Flexible Benefits, Choice, and Work Force Diversity

- This Issue Brief evaluates the prevalence of flexible benefits plans and their ability to achieve cost management goals and to meet the needs of diverse employee groups. In addition, it examines flexible benefits plans' current legislative and regulatory status and typical plan design features.

- Sec. 125 of the Internal Revenue Code allows employers to provide employees with a choice among benefits, including moving otherwise taxable cash compensation to the pre-tax purchase of benefits, without requiring them to include the value of the noncash benefits in their adjusted gross income unless they choose taxable options.

- Although the percentage of full-time employees in medium and large private establishments who are eligible for cafeteria plans has not increased appreciably, the percentage of employees eligible for freestanding flexible spending accounts (FSAs) nearly tripled between 1988 and 1991.

- Generally, the proportion of employers sponsoring cafeteria plans or FSAs increases with employer size. Recent surveys show that 27 percent of employers with 1,000 or more employees offered choice-making plans in 1991, 48 percent of firms offered health care FSAs, and 54 percent offered dependent care FSAs, either in conjunction with cafeteria plans or as a stand-alone option.

- Ten percent of full-time employees in private firms employing 100 or more workers were eligible to participate in cafeteria plans in 1991. Only 5 percent of full-time employees in state and local governments and 1 percent of similar employees in small private establishments were eligible for cafeteria plans in 1990.

- Recent Bureau of Labor Statistics' surveys show that, among full-time employees, 27 percent in private establishments with 100 or more employees, 28 percent in state and local governments, and 6 percent in small private establishments were eligible to participate in freestanding FSAs.

- In 1992, 21 percent of eligible employees contributed to a health care FSA, and only 3 percent of eligible employees contributed to a dependent care FSA. Contributions to health care FSAs averaged $651, and those to dependent care FSAs averaged $2,959.

- National health reform could have a significant impact on these plans if the tax treatment of health benefits is changed. Taxation of health benefits in excess of a standard benefits package would fundamentally reduce the ability to use FSAs.
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The characteristics of the U.S. labor force and population have changed substantially in the last 20 years. Increasing numbers of women in the paid work force, high divorce rates, and a growing proportion of births outside of marriage have led to a decline in the prevalence of two-parent, single-worker families and a corresponding increase in the number of single-parent families (primarily headed by women) and families with children in which both parents work.

The labor force participation of women began to accelerate in the mid-1950s. In 1942, the labor force participation rate among women aged 25 to 44 was 34 percent; by 1991, the rate was 75 percent (U.S. Department of Commerce, 1992). In particular, women with children are entering the paid work force in greater numbers. In 1960, only 28 percent of employed women (with a husband present) with children were employed; by 1991, 67 percent of similarly situated women were employed. The labor force participation rate of single women with children has increased only slightly in the last decade, from 52 percent in 1980 to 54 percent in 1991. In addition, the proportion of households maintained by women increased from 21 percent in 1970 to 33 percent in 1991 (U.S. Department of Commerce, 1992).

In addition to changes in female labor force participation, other demographic characteristics are affecting the benefit needs of the paid work force. First, the population is aging. The percentage of the population over age 65, which was only 10 percent in 1970, is projected to double to 20 percent in 2030. In addition, birth rates are changing. Birth rates bottomed out in 1976 but have been fluctuating around 16 births per 1,000 population throughout the late 1980s and early 1990s. Finally, the average age at the time of first marriage is increasing: it rose from 20.6 years in 1970 to 23.7 years in 1988 among women and from 22.5 years to 25.5 years among men (U.S. Department of Commerce, 1992).

The continuing evolution of the American family is likely to increase the attractiveness of flexible work practices and choice in benefit plans throughout the next decade. Employers have responded to changing employee needs by implementing child care or elder care benefits, flexible work scheduling, long-term care insurance, and/or flexible benefits. Child care benefits can be significant for working single parents as well as for families with two working parents. In 1990, only 14 percent of employed mothers were eligible for child care benefits through their employer (Miller, 1992). A few firms offer similar benefits to workers who have the responsibility of caring for an aged parent. In 1990, more than 20 percent of employed mothers were eligible for flextime, which allows employees to choose a work schedule that best suits their needs within employer-defined limits (Miller, 1992). Other flexible work options include work-at-home arrangements and job sharing. However, these options are administratively more complex and continue to be offered by few firms.

As early as the mid-1970s employers began to offer employees a choice among benefit types and levels. In 1974, TRW Defense Systems Group pioneered the first flexible compensation program, which was the precursor of today’s flexible benefit plans (Frost, et al., 1992). This Issue Brief evaluates the prevalence of flexible benefit plans and their ability to achieve cost management goals and to meet the needs of diverse employee groups. In addition, it examines flexible benefit plans’ current legislative and regulatory status and typical plan design features.
Internal Revenue Code (IRC) sec. 125, created by the Revenue Act of 1978, formally introduced tax-qualified flexible benefit plans. These plans include all those that offer employees a choice between at least one qualified nontaxable benefit and one taxable benefit (including cash). Sec. 125 allows employers to provide employees with a choice among benefits without requiring them to include the value of benefits in their adjusted gross income unless they choose taxable options. In this Issue Brief, the term flexible benefit plans will refer to all qualified plans covered by sec. 125. **Premium conversion plans, flexible spending accounts (FSAs), and cafeteria plans are each a specific type of flexible benefit plan.** Premium conversion plans allow employees to pay for group health plan premiums through pretax salary reduction. FSAs allow employers to set money aside for qualified unreimbursed medical or dependent care expenses through pretax salary reduction. Both salary conversion plans and FSAs offer limited employee choice compared with cafeteria plans, which provide employees with a choice among several qualified nontaxable and taxable benefits (including cash).

### Premium Conversion Plans

**These plans may exist either within a cafeteria plan or separately.** If an employer health care plan requires an employee premium contribution, premium conversion allows employees to make their contribution with pretax dollars. Generally, the premium is deducted directly from the employee’s paycheck.

### Flexible Spending Accounts

FSAs may exist as stand-alone plans or within a cafeteria plan. Employees choose how much money they want to contribute to an FSA at the beginning of the plan year. To the extent that these funds are not used during the plan year, they are forfeited. There are two types of FSAs: health care and dependent care. Employers may offer employees one or both types, but the money contributed to each must be treated separately.

**Money contributed to health care FSAs may be used to pay for any health care expenses not covered by the employer health plan.** These expenditures may include prescription drug purchases, eyeglasses, or other uncovered medical expenses. The funds may also be used to pay for medical expenses incurred as part of health plan deductible or copayments. The law imposes no limit on the amount employees may contribute to a health care FSA. However, employers may choose to limit FSA contributions for administrative purposes.

In the absence of an FSA, dependent care expenses are usually paid for with after-tax dollars. To offset these expenses, the tax code allows workers below certain income levels to take the earned income tax credit (EITC)\(^1\) and all taxpaying parents who pay for the care of a child under age 13 to take the dependent care credit.

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1. Without a sec. 125 plan, qualified individual health care expenditures are deductible from gross income only if they exceed 7.5 percent of a taxpayer’s gross income. Premium conversion plans and health care flexible spending accounts (FSAs) allow employees to exclude these expenditures from gross income even if they do not exceed this amount.

2. A tax credit is available to workers with earned incomes below $23,050 who have a qualifying child and file a joint or head of household income tax return.

