

Group Life Insurance - Our Updated Survey

How much life insurance coverage should an individual have? According to Limra, the life insurance and market research association, the average person has insurance coverage equal to 3.6 times his/her income; less than the amount they believe they should maintain of 5 to 6 times income. Of course, there is no magic number that is right for everyone - family situation, age, health, employment status, other assets and liabilities are just some of the factors likely to influence how much insurance an individual should consider maintaining. Since September is "Life Insurance Awareness Month" (according to Limra), we thought this would be an appropriate time to review the design of employer-sponsored survivor benefits.

Group life insurance remains one of the most common welfare benefits offered by employers. While most employees believe that employer sponsored health insurance and the company's 401(k) plan are more important, life insurance is next in the order of importance, according to a study recently published by Transamerica. A significant advantage of group life insurance is the ability of a worker to obtain life insurance coverage without underwriting or proving good health. In addition, most employers provide or pay for a minimum amount of coverage for their full-time employees, and typically also offer additional coverage that can be purchased at group rates and paid through convenient payroll deduction. But, because coverage under group plans typically is a multiple of salary and disregards other elements of compensation, corporate-sponsored group life insurance may not provide sufficient coverage for higher-paid executives.

We recently updated our informal survey of the group life insurance and other survivor benefit coverage at 300 companies where Ayco provides financial planning services. A significant number of companies now provide group universal life coverage to their employees in addition to, or as a replacement for, the more traditional group term coverage. We also reviewed those companies which still provide a survivor income benefit, company-paid death benefit, or executive-only insurance. The following types of survivor coverage are now being offered by our survey group compared to what was offered 10 years ago (in our informal survey then of 150 companies):

| <u>Type of Coverage</u> | <u>Percent of Companies (Today)</u> | <u>Percent of Companies (10 Yrs Ago)</u> |
|--------------------------------|-------------------------------------|--|
| Group Term Life Insurance | 95% | 94% |
| Group Universal Life Insurance | 35% | 33% |
| Executive Life Insurance | 21% | 34% |
| Company-Paid Death Benefit | 5% | 10% |
| Survivor Income Benefit | 3% | 9% |

➤ **Group Term Life**

Almost all of the companies in our survey group offer group term life insurance to their employees. Those that do not have replaced or carved out coverage utilizing universal or variable life insurance. Of those companies with group term coverage, 95% provide and pay for some amount of basic non-contributory coverage. Nearly one-half of our survey group place a dollar limit on the amount of basic term coverage. We counted 71 companies that limit or permit an employee to elect basic non-contributory coverage of \$50,000 in order to avoid imputed income under IRC §79. Up to \$50,000 of non-discriminatory term life insurance can be provided tax free to employees (often totally unappreciated by employees who receive it). At nearly one-third of the companies surveyed, group term life insurance is part of a cafeteria plan.

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Basic Term Coverage - Of those companies with basic non-contributory term coverage, the amount of coverage provided to active employees, as a multiple of salary, is as follows (we found only three companies that determined coverage amounts by salary plus annual bonus):

| <u>Amount of Basic Term Life Insurance</u> | <u>% of Companies</u> |
|--|-----------------------|
| .5X Salary | 1% |
| 1X Salary | 40% |
| 1.5X Salary | 9% |
| 2X Salary | 31% |
| 2.5X - 3X Salary | 5% |
| \$50,000 | 9% |
| Other Specified Dollar Amount | <u>5%</u> |
| | 100% |

Supplemental Term Coverage - Nearly 85% of the surveyed group offer supplemental term life coverage in addition to providing basic coverage. This coverage is elective, generally not subsidized by the employer, and fully paid for by an employee with after-tax dollars. An employer can elect to treat supplemental group term life which is paid for entirely by employees as not "carried" by the employer for purposes of the imputed income rules for term life insurance. Thus, employees should have no imputed income for supplemental coverage.

