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Health Savings Accounts—The Latest in Consumer Driven Health Plans

by Robert M. Richter, APM

THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT AND MODERNIZATION ACT OF 2003, PUB. L. NO. 108-173, INCLUDED PROVISIONS PERMITTING INDIVIDUALS TO ESTABLISH A NEW TYPE OF CONSUMER DRIVEN HEALTH PLAN CALLED A HEALTH SAVINGS ACCOUNT (HSA). HSAs HAVE GENERATED SIGNIFICANT INTEREST IN THE HEALTH BENEFITS COMMUNITY. IN ADDITION, BECAUSE HSAs ARE BOTH A HEALTH PLAN *AND A SAVINGS VEHICLE,* SOME 401(k) RECORDKEEPERS HAVE BEEN MONITORING DEVELOPMENTS IN THIS AREA. THE GOAL OF THIS ARTICLE IS TO PROVIDE A PRACTICAL GUIDE TO HSAs AND THEIR POTENTIAL USE FOR ONE'S PERSONAL AND/OR BUSINESS NEEDS.

WHAT IS A CONSUMER DRIVEN HEALTH PLAN?

Much of the controversy surrounding HSAs relates to the concept of the consumer driven health plan, or CDHP (and we thought the overuse of acronyms was limited to the qualified retirement plan arena!). A CDHP is a health plan that rewards individuals for limiting medical expenses by permitting unused amounts (*i.e.*, the savings) to be carried over to a later year. The underlying premise of a CDHP is that consumers will be motivated to become more prudent health care purchasers if they have a greater financial stake in the outcome. This premise is different than traditional health insurance where individuals may never have a full appreciation of their total health care costs beyond the current year's co-pays or deductibles.

Critics of CDHPs point out that there are no long-term studies that prove the concept works and fear that in the long-term, health care costs may actually increase due to adverse selection (*i.e.*, when given a choice, healthy individuals will choose the CDHP, leaving a higher risk pool for traditional coverage).

The debate over the CDHP concept will be ongoing. Fortunately, most of us can leave the battle to health benefit professionals and politicians. Whether we agree with the concept or not, CDHPs are allowed under the law. They are being promoted by the Bush administration and their fate will depend, in large part, on their acceptance in the marketplace.

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WASHINGTON UPDATE

SEC Rules to Curb Market Timing Could Cost 401(k) Participants

by Brian H. Graff, Esq.

In March, the Securities Exchange Commission (SEC) proposed substantial rules designed to curtail market timing abuses discovered through its investigation and enforcement activities, including market timing by some 401(k) participants in at least one plan. However, the proposed rules, if adopted in their current form, would impose burdensome and unnecessary administrative requirements on retirement plans, significantly increasing costs that would be ultimately borne by participants.

The currently proposed rules would require plan administrators to impose minimum mandatory two percent redemption fees on redemptions of a mutual fund investment within five days of the purchase of such investment. Importantly, the SEC did not propose that this redemption fee rule become the industry standard. Instead, they proposed to permit mutual fund companies to assess redemption fees based on different standards, such as different aging periods. For plans with multiple fund family options, the result could be a myriad of redemption fee rules that would cause administrative nightmares and could create enormous confusion for participants. The possibility of redemption fees being imposed could be mitigated by a *de minimis* exception for transactions

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FROM THE EDITOR

Fun with Numbers

by Chris L. Stroud, MSPA

MOST OF US IN THE RETIREMENT PLANNING INDUSTRY WORK WITH NUMBERS EVERY DAY. WE EASILY COMMUNICATE TO OTHERS IN OUR PROFESSION USING NUMERICAL CODE SECTIONS. COMPLEX CONCEPTS AND FORMULAS ARE ENGRAINED IN OUR MEMORIES, AND WE OFTEN TAKE FOR GRANTED THE FACT THAT WORKING WITH NUMBERS COMES EASILY TO US. SOME OF US (THE REAL "GEEKS") ACTUALLY THINK NUMBERS AND MATHEMATICS ARE FUN!

I was recently pleased to discover that some of our ASPA members are volunteering to tutor math students. I think this gift of time is a great contribution to society, and it becomes even more meaningful if we can help teach the younger generation why numbers and math concepts are so important.

In my former life (before pensions), I was a middle school math teacher. I became keenly aware that most children, by their early teens, have either learned to like math and enjoy working with numbers—or they are intimidated and have already developed an intense dislike of numbers, often fueling an inferiority complex where mathematical concepts are concerned. One of the challenges of a math teacher is to try to undo this damage by stimulating the students' imaginations and showing them the variety of ways that numbers and math influence their daily lives. Some common techniques I used included having the students write down all of the instances that they came into contact with numbers or math-related concepts between the time they got up in the morning to the time they got to school. (Think about it—alarm clock, shoe size, microwave, electricity, speed limit, street numbers, etc.) Another exercise was to examine various professions and see which ones use numbers or math (and if you try this, you'll find that most do in some way!).

As I was writing this article and pondering our own profession and its dependency on numbers, I found myself toying with the words of John Lennon's song "Imagine." Perhaps you can pick your own theme and do the same with some child that you know. Let your imagination run wild and show them how different life would be without our beloved numbers. In the meantime, please hum along!

Imagine there are no numbers—
Amusing if you try.
Nothing to rank or count with—
No means to measure by.
Imagine all the workers with no clocks to watch…

Imagine there's no money—
Mindboggling if you try.
Nothing to save or contribute—
No means to sell or buy.
Imagine all the brokers living without stocks…

Imagine there are no taxes—
No IRS or DOL too.
No need for audits or shelters—
No forms with deadlines due.
Imagine all the CPAs with nothing left to do…

Imagine there are no benefits—
Quite hard to contemplate.
No need for actuaries—
Nothing to calculate.
Imagine all the Enrolled Actuaries with no Ns and Ds…

Imagine no retirement plans—
Quite scary if you try.
No account balances or annuities—
No jobs for us—oh, my!
Imagine all the workers with no security…

Imagine there's no ASPA… ▲

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Compliance and Nondiscrimination Testing Issues with Puerto Rico Qualified Plans

by Lisa A. Scalia, CPC, QPA, QKA

THE COMMONWEALTH OF PUERTO RICO FALLS UNDER THE JURISDICTION OF MOST FEDERAL LAWS OF THE UNITED STATES; HOWEVER, SIGNIFICANT TAXATION DIFFERENCES EXIST. PUERTO RICO RESIDENTS PAY TAXES TO THE PUERTO RICO DEPARTMENT OF THE TREASURY (HACIENDA) AND PAY NO INCOME TAX TO THE US INTERNAL REVENUE SERVICE (IRS) ON ANY INCOME EARNED IN PUERTO RICO. US SOCIAL SECURITY TAXES APPLY TO PUERTO RICO RESIDENTS WHO ARE US CITIZENS.

The Puerto Rico Tax Code parallels the US treatment of employer-sponsored retirement plans. Qualified plans in Puerto Rico must meet the qualification requirements of the Puerto Rico Internal Revenue Code of 1994 (PRIRC) Section 1165(a). However, these rules are somewhat different from the US rules, creating obstacles for employers who have operations in both the US and Puerto Rico. This summary will discuss a number of these obstacles, with a particular focus on 401(k) coverage and nondiscrimination testing.

BASIC FRAMEWORK

The laws that govern tax-qualified plans in Puerto Rico are generally based on the US Internal Revenue Code (IRC) as it existed prior to 1986. As the IRC has changed substantially over the years, the resulting differences make it difficult to design a plan that simultaneously satisfies both sets of rules. Adding to the complexity is the fact that Puerto Rico plans are subject to Title I of ERISA.[1]

A US or Puerto Rico plan that covers Puerto Rico employees must meet the Puerto Rico rules if favorable Puerto Rico tax treatment is desired for employees and the plan sponsor. The Puerto Rico rules allow the coverage and nondiscrimination rules to be applied after excluding all employees who are not Puerto Rico residents. Contrast this with the US rule that permits exclusion of certain nonresident aliens, that is, individuals who are not citizens and who are not residents. Because all native Puerto Ricans are US citizens by law, there is no statutory exclusion from a US plan.

Thus, the stage is set for careful plan design where an employer (*i.e.,* controlled group) with Puerto Rico operations seeks to provide benefits for US and Puerto Rico employees. If the Puerto Rico employees are included in the US plan, it may be difficult to simultaneously satisfy both sets of rules. If the Puerto Rico employees are covered in a separate plan, the US plan may fail its coverage test.

COVERAGE

As you will discover, simultaneous satisfaction of deferral limits (*e.g.,* \$8,000 in Puerto Rico; \$13,000 in US) and nondiscrimination tests for Cash or Deferred Arrangements (CODAs) [*i.e.,* 401(k) in the US; 1165(e) in Puerto Rico] will generally not be possible. In setting up separate plans, the first objective is to create covered groups that pass muster under the rules of the respective jurisdictions. For the Puerto Rico group, a plan covering all Puerto Rico employees can easily pass the coverage test under Puerto Rico law because the US residents may all be excluded. In addition, on the Puerto Rico side, a number of regulatory options permit plans to satisfy coverage by counting all active employees inside and outside of Puerto Rico (on a controlled group or a subset of the controlled group basis) as long as identical benefits are provided to all employees.

For the US group, excluding Puerto Rico employees requires an examination of ratios developed without benefit of the exclusion of Puerto Rico employees. If the Puerto Rico employees are primarily nonhighly compensated employees (NHCEs) and represent a significant portion of that group, it may be necessary to close the plan to a segment of highly compensated employees (HCEs) so that acceptable coverage ratios are obtained.

An opportunity to solve coverage problems is to include both US and Puerto Rico employees in a common plan. Doing so solves the US coverage problem described above but creates nondiscrimination testing issues.

NONDISCRIMINATION TEST ISSUES FOR SAVINGS PLANS

If Puerto Rico employees are part of the US plan, the special CODA tests must be satisfied under both US and Puerto Rico law.

For example, consider a company based in the US with a Puerto Rico operation employing 30 employees. The US parent decides to include the Puerto Rico employees in the US 401(k) plan. The US plan must satisfy the Actual Deferral Percentage (ADP) and Actual Contribution Percentage (ACP) tests as required under IRC Sections 401(k) and 401(m). The component of the US plan that covers the Puerto Rico employees would also need to comply with the PRIRC. Basically, the Puerto Rico portion is tested twice; first with the entire group of eligible

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What is a Qualified Joint & Survivor Annuity (QJSA)?

by Sandeep Singh

IF A CATEGORY FOR THE NEW "SUPER MILLIONAIRE" SHOW WAS ON IMPORTANT PENSION PLAN CONCEPTS, THERE WOULD ALMOST CERTAINLY BE A QUESTION ON QUALIFIED JOINT & SURVIVOR ANNUITIES (QJSAs). THEREFORE, LET ME BE YOUR LIFELINE, AND LET'S GET THE ANSWER RIGHT. MERELY KNOWING THAT A QJSA IS A FORM OF PAYMENT OF RETIREMENT BENEFITS TO EMPLOYEES FROM PENSION PLANS WOULD ONLY YIELD YOU ABOUT $100. THIS ARTICLE WILL ADVANCE YOUR UNDERSTANDING SO THAT YOU CAN WIN THE BIG MONEY QUESTIONS (OR, MORE IMPORTANTLY, SO THAT YOU CAN PROVIDE PROPER ADVICE TO YOUR CLIENTS AND THEIR QUALIFIED RETIREMENT PLANS). LET US TRY TO UNDERSTAND QJSAs IN THIS ARTICLE THROUGH THE BUILDING BLOCK APPROACH.

BASIC DEFINITIONS

Annuity—A financial technique in which one receives fixed payments for life. For example, Mr. Smith retires today at age 65 and can collect an annuity from the company's pension plan paying him a level $1,000 per month for his life. The payment would cease once Mr. Smith dies. Albeit, I would add that sick individuals "lose" by selecting an annuity and then dying before all expected payments have been received, and healthy individuals "win" as they will receive more payments than were expected.

