2019 Annual Open Enrollment & Voluntary Benefits Offerings

Annual open enrollment season provides an opportunity for employers to educate employees about their benefit options. It often is the primary or only time that employees review their current benefits as well as the benefits for which they are eligible. While experienced HR professionals might suggest communications regarding employee benefits periodically during the year, it can be challenging to get the attention of many employees. Retirement planning, insurance planning, choosing voluntary benefits, as well as compensation deferral and equity decisions, can each be time consuming to understand. Yet, the health care coverage election during annual open enrollment can be an employee’s most important benefit election. With health care costs increasing, open enrollment decisions have become critically important in helping employees meet personal planning objectives. More employers are taking steps to encourage employees to become better at making health care decisions, in part, due to the rising cost of employer-sponsored health care.

We thought that we would once again provide you with a summary of medical plan features and voluntary benefits that will be offered to employees next year. This data comes from a review of the 2019 open enrollment material at 275 companies where Ayco provides financial counseling or education services. Over 95% of our corporate partners have open enrollment in the fall.

The following are design characteristics for the medical plans among our survey group for 2019 compared to what we saw in a similar review we conducted ten years ago (although for far fewer organizations).
One or more high deductible health plans (HDHPs) will be available at a large majority of our survey group. It will be a new feature at six companies. Thirty companies will offer employees the choice of utilizing either a health savings account (HSA) option or a health reimbursement account (HRA) - thus, the percentages on the prior chart exceed 100%.

**Consumer-Directed Health Plans**

High deductible health plans (HDHPs), often called consumer-directed plans, can impact employee behavior and often lead to more cost-conscious decisions about health care utilization. Employees enrolled in HDHPs have had lower per capita health care spending than those covered by traditional plans, according to a study by the Health Care Cost Institute. This is mainly due to less health care utilization. The Kaiser Family Foundation reported that HDHPs once again this year were the second most common type of plan employees enroll in, after PPOs. Mercer’s 2018 Survey of Employer-Sponsored Health Plans reported that 37% of eligible enrolled employees selected a HDHP this year.

Almost all in our survey group continue to offer employees a choice of medical plans. We see slightly more companies offer only a HDHP to their employees – around 8% of our survey group for 2019 – up from 5% for 2018. Full replacement has not taken off as some had speculated.

We continue to see companies expand the number of HDHPs being offered. Nearly 30% of companies will offer two distinct HDHP options, 6% will offer three options, and one company will offer four options. But more choices often require more and better communication to assist employees in comparing options.

**HSA Company Contributions**

Most employers encourage employees to select HDHP coverage by making company contributions to their HSA. This can include a direct company contribution, a matching contribution, and/or having wellness incentives directed to the HSA. Of the 260 companies in our survey group with HDHPs, around 85% will "seed" or make contributions to HSAs on behalf of employees who elect HDHP coverage. Eleven companies in our survey group determine the company contribution by the pay level of the employees, with the higher-paid receiving less. Sixty-two companies will contribute wellness dollars earned to the HSA (nearly 10% more than last year’s annual enrollment). Fourteen companies will match employee HSA contributions with a specified dollar amount, while two companies fund the HSA only for those employees who elect the HDHP for the first time. Forty companies will have tiers of contributions based on the number of family members covered.

Here are the amounts of company contributions for employee-only and family coverage among our survey group (excluding wellness incentive contributions and utilizing the greater company contribution if multiple options are available):

**COMPANY HSA CONTRIBUTION**

### Single Coverage

- Under $500: 21%
- $500: 27%
- $525-$775: 11%
- $800-$3,000: 44%

### Family Coverage

- Under $1,000: 18%
- $1,000: 10%
- $1,100-$1,400: 16%
- $1,500: 42%
- $1,600-$6,000: 17%

Morningstar recently released its annual evaluation of HSAs. It reviews the major HSA providers/recordkeepers as to fees and expenses, as well as investment choices and features. Let us know if you would like a copy to see how your plan is rated.