For those employers that offer elective supplemental term coverage, the maximum coverage amounts are as follows:

| <u>Maximum Amount of Supplemental Coverage</u> | <u>% of Companies</u> |
|--|-----------------------|
| 1-1.5X Salary | 3% |
| 2-2.5X Salary | 3% |
| 3-3.5X Salary | 15% |
| 4X Salary | 19% |
| 5X Salary | 27% |
| 6X Salary | 13% |
| 7-10X Salary | 10% |
| Specified Dollar Amount | <u>10%</u> |
| | 100% |

At approximately two-thirds of the companies, there is a dollar limit on the amount of coverage that can be elected. This is typically between \$1 million to \$2.5 million, considering both basic and supplemental life coverage.

➤ **Retiree Life Insurance**

While most companies continue to provide a level of basic term life insurance coverage to eligible retirees, there is no requirement that such coverage be offered or made available. In fact, within the past year, we have seen several companies reduce or eliminate altogether term life insurance coverage for retirees. An advantage of group universal life insurance to retirees and employees who terminate before retirement eligibility is its portability.

➤ **Group Universal Life Insurance (GUL)**

This type of insurance program often is offered in addition to group term life coverage. At a small number of companies, it has actually replaced basic and supplemental term coverage. Typically, an employee may elect to insure spouse and children, if the employee elects to be covered. Premiums are almost always paid entirely by the employee with after-tax dollars. At an increasing number of companies, variable life insurance (with equity investment vehicles) may be available. The maximum amount of coverage available under these programs, subject to a dollar maximum at many companies, is as follows:

Group Life Insurance *cont'd...*

| Maximum Amount of GUL Coverage | % of Companies |
|---|-----------------------|
| 2X Salary | 6% |
| 3-3.5X Salary | 8% |
| 4X Salary | 8% |
| 5X Salary | 44% |
| 6X-7X Salary | 15% |
| 8X Salary | 9% |
| 9-10X Salary | 5% |
| Specified Dollar Amount | 5% |
| | 100% |

From an employer's perspective, an advantage of a GUL program is that administration is outsourced. The employer may only have to deduct policy premiums and transmit them to the insurer. A significant advantage for employees is that this insurance coverage is portable, so that an employee may elect to continue coverage following termination of employment for any reason.

➤ **Split-Dollar Life Insurance**

Prior to the enactment of the Sarbanes-Oxley Act (SOX) of 2002, just one-third of our survey group offered split-dollar life insurance to select key executives. But, a company's payment of premiums under a collateral assignment contract would be treated as an impermissible loan under SOX for executives; as a result, virtually all public companies have modified or eliminated such programs.

Companies have taken a variety of actions with respect to old split-dollar arrangements. Perhaps the most common approach is the "bonus" arrangement. Under this approach, existing life contracts are retained with the executive paying the entire premium. To put the executive in a similar cash flow position, the company provides a special bonus which is taxable to the executive.

➤ **Survivor Income Benefit**

These are programs intended to provide a surviving spouse or dependent children with an ongoing stream of income for a stated period of time following the death of an employee. Typically, the periodic payment is a percentage of the employee's final salary. Payments may continue until the spouse's remarriage, reaching a stated age (e.g., 65) or for a stated number of years. It can be argued that these programs are representative of a past paternalistic era of employer-employee relations. But, because they are ERISA benefits, it can be difficult for employers to eliminate them.

➤ **Company-Paid Death Benefit**

We continue to see a relatively small number of companies maintain a company-paid death benefit. This is not an insured benefit; hence the proceeds are income taxable to the beneficiary and deductible by the company. Almost always, these programs only provide benefits upon the death of an active employee - not to retirees. An advantage of these programs is that there is no imputed income during the lifetime of the employee.