Joint & Survivor Annuity (JSA)—An annuity that is not just dependent on the participant's life, but also on a beneficiary's life—hence the word "Joint." In this form of payment, continuing with the same example above, if a 100% joint & survivor annuity was chosen, then Mr. Smith would be paid approximately $860 per month for his life and when he dies, if Mrs. Smith (the named beneficiary) is still alive, then she will continue to collect payments of $860 for the rest of her life (and hence the term "Survivor"). Since the payments are over two lives and for a longer period on an expected basis, the same $1,000 over one life gets actuarially reduced to $860 over two lives. However, if Mrs. Smith is not alive upon Mr. Smith's death, then all payments will cease. (In which case, with hindsight, Mr. Smith seems to have chosen an $860 life annuity rather than a $1,000 life annuity; however, since Mr. Smith did not know how long he or Mrs. Smith would live at the time that the election was made, a joint & survivor annuity provided a type of insurance protection for Mrs. Smith if she was to survive Mr. Smith.)

Finally, the term ***"Qualified"*** in QJSA brings in certain statutory provisions:

- If a participant in a Defined Benefit (DB) plan is married at the commencement of benefits, then the form of benefit must be a QJSA, with the spouse named as the beneficiary. The exception being that the spouse can elect in writing to allow the participant to choose an optional form of benefit that is allowed in the plan document.
- The survivor annuity for the spouse should not be less than one-half, nor greater than the amount, of the annuity payable during the joint lives of the participant and his or her spouse.
- The QJSA should be at least the actuarial equivalent of the normal form of life annuity or, if greater, of any optional form of life annuity offered under the plan.
- Payments to the spouse of a deceased participant cannot be terminated or reduced because of such surviving spouse's remarriage.

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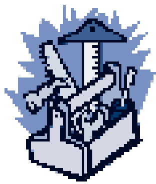

A 50% joint & survivor annuity (50% J&S) means a full annuity payment on the life of the participant (Mr. Smith), and when Mr. Smith dies, Mrs. Smith would receive half of that amount for her life. The determination of the amount of the 50% J&S annuity is such that the present value of the J&S annuity is the same as the present value of the normal form of payment (an annuity or lump sum). The statute specifies that the present value of QJSA shall not be less than the present value calculated by using the applicable mortality table and the applicable interest rate specified in the regulations. Other common forms of J&S annuities have survivor percentages of 66 2/3%, 75% or 100%.

The QJSA rules apply to all defined benefit plans and any defined contribution plan subject to minimum funding (such as money purchase plans and target benefit plans).

Every statutory provision and associated regulation should have a policy goal, and QJSA does. To highlight, take for example that Mr. Smith retires and takes a life annuity from his company's pension plan. If he dies, then his family is left with no support from his expected retirement income. Or, if Mr. Smith takes a lump sum and outlives it, his family again has a problem. To avoid such situations, Congress decided to make QJSA a compulsion so that after his death, his surviving spouse could continue getting at least a portion of his benefit.

The QJSA rules apply to all defined benefit plans and any defined contribution plan subject to minimum funding (such as money purchase plans and target benefit plans). A qualified plan will lose its tax "qualified" status if it does not provide benefits in the form of a QJSA to all married participants. As always, there are exceptions:

Cash-outs: If the present value of the entire benefit is less than $5,000, or a smaller amount as specified by the plan, then such benefits can be paid out as a lump sum without the need for spousal acquiescence.

Elections: A participant can elect in writing not to receive a QJSA only if the spouse consents to the election in writing, as witnessed by a plan representative or a notary public.

These qualified plans are required to provide a written explanation to each participant within a reasonable period of time before the annuity starting date. This explanation must define the terms and conditions of the QJSA and explain the rights of the participant and the spouse. Final regulations were published by Treasury in December 2003, which provide technical requirements for these notices.

A surprising statistic to note is that most people take a lump sum benefit on retirement if given the option, defeating the whole purpose of retirement security. However, if the spouse and the plan participant agree to receive a lump sum rather than a qualified joint and survivor annuity, then there is no violation of the law. For further information, please consult Code §401(a)(11), Treasury Regulations §1.401(a)-11, Code §417 and Treasury Regulations §§1.417(a)(3)-1 and 1.417(e)-1. ▲

Sandeep Singh is an actuarial consultant with the Chicago office of Chicago Consulting Actuaries. Sandeep has over two years of experience in the pension consulting realm. He has a Master's degree in Actuarial Science and is an Associate of the Society of Actuaries (ASA).

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Washington Update
SEC Rules to Curb Market Timing Could Cost 401(k) Participants

less than $2,500 permitted under the proposed rule. But, once again, such an exception is only optional at the discretion of the mutual fund company.

The proposal does provide that the assessment of redemption fees can be made on a first-in, first-out basis. In other words, previous, older purchases of the investment are considered redeemed first. Nonetheless, if a participant decides to transfer the entire amount in an investment option to another option shortly after a payroll or other profit-sharing contribution, they could be hit with a very unwelcome redemption fee.

Significantly, the most onerous aspect of the proposed rules is clearly the mandatory reporting requirements. Once a week, retirement plan administrators would have to report to mutual fund companies, on a participant-by-participant basis, including taxpayer identification numbers, every purchase, exchange and redemption involving their funds. In other words, every single payroll contribution investment purchase, every exchange, including exchanges resulting from rebalances, and every redemption related to withdrawals would have to be separately reported. Across all retirement plans, this rule could amount to literally billions of separate transactions being reported annually. The systems costs associated with these annual reporting requirements would substantially increase 401(k) participant fees, for little discernable enforcement value.

ASPA has filed extensive comments with the SEC addressing these concerns, which are excerpted below. ASPA believes strongly that the SEC's proposed rules must be revised to reflect the unique nature of employer-based retirement plans and the important role they play in providing a cost-effective means for working Americans to save and invest. ASPA's Government Affairs Committee will be meeting with SEC officials to discuss these issues and to press for more sensible solutions.

EXCERPTED SEC COMMENTS

ASPA recognizes that any measures adopted by the Commission to address abusive short-term trading must extend to transactions directed by participants of participant-directed plans. However, the imposition of non-uniform mandatory redemption fees under the current version of the proposed rule will create substantial confusion for plan participants. Further, the related financial intermediary information reporting requirements will result in significant and unnecessary plan administrative and other costs, which will ultimately be borne by plan participants. These administrative issues and increased costs could be substantially mitigated, without impacting the effectiveness of measures to address abusive short-term trading, by adding provisions under the proposed rule that take into account the special nature of participant-directed plans. In particular, ASPA urges the Commission to consider—

- Limiting the application of redemption fees and information reporting requirements to participant-directed "exchanges" and "transfers," which are the only transactions in plans susceptible to late-day trading;
- Establishing uniform standards for redemption fees applicable to participant-directed plans, including a standardized redemption fee percentage and holding period; and
- A <u>mandatory</u> *de minimis* exception that applies for both redemption fee purposes as well as the related reporting requirements.

Following is a more detailed discussion of these points and some additional comments on the proposed rule.

I. REDEMPTION FEES SHOULD ONLY APPLY TO TRANSFERS AND EXCHANGES

Under the proposed rule, mutual funds would be required to impose a 2% redemption fee upon the redemption of mutual fund shares purchased in the previous five days. The proposed rule would also require "financial intermediaries" to assist mutual funds in identifying and collecting redemption fees and to provide weekly reports of all fund shareholder trading activity. ASPA understands that, in the case of participant-directed plans, the Commission intends that the mandatory redemption fee and the information reporting requirements will apply in connection with transactions processed for each participant account under the plan.

Implementing these new requirements and administering the requirements on an ongoing basis will result in substantial additional plan administrative costs that will be borne by plan participants. In addition, the current form of the proposed rule would

impose redemption fees for plan transactions that do not provide an opportunity for market timing. For example, if a participant's payroll contributions are invested in one or more mutual funds on Day 1, and the participant requests a loan transaction on Day 3, shares redeemed to fund the loan payment could be subject to redemption fees. Similarly, if a participant's rollover contributions are received under a plan on Day 1, and the plan fiduciary makes changes to plan investment alternatives that result in redemptions of shares owned by the plan on Day 4, redemption fees could be imposed. In both cases, imposition of a redemption fee would be plainly unfair.

The Commission can address these concerns about the initial and ongoing costs of the proposed rule, as well as its unfair application to routine plan transactions that do not provide an opportunity for market timing abuse, by adopting special provisions so that the proposed rule's redemption fee and information reporting requirements only apply to participant-directed exchanges and transfers between plan investment alternatives. This approach would protect mutual fund investors against abusive trading by plan participants, while substantially reducing the adverse impact and administrative costs of the proposed rule.

In this regard, of all of the types of plan investment transactions described above, only participant-directed exchanges and transfers provide any opportunity for abusive frequent or excessive trading by plan participants. For example, participants do not have the capability to "time" mutual fund share purchases in connection with payroll contributions or periodic loan repayments because the timing of these purchases depends upon when the employer deposits the funds into the plan, and the contributions are invested according to standing participant instructions. Any rollover contributions or lump sum loan repayments by a participant typically require at least one or more days processing time upon receipt by the plan trustee and recordkeeper; therefore, a participant would not be able to "time" purchases of mutual fund shares in connection with these transactions. Also, where plan transactions are directed by a plan fiduciary (*e.g.*, to effect changes in the plan's investment alternatives or rebalance a custom portfolio), the participant also does not provide a direction and could not "time" share purchases or redemptions.

Plan rules may allow a participant to determine the timing of share redemptions under a plan to fund loans, withdrawals or distributions. Nevertheless, these transactions also do not provide opportunity for market timing abuse. In this regard, participants must be eligible for withdrawals and distributions under plan rules and cannot reinvest the withdrawal or distribution proceeds through the plan. Significantly in the case of withdrawals and distributions other than plan loans, the amount would potentially be subject to ordinary income tax rates and possible penalty taxes in the year received, greatly deterring market timing abuse. In the case of a loan, participants cannot "time" the reinvestment of loan repayments because the repayment is typically made by periodic repayments. If the participant makes a lump sum repayment, at least one or more days processing time for reinvestment removes the participant's opportunity to "time" the loan repayment. Also, the reinvestment typically would be implemented based on a participant's standing instructions for the reinvestment of new plan contributions, further adding to the difficulty of using these types of transactions to engage in market timing activities.

Therefore, to address market timing by plan participants, the Commission need only address its regulation of plan transactions to participant-directed exchanges and transfers. Specifically, only participant-directed exchanges and transfers in a participant-directed plan should need to be monitored to determine whether any redemption fees should be assessed, and financial intermediaries should only need to report to mutual fund companies participant-directed exchange and transfer transactions under a plan.

Importantly, this approach would provide substantial relief to plans (and also to mutual fund companies) from the administrative costs and other burdens that would be caused by the proposed rule in its current form. For example, one large recordkeeping firm has reported to ASPA that, of the 1 billion participant "events" (*i.e.*, contributions, loans, withdrawals, etc.) that it processes annually, only about 16 million, or 1.6%, involve exchanges or transfers. Over the entire retirement plan marketplace, ASPA estimates that easily between 12-15 billion individual participant transactions would need to be reported annually to mutual fund companies under the proposed rule. In terms of systems cost, this is not insignificant and will have a major impact on participant fees. Plainly, the number of transactions that would need to be monitored in order to impose redemption fees and for information reporting purposes under the proposed rule would be significantly reduced. By limiting the imposition of redemption fees to only those transactions likely to result in abuse, it will provide significant savings to plans, plan participants, as well as mutual fund companies.

II. UNIFORMITY IS NECESSARY

As the Commission recognizes, implementation and ongoing administration of the redemption fees and the information reporting requirements under the proposed rule are expected to result in substantial costs. In the case of participant-directed plans with an "open-architecture" investment structure, these costs

will be further magnified if mutual fund companies are permitted to impose redemption fee structures as well as other restrictions to curb market timing.

Specifically, a typical participant-directed plan that includes mutual fund investment alternatives offered by several fund complexes could be faced with the possibility that each mutual fund investment alternative offered by the plan could impose different redemption fee procedures. For example, each mutual fund could be subject to including longer or shorter holding periods, "tiered" redemption fees (*e.g.*, 2% for a short holding period and then 1% for redemptions within a longer holder period), and different procedures for applying a *de minimis* standard. Implementing all of these various restrictions would greatly increase costs and make it difficult on an ongoing basis to ensure that the applicability and fee amount are correctly determined in each case. Moreover, all of the different restrictions must be communicated to plan participants, who are likely to find the restrictions confusing when each fund is subject to different rules. The effect of this likely confusion should not be underestimated. Retirement plan participants will get increasingly frustrated with non-uniform redemption fee structures negatively impacting their confidence in the retirement plan as an effective investment vehicle. Significantly, the existence of non-uniform redemption fee structures will create a competitive disadvantage for retirement plan administrators and intermediaries who offer "open architecture" multiple fund family platforms relative to mutual fund companies providing retirement plan services that offer only a single family of funds.