**Health Care Costs**

Costs for employer-sponsored health care are expected as to increase next year by 4%-5.5% (depending on the survey referenced). However, this is projected to be slightly lower than the annual increase in prior years, according to the 2019 Segal Health Plan Cost Trend Survey. While a majority of the companies in our survey group will increase employees’ share of premium costs for 2019, the increase generally will be in the range of 2%-5%, similar to the increases over the last two years. Most companies will raise costs for PPO, POS and HMO coverage to a greater extent than for HDHP coverage. The Kaiser Family Foundation
reported that the average premium cost for family coverage in 2018 was $19,616, with employees paying 29% of the total cost. For single coverage, the average cost was $6,896 with the employee paying 18%. The average premium cost has increased by 55% since 2008.

The total cost of health care at large employers is projected to average $14,800 per employee in 2019, including premiums and out-of-pocket costs, according to the 2019 Large Employers’ Health Care Strategy & Plan Design by the National Business Group on Health (NBGH). Health Costs are rising at two times the rate of wage increases and three times inflation.

The increasing cost of prescription drugs due to price inflation continues to be a major factor propelling a rise in health care spending. Prescription drug costs have climbed to be the third-largest of the major categories of health care spending after hospital costs and doctors/clinician services. Using special pharmacy management programs has become a major cost-management strategy, according to the Segal Group.

Penalties and Tax Reporting - The Tax Cuts & Jobs Act made a few changes in the penalties for non-compliance with the Affordable Care Act. The individual mandate now is in effect only for 2018. Beginning next year, there generally will be no penalties on individuals – but the employer mandate - and potential penalties for employers - remains in place.

Employers are required to provide Form 1095-C to employees confirming employer-sponsored coverage by March 4, 2019, as recently extended by the IRS from the January 31st deadline. The same form and Form 1094-C then need to be e-filed (by employers with at least 250 employees) to the IRS by April 1, 2019. The IRS will not process an individual’s 2018 tax return unless there is reporting that he or she has health coverage.

The IRS also has begun issuing Letter 226J to employers who it is believed owe the employer mandate penalties for calendar year 2016. Thus, the IRS is enforcing the employer mandate.

Spousal Surcharge
We continue to see more companies impose a spousal surcharge if an employee seeks to cover a spouse who has access to medical coverage through his/her own employer. For 2019, just over 25% of our survey group will impose this additional cost, nearly three-times the number of companies that had a similar charge ten years ago. This surcharge ranges from $25 to over $200 per month. Here are the surcharge monthly amounts we saw reported among 70 companies in our survey group with a spousal surcharge:

We also saw one company impose a surcharge if dependents who are eligible for other coverage are covered under the employer’s plan and two companies which excluded spouses from coverage altogether. Eight companies increased the surcharge amount from what was imposed for 2018.

Flexible Spending Arrangements (FSAs)
Almost all companies in our survey group offer a health FSA providing a means for employees to pay for qualified health care expenses not covered by insurance on a pre-tax basis. Limited purpose FSAs are less common. The IRS issued IR-2018-224 last month as guidance on how to take advantage of health FSAs during 2019.

FSAs have certain characteristics similar to their health plan cousins, HRAs and HSAs, although the differences can be confusing. This may explain why only about 35% of employees elect to participate in a health FSA, according to EBRI. In fact, the need for an employee during annual enrollment to estimate, or guess, as to their out-of-pocket health care expenses for the following year makes FSAs a sometimes uncertain reimbursement mechanism. In addition, the “use-it-or-lose-it” rule makes funding FSAs riskier than fully funding a HSA. So, utilization has fallen.

The health FSA spending limit increased from $2,650 to $2,700 for 2019. However, this cost of living adjustment was not formally announced until last month when a large number of companies had already prepared their 2019 materials. A majority of our survey group indicated that the maximum limit was $2,650 for 2019 – the 2018 maximum. Employers are not required to communicate this change or even allow for the $50 additional contribution for 2019. Any new or revised contribution must be made by December 31 (for a calendar year plan) for it to be effective.
A challenge for employers first adopting a HDHP is explaining how an employee must exhaust their FSA balance before year-end (even if the plan has a grace period) in order to be able to fund the HSA or, alternately, delay funding the HSA until the end of the grace period. We saw several companies explain this in their 2019 open enrollment material.

The growth in the number of employees electing to participate in a HDHP and lower participation in limited purpose FSAs has led more companies to not provide a limited purpose FSA. For 2019, 64% of our survey group with a HDHP will offer employees a limited purpose FSA. Thus, over a third of companies with a HDHP will not offer a limited purpose FSA.

