MANAGEMENT & MARKETING

(Editor's Note: This quarterly JCO column is compiled by Contributing Editor Howard Iba. Every three months, Dr. Iba presents a successful approach or strategy for a particular aspect of practice management. Your suggestions for future topics or authors are welcome.)

As early as the 1970s, many dentists began incorporating their practices. There were several good reasons to take this step, but the primary impetus was to establish a tax-deferred retirement plan. To this day, a pension plan remains an excellent investment vehicle for achieving financial independence. Several new options have been created by changes in tax laws over the last few years, and this month's column addresses those changes.

John McGill of Blair/McGill & Co. presents the results of a survey of retirement plan utilization by dentists, along with a prediction of future trends in plan structures. Obviously, the ideal type of plan depends on the age of the dentist. Mr. McGill's division of the survey results into four age groups allows each individual orthodontist to focus on the most pertinent information and to decide what revisions might be advantageous.

This article should bring you up to date on the new options for tax-deferred retirement plans and enable you, with the advice of your professional advisers, to make a more informed decision on which plan is best for you.

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Retirement Plan Survey

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Our recent survey questioned dentists regarding the number and types of retirement plans sponsored by their practices; annual funding levels for themselves, their spouses, and staff; methods used to control staff funding costs; and anticipated future retirement plan changes.

Here's our analysis of the survey results, along with our predictions for the future.

Survey Demographics

We received 859 responses to our survey from more than 8,000 subscribers. Of those responding, 67% were general dentists, 17% were orthodontists, 5% were pediatric dentists, 4% were oral surgeons, 3% were periodontists, 3% were endodontists, and 1% were prosthodontists.

The vast majority (73%) of responding doctors were in solo practice. Another 20% were in two-doctor groups, while the remaining 7% were in group practices with three or more doctors.

Retirement Plan Sponsorship

Ninety-six percent of the dentists responding indicated that their practices sponsored one or more retirement plans. This was the same per-

centage as in our 2000 survey, but up dramatically from the 83% of doctors sponsoring plans in our 1991 survey. Due to recent favorable tax-law changes, it is rare to find situations where retirement plans are not cost-effective for doctors these days.

Of the dentists sponsoring retirement plans, 83% maintained only a single retirement plan, up from 78% in the prior survey. However, we were surprised that 17% of the practices were still operating more than one retirement plan. Given recent tax-law changes, virtually any practice can achieve its desired doctor and staff retirement funding goals using a single retirement plan (Table 1). This not only eliminates the redundant legal, accounting, and administrative costs associated with operating multiple plans, but simplifies the doctor's financial life.

Only 11.2% of the doctors responding indicated that their practices sponsored basic profit-sharing plans, down dramatically from 22.4% in the 2000 survey and 40.9% in the 1991 survey. Furthermore, only 3.3% of the dentists indicated that their practices sponsored traditional money-purchase pension plans, down from 12.1% in the 2000 survey and 21.1% in the 1991 survey.

Smaller declines were registered in the percentage of doctors sponsoring Simplified Employee Pension plans (SEPs)—6.3%, down from 11.4% in the prior survey—and target-benefit pension plans—.1%, down from 2.2% in the prior survey.

As predicted, there were huge gains in the percentages of doctors sponsoring 401(k) and defined-benefit and other age-based plans. The biggest increase was in 401(k) profit-sharing plans, which catapulted from only 12.7% in 2000 to 31.4% just four years later. In prior years, the use of 401(k) plans was most prevalent among younger doctors in group practices, since these plans allowed differing salary deferral levels among doctors and other employees. Moreover, these plans have lower staff funding costs, since part of the contributions come from the employees' own funds through salary deferrals. Recent tax-law changes now allow doctors to make the maximum salary deferrals for themselves, regardless of staff participation, through using one of the two "safe harbor" plan options. Moreover, many doctors have been able to make substantial contributions on behalf of employed spouses through their 401(k) plans, as discussed in more detail below.

Retirement plans that use age as well as salary to allocate contributions on behalf of participants also enjoyed some growth, as predicted. Cross-tested and age-weighted profit-sharing plans accounted for 21.3% of all sponsored plans, up from 19.6% in the prior survey and 0% in the 1991 survey. These plans should continue to experience tremendous growth as more doctors with younger staffs take advantage of the opportunity to generate the maximum possible contribution allocations on their behalf ($41,000 in 2004), while minimizing staff funding costs through these age-based allocations.