These problems can be addressed, however, if the Commission adopts a set of uniform procedures for the application of redemption fees to participant-directed plans. In particular, ASPA urges the Commission to adopt the following as uniform rules for participant-directed tax-qualified defined contribution plans:

- Redemption fees should be uniformly set at 2% (or at another appropriate level as determined by the Commission). For example, plans should not be permitted to impose a higher or lower redemption fee, or to impose "tiered" fees (*i.e.,* a 2% fee charged on redemptions within five days and a 1% fee charged on redemptions after the five days, but within 90 days).
- A standard holding period should be set for participant-directed transactions. If the Commission concludes that a holding period longer than five days is appropriate, ASPA urges the Commission to adopt the longer holding period on a uniform basis rather than allowing funds to define different holding periods that increase administrative complexity and plan participant confusion.

> Therefore, to address market timing by plan participants, the Commission need only address its regulation of plan transactions to participant-directed exchanges and transfers.

- The proposed *de minimis* exception provision should be mandatory and uniform, at least with respect to transactions in participant-directed plans. Specifically, the Commission should require mutual funds to waive the assessment of redemption fees if the amount of shares redeemed is under a certain threshold. In addition, ASPA encourages the Commission to adopt a *de minimis* threshold under which redemption fees and mandatory participant level reporting only would apply if the amount redeemed is greater than $5,000. It is extremely unlikely that transactions below this amount would involve potential market timing abuses to be of any concern to the Commission.

III. INFORMATION REPORTING REQUIREMENTS

As noted above, the number of transactions for participant accounts under a participant-directed plan that occur during the course of a year is overwhelmingly large. An important question is whether all of the information associated with these transactions must be transmitted and whether mutual fund companies will be able to analyze such information.

Due to the substantial costs associated with the information reporting requirements under the proposed rule, ASPA strongly urges the Commission to limit the information that mutual funds receive, in the case of participant directed plans, to information about participant-directed exchanges and transfers that exceed the dollar threshold for imposing redemption fees under the *de minimis* exception. Although this would substantially reduce the total amount of information that mutual fund companies receive, ASPA believes that mutual fund companies would still receive the transaction information they would need to determine whether the fund's market timing policies are successful and to better enforce their policies consistent with the intent of the Commission's rule. ▲

Brian H. Graff, Esq., is the Executive Director of ASPA. Before joining ASPA, he was pension and benefits counsel to the US Congress Joint Committee on Taxation. Brian is a nationally recognized leader in retirement policy, frequently speaking at pension conferences throughout the country. He has served as a delegate to the White House/Congressional Summit on Retirement Savings, and he serves on the employee benefits committee of the US Chamber of Commerce and the board of the Small Business Council of America.

Continued from page 1

Health Savings Accounts—The Latest in Consumer Driven Health Plans

WHAT IS AN HSA?

The quick answer is that an HSA is an IRA that is used to pay for medical expenses. However, that description is only superficial since there are significant differences between IRAs and HSAs. Before proceeding, there are two points to keep in mind when reading this article.

First, getting guidance out on HSAs is a high priority for the government. Therefore, by the time this article is published, it is likely that additional guidance will be issued that will amplify, and possibly change, some of the information contained herein (in fact, both the DOL and IRS issued guidance even as this article was being drafted). Second, because of the evolving nature of this topic and in an effort to ensure that no one gets lost in the details, the focus of this article is to provide a general understanding of HSAs and the environment in which they will be used rather than to provide a thorough outline covering all of the excruciating details.

Now we can get back to the definition of an HSA. As stated earlier, an HSA is very similar to an IRA. The rules governing the actual operation of HSAs are identical to the rules that apply to IRAs. There must be a trust or custodial account with a qualified financial institution and the same prohibited transaction rules apply (*e.g.,* no loans or life insurance are permitted).

The primary distinction between HSAs and IRAs merely relates to their tax treatment. Contributions to an HSA are made with pre-tax dollars, either by an individual or an employer. Contributions made by an individual are deductible and are not subject to the 7½% adjusted gross income threshold that normally applies to medical expense deductions (*i.e.,* it is an "above-the-line" deduction). Contributions made by an employer to an employee's HSA are excludable from income for federal income tax purposes and are not subject to federal payroll taxes (*i.e.,* Social Security or unemployment taxes).

As with an IRA, earnings in an HSA accumulate tax-free. However, distributions from an HSA that are used to pay for medical expenses are also tax-free. **Thus, one of the key elements of an HSA that distinguishes it from a traditional or Roth IRA (and from a qualified retirement plan) is that contributions, earnings and distributions may all be tax-free.** In a traditional IRA, contributions may be tax-free, but distributions (including earnings) are taxable. In a Roth IRA, distributions (including earnings) are generally tax-free, but only after-tax contributions may be made. As we know, the taxation of amounts in qualified retirement plans is similar to the taxation rules for IRAs and Roth IRAs. As one can imagine, HSAs can be a powerful savings vehicle if they are not spent on current medical costs. This topic is covered below in more detail.

WHO IS ELIGIBLE TO ESTABLISH AN HSA?

Not everyone can establish an HSA. There are four requirements that must be met, and the determination of whether these are met is made on the first day of each month. The requirements are:

1. An individual must be covered by a High Deductible Health Plan (HDHP);
2. An individual may generally not be covered by any other non-HDHP, except for certain permissible benefits;
3. An individual must not be entitled to Medicare benefits under Title XVIII of the Social Security Act; and,
4. An individual may not be claimed as a dependent on another person's tax return.

WHAT IS A HIGH DEDUCTIBLE HEALTH PLAN (HDHP)?

The requirements that an individual be covered by an HDHP and have no other coverage are essential to the concept of the consumer driven health plan. These rules are designed to ensure that the individual is primarily responsible for the first level of medical expenses. That, in turn, provides the incentive to the individual to spend health care dollars wisely.

A high deductible health plan (HDHP) is a medical plan that meets certain deductible and out-of-pocket maximum requirements. The limits vary depending upon whether an individual has self-only coverage or family coverage. For self-only coverage, a health plan is an HDHP for 2004 if it has an annual deductible of at least $1,000 and a limit on annual out-of-pocket expenses of $5,000. For family coverage, a health plan is an HDHP for 2004 if it has a deductible of at least $2,000 and a limit on annual out-of-pocket expenses of $10,000. These limits may increase in future years to reflect cost-of-living adjustments.

As with most rules, there are exceptions to these dollar limits. One exception is that preventative care can be provided without being subject to the deductible or out-of-pocket maximum limits. This exception is to ensure that individuals do not forego preventative treatment and end up with a more severe medical condition. The law allows the IRS to define preventative care and,

in Notice 2004-23, the IRS issued a safe harbor for preventative care that can be provided by an HDHP. It is likely that future guidance will be issued further refining the definition of preventative care.

There are other nuances to the definition of an HDHP, such as rules allowing plans using a network of providers to avoid the maximum out-of-pocket limitations for services provided outside of the network. At this point it is probably not worthwhile to explore the intricacies of the HDHP requirements. Consumers will not be able to determine whether a health plan qualifies as an HDHP, so it is expected that health plan providers will provide an opinion as to whether a particular plan satisfies the HDHP requirements.

Perhaps the biggest practical problem with the HDHP requirement is that there are no exceptions for plans that must comply with state insurance laws. Some states have laws mandating certain coverage, and this required coverage can conflict with the definition of an HDHP. For example, some states require that expenses related to mental illness be covered with either no deductible or a very low deductible. Providing such a benefit would disqualify a policy as being an HDHP, and individuals in those states would not be eligible to establish an HSA. While ERISA would preempt the state insurance laws if the HDHP were self-funded, self-funding a health plan is generally only economically feasible for larger employers.

Another practical problem with the HDHP requirement is that, as explained below, there are no exceptions for prescription drug coverage. Thus, prescription drug costs must generally be paid by the individual (but may count towards satisfying the high deductible). Many individuals may find that switching to an HDHP without specific prescription drug coverage will result in a significant increase in their total out-of-pocket medical expenses.

WHAT OTHER HEALTH COVERAGE IS PERMITTED IN ADDITION TO THE HDHP?

The second condition to being eligible to establish an HSA is that an individual have no other health plan coverage for expenses covered by the HDHP, other than certain permissible benefits. Certain types of insurance coverage are permitted in addition to the HDHP. These allowable coverages generally provide ancillary health benefits and include insurance for worker's compensation, liabilities relating to ownership or use of property (*e.g.*, homeowner's insurance), insurance for a specified disease or illness and insurance paying a fixed amount per day (or other period) of hospitalization.

In addition to the permitted types of insurance, an individual is also allowed to have coverage for

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certain types of medical expenses. The reasoning behind these special allowances is that these medical expenses are limited in scope and will not undermine the consumer driven health plan model. For example, coverages for medical expenses related to accidents, disability, dental care, vision care or long-term care are allowed.

The IRS has issued guidance regarding the treatment of prescription drug benefits. In Rev. Rul. 2004-38, the IRS ruled that prescription drug benefits are not benefits that can be provided in addition to the HDHP. Accordingly, prescription drug coverage (such as a separate co-pay for drugs) must satisfy the HDHP requirements. If the benefit is not subject to the high-deductible limit, then an individual is not eligible for an HSA even if the HDHP excludes prescription drug benefits and the prescription drug coverage is provided under another plan or rider. The IRS recognized that this ruling would be problematic for individuals who have existing health plans that otherwise meet the HDHP requirements, so transitional relief was provided. Pursuant to Rev. Proc. 2004-22, for months prior to January 1, 2006, an individual is still eligible for an HSA if the individual is covered by both an HDHP and a separate plan or rider that provides prescription drug benefits before the minimum deductible is met.

The "no other coverage" rule can be a trap for the unwary. The problem is that *all* health care coverage available to an individual, and possibly to the individual's dependents, must be examined to make certain that the requirement is met. Coverage under a spouse's health plan, a Health Reimbursement Arrangement (HRA) or a Health Care Flexible Spending Account (health FSA) offered through a cafeteria plan under IRC §125 can all be potential problems. Coverage under one of these plans by an individual, or even the individual's spouse, could affect the eligibility of the individual to establish or contribute to an HSA unless the other plans are subject to a high deductible or are limited to the permissible types of coverage.

For example, assume Jack has family coverage under an HDHP through his employer. Jack's wife, Jill, participates in a typical health FSA offered through her employer's cafeteria plan. Neither Jack nor Jill are eligible to contribute to an HSA because they have other coverage in addition to the HDHP. Their problems arise because Jill's health FSA, which can reimburse expenses of either Jack or Jill, is not limited to permissible benefits (*e.g.,* dental, vision, etc.) and is not subject to a deductible. Further, due to the restrictions on changing elections in a cafeteria plan, Jack and Jill may need to wait until the beginning of the next cafeteria plan year before being able to opt out of the health FSA in order to be eligible to establish an HSA.

One area where the IRS may provide guidance relates to the interaction of HSAs and Health Reimbursement Arrangements (HRAs, which are discussed later in this article). HRAs are a type of consumer driven health plan where unused amounts may be carried over to pay for medical expenses in a later year. To the extent an individual has participated in an HRA and there are amounts that are being carried over, then absent relief from the IRS, the individual would not be eligible to establish and contribute to an HSA.

WHAT ARE THE HSA CONTRIBUTION LIMITS?

The law imposes a maximum amount that may be contributed to an HSA for a particular year. The limit is an annual limit, but it is determined on a monthly basis, which is why eligibility to establish and contribute to an HSA is determined as of the beginning of each month. The maximum amount that may be contributed for a particular year is the sum of the monthly limits for each month in which an individual is eligible. The monthly limit is 1/12 of the lesser of: (1) the deductible under the HDHP, or (2) $2,600 for self-only coverage or $5,150 for family coverage (as adjusted for future cost-of-living increases). This monthly determination provides employers with flexibility in setting up HSAs at any time during the year.

For married individuals with family coverage, the limit is an aggregate limit. They may split the limit in any manner they want. But, the contribution made to both HSAs may not, in total, exceed the contribution limits. If both individuals have family coverage, then the family coverage with the lowest deductible must be used to determine eligibility for an HSA.

