

CHAPTER 18

THE PBGC AND PLAN FUNDING

The Pension Protection Act

Signed into law in August 2006, the Pension Protection Act (PPA) has been heralded by many as the most comprehensive reform of defined benefit pension plans since the enactment of the Employee Retirement Income Security Act of 1974 (ERISA), the major federal law governing employment-based benefits. In addition to completely revamping the minimum funding requirements for single-employer¹ defined benefit plans, it also expands the deduction limits for contributions to these plans and includes reforms that affect both cash balance pension plans and defined contribution (401(k)-type) plans.

From a public policy perspective, one of the primary reasons for the need to modify the minimum required contributions for defined benefit plans was the financial shape of the single-employer plan termination insurance program administered by the Pension Benefit Guaranty Corporation (PBGC). Enacted as part of ERISA, the PBGC has evolved into a federal government entity providing an insurance-type benefit to indemnify pension plan participants (up to a limit) for certain defined benefit promises made by sponsors who enter bankruptcy with underfunded pension plans.²

The premium system for the single-employer plan termination insurance program has been two-tiered since the mid-1980s (VanDerhei, 1988):³

- The first tier is a per-capita premium that is \$34 for 2009, but will be indexed to average national wage growth.
- The second tier is a variable premium of \$9 per \$1,000 of underfunding.⁴

¹ See the chapter on multiemployer plans for information on how PPA is expected to affect that sector.

² For approximately the first 10 years of the program, the employer merely needed to terminate an underfunded defined benefit plan for the insurance benefit to be effective. The necessity for the sponsor to actually be in bankruptcy was added only after several large underfunded defined benefit plans were terminated in exchange for a portion of the sponsors' net worth (which in many cases was far less than the amount of defined benefit underfunding they were shedding).

³ Some sponsors of terminating plans will be required to pay a "termination premium" for certain distress and involuntary pension plan terminations that occur after 2005. For most affected plans, the annual termination premium is \$1,250 per participant. The termination premium must be paid to PBGC annually for three years after the plan terminates.

⁴ For plan years beginning in 2008 or later, the mandated discount rate is based on corporate bond yields. Under the new premium rules, present value is generally determined using three

However, several studies had predicted that the level of insurance premiums was far below the expected cost for many of the sponsors insured under this program, and that adverse selection and moral hazard would undoubtedly work toward the eventual financial distress of the system (VanDerhei, 1990, and Boyce and Ippolito, 2002). Although the financial position of PBGC had experienced cyclical fluctuations, by the mid-1990s it had entered a surplus position, and by 2000 the surplus had grown to \$9.7 billion. However, after several years of falling discount rates⁵ and negative rates of return on equity portfolios, by 2004 the surplus had turned into a deficit of \$23.3 billion.

In February of 2005, the Bush administration released its Single-Employer Defined Benefit Pension Reform Proposal. This attempted to control for several of the perceived limitations of the minimum funding requirements for the single-employer defined benefit pension system as it existed at the time:

- Underfunded plans were typically given a funding target of only 90 percent. In essence, plans could be up to 10 percent underfunded without being subject to the special rules enacted to deal with the underfunding problem in 1987 and 1994.⁶
- Discount rates used to value the plan liabilities for underfunded plans were averaged over four years. This means that if discount rates were steadily decreasing (a scenario that, in fact, occurred in the early part of this decade), the average discount rate could be much higher than the value needed to close out a terminated defined benefit plan. Since higher discount rates translate into lower present values of pension liabilities, the targets that sponsors were using in their calculations were at times artificially low.
- Similarly, asset values could be averaged over five years, subject to constraints. When equity values were low or negative for several consecutive years (again, a scenario experienced in this country in the early part of this decade), the *actuarial* value of pension assets could be considerably higher than their *true market* value at a time when the plan might be turned over to the PBGC.

interest rates (“spot segment rates”), each of which applies to cash flows during specified periods. Information on the spot segment rates appears on the PBGC’s Web site at www.pgbc.gov. The new premium rules also permit the use of alternative discount rates.

⁵ The discount rate is the value used to adjust future cash flows to the present by reflecting the “time value of money.”

⁶ To improve the funding of underfunded plans, the Pension Protection Act of 1987 and the Retirement Protection Act of 1994 applied deficit reduction rules requiring faster funding to the plans that were less than 90 percent funded.

- Finally, amounts paid in by plan sponsors in prior years that exceeded the minimum amounts legally required could be carried over at book value to be used in future years to reduce or eliminate minimum required contributions. These so-called “credit balances” would automatically accrue at the discount rate used in the calculations and could result in a book value substantially larger than the market value in the future.

The final form of the PPA as enacted by Congress varied substantially from the administration’s proposal with respect to specific details, but it did attempt to deal with the more problematic situations mentioned above. Much of PPA is generally effective in 2008, but many provisions are to be phased in over several years.

The new minimum funding standards replace the previous two-tier system (a funding standard account for all plans plus the deficit-reduction contribution for underfunded plans) with a new system in which all single-employer defined benefit plans will have a new funding target of 100 percent of plan liabilities.⁷ In general,⁸ the minimum required contribution will now be equal to the target normal cost plus a seven-year amortization⁹ of unfunded liability, less any permissible credit balances. The target normal cost is the present value of all benefits that are expected to accrue or to be earned under the plan during the plan year, including prior-year benefit accruals that increase because of compensation increases in the current year.

Two assumptions used in computing pension expense will undoubtedly become more volatile under PPA:

- Instead of mandating a discount rate based on the four-year average of corporate bond rates for current liability calculations (as was the case under prior law), benefits will be grouped into three segments: (1) benefits expected to be payable within five years, (2) benefits expected to be payable after five years but within 20 years, and (3) benefits expected to be payable after 20 years. Each interest rate of the three segments would then be determined by a latest 24-month unweighted average of these rates.¹⁰

⁷ This will be phased in gradually: The target will be 92 percent in 2008, 94 percent in 2009, 96 percent in 2010, before reaching 100 percent in 2011. There is an exception for plans that were already subject to the deficit reduction contribution in 2007: They will have a 100 percent funding target in 2008.

⁸ Specific exceptions for at-risk plans are defined below.

⁹ When the value of plan assets is at least equal to the value of benefit obligations, there is no funding shortfall and no more shortfall amortization installments are required.

¹⁰ It should be noted for investment purposes that a plan sponsor may make a one-time election to use the full corporate bond yield curve without any averaging, rather than using the three separate segment rates.

- Plan asset values will likely also become more volatile under PPA, as the “smoothing period” for interest rate calculations has been reduced from five years to two years and the 20 percent corridor around the market value of assets that served as constraints on the actuarial value of assets has been reduced to 10 percent.

The administration’s proposal attempted to deal with the moral hazard and adverse selection problems for the single-employer plan termination insurance program by establishing a proxy for the likelihood that defined benefit sponsors would go bankrupt and thus possibly present a claim to PBGC. The minimum required contribution under this proposal as well as the risk-based premiums to PBGC would have been based on targets that vary depending on the financial health of the plan sponsor.¹¹ Instead of adjusting for the higher expected likelihood of financially troubled defined benefit sponsors becoming an insured claim for PBGC and directly reflecting this as an increased premium under a full-fledged risk-related premium, PPA reflects the increased severity from these plans by creating a separate category for “at-risk” plans and requires them to provide greater contributions to the plan.

At-risk liability is computed assuming that all participants eligible for benefits in the current year and the next 10 years retire at the earliest possible date and choose the most expensive form of benefits from a present value basis. A plan is defined to be “at risk” if it is both (1) less than 80 percent funded¹² under standard actuarial assumptions and (2) less than 70 percent funded using the at-risk assumptions. For purposes of this determination, plan assets must generally be reduced by the plan’s credit balance.

The consequences of being designated as an at-risk plan under PPA is that it increases required contributions by increasing the target normal cost and the funding target. If the plan *also* was at risk in at least two of the four preceding plan years, the target normal cost is further increased by 4 percent and the value of plan liabilities used to calculate funding shortfalls is also increased by 4 percent, plus a loading factor of \$700 per participant.¹³

¹¹ The financial health of a plan sponsor would be defined as financially weak for this proposal if the plan sponsor had senior unsecured debt that was rated as not being investment grade by each of the nationally recognized statistical rating organizations that has issued a credit rating for the debt.

¹² This percentage is phased in over four years: 65 percent in 2008, 70 percent in 2009, 75 percent in 2010, and 80 percent in 2011 and thereafter.

¹³ Under the law, the full at-risk contribution is not required for the first plan year the plan is at risk. The increase in the contribution is phased in over five years. In the first year a plan is at risk, the minimum contribution is equal to the amount required for a plan that is not at risk, plus 20 percent of the difference between that amount and the amount required by the at-risk calculation.

The treatment of credit balances under prior law is retained in many situations under PPA, but often at a price. For example, if the value of a plan's assets (reduced by any prefunding balance) is at least 80 percent of the plan's funding target (determined without regard to the at-risk rules) for the preceding plan year, the plan sponsor may elect to credit all or a portion of the funding standard carryover balance or prefunding balance against the minimum required contribution for the current plan year, thus reducing the amount that must be contributed for the current plan year. Moreover, existing credit balances and new prefunding balances¹⁴ must both be subtracted from assets in determining the "adjusted funding target attainment" percentage that is used to determine whether certain benefits can be paid and whether benefit increases are allowed (Purcell, 2006). The problems arising from carrying credit balances at book value under prior law are dealt with under PPA by requiring such amounts to be adjusted for investment gains and losses since the date of the original contribution that created the credit balance.

PPA also provides incentives for plan sponsors to attain certain funding thresholds by providing for restrictions on benefit accruals, benefits increases, and utilization of lump-sum distributions (Purcell, 2006).¹⁵ Under the new law, the plan sponsor is required to freeze benefit accruals for current participants in plans funded at less than 60 percent.¹⁶ Plan amendments that increase benefits are prohibited if the plan is funded at less than 80 percent of the full funding level, unless the employer makes additional contributions to fully fund the new benefits. Lump-sum distributions are prohibited if the plan is funded at less than 60 percent of the full funding level or if the plan sponsor is in bankruptcy and the plan is less than 100 percent funded. If the plan is funded at more than 60 percent but less than 80 percent, the plan may distribute as a lump sum no more than half of the participant's accrued benefit.

Condeluci (2007) argues that there may be three reasons to expect PPA to prompt pension plan sponsors to freeze accruals for current employees in their plans:

¹⁴ Credit balances must be separated into two categories: balances carried over from 2007 and balances resulting from contributions in 2008 and later years.

¹⁵ Although annuities are the default form of payment in a defined benefit plan, plan sponsors will often give employees the alternative of taking the actuarial equivalent of the annuity in a single sum known as a lump-sum distribution.

¹⁶ Once a plan is funded above 60 percent, the employer—and the union in a collectively bargained plan—must then decide how to credit past service accruals. This provision does not apply during the first five years of a plan's existence, or if the employer makes an additional contribution prescribed by the statute.

