Our Employer-Sponsored Long-Term Disability Survey Update

May is Disability Awareness Month, so we thought this would be an appropriate time to provide updated information regarding group long-term disability (LTD) coverage. While employer-sponsored coverage is available at almost all large and mid-sized companies, with a majority of companies having auto-enrollment for some level of coverage, the average employee spends little time in understanding the need for this coverage or appreciating their risks of becoming disabled.

Disability is much more common than most believe – and it’s becoming more frequent. The Council for Disability Awareness estimates that workers have a 30% chance of being disabled for at least 3 months during their working career with 1 in 8 workers being out on disability for 5 or more years. The average group disability claim is 34.6 months. In most cases, disability is due to illness or chronic conditions. The Social Security Administration estimates that 25% of today’s 20-year olds will become disabled to some degree before reaching age 67. Yet, it is often easier to convince an employee to acquire life insurance than an appropriate amount of disability coverage, despite the fact that an individual’s chances of becoming disabled are significantly greater than dying while employed. For many, any disability lasting longer than six months could result in severe financial hardship. So, explaining the value of LTD coverage can be part of a company’s financial wellness initiative.

We recently updated our informal survey of the group LTD coverage offered to employees at 400 companies where Ayco provides financial counseling or financial education services. Virtually all these companies offer sick leave and short-term disability benefits prior to when LTD benefits begin - typically, 180 days after the employee becomes disabled. This survey focuses on the level of group LTD coverage offered and who pays for it.

We have illustrated below the highest replacement percentage for disability coverage offered - without regard to the number of coverage choices:
Amount of Disability Benefit

Group long-term disability plans are structured to replace a stated percentage of an employee's "pay" for a defined period of time – often until age 65, or up to five years if the disability occurs after age 60. A plan will define eligible pay. For basic coverage, it typically is a percentage of the employee's base salary. However, approximately 7% of our survey group included target or actual bonus in the definition of eligible pay, often capped by the §401(a)(17) compensation limit ($270,000 for 2017). Amounts payable under basic disability coverage typically are reduced by disability-related benefits payable from other sources, including Social Security and Workers' Compensation. Five states (CA, HI, NJ, NY, RI) have state-mandated disability insurance.

Replacement Ratio - Nearly 40% of our survey group offer employees a choice in the amount of coverage. Here are some other datapoints:

Choice In Level Of Coverage - At just over 60% of the plans in our survey group, there is one level of group disability coverage and employees have no choice as to the level of coverage. At the remaining 40%, employees can select the level of group disability coverage they wish. Sometimes, this election is under a cafeteria or flexible benefit plan. Of the plans that offer coverage choices, there are two choices available at 132 (31%) of the companies in our survey group, three coverage choices available at 33 companies (8%), and four coverage choices available at 5 companies.

A Maximum Monthly Benefit - Nearly 80% of the plans in our survey group limit disability payments to a maximum monthly benefit, with this monthly maximum as follows for those with a payment limit:

Top-Hat Coverage for Executives

A large majority of group long-term disability plans provide inadequate disability benefits for higher paid executives due to one or more of the following:

- Basic group plan does not replace annual bonus and long-term incentive award values;
- Plan has monthly maximum benefit cap or otherwise limits benefit payments;
- Benefits may be taxable when received.

Any or all of these may mean that an executive might want to consider purchasing additional disability protection. Just over one-quarter of the companies in our survey group offer supplemental top-hat coverage to key executives. In most instances, employees who wish to have this additional coverage pay the entire cost through an individual contract. The amount of this voluntary additional protection varies considerably. At a majority of companies with this benefit, the coverage is an additional percentage of "pay", often defined to be salary plus annual bonus. There are often more monthly maximums for this coverage that range from $5,000 per month to $25,000 per month.

Top-hat coverage is a supplement to, and not a replacement for, any group disability benefits. Even if an executive bears the entire cost of this coverage, the ability to have access to such coverage without full underwriting can be valuable to those executives with medical conditions. Furthermore, executives have the option of stopping this coverage as they reach retirement eligibility, but also may be able to continue coverage after termination of employment.