In addition to the above limits, if an individual is age 55 or older as of the end of a year, then a catch-up contribution of $500 may be made (this amount will increase by $100 each year after 2004 until the limit reaches $1,000). This limit is an individual limit, not an aggregate limit, so that if both a husband and wife are age 55 or older, each one is entitled to make an additional $500 contribution.

Amounts may also be contributed to an HSA on behalf of a dependent (*e.g.,* minor child) if the dependent is eligible for an HSA and cannot be claimed as a dependent on someone else's tax return.

HOW MAY CONTRIBUTIONS BE MADE TO AN HSA?

HSA contributions (other than rollovers from another HSA or an Archer MSA) must be made in cash. They may be made by an employer, an individual or a combination of the two. To the extent contributions are made by an employer, they are excludible from the employee's gross income and are deductible by the employer. To the extent the contributions are made directly by an individual, they are deductible.

Contributions for a particular year may not be made earlier than the first day of such year. The latest time to make a contribution for a year is April 15 following such year. There are no restrictions on when contributions may be made during these two time periods. It would be possible to fund an entire year's contribution on the first day of the year. Similar to an IRA, if the amount contributed exceeds the applicable maximum, then the excess (plus attributable earnings) must be withdrawn by the due date of the tax return, including extensions, for such year. If the excess is not withdrawn timely, then the excess is taxed twice and is also subject to a 6% excise tax.

MAY EMPLOYEE CONTRIBUTIONS BE MADE THROUGH A CAFETERIA PLAN?

Yes, an employer can allow employees to contribute to their HSAs through a cafeteria plan. The advantage of making employee contributions through a cafeteria plan is that the amounts are not subject to payroll taxes. Employee contributions made through a cafeteria plan are treated as employer contributions and, as is the case with most amounts contributed through a cafeteria plan, are exempt from payroll taxes to both the employer and the employee. It should also be noted that premiums for the HDHP can be paid through a cafeteria plan just like any other health plan.

The payroll tax savings, in particular for those employees earning less than the taxable wage base, can be significant. However, there are some issues that the IRS is expected to resolve relating to the interaction of the cafeteria plan rules and HSAs, such as the application of the 25% key-employee concentration test, the restrictions on mid-year benefit elections and the ability to provide long-term care (which can be reimbursed or paid from an HSA but not through a cafeteria plan). It is expected that the rules will be favorable and, if so, permitting HSA contributions to be made through a cafeteria plan will be a common cafeteria plan design.

WHY WOULD AN EMPLOYER CONTRIBUTE TO AN HSA ON BEHALF OF AN EMPLOYEE?

An employer switching from a low deductible health plan to an HDHP will typically want to make contributions to employees' HSAs in order to reduce the impact of the increase in the deductible. The change to the HDHP will reduce premiums, and an employer may be willing to contribute all or a portion of the savings to covered employees' HSAs.

For example, assume an employer currently provides employees with a traditional indemnity health plan with a deductible of $300 at an annual cost (*i.e.*, premium) of $1,500 per employee. Assume that by changing to an HDHP with a deductible of $1,000 for self-only coverage, the premium will be reduced by 30%. This scenario results in a savings of $450 per employee. The employer might be willing to contribute the entire $450 to an HSA for each employee. The net increase in the cost to employees would be $250 (the increase in the deductible from $300 to $1,000 is offset by the $450 contributed to the HSA). The employees can contribute the difference of $550 ($1,000 - $450) to their HSAs by making deductible contributions or excludible contributions through a cafeteria plan.

Of course, no rules are complete, at least to those of us who deal with qualified retirement plans, without nondiscrimination requirements. Employer contributions to HSAs must be comparable for all eligible employees with comparable benefits. Pursuant to IRS Notice 2004-2, contributions are deemed to be comparable if they are the same dollar amount or same percentage of the deductible under the HDHP. It is not clear what other methods of contributions would be considered comparable, such as matching employee contributions. Additional IRS guidance is likely on this topic.

One area of concern regarding employer involvement with HSAs has been the application of ERISA. Fortunately, in Field Assistance Bulletin 2004-1, the DOL held that an HSA will not be covered by ERISA solely because an employer makes contributions to that HSA. Specifically, the DOL provided that HSAs are not covered by ERISA if the establishment of the HSAs is completely voluntary on the part of the employees and the employer does not: (i) limit the

Continued on page 19

ASPA Benefits Councils Calendar of Events

Date	Location	Event	Speakers
June 16	Delaware Valley	Turning Administrative Headaches into Consulting Opportunities	Linda Loretti, Steve H. Rosen, MSPA, CPC
June 23	Texas Gulf Coast	Selecting Investments Inside Retirement Plans, Fiduciary Liability and the Recent Mutual Fund Scandals	Ken Robertson, CPC
June 23	Western Pennsylvania	TBD	TBD

The 2004 401(k) Sales Summit—What Are They Saying About It?

by Amy L. Cavanaugh, CPC, QPA, QKA

THE ASPA CONFERENCES COMMITTEE DEVELOPED THE 401(k) SALES SUMMIT A FEW YEARS BACK TO PROVIDE A VENUE FOR THOSE INVOLVED IN THE FINANCIAL ASPECTS OF RETIREMENT PLAN OPERATION TO NETWORK AND PICK UP VALUABLE TRAINING REGARDING 401(k) SALES, OPERATION AND ADMINISTRATION. UNLIKE ASPA'S OTHER CONFERENCES, WHERE THE PRIMARY FOCUS IS ON RECENT LAW CHANGES AND COMPLEX TECHNICAL ISSUES, THE 401(k) SALES SUMMIT FOCUSES ON WHAT IT TAKES TO SELL A RETIREMENT PLAN IN A VERY COMPETITIVE MARKETPLACE. ALTHOUGH THE 401(k) SALES SUMMIT ORIGINALLY TARGETED THOSE WHO SELL OR INFLUENCE THE SALE OF 401(k) PLANS, ALL TYPES OF RETIREMENT PLAN PROFESSIONALS CAN BENEFIT FROM ATTENDING. IN A FEW SHORT YEARS, THE SALES SUMMIT HAS GAINED A REPUTATION AS A HIGH-ENERGY EVENT WHERE RETIREMENT PLAN CONSULTANTS AND SALES PROFESSIONALS CAN PICK UP TIPS REGARDING CLIENT RELATIONS, SALES AND THE OVERALL STATE OF THE RETIREMENT INDUSTRY FROM A FINANCIAL PERSPECTIVE. OFTEN, THOSE OF US ON THE ADMINISTRATIVE AND COMPLIANCE SIDE OF THE RETIREMENT PLAN EQUATION ARE NOT AS UP-TO-DATE AS WE WOULD LIKE TO BE ABOUT THE FINANCIAL ASPECTS OF OPERATING A RETIREMENT PLAN.

The first 401(k) Sales Summit was held in February 2002 at the Doubletree in Scottsdale, AZ, and had an attendance of 466. This past February, the third 401(k) Sales Summit was held at the Orlando World Center Marriott with a record attendance of 981. Proven industry leaders led seminar sessions which were organized into tracks covering Practice Management, Plan Design & Compliance, Investments and Participant Services. This year's Summit was co-chaired by Christine D. Chaia of The Hartford, Hartford, CT, and Mark A. Davis of Mark A. Davis Consulting, Inc., Thousand Oaks, CA.

Pat Williams of the Orlando Magic gave the keynote presentation. In his presentation, "Five Magic Principles To Build a Ladder to Your Dreams," Pat shared five principles of excelling personally and professionally. Here are his five tips:

1. Think tomorrow—make today pay off tomorrow.
2. Free the imagination.
3. Strive for lasting quality. Believe in it strongly.
4. Have "stick-to-it-ivity."
5. Have fun.

Pat must be having fun. He is the father of 19 children, 16 of whom were teenagers at the same time!

Another popular session was the "Top Producers' Round Table—What Is Working and Why?" In this session, James Al Cannon of Smith Barney, Inc., Michael S. David of Summit Financial Corporation, Donald W. Fry, CPC, QPA, of Fry Financial Consultants, Inc. and Michael Quinlivan, CPC, QPA, of Pension Planning Solutions, Inc., shared sales tips on how the top producers separate themselves from the rest of the pack.

I personally attended the Sales Summit as a vendor, but as a first-time attendee to this event, the level of excitement in the exhibition hall struck me. When you get a group of sales people together, the level of interaction goes up a notch or two. I found it to be infectious, so I wanted to talk to other attendees who had a background similar to my own to see what they thought.

All of the consultants that I spoke with said that they saw the three-day event as a great opportunity to network and looked forward to attending future 401(k) Sales Summits. Norman Levinrad, FSPA, CPC, an actuary with Summit Benefit & Actuarial Services, Inc., in Eugene, OR, said that his primary motive for attending the 401(k) Sales Summit was "to concentrate on ideas about the building and managing of our practice as well as to gain different perspective on sales techniques." While he was there, he met quite a few people that he was able to follow up with upon returning to the office to see how they could work together. Norman's experience was such that he expects that either he or his partner will attend every year.

One presentation that received consistently favorable reviews was "The Finals Presentation." At this session, attendees watched top 401(k) sales pros in action. Two "finalists" presented their recommendations based on a hypothetical RFP. By

I came away from the conference with some ideas on how to grow my business, with some new contacts for different products and with some refreshing, motivating and uplifting thoughts.

witnessing the two dramatically different and effective presentation styles, attendees realized that there is not one perfect sales style. Michael L. Bain, MSPA, an actuary with CMC in Glendale, CA, shared that this session was presented as the "live face" of the two closing sales presentations made by competitors. "We saw an extremely polished presentation and a more folksy one. Listening to how people reacted to both was interesting and useful with respect to my own presentation skills."

Mike's partner, Cathy M. Green, CPC, QPA, attended the Summit with "two hats" on. Cathy is ASPA's Conference Committee Chair and she is also a producing TPA. Cathy enjoyed learning more about bonds, how to sell, late-day trading issues and seeing presentations about alliances. Cathy saw the 401(k) Sales Summit as an opportunity to network with financial professionals, and she was also very interested in hearing what the financial professionals considered to be "their issues." Cathy is pleased to have experienced this great conference first-hand and is "glad that ASPA stepped up to the plate [by adding the 401(k) Sales Summit to the list of annual conferences]. I am looking forward to those sales professionals who attended finding a home within ASPA."

Michelle M. Wyckoff, QKA, is the president of Retirement Plan Concepts & Services, Inc., in Fort Wayne, IN. Michelle said that she attended the Sales Summit to see what it was all about. "I have always enjoyed all the conferences that I have attended through ASPA and I was interested in finding out more about this one. I also attended in the hopes of finding new opportunities to do business with investment companies that I currently do not do business with." Michelle found the presentation on "How to Make the Sale" especially interesting. According to Michelle, "It was good to see how brokers and consultants work together to provide the client with what they are looking for." She said she "found it refreshing to have some motivation that touched every aspect of my life, not just my business." Michelle was glad that she attended the Summit and echoed the sentiments that "it really was a great conference." Michelle had not attended in the past because she thought it was exclusively for people who are "truly" in sales. "After attending, I decided that this would probably become one of my annual conferences. I came away from the conference with some ideas on how to grow my business, with some new contacts for different products and with some refreshing, motivating and uplifting thoughts."

Ken Culver, CPC, of FBD Consulting of Oklahoma, Inc., told me that his primary motive for attending the 401(k) Sales Summit was to gain additional insight into fiduciary matters and to learn about making sales presentations. Ken said that he found the sales presentation session most interesting because it confirmed that his own presentation format is on track. Ken added that he appreciated all the efforts of ASPA to present a first class meeting.

It was Ellen Miller, a consultant in Baltimore, MD, who introduced me to the term "accidental salesperson." Ellen told me that she went to the 401(k) Sales Summit to "meet the folks who are actually out there doing the selling to their clients or prospective clients" and because she wanted to "find out more about how professional sales folks do their thing." Ellen referred to herself as an "accidental salesperson." According to Ellen, she has never had formal sales training. In her words, "I know how to do my administration job, but I need the skills to sell my product." Ellen liked the general sessions the best because they were motivational and informative. She mentioned to me that it would be a great idea to infuse some of the sales technique sessions into the other ASPA conferences since "in this day and age, everyone at one time or another is forced to close a sale." (Ellen got me thinking about this concept of the "accidental salesperson." A quick Google search uncovered that Chris Lytle wrote a book on just this topic-*The Accidental Salesperson: How to Take Control of Your Sales Career and Earn the Respect and Income You Deserve*. This book is readily available in paperback.) I would guess that many of the TPAs who attended the Summit would categorize themselves as "accidental sales people," just like Ellen, and that they would benefit equally from this one-of-a-kind conference.

