

# Benefit Insights

## ***Are Your Benefit Plan SPDs Up-to-Date?***

Employee benefit plans constantly undergo changes. Claims procedures are revised, benefits provisions modified, and new administrators or trustees named or their addresses or telephone numbers changed. Whenever such changes occur, plan sponsors have the obligation to communicate these to participants through a revised summary plan description (SPD) or through a summary of material modifications (SMM).

All ERISA-governed plans must communicate their terms to participants in the form of an SPD. Department of Labor regulations specify SPD format and content. Content requirements include, for example, contact information for the plan administrator; eligibility requirements for participation and benefits; a description of how benefits may be forfeited, suspended, etc.; how the plan is funded and the source of contributions; and procedures for claims and appeals. This is just a partial listing of content requirements, and these requirements vary to some degree depending on whether the plan is a pension or a welfare benefits plan.

As to format, the SPD must be written in a manner that the average plan participant can understand. Many plans fall short of meeting this requirement. According to an analysis from the Employee Benefit Research Institute (EBRI), important information contained in SPDs frequently is written at a level that is too high for the average plan participant. In the SPDs examined in the EBRI study (both single employer and multiemployer plans), information on eligibility, benefits and participation rights and responsibilities were written, on average, at a first-year-of-college reading level. While an employer

should take its workforce into account in drafting an SPD, with adults in the United States reading on average at an 8th or 9th grade level, an SPD written at a first-year-of-college reading level would be appropriate for very few employee groups.

As noted at the beginning of this article, when changes are made to an employee benefit plan, the SPD must be revised to reflect this. If the change has been material, an updated SPD, or an SMM, must be issued not later than 210 days after the end of the plan year in which the material change was made. (A shorter time frame of within 60 days of the change applies if the plan is a group health plan and the change is a reduction in covered services or benefits.) In any case, an updated SPD must be issued at least every five years if the plan has undergone material changes, and at least every 10 years if it has not.

Given the specificity of the SPD requirements, prudence dictates that employers periodically review their SPDs to ensure they remain current, and accurately reflect plan provisions. Also, changes in law or the issuance of regulations might require an SPD review and revision.

When a benefit plan is insured, the carrier will supply a certificate of insurance or other booklets or documents that describe the benefits. However, do not assume that these documents fulfill the SPD requirements. These could be generic documents that do not reflect specific provisions that apply to your company's plan; they also were probably written with state insurance laws in mind, not ERISA. The SPD requirement is a plan sponsor obligation, so that is where the penalties will attach in the event that an SPD is found to be lacking.

***Whenever such changes occur, plan sponsors have the obligation to communicate these to participants through a revised summary plan description (SPD) or through a summary of material modifications (SMM)***

### ***Welcome to Our Newsletter!***

As summer is upon us and you're filling your seasonal hiring needs with summer help, you might want to visit the following web-site to make certain your employees 14 thru 18 years of age are not performing work classified as Hazardous. A listing of the DEPARTMENT OF LABOR *Hazardous Occupations for Minors* is available at <http://www.dol.gov/dol/topic/youthlabor/hazardousjobs.htm> Please call our Benefits Department with your questions, 317-844-7759.

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## ***Avoid Common Mistakes That Undermine the Value of a Deferred Compensation Plan***

Companies frequently use nonqualified deferred compensation plans in their pay packages for executives and key employees. Because these plans are not subject to the compensation and benefits limits that apply to qualified plans, they help to build adequate retirement income for high earners. They also offer tax advantages, by deferring taxation of income into later years when high earners may be in a lower tax bracket.

Given the role these plans play in attracting and retaining those individuals most critical to a company's success, it's important that nonqualified deferred compensation plans operate according to applicable law and are designed in a



way to maximize value to participants. Unfortunately, because these plans can be complex, compliance errors, as well as mistakes in administration and communication, can easily occur, negating the advantages that they were intended to provide...or worse.