Who Pays The Premium

Who pays the disability insurance premium is important in determining the tax treatment of any disability benefits received. The general rule is that if the company pays the entire cost of coverage; or the employee pays with pre-tax or flex benefit dollars, all disability benefits are taxable. If the employee pays the entire cost with after-tax dollars, then benefits will be received tax-free. Under Treas. Reg. §1.105-1(d)(2), if group policy premiums are split between the employer and employee, the amount of any disability benefits that will be taxable will be based on the ratio of premiums paid by the employer for the last three policy years over the total premiums during that period. This is known as the “three-year look-back” rule.

A cost-of-living or inflation rider has been incorporated into nearly 3% of the plans surveyed. It provides for an increased disability benefit based either on a pre-established annual adjustment or on actual inflation factors. This inflation rider typically is an alternative coverage choice which an employee may elect at an additional cost.

An employer may give employees a choice as to how coverage is paid. In Revenue Ruling 2004-55 and a series of private letter rulings, the IRS has confirmed that a plan can
be designed so that employees may elect to pay the premium on an after-tax basis or have the company pay for coverage. A relatively small number of companies pay the premium and impute the cost into income. The IRS has indicated that this is the equivalent of the employee paying the cost of coverage with after-tax dollars. From an employee’s perspective, the imputed income approach is less costly than paying the entire premium with after-tax dollars – and both result in tax-free benefits. Offering this as an alternative is an underutilized means of enhancing a benefit at a small cost to the company.

Taxable disability benefits become exempt from FICA taxes as of the seventh month after an employee stops working.

In our survey group of 400 companies, the following represents how premiums are paid:

<table>
<thead>
<tr>
<th>Who Pays For Coverage</th>
<th>%</th>
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<tbody>
<tr>
<td>Company Pays All</td>
<td>39%</td>
</tr>
<tr>
<td>Employee Pays After-Tax</td>
<td>17%</td>
</tr>
<tr>
<td>Employee Pays A/T for Buy-Up</td>
<td>23%</td>
</tr>
<tr>
<td>Cost Is Shared</td>
<td>5%</td>
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<tr>
<td>Company Imputes Into Income</td>
<td>3%</td>
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<tr>
<td>0% 5% 10% 15% 20% 25% 30% 35% 40% 45%</td>
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Claims Procedures – New Rules
More individual lawsuits are filed with regard to denied disability claims than any other ERISA-related matter. The Dept. of Labor (DOL) has been reviewing its rules on disability claims procedures for over the past five years. Earlier this year, it issued new final regulations modifying procedures that had been in place since 2002.

The new rules will require disability plans to offer reasonable claims procedures, provide more information to plan participants when denying a claim for benefits (both initially and upon an appeal), and ensure an impartial review process. Those employers which sponsor plans should review their notifications to those filing claims, as well as their entire claims and appeals process in light of these new rules. While these rules are effective immediately, they will apply generally to claims filed beginning next year in 2018. There are a number of interim rules in place for the remainder of the year.

Disability Statistics
Despite LTD being offered or automatically provided at almost all large and mid-sized companies, about 100 million workers have no LTD protection, according to the Social Security Administration (SSA). Those without such coverage can be eligible for Social Security disability benefits for themselves and certain family members if they are “insured”, meaning that the person worked long enough and paid Social Security taxes. The SSA definition of disability is more stringent than that used by group LTD plans. It should be noted that the Social Security Disability Trust Fund is now projected to run out of money in 2023 unless Congress takes action to improve funding.

More than 30 million Americans between the ages of 21 and 65 currently are disabled. Most disabilities are not work-related. The leading causes of new LTD claims, according to the Council for Disability Awareness (CDA), are:

- Musculoskeletal/connective tissue disorders: 28.6%
- Cancer: 15.1%
- Injuries and poisoning: 10.3%
- Cardiovascular/circulatory: 8.7%
- Mental disorders: 8.3%
- Nervous system-related: 7.7%
- Pregnancy system-related: 5.9%
- Other: 15.4%
As far as anyone’s chances of being disabled, here are statistics from the CDA’s disability risk calculator:

- A typical female, age 35, 5’4”, 125 pounds, non-smoker, who works mostly an office job, with some outdoor physical responsibilities, and who leads a healthy lifestyle has the following risks:
  - A 24% chance of becoming disabled for 3 months or longer during her working career; with a 38% chance that the disability would last 5 years or longer.