To help eliminate the risk that an employee first electing a HDHP in 2019 may not be able to fund a HSA during the year due to having unused FSA dollars from 2018, several companies allow unused FSA funds (often up to $500) to be transferred to a limited purpose FSA in 2019.

The Grace Period or $500 Carryover Option: Health FSA can have a grace period, which can allow up to 2½ additional months to incur and get reimbursed for eligible expenses, or a carryover option. Under rules modified by the IRS several years ago, employers may, but are not required to, allow up to $500 of unused amounts remaining in a FSA at the end of a plan year to be carried over and available to pay for qualified medical expenses at any time the following year. The carryover option is an alternative to the 2½ month grace period provision. A plan may have one or the other, but not both. All eligible participants must be informed of the $500 carryover if it is offered.

Here is what we saw among our survey group:

FSA Features
- Have $500 Carryover Feature 34%
- Have 2½ Month Grace Period 18%
- Have Neither Feature 48%

Dental and Vision Coverage
Dental care is the second-most utilized health care benefit after medical. Almost all of our survey group offer employees the option of selecting dental and/or vision coverage for themselves and eligible dependents. For dental plans, there typically are at least two coverage options made available. Here are the maximum annual amounts that may be reimbursed under the dental plans offered by our survey group, excluding orthodontics, which usually have a separate lifetime maximum:

<table>
<thead>
<tr>
<th>Per Covered Individual</th>
<th>% of Companies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $1,500</td>
<td>2%</td>
</tr>
<tr>
<td>$1,500</td>
<td>29%</td>
</tr>
<tr>
<td>$1,700 - $1,900</td>
<td>8%</td>
</tr>
<tr>
<td>$2,000</td>
<td>45%</td>
</tr>
<tr>
<td>$2,250 - $2,500</td>
<td>11%</td>
</tr>
<tr>
<td>More than $2,500</td>
<td>5%</td>
</tr>
</tbody>
</table>

Wellness Programs
It is generally accepted that wellness programs help employees develop healthier lifestyles, and healthier employees can lead to reduced medical costs. Over 90% of companies currently have some form of employee wellness program, which can include health risk assessments, biometric screenings, gym memberships, and smoking cessation programs. There is evidence of generational differences in how these are viewed. According to the National Health Center for Health Promotion and Disease Prevention, 20% of health care costs for adults in the U.S. are attributable to preventable illness, while 40% of costs are attributable to behaviors that can be modified.

Among our survey group, over 75% will offer employees cash, reduce their share of premiums, or make a contribution to an HSA, if the employee participates in a wellness initiative. The cash reward typically is $240-$500 to the employee and a similar amount to a spouse (although, this incentive is between $500-$950 at 24 companies and exceeds $1,000 at 10 companies). We counted nearly one-third of our survey group imposing a surcharge or increased premiums on those employees who continue to use tobacco, with a few companies offering a cash incentive to cease tobacco use.

Last year, the Equal Employment Opportunity Commission issued guidance which allowed employees to offer wellness incentives up to 30% of the cost of individual health care coverage. But, a federal court nullified certain rules following a lawsuit by AARP. Beginning January 1, 2019, employers may no longer assess penalties on employees who decline to participate in wellness questionnaires or exams.

Decision Making Process
While employees typically are given two to three weeks to review open enrollment material, the “average” employee spends less than an hour studying the information and making benefit elections. A MetLife study of Employee Benefit Trends reported that one-third of employees are not actively engaged in their annual benefits enrollment.
Here are the top mistakes employees make during annual benefits enrollment (according to several reports):

- Not spending sufficient time reviewing enrollment material including new offerings and instead sticking with prior year elections or default coverage;
- Failing to discuss coverage options with spouse;
- Ignoring tax savings available through HSAs and FSAs;
- Making decisions without taking advantage of available assistance.

➢ **Other Items of Interest**

Some of the more interesting features we saw in 2019 open enrollment materials include:

- Just over 15% of our survey group eliminated one or more medical plans for 2019;
- Just under 5% of our survey group will be utilizing a private exchange for active employees in 2019; more companies (around 15% of our survey group) are using private exchanges for their retiree coverage;
- A large majority offer remote access to a doctor on a 24/7 basis, such as through telemedicine services. Utilization of this greatly expanded again this year and helps keep costs down;
- The most common number of coverage tiers is four, with costs based on the number of eligible dependents;
- About 10% of our survey group indicated dependent verification or eligibility audits;
- Six companies will pay employees who opt out of employer-sponsored health coverage; one company eliminated their opt-out credit for 2019;
- Approximately 15% of our survey group offered passive enrollment, with prior year’s coverage continuing unless an affirmative election is made. However, FSA funding requires an affirmative election.

