. Deferred retirement age
4. a. Discuss main advantages and disadvantages of defined-benefit retirement plans.
   b. Explain specifics of different defined-benefit retirement formulas. What formula will you prefer to be applied in case of your retirement plans?
5. Briefly explain a funding agency and a funding instrument.
6. a. Describe the basic characteristics of a Section 401(k) plan.
   b. What is a Roth 401(k) plan?
   c. Describe the basic characteristics of a Section 403(b) plan (also called a tax-sheltered annuity).
7. Explain the major characteristics of a profit-sharing plan.
8. Describe eligible employee for participation in simplified employee pension (SEP).
9. Briefly explain the basic characteristics of a SIMPLE retirement plan.
10. Identify the major problems that are currently present in tax-deferred retirement plans.

APPLICATION QUESTIONS

1. Megaintel Sdn. Bhd. is a new, small-sized company. The company, which has 28 employees, is in the process of establishing a retirement plan. The company is considering several qualified retirement plans including

(1) defined-contribution plan and (2) defined-benefit plan.

a. Distinguish between a defined-benefits plan with a defined-contribution plan.

b. If Megaintel Sdn. Bhd chose a defined-benefits plan.
- What are the types of defined-benefit formula that can be used by the company?
- What are two main advantages of a defined benefits plan as compared with a defined contribution plan?

2. A national labor union representing pipeline construction workers has a defined-benefit pension plan for its members. Ron, age 65, is a heavy equipment operator who wants to retire. He has been a member of the union for 30 years. The pension plan has a unit-benefit formula, which provides a retirement benefit equal to 1.5 percent of the worker's final average compensation for each year of credited service. Final average compensation is based on the worker's three highest consecutive years of earnings prior to retirement. Ron's final average compensation is $70,000. How much will Ron receive each month when he retires?

3. Emma is a 34-year old unmarried accountant with no dependents. She is employed by a small company with 45 employees. Emma is a very ambitious employee with high prospects for the future. Her current salary is $100,000. Emma's employer adopted SIMPLE IRA retirement plan. Emma contributes to SIMPLE IRA 5% of her compensation.

a. How much will be her employers' contribution if matching contribution is applied?

b. How much will be her employers' contribution if nonelective contribution is applied?

c. Discuss retirement plans that Emma could enroll if she will work in your state/country.

4. An employer must select a funding agency and a funding instrument when a pension plan is established.

a. What is a funding agency?

b. Briefly describe each of the following funding instruments:

– Trust-fund plan

– Guaranteed investment contract

INTERNET RESOURCES

- **American Benefits Council** is an organization that represents plan sponsors and technical professionals in the employee benefits field. The site provides an analysis of proposed legislation affecting private pension plans and other employee benefits. Visit the site at
appwp.org

- **Employee Benefit Research Institute (EBRI)** focuses solely on analyzing employee benefits and does not engage in lobbying or advocacy activities. The Institute focuses on employee benefits research as an independent, nonprofit, and nonpartisan organization. As such, EBRI research studies are widely used by private analysts and decision makers, government policymakers, the media, academicians, and the public. Visit this important site at
ebri.org

- **Employee Benefits Security Administration (EBSA)** is an agency of the U.S. Department of Labor that provides information and statistics on qualified retirement plans. Visit the site at
dol.gov/ebsa

- **Charles Schwab** provides informative articles and information on retirement planning, annuities, and individual retirement accounts (IRAs). Visit the site at
schwab.com

- **Fidelity Investments** provides a substantial amount of timely information on retirement planning and qualified retirement plans, including 401(k) plans. Visit the site at
fidelity.com

- **Pension Benefit Guaranty Corporation** is a federal corporation that protects the retirement benefits of workers in defined-benefit pension plans. The site provides timely information on defined-benefit pension plans. Visit the site at
pbgc.gov

- **TIAA-CREF** has an excellent site that provides a considerable amount of information on retirement planning and retirement options. Visit the site at
tiaa-cref.org

- **Vanguard Group** provides timely information on retirement planning, variable annuities, and IRAs. Visit the site at
vanguard.com

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NOTES

1. This chapter is based on Internal Revenue Service Publications 560, 571, and 4222; and *2015 U.S. Master Pension Guide* (Chicago: CCH Inc., 2015).
2. For 2015, highly compensated employees are employees who (1) owned 5 percent of the company at any time during the year or preceding year or (2) had compensation from the employer in excess of $120,000 (indexed for inflation), or, if the employer elects, were in the highest 20 percent of employees based on compensation for the preceding year.
3. For details, see Kathleen Kennedy-Luczak et al., *2015 Master Pension Guide* (Chicago: CCH Inc. 2015), pp. 331–332.
4. Ibid., pp. 1050–1051.
5. David A. Littell and Kenn Beam Tacchino, *Planning for Retirement Needs*, 9th ed. (Bryn Mawr, PA: The American College, 2007), chapter 12.
6. George E. Rejda, *Social Insurance and Economic Security,* 7th ed. Armonk, NY: M. E. Sharpe, 2012, pp. 82–86.
7. Federal Reserve 2013 Survey of Consumer Finances, as cited in Alicia H. Munnell and Anthony Webb, "The Impact of Leakages from 401(k) and IRAs," Working Paper, Center for Retirement Research, CRR WP, February 2015.
8. Alicia H. Munnell, Wenliang Hou, and Anthony Webb, "NRRI Update Shows Half Still Falling Short," Working Paper, Center for Retirement Research at Boston College, Number 14-20, December 2014.
9. Bureau of Labor Statistics, "Employee Benefits in the United States—March 2014," News Release, July 25, 2014, Table 1.
10. Employee Benefits Research Institute, *EBRI Data Book on Employee Benefit*s, Chapter 8, Tables 8.1 and 8.2, updated October 11, 2011.
11. Alicia Munnell and Anthony Webb, "The Impact of Leakages from 401(k)s and IRAs," Center for Retirement Research at Boston College, February 2015.
12. Ibid.
13. Employee Benefit Research Institute, "The Impact of the Recent Financial Crisis on 401(k) Account Balances," *EBRI Issue Brief No. 326*, February 2009.