- Sponsors may be required to fund their plans to a higher level and over a shorter period of time.
- The new restriction on benefits.
- The effect credit balances will have on plan assets.

Under prior law—with basic elements dating all the way back to the passage of ERISA in 1974—the minimum required contributions for defined benefit plans were determined by the plan’s funding standard account. In general, this would require the plan to make an annual contribution equal to its normal cost plus amortization of supplemental liability plus (minus) an amortization based on experienced losses (gains). This value could then be reduced by credit balances that had been carried over at book value and/or funding waivers. In general, the amortization period for supplemental liability was 30 years, while the amortization period for experienced gains or losses was five years.¹⁷

Based on 1987 legislation (and amended in 1994), certain underfunded plans were required to pay an additional amount based on the deficit reduction contribution (DRC) if the funded current liability percentage¹⁸ for the plan year is less than 90 percent. The DRC is generally the sum of (1) the “unfunded old liability amount,” (2) the “unfunded new liability amount,” and (3) the expected increase in current liability due to benefits accruing during the plan year. The “unfunded old liability amount” is the amount needed to amortize certain unfunded liabilities under 1987 and 1994 transition rules.¹⁹ The “unfunded new liability amount” is the applicable percentage of the plan’s unfunded new liability. The applicable percentage is generally 30 percent, but decreases by 0.40 of 1 percentage point for each percentage point by which the plan’s funded current liability percentage exceeds 60 percent. Based on a 6 percent discount rate, the equivalent amortization period for a plan with a funding ratio of 60 percent or less would be approximately three years.

Under the new rule, the underfunded amount must be amortized over seven years. The overall impact of the change to the uniform amortization period under PPA is difficult to assess. However, it would appear in most cases that well-funded plans with substantial supplemental liabilities will now be required to amortize the amount more rapidly; however, underfunded plans, especially those with funding ratios below 60 percent, may find that

¹⁷ Changes in actuarial assumptions were generally amortized over a 10-year period.

¹⁸ A plan’s “funded current liability percentage” is generally the actuarial value of plan assets as a percentage of the plan’s current liability. In general, a plan’s current liability means all liabilities to employees and their beneficiaries under the plan, determined on a present-value basis.

¹⁹ For more information on the unfunded old liability amounts, see VanDerhei (1994).

the amortized amounts may be decreased.²⁰ Condeluci argues that this increase in funding contributions for well-funded plans may be sufficient to force at least some of them to freeze benefit accruals (which would, in essence, either eliminate or greatly reduce the normal cost component of the minimum required contribution).²¹

The argument put forth by Condeluci with respect to restrictions on benefits suggests that some plans with funding ratios less than 60 percent will take the mandated freeze imposed by PPA and choose to make it permanent. Other sponsors that may be forced to at least partially curtail the availability of lump-sum distributions due to the new PPA-imposed restrictions may find this to be sufficient incentive to freeze the defined benefit plan and offer a defined contribution plan to the employees instead. Moreover, the constraints on collective bargaining negotiations going forward may be reduced if the plan sponsor can reach an agreement with the union and freeze future benefit accruals.

Finally, Condeluci argues that the modification in the utilization of credit balances in the post-PPA period may cause some employers to reconsider their original decision to sponsor a defined benefit pension plan at all. He suggests that this may be especially true if a well-funded defined benefit plan would be considered at risk or subject to benefit restrictions as a result of the credit balance's impact on the plan assets.

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²⁰ This may be mitigated to a significant extent by the additional amounts required for at-risk plans, however.

²¹ Stockton (2006) performs a Monte-Carlo simulation on a hypothetical plan to test the impact of many of the new PPA rules and finds that funding ratios increase on average and volatility (as measured by standard deviation of the funding ratio) increases. However, Warshawsky (2007) performs a similar type of simulation for a cash balance plan using proprietary asset/liability software with precise representations of the new and old laws, including transition rules, and finds a reduction in contribution volatility.

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Additional Information

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CHAPTER 19

PLANNING FOR RETIREMENT

Introduction

When the Social Security program was created in 1935, a 65-year-old American had an average life expectancy of 12½ more years; today, it is 18 years and rising.¹ Expanded life expectancy brings with it a new awareness of the aging process. Retirement is increasingly an important part of one's *total* life. However, many still view their retirement years with apprehension. Retirement is a challenging period that can bring rewards and new experiences. However, a satisfying retirement requires an adjustment period that is greatly aided by thoughtful, effective planning in earlier working years.

Ideally, one should begin planning for retirement early in one's career. The 2008 Retirement Confidence Survey, conducted by the Employee Benefit Research Institute (EBRI) and Mathew Greenwald & Associates, Inc., found that:²

- 61 percent of workers are *very* or *somewhat* confident they will have enough money to live comfortably throughout their retirement years.
- 72 percent of workers have saved for retirement.
- 7 percent say they and/or their spouse have tried to calculate how much money they will need for a comfortable retirement.

The first part of this chapter identifies some areas on which those who are preparing for retirement need to focus. It is not intended to provide all the necessary information. Instead, it poses certain questions that need early consideration. Discussion is provided on: financial planning, health care costs, living arrangements, use of leisure time, interpersonal relationships, and estate planning. There are several types of worksheets available to help individuals estimate a retirement savings goal, where they are in relation to that goal, and how much needs to be saved on their behalf to reach that goal.³ The second part of the chapter discusses the potential role of employers in helping employees to prepare for retirement.

¹ The Future of Social Security, www.ssa.gov/pubs/10055.pdf

² Helman, Ruth, Jack VanDerhei, and Craig Copeland, "The 2008 Retirement Confidence Survey®: Americans Much More Worried About Retirement, Health Costs a Big Concern." *EBRI Issue Brief*, no. 316, April 2008.

³ Two versions of this type of worksheet are available for free at <http://choosetosave.org>. The Ballpark Estimate is an easy-to-use, two-page worksheet that helps you quickly

Considerations for the Employee

Financial Planning Considerations—A difficult aspect of retirement planning is ensuring adequate household income. A common misconception is that financial planning is only necessary for wealthy people. Retirement income planning may be even more important for average or low-income people due to the complexities of taxation, the sophistication of financial markets and instruments, and increasing longevity. Workers should be saving and investing large amounts at the peak of their earning power. Additionally, they should understand that certain options existing at one point in time may not be available later.

Throughout their career years, workers should give careful consideration to the following questions: At what age should I retire? What kind of retirement do I want? Where will I live? How much money will I need in retirement? What are my assets and liabilities now? What will they be at retirement? What are my health care costs likely to be? Will I have long-term care needs? How can I cope with inflation? And, for those who are married, if I should die before my spouse, will my family be left with an adequate income?

Retirement Income Sources—Retirement income is generally derived from three sources: Social Security, pensions, and personal savings. In addition, retirees may have access to life insurance, home equity, welfare programs, or new forms of employment. Following are some sources of retirement income.

Social Security—Social Security replaces a portion of covered earnings that may be lost as a result of a person's old age, disability, or death. Various requirements must be met before benefits are payable. For those who qualify, benefits are paid to workers and their spouses, widows, widowers, divorcees, dependent children, and dependent parents. Social Security benefits are automatically adjusted for inflation.

Social Security replaces a portion of preretirement income. It is not intended to provide income sufficient to satisfy *all* retirement needs. For individuals in all income quintiles—but especially for individuals in the higher income quintiles—Social Security must be supplemented by pensions, personal savings, and other investments if individuals hope to maintain their preretirement standard of living. For example, the Social Security replacement rate for an individual age 65 with final annual earnings of \$15,000 in 2008 was 49 percent, while the replacement rate for an individual

identify approximately how much you need to save to fund a comfortable retirement. The Ballpark E\$timate takes complicated issues like projected Social Security benefits and earnings assumptions on savings, and turns them into language and mathematics that are easy to understand. The second version is an interactive program that allows the user to input a large number of assumptions to tailor the results more precisely to his or her situation.

age 65 with final annual earnings of \$100,000 was 21 percent. The design of Social Security helps assure these results with a benefit formula that delivers larger benefits, as a percentage of final compensation, to those earning the least and a maximum salary cap for taxes and benefit calculation.

Today, most workers qualify for reduced retirement benefits at age 62 or full benefits at an age between 65 and 67, depending on year of birth. Social Security has no minimum age or service requirements for participation, thus all covered workers are also program participants. Workers with covered earnings of \$4,200 (indexed) or more in 2008 earned four quarters of Social Security coverage.⁴ For those reaching age 62 after 1990, 40 quarters are required for retirement benefits. An overwhelming majority of the work force ultimately qualifies for benefits. Social Security payments are not automatically provided; workers must apply for benefits. The Social Security Administration advises people to file claims about three months before they want the benefits to begin.

Private Pension Programs—There are several methods of payment for private pensions, although not every plan provides all of these options. One way in which a private pension can be paid to a retiree is the straight-life annuity—a periodic payment for the life of the retiree, with no additional payments to survivors. For married employees, the standard benefit prescribed by law is the joint-and-survivor annuity, which provides payments to a surviving spouse after a retiree dies. The Employee Retirement Income Security Act of 1974 (ERISA), as modified by the Retirement Equity Act of 1984, stipulates that an employee may reject a surviving spouse’s benefit only with the written consent of the spouse. Before retirement, workers and their spouses should confirm the status of their survivor benefits. Another method of payment that may be available to a retiree is the lump-sum payment, which provides the employee with the “actuarial equivalent”⁵ of an annuity. Particular care is required when considering a lump-sum distribution from an employer’s plan. Important considerations include the health of the employee and spouse, the ability and willingness to manage a significant amount of money, the availability of this money for nonretirement purposes, and the complex rules governing the tax treatment of lump sums.

Full private pensions (normal retirement benefits) in annuity form are usually offered at a specified age—frequently age 65. Often, it is possible to retire before normal retirement age and receive reduced pension benefits. Under the Tax Reform Act of 1986 (TRA ’86), individuals receiving pension payments in a lump sum prior to age 59½ will generally incur a 10 percent nondeductible tax penalty (in addition to the regular income tax already

⁴ See www.ssa.gov/OACT/COLA/QC.html for updates.

⁵ Two different benefit amounts are considered to be actuarially equivalent if the present value of the two benefits, considering mortality and interest, is the same.

required) on the distribution if the distribution is not transferred to an IRA or another qualified retirement plan within 60 days. However, the 10 percent tax does not apply to certain distributions.⁶

Generally, if an eligible rollover distribution is paid directly to the participant, the payer must withhold 20 percent of it. This can be avoided by choosing a direct rollover option.

Most private pension plans do *not* provide automatic cost-of-living adjustments, although some provide ad hoc pension supplementation on a discretionary basis. This is an important consideration in retirement planning, since inflation reduces the value of fixed pension income. Some pension plans permit employees to voluntarily contribute to the plan; these contributions may result in higher retirement income.

Private pension plan participants should thoroughly understand their plans. By doing this, they can develop reasonable estimates of future pension benefits. ERISA sets minimum funding, participation, and vesting standards for private pension plans. ERISA also requires reporting and disclosure of pension plan financial and operations information to plan participants and beneficiaries. Reports to participants must be written in a manner that can be understood by the average participant or beneficiary.

