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DISCRIMINATION ISSUES -- HERE TODAY, GONE TOMORROW?

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This panel will discuss current nondiscrimination issues including:

- Has/will the 1994 effective date been/be extended?
- Are the regulations really simpler now?
- Practical problems

MR. STEVEN J. MIKKALO: James Kenney is an actuary with Coates Kenney, Inc. of Berkeley, California. Susan Serota is an attorney from the New York area with the firm of Winthrop, Stimpson, Putnam and Robertson.

As you know, 401(a)-4 is a huge topic, and Mr. Kenney is going to speak first and concentrate on the availability of benefits, rights, and features. Ms. Serota will comment on separate lines of business (SLOB) regulations and how those blend into 401(a)-4, as well as address the two revenue procedures: 93-39 on the determination letter process and 93-42 on the substantiation guidelines.

Before I turn this over to Mr. Kenney, I just want to say a couple of words. One has to do with the recent statement by Assistant Treasury Secretary Samuels regarding the 401(a)(4)8 part of the regulations, the cross-testing. I found it rather sad and amusing at the same time because, for the second time in two years, we have a set of final regulations that are not even cold from the copier, and the Treasury Department is telling us that, no, wait, are we going to address the cross-testing issue and perhaps make massive changes to this portion of the regulations.

Another part of the program that I wanted to take care of, an easy part naturally, concerns the questions in the program: "Will the 1994 effective date be extended?" Probably not. "Are the regulations really simpler now?" That's a matter of opinion, and my opinion is, not really. The last part was "Practical problems?"

There are a couple of other comments I wanted to make concerning the comparison of the original 1991 regulations, let's call them, versus the more recent 1993 regulations, that is some of the striking similarities and a couple of changes and differences. The main similarity is that the basic structure and the choices available to qualified plans really didn't change. A plan must generally demonstrate compliance in three areas: amount of contributions and benefits, availability, and the effect of certain events. Another similarity of note is that the safe harbor for cash balance plans is basically retained in its original form even though the IRS continues to review comments on this issue and expects to propose some revisions down the road.

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A couple of principal modifications, changes from the 1991 regulations to the 1993 regulations are that corrective amendment provisions have been extended to permit certain prospective corrections of problems that relate to availability of benefits, and so on. The final regulations also clarified that, when reviewing a plan amendment for compliance, the focus is on whether the timing of the amendment has a discriminatory effect. A change was also made in the integration rules in that certain primary insurance amount (PIA) offset plans – which at one time at least I felt and I'm certain many others did, too, were a thing of the past – can gain access to the nondiscrimination safe harbors.

Under the general test, the IRS replaced some detailed rules for the determination of accrual rates with more general methods, giving a little more leeway in that area. Defined-benefit plans gained a safety valve in that, if the plan fails the general nondiscrimination test, it may seek a favorable determination letter on a facts and circumstances basis. Again, this is a liberalization.

The 1993 final regulations also replaced some objective tests for testing former employees with facts and circumstances. Perhaps the most helpful, fresh start rules were liberalized somewhat.

MR. JAMES A. KENNEY: How many people here have actively worked with the nondiscrimination regulations? Could we have a show of hands? We have 10-12 people. How many people have studied these regulations although they haven't worked with them? I'm going to try to keep my talk pitched to the intermediate level. I will begin with a general overview and try to move through that overview fairly rapidly and then get to some of the more practical elements of my talk.

NONDISCRIMINATION REGULATIONS

The nondiscrimination regulations have three legs, and each one of these legs begins with the letter A. There is a nondiscrimination requirement for the amount of benefit. There's a nondiscrimination requirement for the availability of benefits, rights, and features. There's a nondiscrimination requirement concerning amendments to plans. I am going to focus on availability.

Obviously, these regulations are immense in their scope. We could talk for hours on almost any part of the regulations and still not really give you the full depth and extent of these regulations. I've chosen to speak on a part of the regulation that I think tends to be given short shrift. People tend to focus a great deal on the amount of testing, either the general test, the safe harbors, the cross-testing, the restructuring, and so forth. I think a lot of times people tend to overlook the requirements in 401(a)-4 concerning the availability of benefits, rights, and features. That's what I'm going to be speaking on.

When we look at the availability of benefits, rights, and features, we need to answer two questions. The first question is, "What must be made available?" The second question is, "How can we show that something is available?"

Let's discuss the question of what must be made available. There are three elements to this. The first is that we must have nondiscriminatory availability of optional forms of benefit. This includes things such as the joint and survivor form of benefit and the

lump-sum form of benefit. It also includes early retirement benefits to the extent that they are protected by 411(d)(6). That includes qualified Social Security supplements.

The second thing that we must have is nondiscriminatory availability of ancillary benefits. Here we're talking about Social Security supplements that are not qualified. We're talking about disability benefits that are not in excess of the qualified disability benefit under the internal revenue code (IRC). We're taking about death benefits, health benefits, and shutdown benefits.

The definition of what constitutes a separate optional form is discussed in the regulations, and it is an extremely picky definition of what is a separate form. Unless forms are offered on "substantially the same terms," they are separate optional forms or separate ancillary benefits. Examples of what can create different benefits are (1) the different actuarial assumptions used to calculate the benefit -- I think we would all probably feel that this does create a different optional form of benefit; (2) different eligibility conditions -- I think we would all agree on that as well; and (3) timing of commencement of benefits, payment schedules, election rights, and even whether the distribution is available in kind as well as in cash.

Finally, besides the optional forms of benefit and the ancillary benefit comes the catchall phrase of "other rights and features." Some examples of other rights and features are the right to a plan loan, the right to make investment direction of your account balance, the right to make rollovers into the plan. There are numerous other rights such as the right to make the various levels of contributions or to receive various levels of matching contributions. These are the types of benefits that we are required to demonstrate are available on a nondiscriminatory basis.