As far as legal requirements, though not qualified, nonqualified deferred compensation plans must follow the guidelines of Tax Code Sec. 409A. Sec. 409A covers the timing of nonqualified plan elections, funding and distributions, as well as documentary compliance requirements. Regulations under Sec. 409A are lengthy and complex. Failure to follow the Sec. 409A regulations can wipe out the intended tax advantages

of income deferral under a nonqualified arrangement. These amounts also may be subject to a 20% tax penalty, and interest.

Choosing the right investment vehicles for a nonqualified deferred compensation plan is important, and mistakes in this regard can result in taxation risks, as well as the possibility of underperformance. If the plan is set up to mirror the 401(k) plan, with administration by the 401(k) plan vendor, there are taxation risks that can occur when participants re-allocate their investment. Regardless of who administers the plan, investment choices should reflect the diversification usually desired by top earners, with attention paid to avoiding investment vehicles that may appear attractive but which may have unintended tax consequences. The services of an investment professional knowledgeable in nonqualified deferred compensation plans can be invaluable in avoiding pitfalls in this area.

Because nonqualified deferred compensation plan participants are high-level employees, a company will sometimes assume that they'll readily understand the plan, and thus not make the same communication efforts that are undertaken with plans for rank and file employees. Underestimating the importance of clear, thorough and up-to-date communications can hamper participation, if eligible executives don't understand the benefit and value of the plan. Among executives who do participate, poor communications can result in misunderstandings and, sometimes, lawsuits. Participants should know what they will have coming to them under the plan and any risks associated with plan participation, such as the status of their nonqualified benefit if the company goes insolvent or what happens if their employment terminates before retirement.

In addition to creating awareness on the part of executives about the plan, the sponsoring company must ensure that it, too, realizes the full extent of the obligations the plan is creating for it down the road. If not managed properly, promises made to today's executives can be burdensome to tomorrow's employees and shareholders, drain future corporate coffers, and put a strain on the ability of the company to continue to be competitive in its industry.

Nonqualified deferred compensation plans can certainly enhance a company's executive pay package and thus be an excellent executive recruitment and retention tool. However, common and easily made mistakes can turn what should be an advantage into a quagmire of unintended consequences. Careful strategic planning, regular review and the assistance of qualified tax, legal and/or financial counsel all can help to avoid errors in compliance, administration and communications.

## Wellness Program Investment Is Worth Every Dollar

Various studies of the return on investment (ROI) generated by wellness and health promotion programs establish that these programs can indeed provide payback on the dollars invested in them. Regardless of the ultimate payback, however, an employer wishing to establish such programs still will need to find the financial resources to set them up—an investment that may be small or large, depending on the extent of the program. Given the added costs generated by employees with unhealthy lifestyles or modifiable health risks, it's worth exploring all possible ways to fund a wellness initiative.



Employees' unhealthy behaviors add greatly to a company's health care costs. Using tobacco, living a sedentary lifestyle, being overweight or obese, eating a diet lacking in nutrition, or failing to properly care for a controllable chronic health condition all

can take a toll on a company's bottom line, as well as on an individual's health. According to data cited in a report from the Wisconsin Public Health & Health Policy Institute, illness and injury associated with an unhealthy lifestyle or modifiable risk factor can account for at least 25% of employee health care expenditures.

This same report cites a handful of studies that support the proposition that wellness, health promotion and disease prevention programs provide "multifaceted payback on investment," through improved worker health, reduced benefit expense and enhanced productivity. Studies cited reported ROI ranging from approximately \$1.50 to close to \$6.00 per dollar invested, varying by type of program and by whether health care costs alone, or also factors such as reduced absenteeism and improved productivity, were considered. Another study published in the Journal of Occupational

and Environmental Medicine found that employers could save \$1.65 in health care costs for every dollar spent on a comprehensive employee wellness program.

