

**20/20 BENEFITS PLANNING FOR 2010**<sup>1</sup>**Employment Seminar**

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**I. INTRODUCTION**

A sluggish economy, global competition, and other competitive pressures have caused many businesses' revenues to decrease over the last few years. At the same time, benefit costs have skyrocketed. Between 1996 and 2006 in Oregon, health insurance premiums for family coverage increased 161%, an average of 10.2% per year.<sup>2</sup> More recently, since 2003 the increase was over 83%, or 13.9% each year.<sup>3</sup> Total benefit costs approach 35-40% of payroll for many firms. These conflicting trends – no additional revenue but greatly increased expenses – have forced many businesses to consider cutbacks or outright elimination of benefits.

So why offer employees any benefits? Why not just pay higher wages and let employees purchase whatever benefits they want, eliminating all the reporting, compliance, and Human Resource staff time and expense spent administering, designing, and explaining benefit plans?

Benefits are indirect forms of compensation that, if properly designed, can provide employees with added protections, promote their loyalty and goodwill, reward them, and encourage desired performance and/or behavior. A number of surveys show that employees value benefits even more than compensation. A recent Society of Human Resource Management (SHRM) survey showed that even in these tough economic times, benefits were more important to employees than compensation.<sup>4</sup>

For some employees, certain benefits cannot be obtained except through employment. An employee with a history of medical problems may be uninsurable outside of a group plan. Although individuals may participate in individual retirement savings programs like IRAs, the contribution limit (\$5,500 for 2009) is a small fraction of the amount permitted in an employer plan (\$49,000 or more), and well below what most individuals should save to provide a secure retirement.

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<sup>1</sup> This memorandum contains a summary of information obtained from laws, regulations, court cases, administrative rulings, and legal publications and should not be viewed or relied upon as legal advice. Ater Wynne LLP urges readers of this memorandum to consult legal counsel regarding specific legal issues and factual circumstances.

<sup>2</sup> *Health Insurance in Oregon*, Dept. of Consumer & Business Services, Insurance Division, January 2009.

<sup>3</sup> *Id.*

<sup>4</sup> Society of Human Resource Management, Job Satisfaction Series Survey Report, June 2009.

In addition, employee benefit plans create a value proposition for the employer. It is possible to use benefit plans to provide more value to the employee than it costs the employer to provide. One dollar of cash compensation costs an employer in the Portland metro area \$1.11 after paying FICA, FUTA, and Tri-Met payroll taxes. The employee receives only \$0.68 after deductions for FICA, federal (15%) and state (9%) income taxes. Thus, the employer spends \$1.11 to give the employee \$0.68. In contrast, one dollar's worth of benefits may cost the employer less than a dollar, after adjusting for favorable tax treatment, and the employee may be eligible to receive the benefit tax-free. It becomes easy to see why eliminating benefits in favor of all-wage compensation would quickly become a competitive disadvantage.

## **II. HEALTH INSURANCE**

### **A. Background**

Employer-paid health benefits receive more favorable tax treatment than additional cash compensation. The employer-paid premiums are deductible to the employer and not taxed to the employee. The value of the medical services received by the employee are also tax-free. Although employer-paid health benefits may offer large tax savings to both the employer and employee, the premium costs remain substantial, and both parties' ability to absorb continued cost increases is limited. Employers should identify the cost drivers that affect their health care premiums and develop alternatives for providing benefits in ways that encourage employees to reduce costs and address underlying health issues.

Insurance companies merely spread the costs of the benefits consumed over the number of members of the group. An employer, in turn, allocates those costs between it and its employees. However, the employer has control over three factors that determine the premium paid for health care insurance: (1) who gets the benefits, (2) what benefits are provided, and (3) how those benefits are provided.

### **B. Who Gets Health Benefits**

To maximize its investment, an employer needs to consider who will be eligible to receive health benefits and how eligibility criteria can serve the employer's goals. The employer may exclude certain employee groups (part-time or seasonal employees, for example). In addition, eligibility may be conditioned on satisfying specified eligibility requirements or waiting periods. Health plan eligibility should be a strategic decision based on who the employer wants to receive benefits and how providing those benefits furthers the employer's business needs.