➢ **Voluntary Benefits**

Annual enrollment is also an opportunity for many companies to provide information concerning available voluntary benefits. Many more companies, of all sizes, are providing personalized or customized benefit offerings. Paid family leave is becoming much more common as more states and cities now recommend or even require it and there is a new federal tax credit for 2018 and 2019.

Here are some of the more common voluntary benefits offered by our survey group and other Ayco corporate partners, a total of 400 companies. The largest increases from our review last year are in Theft or ID Protection, Critical Illness Insurance and Student Loan Assistance.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Legal Services</td>
<td>61%</td>
</tr>
<tr>
<td>Homeowner’s/Auto Insurance</td>
<td>49%</td>
</tr>
<tr>
<td>Critical Illness Insurance</td>
<td>45%</td>
</tr>
<tr>
<td>Long-Term Care Insurance</td>
<td>44%</td>
</tr>
<tr>
<td>Commuter Benefit</td>
<td>35%</td>
</tr>
<tr>
<td>Pet Insurance</td>
<td>35%</td>
</tr>
<tr>
<td>Theft or ID Protection</td>
<td>35%</td>
</tr>
<tr>
<td>Ayco SurvivorSupport*</td>
<td>30%</td>
</tr>
<tr>
<td>Excess Liability Insurance</td>
<td>25%</td>
</tr>
<tr>
<td>§529 Plan</td>
<td>13%</td>
</tr>
<tr>
<td>Estate Planning</td>
<td>7%</td>
</tr>
<tr>
<td>Student Loan Assistance</td>
<td>5%</td>
</tr>
<tr>
<td>Fertility Assistance</td>
<td>4%</td>
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</tbody>
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When Can A Golden Parachute Payment Be Denied?

Generally, a separation payment following a change of control under an employment contract can and should be paid. However, there actually are situations in which the payout of a golden parachute is unlawful. Here is a recent example, confirmed by the U.S. Court of Appeals for the 7th Circuit.

James Bunn was an executive vice president for Valley Bank Illinois. Valley Bank was an FDIC-insured, state-chartered bank regulated by the Federal Deposit Insurance Corporation (FDIC). In 2003, the bank entered into a salary continuation agreement with Bunn that would provide payments to him in various scenarios, including upon his retirement, death, disability, early termination before retirement, and termination following a change of control. A change of control that would trigger an entitlement to salary continuation payments would occur either upon a change of ownership of the bank’s capital stock or the sale or other disposition of substantially all of the bank’s assets. The bank purchased two life insurance policies for the express purpose of funding the agreement and for which Bunn was named the insured. The agreement provided that Bunn’s rights and benefits were subject to, and conditioned upon, compliance with all federal and state laws, regulations and rules relating to banking institutions and the compensation of bank officers and employees.

Valley Bank began to experience severe financial troubles in 2009. Eventually, in 2014, the Illinois Department of Financial and Professional Regulation took control of the bank and closed it after concluding that it had been conducting its business in an unsafe and unsound manner. The FDIC accepted appointment as the bank’s receiver and subsequently entered into a sale of the bank’s assets to Great Southern Bank. Great Southern continued Bunn’s employment, but only for one week.

Upon his termination, Bunn requested a separation payment of $240,000 pursuant to his Salary Continuation Agreement. However, a few months later, the FDIC notified Bunn that it would disaffirm the Agreement and refuse to make the separation payment because it constituted change of control benefits. Bunn then sued in federal court seeking either the $240,000 separation payment or, in the alternative, the $444,000 accrued cash value of the two bank-owned life insurance policies which Valley Bank had purchased to fund the Agreement, as well as his attorney’s fees. In 2017, a federal district court granted the FDIC’s motion for summary judgement – meaning that Bunn would receive no payments. Bunn appealed that decision and last month, the 7th Circuit upheld the lower court’s decision (Bunn vs. FDIC).