➤ **Pension Plan Death Benefit**

More than a generation ago, when defined benefit pension plans were the primary, and sometimes only, retirement plan offered to employees, a handful of pension plans provided a lump sum death in addition to any spousal or joint and survivor benefits. Typically, the amount of this special death benefit was one-times pay. (AT&T is one company that offered it, and after its 1984 divestiture, this feature was part of the pension plans of the regional Bell operating companies). These pension death benefits, which are not funded by insurance, are now rare in either qualified or nonqualified plans. ERISA's anti-cutback rule generally prevents qualified

Group Life Insurance *cont'd...*

pension plans from reducing or eliminating certain accrued vested benefits earned by plan participants. This is the reason that a company cannot unilaterally eliminate a lump sum payment option from a pension plan for benefits already earned.

Recently, a federal appeals court was asked to determine whether a company's attempt to eliminate a pension plan lump sum death benefit violated ERISA's anti-cutback rule (*Kerber vs. Qwest Pension Plan*). In 2000, Qwest Communications acquired and merged with U.S. West (a regional Bell company created by the 1984 divestiture). In 2003, Qwest eliminated the pension death benefit for employees retiring after 2003. Several retired employees sued claiming that the right to the death benefit had become vested and that such action was improper under ERISA rules. A federal court found in favor of the company and that decision has now been upheld by the 10th Circuit Court of Appeals. The court ruled that the pension plan death benefit was not an accrued benefit or retirement-type subsidy protected from elimination by ERISA rules. As a result, the action taken by the company was permissible. Thus, we expect this benefit to slowly disappear.

More Time To File Foreign Financial Account Disclosures

Any U.S. person with a financial interest in, or signature authority over, a foreign financial account is required to file Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts (commonly referred to as "FBAR"), if the aggregate value exceeds \$10,000 at any time during the calendar year. The filing deadline for the FBAR form is June 30 of the following year and is to be filed with the Detroit Service Center. These filing requirements are not new - they have been in effect since the 1970's. However, in 2008, the IRS revised FBAR filing instructions and there has been a great deal of confusion and uncertainty since then as to exactly what types of interests constitute financial accounts which require filing a FBAR form. This past June, the IRS extended the filing deadline to September 23, 2009 for 2008 and all prior year filings for taxpayers who have reported and paid tax on all 2008 income, including foreign bank account income. Last month, the IRS issued Notice 2009-62 which further extends the filing deadline until June 30, 2010, but only for persons that have only signature authority over foreign financial accounts or have beneficial ownership over "foreign commingled funds" (such as offshore hedge funds). The new extension does not apply to a U.S. individual or entity that directly holds an offshore bank account. Thus, anyone with a foreign bank account should file a FBAR form by September 23, 2009.

A financial account requiring a FBAR filing may include certain benefit and compensation related accounts; for example, a benefit plan that has invested in an offshore hedge fund, offshore mutual fund, or offshore variable life insurance. In addition, where U.S.-based employees receive equity compensation awards under a plan of a multinational company, a FBAR filing requirement may be triggered if the administration of the plan results in an employee having an interest in a foreign financial account. This could be the case when stock options or SARs in a company with stock registered on a foreign stock exchange need to be exercised, or upon the vesting and distribution of restricted stock or restricted stock units. It also isn't clear whether foreign pension accounts should be reported or if reporting is required for a U.S. pension or employee benefit trust that hold foreign assets as investments.

Penalties for a non-willful failure to file the FBAR form can be up to \$10,000, while the penalties for a willful failure to file can be as high as \$100,000 or 50% of the total value in a foreign account, plus criminal penalties. The IRS website indicates that it will not seek to impose penalties for failure to file a FBAR form if it is timely filed by the new 2008 filing deadline and as long as taxes have been properly paid on foreign bank accounts. As part of its crackdown on U.S. tax-evaders with Swiss bank accounts, the Justice Department last month agreed to accept a guilty plea for failure to file a FBAR report by a UBS client. He faces a maximum penalty of five years in prison and fines totaling \$250,000 when sentenced, according to published reports.