Personal Savings—Personal savings are an important part of retirement income, supplementing pensions and Social Security benefits. In determining how much money you will need from savings to maintain your standard of living throughout your retirement years, it is important to factor in the effect inflation has on purchasing power.

Individuals who have access to a personal computer may also consider using one of the many retirement planning software packages available. Most packages contain an introductory section that discusses basic retirement concepts, a work sheet section that looks at retirement goals and current savings, and a strategy section that helps individuals determine how to achieve their retirement goals. Individuals may also want to check with the benefits representative at their place of employment, since many employers provide software packages for use by employees. Often the employer-provided packages have a retirement factor specific to the employer built into the programs.

Homeownership—Often individuals accumulate their largest share of personal wealth in home equity. A substantial proportion of homes owned by the elderly do not have outstanding mortgages. At retirement, individuals can convert their home value into income-generating assets, or they can continue to enjoy the financial and personal advantages of owning residential property. Many elderly persons have a financial incentive to continue living

⁶ Additional details with respect to these exceptions may be found in Internal Revenue Service, *Individual Retirement Arrangements (IRAs)*, Publication 590.

in their homes, since normal maintenance costs and taxes may be less than the amount of rent required for comparable facilities.

A reverse mortgage is a loan made against home equity that provides cash advances and requires no repayment until a future time. The cash advances may be paid to the homeowner in a variety of ways, including: a single lump sum, monthly advances, or a line of credit. Repayment of all loan advances (plus interest) is required when the homeowner dies, sells the home, or permanently moves. When a homeowner takes out a reverse mortgage, he or she keeps the title to the property and any ownership responsibilities (including making repairs, doing maintenance work, paying property taxes, and paying homeowners' insurance). New variations of reverse mortgages occur regularly. Careful review of the reverse mortgage documents by a qualified independent advisor is critical prior to entering an arrangement.

Life Insurance—One major purpose of life insurance is to produce an immediate income for surviving dependents when working spouses or pensioners die. As a source of retirement income, life insurance assures that benefits will be paid to surviving beneficiaries according to the policy's stated conditions. However, the rate of return on savings invested in some policies may be lower than that of other investment alternatives.

Employees may purchase individual life insurance and pay premiums out of personal income. Sometimes employers pay group life insurance premiums for active and retired employees. Employees should inquire whether employer plans will continue to provide coverage after retirement and whether there are conversion privileges if coverage will not be continued.

Other Savings Alternatives—There are many other types of investment instruments that produce retirement income (e.g., stocks, bonds, mutual funds, and savings accounts). Workers should understand their alternatives and weigh the advantages and disadvantages of each against their individual needs. They should also consider the different tax aspects of these various investment instruments.

Employment—Many older persons who are eligible for retirement continue working—at least part time. Aside from the financial advantages, employment provides a productive and structured activity. Currently, there is a Social Security earnings test limiting the amount that can be earned before Social Security benefits are partially or fully reduced for individuals retiring early. The retirement earnings test applies only to people below normal retirement age (NRA), which ranges from age 65 to 67 depending on year of birth. Social Security withholds benefits if the earnings exceed a certain level, and if the individual is under NRA. One of two different exempt amounts apply, depending on the year of attaining NRA. These exempt amounts generally increase annually with increases in the national

average wage index. For people attaining NRA *after 2008*, the annual exempt amount in 2008 is \$13,560. For people attaining NRA *in 2008*, the annual exempt amount is \$36,120 (information online at www.ssa.gov/OACT/COLA/rtdet.html#lower). This higher exempt amount applies only to earnings made in months prior to the month of NRA attainment. Social Security withholds \$1 in benefits for every \$2 of earnings in excess of the lower exempt amount and \$1 in benefits for every \$3 of earnings in excess of the higher exempt amount. Earnings in or after the month you reach NRA do not count toward the retirement test.

Public Welfare Programs—For those who reach retirement age without adequate income, public welfare programs are available. These assistance programs offer economic support based on demonstrated need.

Supplemental Security Income (SSI) is a federally administered program that went into effect in 1974. It provides monthly cash assistance to low-income elderly, blind, and disabled persons who have assets below specified limits. Benefits are indexed to Social Security cost-of-living increases. Additionally, most states supplement the basic federal benefit. Income from other sources reduces available SSI benefits. More information on SSI can be obtained by contacting a Social Security Administration office.

Independent Living Considerations—Choosing an appropriate living environment after retirement requires careful thought and planning. Many options are available and should be considered before making a decision. For example, a retired couple may choose to stay in their present home or move into an apartment, smaller house, mobile home, or continuing care community. They may buy or rent a home. They may stay in the same geographic area or move—possibly to an area with a more comfortable climate. Some older people choose to share homes with others as an alternative to living alone. There are many considerations that people should keep in mind as they plan for living arrangements in retirement. For example, if they plan to stay in the homes that they have lived in most recently and have paid off the mortgage, they must not forget that budgeting for home maintenance, taxes, and possible remodeling is still necessary—especially as the home gets older. If moving to a new area is an option, costs of moving and changes in the cost of living should be considered when making a decision. Deciding on living arrangements in retirement should be based on financial considerations as well as individual needs and desires.

Physical and Social Considerations—Before moving to a new home, individuals should consider such issues as the accessibility of public transportation. A time may come when driving a car is not possible. Retirees should be in close proximity to grocery stores, doctors' offices, and other frequently used places. Isolation and loneliness are common concerns for

retirees; they should locate where it is easy to establish and maintain contact with others.

Use of Leisure Time—One of the greatest challenges to workers facing retirement is the satisfactory use of a dramatic increase in leisure time. Discovering positive ways to use free time requires energy and imagination. People who develop outside interests and commitments in their working years are more likely to adjust well in retirement. Retirement frequently provides an opportunity for more active involvement in the community, travel, an avocation, and/or further education.

Interpersonal Relationships—Work provides an environment for meeting people and sharing common interests; thus, retirement can result in less interaction with people. Finding new ways to meet people and develop friendships is important. Those who develop strong friendships and family relationships in earlier years usually have a happier, more productive retirement.

Adjustments are also necessary in spousal relationships. Developing friendships and outside interests before retirement reduces the strain of retirement on a marriage. Another area that needs attention is that concerning the death of one's spouse. Early discussion of coping methods that can be used after a spouse dies may reduce present and future anxieties. Psychological and financial adjustments must be considered.

Conclusion

Increasing life expectancies and increasing health care costs make the need for retirement planning even more crucial today than it was in the past. Through individual and company retirement planning efforts, employees can prepare more effectively for a happy, healthy, and productive retirement.

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Additional Information

AARP
601 E Street, NW
Washington, DC 20049
(888) 687-2277 or (202) 434-3840
www.aarp.org

American Association of Homes and Services for the Aging
2519 Connecticut Avenue, NW
Washington, DC 20008
(202) 783-2242
www.aahsa.org

International Foundation of Employee Benefit Plans
18700 W. Bluemound Road
Brookfield, WI 53045
(262) 786-6710
www.ifebp.org

Pension Benefit Guaranty Corporation
1200 K Street, NW
Washington, DC 20005
(800) 400-7242
www.pbgc.gov

Pension Rights Center
1350 Connecticut Avenue, NW
Suite 206
Washington, DC 20036
(202) 296-3776
www.pensionrights.org

U.S. Department of Labor
Employee Benefits Security Administration
Frances Perkins Building
200 Constitution Avenue, NW
Washington, DC 20212
(866) 444-3272
www.dol.gov/ebsa

U.S. Department of the Treasury
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224
(800) 829-3676 (Tax Forms and Publications)
(800) 829-1040 (Taxpayer Assistance and Information)
www.irs.gov

U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415
(202) 606-1800
TTY: (202) 606-2532
www.opm.gov

U.S. Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235
(800) 772-1213
TTY: (800) 325-0778
www.ssa.gov

Retirement Planning Tools

Choose to Save® Ballpark E\$timate
www.choosetosave.org/ballpark

CNN/Money: Retirement
money.cnn.com/retirement

Fidelity Investments Retirement Resource Center
<http://personal.fidelity.com/retirement/?bar=c>

Quicken® Personal Finance Software
www.intuit.com

Smartmoney.com: Retirement
www.smartmoney.com/retirement

Social Security Online: Benefit Calculators
www.ssa.gov/OACT/ANYPIA/compute.html

T. Rowe Price: Retirement Income Calculator
www3.troweprice.com/ric/ric/public/ric.do

TIAA-CREF Retirement Countdown
www.tiaa-cref.org/retready/index.html

APPENDIX

AUTOMATIC ENROLLMENT ARRANGEMENTS UNDER THE PENSION PROTECTION ACT OF 2006

Introduction

One of the important plan design decisions a 401(k) plan sponsor must make as a result of the Pension Protection Act of 2006 (PPA) is whether to introduce automatic enrollment features. There is extensive literature on the potential benefits of automatic enrollment on participation rates, especially for lower-paid employees.¹

The PPA provides a significant incentive for employers that have not already adopted automatic enrollment to reconsider their decisions. The PPA pre-empts state laws that might affect plans adopting automatic enrollment provisions² and provides additional nondiscrimination safe harbor protections.

Automatic Enrollment Arrangements

Under the PPA, there are two types of automatic contribution arrangements: eligible automatic contribution arrangements and qualified automatic contribution arrangements.

Eligible Automatic Contribution Arrangement (EACA)—If plan sponsors apply a uniform automatic contribution percentage for all employees, invest the contributions in a qualified default investment alternative (discussed below), and provide the required notices to employees, their plans are considered “eligible.” Plan sponsors providing EACAs will have six months after the end of the plan year to perform nondiscrimination tests (such as the actual deferral percentage test, actual contribution percentage test, and top-heavy rules) and make corrections. Plan sponsors can allow a 90-day revocation withdrawal provision in an EACA, meaning that an

¹ For more details, see Jack VanDerhei, “The Expected Impact of Automatic Escalation of 401(k) Contributions on Retirement Income,” *EBRI Notes*, no. 9 (Employee Benefit Research Institute, September 2007: 2–8) and Jack VanDerhei and Craig Copeland, “Impact of PPA on Retirement Savings for 401(k) Participants,” *EBRI Issue Brief*, no. 318 (Employee Benefit Research Institute, June 2008).