Once the target employee group is identified, the employer should next consider spousal coverage. The federal income tax code restricts the tax-free receipt of medical benefits to "spouses" and "dependents." Current federal law defines "spouse" as an opposite-sex, married couple. Thus, an employer may offer benefits to non-traditional spouses (domestic partners, partners in civil unions, spouses in same-sex marriages), but they cannot receive the benefits tax-free unless they meet the federal tax definition of "dependent." The key test is whether the non-employee partner receives over 50% of their support from the employee. Failure to meet this test does not prevent the employer from offering it; it simply makes the value of the benefit taxable to the employee.

Many insurers and/or employers that offer benefits to non-traditional spouses require a certification or affidavit attesting to the nature of the relationship with the employee before providing the benefits. Some employers exclude spouses from their health plan if the non-employee spouse has other group medical benefits. Such limitations may create administrative difficulties with respect to monitoring the non-employee spouse's benefit or relationship status, and force the employer to decide on sanctions that will be imposed for providing a false statement. In addition, such actions may be discriminatory if not done with traditional spouses.

An employer may reduce its costs by selecting an insurer offering multiple coverage combinations, such as employee plus spouse or employee plus children, as opposed to simply offering "family" coverage. This enables an employer (or the employee) to avoid the cost of duplicate health insurance for an already-covered non-employee spouse.

The new dependent rules now define a "child" as a relative under age 19 (age 24 for full-time students) who receives over 50% of his/her support from the employee and resides with the employee for at least 50% of the year. A child receiving substantial support from a non-employee parent, or one attending college that turns 24 may receive benefits if the plan's eligibility rules allow it, but the benefits will be taxable to the employee. Employers must actively audit these requirements to ensure that they are not paying for benefits for ineligible dependents and to avoid the income tax reporting obligations.

To ensure that the health care budget is being spent on the desired beneficiaries, employers must be very familiar with their group health insurance policy and its eligibility requirements. Employers must also monitor internal procedures to make sure that their practices are consistent with the policy requirements.

### **C. What Benefits Are Covered?**

Many employers have focused their cost-containment efforts on the scope of health care coverage provided to employees. There are several options available for employers that want to reduce the cost of the total benefit by restricting certain types of benefits. Drugs or pharmacy costs, co-pays and deductibles, and overall benefit levels are all cost drivers that employers usually have the flexibility to adjust as they wish.

Restricting drug choice to a formulary, requiring higher co-pays for non-generic drugs, or utilizing mail-order pharmacies or pharmacy benefit managers are all common cost containment measures. Some employers eliminate "lifestyle" drugs (e.g., Viagra) or those with over-the-counter equivalents. As the costs of these benefits increase, many employers are raising deductible or out-of-pocket maximums or selecting plans with lower co-pay benefit levels (80% instead of 90%) or lower lifetime or annual maximums.

By reducing the costs of treating chronic conditions and the number of employees seeking treatment, the insurer can reduce its risk exposure and the cost of the coverage. To encourage healthier habits and pro-actively control chronic conditions, such as diabetes or heart conditions, many insurers now offer wellness programs. Insurers and employers are also creating web-based portals that provide employees with specific benefit plan information and access to general health and wellness information. These sites often include health risk assessments and other pre-emptive methods that seek to reduce an employee's health costs. These sites may also allow

employers to enroll new members, update eligibility, and receive claims status and benefits information, eliminating some in-house HR costs.

Larger employers typically have more control over the medical procedures included in the benefit plan because they have more leverage to negotiate customized benefit structures and levels. For example, if a large employer decides to provide orthodontia, Lasik surgery, or gastric bypass surgery as benefits to its employees, it may be able to do so – for a price. Alternatively, it may choose to restrict the benefits that it is willing to pay for or provide greater benefits for preventive care than other types of medical services.