Defined-benefit pension plans also experienced tremendous growth in this year's survey, up to 9.0% of all dentists responding from just 4.1% in 2000. Given the decline in doctors' investment assets over the past few years, defined-benefit pension plans represent an ideal opportunity for doctors age 40 and older to make up for lost time by significantly increasing tax-deductible contributions on their own behalf. Defined-benefit pension plans are not limited by the $41,000 annual allocation limit applicable to other plans. In many cases, doctors age 40 and older are contributing $50,000-250,000 per year on their own behalf to reach their retirement accumulation goals at a normal retirement age (usually age 62 or 65). Therefore, we expect the percentage of dentists sponsoring defined-benefit pension plans to substantially increase as more doctors take advantage of this opportunity to rebuild their retirement asset balances.

Annual Doctor Contributions

We also asked what the average retirement plan contribution made on behalf of each doctor was for 2003. The highest percentage of doctors (37%) received the maximum annual contribution allowed under a defined-contribution plan

TABLE 1
GLOSSARY OF RETIREMENT PLANS

Defined-Contribution Plans
Contributions may be made by the employer, the employee, or both. Each participant has an individual account; the final benefits paid out depend on the amount contributed and the rate of return on investments, which are selected by the employee from among the employer's options. Types of plans include:

Money-Purchase Plan
A fixed percentage of the employee's compensation is contributed annually by the employer.

Profit-Sharing Plan
The employer's contribution is discretionary, and may or may not be based on the company's profits for that year and a percentage of the employee's compensation.

401(k) Plan
In this form of profit sharing, the employee makes regular, tax-deferred contributions that may be matched in whole or in part by the employer. If "safe harbor" requirements are met, there is no discrimination testing for highly compensated employees.

Stock-Bonus Plan
This is another profit-sharing plan in which the employer's contributions are made in company stock.

Employee Stock Ownership Plan (ESOP)
The employer also contributes shares in company stock, but not on a profit-sharing basis.

Target-Benefit Plan
The employer determines a target benefit for each participant, and contributions are based on a projection of that amount.

Simplified Employee Pension (SEP)
For small businesses, this plan has less complex filing requirements.

Savings Incentive Match Plan for Employees (SIMPLE)
In another plan for small companies, the employee contributes a percentage of salary and the employer either matches that amount or contributes a percentage of the employee's compensation.

Cross-Tested Plans
Discrimination in favor of highly compensated employees is tested on the basis of benefits rather than contributions.

Age-Weighted Plans
Non-discrimination testing is based on the age of the participant; calculations are less complex, but less flexible, than with cross-testing.

Defined-Benefit Plans
Contributions are made only by the employer. Benefits for qualified employees are determined by a formula based on compensation and length of service. The investment risk is assumed by the employer.

Note: According to Jason Arnold, East Coast District Manager of PenSys, Inc.,* the most recent major tax-law changes have made some of the plans listed above obsolete. Most employers can achieve maximum results through SEPs, SIMPLEs, or profit-sharing or 401(k) plans (with or without cross-testing and "safe harbor" features), or defined-benefit pension plans.

TABLE 2
STAFF FUNDING LEVELS BY DOCTOR'S AGE

	30-39	40-49	50-59	60-69	Total
0-5% of pay	64.7%	52.6%	54.7%	63.7%	55.9%
6-10% of pay	18.1	26.1	24.9	17.6	23.9
11-15% of pay	12.4	12.7	15.2	14.3	14.0
More than 15% of pay	4.8	8.6	5.2	4.4	6.2

for that year ($40,000). Another 18% received contributions in the $10,000-20,000-per-year range, 13% were contributing $20,000-30,000 per year, 13% were contributing $0-10,000 per year, and 8.6% were contributing $30,000-40,000 annually.

As discussed above, dentists with defined-benefit pension plans were contributing even greater amounts to their plans on a tax-deductible basis: 2.5% of the total respondents were contributing $40,000-60,000, 2% were contributing $60,000-80,000, and another 2% were contributing $80,000-100,000 annually. Nearly 4% of the doctors were contributing more than $100,000 to their defined-benefit pension plans in 2003.

Spousal Contributions

Recent tax-law changes have fueled a dramatic increase in the number of spouses employed in dental practices. Fully 65% of the doctors responding employed their spouses in their practices in 2003, primarily for retirement plan contribution purposes. Of these, 72% made contributions on behalf of an employed spouse, while only 28% did not—well above our expectations. This tax-saving strategy was most often used by doctors sponsoring SIMPLE-IRA and 401(k) plans.