If this same person used tobacco and weighed 160 pounds, the risk would increase to a 41% chance of becoming disabled for 3 months or longer.

- A typical male, age 35, 5’10”, 170 pounds, non-smoker, who works an office job, with some outdoor physical responsibilities, and who leads a healthy lifestyle has the following risks:
  - A 21% chance of becoming disabled for 3 months or longer during his working career; with a 38% chance that the disability would last 5 years or longer.

If this same person used tobacco and weighed 210 pounds, the risk would increase to a 45% chance of becoming disabled for 3 months or longer.

Conclusion
Employers should periodically assess the adequacy of the coverage offered to employees, as well as who is paying the cost of coverage. In a MassMutual survey of group disability benefits, just one-quarter of companies indicated they are considering making changes to their current group LTD program. Expanded employer wellness initiatives related primarily to helping keep healthcare costs down may also help in reducing disability risks.

Paid Family Leave – Could It Become Mandatory?
The United States is the only developed country in the world that currently doesn’t require employers to provide paid family leave for workers. Nearly 25 years ago, Congress enacted the Family & Medical Leave Act (FMLA) giving eligible employees at public agencies and private employers with 50 or more workers up to 12 weeks of unpaid leave for the care of seriously ill family members or upon the birth of a child. It also provides a limited degree of job protection when an employee returns from such leave. However, only about 60% of American workers are eligible for this since small employers are exempt and part-time workers may not be eligible. There has been growing support for the enactment of a federal law that would mandate paid leave in certain defined situations. In addition, a number of states and cities have enacted paid leave requirements and a growing number of employers have adopted their own paid leave policy.

Paid leave is intended to allow either or both parents time off from work upon the birth or adoption of a child. In addition, it could apply to care for an ailing family member. This would be distinct from paid sick leave - which almost all large and medium size employers currently provide – although, there is no federal law requiring sick leave be offered.

Currently, four states – CA, MN, NJ, and RI – have enacted laws allowing paid family leave. New York recently passed its law to be phased in over a three-year period beginning in 2018. Washington, DC also recently adopted paid leave – although it still must be approved by Congress. In addition, several other cities have their own rules. These are separate from distinct paid sick day rules currently in place in seven states, as well as 28 cities and two counties that require employers to pay eligible employees if they take leave to care for themselves or sick children.

Here are some of the daunting statistics that illustrate the wide support for paid family leave. Nearly one in four U.S. workers has taken leave to care for a seriously ill family member, according to the Pew Research Center. Not surprisingly, women have assumed more responsibility as caregivers than men, although a recent survey reported that a narrow majority of Americans say that when a family member has a serious health condition, caregiving responsibilities should fall equally on men and women. Data collected by the Pew Research Center also indicates that just over 6 in 10 Americans says they either have taken or are very likely to take time off from work for family or medical reasons at some point in their careers. Lower paid workers generally have taken less time off when it is available. Those who have taken unpaid family leave, including over 50% of those who have taken parental leave, say that they took less time off than needed or they wanted primarily due to financial concerns and fear of job loss.

While the idea of paid leave has grown in popularity, one of the key questions is who will pay for it. There have been a number of ideas discussed including offering a tax credit to employers who offer the leave, as opposed to having the government (state or federal) fund the benefit with
contributions from employers. Another idea is allowing pre-tax savings by employees – similar to a health savings account – for leave purposes. Those states which have paid leave administer and fund it through their own disability programs. They are typically supported through employee and employer payroll taxes.

There are several bills currently before Congress, including one that would allow for paid leave upon the death of a child. It has support from members of both major political parties. The American Enterprise Institute, a conservative, nonpartisan public policy group, has proposed an income-based paid parental leave program. Paid leave only would be available for the birth or adoption of a child (and not expanded for assisting other family members) and available only for workers in households whose family income is under 325% of the federal poverty threshold – about $62,000 for a family of three. This would limit as to eligibility and also limit significantly the cost of such a program, which the federal government would assume.