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In 1993, the EITC is equal to 18.5 percent of the first $7,750 of adjusted gross income (AGI) indexed for families with one qualifying child and 19.5 percent of AGI for families with two or more qualifying children. The maximum credit is $1,434 for families with one qualifying child and $1,511 for families with two or more qualifying children. The credit is reduced by 13.21 percent (13.93 percent for families with two or more qualifying children) of earned income above $12,200 and is totally phased out at $23,050 (IRC sec. 32).
tax credit (DCTC). A dependent care FSA sponsored by an employer provides an additional tax-favored means of paying for dependent care expenses. Employees can set aside up to $5,000 through pretax salary reduction to pay for dependent care expenses without income restrictions. The rules governing dependent care expenses have changed in many ways in recent years. First, since 1989, every dollar of employer-provided dependent care benefits (including benefits provided through a dependent care FSA) reduces the DCTC available by the same amount. Second, dependent care spending accounts have been limited to children under age 13 (lowered from age 15 in 1989). Finally, a new "young children" credit has been added for taxpayers with children under age one. Any child claimed under this credit may not be claimed under the DCTC or the dependent care exclusion (Frost, et al., 1992). Employees in higher tax brackets who have large dependent care expenses generally realize greater tax savings by contributing to a dependent care FSA than by using the tax credit. For employees in lower tax brackets, however, the DCTC generally provides the greatest tax savings (U.S. Department of Labor, 1989b).

**Cafeteria Plan Benefits**

Generally, cafeteria plan benefits fall into four categories: qualified nontaxable benefits, qualified taxable benefits, nonqualified benefits that defer the receipt of compensation, and other nonqualified benefits. Cafeteria plans must offer a combination of qualified nontaxable benefits and taxable benefits (or cash). The former category includes health insurance, sickness and accident insurance, long-term disability insurance, accidental death and dismemberment plans, group term life insurance up to $50,000, dependent care assistance plans, and both health and dependent care FSAs. Taxable benefits may include elective vacation days, group term life insurance above $50,000, group legal services, and cash. Employees may purchase taxable benefits with after-tax dollars or be treated for all purposes, including reporting and withholding, as having received the cash equivalent of employer-paid taxable benefits. Cafeteria plans may not offer benefits that defer the receipt of compensation with the exception of pre- or post-tax contributions to 401(k) plans. This exception enables employers to provide a comprehensive benefits package through a cafeteria plan. 401(k) plans allow individuals to make contributions to a qualified retirement plan, often with an employer matching contribution. Other benefits, although excluded from a taxpayer's gross income under specific sections of the IRC, may not be offered through a cafeteria plan and are considered nonqualified benefits. These include scholarships and tuition assistance, transportation expenses, educational assistance, and other benefits such as employee discounts or subsidized meals.

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3 The DCTC gives workers a credit of 30 percent of dependent care expenses (up to $2,400 for one child and $4,800 for two or more children) for the care of children aged 13 or younger. The credit is reduced by 1 percent for each $2,000 of AGI above $10,000 and remains at 20 percent for families with AGI above $25,000.

4 Under the Omnibus Reconciliation Act of 1993 (OBRA '93), passed by the U.S. House of Representatives on May 27, 1993, the EITC would be expanded. The bill would raise the credit for a family with one child to $2,063 in 1994 and the credit for two or more children to $2,885 in 1994. In addition, the supplemental young child credit described here would be repealed to ease compliance burdens for lower income taxpayers.

5 Until 1992, group legal services were considered qualified nontaxable benefits. Their nontaxable status expired June 30, 1992. Group legal services are now considered taxable benefits under the Internal Revenue Code (IRC) and may be included in cafeteria plans only as a taxable benefit.
Since the enactment of sec. 125, flexible benefit plans have grown as legislative and regulatory guidance laid the groundwork for their implementation. Until 1984, when proposed regulations were released, few employers had implemented sec. 125 plans. Early experience of companies with flexible benefit plans suggested that they could improve employee understanding of the total compensation package as well as help control employers’ benefit expenditures. Interest in these plans continued to grow after regulations clarified legal requirements and computer software emerged that facilitated plan administration and development.

Survey data indicate that flexible benefit plans are popular among some segments of the work force. A recent EBRI/Gallup poll found that 40 percent of respondents indicated that if they had a choice between two jobs with the same salary and benefit level, one that provides choice and one that does not, the choice in benefits would have a great deal of influence on their decision (Employee Benefit Research Institute/The Gallup Organization, Inc., 1992). Flexible benefits plans are likely to continue growing throughout the 1990s as the work force continues to change.

An important factor in facilitating the growth of flexible benefits plans has been rising health care costs. Most firms are continuing their efforts to manage employee health care expenditures by increasing cost sharing, introducing utilization review, and encouraging the use of alternative delivery systems such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

Although the percentage of full-time employees in medium and large private establishments who are eligible for cafeteria plans has not increased appreciably, the percentage of employees eligible for freestanding FSAs nearly tripled between 1988 and 1991. The percentage of full-time employees eligible for cafeteria plans increased from 5 percent to 10 percent between 1988 and 1991, while the percentage of full-time employees eligible for freestanding FSAs increased from 8 percent to 27 percent during the same period (table 1) (U.S. Department of Labor, 1989a, 1990, 1993).

Employers adopt flexible benefits plans for a variety of reasons. Some want to provide employees with a choice among benefits or to manage their health care expenditures. Others want to offer their employees a tax-favored way of paying for qualified health or dependent care expenses through an FSA or a salary conversion plan. FSAs are also used by employers to ease increased cost sharing with employees. Employers can also use flexible benefit plans as a tool to recruit new employees or to compete with other firms for skilled workers. Employers with national or global work forces can use a flexible benefits plan to minimize regional cost differences and/or allow for cost variation based on separate lines of business within an organization. In addition, some employers are using flexible benefits plans to emphasize the defined contribution nature of their benefits plan or to present a total compensation package to employees. This philosophy suggests that, like wages, benefits will not increase.

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6 Utilization review refers to a process in which specialized firms communicate with the insurer, the patient, and the physician to determine the appropriate care for a given medical episode and the payment that will be provided for that episode.
premium gives each individual the opportunity to determine (within employer defined limits) the

care premiums, uncovered dependent care expenses, and/or uncovered health care expenses. FSA participants can increase their disposable income because pretax salary contributions are exempt from both federal income tax and Social Security (FICA) tax (table 2). Employers can also realize tax savings when employees contribute to an FSA because they are not required to pay FICA tax on employee salary reduction contributions to these accounts (table 3). The tax savings realized through an FSA may be used to at least partially offset the cost of plan administration.

Cafeteria Plans

Generally, cafeteria plans provide benefits similar to those included in a traditional benefits plan. However, these benefits are offered through an alternative delivery mechanism that focuses on limiting employer expenditures, promoting individual choice, or both. A cafeteria plan gives each individual the opportunity to determine (within employer defined limits) the

7 A traditional benefits plan refers to one that offers a uniform set of benefits to all employees including, but not limited to, medical insurance, pension, life insurance, and disability insurance.
Tabl

Table 3
Employer Tax Savings Realized from a Flexible
Spending Account (FSA), 1992 Tax Year

<table>
<thead>
<tr>
<th>Employer Savings</th>
<th>With FSA</th>
<th>Without FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Payroll Expense</td>
<td>$3,000,000</td>
<td>$3,000,000</td>
</tr>
<tr>
<td>Less Employee health care FSA contribution</td>
<td>13,671</td>
<td>0</td>
</tr>
<tr>
<td>Taxable Payroll Expenses</td>
<td>2,986,329</td>
<td>3,000,000</td>
</tr>
<tr>
<td>Add: FICA tax</td>
<td>228,454</td>
<td>229,500</td>
</tr>
<tr>
<td>Total Payroll Expenses</td>
<td>3,228,454</td>
<td>3,229,500</td>
</tr>
<tr>
<td>Net Employer Savings</td>
<td>$1,046</td>
<td></td>
</tr>
</tbody>
</table>

Source: Employee Benefit Research Institute.

