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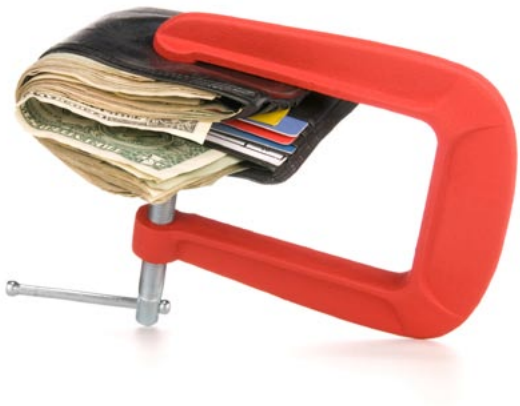
Understanding Retirement Plan Fees and Expenses

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

Why Consider Fees?

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

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



Plan Administration Fees. These fees cover the plan's day-to-day operating expenses, such as recordkeeping, accounting, legal and trustee services. This can also include the cost of providing additional services to participants, such as educational seminars, retirement planning software, investment advice, electronic access to plan information, daily valuation and online transactions.

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

Investment Fees. By far the largest component of plan fees and expenses is associated with managing plan investments. Fees

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This Just In

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

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

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

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

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

Do Your Safety Incentives Violate OSHA Regulations?

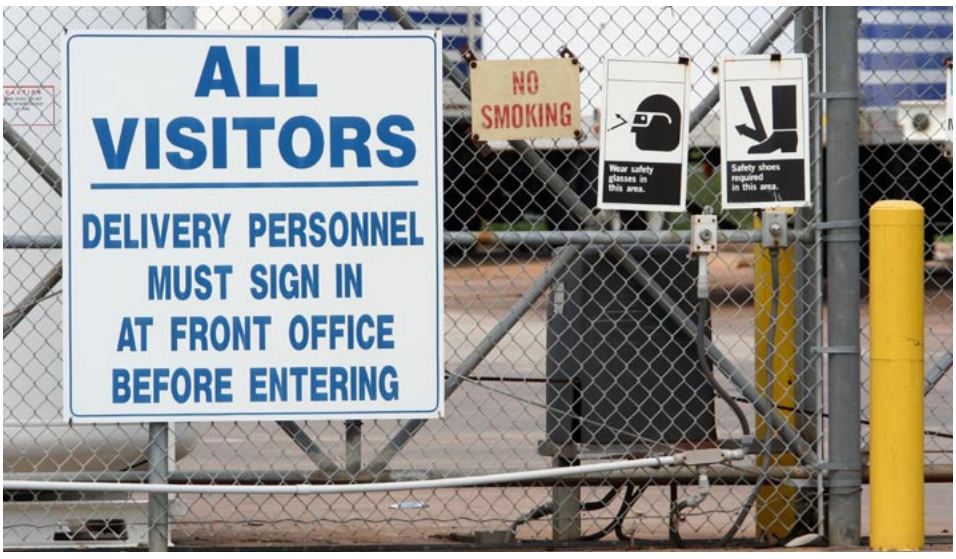
You consider your company's safety incentive program an effective way to promote safe behavior among your employees and reduce injuries. But OSHA could see the very same program as unlawful discrimination and a violation of OSHA recordkeeping regulations and whistleblower protections. Knowing the difference between lawful and unlawful incentives can help you keep an effective prevention tool while avoiding fines and other penalties.

OSHA regards the ability to report injuries or illnesses without fear of retaliation as "crucial to protecting worker safety and health." Without that right, "Employees do not learn of and correct dangerous conditions that have resulted in injuries, and injured employees may not receive the proper medical attention or the workers' compensation benefits."

Earlier this year, OSHA released a memorandum to compliance officers and whistleblower investigative staff that outlined "employer practices that can discourage employee reports of injuries and violate section 11(c), or other whistleblower statutes."