² The PPA preemption eliminates any concern employers may have about violation of state or local laws that require an employee’s written consent to deductions from the employee’s paycheck. Some employers were reluctant to use automatic enrollment because of a concern about liability for violating state payroll-withholding laws (O’Hare and Amendola, 2007).

employee must make the election to receive a distribution of erroneous automatic contributions within 90 days after automatic enrollment begins.³

Qualified Automatic Contribution Arrangement (QACA)—The PPA waives the nondiscrimination testing requirement for a plan sponsor that has a QACA. This is often referred to as a safe harbor automatic enrollment arrangement. It requires meeting the EACA requirements and complying with two additional requirements:⁴

- The initial automatic enrollment amount must be at least 3 percent (but not more than 10 percent) of compensation. The plan sponsor must increase in annual 1 percent increments to 6 percent of compensation (e.g., at least 4 percent in the second year, at least 5 percent in the third year, and at least 6 percent in the fourth year), but not exceed 10 percent of compensation.
- The plan sponsor must fund a “safe harbor” contribution which must be 100 percent vested after two years of service.⁵ The minimum employer safe harbor contributions are required. The plan sponsor must make either a matching contribution of 100 percent of the first 1 percent of compensation deferred plus 50 percent of the next 5 percent deferred (for a maximum match of 3.5 percent of compensation) or a non-elective contribution of at least 3 percent of compensation to all eligible nonhighly compensated employees.

Qualified Default Investment Alternatives (QDIA)—Plan sponsors must decide how to invest automatic enrollment contributions, because the employee is not making this election. The PPA offers fiduciary protection, if plan sponsors invest the automatic enrollment contributions in a QDIA. The Department of Labor recently issued final regulations providing for four types of QDIAs: (a) an investment fund product that takes into account the participant’s age or retirement date (e.g., a life-cycle or targeted-retirement-date fund), (b) an investment fund product that takes into account the characteristics of the group of employees as a whole (e.g., a balanced fund), (c) an investment management service where assets are allocated based on the participant’s age or retirement date (e.g., a professionally managed account), and (d) a capital preservation product that may be chosen for

³ The corrective distributions of erroneous automatic contributions from a plan are not subject to the IRC Sec. 672(t) 10 percent early withdrawal penalty, and such distributions are not taken into account for purposes of applying the nondiscrimination tests or the limit on elective deferrals (O’Hare and Amendola, 2007).

⁴ To satisfy the QACA provisions, the plan sponsor does not need to invest the automatic contributions in a qualified default investment alternative (QDIA). In most situations, plan sponsors may want to invest money in a QDIA for fiduciary protection, but it is not required.

⁵ In regular 401(k) safe harbor arrangements (i.e., those that are not QACAs), however, *immediate* full vesting of safe harbor contributions is mandated.

the first 120 days after the first elective contribution is made in an eligible automatic contribution arrangement. However, the investment must be redirected to one of the other QDIAs, for use after the 120-day period ends. Overall, with QDIAs, the participant can be automatically enrolled, have the contributions automatically invested in the appropriate QDIA, and the plan sponsor is protected from liability.

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PART THREE
HEALTH BENEFITS

CHAPTER 20

HEALTH BENEFITS: OVERVIEW

Introduction

Employers offer health benefits in order to provide workers and their families with protection from financial losses that can accompany unexpected serious illness or injury. They also offer the benefits to promote health, to increase worker productivity, and as a form of compensation to recruit and retain qualified workers.

Employment-based health benefit programs have existed in the United States since the late 1800s. In the 1870s, for example, railroad, mining, and other industries began to provide the services of company doctors to workers. In 1910, Montgomery Ward entered into one of the earliest group insurance contracts for its employees.

Prior to World War II, few Americans had health insurance, and most policies covered only hospital room, board, and ancillary services. During World War II, the number of persons with employment-based health insurance coverage started to increase. When the National War Labor Board froze wages as a result of the shortage of workers, employers sought ways to get around the wage controls in order to attract scarce workers, and health insurance was often used in this way. Health insurance was an attractive means to recruit and retain workers during a labor shortage for two reasons: unions supported employment-based health insurance and workers' health benefits were not subject to income tax or Social Security payroll taxes as cash wages were.

Today, as the cost of health care climbs, health insurance remains a valuable employee benefit. Employers view it as an integral component of the overall compensation packages that allow them to attract and retain workers. In addition to health protection for themselves and their family members, many employees view health insurance as a significant source of income protection. Depending on the nature of an illness and the benefits provided, an employee's financial well-being could be jeopardized by unanticipated medical expenses, if he or she lacks health insurance.

Currently, employment-based health insurance is the most common form of health insurance coverage in the United States. In 2006, 105.1 million workers ages 18–64 were covered by employment-based health benefits (Fronstin, 2008). Seventy-six percent of these workers had coverage through

their own employer, while a family member's employer covered the remainder. The employment-based health benefits system also covers 15.1 million nonworking adults, ages 18–64, and 42.3 million children under age 18. In 2008, virtually all employers with 200 or more employees offered health benefits to their workers, while 62 percent of employers with 3–199 employees made the same offering (Claxton et al., 2008).

This chapter first explains the taxation of employment-based health benefits. The chapter continues with sections on employee participation, insurance program administrators, managed care, health providers reimbursement, beneficiary out-of-pocket responsibilities, preexisting condition limitation provisions, health insurance program comparison, other health care plans, the Employee Benefits Security Administration (EBSA),¹ and federal laws.

Taxation of Health Benefits

Under the current tax code, health insurance premiums paid by employers are deductible as a business expense (see Internal Revenue Code (IRC) Sec. 162(a)), and are excluded, without limit, from most workers' taxable income. The exceptions are some cases of highly compensated employees (HCE), when the benefits discriminate in favor of HCEs in non-fully insured plans, and, starting in 2003, in the case of self-employed individuals, partners, and Subchapter S owners who participate in health insurance programs that are not medical savings accounts (see IRC Sec. 162(l)). In addition, workers whose employers sponsor flexible spending accounts (FSAs) are able to pay for health care expenses with pretax dollars through the FSA, meaning they are not taxed on the amount of money that is put into the FSA (see IRC Secs. 105(h)(6) and 125(a)), and workers with certain high-deductible health plans are able to make contributions to a health savings account on a tax-preferred basis.

For individuals who do not receive employment-based health benefits, total health care expenses (including premiums) are deductible only if they exceed 7.5 percent of adjusted gross income (AGI), and only the amount that exceeds 7.5 percent of AGI is deductible, though individuals are also allowed to deduct the entire contribution to an HSA even if the amount does not exceed 7.5 percent of AGI. Figure 20.1 contains a summary of the sections in the IRC that affect the provision of employment-based health benefits. The Internal Revenue Service (IRS) Web site (www.irs.gov) provides extensive information on all these matters.

¹ Formerly the Pension and Welfare Benefits Administration.

Figure 20.1

**PROVISIONS IN THE INTERNAL REVENUE CODE (IRC) AFFECTING
EMPLOYMENT-BASED HEALTH BENEFITS**

IRC SECTION	DESCRIPTION
104(a)(3)	Exclusion from gross income of employee for benefits attributable to employee contributions. Available to partners, Subchapter S owners, and self-employed individuals as if they were employees.
105(b)	Exclusion from gross income of employee for benefits attributable to employer contributions (including benefits received from such plans by partners, Subchapter S Owners and self-employed individuals).
105(h)	Any non-fully insured medical reimbursement plan that fails to meet nondiscrimination requirements will result in Highly Compensated Employees (HCEs) being taxed on the "excess reimbursement."
106(a)	Value of employment-based health accident or health plan provided by the employer is excluded from employee's gross income. Not available to partners, Subchapter S Owners and self-employed individuals (see Sec. 162(1) below).
106(b)	Exclusion for contributions to a medical savings account (MSA), but only to the extent allowed under Sec. 220. Also see Sec. 162(1) below(b)(1).
125(a)	Cafeteria plans provide participants with choices between cash (which may include certain taxable benefits) and qualified nontaxable benefits. Participant who chooses nontaxable benefit not taxed on the cash that could have been chosen. If cash is chosen, taxed on cash. HCEs receive this advantage only if the plan does not discriminate in favor of HCEs.
162(1)	Insurance paid for medical care to partners, Subchapter S Owners, and self-employed individuals is deductible from such individuals' gross income (and includable in the income of partners, Subchapter S Owners, and self-employed individuals). For taxable year 2002, 70 percent is deductible; and taxable years 2003 and after 100 percent is deductible from gross income. The remaining premiums that are not deductible, may, with all other IRC Sec. 213(d) allowed medical expenses, be itemized on Form 1040 Schedule A, subject to the 7.5 percent limit and overall limits for itemized deductions allowed under IRC Sec. 68.
213(d)	Determines whether the benefit is a medical benefit that can be excluded from gross income.
220	Tax-favored individual accounts that eligible individuals may establish pursuant to IRC Sec. 220. The Job Creation and Worker Assistance Act of 2002 extends the demonstration period through Dec. 21, 2003. MSAs were originally enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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7702B Long-term care benefits are defined as accident and health insurance and the amounts received under such long-term care benefits are considered as reimbursement under Sec. 213. Favorable tax treatment is not permitted for long-term insurance under IRC Sec. 125.

The tax preference for health insurance is generally viewed as being regressive. In dollar amounts, the tax exclusion can be viewed as regressive because it benefits higher-income individuals more than lower-income individuals. The regressive tax structure enables workers in higher tax brackets to receive greater tax advantages in dollar amounts than those received by lower-paid workers. This occurs because, although the amount of the benefits is generally the same for all workers with the same employer regardless of income, high-income workers face a higher marginal tax rate.

Figure 20.2 illustrates the value of the health insurance tax exclusion to families with different income levels who work for the same firm. Under the 2003 tax rate structure, the first family in Figure 20.2 faces a 10 percent marginal tax rate. If a \$5,000 health plan were excluded from income, the value of the exclusion in terms of taxes not paid that would be attributable to health insurance would be worth \$500. For the second family, with \$45,000 of taxable income and a 15 percent marginal tax rate, the absolute value of the exclusion is \$750, and the absolute value increases to \$1,750 for the family with \$350,000 of taxable income. The tax exclusion is worth

Figure 20.2

VALUE OF \$5,000 EXCLUSION TO SIX FAMILIES OF DIFFERENT TAXABLE INCOME LEVELS, A SIMPLE ILLUSTRATION

	Taxable Family Income	Exclusion as a Percentage of Taxable Income	Marginal Tax Rate	Amount of Exclusion	Exclusion as a Percentage of Taxable Income
Family 1	\$ 10,000	50 %	10 %	\$ 500	5.0 %
Family 2	45,000	11	15	750	1.7
Family 3	100,000	5	25	1,250	1.3
Family 4	150,000	3	28	1,400	0.9
Family 5	250,000	2	33	1,650	0.7
Family 6	350,000	1	35	1,750	0.5

Source: Employee Benefit Research Institute calculations based on 2007 U.S. tax tables for married persons filing jointly.

nearly twice as much or more to families in the 28 percent tax rate bracket as it is to families in the 15 percent bracket. For families with no taxable income, the value of the exclusion is worth nothing.

However, as a percentage of income, the exclusion may also be viewed as progressive, as the exclusion represents greater savings for lower-income families than for higher-income families (Institute of Medicine, 1993). Again looking at Figure 20.2, for a \$5,000 health plan, the value of the exclusion is 5 percent of income for family one, 1.7 percent for family two, 1.3 percent for family three, and less than 1 percent for the other families.