If you accept that wellness programs will save you money over time, you still need to find the money to get such a program up and running. Try not to let funding concerns convince you to skimp on the quality of the program, as it takes a well-designed, targeted and comprehensive program to achieve the kind of ROI found in the studies. That said, consider these funding possibilities:

- Implement the wellness program at the same time that you make other health plan changes. If your benefit program does not include any high deductible health plan options (with lower premiums), now would be a good time to think about adding a consumer-driven plan to the mix.
- Make a health risk assessment part of the wellness program, charge a higher health plan premium rate for employees who decline to take the assessment, and apply these funds to wellness program costs.
- Ask your health plan vendors what wellness programs they offer and whether they are integrated with your current plan, or if they could be added to your plan at a discount.
- Survey employees to ascertain what types of programs they would use and, furthermore, would be willing to contribute to.
- Look at your benefits program overall for possible sources of funding. For example, are there little-used benefits that could be converted to a voluntary program? Or any high cost (for both employer and employees) health plan options that draw a low enrollment and, potentially, could be eliminated?

Employees with unhealthy lifestyles or modifiable health risks are likely to cost more to employ. It's worth taking the time and exploring all options to fund programs that target these employees' needs.

### **continued from page 4...Separate Fact from Fiction in Promoting Consumer-Directed Health Plans to Employees**

- **Fiction:** Because of the HDHP high deductible, HSA funds are quickly depleted; even for individuals with only basic health care expenses, an HSA account holder is unlikely to have any funds left to roll over at the end of the year. **Fact:** For many individuals, the bulk of their medical expenses consists of preventive care, and HDHPs can cover preventive health care expenses at 100% before the deductible. Depending on plan design, such expenses can include well-baby and well-child doctors' visits and immunizations; adult physical exams and immunizations; and routine adult screenings, such as mammograms, Pap smears, prostate screenings and colonoscopies.
- **Fiction:** Unless you can predict your annual health care expenses accurately, you stand a chance of losing the money you contribute to an HSA. **Fact:** HSA funds that are unused in one year—whether they represent the contributions of the account holder or employer—carry over, and can be used to pay for health care expenses incurred in future years, even in retirement.

Resolving the confusion surrounding these and other consumer-directed health plan misconceptions can help employees better understand and appreciate the potential benefits of participating in these plans.

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## Separate Fact from Fiction in Promoting Consumer-Directed Health Plans to Employees

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Though participation in consumer-directed health plans is growing, only a small percentage of employees join these plans, and even fewer set up health savings accounts (HSAs). According to a survey from the Employee Benefit Research Institute, in 2008, 3% of the insured population, or 4.2 million individuals, were enrolled in a consumer-directed health plan, defined as an HSA paired with a high deductible health plan (HDHP). More—11%, or 13.4 million individuals—were enrolled in an HDHP, and of these, 42% were eligible to contribute to an HSA, but chose not to do so.

Misunderstanding the mechanics of HSAs and ignorance of their potential advantages keep many people who are eligible for an HSA from seriously considering opening an account. Similarly, employees who have a consumer-directed health plan option might see the high deductible feature as offsetting, and not consider other advantages of the plan. If your company offers employees the opportunity to participate in a consumer-directed health plan, or if you are considering making this opportunity available, it's important that employees understand how these plans work, so those for whom they are appropriate can benefit from this form of health care coverage.

Here's a quick rundown of a few common consumer-directed health plan and HSA fictions, along with the clarifying facts.

- **Fiction:** The only reason an employer implements a consumer-directed health plan is to shift health care costs to employees. **Fact:** An employer makes an investment in a consumer-directed plan, just as it does with a traditional plan. Though the premium cost might be less for the employer, it is less for the employees' share, too, and many employees would rather pay less for health care upfront (the premium) and the bulk of their costs at the time of service. Consumer-directed plans really represent an expansion of health plan choices for employees.
- **Fiction:** Since they're paired with a HDHP, HSAs only make sense for individuals who are young and healthy. **Fact:** An HDHP-HSA pairing provides comprehensive health care coverage at an affordable price for individuals with all sorts of medical needs. Though the HDHP deductible is higher than that found in more traditional plans, the premium is lower as a result. So, even if the account holder must dip into the HSA to pay for expenses that would be covered at an earlier point by a more traditional plan, this must be balanced against the premium savings. Also, as noted below, most preventive care is not subject to the deductible and can be covered at 100% by the HDHP.

*continued on page 3*

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