Ayco financial counselors have been helping our individual clients identify whether they have an FBAR filing requirement. This is an example of how corporate-sponsored financial counseling can help executives meet compliance requirements, as well as helping to minimize risk - both to the individuals with filing requirements and to employers who face a reputational risk.

New Rules Regarding Breach Of Personal Health Information

As part of the American Recovery and Reinvestment Act (ARRA) of 2009, health plans and health care providers, such as doctors and hospitals, must notify individuals if their personal health information is "breached." These new disclosure rules were created by the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was incorporated into the ARRA. The Department of Health & Human Services (HHS) recently issued interim final regulations which will help covered entities and employers determine whether a breach has occurred, exactly what notification has to be made and to whom. These new rules are effective for breaches occurring on or after September 23, 2009 - although, HHS indicates that it will not impose penalties for breaches discovered before February 22, 2010, to allow time to develop compliance systems.

The new notification rules apply only in the event of a security breach of "unsecured" personal health information (PHI). This is information that has not been encrypted or destroyed under an approved method. A "breach" occurs when unsecure PHI is disclosed in an unauthorized manner and the disclosure poses a "significant risk of financial, reputational or other harm to the individual." There are certain exceptions, including for the unintentional access by a covered entity's own employees (i.e., in a billing situation), or when the recipient would not reasonably have been able to retain the information (i.e., an explanation of benefits is sent to the wrong person and the envelope is returned unopened; if it was opened, it likely would constitute a disclosable breach).

If there is a breach, notification must be made to the individual affected without unreasonable delay, but not later than 60 days after discovery of the breach. The preamble to the regulations indicates that if an insurer or plan has the necessary information to provide this notice within ten days of the discovery of a breach, but fails to notify the person until 60 days after the discovery, the plan would be in violation of the intent to provide notice without unreasonable delay. The notice must be written in plain language and include the date of the breach, a brief description of the breach, what the plan or provider is doing to mitigate damages and protect against future breaches, and steps that the individual should take to protect him or herself.

In addition to notifying individuals affected, notice must be given to prominent media outlets if the breach affects more than 500 residents of a state, city or town. Employer-sponsored health plans also must notify HHS of the breach. The manner and content of the notice are expected to be specified on the HHS website. In the event that a third party administrator, claims administrator, pharmacy benefit manager or other business associate has knowledge of a breach, it must notify the plan itself.

These new rules are in addition to, and do not replace, existing state rules that require notice of security breaches. In light of these new rules, all employers should review their existing procedures dealing with the release of personal health information. A sample notice should be prepared, just in case, and security breach notification rules should be incorporated into the policies and procedures of a covered entity. While employers with insured plans may believe that the insurer will adopt procedures to meet the notice requirements, steps should still be taken to confirm compliance. Furthermore, the HITECH Act also subjects vendors of web-based personal health record systems to similar breach notice rules under new Federal Trade Commission regulations.

ERISA §404(c) Shields Trustee From Fiduciary Liability

Under ERISA §404(c), plan trustees and other plan fiduciaries are relieved of potential liability for the investment losses realized by 401(k) plan participants who can exercise control over their plan investments, if certain other requirements laid out in 1992 Dept. of Labor regulations are met. The protection that ERISA §404(c) provides to 401(k) plan fiduciaries is illustrated by a recent Ohio federal court decision (*Tullis vs. UMB Bank NA*). Tullis and Mack were doctors employed by The Toledo Clinic. The clinic maintained a 401(k) plan with UMB Bank as the plan's trustee. The plan allowed for individually directed investment accounts. Tullis and Mack hired William Davis of Continental Capital Corp. as an investment advisor to help them make investment decisions. In 1999, after an investigation concerning allegations of fraudulent

ERISA cont'd...

activities, the SEC issued a temporary restraining order against Continental Capital. In 2001, UMB, the plan trustee, filed a lawsuit against Davis and Continental Capital alleging that several investments made by Davis were improper or never took place. The trustee apparently did not disclose to plan participants - including Tullis and Mack - this action. In 2003, Continental Capital filed for bankruptcy and at that point, Tullis and Mack learned the full extent of the losses in their plan accounts - Tullis claimed he lost over \$500,000 and Mack believed he had lost over \$1 million.