#### **D. How Health Benefits Are Provided?**

The last couple of decades have produced a large increase in the types of health care benefit models. Most employers are familiar with traditional HMOs, POS, PPOs, EPOs, or indemnity arrangements. Generally, these models exchange participant flexibility for cost savings. If a participant's choice of medical providers is restricted, the employer's cost is often lower because the insurer has negotiated more favorable rates with the selected providers. Newer or less common arrangements include Health Savings Accounts, Medical Reimbursement Accounts, or self-insurance.

##### **1. Health Savings Accounts (HSA)**

HSAs allow an individual or employer to establish an IRA-like account to save for medical expenses on a pre-tax basis. An individual is not eligible to make or receive HSA contributions unless he/she is a participant in a High Deductible Health Plan (HDHP). The HDHP looks just like any other health plan, except it has a deductible of at least \$1,150 for individuals and \$2,300 for families. Employers may contribute to the HSA. The individual may invest the HSA in whatever options the HSA provider offers, which can include stocks or mutual funds for larger balances. Employer contributions to the HSA are deductible, employee contributions are pre-tax, and withdrawals for qualified medical expenses are tax-free. After age 65, all withdrawals are tax-free.

Because of the large deductible, premiums for the HDHP are much lower than other plans with similar benefits. Employers often deposit the premium savings in the HSA to offset the cost of the deductible. The maximum contribution is \$3,000 for an individual and \$5,950 for family coverage. The HDHP's maximum out-of-pocket limit is \$5,800/\$11,600. The account belongs to the individual and must have accrued deposits (made by the employee, the employer, or both) before the individual may make tax-free withdrawals for medical expenses. The contributions remain in the account until withdrawn, meaning there are no end-of-year forfeitures as those that occur in Flexible Spending Accounts (*see* FSAs discussed below). The earnings from the investments in the HSA also are not taxed.

The flexible features of HSA accounts may make them less attractive to employers. First, they are completely portable: when employees leave the company, they take their HSAs (and any employer contributions) with them. Employees may access their accounts for non-medical expenses, although such withdrawals trigger ordinary income tax plus a 10% penalty for withdrawals made before age 65. If the employer provides a contribution to the HSA, the employee may use it to purchase a motorcycle, pay medical bills, or for nothing at all. In

addition, employees are not eligible for an HSA if they have “other health coverage,” which includes an FSA, HRA (discussed below), or most other types of health insurance.

## **2. Medical Reimbursement Arrangements**

Also known as a Health Reimbursement Arrangement (HRA), a medical reimbursement arrangement allows an employee to submit medical expenses to the employer, who then reimburses the employee or provider directly. Employees cannot contribute to an HRA. The employer may deduct the cost of the reimbursement, and the employee receives the payment tax-free. The employer may fund the reimbursements out of company assets on an as-needed basis. Although the participants do not have “accounts” like an HSA, they can carry over unused balances from year to year, increasing their potential benefit. If employees do not submit reimbursement requests, the employer pays nothing and retains the funds otherwise used to pay for benefits. If the employee leaves, the employee takes nothing with them.

Reimbursements are limited to medical expenses defined by the employer, unlike other types of arrangements (e.g., HSAs) that allow reimbursement for other purposes. The employer may choose what medical expenses to cover, the benefit level and eligibility criteria that best suits its needs. Employers may choose to define medical expenses more narrowly than the “qualified medical expense” definition used by HSAs, or cover procedures not typically provided by an insurer (e.g., orthodontia, acupuncture). Reimbursements may even include long-term care premiums or premiums for other accident or health insurance, including COBRA benefits and retiree medical expenses, unlike an FSA.

Some employers choose to use an HRA with HDHPs. The employer may select an HDHP with a \$3,000 deductible and establish an HRA with a \$2,000 benefit level. For most employees, this means 100% employer-paid health care. For employees with higher medical expenses, they have a maximum expense of \$1,000. The employer premiums are much lower, offsetting the cost of funding the HRA. If employees do not submit claims, the employer keeps that money, unlike the HSA. One disadvantage is the administrative cost of the HRA is borne by the employer.