Figure 20.2 shows that while the exclusion is greater in dollar amounts for the families with higher income, as a percentage of income the relative value of the exclusion falls as income rises. When examining the tax exclusion by the percentage of income, it should be noted that it is not progressive at all income levels. Families with no taxable income receive no tax exclusion because they pay no taxes. A refundable tax credit would result in a reduction in taxes for these families.

The analysis above includes only the impact of the federal income tax on employment-based health benefits. Additional savings are realized by employees and employers as a result of not having to pay employment taxes (e.g., Social Security and Medicare taxes). In addition, states with individual tax liability laws may also exclude from state taxable income those amounts received in the form of employment-based health benefits.

Employee Participation

Many employers cover all eligible employees under a single health plan, although different employee groups may have different plans (e.g., union members and nonunion employees may have separate plans). In Feb. 2005, 80.9 percent of wage and salary workers ages 18–64 were offered health insurance by their employer, and 83.5 percent of these workers took the insurance (Fronstin, 2007). Claxton et al. (2006) found that, in 2006, 78 percent of workers (all ages) were offered insurance, and 82 percent of these workers took the insurance. Part-time workers are often not eligible for health benefits.

Most full-time employees are covered at the time they are hired or after they satisfy a waiting or service period. In 2006, the average waiting period for health coverage was 2.2 months (Claxton et al., 2006). Workers in the retail industry were subject to, on average, a 2.7 month average waiting period, while those in state and local governments and health care were subject to, on average, a 1.8 month waiting period. In addition, the waiting period among small firms was longer than in large firms.

In addition to covering employees, many plans cover their dependents. Employers may pay all or part of the cost of the coverage for an employee or for his or her dependents. However, in many plans, the employer contributions for employee coverage may differ from the employer contribution for dependents' coverage. Employee and dependent costs for coverage are generally paid through payroll deduction and may be paid with pre-tax dollars under IRC Sec. 125(a). In 2008, employees paid an average of \$60 per month for employee-only coverage (16 percent of the premium), while they paid an average of \$280 per month for family coverage (27 percent of the premium) (Claxton et al., 2008).

Type of Health Insurance Administrators

Employment-based health benefits may use any of a variety of administrators: commercial insurance programs, Blue Cross and Blue Shield plans, self-insured plans administered by third-party administrators (TPAs), or multiple employer welfare plan arrangements (MEWAs). Commercial insurance and Blue Cross and Blue Shield plans are primarily regulated by the states where they provide coverage. The federal government regulates self-insured plans exclusively.

Commercial Insurance Plans—Insurance companies are a major source of health insurance. The premium for such insurance protection is calculated to cover the benefits that will be paid, administrative costs, insurance sales commissions, state premium taxes, and surplus (e.g., profit). Generally, for employee groups of 50 or more, the insurer maintains separate claims records for the group and annually adjusts the premium to reflect the group's claims experience; these are called *experience-rated plans*. In contrast, a *community-rated plan* is an insurance plan in which the risk is shared among all members of the community and the premium is based on the health of individuals in the community and claim experience generated by that community or pool. Several states regulate when community rating can be applied. Commercial insurance companies also offer and administer self-funded health plans.

Blue Cross and Blue Shield Plans—Blue Cross and Blue Shield plans were originally started in the 1930s. Blue Cross plans were developed based on the concept of a community-based, voluntary, nonprofit group hospitalization or prepayment plan for hospital services. Based on the same concept, Blue Shield plans cover physician services. Although many plans operate under the Blue Cross and Blue Shield name, each plan is independent, generally operates in a specific geographic area, and offers different benefit structures.

Blue Cross and Blue Shield plans must comply with certain standards established by the Blue Cross Blue Shield Association. In addition, in some states, Blue Cross and Blue Shield plans are required to enroll all applicants regardless of health status. In recent years, several Blue Cross Blue Shield plans have converted to for-profit status and merged into larger plans. These plans are still required to comply with Blue Cross Blue Shield Association standards.

Self-Insured Plans—In a self-insured plan, the employer, or a trust to which the employer contributes, pays employee health care claims directly. Thus, the employer essentially acts as its own insurance company and bears the financial risk of making payments to providers. A limited number of employers self-insure and self-administer their medical plans with TPAs, commercial carriers, or Blue Cross Blue Shield. Other employers self-insure their plans but purchase administrative services contracts to take care of their administrative needs. Additionally, some insurers offer *stop-loss insurance* to employers, which covers catastrophic health expenses above a maximum and, therefore, limits a self-insured plan's liability.

The two main types of stop-loss coverage are individual stop loss (ISL) and aggregate stop loss (ASL). ISL, sometimes called *specific stop loss*, protects the employer against catastrophic claims by single individuals that exceed a dollar limit chosen by the plan sponsor. For example, if a covered participant incurs catastrophic injuries in an accident and has claims exceeding the contract's agreed-upon dollar limit (deductible), the ISL coverage would reimburse the plan for the covered expenses beyond that dollar limit. ASL, or *excess risk insurance*, insures against either non catastrophic or all claims exceeding a total dollar amount for a plan year.

Employers that self-insure do so for a number of reasons. Some employers self-insure in order to retain control of the plan reserves while others self-insure in an attempt to manage health care costs more directly. Some employers prefer to self-insure because these plans are not subject to state mandated benefit laws and insurance premium taxes. In effect, by avoiding state mandated benefits, employers are able to provide a uniform set of benefits to all employees, regardless of where they live. For some employers it makes sense to self-insure because their population of workers is healthier and less costly than the community pool. The Employee Retirement Income Security Act of 1974 (ERISA) prohibits states from regulating self-insured plans. Finally, some employers self-insure to avoid carrier risk charges and charges for surplus.

Multiple Employer Welfare Arrangements (MEWAs)—A MEWA is an employee welfare benefit plan or any other arrangement that provides any of the benefits of an employee welfare benefit plan to the employees of two or more employers. MEWAs that do not meet certain conditions or are

not certified by the U.S. Department of Labor may be regulated by states. MEWAs that are fully insured must meet state insurance laws regulating reserves.

Managed Care

In 2008, 98 percent of Americans with employment-based health benefits were enrolled in some kind of managed care plan (Claxton et al., 2008). Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) represent a great majority of that enrollment, with approximately 80 percent. A managed care system typically provides, arranges for, and finances medical services using provider payment methods that encourage cost containment by contracting with select networks of providers.

Before the spread of managed care in the 1990s, insurance coverage was mostly based on a fee-for-service (FFS) system. Beneficiaries in the plan picked their doctors and hospitals at will. Payment was made by the beneficiary when service was rendered, or the health care provider accepted assignment of the claim from the beneficiary, and afterward claim forms were submitted to the insurance company (or self-insured plan sponsor) for reimbursement. Under managed care, enrollees are often required to follow utilization review and disease management procedures in order to secure coverage for services received.

Reimbursing Health Providers

Health plans calculate payments to providers in different ways: fee-for-service (FFS), discounted fee-for-service, resource-based relative value schedule (RBRVS), per diem, diagnosis-related group (DRG), capitation, or a combination of these. Some health plans are beginning to experiment with pay for performance programs that pay hospitals and physicians additional amounts for meeting specific quality or other targets.

The traditional health care payment system (FFS), which dominated the marketplace from the 1950s through the early 1990s, used a method of reimbursement under which physicians and other providers received a payment, based upon prevailing charges, for services rendered. Most FFS systems today include consideration of usual and customary rate of charges (UCR). UCR means that the provider's usual fee for the service does not exceed the customary fee in that geographic area, and is reasonable based on the circumstances. A fee may be considered reasonable when special circumstances require extensive or complex treatment, even though it does not meet the

standard UCR criteria. Today, many health plans arrange prices for services based upon a fee schedule agreed to in advance of services being rendered.

Discounted FFS is a reimbursement methodology in which the provider is paid a fixed percentage discount from full charges. Discounts may be made in a variety of ways such as package pricing, or established prices for specific items or services (i.e., fee schedules) or maximum price limits imposed through determination of reasonableness. Discounted FFS is commonly used by PPOs.

The RBRVS reimbursement methodology ranks physician services according to the resource inputs required to perform these services. The challenge in producing an RBRVS both properly and fairly requires that each of the resource inputs be defined accurately and that its measurement, weighting, and correlation be based on the best available data and a high level of validity. Medicare heavily relies on the RBRVS reimbursement methodology in order to determine payment amount to physicians.

A per diem is a set daily payment amount for hospital services, agreed to in advance, by a managed care organization (e.g., HMO or PPO) and the hospital. Per diem payment can be a single amount encompassing all levels of hospital treatment or there can be service-specific per diems (e.g., different amounts for medical/surgical, intensive care, maternity services, etc.).

Another reimbursement system, diagnostic-related groups (DRG), uses diagnosis information to establish hospital payments. Medicare uses the DRG approach, as do some other managed care organizations. This system groups patient needs into about 467 categories, based upon the coding system of the International Classification of Disease.

Capitation reimbursement stipulates a dollar amount established to cover the cost of health care services delivered to a person, usually expressed in units of per member per month (PMPM). The term usually refers to a negotiated per capita rate to be paid periodically—usually monthly—to a health care provider. The provider is responsible for delivering or arranging for the delivery of all health services to the covered person under the condition of the provider contract. Capitation is a fixed periodic prospective payment to a provider regardless of the number of services provided to each member. This payment is the same regardless of the amount of services rendered by the provider. Most commonly, capitation reimbursement is limited to HMOs and is confined to primary care services (e.g., it excludes specialty care, hospital care, etc.).

Beneficiary Out-of-Pocket Responsibilities

Virtually all covered services in health care plans are subject to payment limitations and require the employee to share in the costs of coverage. These

cost-sharing features generally include some combination of premiums, deductibles, coinsurance, copayments, and maximum caps on benefits. These plan features are intended to reduce plan costs, encourage employee cost consciousness, and lower administrative expenses.

A *deductible* is a specified amount of initial medical costs that would otherwise be treated as covered expenses under the plan, which each beneficiary must pay before any expenses are reimbursed by the plan. Deductibles typically range from \$100 to \$500 per person, though they can be higher. In fact, high-deductible health plans associated with a health savings account (HSA) must have minimum annual deductibles of at least \$1,100 for self-only coverage and \$2,200 for family coverage in calendar year 2008.

Under a plan with a \$200 individual deductible, for example, a participant must pay the first \$200 in recognized expenses for covered health care services according to the plan provisions. Some plans have different deductibles for different types of health care services. For example, a plan can have one deductible for inpatient care and a different deductible for outpatient pharmaceutical benefits.

The deductible must be satisfied periodically (generally every calendar year) by each participant, sometimes with a maximum of two or three deductibles per family. However, some plans contain a three-month carry-over provision. In this case, any portion of the deductible that is satisfied during the last three months of the year can be applied toward the satisfaction of the following year's deductible.

Coinsurance provisions require the plan participant to pay a portion of recognized medical expenses; the plan pays the remaining portion. Commonly, the employee pays 20 percent, with the plan paying the remaining 80 percent of recognized charges. Most major medical plans include both deductibles and coinsurance provisions. Thus, once the plan participant pays the deductible (e.g., the first \$200 in medical expenses), the plan pays 80 percent of all other covered charges. Some services may have special coinsurance provisions.