Ironically, the key was the fact that the potential payments did constitute golden parachute/change in control payments. Under Federal banking laws, a golden parachute payment is one in the nature of compensation by any insured bank which is contingent on termination of employment and received on or after the date the bank becomes insolvent or any receiver is appointed or the federal banking agency determines that the institution is in troubled condition or certain other situations. The FDIC has the authority to disaffirm or repudiate any contract to which a failed banking institution is a party which it determines to be burdensome.

Bunn had argued that the separation payments constituted deferred compensation rather than a golden parachute. However, he could produce no specific facts or evidence differentiating the payment from a change in control golden parachute. As a result, the appellate court upheld the finding in favor of the FDIC that the contractual payments need not be made to Bunn.

Proposed Rules Would Change Hardship Withdrawal Regulations

Almost all 401(k) plans and most 403(b) plans allow for qualifying hardship distributions necessary to satisfy an immediate and heavy financial need while employed. Based on a number of changes made by the Bipartisan Budget Act of 2018, the IRS recently issued a Notice of Proposed Rule Making relating to hardship distributions from qualified plans, including 401(k) plans.

Current IRS regulations provide a safe harbor rule so that a plan may determine whether the requirements have been satisfied. But a plan could also allow for a hardship distribution on the basis of individual facts and circumstances as to whether the plan participant’s need is “immediate and heavy” and whether it is necessary to have the funds withdrawn to satisfy the need.

Current rules also have a six-month suspension period for making future plan contributions following a safe harbor hardship distribution. In addition, the participant is required to take all available loans from the plan prior to a distribution. A hardship distribution can be taken if the
individual qualifies for a casualty loss deduction under IRC §165. The proposed new rules will alter many of these current rules – however, most of the changes are optional on the part of the plan sponsor.

If the proposed rules are finalized, employees would no longer be prohibited from making elective contributions to a plan after the receipt of a hardship distribution. In addition, there would be an elimination of the requirement to take plan loans prior to obtaining a hardship distribution. There would be one general standard for determining whether a distribution is necessary to satisfy a financial need. The hardship distribution may not exceed the amount of this need (including any amounts necessary to pay income taxes or penalties reasonably anticipated to result from the distribution), and the employee must have obtained other available distributions under employer plans. In addition, the employee must represent that he/she has insufficient cash or other liquid assets to satisfy the financial need. A plan administrator may rely on a representation of this fact, unless the administrator has actual knowledge to the contrary.

The new regulations would change the current rules relating to casualty losses imposed by the Tax Cuts & Jobs Act. A distribution could be allowed for casualty losses, including to the employee’s principal residence, even if the damage is not related to a federally-declared disaster.

The proposed new rules would permit a hardship distribution from not only employee elective contributions, but qualified non-elective contributions (QNECs), qualified matching contributions, as well as earnings on these amounts, regardless of when contributed or earned. However, a plan sponsor may decide to limit the type of contributions available for hardship distributions and whether earnings on any contributions are available.

In general, most of these new rules would only apply for distributions made on or after January 1, 2020. They would also eliminate the previously permitted “facts and circumstances” test and replace it with a three-part general standard. Certain of the rules may not apply to §403(b) plans.

Employers will likely need to make plan amendments in order to make the changes permitted by these new rules once they are finalized. Since these proposed rules would expand allowable hardship distributions, including eliminating any delay or uncertainty concerning access to plan assets following a disaster in an area designated by the Federal Emergency Management Agency (FEMA), employers should review what changes they expect and make the necessary plan amendments on a timely basis. Then communications will need to be drafted to all employees. So, more to come on this.
Did You Know…?

- Employer-sponsored health insurance covers around 152 million non-elderly Americans, over half the population.

- While the health FSA maximum increased by $50 to $2,700 for 2019 due to a cost-of-living adjustment, there was no increase in the $5,000 maximum dependent care FSA. This is due to the fact that it is not indexed by a COLA and the threshold remains the same year to year.

- In 2013, the IRS Employee Plans Compliance Unit sent letters to a sample of retirement plan sponsors asking about their Form 5500 coding for pension/401k plans. In a recently released report, the IRS indicated that 87% of plan sponsors made filing errors.

- Over 44 million Americans have outstanding student loans with the outstanding amounts owed having doubled in the past decade.

- The Social Security Administration reported recently that Social Security retirement benefits paid out in 2018 exceeded its revenues for the first time in 35 years.

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