## **3. Self-Insurance**

Self-insurance is simply taking the HRA concept to a higher level. In this situation, the employer designs its own health plan and typically hires an administrative firm to process claims that the employer pays. The employer usually purchases a “stop-loss” insurance policy that reimburses the employer once a single claim or cumulative claims exceed the threshold specified in the policy. Some large employers forego the insurance entirely and completely self-insure their workforce.

The reduction in premium cost savings due to not having an insurer bear the risk for every claim and make a profit can more than offset the administrative costs and claim expenses borne by the employer or its claims processor). Using this approach also allows employers to create a very customized health benefit for their employees. For employers unwilling or unable to assume the risk of self-insuring medical claims, dental or vision benefits are a less-risky source of cost savings. The lower benefit limitations in these plans may allow an employer to self-insure at no additional risk, yet provide cost savings.

### **III. CAFETERIA PLANS**

#### **A. Background**

A cafeteria plan, also called a Flex Plan or Section 125 Plan (after the section of the tax code that governs them), allows employees to make a choice between receiving at least one taxable benefit and one nontaxable benefit. The simplest form is a premium-only plan that allows employees to reduce their salary to pay the employees' portion of a health insurance or other benefit premium. The participants making that election choose a nontaxable benefit (health insurance) over a taxable benefit (cash). Cafeteria plans are extremely easy to administer and generally have no reporting obligations (although the underlying benefit plans may).

A cafeteria plan is another opportunity to provide an employee benefit with a value that exceeds the cost of the benefit. Cafeteria plan contributions are not subject to FICA, FUTA, or other payroll taxes. If employees are required to pay a portion of the health care premium, by adopting a cafeteria plan, employees are able to fund their portion of the premium with pre-tax dollars (not reduced by FICA or income tax – a savings of at least 31% for an Oregon resident). The employer also saves 11% of the amount contributed because no FICA, FUTA, or other employment taxes are paid on the amount contributed. These savings typically exceed the administrative cost of the plan.

One limitation to using a cafeteria plan is that only “employees” or their dependents are eligible for cafeteria plan benefits. Sole proprietors, partners or LLC members, S-Corporation shareholders, and retired employees are not eligible to participate in the plan. A partnership can still offer a plan to its employees, but the partners cannot participate.

Employers need to be careful if they have opt-out arrangements that allow employees to opt out of taking a benefit (for example, health insurance) and instead receive the equivalent premium cost in cash. That choice between cash and a nontaxable benefit constitutes a cafeteria plan. Such an arrangement must comply with the cafeteria plan requirements (written document, compliance testing, summary plan description, etc.).

Employers may offer a “menu” cafeteria plan, under which the employer contributes a fixed amount (sometimes called flex credits) to the plan on behalf of an employee. The employee then chooses whatever benefit options available in the plan that they want to receive. These plans may offer a choice between a lower benefit, less-expensive health plan and a higher benefit, higher-cost health plan. If the contribution exceeds the benefit costs, the employee receives the difference in cash; otherwise, the employee makes up the difference. This design is more complex but allows the employer to provide more flexible coverage and benefit options, determine the subsidies it provides for each benefit, and more directly tie the benefits to the company's strategic objectives.

#### **B. Flexible Spending Accounts**

Another common offering in a cafeteria plan is a Flexible Spending Account (FSA). This account allows employees to make pre-tax contributions to fund reimbursements of medical expenses, similar to an HSA. The employer may establish the maximum amount of reimbursement, which must be available every day of the period (called the uniform coverage

rule). The plan is, therefore, at risk that employees may receive reimbursements in amounts greater than their contributions to date, and then leave the company.

Expenses incurred by “dependents” (as discussed above) of the employee are eligible for reimbursement under an FSA. The FSA cannot be used to reimburse health insurance or other premium expenses, unlike an HRA.