ASPA has definitely scored a home run with its unique 401(k) Sales Summit. Its appeal to a broad array of retirement plan professionals will ensure its future success. I hope to see you there next year! ▲

Amy L. Cavanaugh, CPC, QPA, QKA, is a document consultant with AccuDraft in Altamonte Springs, FL. She has over 23 years of experience in the employee benefits industry. Amy is the author of the Coverage and Nondiscrimination Answer Book *and a frequent author of pension related articles. Amy serves on ASPA's Education and Examination Committee and on The ASPA Journal Committee.*

2004 401(k) Sales Summit

WHAT AN EXPERIENCE!

ASPA President-Elect Stephen H. Rosen, MSPA, CPC, and ASPA President, Bruce L. Ashton, APM, were surprised and pleased at the growth of the event. Within three years, ASPA's 401(k) Sales Summit topped 1,000 speakers, exhibitors and attendees and 98 exhibit booths.

E. Thomas Foster, Jr., JD, a 30-year veteran in the retirement industry who works with The Hartford, shared creative tips and insights on the unique characteristics that define a successful sales person.

The sessions were informative and well attended.

ASPA 401(k) Sales Summit Committee member Kristine J. Coffey, CPC, said, "The long and the short of the conference is that it was educational, inspirational, informative and just plain fun!"

Co-Chair Christine D. Chaia welcomed the crowd at the opening session.

ASPA Executive Director, Brian H. Graff, Esq., presented the very popular "Washington Update: From the Hill to the Summit."

The exhibit hall boasted 98 exhibit booths presenting products and services vital to the retirement plan industry—and entertainment, too.

Pat Williams, Senior Vice President with the Orlando Magic, gave the attendees a lot to think about with his presentation, "Five Magic Principles to Build a Ladder to Your Dreams."

ASPA staff members Xenia Murphy, Education Services Manager, and Rachel Wallmuller, Meetings Assistant, were kept busy at the registration desk.

The exhibit hall was a great place to meet new contacts and greet old friends while learning about the products and services available.

Mark your calendar now!

March 17 – 19 are the dates you want to mark for the 2005 401(k) Sales Summit at the Manchester Grand Hyatt in beautiful San Diego, CA.

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AIM Investments
Alliance Benefit Group
Alliance Bernstein
American Express Retirement Services
American Express Tax and Business Services, Inc.
Ameritrade Corporate Services
The Annuity People
Arnerich Massena & Associates
Artisan Funds
ASPA
AST Trust, a Division of American Stock Transfer & Trust Company
BenefitStreet
BISYS Retirement Services
Ceridian
Charles Schwab Corporate Services
CIGNA Retirement & Investment Services
Circle Trust Company
Colonial Surety Company
Columbia Funds
Daily Access Corporation
DATAIR Employee Benefit Systems, Inc.
Davis Funds
Diversified Investment Advisors
Eaton Vance
ExpertPlan, Inc.
Fidelity Advisor Funds
Fidelity Investments
Financial Finesse, Inc.
Financial Planning Magazine
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Jensen Investment
Judy Diamond Associates, Inc.
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Lincoln Financial Group Retirement Financial Services
Mand Marblestone & Danziger, P.C.
Manulife Financial
MassMutual
Matrix Settlement & Clearance Services
Morningstar, Inc.
Mutual of Omaha
Nationwide Financial
Newkirk
The Newport Group
NYLIM Retirement Plan Services
Ohio National Financial Services
PAi
PenChecks, Inc.
PensionPlanet.com
Pioneer Investments
PLANSPONSOR Magazine
The Principal Financial Group
Prudential Retirement
Redwood Administrators, Inc.
Salomon Brothers Asset Management
Scudder Retirement Services
Smart Money Custom Solutions
Standard Insurance Company
State Street
SunGard Corbel
Thornburg Investment Management
Total Benefit Communications, Inc.
Transamerica Retirement Services
Travelers Life & Annuity
T. Rowe Price Investment Services
Trustlynx/Fiserv Trust Services
Victory Capital Management
Wells Fargo
Wilmington Trust Company
WySTAR Global Retirement Services

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ability of eligible individuals to move their funds to another HSA beyond restrictions imposed by the IRC; (ii) impose conditions on utilization of HSA funds beyond those permitted under the Code; (iii) make or influence the investment decisions with respect to funds contributed to an HSA; (iv) represent that the HSAs are an employee welfare benefit plan established or maintained by the employer; or (v) receive any payment or compensation in connection with an HSA.

HOW ARE AMOUNTS IN AN HSA INVESTED?

The rules regarding the investment of HSAs are identical to the rules that apply to traditional and Roth IRAs. For example, loans and life insurance are not permitted. Also, only certain "collectibles" are permitted investments.

In general, most of the investment restrictions associated with IRAs are imposed by the custodian or trustee of the account rather than by limitations imposed by law. With HSAs, financial institutions will impose even more restrictions. In many cases there will be frequent withdrawals throughout the year to pay for medical expenses. As with health FSAs, some HSAs will be linked with medical debit cards to make the withdrawal process easier for all parties.

For most individuals, the HSA will have a high level of activity and may have little or no assets at the end of each year. Thus, one can easily see why financial institutions will require that certain minimum balances be maintained before investment options become available. For example, if the value of an HSA is less than $2,500, the financial institution may require that it be invested in a non-interest bearing account or money market fund. If the value is at least $2,500, then the financial institution may permit investments in a limited number of mutual funds.

WHAT ARE THE RULES GOVERNING THE TAXATION OF DISTRIBUTIONS FROM AN HSA?

Funds may be withdrawn from an HSA at any time. Any amounts paid or distributed from an HSA that are used to pay for "qualified medical expenses" are not includible in gross income for federal income tax purposes. Amounts not used for "qualified medical expenses" are generally subject to federal income taxes, and unless made on account of disability, death or entitlement to Medicare (generally age 65), are also subject to a 10% excise tax. There are also special rules that address the death or divorce of the HSA owner, which allows an ex-spouse or surviving spouse to continue to maintain the HSA.

WHAT IS A "QUALIFIED MEDICAL EXPENSE"?

A "qualified medical expense" is an amount paid for medical care that would generally be deductible for federal income taxes (without regard to the 7½% of income threshold). Expenses for items such as doctor visits, hospital stays and drugs (including over-the-counter drugs) for the individual or the individual's spouse or dependents are permitted. However, there are some medical expenses that are not permitted to be withdrawn tax-free from an HSA. For example, tax-free withdrawals are not permitted from an HSA to pay premiums for certain health care coverage. Some of the types of premiums that can be reimbursed from an HSA tax-free are premiums for COBRA and long-term care insurance. In addition, once an individual is entitled to Medicare, any premiums to pay for health insurance other than a Medicare supplemental policy may be reimbursed tax-free from an HSA.

IRS Notice 2004-2 makes it clear that the trustee or the custodian of the HSA has no obligation to determine whether an expense is a qualified medical expense. It is up to the individual to make this determination. When a withdrawal is made from an HSA, it will be reported on the taxpayer's Form 1040. It is up to the taxpayer to determine whether the withdrawal is tax-free (*i.e.,* was for a "qualified medical expense") and to retain receipts if the expenses ever need to be verified. Nevertheless, some HSA service providers may decide to offer a value-added service to determine whether an expense qualifies as a medical expense.

CAN AN HSA BE A SAVINGS VEHICLE?

HSAs have dual purposes—to provide funds for current health expenses and to provide a savings vehicle for future health expenses. The hope, with all consumer driven health care, is that individuals will limit medical expenses today to save for tomorrow. There are also significant tax advantages to encourage the retention of funds in an HSA.

A "qualified medical expense" may only be paid or reimbursed from an HSA if the expense was incurred after the time the HSA was established. However, in Notice 2004-25, the IRS provided transitional relief from this rule because of the lack of trustees or custodians willing to offer HSAs. Under the relief, for calendar year 2004, an HSA established by an eligible individual before April 15, 2005, may pay or

reimburse, on a tax-free basis, any "qualifying medical expenses" that are incurred on or after the later of January 1, 2004, or the first day of the month that the individual is an eligible individual.

Once an HSA has been established, all "qualified medical expenses" incurred after that date may be reimbursed or paid from the HSA on a tax-free basis. At this time, the IRS has not issued any guidance that would limit the time period for requesting a reimbursement from an HSA to pay for a medical expense; therefore, "qualified medical expenses" could be paid out-of-pocket today and then could be reimbursed many years later.

For example, Michele establishes an HSA on January 1, 2005, and makes a contribution of $1,000. In August 2005, Michele incurs a "qualifying medical expense" of $1,000. If Michele has a savings account (in addition to the HSA) with $1,000, she may be better off paying the medical expense with funds from the savings account and leaving the HSA funds intact. From a financial perspective, if Michele leaves the $1,000 in the savings account and pays the expense from her HSA, earnings on that savings account are taxable. Instead, if she pays the expense from the savings account, the earnings in the HSA accumulate tax-free. As long as she does not deduct the medical expense on her income tax return, she will be able to withdraw $1,000 from the HSA tax-free at any time in the future (*e.g.,* 40 years from now when she is 80 years old).

Many financial planners and health care consultants will advise individuals to accumulate funds in an HSA if they can afford to do so. Again, at the time this article is being written, there are no IRS rules preventing the accumulation of medical expenses over a period of time. Imagine the delight of your CPA when instead of a shoe box, you walk in with a refrigerator box full of medical expense receipts that you have accumulated over the past 40 years so that you can get a tax-free withdrawal of your entire HSA!

IS THERE A ROLE FOR 401(k) RECORDKEEPERS?

Stay tuned for the answer to this question. Accounts with small balances and frequent transactions are not particularly attractive to financial institutions. In fact, finding independent financial institutions willing to accept HSA accounts will be difficult in these early years. Further, the concept of an account balance with an allocation of earnings is relatively new to the health insurance industry.

A potential opportunity for 401(k) recordkeepers could be on the horizon. Amounts in an HSA may not be commingled with other investments *except in common or collective funds*. This exception would permit HSAs to be structured in a manner similar to a 401(k) plan. An omnibus HSA custodial or trust account is created with a financial institution, and a recordkeeper performs the various administrative functions on behalf of the institution. However, unlike a 401(k) plan, HSA balances will be small for most individuals (however, as discussed above, some individuals may accumulate large balances). Thus, the appeal to providing this type of recordkeeping service is that it can generate higher monthly service fees, and for those who are licensed to sell health insurance, it provides an inroad to selling HDHPs. Currently, many HDHP providers link the HSAs with their own products and provide limited or no investment options.

HOW ARE HSAs DIFFERENT FROM ARCHER MSAs, HRAs AND FSAs?

The length of this article could be doubled in an attempt to describe the details of the other types of individual "account" health plans. Accompanying this article is a chart that outlines the primary features of each of the types of plans (see pages 22–23). However, a brief description of these other types of plans is warranted in order to provide a context in which to understand HSAs and their role in the marketplace.

ARCHER MSAs

Let us begin with the father (or mother) of HSAs—Archer MSAs (Medical Savings Accounts). HSAs are actually the replacement for Archer MSAs because Archer MSAs cannot be established after December 31, 2003. In essence, the HSA rules are those of the Archer MSA with numerous enhancements. Fortunately, we do not need to examine all of the rules that apply to Archer MSAs. Rather, we only need to address the question "Why will HSAs be more popular than Archer MSAs?" This question is legitimate considering the fact that less than 100,000 Archer MSAs were established and were viewed by many as a failure. The reason many people think HSAs will be considerably more popular is because of four significant enhancements:

1. The deductible limit for a health plan to qualify as an HDHP is lower for HSAs than for MSAs, so it may make the HDHP more appealing. The minimum deductible for Archer MSAs was $1,700 for self-only coverage and $3,350 for family coverage.
2. *Any* employer or individual can establish an HSA, while only small employers (generally less than 50 employees) and self-employed individuals were eligible to establish Archer MSAs.
3. The contribution limit to an HSA can potentially be as high as 100% of the deductible under the HDHP, while the limit on an Archer MSA was either 65% or 75% of the deductible. This MSA limit effectively meant that up to 35% of the deductible would need to be met outside of a health plan and could not be paid pre-tax unless the medical expenses were deductible (subject to the 7½% adjusted gross income threshold).