Over 900 American employers have in place some form of paid leave, according to reports. Several companies recently announced expanding their leave policies in order to attract and retain employees. It should be noted that during the last Presidential campaign, both candidates supported a paid leave policy with President Trump suggesting six weeks of paid leave only for new mothers. So it remains to be seen whether any federal legislation will be enacted in this area, whether we will see an expansion of state-based leave policies, or just employers adopting and paying for this benefit on their own.

Substantiation Required For A Hardship Distribution

Do you know whether your 401(k) or 403(b) plan allows for qualifying hardship distributions? Hardship withdrawals must be authorized under the plan and meet certain standards outlined in IRS regulations. Generally, a 401(k) or 403(b) plan may allow for hardship distributions on account of an immediate and heavy financial need of the participant that cannot be satisfied from other sources, including plan loans. Those “other sources” can include a nonqualified plan subject to §409A rules, which can create a “Catch 22” situation and dilemma for some.

IRS regulations provide a “safe harbor” for certain distributions – if properly substantiated – that will be deemed to meet the standard of an immediate and heavy financial need. These include the following:

- Unreimbursed medical expenses for the employee or the employee’s spouse, children or dependents;
- Purchase of an employee’s principal residence;
- Payment of college tuition, related educational fees, room and board expenses for up to the next 12 months for the employee or the employee’s spouse, children or dependents;
- Payment necessary to prevent eviction of the employee from the principal residence or the foreclosure of a mortgage on that residence;
- Payment for the burial or funeral expenses for the employee’s deceased parents, spouse, children or dependents; or
- Expense for the repair for damages to the employee’s principal residence that would qualify for a casualty deduction.

Unlike plan loans, hardship withdrawals are subject to income taxation and, if the recipient is not at least age 59½, may be subject to the 10% early payment penalty, unless an exception applies. Because of this tax consequence, hardship withdrawals should generally be considered only after plan loans. How would a plan administrator know whether a request for a hardship distribution met a safe harbor standard – or such other requirement as stated in the plan? It is possible for the employer to have a self-certification process in which the plan participant would submit or maintain the necessary support that the request met the necessary standard. The IRS recently issued examination guidelines for its field agents to use in determining whether an employer’s self-certification process has an adequate documentation procedure. Although these memos cannot be relied upon as official guidance, they should be reviewed by employers and third party administrators (TPA) to avoid potential issues upon a plan audit.

The examination guidelines describe three components for an employer’s self-certification process for hardship withdrawals. They include the following:

1. The plan sponsor or TPA must provide a notice to plan participants with certain required information regarding hardship withdrawals;
2. The plan participant must provide a certification statement with information describing the nature of the particular financial hardship;
3. A TPA must provide the plan sponsor with a summary report or other data regarding all hardship distributions made during each plan year.
The notice to be provided must state that the hardship distribution is taxable and that additional penalty taxes could apply. It must indicate that the distribution cannot exceed the amount of an immediate and heavy financial need (plus applicable taxes). It also will require an acknowledgement by the participant that he/she will preserve source documents that support the requirement of the qualifying hardship. The hardship distribution also cannot be made from earnings accrued under the plan.

A plan can, but need not, limit the number of financial hardship distributions in any single plan year. In cases where a participant receives more than two financial hardship distributions in a year, the audit guidelines advise agents to request source documents supporting these distributions unless a credible explanation for multiple distributions cannot be provided.

Employers may want to review their hardship withdrawal procedures in light of this new guidance to ensure that they or any TPA is meeting the safe harbor standards outlined.

**Different Rules for Nonqualified Plans**

Nonqualified deferred compensation plans (and 457(b) plans) generally cannot permit early withdrawals, distributions or loans under IRC §409, with a few limited exceptions. Otherwise, the 20% penalty tax under §409A could become payable by the participant. One such permissible early distribution is to relieve a financial hardship caused by an unforeseeable emergency. Under Treasury Regulations, this includes:

- An illness or accident of the participant, their spouse, dependents or beneficiary;
- A casualty property loss not covered by insurance;
- Funeral expenses of the participant’s spouse or dependent;
- Other extraordinary and unforeseeable circumstances resulting from events beyond the control of the participant.