8 Cafeteria plans are allowed to include a qualified cash or deferred arrangement under IRC sec. 401(k). Other benefits that defer the receipt of compensation, such as a defined benefit pension plan or a profit-sharing plan, may not be included in a flexible benefit plan.

Employers often cite health care cost containment as one of their most important reasons for adopting a flexible benefit plan (chart 1). Employers with a traditional health indemnity plan may seek to reduce expenditure growth by introducing alternative health care delivery systems (HMOs and PPOs), adding managed care features, or increasing cost sharing with employees. Cafeteria plans provide an additional expenditure control mechanism because they allow employers to use a defined contribution approach to health benefits by determining the level of funding for the flexible program annually rather than providing the same level of benefits coverage regardless of cost increases. This approach is often used in funding retirement plans and has the advantage of shifting part or all of cost increases to...

5...
employees. Employers can use this approach to limit rising health care expenditures, although these savings may come at the expense of employee satisfaction.

Both employers and employees may benefit from the implementation of a cafeteria plan. Employees may be able to make their total compensation more valuable by choosing their desired combination of pay and benefits. If employees are more satisfied with their benefits plan, employers may benefit from a more productive and satisfied work force. Surveys of employers with cafeteria plans indicate that meeting diverse employee needs is often a major plan objective (chart 1).

Before the enactment of IRC sec. 125, employers who offered their employees a choice between taxable and nontaxable benefits triggered a tax doctrine called constructive receipt. Generally, this doctrine provides that if employees are offered a choice between taxable and nontaxable benefits, they will be taxed as if they received cash even if they choose only nontaxable options. Under sec. 125, employers can offer their employees a choice among taxable and nontaxable benefits without automatically triggering the doctrine of constructive receipt as long as specific nondiscrimination standards are met. The value of a particular benefit is included in an employee’s gross income only if the benefit chosen is taxable. Flexible benefit plans were granted an exception to the constructive receipt doctrine because they were thought to be consistent with social policy goals. However, the laws governing flexible benefit plans may be affected by the deficit reduction efforts of the 103rd Congress because the tax loss attributable to flexible benefit plans is significant. The Joint Committee on Taxation estimated that tax expenditures for flexible benefit plans were $3.5 billion in 1992 (U.S. General Accounting Office, 1992). In addition, much discussed comprehensive health care reform could affect the status of flexible benefit plans in general and health care FSAs in particular.

Prior to the enactment of sec. 125, employers who offered their employees a choice among benefits generally limited the choice to either all nontaxable benefits or all taxable benefits in order to avoid the application of constructive receipt. Today many employers still offer employees a choice among only nontaxable benefits, particularly in the area of health insurance. These plans are not flexible benefits plans as defined by sec. 125 because they do not offer a choice between nontaxable benefits such as health insurance and taxable benefits or cash; however, they may be subject to IRC sec. 125 if employers allow employees to pay for uncovered health care premiums on a pretax basis.9

Nondiscrimination Rules

Each benefit offered within a flexible benefit plan must satisfy nondiscrimination rules specific to it as well as the rules governing cafeteria plans. The rules applicable to sec. 125 plans prohibit discrimination in favor of either highly compensated participants or key employees. If a flexible benefit plan does not meet the sec. 125 nondiscrimination tests, highly compensated participants and/or key employees in whose favor the plan discriminates will be taxed as if they chose the maximum amount of taxable benefits or cash even if they chose all nontaxable benefits.

Flexible benefit plans may not discriminate in favor of highly compensated employees in terms of

9 In this Issue Brief, the term choice-making plan refers to any combination of cafeteria plans and plans that provide employee choice among only taxable or only nontaxable benefits but not both. This term will be used where survey data do not differentiate between sec. 125 qualified plans and other plans offering employee choice.
Employee salary reduction contributions to flexible benefit plans are granted preferential tax treatment only if the plan meets all requirements of sec. 125.

Second, the benefits provided by the plan may not discriminate in favor of highly compensated participants (nondiscriminatory benefits test).

To pass the nondiscriminatory eligibility test, the plan must satisfy one of three requirements: 1) the plan must cover 70 percent or more of all employees; 2) 70 percent of all employees must be eligible to be covered under the plan, and 80 percent of eligible employees must be covered under the plan; or 3) the plan must cover a classification of employees that does not discriminate in favor of the highly compensated. To pass the nondiscriminatory benefits test 1) all benefits provided to highly compensated participants must be provided to all other participants in that plan; 2) all benefits available for the dependents of highly compensated participants must also be available on the same basis for the dependents of all other employees who are participants; 3) a plan that provides optional benefits will be treated as providing a single benefit provided that (a) all eligible participants may elect any of the benefits covered by the option, and (b) there are no required employee contributions or the required contributions are the same; 4) any maximum limit that is set for benefits under the plan must be uniform for all participants and their dependents and may not be modified by reason of an employee’s age or length of service; and 5) a plan may not discriminate in its operation.

Individual Taxation Issues

Employee salary reduction contributions to flexible benefit plans are granted preferential tax treatment only if the plan meets all requirements of sec. 125. Generally, because pretax salary reduction contributions are considered employer contributions to a

10 A flexible benefits plan is not considered discriminatory merely because highly compensated employees choose to participate in the plan in greater numbers than do other employees.

11 The health benefits nondiscrimination test applies to "similarly situated" highly compensated participants, referring to the participants’ age, years of service, and other characteristics.
In the last decade, two significant changes were made to flexible benefits plans (see chart 2). The Tax Reform Act of 1986 (TRA '86) introduced IRC sec. 89, which attempted to impose a set of uniform regulations for welfare plans similar to those that regulate pension plans. However, the provisions were repealed in November 1989. The release of proposed regulations for sec. 125 in 1989 represented a more permanent change for flexible benefits plans. Surveyed employers initially indicated reluctance to implement flexible benefits plans because they were unable to estimate the effects that the 1989 proposed regulations would have on plan viability and were worried that there would be additional legislative or regulatory changes (A. Foster Higgins, 1990). More recent survey data indicate that the proposed regulations are not causing adverse losses among employers with cafeteria plans (Hewitt Associates, 1993).

Sec. 89

Prior to the enactment of sec. 89, each benefit included in a cafeteria plan had to satisfy all regulations and nondiscrimination rules applicable to that benefit as well as supplemental sec. 125 regulations and in order to qualify for tax-favored treatment. Sec. 89 would have imposed uniform qualification and nondiscrimination rules for all employee welfare and benefits plans. The qualification rules would have required all welfare plans to meet certain minimum requirements. These nondiscrimination rules would have affected accident and health insurance plans and group term life insurance.

Although sec. 89 rules were scheduled to take effect for plan years beginning on or before January 1, 1989, the effective dates were delayed due to dissatisfaction among employers, who argued that the rules were complex and imposed burdensome record keeping requirements. Others claimed that, because of the high cost of compliance, the rules would effectively reduce health insurance coverage rather than reduce discriminatory practices as it was intended to do. These concerns as well as others not discussed here led Congress to repeal sec. 89 in 1989.