According to the memo, certain incentive programs discourage the reporting of injuries and encourage discrimination against workers who report injuries. These include:

1. Taking disciplinary action against all employees who are injured on the job, regardless of circumstances. Reporting an injury is always a protected activity, and OSHA views discipline against an employee who reports an injury as a direct violation of whistleblower statutes.
2. Taking disciplinary action against an employee who violates an employer rule about the time or manner for reporting injuries and illnesses. OSHA recognizes that employers have a legitimate interest in establishing procedures for receiving and responding to reports of injuries. However, such procedures must be reasonable and may not unduly burden the employee's right and ability to report. For example, the rules cannot penalize workers who do not realize immediately that their injuries are serious enough to report, or even that they are injured at all.
3. Disciplining an injured employee because the injury resulted from his/her violation of a safety rule. OSHA encourages legitimate workplace safety rules to eliminate or reduce workplace hazards and prevent injuries. In some cases, however, an employer may use a work rule as a pretext for discrimination against a worker who reports an injury. OSHA will investigate these situations carefully, looking at whether the employer monitors for compliance with the work rule in the absence of injury and whether it consistently disciplines employees who violate the work rule in the absence of an injury. Enforcing a rule more stringently against injured employees than noninjured employees may suggest that the rule is a pretext for discrimination against an injured employee.
4. Creating a program that unintentionally or intentionally incentivizes employees to not report injuries. For example, an employer might enter all employees who have not been injured in the previous year in a drawing to win a prize, or a team of employees might be awarded a bonus if no one from the team is injured over some period of time. Such programs might be well-intentioned efforts to en-



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RETIREMENT—*continued from Page 1*

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

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

Fees Associated with Investment Choices

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

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

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

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

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

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courage workers to use safe practices. However, there are better ways to encourage safe work practices.

Acceptable Safety Incentives

A safety incentive program structured to recognize and reward positive behaviors, rather than punishing negative ones, is less likely to draw the wrath of OSHA. Suggestions include:

- providing tee shirts to workers serving on safety and health committees
- offering rewards for suggesting ways to strengthen safety and health
- throwing a recognition party at the successful completion of company-wide safety and health training.

For more suggestions on structuring a safety program and complying with OSHA rules and guidelines, please contact us.

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group plan, then supplementing it with individual policies. Insurers typically individually underwrite individual disability income plans, but may make individual policies available on a guaranteed-issue basis for larger groups. Individual plans offer better rate guarantees and portability than group policies.

Gross-up plans for key employees: When the employer pays premiums, benefits received count toward taxable income. Since it may be difficult to get an insurer to replace enough of highly compensated employees' pre-disability pay, you might not want taxes to take an additional bite. To avoid this, the employer can increase the employee's pay by the amount of the premium, and have the employee pay the premium with after-tax dollars, making the benefits essentially tax-free. In this arrangement, the employee pays the tax only on the amount of the pay increase, and receives any benefits tax-free.

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

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

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

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Covering the Disability Income Gap

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

A basic group disability income policy probably provides enough coverage for rank-and-file employees, but it can leave a major coverage gap for higher-income employees.

Most group policies replace 50 to 60 percent of pre-disability income. Policies also have a maximum monthly benefit. Depending on the insurer, your industry, location and the size of your group, that maximum could be as low as $3,000 or $4,000 for smaller groups, and range from $7,000 to $15,000 for larger groups. If you have executives, salespeople and others earning more than $300,000 per year, a basic group plan might not replace even 60 percent of pre-disability earnings.

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

To remedy this problem, a number of insurers have developed supplemental group disability plans, known as buy-ups, that allow highly compensated employees to combine basic group coverage with another plan to receive a higher monthly benefit. You can structure a buy-up plan in several ways:

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

An executive buy-up plan often involves two tiers of coverage: a **guaranteed issue policy** and a **modified guaranteed issue policy**. If your group of highly compensated employees is large enough, your insurer might be willing to write a guaranteed issue policy, which means the insurer asks no medical questions and provides a group policy at standard rates. This ensures that even executives with health problems can obtain coverage. For the second tier of coverage, a modified guaranteed issue plan, the insurer will ask some simple medical questions to make its coverage decision. It may decline to cover an individual, exclude coverage for a preexisting condition or charge extra premium.

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

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Supreme Court Rules on Affordable Care Act

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

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

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

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

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