The recipient must show that the expenses could not otherwise be met by insurance, liquidation of personal assets, or due to the cessation of deferrals under the deferred compensation plan. In addition, the amount of the distribution cannot exceed the amount needed to satisfy the emergency, plus any income taxes payable.

Thus, these rules have a higher standard than for 401(k)/403(b) hardship withdrawals. Plus, there are no safe harbor rules or self-certification rules for these hardship distributions. Perhaps more significantly, the requirement for a hardship withdrawal from a 401(k)/403(b) plan that the financial need cannot be met from “other sources” may require that a hardship withdrawal be taken first from any nonqualified plan — if it meets the different standard — and that elective deferrals cease. This can be a dilemma for those who administer these plans, especially if there are separate plan administrators. A Catch-22 situation.

### Where Do Health FSA & Cafeteria Plan Forfeitures Go?

Most large employers and many mid-sized employers offer a health flexible spending account (FSA) and/or §125 cafeteria plan to eligible employees. Health FSAs have a “use-it-or-lose-it” feature under which a participant can forfeit unused amounts if not timely requested. Many employers have added a grace period or carry-over feature to their health FSA programs (see the December 2016 *Digest* for data on this). Do you know what happens to any amounts forfeited by an employee? The IRS recently issued Information Letter (IL) 2016-0077 addressing the treatment of cafeteria plan forfeitures. The IL was in the context of unused funds in a flexible benefit plan when a business ceased operations and the plan terminated. In this guidance, the IRS confirmed that any forfeitures would not revert to the U.S. Treasury, but where forfeitures went would depend on the terms in the plan document concerning plan termination and the facts and circumstances. However, the IL does refer to IRS proposed regulations and the general rules that deal with plan forfeitures, including unused health FSA funds that are forfeited upon termination of employment.

Under Treas. Reg. §1.125-5(O), forfeitures may be:

- Retained by the employer;
- Used to defray plan expenses;
- Returned to current plan participants and allocated on a reasonable and uniform basis.

Each plan should describe what would happen with unused funds that are forfeited. This can also occur upon an employee’s termination of employment where an employee does not timely submit a claim for reimbursable expenses. The rules generally prohibit a plan from reimbursing eligible expenses incurred after an employee terminates employment and no longer participates in the plan. However, a health FSA is eligible for a COBRA election which most employees may not be aware of. This election can allow an individual to incur an expense following termination of employment and receive reimbursement from the plan.
There’s a New Process For Any FICA Tax Refund Claims

There are many different reasons that an employer — and an employee — may overpay Federal Insurance Contributions Act (FICA) taxes on compensation paid or earned. For example, often when an employee changes business units within the same employer, the payroll system will start withholding Social Security taxes from dollar one without regard to the taxes withheld earlier by a different business unit. Under IRS regulations, employers are entitled to claim a refund for overpaid FICA by filing Form 941-X with the IRS, designating the period for each the refund claim, explaining the basis for the refund claim, and meeting certain other requirements. An employer that receives a refund of such taxes must give to the employee his/her share of the amount received. In addition, to protect an employee’s interest, IRS regulations prohibit any refund to the employer unless the employer has first repaid or reimbursed the employee for his/her share, or has included a claim for refund of the employee’s share of overpaid FICA taxes, along with the employee’s consent to the refund claim. The employer then must certify that it has repaid or reimbursed the employee or has obtained the employee’s written consent for the refund claim, except if such taxes were not withheld from the employee. If no FICA had been withheld from the employee’s compensation, then the employer may file a claim for refund for the employer’s share. In addition, the employer may do so if the employer cannot locate the employee or if the employee will not provide consent to file the refund claim after the employer has made reasonable efforts to request such consent.

The IRS recently issued new guidance explaining slightly revised rules on filing a claim for refund of overpaid FICA taxes (Rev. Proc. 2017-28). These also apply to refunds for overpaid Railroad Retirement Tax Act (RRTA) taxes. Most employers likely will need to review and update their process for filing new claims for refund of FICA taxes based on this recent guidance.