Of the doctors who made contributions on behalf of employed spouses, 53% contributed $0-10,000, while 34% contributed $10,000-20,000 annually. Using cross-tested, age-weighted plan designs, another 6% were able to generate the $40,000 maximum contributions on behalf of employed spouses. Finally, 3% of the doctors (those sponsoring defined-benefit pension plans) were able to fund contributions of more than $40,000 on behalf of their employed spouses. These contribution levels were significantly above those in the prior survey. In 2000, nearly 90% of the dentists employing spouses were funding annual tax-deductible contributions of only $0-10,000 on their behalf.

Staff Funding Levels

We also questioned the dentists regarding the percentage of pay contributed on behalf of staff members to their retirement plans (Table 2).

In December 2001, we recommended that doctors take advantage of new retirement plan design options to reduce largely unappreciated staff contributions and reallocate all or part of the excess to more appreciated forms of compensation. This saves the practice money while increasing the perceived benefit to employees. We were pleased to see that doctors had heeded our advice.

Dentists age 30-39 had the highest percentage (64.7%) contributing 0-5% of staff pay. This was followed closely by 63.7% of doctors age 60-69 contributing in the same range. In comparison, only 54.7% of doctors age 50-59 contributed 0-5% of pay on behalf of staff members. Doctors age 40-49 had the lowest percentage (52.6%) contributing 0-5% of pay and the highest percentage (8.6%) contributing more than 15% of staff pay to their retirement plans.

Overall, the 859 dentists who responded to our survey were contributing 6.4% of pay on behalf of staff members, computed on a weight-

ed-average basis. This was a drop of 1.2 percentage points from the 7.6% of pay average in our 2000 survey. Doctors age 30-39 had the lowest weighted-average staff funding costs (5.6%, down from 7.6% in 2000). Doctors age 60-69 followed closely with weighted-average staff funding costs of 5.7% of pay, down from 6.9% in 2000.

How did these doctors achieve the significant decline in staff funding costs? For starters, doctors age 30-39 made much heavier use of the two retirement plans—SIMPLE-IRAs and 401(k) profit-sharing plans—that require staff contributions. For example, 46.5% of doctors age 30-39 sponsored 401(k) plans, vs. only 31.4% overall. Also, 21.9% of doctors age 30-39 sponsored SIMPLE-IRA plans, substantially higher than the 13.1% overall.

Doctors age 50-59 contributed a weighted average of 6.4% of pay, down slightly from the 7.2% of pay contributed in the 2000 survey. Meanwhile, doctors age 40-49 continued to be the heaviest funders—contributing 6.8% of pay, down from 8.2% in 2000.

Controlling Staff Funding Costs

We also asked the dentists to indicate what strategies they were using to reduce staff plan funding costs. Apart from switching to plans requiring employee contributions, as discussed above, a number of other strategies emerged.

The majority of doctors surveyed were using standard retirement plan provisions requiring one year of service and attainment of age 21 to be eligible. A majority of doctors were also excluding part-timers (less than 1,000 hours per year) from participation in their plans. However, very few doctors were taking advantage of other little-known provisions to control staff funding costs, says Jason Arnold, East Coast District Manager of PenSys, Inc., a retirement plan consulting firm specializing in dental clients.* The tax law allows doctors to exclude certain classes of employees from participation, as long as 70% of eligible staff members are covered. Excluding family members and other highly compensated employees can further reduce the percentage of staff members otherwise required to be covered. Yet only 5% of the dentists surveyed took advantage of this provision.

Arnold notes that he has helped several practices exclude highly paid hygienists (paid on commission) from participation in their plans, saving thousands of dollars in unnecessary staff funding costs. Lab employees, office managers, and others can be excluded from participation, provided the 70% test is met, he adds.

We were also surprised that only 20% of the doctors had plan provisions minimizing contributions required on behalf of terminated employees. Arnold recommends that doctors include plan provisions eliminating, or at least limiting, their liability for such contributions. While terminated employees cannot be prevented from sharing in "safe harbor" contributions, it may be possible to require service through the end of the year and/or a minimum of 1,000 hours. However, there are situations in which contributions to terminated participants can actually lower overall staff funding costs. For example, cross-tested plans often benefit from the inclusion of terminated participants, Arnold says.

We were disappointed that only 23% of the dentists were taking advantage of retirement plan provisions that deferred participation for new employees until the latest date possible. Although many plans include provisions requiring a full year's contribution on behalf of employees who become eligible during a plan year, it's not required, says Arnold. Rather, he recommends that doctors limit contributions by including a provision that says participation by (and contributions for) new employees will begin at the later of the first day of the seventh month (usually July 1) or the following Jan. 1, next following the date that the employee satisfies the plan's eligibility requirements. This can save thousands of dollars in contributions on behalf of a new employee.