The second thing is, how do we test this? We look at two things: the current availability and the effective availability. I'd like to talk just briefly about effective availability because it is extremely vague. If a benefit passes the current availability test but for reasons that are peculiar to the circumstances of the plan sponsor, the benefit is not truly available to the nonhighly compensated employees (NHCEs) -- for instance, they're not told about it or the only one who is eligible for this particular benefit is a highly compensated employee (HCEs) -- these benefits are not effectively available. Effective availability could also be created by other issues. For instance, suppose you had to have an account balance of at least $5,000 in order to establish a segregated account. The only people with account balances of that size were HCEs. You might have an effective availability issue there -- there's a very good chance that you would.

Current availability, however, is the test that is easiest for us to understand and deal with because it is a numbers test. It's strictly a numbers game, and the method of demonstrating whether you are passing the current availability test is that you must meet the nondiscriminatory classification test in the 410(b) regulations. I believe that is -4 of those regulations as well.

Basically, that test is done in the following method. You find two ratios. The first is the number of NHCEs who are benefiting from this particular right or feature divided by the total number of NHCEs. The second ratio is the number of HCEs benefiting

from this right or feature divided by the total number of HCEs. Then you take the ratio of these two ratios.

For instance, if you have 10% of your NHCEs who are eligible for a particular feature of the plan and 40% of your HCEs are eligible for the same feature of the plan, then your availability coverage ratio is 25%. Whether or not this is good enough has to be determined by taking a look at the 401(a)-4 regulations or 410(b), and there is a table in those regulations that depends on the proportion of HCEs and NHCEs in your work force. Basically speaking, the higher the proportion of NHCEs, the lower the ratio that is required in order to demonstrate that you have met this availability requirement. It will never go below 20%. If you have a feature that is available to less than 20% of employees, you cannot get that right or feature to pass without doing something else. Fortunately, when it comes to the question of determining who is eligible, we can ignore certain things. The most important thing that we can ignore is the age and service of the employee, so if there are age and service related conditions for satisfying eligibility requirements for the benefit, for instance, an early retirement benefit where you need to be age 55 and 15 years of service, we don't have to just look at the group of people who meet those conditions. You're allowed to assume that everyone meets those conditions. That's a very important exception in determining whether people are benefiting from this feature or not. There is a catch on that which is that, if the conditions referring to age or service are time limited in some way, that is to say they must be met by the end of December 1993, then you are not permitted to ignore the age and service of the people whom you are looking at. You must carve out the group of people who will meet those conditions by that time limitation and then test them separately. Generally speaking, benefits, such as the early retirement benefit, are an important exception to be able to assume that people who are, for instance, age 43 and who have two years of service are still benefiting from the fact that the plan has an early retirement feature.

The government realized that this test by itself is not going to work if it did not provide certain exceptions. The government people provided us with some special rules that we can utilize. In this talk I'm just going to hit the highlights of the most important of these special rules.

The most important of these four special rules concerns mergers and acquisitions, frozen participants, early retirement windows, and the ability to permissively aggregate benefits, rights, and features. For mergers and acquisitions, it is possible to keep certain special benefits, rights, and features for an acquired group of employees on an ongoing basis. That is, you not only cover the accrued benefit with that benefit write-in feature, but also you can continue to provide that benefit write-in feature to benefits that are accrued by this group of employees after the acquisition date. In order to do so, you have to meet certain standards. The most important standard is that you must be able to satisfy 410(b) on the day after the transaction occurs. When you have combined your normal group and the group of acquired employees and tested that benefit write-in feature and if it passes the nondiscrimination and availability standard on that day, then you don't have to keep testing it. But you do have to satisfy it on that day. If you can't satisfy it at that point, you cannot continue to provide it on an ongoing basis.

Another element is that you provide the feature unchanged. A third element is that you only provide the feature for acquired employees. You don't give that feature to anyone else.

The second special rule concerns frozen participants. These are not popsicles. These are people who are not accruing benefits but who are still employees in your corporation. Even though these people are not accruing benefits, you cannot ignore them when it comes to the benefit write-in feature issue. You can ignore them for purposes of your amounts testing because they are not benefiting under the plan as long as they are not accruing benefits. But if you are providing optional forms of benefits on their accrued benefits, those forms must be nondiscriminatory in their availability. You can't just ignore this group of people.

The rules have been eased somewhat for this group of people, and there is a set of four exceptions that will allow you to skip over the numeric tests if you can pass those particular exceptions. I won't go through them here, but they are in the 401(a)-4 regulations under the special rules section.

The third special rule concerns early retirement windows. Many early retirement windows are fairly short in duration but some are longer. Where you have an early retirement window that spans two different plan years, you are permitted to do the testing solely in the first of those two plan years. That is assuming that your early retirement window is no longer than one year in duration. If it goes beyond one year in duration, then you are not permitted to use this special rule.

This rule can be extremely important if you do cross over a plan-year boundary because it may well be that when the window is open, the first people who will begin taking the benefits will be predominantly NHCEs. If you have a window that satisfies these requirements at the beginning and a bunch of NHCEs leave, then you have to test it again in the second plan year, and now it is discriminatory in makeup solely because a bunch of NHCEs have already taken advantage of the window, and they're no longer there to be counted. This would cause your window to be discriminatory. Therefore, the IRS has put in a special exception that allows you not to make the test in the second year. If you can pass it in the first year and the window is not over a year in duration, then you do not need to test it in the second plan year.

Finally, the fourth special rule, which took me a while to appreciate how important this rule can be, is the permissive aggregation of benefits, rights, and features. I think the IRS must love the word aggregation. Everything is aggregated or disaggregated. This should not be confused with permissive aggregation of plans. This is permissive aggregation of particular benefits, rights, and features within the plan you are testing.

The way permissive aggregation works, is if you have two benefits, rights, and features that are basically similar but are different under the definitions of 401(a)-4 regulations and you can show that one benefit, right, or feature is always of equal or greater value than the other and if the feature which is of equal or greater value passes 410(b), then you can aggregate the two features and test the second feature on a combined basis. The reason the IRS lets us do this is that, if the first feature is worth more and it covers a nondiscriminatory group and the second feature is worth

less and doesn't, basically you're giving something better to the lower paid than the higher paid, and I guess the IRS doesn't feel that this is something it needs to police.