4. Only an employer or an employee (but not both) could contribute to an Archer MSA.

HEALTH REIMBURSEMENT ARRANGEMENTS (HRAs)

Health Reimbursement Arrangements (HRAs) were formally recognized by the IRS in Rev. Rul. 2002-41. HRAs are individual account health plans that permit the carryover of unused amounts to a later year. While they have a consumer driven health care component to them, they are not full consumer driven health plans because the ability to carryover unused amounts to later years can be limited by the employer as part of the plan design. Unlike HSAs, there is no separate account that is established for an individual covered by an HRA (thus, there are no earnings to be allocated) and there is no absolute guarantee that amounts may be carried over indefinitely. HRAs are strictly employer provided arrangements and no employee contributions are permitted. As such, the employer has flexibility in designing the plan, especially with respect to the ability to carry forward unused amounts. An HRA could be designed to provide that there is a maximum dollar amount that may be carried forward and that no amounts may be carried forward after termination of employment. In addition to the flexibility permitted in the HRA plan design, there are no rules regarding other health coverage that an individual may or must have *(e.g.,* there is no requirement that an individual be covered by an HDHP). HRAs have become fairly popular. But, as identified earlier in this article, coverage under an HRA may prevent an individual from being eligible to contribute to an HSA.

HEALTH CARE FLEXIBLE SPENDING ACCOUNTS (HEALTH FSAs)

Health Care Flexible Spending Accounts (or health FSAs) are so popular that most people are familiar with them. Health FSAs are typically funded with employee contributions through a cafeteria plan. The individual selects the maximum benefit and there are no rules regarding other health coverage that an individual may or must have (*e.g.,* there is no requirement that an individual be covered by an HDHP). However, health FSAs work in a manner that is the opposite of a consumer driven health plan. Rather than being encouraged with a financial incentive to limit or reduce medical expenses, individuals covered by health FSAs are encouraged to obtain medical care before the end of the coverage period in order to avoid a forfeiture due to the "use-it-or-lose-it rule."

HSAs and health FSAs do not interact well. Contributions may not be made to an HSA if an individual is also covered by a health FSA unless the health FSA is either limited to permissible coverage or is subject to the HDHP requirements. Either of these would be so restrictive that participation in health FSAs would significantly decrease and many employers would probably just eliminate the health FSA as a benefit.

CONCLUSION

Congress will continue to focus on ways to control spiraling health costs and to ensure that Americans have adequate post-retirement medical coverage. Some think HSAs are a step in the right direction. It is too early to tell whether employers will embrace HSAs as part of their benefits package. In order for HSAs to become popular, it will require a change in the attitude about how individuals think health care coverage should be provided, which will take time. In the meantime, HSAs have generated a significant amount of attention and everyone in the employee benefits area should at least be familiar with them. ▲

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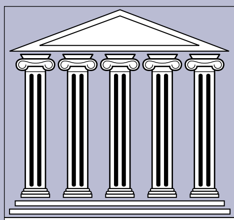
401(k) Plans for Small Businesses



The Department of Labor's Employee Benefits Security Administration (EBSA) and the Internal Revenue Service (IRS) have developed a new publication, *401(k) Plans for Small Businesses,* which assists employers in understanding and complying with federal law. The publication presents a comprehensive overview of 401(k) plans, focusing on the key issues involved in setting up and operating plans. It is designed to help small business employers and plan officials better understand the important role they play in ensuring the security of their plans and their responsibilities under the Employee Retirement Income Security Act (ERISA).

Copies can be obtained by calling EBSA toll-free at (866) 444-EBSA, or by visiting **www.dol.gov/ebsa/pdf/401kplans.pdf or www.irs.ustreas.gov/pub/irs-pdf/p4222.pdf.**

Information on 401(k) plans for businesses, in general, can be found at **www.dol.gov/ebsa/publications/401kplans.html** or **www.irs.ustreas.gov/retirement/article/0,,id=120298,00.html.**

COMPARISON OF HSAs, MSAs, FSAs AND HRAs

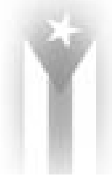
	Health Savings Accounts (HSAs)	Medical Savings Accounts (Archer MSAs)	Health Flexible Spending Accounts (Health FSAs)	Health Reimbursement Arrangements (HRAs)
Is any employer eligible?	Yes	No. Only small businesses (under 50 employees) and self-employed may establish.	Yes, but the following cannot benefit: partners, sole-proprietors and more than 2% shareholders of S Corporations or members of an LLC.	Yes, but the following cannot benefit: partners, sole-proprietors and more than 2% shareholders of S Corporations or members of an LLC.
Are individuals required to have other health coverage?	Yes, must be covered by HDHP: The minimum deductible must be $1,000 for self-only coverage; $2,000 for family coverage. Maximum out of pocket is $5,000 ($10,000 if family coverage).	Yes, must be covered by HDHP: The minimum deductible must be $1,700–$2,600 for self-only coverage; $3,450–$5,150 for family coverage. Maximum out of pocket is $3,450 ($6,300 if family coverage).	No	No
Are there limits on other health coverage that can be maintained?	Yes. Only certain excepted benefits may be maintained (*e.g.*, dental, vision, accident insurance, etc.)	Yes. Only certain excepted benefits may be maintained (*e.g.*, dental, vision, accident insurance, etc.)	No	No
What is the maximum annual contribution?	Lesser of (1) 100% of deductible or (2) $2,600 for self-only coverage or $5,150 for family coverage.	65% of deductible for self-only coverage; 75% of deductible for family coverage.	No statutory limit. It depends on plan design.	No statutory limit. It depends on plan design.
Can older workers make “catch-up contributions”?	Yes. Those ages 55 and older can contribute an extra $500 (increases by $100 until $1,000 in 2009).	No	N/A. There are no maximum contribution limits.	N/A. There are no maximum contribution limits.
Who can contribute to the account?	Individuals and/or employers. Can be offered through a cafeteria plan.	The individual or employer, <u>but not both</u>. Cannot be offered through a cafeteria plan.	Individuals and/or employers. Typically offered through a cafeteria plan.	Employer only. Cannot be offered through a cafeteria plan.

COMPARISON OF HSAs, MSAs, FSAs AND HRAs

	Health Savings Accounts (HSAs)	Medical Savings Accounts (Archer MSAs)	Health Flexible Spending Accounts (Health FSAs)	Health Reimbursement Arrangements (HRAs)
What is a qualified medical expense for purposes of tax-free distributions?	IRC §213(d) expenses (which includes OTC drugs) that are not deducted or reimbursed by other plans. However, only certain insurance premiums qualify as medical expenses (*e.g.,* COBRA and long-term care).	IRC §213(d) expenses (which includes OTC drugs) that are not deducted or reimbursed by other plans. However, only certain insurance premiums qualify as medical expenses (*e.g.,* COBRA and long-term care).	IRC §213(d) expenses (which includes OTC drugs) that are not deducted or reimbursed by other plans. However, insurance premiums do not qualify as medical expenses. Also, the plan may limit expenses that qualify.	IRC §213(d) expenses (which includes OTC drugs) that are not deducted or reimbursed by other plans. May include insurance premiums. Also, the plan may limit expenses that qualify.
Can unused amounts be carried over to a later year?	Yes	Yes	No	Yes, depending on plan design.
Is claim adjudication required?	No	No	Yes	Yes
Is plan funded (*i.e.,* are funds required to be in a separate account or trust)?	Yes	Yes	Not required to be funded.	Not required to be funded.
Are there nondiscrimination rules that apply?	If employer contributions, then contributions must be "comparable" for participating employees. If offered through a cafeteria plan, IRC §125 rules may apply (*e.g.,* 25% concentration test).	If employer contributions, then contributions must be "comparable" for participating employees.	If employer contributions, IRC §105(h) rules apply. If offered through a cafeteria plan, IRC §125 rules apply (*e.g.,* 25% concentration test).	IRC §105(h) rules apply.
What is the tax treatment of distributions that are not for medical expenses?	Taxable and may be subject to 10% excise tax for certain early distributions.	Taxable and may be subject to 15% excise tax for certain early distributions.	N/A. Distributions must be for medical expenses.	N/A. Distributions must be for medical expenses.
Is the plan subject to COBRA?	No	No	Yes, depending on the size of the plan.	Yes, depending on the size of the plan.
Is the plan subject to ERISA?	Generally no, but could be if there is enough employer involvement.	No	Yes	Yes

Continued from page 4

Compliance and Nondiscrimination Testing Issues with Puerto Rico Qualified Plans



participants under US rules and second, the Puerto Rico portion is tested separately under Puerto Rico rules.[2]

Although there is a requirement to satisfy a similar ADP test under Section 1165(e) of the PRIRC, there is no equivalent ACP test under the PRIRC. Unfortunately, the ADP test required by the PRIRC is not the same test as required by the IRC and the differences can significantly complicate nondiscrimination testing.

The first difference that contributes to the complication is the definition of Highly Compensated Employee (HCE). An HCE under the IRC is an individual employed by any member of the controlled group who earned in excess of $80,000 (as indexed) in the prior year, but under the PRIRC, an HCE is someone who has compensation in the current year in the top one third of the group of eligible Puerto Rico employees. As such, ten of the 30 Puerto Rico employees will be HCEs regardless of their compensation.[3]

In the event that the Puerto Rico portion of the plan fails the Puerto Rico ADP test, a refund in the amount required to fix the Puerto Rico test is unlikely to match the refund needed under the US test, if any, even if the individual is an HCE under US rules. There is no provision in the IRC to provide this "non-US HCE" a distribution. Similarly, in performing the US ADP test, if the test fails, any required refund to a Puerto Rico employee is likely to be different than the amount permitted to be distributed under the Puerto Rico rules. The only option may be to provide additional benefits to the NHCEs in the form of Qualified Nonelective Contributions or Qualified Matching Contributions.

ELECTIVE DEFERRAL LIMITS

Another issue that arises is that Puerto Rico residents may not defer in excess of the lesser of 10% of compensation or $8,000. This limit is not indexed for future cost of living increases. This is coordinated with Individual Retirement Account (IRA) contributions.

Plans that cover both US and Puerto Rico residents should contain specific language in the plan document referencing the PRIRC and include different deferral limits for these participants. The US plan would need to cap contributions appropriately for the Puerto Rico employees. If the US employees can defer up to $13,000 (2004 limit), a benefits, rights and features issue exists in that there are different benefits for different groups of employees in the same plan. This will require additional testing, or a 10% or $8,000 deferral limit for all employees.[4] In addition, should a Puerto Rico resident defer more than $8,000, this additional contribution would not be an excess deferral under the US rules; thus, there is no easy method for correcting the breach of the Puerto Rico rule. It would, therefore, be essential to prevent the contributions for Puerto Rico employees from exceeding their limits.

With the revisions under the Economic Growth and Tax Relief Recovery Act of 2001 (EGTRRA) to the 415 limits and the exclusion of deferrals from deductibility calculations, many employers have amended their plans to allow deferrals as high as the IRC Code Section 402(g) limit. If not the 402(g) limit, the trend has been toward percentages of 25%, 50%, etc. Payroll systems, participant Web sites and voice response systems must recognize the different plan limits and prevent violations of the applicable Codes.

US LIMITS NOT APPLICABLE TO PUERTO RICO PLANS

While Puerto Rico plans are not subject to the IRC, certain US limits do not apply. There is no compensation limit like the $200,000 (as indexed) under IRC Section 401(a)(17). As such, compensation would be limited when testing the Puerto Rico residents in the US test, but not in the Puerto Rico test. As previously mentioned, no ACP test is required under the PRIRC.[5] There is no equivalent of the US Code Section 415, so employees are not limited to the lesser of 100% of compensation or $40,000 (as indexed). There is also no penalty for withdrawal of funds prior to age 59½, no required minimum distributions and no top-heavy minimum contributions.

LIMIT ON AFTER-TAX CONTRIBUTIONS

While there is no limit on contributions due to IRC Section 415, some limits do apply to after-tax contributions under Puerto Rico law. After-tax contributions are limited to 10% of the aggregate compensation of the employee since plan participation. This limit only applies to after-tax contributions that are not matched. The contributions cannot be a condition on participation in the plan.