Because 20 percent of a large medical claim may pose a significant financial burden for many individuals and families, most plans limit beneficiaries' out-of-pocket expenditures for covered services. In this case, once a beneficiary has reached the out-of-pocket maximum, covered expenses are reimbursed in full for the remainder of the year. The out-of-pocket limit may be renewed at the start of the calendar year for each individual beneficiary. In 2006, the median employee-only out-of-pocket limit was \$1,500 (in-network)/\$3,000 (out-of-network) for POS plans and \$2,000 (in-network)/\$3,000 (out-of-network) for PPOs (Mercer Human Resources Consulting, 2007).

Most medical plans impose a maximum annual or lifetime dollar limit on the amount of health insurance coverage provided. Individual lifetime maximums are usually set at very high levels, such as \$1 million or more. Although less common, plans that impose limits may do so on an episodic (or per episode) basis, such as per hospital admission or per disability.

As health benefit costs continue to escalate, employers are increasingly changing the design of cost-sharing features. Employees are often required to contribute toward routine health benefit cost expenses such as premiums and deductibles. However, a growing proportion of employees are protected against catastrophic loss by out-of-pocket limits on the overall amount they must pay toward health care costs.

Pre-existing Conditions

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) defines a pre-existing condition as a health care condition for which care or treatment was recommended or received during the six months prior to coverage under a health plan. Genetic information is not considered a pre-existing condition. Group health plans are allowed to exclude coverage for pre-existing conditions, but they are prohibited from applying pre-existing condition limits for periods longer than 12 months (or 18 months for late enrollees). The pre-existing condition limit cannot be applied in cases involving pregnancy or in cases involving newborns or newly adopted children, who become covered under the plan within 30 days of eligibility. HMOs are allowed to substitute a 60-day affiliation period (90 days for late enrollees) for a pre-existing condition limit.

When excluding a pre-existing condition from coverage, group health plans are required to take into account an individual's prior creditable coverage when determining the length of the limit. A plan must reduce the duration of its pre-existing condition limit by one month for every month of prior creditable coverage, so long as the individual does not have a break in coverage exceeding 63 days. Waiting periods and affiliation periods are not counted as a break in coverage.

Comparing Health Insurance Programs

The term *health insurance* refers to a wide variety of insurance policies. These range from policies that cover the costs of doctors and hospitals to those that meet a specific need, such as paying for dental care. In the past, health insurance policies that covered medical bills, surgery, and hospital expenses were typically referred to as comprehensive or major medical policies. Today, when individuals talk about an insurance program, instead

of using the term major medical, they are more likely to refer to FFS (e.g., indemnity), PPO, POS, HMO, or some other type of insurance program. These descriptions more accurately describe for consumers the type of health insurance coverage they have. In evaluating a health program, one should consider services covered; cost (premium, annual deductibles, coinsurance, and copayments); access (ease of obtaining appointments, waiting time in physicians' offices, telephone access to physicians); choice of physicians and hospitals, including referrals to specialists; continuity (do patients see the same physician each time care is sought, what provision is made for changes in the program's coverage of certain specialists); convenience (location of doctors/hospitals and claim filing procedures); coordination (how is care between the primary care physician and specialists coordinated); flexibility (switching physicians, second opinions, denials of care); and quality. The following section discusses differences among health insurance programs in terms of services covered.

Services Covered

Most insurance programs cover medical expenses for hospital and physician fees, surgical expenses, anesthesia, x-rays, laboratory fees, emergency care, and maternity care. Some programs cover physical exams; preventive care (e.g., vaccinations); health screenings (e.g., mammography); chemical dependency treatment; prescription drugs; dental, vision, mental health or other psychiatric care; and home health, nursing home, and hospice care. In addition to reviewing what is covered, one should also consider any financial or other limitations on the coverage offered (e.g., the program may cover physical therapy expenses, but limit coverage to a certain number of visits annually).

Most health insurance programs do not cover treatment that is experimental or investigational. However, virtually every treatment is "experimental" when first introduced. In order to overcome an insurance program administrator's determination that a treatment sought is experimental, the administrator would need to be convinced of at least the following: experts in the field recommend the treatment, the patient will benefit from the treatment, and the treatment is not just for the purpose of furthering scientific research. Some health insurance programs allow access to high-quality clinical trials, while other programs may only pay for the patient care costs associated with participating in clinical trials.

Insurance programs typically cover only medically necessary care. A typical definition of appropriate and medically necessary care is the standard for health care services as determined by physicians and health care providers in accordance with prevailing practices and standards of the

medical profession and community. For example, certain treatments may not be covered as appropriate and medically necessary if the treatment has not been shown to be safe and effective. The utilization review process evaluates requests for medical treatment and determines whether the treatment is medically necessary.

A typical insurance program has many restrictions on coverage. As mentioned above, most policies have a lifetime maximum on what they will pay. Some have a lifetime maximum per illness, per member, and/or per family. Many policies require pre-certification before hospitalization. Pre-certification means that someone must contact the health insurance program administrator and get approval before the plan will agree to pay for services. Health insurance programs can also have limits on hospital room charges, amounts paid specialists, the number of hospital days covered, and other restrictions and limits.

Other Health Care Plans

Medical plans generally exclude services that are not considered medically necessary, including most types of dental, vision, and hearing care. As a result, stand-alone plans providing these benefits are growing in popularity. Because of their highly elective nature, various limits are placed on the benefits provided. For more information, see chapters on dental and vision care benefits.

Employee Benefits Security Administration

The Employee Benefits Security Administration (EBSA), an agency within the Department of Labor (DOL), protects the integrity of pensions, health plans, and other employee benefits for more than 150 million people. The agency mission is to:

- Assist workers in getting the information they need to protect their benefit rights.
- Assist plan officials to understand the requirements of the relevant statutes in order to meet their legal responsibilities.
- Develop policies and laws that encourage the growth of employment-based benefits.
- Deter and correct violations of the relevant statutes.

In order to assist workers in getting information about their employment-based health benefits, the EBSA Web site (www.dol.gov/ebsa/Publications/10working4you.html) provides 10 ways to maximize the value of these health benefits. It recommends that plan participants become

familiar with their benefit options, look for and demand quality medical care, understand how changing jobs or other life events affect health benefits, plan for retirement medical needs, and know how to assert beneficiary rights under the plan.

As part of its mission, on Nov. 21, 2000, DOL published in the *Federal Register* a final regulation that sets new standards for processing benefit claims of participants and beneficiaries who are covered under employee benefit plans governed by ERISA. The claims procedure regulation changed the minimum procedural requirements for the processing of benefit claims for all employee benefit plans covered under ERISA, although the changes were minimal for pension and welfare benefits plans other than those that provide group health and disability benefits. For group health and disability benefit claims, the regulation substantially changed the procedures for benefit determinations. Among other things, it created new procedural standards for initial and appeal-level decisions, new time frames for decision-making, and new disclosure rights for claimants.

In addition, the EBSA is responsible for collecting annual reports (Form 5500) from ERISA-covered health plans. Smaller plans are able to file simplified versions of Form 5500 on a less frequent basis.

Federal Laws

ERISA and Health and Welfare Plans—As discussed in the Introduction section of this book, the Employee Retirement Income Security Act of 1974 (ERISA) is the major federal law governing employee benefits in the United States. ERISA primarily applies to private retirement plans, but almost all employee benefit plans are subject to some provisions of the law. The legislation affects welfare plans, such as health insurance, group life insurance, sick pay, long-term disability income, and retirement plans.

A first important step to understanding ERISA and how it relates to employee health plans is to understand the terms used in ERISA that relate to employee health plans. The term *employee benefit plan* applies to employee pension plans and employee welfare plans. Both terms are given very broad meanings. The term *employee welfare plan* applies to any kind of non pension employee benefit plan, including health plans (both insured and not insured), life insurance, disability plans, etc. Under the terms of ERISA, all employment-based health plans, insured or not insured, are ERISA plans except for health plans maintained by government entities for the employees of federal, state, and local governments and church plans maintained for the employees of churches.

The key provisions of ERISA that relate to employment-based health plans are found in Sec. 514(a) of ERISA, known as the “pre-emption” clause,

which states that, “the provisions of this title and Title 4, shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan.” The pre-emption by ERISA of state regulations is very broad. Under current law, there is only one way for a state to get around ERISA’s pre-emption and that is by an act of Congress with the president’s signature. To date, only Hawaii’s Prepaid Health Plan has an exemption from ERISA pre-emption. Sec. 514(b), known as the “savings” clause, exempts state regulation of insurance from ERISA pre-emption. Sec. 514(c), known as the “deemer” clause, stipulates that a state cannot deem an employee health plan as insurance to avoid ERISA pre-emption.

The results of these definitions and Sec. 514 are that most private-sector non church employment-based health plans are ERISA plans and therefore exempt from state regulation. However, given that ERISA does not pre-empt state regulation of insurance, states indirectly regulate ERISA health plans that purchase an insurance contract (the state regulates the insurance contract not the employment-based health plan).

An employer can avoid any state regulation of its health plan by self-funding, or self-insuring, the health plan. Under this funding arrangement, the employer assumes the financial risk for the health plan. Under a fully insured arrangement, the employer shifts the financial risk of the health plan to another party, usually an insurance company. The term *self-funding*, although commonly used, can be misleading. The term *self-fund* leads one to believe that the employer sets up a separate fund from which the employer pays health benefit claims. However, most employers that self-fund their health benefit plans pay health benefit claims on a pay-as-you-go basis out of general funds. Also, not all employers that choose to self-fund their health plan are fully self-funded. Some employers find that it is more cost effective to carve out certain segments of their health plan, e.g., mental health benefits or prescription drugs, and purchase an insurance contract to cover the funding of these benefits. By doing this, the carved-out segment of the employer’s plan is now indirectly regulated by the state in which the benefit is available.

Another way self-funded plans may be partially insured is through the purchase of stop-loss coverage. To cover against catastrophic losses, some companies that self-fund their health plans purchase stop-loss coverage. There are two types of stop-loss coverage: specific stop-loss coverage, which insures against the risk that any one claim will exceed a certain amount, and aggregate stop-loss, which insures against the entire plan’s losses exceeding a certain amount. Most plans purchase both types of stop-loss coverage.

When an employer self-funds its employee health plan, the health plan is exempt from taxes and other assessments that states levy on insurers. Nearly all states assess a premium tax on commercial insurers that operate

in that state. These taxes range from 1 percent to 4 percent of premiums collected. All states operate a guaranty fund that pays outstanding claims when an insurer fails. Depending on their competitiveness and market strategy, many insurers are able to pass this cost on to their customers. These funds get their moneys from assessments on insurers in the state. By self-funding, an employer can avoid these costs.