For instance, let's suppose you have two divisions, Division A and Division B. Division A has a death benefit, which is a full joint and survivor form of benefit. Division B has a death benefit for active employees, which is a half joint survivor form of benefit. You can demonstrate mathematically that, under any given set of ages of the employee and spouse, that the full joint survivor benefit will always deliver a higher death benefit to the spouse. Therefore, if Division A's benefit can satisfy 410(b) on its own, you are permitted to aggregate the two death benefits for the purpose of testing the half joint and survivor form of benefit to see whether it can pass. The key word here is the word *always*. The benefit, right, or feature must always be more valuable or at least as valuable. You cannot have a circumstance in which in this one situation here it is not worth as much. If you have that kind of a situation, then you cannot aggregate these forms of benefit.

This basically concludes the introductory portion of my talk. This is kind of an overview of what the 401(a)-4 regulations provide. What I would like to do now is look at things that are a little more practical in nature. The questions I am going to look at are:

1. How can you determine whether your plan is in compliance with the benefits, rights, and features rules?
2. What can you do if your particular benefit, right, or feature does not pass this test?
3. What sort of situations commonly lead to problems with availability? Then I will take a look at two typical problems so we can see it in a little more depth.

How can you tell if your plan is fine? The first thing you should do is review the plan document with respect to benefits that are offered under that document. The second thing you should do is review the document for the rights and features that are offered under that document. The third thing you should do is review the administrative procedures that are utilized in carrying out the plan. The fourth thing is, if necessary, conduct an actuarial analysis of the demographic characteristics of your group where you do have benefits, rights, and features that are not universally available.

In your document review, you should itemize all benefits that are available under the plan. You should do this for optional forms of benefit. You should do this for ancillary benefits. Then you should itemize and review the eligibility requirements of these various benefits.

The most important question is: Are there restrictions on the availability of this benefit based on either category of employment, for instance, salary versus hourly or sales versus nonsales? Are there differences in eligibility based on location, division, or department? Are benefits available only to people who belong to a closed group of employees based on a hire date? In other words, this means if you were hired before a certain date, then the benefits accrued to that date are available under a certain option or you continue to have your entire benefit covered by a certain option.

Finally, something that many of us may have not looked at really carefully is whether your plan provides nonuniform normal retirement dates. There are two easy ways in which your plan might have a difference in normal retirement dates. One is that plans that provide different normal retirement dates based on the Social Security retirement age of the individuals are becoming more popular. There was a time when the IRS said you could not have a plan like this. However, those type of plans are now in existence, and that would create different optional forms of benefit because the benefits do not commence at the same time.

Another way you can have a difference in normal retirement age is the five-year wait rule. Anyone hired within five years of age 65 may be forced to wait until the fifth anniversary of hire before his or her normal retirement date. There is a special exception for that in the 401(a)-4 regulations. If that is the reason for the difference in normal retirement age, that is not considered a different optional form of benefit. Nevertheless, I think it's a very instructive example of the mental process that you should go through when you look at your plan document. We tend to think of benefits as being available at normal retirement age and we stop there. I think we tend to forget that for some people the normal retirement age is not age 65 due to this five-year wait rule. If it weren't for the specific exemption in the 401(a)-4 regulations, the five-year wait rule would create an additional optional form of benefit, and we would probably miss that on our review.

I think this points out that as actuaries we have certain blind spots. I think one of our most important blind spots is that something is just as good as something else or that the only difference between these two is that this person can choose something and this person doesn't have that same right, but it really doesn't matter because the two are actuarially equivalent. This is not good enough under the 401(a)-4 regulations. Actuarial equivalence does not matter. The only thing that matters is the options have to be the same. They cannot be equivalent or similar, they must be the same.

Some of the things to look at are the actuarial assumptions used to calculate the optional form of benefit. I think that makes a lot of sense. Obviously, if you're using the 1983 Group Annuity Mortality table at 7% for one group and the 1951 Group Annuity Mortality table at 6% for a different group, you really have different optional forms of benefit. I think we can all see that easily.

Another thing to do is look at the factors that are used to calculate optional forms. Sometimes you don't use the actuarial equivalent; you just have a factor that's in the plan document. This could be a factor concerning reduction for early retirement; it could be a factor concerning joint and survivor forms of benefit that are based on the 5-year difference in age, 10-year difference in age, 15-year difference in age. If these factors are not identical, then you have a different optional form of benefit. You need to look at everything to do with distribution of that benefit. You need to look at the payment schedule, when the benefits commence, whether the benefits are available only in cash or whether they may also be distributed in kind, and the various election rights that people have concerning those distributions.

I think the rule concerning cash or distribution in kind can be a very difficult rule, particularly when you have small plans where the doctors or the professionals or the HCEs have a lot of stock in the plan or other things that are difficult to liquidate and

frequently take those in kind but always pay off terminating participants in cash. We'll get to that when we talk about administrative procedures.

Once you have gone through all this concerning the benefits, it's time to take a look at the rights and features in your plan. There's a big laundry list of what constitutes rights and features in the 401(a)-4 regulations, and it is not an exclusive list. It is a list of things that the IRS recognizes are different rights and features that you have to be concerned with. There could be other elements that the IRS would later decide, yes, that's a significant right or feature, and you need to make that available on a nondiscriminatory basis, but some of the ones that the IRS has particularly flagged for us are plan loans, the right to make self-directed investments, the right to make various levels of contributions, both pre- and post-tax, the rights to various levels of employer match, and the rights to make rollover contributions. When you look at your rights and features, you especially need to look at your loan requirements, your hardship withdrawals, your investment direction. But you also need to look at things that I think of as somewhat silly, such as the right to make a rollover contribution. I wouldn't particularly, on my own, have thought that, if I have Plan A and Plan B which are identical except that Plan B allows you to make a rollover contribution from another plan and Plan A doesn't, that was significant enough to disqualify Plan A or Plan B, but the IRS does not agree with me. Some of the things that we may consider to be frivolous or unimportant or very minor rights may actually be significant enough under the 401(a)-4 regulations that you have to do something about it if you want to be sure that your plans are going to qualify.