If a participant has no after-tax contributions for two years, technically, in the third year, the participant could contribute 30% in after-tax dollars and not violate the aggregate limit. Rather than monitor the 10% aggregate limit, employers may prefer the administrative shortcut of limiting the amount of after-tax contributions to only 10% per year.

CATCH-UP CONTRIBUTIONS

One of the amendments to the IRC, as directed by EGTRRA, is the ability to offer catch-up contributions to employees who attain age 50. Puerto Rico tax law does not contain a similar provision. Under US rules, normally catch-up contributions must be offered to all employees of a controlled group if offered under any CODA plan ("universal availability"). But in the case of Puerto Rico employees, the IRS allows an exception.[6]

PUERTO RICO PARTICIPANTS AS PART OF A SEPARATE PLAN

The simplest way to handle the presence of a Puerto Rico company in a US controlled group is usually to provide for two separate plans. While there is an added expense in providing two plans—two trusts and two Form 5500s[7]—the employer will be free from many of the complications of dealing with the two Codes within one plan.

The fact that Puerto Rico has no compensation limit or ACP test and has more lenient coverage rules can lead one to more creative design for the Puerto Rico plan. While the PRIRC limits deferrals to the lesser of 10% or $8,000 (offset by any IRA contribution), excess deferrals can be "recharacterized" as after-tax contributions. Recharacterization rarely works with a US plan since the "new" after-tax money must satisfy the ACP test. Because there is no such test in Puerto Rico, the problem never presents itself. The employer need only address the limits on after-tax contributions. The recharacterization must occur within the first 2½ months following plan year-end.

Another correction method that is available to the Puerto Rico plan, if separate, is the ability to make corrective distributions. These corrective distributions or refunds are due no later than 12 months after plan year-end. The corrective distribution is determined using the process of leveling based on the contribution percentage contributed. Refunds are applied to the HCEs with the highest percentage contribution using leveling until the test is passed. This same method is used to identify how much to recharacterize as discussed above. While no 10% excise tax is levied on the employer for issuing refunds more than 2½ months after plan year-end, the contributions that are refunded will be taxable to the employee in the year contributed. To prevent any income tax filing issues for the Puerto Rico employees, the employer would need to make every effort to process refunds as soon as possible after the plan year ends.

However, as noted earlier, using a separate plan for Puerto Rico employees may lead to coverage restrictions for HCEs in the US population.

TAXATION

While the scope of this article is primarily to address the compliance testing issues, it is worth noting that the taxation rules pose a significant issue. Although Puerto Rico residents pay Social Security taxes, they do not pay US income tax on their income if solely earned in Puerto Rico. When the Puerto Rico resident participates in the US based plan and ultimately takes a distribution, a portion of the distribution is US source income. Because Puerto Rico residents are not subject to US income tax on income earned for services rendered in Puerto Rico, the employee contributions and matching contributions will not be subject to US income tax when distributed. The earnings on the investments, however (due to investment in a US trust), will be US source income. As such, the participant may need to file two tax returns—one to the Hacienda and one to the IRS. In the event that the Puerto Rico employees are covered by a plan solely qualified under the PRIRC and funded solely through a Puerto Rico trust, this problem is eliminated and the participants can enjoy additional tax savings. Issues can also arise if the employee moves from Puerto Rico to the United States and vice versa.

SUMMARY

There are many issues that must be addressed when providing retirement benefits for employees of Puerto Rico employers who are part of a US controlled group. In addition to the coverage, nondiscrimination and taxation issues discussed above, other issues could include reporting requirements, distribution rules and qualification procedures. An employer facing such a situation would be well advised to consult legal counsel both in the US and Puerto Rico prior to deciding on a course of action. ▲

Footnotes

1 Therefore, Puerto Rico plans must file the Form 5500. In addition, the PRIRC also requires the annual completion of the Form 480.70, which is due three and a half months after plan year-end. Puerto Rico plan sponsors are also required to submit a determination letter request when adopting or amending their plan.

2 As mentioned above, it is possible to test the combined groups under Puerto Rico law, but only if uniform deferrals and allocations are available.

3 The Puerto Rico regulations define HCEs differently for coverage and nondiscrimination purposes. For purposes of coverage, the top 1/3 highest paid of all nonexcludable employees will be HCEs, while the top 1/3 highest paid of eligible employees will be HCEs in the nondiscrimination tests.

4 Indeed, if all participants are not limited to the Puerto Rican cap, combined testing under the Puerto Rican rules is not permitted.

5 In a combined plan, these would be subject to the ACP test. If refunds are required under the US rules, presumably there would be no breach of the Puerto Rico requirements.

6 Notice 2002-4.

7 The Puerto Rico Form 480.70 is required, regardless of whether the plan is separate or combined with a US plan.

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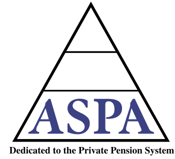
Letter from the President

by Bruce L. Ashton, APM



Dear Fellow Members:

John F. Kennedy once remarked during his presidency that even though many people called him the most powerful man in the world, he really had very little control over the federal bureaucracy. The most he could do, he said, was to try influence the outcome.

Having sat in this chair for about six months, I can say the same for the ASPA President. ASPA is the sum of so many parts that are, in reality, controlled by the volunteer members and the ASPA staff who get things done. I often think of my role as a shepherd—the flock stays together pretty much by itself, without much prodding. Though occasionally I have to round up a random stray, my main job is to get the entire flock headed in the same direction and oversee getting from here to there without running the entire flock over a cliff.

Which leads to the real question: where is “here and where is “there?”

Here’s the “here” as I see it: ASPA does a great job of protecting the employer-based retirement plan system through our lobbying and educational efforts. ASPA does a very good job in educating pension professionals on the technical rules related to qualified retirement plans. ASPA does a good job of credentialing—providing creditability—to technical pension professionals.

That said, we face a number of challenges. The ASPA flock is getting bigger, more diverse. The retirement plan world is changing, from both governmental pressure and market pressures. What worked 20 years ago, even a decade ago, probably doesn’t work today; and if ASPA is going to survive and prosper, I believe it needs to address these changes in a positive and thoughtful way without losing sight of how we got here.

We’ve already started that process. The adoption of the new strategic plan for ASPA, which I discussed two issues ago, is a significant start. But the devil’s in the details and implementing that plan presents some real challenges. One of the challenges is that the concept of a “pension professional” is changing. To some degree, we have begun to embrace that change by offering the ASPA 401(k) Sales Summit to the professionals on the marketing, sales and investment sides of the 401(k) world. However, if we are truly to become the premiere educational organization for all retirement plan professionals and achieve the goal of having all retirement plan professionals recognize the value of membership in ASPA, we need to do more than simply put on a conference. Thus, we’re exploring additional educational opportunities that we should be providing to these professionals.

Let me hasten to add an essential ingredient. We must ensure that in the process of growth and change, we don’t lose what got us here in the first place. That means, in part, re-dedicating ourselves to the education and continuing education of actuaries. To that end, I have appointed a third co-chair to the Government Affairs Committee (GAC), George Taylor, MSPA, whose principal charge is to make sure that GAC is adequately staffed with actuaries at all levels. The Education & Examination Committee has embarked on an investigation of additional educational opportunities for those individuals who want to become an actuary. The Conference Committee is looking at ways to provide more focused and advanced actuarial programs for our existing members and those who should become members. The Membership Committee is looking at ways to reach out to actuaries who are not members and explain to them the value of belonging to this organization. These are important steps to ensure that we keep what we’ve got and make it better.

At the same time, each of these committees is also looking at educational, programming and outreach opportunities for the other pension professionals I mentioned earlier, and we have a task force working on issues related to a possible new designation for the sales professionals, as discussed in the March-April 2004 issues of *The ASPA Journal* (page 21).

Will it work? Will we get “there”? Given the commitment and dedication of so many of the volunteer members who provide their time and talent to our various committees, given the focus and hard work of our staff and given an occasional nudge from the President, I believe we will. ▲

Bruce L. Ashton, APM, is a partner with Reish Luftman Reicher & Cohen. His practice focuses on all aspects of employee benefits issues, including representing plans and their sponsors before the IRS and DOL’s EBSA. Bruce currently serves as ASPA’s President. He has served on ASPA’s Board of Directors and as Co–chair of ASPA’s GAC.

It's Your Board of Directors

by Scott D. Miller, FSPA, CPC

AN IMPORTANT RESPONSIBILITY OF ALL CREDENTIALED ASPA MEMBERS IS THE SELECTION AND ELECTION OF THE ORGANIZATION'S BOARD OF DIRECTORS. AN ORGANIZATION LIKE ASPA CANNOT SURVIVE WITHOUT THE INPUT AND DEDICATION OF A GROUP OF INDUSTRY LEADERS WHO CAN ADVANCE ASPA'S CORE VALUES AND MISSION. WHO ARE THOSE APPROPRIATE LEADERS AND WHO WILL REPRESENT YOUR INTERESTS? YOUR HELP IS NEEDED IN NOMINATING ASPA MEMBERS TO THE BOARD.

The ASPA Board of Directors is made up of the current ASPA Officers, the Past Presidents and 18 additional Board members, each with three-year terms. There are six Board terms that expire each year. A Board member cannot serve more than two consecutive three-year terms on the Board. It is the ASPA credentialed members who nominate and elect these Board members.

WHAT CRITERIA ARE CONSIDERED?

Many criteria are considered in choosing potential Board members, including:

- Professional designations
- Historical involvement on ASPA committees
- Prior input into ASPA committees and industry activities
- Leadership abilities
- Commitment to ASPA and the industry
- Time availability for volunteer activities

Care is taken to assure that the Board has a broad make-up so that the needs and concerns of all committees, designated members, types and size of firms, geographic locations, etc. are represented. Since there are a limited number of Board slots available in a given year, it is common for a qualified individual who is nominated not to be elected in a given year. To be reconsidered in a subsequent Board election, that individual must be renominated. In fact, an individual is frequently nominated for a number of years before actually getting elected. Even if never elected, there are many opportunities to serve ASPA through other volunteer efforts.

It is important to know that ASPA recognizes the professional and personal sacrifices of our Board members, and there is an expense reimbursement policy in place for those who serve ASPA as Board members and for those who volunteer in other ways.

WHAT IS THE PROCESS?

ASPA has a specific process that must be followed in selecting your Board of Directors. The beginning and end of this process requires the input and support of our credentialed members.

Two credentialed members are required to nominate a potential Board member. The nominee should be someone who is believed to have a dedication to and interest in ASPA and our industry. This individual must also be a credentialed ASPA member. Nominations must be submitted at least 60 days prior to the annual ASPA Business Meeting, which is held at the ASPA Annual Conference.

Nominees are then contacted to confirm their interest in this position should they be elected and to request information on their background, including their ASPA and industry activities.

Next, the ASPA Screening Committee reviews and discusses all nominations. The Screening Committee consists of the current ASPA President, who chairs the Committee, and four additional Board members. After reviewing and discussing the nominee's qualifications and backgrounds, they provide their input to the Nominating Committee.

The Nominating Committee consists of the six most recent Past Presidents (the Immediate Past President serves as Chair) and the current President. This Committee reviews the findings of the Screening Committee, and conducts an analysis of the nominees. The Nominating Committee then produces the proposed slate of new Board members to be presented to the ASPA membership for election.

The election of the new Board members takes place at the annual ASPA Business Meeting held during the ASPA Annual Conference in Washington, DC.

Now you know the process of electing ASPA Board members and your responsibility in this process. I strongly encourage you to actively participate in this important process. A nomination form is included with this issue of *The ASPA Journal*, is available on the ASPA Web site at: **www.aspa.org/forms/boardnomform.htm**, or can be obtained directly from ASPA at (703) 516-9300. Nominations must be submitted no later than August 25, 2004. ▲

Scott D. Miller, FSPA, CPC, is a principal and consulting actuary with Actuarial Consulting Group, Inc. (ACG). Scott is ASPA's Immediate Past President and a member of ASPA's Executive Committee. He is also an Enrolled Actuary, a member of the American Academy of Actuaries and a Fellow of the Conference of Consulting Actuaries.

Philadelphia Offers More than Cheese Steaks and Soft Pretzels

by David M. Burns, MSPA, CPC, QPA

THERE'S NO DOUBT THAT THE BEST CHEESE STEAKS AND SOFT PRETZELS ARE FOUND IN PHILADELPHIA. HOWEVER, LOCAL PENSION PROFESSIONALS CAN ALSO FIND PLENTY OF FOOD FOR THOUGHT (NOT TO MENTION CONTINUING PROFESSIONAL EDUCATION CREDITS) BY ATTENDING THE NUMEROUS EDUCATIONAL SEMINARS HOSTED BY THE ASPA BENEFITS COUNCIL (ABC) OF THE DELAWARE VALLEY.