12 Individual salary reduction contributions to a 401(k) plan are subject to different rules. Elective, nonelective, and matching contributions to a 401(k) plan are excluded from the employee's gross income until distribution but are not exempt from FICA taxation or FUTA taxation. However, the employee is able to defer federal income tax and most state and municipal tax.
### Chart 2
**Impact of Legislation and Regulations on Flexible Benefits Plans**

<table>
<thead>
<tr>
<th>Legislative or Regulatory Action</th>
<th>Important Provisions</th>
</tr>
</thead>
</table>
| Revenue Act of 1978              | • Created section 125 and section 401(k) of the Internal Revenue Code (IRC).  
• Section 125 allows employees to choose between taxable and nontaxable benefits (which do not defer the receipt of compensation) without taxing the cash which could have been chosen.  
• Section 401(k) allows employees to choose between cash and deferred contributions to a profit sharing or savings plan without taxing the cash if it is not chosen. |
| Miscellaneous Revenue Act of 1980| • Permitted section 125 plans to include 401(k) plans as a qualified benefit (only exception to the deferred compensation restriction). |
| Proposed Section 401(k) Regulations (1981) | • Permitted individuals to choose to defer a portion of their compensation. |
| Information release 84-22 (1984)  | • Prohibited the use of salary reduction after incurring an expense. |
| Proposed section 125 regulations (1984) | • Defined terms, indicated which benefits may be included in a plan, specified flexible spending account (FSAs) rules, and addressed tax issues, nondiscrimination rules, and effective dates.  
• Imposed three major restrictions on the design of flexible benefit plans:  
  (1) Neither a cafeteria plan nor an FSA may allow more frequent than annual elections of the sources or uses of funds (unless changes are related to a change in family status);  
  (2) FSA funds may be used only for health care, dependent care, or personal legal expenses;  
  (3) FSA funds must be used for expenses incurred during the plan year, all unused funds are forfeited ("use-it-or-lose-it" rule). |
| Deficit Reduction Act of 1984     | • Confirmed section 125 proposed regulations and established reporting requirements for Section 125 plans. |
| Tax Reform Act of 1986            | • Confirmed the permissibility of FSAs and individual salary reduction under section 125. Reaffirmed the exemption of section 125 deferrals from FICA taxation.  
• Created section 89 of the IRC which contained complex nondiscrimination rules for all welfare plans (including cafeteria plans). |
| Proposed section 125 regulations (1989) (effective for plan years beginning after December 31, 1988) | • Regulations clarified the kinds of benefits which can be included in a plan, the circumstances under which participants may change or revoke elections, and the requirements that health FSAs must exhibit insurance characteristics.  
• Benefits were divided into several categories: (1) qualified benefits (do not defer the receipt of compensation and are not includable in an employee's gross income); (2) currently taxable benefits treated as cash; (3) qualified cash or deferred arrangements (pre- and post-tax contributions to 401(k) plans); and (4) non-qualified benefits.  
• Participants may now change or revoke elections under the following circumstances: (1) significant cost changes of an independent third party health plan; (2) family status changes; (3) separation from service; and (4) cessation of required contributions. Elective contributions to 401(k) plans may be changed at any time.  
• FSAs must function as accident or health plans so that: (1) the maximum amount of reimbursement under a health FSA must be available at all times during the period of coverage; (2) the period of coverage must be generally 12 months; (3) a health FSA may only reimburse medical expenses covered under section 213 of the IRC; (4) medical expenses must be substantiated by a receipt from a third party; (5) medical expenses must be incurred during the period of coverage; (6) the excess of premiums paid and income of an FSA over claims reimbursements may be used to reduce premiums for the following year or returned to participants as long as funds are allocated on a reasonable and uniform basis (not based on claims experience); (7) analogous rules apply to dependent care spending accounts except for uniform coverage (see (1) above). |
| Repeal of section 99 (1989)       | • Pre-section 99 nondiscrimination testing was reinstated for all welfare plans. |

ance-type element of risk for employers who sponsor health care FSAs, and clarify the treatment of buying and selling vacation days under a cafeteria plan.

Flexible benefit plans maintain their tax-favored status only if each participant makes benefit elections prior to the start of the plan year. Once an employee elects and begins to receive benefits, that choice is generally binding for the entire plan year. Even if an employee does not use a benefit, this choice cannot be revoked or cashed out without incurring a penalty. This use-it-or-lose-it rule applies to all benefit choices, including elections under an FSA for health or dependent care expenses. For example, if an employee elects to contribute $1,200 to a health care FSA but the total amount of unreimbursed health care expenses incurred by that employee is only $1,000, the employee may not change his or her initial election without penalty. At the end of the plan year, any contributions not used for qualified expenses are forfeited. If the employer allows employees to take the unused portion in cash, each employee will be taxed on the entire amount elected at the beginning of the year. The proposed supplemental 1989 regulations expand and clarify the exceptions to this rule.

There are circumstances under which a participant may change or revoke an election during the plan year without penalty. If the cost of a health care plan provided by an independent third party provider significantly increases during the year, an employer may allow participants either to change their election to cover the increased cost or to revoke their election and choose another health plan with similar coverage. Flexible benefit plans may also permit employees to revoke their elections and make new elections if they are consistent with a change in family status such as marriage or divorce, death of a spouse or dependent, birth or adoption of a child, termination or commencement of employment by the spouse, or a significant change in the health coverage of the employee or spouse attributable to the spouse's employment. A flexible benefit plan may also allow employees who terminate employment during the plan year to revoke their existing benefit elections. Although the plan may permit employees to make changes during the year for any of these reasons, it may restrict changes. The more changes that an employer permits, the greater the administrative complexity and cost. The plan may also condition the receipt of benefits on employees' continued payment of required premium contributions.

The 1989 regulations also require a 12-month period of coverage, impose tighter claims substantiation for all FSAs, and provide guidelines for the distribution of experience gains. Expenses must be verified by a third party before an employer can reimburse claims under a health care FSA. Experience gains (the excess of premiums paid and income over the cost of claims and administrative expenses) may be used to reduce the price of premiums during the following year. The plan may also rebate experience gains to participants as dividends as long as they are allocated to all participants on a reasonable and consistent basis that is unrelated to claims experience.

Vacation days have become an increasingly popular option to include in cafeteria plans. About one-quarter of full-time employees eligible for choice-making plans in 1992 could choose either to expand and/or reduce their vacation days through the plan (Hewitt Associates, 1993). The supplemental sec. 125 regulations clarify how employers should allocate unused vacation days. Because cafeteria plans are generally prohibited from offering benefits that defer the receipt of compensation, vacation days selected...

14 The IRS proposed sec. 125 regulations represent current law for flexible benefits plans. Because they are not final regulations, however, the IRS may issue others at a later date that will supersede the proposed regulations.

14 Hewitt Associates surveys plans that provide benefit choice making (including both cafeteria plans and plans that do not offer taxable benefits) as well as plans that offer only FSAs. Premium conversion only plans are excluded from their analysis.
through a flexible benefits plan may not be carried over from one year to the next. An ordering rule requires that nonelective days be used first. The 1989 regulations also introduced a cashout option for purchased vacation days. The cafeteria plan may pay employees for unused days purchased through the cafeteria plan at the end of the plan year as long as the cash value is received on or before the plan year’s last day or the last day of the employee’s taxable year that includes the elective vacation, whichever is earlier.