Other examples of this are the right to buy an annuity through the plan. Suppose you have a profit-sharing plan, and it provides that people with segregated accounts can buy an annuity, and people with a general account just get a distribution in cash. That's not going to work. The right to buy life insurance with a portion of your account balance, and the right to transfer money to a savings account after age 55 may well be examples of something like this. I've seen a lot of plans, particularly in the governmental sector, where people approach retirement that in order to give some benefit security to the people who are nearing retirement, anyone age 55 and over is permitted to transfer their funds to a savings account or some sort of secure form of investment. No one under age 55 is allowed to do this. That may constitute a right or feature of the plan that has to be tested for availability. If you can't pass that availability test because the people who are 55 and up are predominantly higher paid, then you have a problem. You just need to look at all the quirks and all the perks in your plan.

The next thing to do is to engage in an administrative review. Are the same investment options available to all participants? That's probably one of the most important questions. If Division A has a choice of five Vanguard funds and Division B has a choice of five comparable Magellan Funds, are these different rights and features? Arguably under the regulations, maybe they are. I'm trying to avoid citing the regulations, but -4(e)iii(c) says that "the right to a particular form of investment is a right or feature which has to be tested taking into account any differences in conversion, dividend, voting, liquidation, preference, or other rights." I'm not saying in this particular case you would have something that has to be tested. I'm saying I don't know whether you have something that has to be tested or not. I'm sure that if you offered five Vanguard funds to one group and three Magellan funds to a different

group or even three Vanguard funds to a different group, you would have different rights and features, and you would have to look at that and test it.

I think you should look at plan loans extremely carefully. How are the interest rates determined? What about the repayment of this loan? Do the NHCEs have to make payroll deductions? Are the HCEs permitted to make quarterly repayments with personal checks? What happens in the event of the default on the loan? Are the HCEs treated any differently? Are they treated a little more deferentially? Nobody who is an office manager is going to want to go to the doctor who owns the corporation and say, "Gosh, you're in default of your loan. I'm going to have to foreclose on your house because that's what the plan provides." There is a temptation there to treat the HCEs differently when it comes to default. We all know that doctors do default, sometimes, on these loans. It's a question of how is that dealt with and does the way in which it is dealt with create essentially a different form of benefit? Is the interest on the loan allocated to the participant's account for some groups but not for others? What about distributions under the plan? Are the HCEs paid off right away but the rank and file have to wait? Do the doctors receive distributions in kind and everyone else gets cash?

If you have a large client with plans that, for a variety of reasons often occur in large clients, the benefits, rights, and features are not universally available, you should always do a 410(b) analysis before certain events occur, and often you should do it before the employer makes the final decision as to whether or not these events will take place.

The next question is, what do you do if your benefit, right, or feature doesn't pass? The first option is, eliminate it. You have two ways to do this. The first is, you can eliminate it prospectively. The second is you can eliminate it retroactively. Prospectively, you must meet 410(b) on the date of elimination. What this means is, prospective elimination will only help you if you see the problem coming before it gets there. If you suddenly discover you have a problem, and your method of dealing with it is to simply eliminate the benefit, right, or feature from that point forward, that will not resolve the problem.

RETROACTIVE ELIMINATION

Retroactive elimination is my favorite and the reason why it's my favorite is because, under certain circumstances, you are allowed to take away 411(d)6 protected benefits. Most people think that is not possible. This method works only for optional forms of benefit. It is possible to remove an optional form of benefit retroactively under certain circumstances, and that is spelled out in the 1.401(a)-4 Q&A #5 regulations. These are the regulations that are the regulations that preceded the 1.401(a)-4 regulations. You have to have exactly the right set of circumstances to do this. If you have a problem like this, I suggest you look at it. First thing is, you have to fail 410(b) at a certain point in time. The second thing is that in between the date when you're going to retroactively remove the feature and the date of the amendment, the plan had to have operationally complied with the amendment. That can work out for you if it just turns out that nobody took this particular optional form of benefit. You may have an optional form of benefit that is not used very much that creates the problem, and you want to get rid of it. If nobody has taken it, then you can get rid of it.

If you don't go the elimination route, you may consider extending your benefit, right, or feature to enough NHCEs to make it nondiscriminatory. Here you have cost issues, you have benefit philosophy issues, you have administrative issues, but it may be your only answer under certain circumstances. Obviously, what you can do is combine this approach with the elimination approach, extend the right or feature, and then kill it prospectively. This does create accrued benefits with that benefit, right, or feature hanging around until that entire group of people are gone.

A fourth thing you can do is try aggregating that benefit, right, or feature with a benefit, right, or feature of greater value. Maybe there is something you can do to another feature that will make it always more valuable than this so that you can then go ahead and aggregate it.

A fifth thing you can do here is what I refer to as gerrymandering your groups. This is my other favorite, and that is to identify a subgroup of NHCEs that is big enough to give you a pass on the test but small enough not to be a headache and then go ahead and give the benefit, right, or feature solely to that subgroup. This works best if there is something logical about the group that you're choosing. They have some characteristic in common that makes them a reasonable group and not just if they're an arbitrarily chosen group that happens to help you pass this test.

Some of the situations that can lead to problems are where you have different plans for different employee groups: salaried versus hourly; sales versus nonsales; different divisions within an employer; and so on. If you have a plan where the only difference is that one is for union and one is for nonunion, you do not have a problem because you carve all the union people out before you do your testing. Another way in which potential problems can arise is through historical features that are available only to a closed group of employees. Acquisitions can create problems. Maybe you can use a special rule in the regulations, but it's not a slam dunk because you have to meet the availability test after the transaction occurs. If you can't meet that, then you cannot use the special rule. Often when you're downsizing, that can create situations in which you're giving special benefits to certain groups of people in order to encourage them to leave or to make the fact that you're forcing them to leave more palatable, and these need to be tested. You see your early retirement windows, but you also sometimes see special termination incentives. Finally, where you have different investment options, it's always a dangerous situation.