They initially filed a lawsuit against Davis and Continental Capital, but that lawsuit was held in abeyance because of the bankruptcy filing. After the 401(k) plan refused to sue the plan trustee, UMB, for a breach of fiduciary obligations (due to an indemnification clause in an agreement between the parties), Tullis and Mack sued UMB, the plan trustee, to recover the value of plan assets they claimed they had lost. They argued that the trustee breached its fiduciary obligation by not disclosing to them information about the fraudulent activities of their investment advisor, Davis. In 2006, the lower federal court dismissed the lawsuit because the plaintiffs did not seek relief on behalf of the plan as a whole. However, on appeal, this decision was reversed and the case was sent back to the federal district court to determine whether Tullis and Mack had a cause of action against the plan trustee.

Last month, an Ohio federal district court ruled in favor of UMB, finding that the plan trustee was shielded from liability by ERISA §404(c). If a 401(k) plan meets stated requirements, plan fiduciaries are relieved of liability from losses caused by the participant's independent exercise of control over their investments. In this case, the court found that Tullis and Mack had entered into agreements with Davis and Continental Capital giving their investment advisor the right to make investment decisions on their behalf. The plan did meet the requirements of ERISA §404(c), including that the plan offer a broad range of investment alternatives and provide proper notice to participants. As a result, §404(c) shielded UMB from liability. While the investment advisor, Davis, may have engaged in fraudulent and prohibited transactions, the court determined that the trustee, UMB, did not cause these to occur. Even if the plan trustee had knowledge of certain nonpublic information, it had no affirmative duty to disclose this information to plan participants, unless they requested this information. As a result, the plan trustees were protected by the cloak of ERISA §404(c) and cannot be sued for the investment losses incurred by the plan participants.

Virtually all large and small companies with 401(k) plans will want to confirm periodically that they comply with ERISA requirements to maintain §404(c) protection. This helps ensure that the plan fiduciaries will be protected from liability due to the investment decisions made by plan participants, especially with regard to self-directed investment accounts. What §404(c) does not cover is the failure of a plan fiduciary to monitor a plan's investment choices. Recently, a federal judge approved a \$55 million settlement between Countrywide Financial Corp. and former employees who sued the company for retaining company stock in the firm's 401(k) plan. But, a N.Y. federal court dismissed a lawsuit filed by current and former employees alleging a breach of fiduciary duty by Citigroup for maintaining company stock in its 401(k) plan.

Does Liability Insurance Cover Stock Option Payment Claim?

Most employers maintain fiduciary liability insurance intended to indemnify the company for payments required due to violations of fiduciary obligations, particularly for ERISA plans. An issue in recent litigation in New Jersey was whether this type of insurance would cover claims by executives and directors that they did not receive appropriate payment for their stock options following a merger (*AT&T Corp. vs. Certain Underwriters At Lloyds of London*).

In 1999, MediaOne Group was acquired by AT&T Corp. As part of the merger agreement, AT&T agreed to pay the officers and directors of MediaOne the full economic value of their stock options upon the merger of AT&T Wireless Services and Cingular Wireless. When that merger occurred, the MediaOne executives did receive payment for their stock options; however, they claimed that the payments represented less than true economic value because it did not include the time value associated with the unexercised options. When the company refused to increase the payment, they sued in a Delaware court (where the company was incorporated) and

**Liability
Insurance** *cont'...*

ultimately won a judgment for just over \$11 million in 2008. Thereafter, AT&T Corp. filed a claim with its insurance underwriters, including Lloyds of London, seeking reimbursement for the payments it would be making to the successful plaintiffs. When the insurers refused to pay, the company sued them in a New Jersey state court. Last month, the New Jersey Superior Court ruled that the insurers were not required to indemnify the company for the payments relating to the stock options.

