

Cost Effective Benefits Design¹

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I. INTRODUCTION

A sluggish economy, global competition, and other competitive pressures have caused many businesses' revenues to flatten over the last several years. At the same time, benefit costs have skyrocketed. Since 2000, the average annual increase in medical insurance premiums is 12.5%.² Total benefit costs approach 35-40% of payroll for some 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, Human Resource (HR) time and expense spent administering, reporting, designing and explaining benefit plans, and the costs associated with benefit programs?

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 64% of employees considered benefits very important, while only 59% viewed compensation as very important. Interestingly, HR professionals in the same survey responded that only 53% of their employees viewed benefits as very important.³

For some employees, certain benefits cannot be obtained except through employment. An individual 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 (\$4,000 for 2005) is a small fraction of the amount permitted in an employer plan (\$42,000 or more), and well below what most individuals should save to provide a secure retirement.

¹ 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.

² U.S. Bureau of Labor Statistics, All Items for Urban Consumers, Mid-Year Comparison.

³ Society of Human Resource Management, Job Satisfaction Series Survey Report, August 2004. The survey is available to SHRM members at http://www.shrm.org/hrresources/surveys_published/JobSatisfactionSeriesSurveyReport.pdf.

In addition, employee benefits present a value proposition. 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 Portland, Oregon, \$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 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 also is 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.

Insurance companies merely spread the costs of benefits consumed over the group. However, the employer has control over three factors that determine the premium paid for health care insurance: who gets the benefits, what benefits are provided, and how those benefits are provided.

B. Who Gets Health Benefits

To maximize coverage, employers need to consider who will be eligible to receive health benefits and how eligibility criteria can serve the employer's goals. Certain employee groups (part-time employees, for example) may be excluded. In addition, eligibility may be conditioned on satisfying eligibility or waiting periods. 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 consider spousal coverage. Recent tax code changes to the definition of "dependent" restrict those who qualify as a "spouse" eligible to receive employer-provided medical benefits on a tax-free basis. 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 definition of "qualifying relative" under federal tax law. The key test is whether the non-employee partner

receives over 50% of their support from the employee. Failure to meet this test makes 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 if the non-employee spouse has other group medical benefits. Such limitations create administrative difficulties with respect to monitoring the non-employee spouse's employment or benefit status, and force the employer to decide on sanctions that will be imposed for providing a false statement.

An employer may reduce its cost by selecting an insurer offering employee plus children coverage (as opposed to an employee plus spouse plus children). 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 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

The scope of health care coverage provided has been a recent focus of many employers' cost containment efforts. 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 levels, 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 in-house HR costs.

Larger employers typically have more control over the medical procedures included in the benefit provided because they have more leverage to negotiate customized benefit structures and levels. For example, if a large employer decides to provide Lasik 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 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 and less common arrangements include Health Savings Accounts, Medical Reimbursement Accounts, or self-insurance.

1. Health Savings Accounts (HSA)

HSAs were created in the 2003 Medicare Amendments. They 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 for an HSA 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 \$1,000 for individuals and \$2,000 for families. Employers may contribute to the HSA. The individual may invest the HSA in whatever options the account 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.

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 \$2,650 for an individual and \$5,250 for family coverage. The HDHP's maximum out-of-pocket limit is \$5,100/\$10,200. 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. The earnings from the investments in the HSA are also 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 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 a flexible spending account, HRA (discussed below), or any other type 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 directly. Employees cannot contribute to an HRA. The employer deducts 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.

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 needed. 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 and pay claims. The employer usually purchases a “stop-loss” insurance policy that pays 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.

Like the HDHP arrangement, the higher threshold for insurance benefits greatly decreases the premium. The reduction in premium cost savings of not having the insurer bear the risk for even small levels of claims can more than offset the administrative costs and claim expenses borne by the employer. 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.

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 the health insurance 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, 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 are included in the plan that they want to receive. These plans may offer a choice between 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, like 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 of the employee are eligible for reimbursement under an FSA (the new definition of “dependent” will apply). The FSA cannot be used to reimburse health insurance or other premium expenses.

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. Recent guidance from the IRS allows FSAs to adopt amendments that 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 are under age 13 or disabled. The maximum annual employee contribution is \$5,000. 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. In addition, the new tax rules apply to determine who is a “dependent.” Formerly, a

DCAP could be used to pay for a disabled domestic partner or parent, but the new rules make that extremely difficult.

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. The flexibility of the plan means the employer may include options 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. 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 provide up to \$100 per month for transit passes or vanpooling and up to \$190 each month for parking costs tax-free. Many employers choose to subsidize the cost and the employee then pays the remaining share 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.⁴ Interestingly, employees in the SHRM survey ranked compensation/pay fifth, lower than benefits and work/life balance. Again, HR managers surveyed had a different perspective. The HR managers ranked compensation fifth (54%), benefits sixth (53%) and did not rank work/life balance among the top six responses (46%).

For small employers (less than 100 employees), the results are even more surprising. Work/life balance was the most common "most important" feature at 62%. Benefits were third (60%) and compensation fifth (53%).

The difference in responses may reflect the difficulty identifying what balance is or looks like. For example, for a younger employee, work/life balance might mean 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 good retirement and medical benefits.

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.

⁴ See *SHRM survey at footnote 2, supra*.

VI. RETIREMENT AND DEFERRED COMPENSATION PLANS

Recent enforcement actions by the U.S. Dept. of Labor and several high-profile lawsuits by participants in the Enron, WorldCom, and other 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 plan sponsor 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 performance, or other objectives of the employer. Plan investments can target socially responsible companies or funds.

Employers often find the 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 plans are all examples of nonqualified deferred compensation plans. These plans use stock 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 more strictly, requiring extra diligence. Even bonuses are now potential sources of a violation of the new deferred compensation rules.

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 insurance, homeowners, automobile, and life insurance. Newer products include pet insurance, prepaid legal services, and identity theft protection.

Properly-established voluntary insurance arrangements are not ERISA plans or employee benefits. 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 a nominal cost.