We have segregated accounts and small defined-contribution plans. If you have a situation where only HCEs have segregated accounts, it may well be that the NHCEs were never told that they could have a segregated account; therefore, you have an effective availability issue here. Any time there is a feature that only the HCEs utilize, that's a danger sign. It doesn't mean that it's bad. What it means is, you should watch out and you should ask questions of the employer. Why is it that the only people utilizing this are the HCEs? We don't let the NHCEs have segregated accounts. I've heard that. Right away you know you have a problem.

This is a situation with respect to early retirement windows. I think these can easily create problems with respect to availability. The danger here is that the HCEs are more likely to qualify for this window. The reason is that generally speaking they're older and they've been there longer. Because it's a numbers game and because you

cannot ignore the age and service under these circumstances, you may have trouble meeting this test.

Here is an example of an early retirement window analysis for 410(b). You have 35 NHCEs out of a 2,000 NHCE group who are eligible. You have nine HCEs who are eligible out of 100. The NHCEs availability ratio is one and three quarters. The HCEs ratio is 9%. Your availability coverage ratio is 19.44%. Anything below 20 is an automatic fail. This window violates 410(b) because the coverage ratio is below the unsafe harbor.

This shows you how you would go about calculating the number of NHCEs you need in order to make the window work. You have an unsafe harbor of (1) 20%. For this group you have a safe harbor ratio of (2) 23.75%, and that's taken out of the 410(b)-4 regulation. Your HCEs' ratio is (3) 9%, and you have (4) 2,000 NHCEs. To meet the unsafe harbor you would take (1) times (3) times (4). When you do that, you get 36 NHCEs who are eligible. That means you need one more to get you to the unsafe harbor, that will put you at the point where maybe you can demonstrate to the IRS that on the basis of facts and circumstances in this situation you're fine.

If you take (2) times (3) times (4), you get the number, 43, which you need to meet the safe harbor. That's only eight more than you already have. This illustrates what I'm talking about when I talk about gerrymandering of employee groups. You might want to go out and find yourself an employee group that has six or eight potentially eligible people and include them in this window even though for business reasons you wouldn't necessarily think of doing that or want to do that. You do it strictly from the point of view of trying to satisfy the 410(b) requirements so you can give the early retirement window to the group of employees that you really want to give it to.

MS. SUSAN SEROTA: What I thought I'd talk about were basically two different areas, one being the SLOB rules and the new proposed amendments to them, and the other, some of the procedure and administrative matters that have just recently come out of the IRS. The IRS has issued four Revenue Procedures and one announcement dealing with opening and determination letter process, data substantiation, and some other ways of effectuating the SLOB exception.

SEPARATE LINES OF BUSINESS

The SLOB exception was initially put into the IRC under Section 414(r) as a businessman's rule. The reason it was is because, with the new 410(b) requirements for testing for average benefits and coverage, it was apparent that there were some companies, which on a control group basis really had such different benefits being provided, different segments of their business, that it just wasn't right to test them as if they were all part of the same control group. An example that is always given is the Mobil Corporation/Montgomery Ward situation where one is in the oil business and one is in the department store business. The groups of employees that they have, the nature of the business, the competitiveness of both the business and the compensation and how you design the compensation is so different that even Congress and the IRS and Treasury recognize that basically we shouldn't be testing these two groups together.

Those two types of business segments are so far apart that it is very easy to recognize that those are SLOBs. What the Treasury had problems with deciding was, where do you draw those lines where it isn't so evident that they really are SLOBs? The people at the Treasury went through enormous analysis as to whether or not they should use the six codes used, for example, by the Justice Department for antitrust purposes (those codes are used in other parts of the IRC); whether or not they should have just an administrative-scrutiny-type test where everyone had to come into the IRS and get approval for their SLOBs; or whether they could set up some sort of standards that would be appropriate so that businesses could have comfort that, if they followed certain rules, they knew that they had a SLOB.

The people at the Treasury sort of came out in the middle. In other words, they didn't really come out answering anybody's questions or meeting anybody's requirements, at least not the first time around. What happened was that a number of us, and I'm sure a number of you, who had clients who were in the situation where they did provide different benefits to different groups of employees because they were in different businesses, found that the SLOB rules as initially put forth by the Treasury and the IRS just didn't meet their goals. Here the IRS people had spent umpteen years developing these regulations, which in the preamble they said, maybe 60 companies in the U.S. could use. Basically they then received a number of comments even after they had finalized those regulations saying that they really had to make the regulations more flexible; they really had to look at this from a business point of view; and there were just certain stringencies that they had built into this type of arrangement that really were impossible to meet and really shouldn't be necessary to meet. If you go back to what is required, you go back to the fact that, in order to be able to test separately for 410(b) or for 401(a)(26) purposes, you have to have what are called qualified separate lines of businesses (QSLOBs).

First of all, to get to a QSLOB, you have to go through a Monopoly game. Even in the regulations, the IRS gives you a chart which looks just like Monopoly. You go up the line, down the line. If you miss it, you go back to GO, and you start all over again. It basically says there are a bunch of ways, but you have to go through each step to see if you can get through those tests in order to become a QSLOB. For example, the first thing you have to do is establish a line of business. What does a line of business mean? It means that you have a service or product that you're selling to customers that is different from the service or product you're selling to different customers. If you can't meet that line of business test, you never even get started down this road. One of the problems that we had found in analyzing is that, a number of clients, who had vertically integrated businesses but were basically in such separate geographical areas that their competitiveness on wages or the type of level on the integration was vastly different, basically weren't providing the same benefit. Even in the initial final regulations that were issued in 1991, the IRS recognized that certain vertically integrated businesses should be able to establish part of that business, what they call the upstream line of business, which to me always was the one farther down because I always think of the holding company as being up, but when they say the upstream line of business, they really mean the one that is providing services or products to another company in the control group down the line. Basically, this is the real production plant, let's say. The IRS uses the furniture industry as one example. So let's say this is a manufacturer of furniture in North or South Carolina. It's basically manufacturing the furniture, which is then being shipped

up to Chicago, let's say, where part of the distributing unit is being sold, and this distribution unit may actually sell to customers or it may indeed be selling up the line to a final distribution circuit which basically sells to customers. The problem is that the original plant manufacturer operation wasn't selling to any customers other than its own parent or brother/sister corporation. Therefore, in the initial final regulations where you were required to get the exceptions of vertical integration rule was that you sell at least 25% of your product or services to customers just couldn't be met. It was very evident that in North and South Carolina historically, qualified plan benefits are not as predominant as wages. Typically even in noncollectively bargaining situations and a lot of the situations in North and South Carolina are not collectively bargained, the employers paid higher wages or whatever wages were necessary to retain the employee and weren't providing very good or any qualified plans. On the other hand, the distribution unit in Chicago, which is probably collectively bargained or has some collectively bargained employees and has some other noncollectively bargained employees, was providing qualified plan benefits on a level that was necessary to compete for those employees.