One of the most important changes that the 1989 proposed regulations made was to require employers sponsoring health care FSAs to assume a risk of loss. The IRS ruled that, because FSAs receive preferential tax treatment, they must also function as true health insurance plans and should, therefore, exhibit risk shifting and risk distribution characteristics common to other insurance plans. The regulations require employers to make the maximum reimbursement under an employee’s plan available at all times during the plan year, even if the employee has not contributed enough to cover expenses at the time of the claim. This is called the uniform coverage rule because it requires employers to make the entire amount by which an employee agrees to reduce his or her salary during the year available to the employee uniformly throughout the coverage period. For example, an employee electing to contribute $1,200 in equal pretax salary reductions throughout the year must be allowed to be reimbursed for covered expenses up to $1,200 during the second month of the plan year even if he or she has only contributed $100 to the account. Only reimbursements already paid from the employee’s account can lower the maximum amount available. The regulations also restrict plans from determining the payment schedule for premiums according to the rate or level of claims incurred. In 1992, the majority of employers with health care FSAs reported that amounts forfeited by employees exceeded losses incurred from underfunded accounts (Hewitt Associates, 1993).

Employer surveys taken following the release of the proposed regulations indicated that employers were reluctant to implement FSAs particularly because of the uniform coverage rule. Some employers indicated that, in order to reduce their potential liability, they would make plan design changes such as reducing the maximum amount of salary reduction contributions, restricting coverage of certain expenses (such as elective surgery), requiring continued participation throughout the plan year even if the employee terminates employment, and imposing an extended waiting period before an employee is eligible for participation. In a survey conducted several months after the release of the 1989 regulations, 27 percent of employers with FSAs reported that they would reduce their maximum contribution limit, 4 percent would limit the types of expenses eligible for

Table 4
Prevalence of Medical or Dependent Care Reimbursement Accounts and Choice-Making Plans, 1991

<table>
<thead>
<tr>
<th>currently offer</th>
<th>choice-making plan</th>
<th>plan to offer by 1993</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical reimbursement account</td>
<td>Dependent reimbursement account</td>
<td>Medical reimbursement account</td>
</tr>
<tr>
<td>All Employers with 1,000 or more Employees</td>
<td>48%</td>
<td>54%</td>
</tr>
<tr>
<td>Industry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumer products</td>
<td>45</td>
<td>55</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>45</td>
<td>50</td>
</tr>
<tr>
<td>Mining/construction</td>
<td>25</td>
<td>32</td>
</tr>
<tr>
<td>Energy/petroleum</td>
<td>63</td>
<td>63</td>
</tr>
<tr>
<td>Wholesale/retail trade</td>
<td>15</td>
<td>28</td>
</tr>
<tr>
<td>Technical/professional services</td>
<td>46</td>
<td>59</td>
</tr>
<tr>
<td>Utilities</td>
<td>53</td>
<td>58</td>
</tr>
<tr>
<td>Transportation services</td>
<td>33</td>
<td>33</td>
</tr>
<tr>
<td>Health services</td>
<td>61</td>
<td>67</td>
</tr>
<tr>
<td>Financial services</td>
<td>66</td>
<td>76</td>
</tr>
<tr>
<td>Communications</td>
<td>48</td>
<td>57</td>
</tr>
<tr>
<td>Government</td>
<td>39</td>
<td>48</td>
</tr>
<tr>
<td>Education</td>
<td>57</td>
<td>61</td>
</tr>
<tr>
<td>Insurance</td>
<td>72</td>
<td>76</td>
</tr>
<tr>
<td>Other</td>
<td>40</td>
<td>43</td>
</tr>
</tbody>
</table>

reimbursement, and 15 percent would eliminate their health care FSA completely (A. Foster Higgins, 1990). However, recent reports indicate that the new regulations have not deterred most employers from adopting and maintaining flexible spending accounts (A. Foster Higgins, 1992).

Final regulations on flexible benefits plans will probably not be issued for another year, primarily because any health care reform plan proposed by the Clinton administration will have a substantial effect on those plans, Harry Beker, Branch Chief of the Office of Associate Chief Council at the Internal Revenue Service, said May 17. Beker also said that further written guidance on flexible benefits plans was unlikely following health care reform implementation (Bureau of National Affairs, 1993a).

A substantial proportion of large employers has chosen to implement choice-making plans and/or FSAs to meet their workers' needs. Large firms frequently employ workers from a variety of backgrounds who are at different stages in their lives. Their work force is likely to include single persons with no children; two-income couples, both with and without children; and single parents—each with distinct benefits needs. Generally, the proportion of employers sponsoring cafeteria plans or FSAs increases with employer size. Twenty-seven percent of employers with 1,000 or more employees offered choice-making plans in 1991 (A. Foster Higgins, 1992). Separately, 48 percent of surveyed firms offered health care FSAs, and 54 percent offered dependent care FSAs, either in conjunction with cafeteria plans or as a stand-alone option (table 4) (A. Foster Higgins, 1992). However, compared with the 99 percent of large employers who offer health insurance to their employees, relatively few firms have begun to offer choice-making plans or a tax-favored means of paying for health and dependent care expenses (ICF Incorporated, 1987).

Flexible Spending Accounts

Recent Bureau of Labor Statistics' surveys show that, among full-time employees, 27 percent in private establishments with 100 or more employees, 28 percent in state and local governments, and 6 percent in small private establishments were eligible to participate in freestanding FSAs (table 1, table 5). In addition, 9 percent of similar employees in private establishments with 100 or more employees, 1 percent of those in private establishments with fewer than 100 employees, and 3 percent of employees in state and local governments were eligible for FSAs within a cafeteria plan (see table 1) (U.S. Department of Labor, 1991, 1992, 1993).

Although many large employers offer their employees FSAs to pay for unreimbursed health or dependent care expenses, studies show that only a small percentage of employees actually take advantage of the potential savings available to them (Hewitt Associates, 1993). In 1992, 21 percent of eligible employees contrib-

---

### Table 5

<table>
<thead>
<tr>
<th>Provided Cafeteria Benefits and/or FSA</th>
<th>Professional and Administrative Employees</th>
<th>Technical and Clerical Employees</th>
<th>Production and Service Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total 100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Provided Cafeteria Benefits and/or FSA</td>
<td>37</td>
<td>50</td>
<td>42</td>
</tr>
<tr>
<td>Cafeteria benefits with FSA</td>
<td>9</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Cafeteria benefits with no FSA</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Free-standing FSA</td>
<td>27</td>
<td>34</td>
<td>32</td>
</tr>
<tr>
<td>Not Provided Cafeteria Benefits or FSA</td>
<td>63</td>
<td>50</td>
<td>58</td>
</tr>
</tbody>
</table>


\(^a_{\text{Less than 0.5 percent.}}\)
uted to a health care FSA, and only 3 percent of eligible employees contributed to a dependent care FSA. Contributions to health care FSAs averaged $651, and those to dependent care FSAs averaged $2,959 (Hewitt Associates, 1993). In contrast, a 1992 EBRI/Gallup survey found that 73 percent of respondents in worker families would reportedly contribute to such an account if it were available (Employee Benefit Research Institute/The Gallup Organization, Inc., 1992).

Cafeteria Plans

Ten percent of full-time employees in private firms employing 100 or more workers were eligible to participate in cafeteria plans in 1991 (table 5) (U.S. Department of Labor, 1993). Only 5 percent of full time employees in state and local governments and 1 percent of similar employees in small private establishments were eligible for cafeteria plans in 1990 (table 1) (U.S. Department of Labor, 1991, 1992). Cafeteria plans often offer employers a choice among levels and types of coverage, particularly health insurance. Because small employers may be unable to afford a comprehensive health insurance plan, implementing a cafeteria plan may not be feasible. Small employers are also less likely to implement a cafeteria plan because they have fewer resources to devote to administrative costs. Large employers are able to spend more time researching and developing their plans than small employers because they realize economies of scale in both their research efforts and plan administration.