We were further disappointed to see that the percentage of doctors using Social Security inte-

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gration to lower staff funding costs declined from 40% in 2000 to only 26% in this year's survey. Through Social Security integration, the doctor can receive an extra contribution allocation of 5.7% of the portion of the doctor's pay that exceeds the Social Security wage base for the year ($87,900 in 2004), but does not exceed the maximum compensation that can be taken into account for retirement plan purposes ($205,000 in 2004). Thus, in 2004, a doctor earning a total salary of at least $205,000 can receive an extra retirement plan contribution allocation of more than $6,000 using Social Security integration. This allows the doctor to reach the maximum contribution allocation ($41,000 in 2004) with a lower percentage of pay contribution on behalf of staff.

Arnold says that using age as well as compensation in determining how retirement plan contributions are allocated is one of the most popular cost-saving strategies among older doctors. In our survey, 60% of the dentists age 60-69 reported using this strategy, along with 54% of dentists age 50-59—up from the 2000 survey. On the other hand, only 31% of doctors age 40-49 were using age as a factor in determining retirement plan contribution allocations, down from 33% in 2000. Arnold's experience is that more than 80% of doctors age 40 and older can benefit by switching to an age-based retirement program.

Few Changes Planned

More than 82% of the responding dentists indicated that they planned no changes to their retirement plans during 2004. Doctors age 50-59 were the most content, with 85.9% contemplating no change, followed closely by doctors age 40-49, of whom about 83% planned to maintain the status quo.

Conversely, 29% of the doctors age 30-39 planned changes—the highest percentage of any age group. The most common changes expected by these doctors were switching to a more cost-effective defined-contribution plan (13.8%), adding a second retirement plan (4.6%), and starting a new plan (3.7%).

Predictions

In February 2000, we predicted five retirement plan megatrends. Here, we report on the accuracy of these predictions and give our forecast for the future.

1. Continued growth of SIMPLE-IRA plans. We correctly predicted an increase in the percentage of doctors sponsoring SIMPLE-IRA plans, but their use was up only slightly, from 12.5% in 2000 to 13.1% in 2004. Since our readership consists of doctors at the highest income levels in each age group, we suspect that the percentage of respondents sponsoring these types of plans is considerably higher than among dentists as a whole.

A SIMPLE-IRA is a retirement plan that can provide benefits for the doctor, spouse, and staff on a cost-effective basis in virtually every case. This plan is best suited for doctors who can

afford to contribute no more than around $25,000 annually, but who wish to take advantage of the plan's simplicity (no setup or annual administrative fees) and low staff funding costs (maximum 3% of pay). As a result of these favorable factors, we expect this plan to continue to grow in popularity, particularly among younger doctors with limited retirement plan funding potential.

2. Increased use of cross-tested retirement plans for doctors age 40 and older. This prediction also came true, as the percentage of doctors sponsoring either cross-tested or age-weighted retirement plans grew from 19.6% in 2000 to 21.3% in 2004. The actual percentage of doctors sponsoring this type of plan is probably higher, since many 401(k) profit-sharing plans now contain age-based allocation features for profit-sharing contributions.

3. Growth of defined-benefit plans among doctors age 50 and older. The percentage of doctors sponsoring defined-benefit plans doubled over the past four years, and this trend should continue. A doctor can now fund a defined-benefit pension plan to accumulate more than $2.2 million in new retirement plan assets at age 65, $2.4 million to fund retirement at age 62, and more than $1.6 million in new retirement plan assets to fund early retirement at age 55. These amounts are in addition to those accumulated under prior retirement plans and IRA accounts.

This creates a huge potential for dramatic increases in tax-deductible retirement plan contributions, according to Arnold. For example, he recently designed a defined-benefit pension plan allowing tax-deductible contributions of more than $200,000 for a doctor age 55 who wished to achieve the maximum retirement plan accumulation by age 65.

4. Increased spousal funding. More than 72% of the dentists in this year's survey made contributions on behalf of employed spouses, up dramatically from 40% in the 2000 survey. We expect this trend to continue, as allowable contributions on behalf of employed spouses increase annually under the SIMPLE-IRA and 401(k) tax-law limits.

5. Increased use of 401(k) profit-sharing plans. The percentage of doctors sponsoring 401(k) profit-sharing plans almost tripled, from 12.7% in the 2000 survey to 31.4% in this year's survey. We expect this trend to continue, with many of the doctors who are now operating profit-sharing plans (11.2% of the total), money-purchase pension plans (3.3%), and SEPs (6.3%) switching over to 401(k) plans to take advantage of the increased contribution amounts available on behalf of doctors and spouses while limiting staff funding costs.

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