What happened was that, through a process of comments being given to the IRS, for example, by the American Bar Association (ABA) and I'm certain by other groups as well, the IRS agreed that there should be a change and added the vertical integration exception to the line of business, which basically expanded that exception. No longer do you have to sell 25% of the product or service to outside customers unrelated to the controlled group. Rather, all you have to do is produce. It doesn't apply to service companies. You have to produce a product that someone else in the industry is selling to customers. For example, let's take the drug industry, with manufacturing plants around the country, in Europe, and everywhere else. Let's say we're talking about ones at least in the U.S. They basically manufacture both the final product and manufacture chemicals or whatever. Some final product is distributed through the chain, through the big top product pharmaceutical companies and, therefore, to customers. Some of it is actually packaged and then sold by other people under a generic name. Some of it is chemical that is just sold actually to competitors who then use it because that's part of the business. Whatever it was, there were obviously things going on within the pharmaceutical industry that meant that it couldn't meet the 25% to customers' requirement, yet there were various parts of the pharmaceutical industry that were selling that same or similar type products to customers. That's what is basically recognized by the change in the proposed regulations.

Let's go through some of the other changes, and then I want to spend some time on the procedural determination letter process and the data substantiation guidelines that were issued at the end of last month.

In general, as we said, all employees within a controlled group or a group of trades or businesses are considered employed by a single employer for both 410(b) and 401(a)26 purposes. What the SLOB regulations permit is that an employer divide its business into QSLOBs, and then apply the new coverage rules and the nondiscrimination rules to the employees on each SLOB as if it was a separate employer and not part of the controlled group. This only applies for 410(b) and 401(a)(26) and the 401(a)-4 regulations; it does not apply, for example, for alternative rights and features and other aspects of the IRC qualification requirements. It is a limited thing, but this

is where you're really testing employees' compensation and employees' benefits, and you're trying to decide whether or not they meet the nondiscrimination requirements.

The first thing you have to do is to determine how many lines of businesses you have. The second thing you have to do is to determine that the lines of business are really separate from each other. That was what we were just talking about concerning the vertical integration issue. The third thing you have to show that these SLOBs meet the requirements for being QSLOBs. To do that, to be a QSLOB, the employer has to designate its lines of businesses by reference to the property or service provided by each line. Each line of business has to be organized and operated separately for the remainder of the employer, and each SLOB must meet additional statutory requirements including administrative scrutiny.

What were the modifications? Most of the modifications that were proposed this last September 1993 were to the separate work force and separate management test. For a line of business to be considered a SLOB, that line of business must have its own separate work force, and it must have its own separate management. The separate work force test focuses on the percentage of the employees providing services to that line of business. They're called Substantial Service Employees (SSE). There's a parallel test for management.

Generally, a line of business has its own work force if at least 90% of the employees who provide services to that line of business are SSEs. The current regulations -- in other words the regulations that were in final form -- required that a SSE had to provide at least 75% of the employee's services to that line of business. Then the employer had the option of assigning an employee to a line of business if at least 50% of the employee's services was provided to that line. You had to basically assign every employee to a substantial line of business, or the employee had to be considered to be a residual shared employee, in other words to provide services to more than one line of business.

The change that is in the proposed regulations provides that the employer can elect on an employee-by-employee basis to treat the employee who provides at least 50%, but not less than 75%, of his services to the line of business as a SSE. Therefore, there is a lower threshold for the SSE, which makes it easier to satisfy the separate work force test. Furthermore, the SSEs of one line of business can be disregarded in applying the separateness test to another line of business even if they provide more than negligible services to that second line. It also means that, when you're running these tests on separateness, you can now ignore any employee who is considered to be a SSE with respect to another line of business even though he is providing more than negligible services to the line of business you're trying to qualify.

There were a lot of problems involved with either foreign-owned companies, which had operations in the U.S. and had plans for those employees of their U.S. operations, or U.S. companies, which had foreign employees. Under the current regulations, the nonresident aliens could be excluded only if you could show that they provided substantial service to another line of business, which meant basically you were supposed to find out what all employees outside the U.S. did and whether or not they performed 50 or 75% of their services for another line of business outside of

the U.S., which meant you were requesting data all over the world, and it was impossible. It was unworkable.

The IRS has now recognized this, and now you're going to be made to exclude all nonresident aliens from both the work force and the management separateness test. This is really a relief because it eliminates the need for employers to gather data on service by nonresident aliens performing services outside the U.S. In fact, in some countries you couldn't even get the data because it's illegal to give data on compensation of employees without their permission. It really became an impossible situation.

When an employee changes status, let's say he moves from one line of business to another line of business, or he goes from collectively bargained to noncollectively bargained, under the current regulations, you are allowed to treat that person as continuing a line of business for approximately two years. That's now been changed to three years, and they've added more flexibility in how to deal with employees whose employment is transferred.

We've already talked about the change in the vertical integration. Administrative scrutiny is very restrictive under the current regulations as to whether or not you can go to the IRS and ask for a letter to determine whether or not you had a SLOB. Now that has been broadened dramatically, and the restrictions on access for individual determinations has been removed.

There were also some modifications on some of the safe harbors and the definition of HCEs and some of the rules that deal with this aggregated plan rule. These changes only come out the second week of September. It has made us look again to reassess whether or not a SLOB is indeed a viable alternative as a way to analyze and then test plans for employers who are providing different benefits in different business operations.