Self-funded employers are also exempt from state regulations. The most widely known state regulations are the state-mandated benefits. State-mandated benefits are legal requirements that insurers operating in that state must offer specific health services or the services provided by specified providers. The mandates are generally narrowly defined and apply to all commercial insurers, Blue Cross and Blue Shield Plans, and health maintenance organizations (HMOs). As of 2006, there were over 1,800 state-mandated benefits. Research shows that state mandated-benefits increase claims costs, yet their impact on premium costs is unclear.

A further complication of the issue arises when a self-funded health plan contracts with an HMO. State regulation of HMOs varies greatly from state to state. Some states regulate HMOs as they would insurance companies, while other states do not consider HMOs to be insurance. The issue of whether self-funded health plans that contract with HMOs are regulated by the states is still unclear.

Two commonly asked questions regarding self-funded health plans are: how many employers self-fund their health plan and how many individuals are covered by a self-funded health plan? Data on the number of employers that self-fund their health plan are not available. Among the reasons are: current federal reporting requirements focus on pension plans and not health plans; health plans with fewer than 100 participants are generally exempt from reporting; and inconsistencies exist among the data reported for health plans (U.S. General Accounting Office, 1995).

As to the number of individuals covered by a self-funded health plan, the Kaiser Family Foundation/Health Research and Educational Trust survey indicates that in 2008, 55 percent of all workers with health insurance were in a plan that was either fully or partially self-funded. Only 12 percent of workers in firms with 3–199 workers were in full or partially self-funded plans, while 89 percent of workers in firms with 5,000 or more employees were in those plans. Self-funding also varies by plan type. The KFF/HRET survey found that 64 percent of workers in PPOs were in full or partially self-funded arrangements, compared with 29 percent among workers in POSs.

Laws and Jurisdiction

The sections below summarize several major federal laws that affect how workers and their families receive health benefits from employment. These laws are discussed below by federal agency responsibility: Department of Labor (DOL) and the U.S. Equal Employment Opportunity Commission (EEOC). Other federal agencies such as the Internal Revenue Service and the Department of Justice may also share responsibility for these laws.

Department of Labor (DOL)—

- *The Employee Retirement Income Security Act of 1974 (ERISA)*: Offers protections for individuals enrolled in health benefit plans sponsored by private-sector employers, provides rights to information, and outlines a grievance and appeals process for participants to get benefits from their plans.
- *The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)*: Contains provisions giving certain former employees, retirees, spouses, and dependent children the right to purchase temporary continuation of group health plan coverage at group rates in specific instances. For more information, see chapter on COBRA.
- *The Family and Medical Leave Act of 1993 (FMLA)*: Administered by the Wage and Hour Division of DOL, this law requires employers of 50 or more employees to give up to 12 weeks of unpaid, job-protected leave to eligible employees for the birth or adoption of a child or for the serious illness of the employee or a spouse, child, or parent. The employee receives his or her self-only health insurance coverage at the same premium paid by a similarly situated employee on active status. For more information, see chapter on leave benefits.
- *The Health Insurance Portability and Accountability Act of 1996 (HIPAA)*: Includes protections for millions of working Americans and their families who have pre-existing conditions, prohibits discrimination in health care coverage, and guarantees issuance of individual policies for certain eligible individuals.
- *The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)*: Requires that employment-based group health plans cover a minimum hospital length of stay for mothers and newborns of 48 hours for a vaginal birth and 96 hours for a cesarean section. Insured plans are governed by state law and not by NMHPA if the state law fulfills the following criteria:
 - ▲ Minimum coverage is a length of inpatient hospital stay of 48 hours for a vaginal birth and 96 hours for a cesarean section.

- ▲ Guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or any other established professional medical association are followed for such purposes.
- ▲ The hospital length of stay is allowed to be determined by the attending provider in consultation with the mother.

Under NMHPA, the length of stay starts either when the child is born or, for births occurring outside of the hospital, when the mother and/or newborn are admitted to the hospital. The attending provider, in consultation with the mother, is allowed to waive the minimum length of stay.

- *Mental Health Parity and Addiction Equity Act of 2008 (MHPA)*: Per final legislation in 2008, requires that annual or lifetime dollar limits on mental health benefits be no lower than those dollar limits for medical and surgical benefits offered by a group health plan. For more information, see chapter on mental health benefits.
- *The Women’s Health and Cancer Rights Act of 1998 (WHCRA)*: Requires that employment-based group health plans provide coverage for certain breast reconstruction surgery in connection with a mastectomy. Self-insured church plans are exempt from the law.

If an employment-based health plan provides medical and surgical benefits for mastectomy, it must also cover:

- ▲ Reconstruction of the breast on which mastectomy has been performed;
- ▲ Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- ▲ Prostheses and treatment of physical complications of all stages of mastectomy, including lymph edemas.

DOL provides guidance in the form of questions and answers on WHCRA at www.dol.gov/ebsa/FAQs/faq_consumer_womenshealth.html

Equal Employment Opportunity Commission (EEOC)—EEOC has developed a *Compliance Manual* section that explains how the employment discrimination laws apply to health insurance benefits. The section covers discrimination in health insurance benefits under the Age Discrimination in Employment Act of 1967 (ADEA), the Americans with Disabilities Act of 1990 (ADA), the Equal Pay Act of 1963 (EPA), and Title VII of the Civil Rights Act of 1964 (Title VII).

Title VII requires employers to provide identical coverage to men and women if they both can contract a condition or benefit from a treatment or

test. Sometimes an employer will use a neutral standard to exclude treatment for a condition that only, or disproportionately, affects members of one sex, race, or other protected group. For example, an employer might refuse to cover certain treatments for prostate cancer as “experimental.” In that case, the employer may have to show that its standard was neutrally applied and is based on generally accepted medical criteria.

The Pregnancy Discrimination Act of 1978 (PDA) amends Title VII and requires that women who are affected by pregnancy, childbirth, or related medical conditions be treated the same as any other employee who is similarly able or unable to work. When an employer offers benefits of any sort, it must cover pregnancy and related medical conditions in the same way that it covers other medical conditions. Health insurance for expenses arising from abortion is not required, except where the life of the mother is endangered. Pregnancy-related expenses should be reimbursed to the patient exactly as those incurred for other medical conditions. The amounts payable can be limited only to the same extent as costs for other conditions. No additional, increased, or larger deductible can be imposed. Employers must provide the same level of health benefits for spouses of male employees as they do for spouses of female employees.

Conclusion

For many decades, health insurance plans have played a significant role in employee benefits planning. Modern technology, increased longevity, and a growing emphasis on good physical and mental health make these plans even more important today. The development of managed care plans, and dental, prescription drug, vision, and hearing care plans attests to the dynamic nature of this employee benefit area, as does the development of wellness and employee assistance programs. Future innovative efforts in plan design will be influenced strongly by the continuing need for health care cost management, ever-changing medical technology, and constantly changing government regulations.

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Additional Information

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, DC 20004
www.ahip.org

American Medical Association
Center for Health Policy Research
515 North State Street
Chicago, IL 60610
(312) 464-5022
www.ama-assn.org

American Benefits Council
1212 New York Avenue, NW, Suite 1250
Washington, DC 20005
(202) 289-6700
www.americanbenefitscouncil.org

Aon Corporation
200 E. Randolph Street
Chicago, IL 60601
(312) 381-4844
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BlueCross BlueShield Association
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Chicago, IL 60601
(312) 297-6000
www.bluecares.com

ERISA Industry Committee
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National Association of Insurance Commissioners
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Society for Human Resource Management
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(866) 444-3272
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Bureau of Labor Statistics
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CHAPTER 21

PRESCRIPTION DRUG PLANS

Introduction

Expenditures on prescription drugs have been rising steadily over the last several years. In 2005, for example, the United States spent \$200.7 billion on prescription drugs, compared with \$51.3 billion in 1993 (Catlin et al., 2007). Spending on prescription drugs increased 7.2 percent in 2006, and increased faster than spending on inpatient hospital services (5.1 percent) but more slowly than outpatient hospital services (10.3 percent) or physician services (7.7 percent). Increased utilization remains a primary driver behind the trend in drug spending, in part reflecting the “graying of America” and direct-to-consumer advertising. Other motivating factors behind the trend include the therapeutic drug mix, inflation, the entry of new drugs, enhancements in the standards of care, and better diagnostic tools.

Coverage for prescription drugs encourages participants to complete prescribed drug therapy in order to best manage their disease state and avoid more costly medical complications later. Most prescription benefit plans have similar characteristics:

- Participants have some form of outpatient drug coverage through their medical provider or a “carve-out” pharmacy benefit manager (PBM).
- Participants pay an up-front fee or copayment to help cover the expense of the medication.
- Participants can fill their prescriptions through a retail network (chain and independent pharmacies) or a mail-order facility for maintenance drugs.
- Participants may pay varying copayments, depending on whether their drug is brand or generic, mail-order or retail, preferred or non preferred on the formulary.

Services

Prescription drug plans provide coverage for outpatient prescription medication. Generally, most plans do not cover medical appliances or devices, nonprescription drugs, in-hospital drugs, blood and blood plasma, immunization agents, or any drugs or medicines lawfully obtained without

Figure 21.1

DRUG PLAN INCENTIVES, BY PLAN TYPE, FIRMS WITH 1,000 OR MORE EMPLOYEES, 1998–2002

	Indemnity			PPO			POS			HMO		
	1998	2000	2002	1998	2000	2002	1998	2000	2002	1998	2000	2002
Generic Incentive	34%	41%	52%	45%	56%	65%	49%	61%	72%	41%	56%	66%
Lower copayment	2	2	<1	1	<1	1	1	2	n/a	n/a	<1	n/a
No deductible	7	5	5	10	7	6	4	2	2	1	1	<1
Higher coinsurance	4	9	10	6	12	10	11	14	11	4	4	3
Pay difference between generic and brand name												
Mail Order Incentive												
Lower copayment	23	35	46	31	47	55	37	50	60	11	23	30
No deductible	16	15	12	12	12	10	7	8	4	1	<1	<1
Higher coinsurance	22	20	16	21	18	14	12	12	9	1	1	1
Combination of Generic and Mail Order Incentive												
Lower copayment	28	41	50	32	47	56	30	44	56	6	16	21
Higher coinsurance	n/a	<1	n/a	1	1	1	<1	<1	<1	n/a	<1	n/a
Pay difference between generic and brand name	1	3	2	2	3	3	2	4	3	<1	<1	<1
No Generic or Mail Order Incentive	34	28	22	22	14	10	22	13	9	51	34	25

Source: Hewitt Associates LLC, various years

prescription. Some employers may choose to not cover “lifestyle” drugs or drugs used exclusively for cosmetic conditions.

Many plans place limits on the quantity of a drug that may be dispensed at any one time. A typical limitation is a 30-day supply at a retail pharmacy, though 90-day supplies are typical at mail-order pharmacies. In addition, higher limitations often apply to maintenance drugs, or drugs that must be taken on a continuous basis for life. Most plans do not place a maximum on the overall covered quantity of a drug. However, some plans may limit the total dollar cost of prescription drugs that will be reimbursed in a plan year.