It should be noted that the recent guidance indicates that an employer cannot claim a refund on an employee’s behalf for any overpaid 0.9% Additional Medicare Tax. While an employer generally must withhold such tax on compensation that exceeds certain limits, only the employee owes this tax. As a result, an employer cannot claim a refund or credit for any additional Medicare tax.

Here are some of the new rules which will apply to employer refunds requested on or after June 5, 2017:

- **New Rules on Requesting Employee’s Consent**
  Unless the employer failed to withhold any excess FICA from the employee’s compensation, the employer will need to obtain an employee’s consent to file the claim for refund. A request for this consent must provide employees a reasonable period of time to respond of not less than 45 days. Any such request must clearly state the purpose of the employee consent that the employer will repay or reimburse the employee’s share of any refund, including allocable interest, and that an employee cannot authorize the employer to claim a refund for any overpaid Additional Medicare Tax. This request may also include an express presumption that if an employee’s response is not received during the specified time, the employee will be considered as having refused to provide consent. The request may also ask the employee to keep the employer informed about any change in the employee’s mailing address or email address.

  An employer may establish a system to request and retain an employee’s consent in an electronic format that ensures the authenticity and integrity of an electronic signature. However, if an employer uses an electronic consent, the employer must provide an employee the option of reviewing the consent request and providing it in a paper format.

  An employer may file a claim for refund without obtaining an employee’s consent only if the employer makes “reasonable efforts” to repay or reimburse the employee or secure the employee’s consent to file the refund where the employer cannot locate the employee or the employee will not provide such consent. There are a number of rules relating to what constitutes a reasonable effort. For example, if an employer’s initial request fails to be delivered, an employer must attempt to obtain a consent a second time, but this time with a 21-day response period. An employer may also email a request to an employee. However, if the email is undeliverable or if the employee does not acknowledge receipt of the email, an employer must send a paper request to the employee’s last known address by mail or personal delivery.

- **Employee Consent Requirements**
  There are a number of required items relating to an employee’s consent for the employer to file the claim for refund. There must be an identification of the specific basis of the refund claim. In addition, the consent must have the employee’s signature stated under penalties of perjury.
The employee consent also must contain the employee’s name, address and a taxpayer identification number (TIN). However, the revised new rules allow use of a truncated taxpayer ID number (TTIN). This is one in which the first five digits of the nine digit number are replaced with X’s or asterisk’s and only the last four digits are provided. This is to address concerns regarding identity theft. However, a TTIN may not be used if the employer requires that the full Social Security number of the employee be provided.

Because of these revised procedures, including in particular the new rules on employee consent, most employers will want to review and possibly revise their process for requesting a claim for refund of FICA taxes.

The employee consent also must contain the tax periods of the refund claim, the type of tax (e.g., Social Security and/or Medicare taxes), and the amount of tax for which the employee consent is provided. The consent also must state that the employee authorizes the employer to claim a refund for the overpayment for the employee’s share. The employee must also certify that he/she is not made previous claims and will not make any future claims for such refund.

Ayco’s 2017 Executive Benefits Survey – Your Last Chance

We invite you to participate in our 2017 Survey of Select Executive and Broad-Based Benefits. An interactive survey form is attached to the homepage of this month’s edition. Representatives of all organizations that participate in this survey will receive complimentary copies of the survey results when published and can also request a “special cut” by industry or peer group participants.

The survey will close this week – so take action if you have not already.

Did You Know...

- According to the 2016 IRS Data Book, during the 2016 fiscal year, the IRS collected $3.3 trillion in taxes, processed more than 244 million tax returns and forms, and issued more than $426 billion in tax refunds (interest-free loans to the gov’t, in a sense). The IRS audited just over 1 million individual tax returns in FY2016, but this was down 16% from 2015 and the lowest number in more than a decade.
- Starting this year, the IRS may begin using private debt collection agencies to collect past-due taxes when the IRS no longer has sufficient resources to pursue collection.
- The deadline for those with a foreign financial account to file their Report of Foreign Bank and Financial Accounts (FBAR) has been changed as of this year from June 30 to the filing deadline for individual tax returns – April 18 this year. However, those who fail to meet this new deadline can still file their FBAR forms by October 15 without penalty. It must be filed electronically if the total value of the foreign accounts exceeds $10,000 at any time during the year.
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