The prevalence of choice-making plans among firms with 1,000 or more employees varies only slightly by firm size but moderately by region (A. Foster Higgins, 1992). New England region employers report the highest incidence of choice-making plans, while employers in the mid-Atlantic region report the lowest incidence. Such regional variation may be partially explained by different employer perspectives, levels of competition for skilled workers, or degrees of unionization. Generally, more traditional employers or those with highly unionized work forces are less likely to implement flexible benefit plans. Among firms employing 1,000 or more employees, 20 percent of those with work forces that were more than one-half unionized had flexible benefits plans in 1991, compared with 30 percent of similar, less unionized employers (A. Foster Higgins, 1992). Survey data indicate that heavily unionized firms that offer flexible benefits plans to salaried employees are likely to offer flexible plans to union employees as well (TPF & C. 1990). Fifty-eight percent of firms that employ union workers and provide flexible benefits to their salaried employees also offer their union employees flexible benefits. However, 21 percent of employers offering a flexible plan to their salaried employees reported that it was rejected by the union (TPF&C, 1990).

The prevalence of flexible benefits plans varies by industry. They are most prevalent in the financial services (46 percent), communications (39 percent), insurance (36 percent), energy/petroleum (35 percent), health services (34 percent), and consumer products (32 percent) industries. The industries in which these plans are least common are mining/construction (19 percent), and wholesale and retail trade (19 percent) (table 4). The latter industry groups usually have highly unionized work forces, a large percentage of part-time employees, and/or high turnover. Employers often perceive that flexible benefits plans are not as effective in these situations (A. Foster Higgins, 1992).

Flexible benefits plans may be financed by employers, employees, or both, with employee contributions usually occurring through pretax salary reduction arrangements. Credit and pricing practices vary based on employer objectives. These objectives generally include
Table 6
Percentage of Full-Time Employees in Medium and Large Private Establishments Eligible for Cafeteria Plans and Flexible Spending Accounts (FSAs) by Type of Employee Contribution, 1991

<table>
<thead>
<tr>
<th>Type of Employee Contribution</th>
<th>All Employees</th>
<th>Professional and Administrative Employees</th>
<th>Technical and Clerical Employees</th>
<th>Production and Service Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Employee Contribution</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-tax</td>
<td>86</td>
<td>83</td>
<td>83</td>
<td>94</td>
</tr>
<tr>
<td>After tax</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>No Employee Contribution Allowed</td>
<td>10</td>
<td>14</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Data Not Available</td>
<td>4</td>
<td>3</td>
<td>7</td>
<td>2</td>
</tr>
</tbody>
</table>


Achieving an equitable allocation of benefit dollars, communicating the value of employer-provided benefits, and avoiding disruptions in employee contributions.

Flexible Spending Accounts

Among full-time employees in private establishments with 100 or more employees who were eligible for FSAs or cafeteria plans in 1991, 84 percent were allowed to make pretax contributions to the plan (table 6) (U.S. Department of Labor, 1993). Full-time employees in private establishments with 100 employees or more who were eligible to participate in FSAs were most often allowed to use FSA funds for reimbursement of health care premiums (44 percent), health care expenses (72 percent), or dependent care expenses (77 percent) (table 7) (U.S. Department of Labor, 1993).

Cafeteria Plans

Major funding sources for choice-making programs include salary conversion, employer contributions, credits from opting down to less expensive plans after-tax payroll deductions, and vacation selling. One survey indicated that 98 percent of choice-making plans were at least partially funded by employee salary reduction in 1992, while 82 percent of these plans provided flexible credits (Hewitt Associates, 1993). Many cafeteria plans attempt to supply all employees with basic coverage in certain areas such as

Table 7
Percentage of Full-Time Employees in Medium and Large Private Establishments Eligible for Flexible Spending Accounts (FSAs) by Expenses Covered, 1991

<table>
<thead>
<tr>
<th>Expenses Covered</th>
<th>All Employees</th>
<th>Professional and Administrative Employees</th>
<th>Technical and Clerical Employees</th>
<th>Production and Service Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Health Care Premiums</td>
<td>44</td>
<td>41</td>
<td>45</td>
<td>47</td>
</tr>
<tr>
<td>Premiums only</td>
<td>12</td>
<td>9</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>Health Care Expenses</td>
<td>72</td>
<td>78</td>
<td>73</td>
<td>64</td>
</tr>
<tr>
<td>Other Insurance Premiums</td>
<td>8</td>
<td>6</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Dependent Care Expenses</td>
<td>77</td>
<td>81</td>
<td>78</td>
<td>70</td>
</tr>
<tr>
<td>Legal Expensesa</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Other Expenses</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>


Note: Details may not add to totals because individuals may receive more than one type of coverage.

The tax preference for group legal expenses expired in 1992.

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Chart 3
Credit Allocation Factors for Flexible Benefits Plans, 1992

Note: Hewitt Associates data are based on 472 surveyed employers. These programs include plans with benefit choice-making, flexible spending accounts, or a combination of both. Because employers generally use a combination of credit allocation factors, their sum is greater than 100 percent.

health, life, and/or disability insurance. Then, employees receive a specified amount in flexible credits that may be used to purchase additional coverage in core benefits areas or in supplemental benefits areas such as child care and vacation days or traded in for a cash equivalent. Some employers require employees to choose at least a minimum level of coverage in particular areas such as health care or life insurance unless the employee demonstrates coverage from another source. Without these controls, employees could choose no coverage even if they are otherwise uninsured.

Two features requiring careful design in a cafeteria plan are the allocation of employer contributions and the pricing of benefit options. Employers generally base these features on objectives that need to be balanced. Common objectives include creating a pricing structure that conveys a realistic benefit value to employees, giving all employees equal credits, providing employees with coverage similar to that offered under the previous plan without increasing employee cost, and implementing the plan without added employer cost. Employers also need to consider the risk of incurring increased costs as a result of adverse selection. In general, the potential for adverse selection increases with the degree of choice available to employees and their ability to predict their benefit needs. For example, most individuals can accurately predict their need for vision care. If this coverage is offered as a stand-alone benefit within a cafeteria plan, only those employees who need the coverage will choose it.

Employers cannot meet all of these objectives in part because of the time of cafeteria plan implementation. Most firms do not allocate benefit dollars equally among all employees. This is especially true in regard to health insurance. The following simplified example illustrates how, in a traditional benefit plan, employees who choose individual coverage subsidize those who choose family coverage in a group plan. A company offers a health insurance plan that requires no contribution from the employees regardless of whether they choose individual or family coverage. If two employees earn the same salary, but one chooses individual and the other chooses family coverage, total compensation of the later employee is higher than that of the former. If the company decides to implement a cafeteria plan, it must decide whether to maintain this subsidy, move to a uniform allocation of credits, adjust the prices of benefit options, or use a combination of these methods.

Although some employers allocate flexible credits on a per capita basis, most use a combination of factors, including years of service, salary level, age, family status, or work status (chart 3) (Hewitt Associates, 1993). In this way, employers can provide certain employees with more flexible credits, thus maintaining certain subsidies that were in place.