OUR LOCAL ASPA BENEFITS COUNCIL

Our ABC was formed in 1997 and has flourished due to the dedication of a number of Philadelphia-area pension professionals. The current leadership team consists of our president, Jo-Ann Massanova, CPC; immediate past president, Joe Leube, FSPA, CPC; vice president, John Van Buren, MSPA; treasurer, R. Dennis Vogt; secretary, David Burns, MSPA, CPC, QPA; ASPA GAC liaison, Robert Bildersee; ASPA liaison, Stephen H. Rosen, MSPA, CPC; and board members Arthur Bachman, W. Michael Gradisek, Marcia Hoover, QPA, Kenneth Marblestone, Marlynn Orlando and Sandy Uzadavinis.

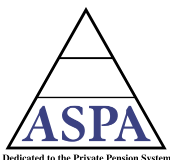
RECENT PROGRAMS

The past 12 months have been full of activity for our members. Last May, our ABC teamed up with ASPA and the IRS to help facilitate the Mid-Atlantic Benefits Conference in Philadelphia, PA. This two-day conference presented top government speakers and pension professionals covering a wide range of current regulatory, legislative, administrative and actuarial topics.

In June 2003, Alex M. Brucker, APM, joined us for an interesting and informative session covering "Recent Court Cases and Legal Considerations Affecting Administrators." Alex's focus on the constantly changing interpretation by the courts of the ever-evolving pension law was very well received.

After a summer break, our program kicked off its fall series in September with "The Stealth 401(k) Regs: Is Your Plan Still O(k)?" presented by attorney Robert Bildersee. An in-depth review of the new proposed 401(k) and 401(m) regulations as well as the final cross-testing regulations was offered in this session.

In October, S. Derrin Watson, APM, delivered an entertaining and instructive presentation covering Controlled Groups and Affiliated Service Groups. This lively presentation even featured a song by the speaker!



Covering a topic on everyone's minds these days, Brian Dougherty, a partner at the law firm of Morgan Lewis in Philadelphia, delivered a thought-provoking session on November 13, 2003, on fiduciary issues and litigation in the post-Enron era.

The first program of the New Year featured a very insightful session entitled "Plan Audits: IRS and DOL Perspectives." This panel discussion, presented in February, included George Brim, Mid Atlantic Area Coordinator for the IRS, and Jean Machiz, Deputy Regional Director for the Philadelphia Region, DOL, along with attorney Elliot D. Raff, APM, of Flaster/Greenberg, PC.

On March 29, 2004, we were very excited to welcome Joan A. Gucciardi, MSPA, CPC, for an extended breakfast meeting during which she delivered an excellent presentation on DB/DC Combination Plans.

PROMOTING ASPA AND PENSION CAREERS

In order to help promote careers in the retirement plan industry, the ABC of the Delaware Valley has a long-standing practice of awarding scholarships to deserving students pursuing a course of study in actuarial science at Temple University's Fox School of Business and Management. We are proud to continue this tradition and will be awarding two $500 scholarships again this year.

NOT A MEMBER YET?

For information about the ABC of the Delaware Valley, including membership and upcoming events, contact Maureen Waddington at (215) 393-3144 or via e-mail at **Maureen.Waddington@comcast.net**. ▲

David M. Burns, MSPA, CPC, QPA, is an enrolled actuary and a senior consultant at The Vanguard Group in Valley Forge, PA, with over 28 years of experience in the design and administration of qualified retirement plans. Dave currently serves as a board member and secretary of the ABC of the Delaware Valley.

ASPA Benefits Council of Cleveland

by Edward Paul Bock, II, QKA

THE CLEVELAND AREA ASPA BENEFITS COUNCIL (ABC) CONTINUES TO ROLL ALONG AND ENJOY THE SUCCESS THAT COMES WITH AGE. NOW IN OUR SEVENTH YEAR, OUR MEMBERSHIP REMAINS SOLID AS WE CONTINUE TO GROW. WE HAVE WELCOMED MANY NEW MEMBERS, IN ADDITION TO PARTNERING WITH THE EMPLOYEE BENEFITS COUNCIL OF NORTHEAST OHIO, TO EXPAND OUR EDUCATIONAL AND NETWORKING OPPORTUNITIES.

Our annual summer workshop held in August 2003 was a huge success. The goal of our annual workshop is to provide a wide variety of related retirement topics to attendees with various levels of experience and background. The all-day event included eight breakout sessions with an introduction by our keynote speaker, Bruce J. Temkin, who we were very fortunate to have with us. Bruce provided comment and insight on how the Internet and longer life spans will transform retirement planning. Bruce was also kind enough to serve on a panel during the breakout session on "Cash Balance Plans, Design Issues and Traps" with Mary Giganti, Esq., and Ken Kranyak.

Other sessions included Robyn Morris, who covered welfare and fringe benefits, and Cynthia D. Wargo, QPA, QKA, who discussed ADP/ACP basics. Dale Vlasek, Esq., reviewed gateway rules. Gary Zwick provided valuable insight on the relationship between retirement and estate planning. William Venter unveiled the burgeoning topic of fiduciary responsibility. The day concluded with Michael A. Spielman addressing controlled groups and Michael A. Viola, CPC, QPA, who we were fortunate enough to have with us from the ABC of Western Pennsylvania, tackling compensation issues.

Our current year began in October and will run through June as we continue to hold well received luncheon meetings. We utilize the formal feedback we receive from our attendees throughout the year in order to develop and plan the topics that we cover both during the year as well as for our summer workshop. To date, our programs have included Patricia Shlonsky, presenting "Truth Is Stranger than Fiction," Susan E. Austin, discussing "The Return of the 412(i) Defined Benefit Plan," and Philip Moshier, covering estate planning.

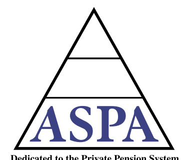
We were privileged to have Brian H. Graff, Esq., ASPA Executive Director, speak at our April 21 meeting. Brian provided his valuable and entertaining insight and commentary on what is transpiring in Washington, DC, and the potential effects on our profession.

Finally, our year will end in June as we cover small plan audits. During the year, our sessions offer continuing education credits for insurance and accounting professionals, in addition to ASPA CE credits.

Last, but certainly not least, we want to give a sincere "thank you" to our outgoing president, Donna Brewster, QPA, whose term expired in April. Donna's dedication and enthusiasm have been instrumental in keeping our chapter strong, providing ongoing educational and networking opportunities and in furthering the goals of ASPA. We welcome our incoming president, Mr. McKim (Kim) Wertz.

For more information on the ABC of Cleveland, please contact us at **aspacleveland@aol.com**. ▲

Edward Paul Bock, II, QKA, is a relationship manager for Manulife USA who provides ongoing support and services for financial advisors and third party administrators working with the Manulife product. Paul has been involved in all aspects of defined contribution plan administration for more than ten years, has been a member of ASPA since 1998 and is currently a board member of the ABC of Cleveland, serving as secretary.



WELCOME NEW MEMBERS!

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Anneli E. Schalock
Russell D. Spinner
Nachman Yaakov Ziskind

MSPA

Adam S. Chan
Hung-Hsun Jonathan Cheng
James W. Jacobson
John S. Mincin
Edward Repper
Brian D. Zange

CPC

Randall J. Crouch
Kelley S. Edwards
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Nathan A. Hahn
Anita W. Haynes
Margaret M. Heffernan
Brian S. Hermann
Guy J Hocker III
Mychelle L. Holloway
Aaron J. Juckett
Diane E. Kelley
Peter A. Kneedler
Gina P. Lawrence
Frank W. Lodato
Mary T. Miller
Joost J. Revis
Eve P. Savastano
Beena Y. Shevade
John A. Stoffel
Ann L. Woloszynski

QPA

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Travis A. Bickford
Karen Botvin
Randall J. Broscious
DeVan C. Brown
Mary Alice Brown
Shannon L. Childress
Pamela Ka Ming Chu
Joyce E. Coon
Rhonda L. Corbitt
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Jean H. Crook
Christine M. Danko
Jeffrey R. Darnowski
Beverly L. Davis
Alice Frazier
Chrysanthi M. Golden
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Stacey D. Hall
Todd A. Henry
Sheryll J. Hirschi
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Kevin E. Mahoney
Robert E. Metcalfe
Andrew J. Molzahn
Michael R. Nelsen
Jeff S. Nichols
Steve R. Perkins
Carrie L. Petersen
Gustavo A. Pitta
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Tracy W. Stephens
John J. Sullivan Jr.
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Jeff D. Williams
Linda M. Wyttenbach

QKA

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Karen Ambroz-Thompson
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Stephanie L. Bean
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Anatoly Prehar
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Roberta B Romano
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Mary Anne Steinmetz
Timothy M. Stephan
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Pamela L. Stitt
Wesley T. Stohler
Brian D. Stokes
Marilee Talbot
Heidi Nicholl Taylor
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Sharon G. Temple
Roger E. Tucker
Devon D. Venti
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APM

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FUN-da-MENTALs

Side Fun

"____"

CONTEST

Study the cartoon on the left, and e-mail us with your best ideas for a caption.

Extra points for those captions that are somehow related to the retirement planning industry! The winners' names and submissions will be published in a later issue of *The ASPA Journal*. The first place winner will receive various ASPA souveniers.

Please e-mail your submissions to **tcornett@aspa.org**. All submissions must be received by July 31, 2004.

Word Scramble

Unscramble these four puzzles—one letter to each space—to reveal four pension-related words. Answers will be posted on ASPA's Web site at **https://router.aspa.org**. Once you have logged in, place your cursor over the Membership tab in the navigation dropdown menu. Move to Membership Benefits, then select *The ASPA Journal*. The answers are located near the bottom of the page.

BONUS: Arrange the circled letters to form the Mystery Answer as suggested by the cartoon.

K COST	_ _ ❍ _ ❍
RECEDE AS	_ ❍ _ _ ❍ _ _ ❍
MC PLOY	_ _ ❍ ❍ ❍ ❍
YEAR RUST	_ _ ❍ _ _ _ _ ❍

Mystery Answer

A "_ _ _   _ _ _ _ _ _ _ _ _."

What the locksmith wanted to hire.

Calendar of Events

2004		ASPA CE
Jun 30	Early Registration Deadline for Summer Examinations	
Jul 18–21	Summer Conference San Francisco, CA	20
Jul 31	Final Registration Deadline for Summer Examinations	
Aug 1–31	DC-1, DC-2, DC-3 and DB Summer Examination Window	
Aug 15	Postponement Deadline for Summer Examinations	
Aug 18	What Does It All Mean? Late-Day Trading Webcast	2
Sep 13–14	Central and Mountain States Benefits Conference Denver, CO	15
Sep 22	New Distribution Rules for Defined Benefit Plans Webcast	2
Sep 30	Early Registration Deadline for Fall Examinations	
Oct 24–27	Annual Conference Washington, DC	20
Oct 31	Final Registration Deadline for Fall Examinations	
Nov 1–Dec 15	DC-1, DC-2, DC-3 and DB Fall Examination Window	
Nov 12	C-3, C-4 and A-4 Postponement Deadline for Fall Examinations	
Nov 17	C-3 and A-4 Examinations	

2004 ASPA Summer Conference

Plan now to attend an educational opportunity that pension professionals can't afford to miss! Mark your calendar for **ASPA's Summer Conference, July 18–21, 2004, in San Francisco, CA, at The Palace Hotel**.

ASPA's sixth Summer Conference offers five concurrent workshops designed with all retirement plan professionals in mind. Private sector experts and government officials will share their knowledge and skills, as well as solicit your input on a variety of issues. You will have the opportunity to learn from the best in the business and to share your experience with your peers on topics of interest to you. Find out about the latest developments in our industry and stay ahead of the curve!

Early registration, received by June 26, 2004, is $790 for ASPA members and $970 for non-members. Room rates at The Palace Hotel are $215, single or double.

Watch your mail this spring for the conference brochure, or check out the ASPA Web site for all the latest information and updates.

For more information, contact ASPA's Meetings department at (703) 516-9300, by e-mail to **meetings@aspa.org** or visit our Web site at www.aspa.org.