The two revenue procedures that we'll just mention in passing really deal with (1) how to notify the IRS that you have a SLOB, and you're testing that way, and (2) the administrative scrutiny required that the IRS sets forth in the procedures for going to the IRS and obtaining a letter from the national office on that issue.

The two major revenue procedures that I wanted to talk about were 93-39 which deals with the determination letter process, and 93-42, which deals with data substantiation. These were issued on September 28, 1993, but 93-39 regarding determination letters says that beginning October 12, 1993, the IRS has begun to accept requests for determination letters covering all tax reform act compliance with respect to all qualified pension and profit sharing plans. In general, there is no longer restriction of going into the IRS for a determination letter. Before you could only go in if you had a safe harbor plan. Now you can go in on all the plans. The letters that the IRS issues will apply only to 1994 or whatever the effective date for the tax requirement amendments will be. If you have a collectively bargained plan, it might be later. You just will have to rely on good faith for the 1989-93 years unless you amend your plans retroactively back to 1989 and have basically administered the plans in accordance with those amendments. In other words, you can meet the requirements for those years as well.

The IRS is offering a lot of alternatives. In other words, it used to be you went in, and you got one letter and occasionally the IRS people caveated it because there was some new regulation or there was a new law that passed, and they said, basically, this letter applies except that you haven't shown us and we haven't issued regulations yet on some law. They're now offering alternatives, and the alternatives basically are at the lowest level to get a determination letter that covers your plan documents, but you cannot rely on it for either meeting the general test, the average benefits test, or current availability of benefits, rights, and features. On the other hand, if you want to show additional demonstrations for each of these various matters and if you're willing to pay an additional user fee, you can get a letter that will tell you that your general test as to nondiscrimination and amounts of contributions or benefits does meet the requirements of 401(a)(4)-2 or -3. Or if you want to know that your average benefits testing does work, and this is only for plans not satisfied in the 70% ratio percentage test, you can go in and have the IRS actually agree that your demonstration shows that you meet those requirements. Third, if you have certain benefits, rights, and features that you want the IRS to review, you can go in and ask the IRS people to review those benefits, rights, and features as to current availability. Only to the extent that you actually identify that benefit, right, or feature, will you get a letter back. It will not apply to any other benefit, right, or feature that you don't ask the IRS to review. Basically, the IRS will not give you a letter or any comfort as to the effect of availability of benefits, rights, and features. That will be done only, I assume, through the audit process.

The revenue procedures provide guidelines for preparing all these demonstrations. There's a Schedule B that runs on for about eight or ten pages telling you exactly what you have to show and how to show it in demonstrating the general test, the average benefits test, or current availability. The other thing to remember is that the IRS has eliminated Form 5302. Form 5302 was the one page that showed the 25 highest paid participants in the plan, their salaries, their excluded compensation, what benefits they received under this plan, and what benefits they were getting under other plans. The IRS was then supposedly able to test whether or not you were discriminatory as to those highest paid 25. That no longer is necessary to file. In fact, the IRS is eliminating the whole form and any determination letter request that is in process or at least has not yet been filed; you just ignore that form. But, as I said, there is plenty of room here for you all to do work in preparing the demonstrations for general test, average benefits testing, and current availability.

The letter will cover the timing of amendments. If you remember under 401(a)(4)-5, the timing of amendments is also a discrimination test. In the letter that is submitted if you're submitting that amendment, the IRS people will look to see whether they think that's discriminatory or not. The letter will not cover anything dealing with minimum funding requirements, deductions, or use of the substantiation guidelines in revenue procedures 93-42. It will not cover SLOBs other than the nondiscrimination classification test and 410(b) and 401(a)(26) if they're being tested on an employer-wide basis. The new schedule for fees depends on the type of letter you request. For the lowest level letter, that's $700 for an individually designed plan.

If, on the other hand, you want to get the general test approved that you qualified or the average benefits test, then the fee goes up to $1,250 for the first request.

The IRS has also extended the reliance period. If you remember under the last revenue procedures, the IRS issued that, if you filed for those plans that could be filed by December 31, 1993, then you were allowed to rely on those determination letters through, I think it was 1988. Because the IRS has just opened up the process again, it is saying, if you file by June 30, 1994, you can get that extended reliance. If you're going to be testing on a QSLOB basis, then the determination letter request for that plan has to be filed with the key district director for the district in which the principal place of business of the employer is located so that you no longer go to the local district director. You'd have to go to whatever location the principal business is in. You'd have to attach the forms and information on the QSLOBs, which would apply also to all sets of information.

I'm not going to go over it because of time, but the 414(r) notification requirements, which is that one of the requirements of having a QSLOB is that you have to notify the IRS, but you use a Form 5310A for that purpose.

Again, on revenue procedures 93-41 the administrative scrutiny requirement provides the exclusive method by which an employer can request and receive a determination letter from the IRS as to whether a SLOB satisfies the administrative scrutiny test of the regulations. The point here to remember, however, is that an employer cannot make a request for administrative scrutiny for a testing year that has ended prior to the date you make the request. You have to remember that, if any of your clients want to go in for administrative scrutiny, they have to do it before the end of that testing year.

The user fee for administrative scrutiny, just so you get an idea of how much the IRS is asking these days, for the first SLOB is $2,750 to go through the administrative scrutiny process and get a letter from the national office. Every additional SLOB that you want to qualify will be $875. The IRS is putting a premium literally on the obtaining of determination letters in different circumstances, partially, I guess to offset its cost in reviewing all these determination letters that are going to come in.

The revenue procedures that I want to spend the remainder of my time on is 93-42, which deals with data substantiation and guidelines of the nondiscrimination requirements. If you remember, the IRS has issued a few announcements in the past that said that it was going to provide more flexibility in the quality of data that were issued in 1992. What this revenue procedures does is conforms and confirms those previous announcements with some changes. In general the IRS will permit other types of data -- data which are not precise data -- to be used. It will ease the burden of demonstrating compliance with the following components of nondiscrimination testing. For example, you can use this other than precise data for testing when plans meet minimum coverage, for determining when an employer operates a QSLOB, protesting the amount of benefits under the general rule, but not for defined-contribution plans. The IRS requires precise data for defined-contribution amounts testing; testing the current availability of optional forms of benefits, rights, and features; and testing whether a nonsafe harbor definition of pay is discriminatory, and the release, if not available, for 401(k) or 401(m) under the average deferral percent, the average contribution percentage.