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17 Adverse selection occurs in health insurance when individuals who have greater health care needs choose a more comprehensive plan and those who are healthy choose a less comprehensive plan, resulting in groups segregated by health status. The average cost of caring for these groups then diverges.
before the new plan. Pricing benefit options is a com-
licated and research intensive process. Employers must
analyze claims data and determine a fair price for each
benefit option, including prices for alternative coverage
categories (that is, employee only versus family cover-
age). After arriving at realistic benefit option prices,
employers may choose to adjust these prices to encourage
employees to choose lower levels of coverage or hide
subsidies in particular benefits such as family health
insurance.

Medical plans are the most
common benefit offered in
cafeteria plans. In addition to
health benefits, cafeteria plans
may include an FSA, group term life insurance,
accidental death and dis-
memberment insurance (AD
& D), and long-term disabil-
ity insurance (chart 4).

Medical Benefits
Survey data indicate that

Chart 4
Percentage of Choice-Making Plans Offering Selected Benefits, 1992

Note: Hewitt Associates data are based on 472 surveyed employers. These programs include plans with benefit choice-making, flexible
spending accounts, or a combination of both. Because employers generally use a combination of credit allocation factors, their sum is greater
than 100 percent.

more than 90 percent of choice-making plans offer
one or more medical options other than HMOs or
PPOs (A. Foster Higgins, 1992). Another survey found
that 99 percent of employers with choice-making plans
offered a medical indemnity plan in 1992, 82 percent
offered an HMO, 50 percent offered a PPO, 92 percent
offered dental coverage, and 32 percent offered vision
care plans (chart 4) (Hewitt Associates, 1993). On
average, choice-making plans offered more options for
medical than for dental or vision care coverage. Offering
a variety of medical plan options under a cafeteria plan
provides employees with the opportunity to meet indi-
vidual needs and weigh the relative cost and value of
benefits. Medical options in cafeteria plans are also
useful in managing employer health care expenditures.
Employers often change their core medical plan or
introduce managed care features in conjunction with
cafeteria plan implementation. Although some of those
implementing choice-making plans retained their health
plan without making changes in coverage provisions,
most surveyed employers modified their medical plan.
Frequent changes included increased contributions for
dependent coverage (68 percent), increased contributions
for employee coverage (57 percent), increased deductibles
(48 percent), and/or increased annual out-of-pocket
maximizes (45 percent) (A. Foster Higgins, 1992). In addition, more than three-quarters of employers implementing flexible benefit plans introduced cost management features concurrently.

About 80 percent of employers who offer health insurance through a cafeteria plan allow their employees to waive medical coverage (Hewitt Associates, 1993). Giving employees this option can benefit both the employer and employee in certain circumstances. The employer can reduce health care expenditures by shifting coverage to a spouse’s employer. The employee can use employer benefit dollars that would have been spent on medical benefits to purchase other benefits or trade them for additional cash compensation. Survey data indicate that, on average, 11 percent of employees choose to waive their health insurance coverage (Hewitt Associates, 1993). Employee Benefit Research Institute (EBRI) analysis of the March 1992 Current Population Survey indicates that 12 percent of persons with direct employer-sponsored health insurance coverage in 1991 had a second source of coverage. In these families with two employed adults, a cafeteria plan that permits opting out would enable the family to receive greater cash compensation or greater levels of other benefits rather than duplicate group health insurance.

Employees who do not select health insurance coverage may lose future rights to receive it. More than 60 percent of cafeteria plans permitting employees to waive medical coverage require proof of other coverage in order to discourage employees from choosing no health insurance coverage. The remaining plans may unintentionally increase the percentage of the population who are uninsured. Among programs with medical opt-out provisions, over one-half permit reentry into the plan without restriction, as long as it occurs during open enrollment or is the result of a change in family status (Hewitt Associates, 1993). Reentry restrictions, where applied, often include limitations on preexisting conditions, proof of insurability requirements, or both (table 8).

Cafeteria plans may also limit election changes from year to year for dental and vision coverage. Without such restrictions, an employee could choose a high option dental plan in a year in which he or she expects to undergo oral surgery and in a subsequent year reduce or even eliminate coverage. This kind of behavior can adversely affect insurance premiums. More than one-half of choice-making plans place some restrictions on dental benefit elections, most commonly locking employees into or out of coverage for two years (Hewitt Associates, 1993).

Flexible Spending Accounts

After health insurance, FSAs are the most common benefit offered through a cafeteria plan. Ninety-six percent of surveyed employers offered an FSA in conjunction with a choice-making plan in 1992 (Hewitt Associates, 1993).

Death and Disability Insurance Benefits

Death and disability insurance plans protect employees and their dependents from loss of income due to an accident, injury, or illness. These benefits, including employee and dependent group life insurance, AD & D, and long-term disability, are common options in cafeteria plans. Employees prefer a choice among types and levels of death and disability insurance because the need for these benefits changes with age and family status. However, special tax considerations often complicate the treatment of these benefits.

<table>
<thead>
<tr>
<th>Table 8: Reentry Restrictions Following Medical Opt-Out In a Choice-Making Plan, 1992</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restriction</td>
</tr>
<tr>
<td>No Restrictions if Due to Change in Family Status</td>
</tr>
<tr>
<td>No Restrictions if During Open Enrollment</td>
</tr>
<tr>
<td>Preexisting Condition Limitations</td>
</tr>
<tr>
<td>Preexisting Condition Limitations and Proof of Insurability</td>
</tr>
<tr>
<td>Proof of Insurability</td>
</tr>
<tr>
<td>Restricted to Specific Option(s) upon Reentry</td>
</tr>
<tr>
<td>Other Restrictions</td>
</tr>
<tr>
<td>Number of Plans Reporting</td>
</tr>
</tbody>
</table>

Source: Hewitt Associates, Flexible Compensation Programs and Practices: 1993 (Lincolnshire, IL: Hewitt Associates, 1993). Note: Hewitt Associates data are based on 472 surveyed employers. These programs include plans with benefit choice-making, flexible spending accounts, or a combination of both.
Most firms (88 percent) with life insurance options in their cafeteria plan require employees to choose a minimum level of coverage. However, because group term life insurance coverage above $50,000 must be included in an employee's gross income, employers need to decide whether to permit premium payment on a pre- or post-tax basis. In 1992, 75 percent of employers with group term life insurance used pretax premium payment (Hewitt Associates, 1993). For most employees, any tax liability resulting from additional imputed income would be offset by the tax savings gained through salary reduction. Generally, choices between pre- and post-tax life insurance premium payments are not offered within the cafeteria plan framework because the administration and communication of these options is complex.

About two-thirds of choice-making plans include dependent life insurance options. However, new IRS guidance on the taxation of dependent life insurance effective in 1992 states that dependent life insurance with a de minimus value, such as small amounts of coverage under $2,000, cannot be included in a cafeteria plan. The value of all employer-provided dependent life coverage is taxable to employees. Therefore, most respondents indicated that they offer dependent life insurance on an after-tax basis outside of the cafeteria plan (Hewitt Associates, 1993). Under this arrangement, imputed income is not an issue as long as the of coverage is considered de minimus (Hewitt Associates, 1993).

Disability insurance is often used to expand the scope of choices under a flexible benefits plan rather than to meet employee needs because these needs do not change substantially over time (Frost, et al., 1992). Short-term disability options—offered by 16 percent of choice-making plans in 1992—are a growing but uncommon benefit, generally because many employees are covered by sick leave policies that provide full or partial income replacement for a period of time (Hewitt Associates, 1993). On the other hand, long-term disability choices were offered by 62 percent of cafeteria plans. Generally, employers offer a disability plan option similar to the plan in place prior to the flexible plan's implementation. Employers must choose whether or not to allow employees to use salary reduction to pay for disability benefits. Benefits purchased with after-tax dollars are nontaxable to an employee who becomes disabled, whereas benefits attributable to pretax employee contributions are considered employer provided and are taxable when paid. Sixty percent of employers who offer disability plans collect employee contributions on a pretax basis; salary reduction is more cost effective in paying for the coverage because the tax liability after an employee becomes disabled is likely to be less than it was during his or her working years (Hewitt Associates, 1993).