The distinguishing characteristic of the FSA is the well-known “use it or lose it” rule. Balances remaining in a participant’s account at the end of the year are forfeited to the employer. FSAs may provide for a 2½-month grace period after the end of the year to exhaust the prior year balance. However, this creates substantial administrative complexity.

### **C. Dependent Care Assistance Plan**

A Dependent Care Assistance Plan (DCAP) works like an FSA but, instead of reimbursing medical costs, it reimburses childcare expenses of the employee. Qualifying “dependents” (as discussed above) are under age 13 or disabled. The maximum annual employee contribution is \$5,000 (for married employees filing jointly). Although DCAPs also are subject to the “use it or lose it” rule, they are not subject to the uniform coverage rule, so a claim is not reimbursed until there are sufficient funds in the participant’s account to pay it. Formerly, a DCAP could be used to pay for a disabled domestic partner or parent, but now that is allowed only if that partner or parent satisfies the federal tax definition of dependent.

### **D. Other Benefit Options for Cafeteria Plans**

The tax code contains a list of additional benefits that an employer may include in a cafeteria plan. This means the employer may include options in the plan that it does not pay for. In other words, it may use the cafeteria plan to offer benefit plans paid for entirely by the participants who want that particular benefit. Participants like the arrangement since they are typically buying on a pre-tax basis (meaning at a 31% or more discount) something they would buy in any event. An employer can afford to do this because every dollar contributed by an employee saves the employer \$0.11.

#### **1. Disability and Accident Insurance**

Disability and accident insurance benefits provide monthly income or lump sum payments for personal injuries or illness. Insurance premiums paid through the cafeteria plan are pre-tax, but a special tax code provision makes the benefit payments subject to income (but not employment) taxes. Employees that want to receive disability benefits tax-free can opt to pay for them using after-tax contributions, where the payment is not made through the cafeteria plan but the employer simply deducts it from the paycheck. Note that long-term care insurance is not considered disability or accident insurance and is not a possible cafeteria plan benefit.

#### **2. Life Insurance**

Life insurance is treated similarly to disability insurance, except the employer may provide up to \$50,000 in benefits tax-free. Since employees generally desire a larger benefit, the employee may use the cafeteria plan to purchase benefits above the employer-paid threshold.

### **3. Adoption Assistance**

Although an employer may offer adoption assistance benefits directly as a fringe benefit (subject to some benefit limitations and other conditions), most employers choose to provide the benefit through a cafeteria plan instead due to the small number of employees that typically use the benefit. The adoption assistance benefit functions like an FSA, except the reimbursement is for adoption expenses, not medical expenses. Also like an FSA, only certain expenses are reimbursable.

### **IV. NONTAXABLE FRINGE BENEFITS**

An Employer can also use several fringe benefits for targeting specific employees with additional compensation-like rewards that are not taxable to the employee, and do not subject the employer to employment taxes. There are literally dozens of benefits that are nontaxable, or are nontaxable up to certain limits. One example is long-term care insurance. Like medical or health benefits, this is an employer-provided, tax-free benefit. A drawback to these benefits is that they can be very expensive.

Perhaps the most common example of a nontaxable fringe benefit in the Portland area is the qualified transportation benefit. Employers may now provide up to \$230 per month tax free for transit passes, vanpooling, and parking costs. Bicycle commuting benefits are limited to \$240 per year. Many employers choose to subsidize the cost of the various benefits and the employee then pays the remaining share on a pre-tax basis through a cafeteria plan.

Examples of other nontaxable fringe benefits that an employer may provide (within some limitations or conditions) are educational assistance reimbursement, laptop computers, office decorations, transit passes, no-additional cost service, employee discounts, and tickets to sporting or cultural events. Even if statutory limitations are exceeded (for example, if educational reimbursements exceed \$5,250), the benefit may remain nontaxable if the employer can meet some additional tests. Employers may use these benefits to provide value to employees without triggering any form of taxation and maintaining the employee's current salary level. Moreover, these arrangements may be targeted to a specific group because they have few or no discrimination rules.