What it does do is say that the quality of data that you can provide can be something less than precise, if indeed, they are the best available data for the plan year that can be obtained at a reasonable cost. The employer reasonably concludes that demonstrating compliance with nondiscrimination requirements using these data, would establish a high likelihood that the plan would satisfy the nondiscrimination requirements if the employer actually used precise data. The IRS calls this substantiation quality data.

Let me give you a couple of examples that the IRS has in the revenue procedure so you get an idea of when you can use this and what types of things the IRS is saying is fine. The first example is an employer that sponsors a defined-benefit plan for employees in three different divisions, which I have located in different geographical areas. Each division maintains its own payroll and its own personnel records. Under that employer's plan, the relevant components for determining employees' accrual rates are compensation, age, and service. The IRS uses a definition of the compensation that meets 414(s). But the cost of gathering the data and merging the precise data with three different payrolls and three different geographical areas is considered to be very expensive. The employer determines, for 1995, the best data that are available at reasonable expense are the data that are gathered as of the 1995 valuation date and used to prepare the Schedule B for Form 5500. The employer can use this because the employer reasonably expects these data to approximate the relevant compensation, age, and service components. The employer concludes that there is a high likelihood that if it actually gathered that precise data, that it would still pass the nondiscrimination requirements. The substantiation of quality data means that you can use valuation data.

A second example is where one of the divisions is missing information with regard to the date of hire of a group of employees. The employer decides that the missing relevant data are fairly similar to the data that would be on the other groups of employees for which it does have data. Therefore, the IRS allows the employer to estimate the missing data and use estimates in running the test. The only time the IRS says you can't do that is if the employer was missing the relevant data on one or more of the most HCEs in the plan or a group of employees who have a benefit formula that is not available to other employees. Then again you have to go back to using precise data.

A third example the IRS gives is where you have two different plans or two different eligibility requirements: one has both an age and service requirement and one just has an age requirement. Therefore, you never gathered the data on the service for that group for which it had no meaning. The IRS is saying that, as long as the employer reasonably believes that the two groups are equivalent, and that if they had really gone out and obtained the data, it would have shown that the employer had passed it, the employer again can make certain assumptions, use certain estimates to fulfill that missing data; the employer doesn't have to actually collect it.

Second, the IRS has approved single-day snapshot testing so that you can substantiate that a plan complies with the nondiscrimination requirements on the basis of the employee's work force, on a single day during the plan year provided that the day is reasonably representative of the employer's work force and the plan coverage throughout the plan year. You can ignore certain extraordinary events such as a

merger and acquisition. Again, the IRS has said that there is now a simplified identification for HCEs, and basically you can use this new format for identifying HCEs, which is a simple way of doing it. This is the only time the IRS said that, if you are going to do this and use a different definition of HCE, the plan has to be amended to permit you to use this. What it does allow is that the employee you enter and count all 5% owners, you get to use the employees exceeding the Q1B amount or the Q1C amount or if the employee is an officer. Basically, you can take into account compensation that is reasonably approximate to the compensation from the plan year. You don't have to use the look-back provision. It makes it somewhat simpler to determine who your highly compensated group is.

The three-year testing cycle I think is rather important. Originally, the IRS said that the first testing year had to be the year in which the effective date for the non-discrimination requirements had gone into effect. The IRS has now said that, if you had a year prior to the first year in which you tested and you come out fine, for example, maybe you did in 1990 or 1991, you can use that as your three-year testing cycle so that you wouldn't have to test again until three years after that. Everybody does not have to do a testing cycle in 1994 if you've already done a test and found that you meet the 401(a)-4 and 410(b) requirements.

There are certain special rules on multiemployer plans and QSLOBs, again. Indeed, what has happened is that the IRS has finally come out and has given us enough information, we hope, to go forward one with amending plans, testing plans, and submitting plans to the IRS for determination letters. I think now the IRS feels that this whole regulatory process is finished. What it wants to do now is get into the determination letter process.

FROM THE FLOOR: When you do the ratio test, you can exclude people who don't have the age and service requirement unless they've been in one year and one out. I have a lot of people coming in under 1,000 hours, over 1,000 hours. Can you go over a little bit how that works?

MS. SEROTA: Are you going to be at workshop?

FROM THE FLOOR: Yes.

MS. SEROTA: That would be an excellent time to talk about that issue.

FROM THE FLOOR: I want to refer to Mr. Kenney where you spoke about different actuarial assumptions affecting optional benefits availability. In situations where you have a frozen pre-1989 accrued benefit and then a new set of accruals commencing with 1989 plan years and assign different actuarial equivalent assumption to each of those two sets of accrued benefits and you have in the pre-1989 group only HCEs, just by the natural scope of things and in the post-1988 world you have both HCEs and nonHCEs, do you run into a problem akin to what you mentioned?

MR. KENNEY: I think you very well could run into a problem there. Are you going to be at our workshop?

FROM THE FLOOR: No, and I'd like you to mention as briefly as you can the problem.

MR. KENNEY: The problem could be, and I would have to look at the regulations here and go through that, that you have different actuarial assumptions available to different groups.

FROM THE FLOOR: Different sets of benefits, I might add, not different groups necessarily.

MR. KENNEY: You have different actuarial assumptions available to different groups of employees. It's one of these wasting-away-type situations where you have a group that is closed and no additional people are being added to that group. I would like to walk through the regulations with you, but that creates different optional forms of benefit and those have to be tested.

FROM THE FLOOR: And the testing that you refer to is the basic 410(b), that testing?

MR. KENNEY: Yes, that's correct. There may be an exception under those circumstances, and I'd be willing to walk through the regulations with you and see if we could find one.