Survey data indicate that employers require nine months, on average, to plan and implement a flexible benefits administration system. Stand-alone spending account plans require less lead time, only about five months on average (Hewitt Associates, 1993). Larger employers often spend more time planning and implementing a program, probably because their programs tend to be both more comprehensive and more complicated. Thirty-two percent of organizations with choice-making plans hired additional staff to administer the program in 1992 (Hewitt Associates, 1993). Flexible benefits plan administration costs are affected by several factors, including both the program complexity and the size and logistics of the covered population. Surveyed employers estimated the costs associated with both administration setup and ongoing administration. Reported initial setup costs ranged from $10,000 to $1.5 million. Although larger organizations generally spend more for an administration system, both their ongoing administrative costs and their initial set-up costs are lower per capita because...
Table 9
Average per Capita Administrative Costs Related to Choice-Making Programs and Flexible Spending Accounts (FSAs), 1992

<table>
<thead>
<tr>
<th>Eligible Population</th>
<th>Choice-Making Programs</th>
<th>Flexible Spending Accounts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>System setup</td>
<td>Ongoing administration</td>
</tr>
<tr>
<td>Fewer than 1,000</td>
<td>$104</td>
<td>$ 46</td>
</tr>
<tr>
<td>1,000-4,999</td>
<td>48</td>
<td>25</td>
</tr>
<tr>
<td>5,000-9,999</td>
<td>33</td>
<td>16</td>
</tr>
<tr>
<td>10,000 or more</td>
<td>28</td>
<td>21</td>
</tr>
<tr>
<td>Total Survey</td>
<td>48</td>
<td>26</td>
</tr>
<tr>
<td>Number of Plans Reporting</td>
<td>113</td>
<td>121</td>
</tr>
</tbody>
</table>


Note: Hewitt Associates data are based on 472 surveyed employers. These programs include plans with benefit choice-making, FSAs, or a combination of both.

Employers report that cafeteria plans have been generally successful in meeting major program objectives. In a recent survey, 99 percent of employers with choice-making plans reported that they had reached their major program objective of meeting diverse employee needs (Hewitt Associates, 1993). However, only 72 percent of employers who cited controlling health expenditures as a major program objective felt they had met their goal (Hewitt Associates, 1993).

Various analyses have shown that choices in the medical area can slow the rate of increase in health care claims, but usually not dramatically. Cost reduction is limited by several factors. Employees who choose medical options with greater first dollar cost sharing tend to be more deliberate in their use of services as a result of participating in the health insurance purchasing decision. In addition, typically less than one-half of the employees shift away from the highest option available in the first two years of implementation. Therefore, utilization savings occur for only a portion of the work force. When an employee chooses a less costly health insurance option, the full impact on utilization is felt in the first year. No further decreases are likely to occur until the employee moves to a lower cost option (Frost, et al., 1992). Survey data indicate that employers with flexible benefits plans have only very slightly lower average per employee medical plan costs. In 1991, surveyed employers with a choice-making plan had average costs of $3,644 while those without a choice-making plan had average costs of $3,680. However, when evaluating per employee plan cost, it is important to remember that employers with flexible benefits plans tend to be larger and that larger employers may have higher per employee costs because they have more benefits maintained. If an employer implements a plan in which employees are forced either to reduce coverage or increase their net contribution to benefits, the reaction may be negative.

Employers

By offering employees a choice among types and levels of coverage, employers may meet many of their employees' needs. With effective communication, employees may appreciate their ability to choose, particularly those who currently have duplicate coverage or need additional coverage in nontraditional areas. Employers may also benefit from a cafeteria plan by introducing cost management strategies. By limiting annual increases in benefit credits, employers can introduce cost sharing to employees slowly.

they can spread the costs across a larger number of employees (table 9) (Hewitt Associates, 1993). The advantages and disadvantages of flexible benefits plans vary with the perspectives of employers and employees. Actual experience is often based on original employer objectives and plan design. Employers may gain from increased morale and productivity of employees who are satisfied with their benefits package. The extent of employee appreciation varies with the degree of choice offered, range of benefits offered, and level of benefits maintained. If an employer implements a plan in which employees are forced either to reduce coverage or increase their net contribution to benefits, the reaction may be negative.
generous benefit plans (A. Foster Higgins, 1992). Employers cannot be certain that implementing a cafeteria plan will result in a net gain in terms of either reduced or stable benefit expenditures or employee satisfaction. Without proper planning, a cafeteria plan could increase total employer expenditures and/or receive a negative reaction from employees. Employers must consider that, with increased choice, employees may utilize services more often. Such adverse selection, particularly in medical, dental, and vision care, may result in higher premiums during subsequent years. As mentioned previously, small employers are at a disadvantage in implementing cafeteria plans because they do not experience the economies of scale of large employers and must, therefore, realize greater overall cost savings in order to be successful.

Employees

Cafeteria plans give individuals the opportunity to determine the mix of cash and benefits in their total compensation. Employees covered by such plans do not have to accept a uniform benefit structure designed to meet the needs of one segment of the work force. As two-earner families, single parent families, unmarried partners, and single persons without children become more prevalent, traditional plans are also less likely to meet the needs of all workers. With a cafeteria plan, employees can eliminate duplicate coverage and/or expand coverage to other needed areas. As family needs or personal finances change, employees can alter their benefit elections to meet changing needs. However, even if employers undertake a communication plan to educate employees about benefit options, employees may not choose an appropriate mix of benefits and cash. Employers try to limit election errors, particularly for health insurance, by requiring proof of coverage before benefits can be waived. However, not all employers require such proof, and elections in other benefits areas are often not examined as carefully. In addition, employees who were satisfied with their total compensation package prior to the implementation of a cafeteria plan may dislike the plan, particularly if it is introduced in conjunction with a reduction in coverage in areas they consider important. Finally, employees who are eligible for an FSA but are unable to estimate uncovered health care expenses accurately may forfeit the unused balance of their account at the end of the plan year. About 20 percent of health care FSA participants and 13 percent of dependent care FSA participants forfeited funds at the end of the 1991 plan year. The average forfeiture for health care FSAs and dependent care FSAs was $127 and $165, respectively (Hewitt Associates, 1993).

Employee benefits are an important component of total compensation for most American workers. In 1991, benefits represented 17 percent of total compensation, up from 8 percent in 1960 (Piacentini and Foley, 1992). As the population continues to grow older and as women enter the work force in increasing numbers, the traditional compensation package is likely to adjust in response to diverging needs. Sec. 125, enacted 15 years ago, provided a means for employers to offer a different set of benefits to each employee, based on individual needs, as long as certain nondiscrimination rules were met. However, to date, only a small percentage of full-time employees have cash and benefit tradeoffs available. This is due in part to the complex nature of these plans, the resource investment required to implement an effective plan, and legislative uncertainty. A relatively larger proportion of employees is given the opportunity to pay for unreimbursed health or dependent care expenses on a tax-favored basis through an FSA. However, only a fraction of eligible employees use this
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- Profit-Sharing Plans
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