### **V. WORK/LIFE BENEFITS**

After fringe benefits, flexibility to balance life and work issues is often ranked among the most important issues to employees. Single parents, younger retirees, and other non-traditional workers now constitute a greater portion of the available workforce. Many of these individuals have valuable skills but do not want to work a 40-hour week or be in an office from 8-5. For example, for a younger employee, work/life balance might mean more cash to spend and time off from work to spend it. Mid-career employees may value childcare-related benefits and flexible work schedules. Older employees might appreciate the opportunity to retain benefits while working part-time.

The advantage of using work/life benefits is that they usually cost nothing, may save the employer money, and may help attract and retain valued employees. For example, flexible work schedules involve no tangible expense, reporting obligations, tax, or other negative consequences

common to other forms of employee benefits. Compressed workweeks, job sharing, and telecommuting are other examples of benefits that may be implemented at little or no cost, but have significant value to employees.

## **VI. RETIREMENT AND DEFERRED COMPENSATION PLANS**

Recent enforcement actions by the U.S. Dept. of Labor and several high-profile lawsuits by participants in Fortune 500 company retirement plans have refocused attention on retirement plans. There are dozens of types of plans, each with advantages and disadvantages. Employers sponsoring retirement plans should regularly ask themselves these questions:

- Do the employees understand and appreciate the plan benefits?
- What strategic business objective does the plan fulfill?
- Can we provide the same benefits at a lower cost by switching types of plans or service providers?
- Does the plan's benefit structure provide the appropriate level of benefits to the appropriate classes of employees?

Answering these questions will go a long way toward telling the employer what type of plan is needed or what changes to the plan will help make it more attractive to employees. Retirement plans can be very useful tools for recruiting and retaining employees. Some plan designs allow benefits to reward longevity, group or individual performance, or other objectives of the employer. Plan investments can target socially responsible companies or funds.

Employers often find that nondiscrimination requirements of qualified plans prevent them from appropriately compensating key employees. Nonqualified plans offer a very powerful and flexible alternative. Stock options, phantom stock, restricted stock, and other equity-based compensation plans are all examples of nonqualified, deferred compensation plans. These plans use stock or equity values as the basis of compensation to align the interests of management and the shareholder, even in companies without publicly-traded stock. Other designs focus on cash compensation available only if the employee's performance meets established criteria. The design of these plans should take into account the eventual taxation of the award of stock or compensation and how to minimize it. Recent statutory changes enacted in response to abuses now regulate these arrangements much more strictly, requiring extra diligence. Even common arrangements such as bonuses and severance benefits are now potential sources of a violation of the new deferred compensation rules. Such violations trigger a 20% penalty tax, in addition to making the benefit amount immediately taxable *even if not received* by the employee.

## **VII. VOLUNTARY INSURANCE**

Voluntary insurance arrangements are created to provide a convenience for the employees by purchasing a product at group rates. Examples of the types of insurance or benefits purchased through voluntary rates are travel, homeowners, or automobile insurance, and life or disability insurance. Newer products include pet insurance, prepaid legal services, and identity theft protection.

Properly-established voluntary insurance arrangements are not subject to ERISA. The employer simply agrees to act as a payroll agent, withhold the appropriate premium amount from employees' paychecks each month and forward it to the insurer. The insurer offers a group discount, allowing the employees to save over what they would otherwise pay. By not establishing an ERISA plan or placing these benefits in the cafeteria plan, the employer avoids ERISA liabilities and duties and still offer additional benefits to its employees at no cost, other than the time spent setting up the payment transfers.

## VIII. CONCLUSION

Employee benefits constitute a large and increasing share of employer's expenses. Most employers never strategically consider their benefit plans and how they might become competitive advantages instead of merely an expense. Even within the restrictions of ERISA and the tax code, employers have lots of options. By identifying what it wants to achieve by making an expenditure on benefit plans, an employer can create better recruiting, retention and incentives for their employees, lower costs, and increase employee loyalty and productivity.



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