The court agreed with the insurers that the stock option plan was not an ERISA plan - the insurance in question covered fiduciary breaches with respect to ERISA plans. However, there was an additional endorsement to the insurance contract which also covered any negligent act, error or omission in the administration of the plan. The court rejected the company's argument that Delaware lawsuit dealt with the administration of the stock option plan. To begin, the company did not administer the stock option plan. In addition, the stock option lawsuit was a claim for a breach of a contractual obligation rather than a claim relating to the administration of the plan. As a result, the court agreed with the insurers that they had no obligation to reimburse the company for the award determined by the Delaware Supreme Court.

**Late Payment
Dooms COBRA
Coverage**

With certain limited exceptions, a group health plan participant who loses coverage following a qualifying event may elect to continue coverage for a defined period of time by making a continuation election under COBRA. A valid COBRA election must be made timely. The election period begins not later than the date on which coverage under the plan terminates on account of a qualifying event, and ends not earlier than 60 days later (unless proper notice is not given concerning COBRA election rights, in which case the election period is up to 60 days after notice is provided). The COBRA election notice generally should be sent to the individual's last known address, based on the most recent information available to the plan. In a 2008 Kansas federal court case, the court ruled that a COBRA notice was adequate when the form was sent to an incorrectly spelled address provided by the former employee (*Austin vs. Jostens*). This year, an Illinois federal court ruled that a COBRA notice was adequate despite not being received, when the former employee conceded he did not regularly check his mail and was not living at the mailing address of record.

COBRA coverage also is based on the former employee making a timely payment of the COBRA premium. IRS regulations provide that a COBRA payment is timely if submitted within 30 days after the first day of the period of coverage or any longer period provided under the terms of the plan. The results of failing to meet this premium payment are illustrated by a recent federal appeals court case - *Harris vs. United Automobile Insurance Group Inc. (UAIG)*.

J.B. Harris was employed as in-house counsel by UAIG and participated in the firm's self-funded health insurance plan. After his employment was terminated in May 2007, he elected COBRA coverage. The plan provided that COBRA payments were due on the first day of each month, but those who had elected COBRA were given a grace period of 30 days to make each monthly payment. The plan also provided that COBRA coverage would be terminated without the possibility of reinstatement if a participant failed to make a payment before the end of the grace period. To be considered timely, the payment had to be postmarked on or before the end of the grace period and subsequently received by the COBRA administrator. When Harris failed to pay his January 2008 payment by the February 11 grace period deadline, his COBRA coverage was cancelled. He sued in federal court in Florida to reinstate coverage. He claimed that his wife placed a check as payment in a mailbox on February 11, the last day of the grace period. However, it was not postmarked until the following day. He also argued that because the company had set no time limit to pay the premium, he had more than 30 days to make the payment. The court found that the IRS regulation on allowing longer than 30 days to make a payment, applied only to insured medical plans. Since UAIG had a self-funded plan, the regulation did not apply. As a result, when Harris failed to make the payment within the 30-day deadline of the COBRA rules, the company was within its right to cancel his coverage. The company had complied with required COBRA notice rules.

COBRA *cont'd...*

This is an important illustration of the care individuals must take in meeting all timing rules to elect and maintain COBRA coverage. According to Spencer's Benefit Reports, only one in ten former employees eligible for continued coverage actually elected COBRA last year, with the average COBRA premium being \$10,988.

Did You Know...

The cost of family medical coverage in the United States increased 119% from 1999 to 2008, according to a recently released Commonwealth Fund study. The states with the highest family premium increase were Indiana and North Carolina.


If medical insurance premiums for employer-sponsored coverage continue to increase as predicted by health economists, the average premium for family coverage will increase from \$12,298 in 2008 to \$23,842 by 2020.

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