Prescription drug plans typically require only a co-payment from the participant for drugs provided under the plan. Many plans encourage the use of generic drugs in an effort to contain costs. Cost containment can also be accomplished through employee education and/or plan design. For POS and HMO plans, the percentage of employers allowing lower co-payments for generic drugs increased from 2002 to 2004 (Figure 21.1). In addition, the percentage allowing lower co-payments as an incentive to use a mail-order service increased. Overall, the percentage using no incentive for increased use of generic drugs or a mail-order service decreased for all plans.

Cost Controls

Employers generally provide pharmaceutical benefits through their health plan or by “carving-out” the benefit from the general health plan. In addition, the health plan or the employer can offer pharmaceutical benefits by using a prescription drug card plan or mail-order plan, and can also require the substitution of less expensive generic drugs or restrict the number of drugs approved for coverage through the use of formularies—lists of a prescription drug plan’s preferred drugs.

Pharmacy Benefit Managers—Employers often offer prescription drug benefits separate from the rest of the health plan in order to control the costs and improve the quality of the benefit. These plans are usually provided through a pharmacy benefit manager (PBM). In 2006, 81 percent of employers offered drug coverage through their primary medical plans, while 19 percent carved out the benefit and engaged a PBM to administer the benefit under a separate contract. Even among the 81 percent that did not offer a stand-alone drug plan, most employers used a PBM to administer pharmacy benefits as well (Mercer, 2007).

PBMs currently provide managed pharmacy benefits for almost three-quarters of the insured population in the United States. Medco Health Solutions, Express Scripts, and Caremark Rx are the largest of about 60 PBMs operating in the United States and collectively account for 52 percent

of the market, leaving 48 percent to be covered by other and smaller PBMs (Consumers Union, 2005). PBMs originally provided only prescription claims processing and mail-order services. However, in recent years PBMs have expanded their services into the development and management of formularies, the negotiation of drug rebates with manufacturers, the establishment of pharmacy networks, the proper substitution of generics, and the utilization review of drug use, among other areas. Some PBMs have even instituted disease management programs that attempt to provide the most cost-effective treatments of specific diseases. Many managed care plans also contract with PBMs or provide the same services within their plan as those offered by PBMs. Under these arrangements, PBMs (or health plans) can monitor all the prescription drugs that an individual receives. This allows the PBM to check for appropriate drug therapy. This check would not be possible if the drug benefit was not integrated into the entire health care plan.

In addition, the PBM can suggest more appropriate drug treatments for various ailments, since it focuses on utilizing the most cost-effective and quality-enhancing drugs, though PBMs' access to health care data has been questioned. In particular, patient privacy concerns have been raised due to PBMs' practice of suggesting additional treatments or influencing the medication choice for plan participants. A PBM's practice of enrolling individuals in (or suggesting individuals enroll in) group therapy or other types of treatment designed for those who are taking a drug associated with a particular mental illness has provoked media attention. Despite the potential benefit of this type of treatment, patients may not want their employer or others to know or discover that they have a mental condition requiring medical attention. Most employers choose not to receive this type of information, and PBMs say they have procedures in place to limit access to information.

Another issue with PBMs is the fact that some discuss with physicians the medications their patients are receiving and suggest alternative treatments or drugs that might be better suited or less costly with near-equal or equal efficacy for the patient. Many physicians are reluctant or refuse to discuss their prescribing patterns with PBMs because of ethical considerations and concern for their patients' privacy. In contrast, some physicians welcome the discussions and use them to learn about new or alternative treatment options. PBMs also offer benchmark data to physicians, allowing them to compare their prescription patterns with those of physicians who have similar patient loads. A PBM can also provide the physician with outcome data not otherwise available to him or her. For example, an allergist might find it very informative that many of his patients on asthma inhaler medications end up in the emergency room or urgent care center with acute asthma attacks.

Recently, PBMs have come under scrutiny over the concern that they negotiate rebates with pharmaceutical companies to promote the use of their particular drugs. Thus, the PBM may encourage the use of a particular drug not based on its therapeutic appropriateness but because it is less expensive to the PBM as it generates rebate income for them. It is unclear how extensive rebate income is for PBMs, but it is thought to be considerable.

While these PBM activities can irritate both patients and physicians and raise important questions, they also can have beneficial effects. Patients may discover new or additional therapies that they may not know were available. Because new medications are always coming on the market, it is difficult for physicians to keep up with all drugs for treating all illnesses. Thus, PBMs can provide easily accessible education for physicians. Furthermore, close monitoring by PBMs can screen for allergies and potential interactions among the multiple prescriptions that patients may receive. Consequently, while there are potential benefits to enrollees when PBMs undertake such activities, these benefits need to be weighed against individuals' rights to or desires for privacy.

Cost Containment and Quality-Enhancing Techniques—In providing drug benefits, health plans and PBMs typically employ certain techniques that allow them to contain the costs and improve the quality of the benefit. First, the use of a drug card by an enrollee allows a participating pharmacy to verify enrollment and easily submit claims for payment. It also allows the pharmacist to charge the correct copayment or coinsurance, which reduces fraud and billing errors and thereby lowers reimbursement costs for all parties.

Second, mail-order drug plans are often used because health plans and PBMs can negotiate better prices from one mail-order pharmacy to provide drug benefits to the entire membership of the plan, due to volume discounts and efficiency gained by making payments to only one company. This benefit is offered concurrently with a standard drug benefit, since it is only practical to use the mail-order feature for the delivery of maintenance drugs. Sometimes the mail-order feature is required for enrollees, but generally enrollees are offered an incentive to use this feature voluntarily—such as a lower copayment or coinsurance or a higher quantity of drugs for the same copayment.

Another feature that health plans and PBMs use to contain costs is the use of generic substitution for brand-name drugs. Generic drugs are often less expensive than brand name drugs because of lower marketing and research costs. Individuals typically pay lower copayments for generic drugs. Consumers may also be encouraged to use less costly generic drugs by the drug plan's use of deductibles and coinsurance.

In general, pharmacists are allowed to make a generic substitution unless the physician specifies that no substitution be allowed. Some states allow “therapeutic substitution,” where a pharmacist can substitute an entirely different drug from the one prescribed by the physician, if it has the same therapeutic effect. Prescription drug plans also frequently use formularies, which are lists of preferred drugs in various dosages and forms. Formularies generally indicate which drugs are covered by a particular health plan and are categorized as follows:

- *Open formularies* include all FDA-approved drugs and drug products (with some rather limited exceptions).
- *Managed (incentive-based) formularies* are essentially open formularies that contain preferred drugs, the use of which is encouraged by financial incentives to physicians, pharmacists, and patients.
- *Closed (restricted) formularies* contain a specific list of approved drugs for coverage. Many plans with closed formularies allow coverage for drugs outside the formulary on a limited basis through pre-authorization by the plan, and the patient is likely to face an additional cost.

Many employers have also adopted “three-tier” copayments for prescription drug benefits. Employers generally structure three-tier copayment benefits in the following way: the lowest copayment is for generic drugs, the second highest copayment is for preferred brand drugs, and the highest copayment is for non preferred or non formulary drugs. The third tier may also include brand name drugs no longer on patent and available with a generic alternative. Employers generally provide benefits—including prescription drug coverage—in order to keep their employees healthy and productive, as well as to help recruit and retain valued workers. Consequently, a restrictive drug benefit design—such as a formulary that is very limiting—could counter the goal of providing coverage in the first place. In addition, in some cases, expenditures for drugs may prove to be small if they achieve a significant reduction in sick leave and lost productivity. For example, a study by Legg et al. (1997) showed that a new migraine drug reduced losses in productivity and labor costs. While the cost of the medication was valued at \$43.78 per employee per month, the savings attributable to reduced loss of productivity and labor costs was valued at \$435 per employee per month. Careful design of prescription drug benefits is critical if employers are to take advantage of their potential cost savings, both for overall health care spending and for labor expenses.

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CHAPTER 22

DENTAL CARE PLANS

Introduction

Nearly all large employers offer dental health benefits to their employees. A survey of employers with 1,000 or more employees found that 99 percent had a dental plan in 2005 (Hewitt Associates LLC, 2005). Another study indicates that 96 percent of employers with 500 or more employees offered a comprehensive dental plan in 2005 (Mercer Human Resources Consulting, 2006). Only 17 percent of employers provide dental coverage through their medical plan. Most dental benefits are offered in a freestanding plan. Although smaller employers are less likely than large employers to offer dental benefits, 66 percent of employers with 10–499 employees offered dental insurance in 2005 (Mercer Human Resources Consulting, 2006).

Dental benefit costs are rising and, as is the case with medical plans, employers are shifting a greater percentage of the costs to employees. In 1988, 63 percent of large employers required employee contributions. By 2005, that portion had increased to 94 percent (Hewitt Associates LLC, 2005).

A sound dental insurance plan has two primary objectives: to help pay for dental care costs and to encourage people to receive regular dental attention, which can prevent serious dental problems while identifying potential medical problems that first manifest as dental health issues.

The three major dental care plan benefit structures are the traditional indemnity plans, network plans, and dental health maintenance organizations (DHMOs). Employers may combine these options. Overall, 48 percent of large employers offered traditional indemnity dental plans, 56 percent offered network plans, and 29 percent offered DHMOs in 2005 (Hewitt Associates LLC, 2005). Direct reimbursement and discount/referral plans are usually grouped with indemnity plan models.

Services

A dental insurance plan should specify the types of services that are and are not covered. Preventive services (i.e., examinations and x-rays) are commonly covered up to 100 percent of the usual, customary, and reasonable amount. Depending on the type of plan, other services typically provide less coverage. For example, indemnity plans commonly cover 80 percent of restorative services such as fillings, endodontics, periodontics, and dental

surgery, and likely cover 50 percent of major restorative services (i.e., crowns, prosthetics, and orthodontia). Orthodontia coverage is an optional feature, with services typically reimbursed at 50 percent up to a separate lifetime maximum. Participants in an indemnity plan have the choice of using any licensed dentist.

A network plan is typically structured similarly to an indemnity plan except that the allowable charge for network-provided services is contractually negotiated by the network with the dentist. There may also be a higher reimbursement percentage and/or lower deductibles for use of network providers. While participants have the choice of using any licensed dentist, they can usually reduce out-of-pocket costs by using a provider who is in the network.

A DHMO benefit plan typically has specified copayments for all covered services, ranging from zero for some preventive services to hundreds of dollars for major restorations. Unlike a network plan, participants in a DHMO usually are required to use dentists in the network in order to receive any benefit.

Benefit Limitations

Services that are usually not covered by any type of dental plan include hospitalization due to necessary dental treatment (though this is often covered by the medical plan as inpatient care); cosmetic dental work (e.g., whitening); cleaning and examinations performed more often than twice a year; and services covered by workers' compensation or other insurance programs.

Indemnity and network plans typically include annual deductibles ranging from \$25 to \$100, annual maximums ranging from \$500 to \$2,000, and lifetime maximums for services such as orthodontia of \$500 to \$2,500. In 2005, 70 percent of plans had a deductible, with \$50 being the most common (Hewitt Associates LLC, 2005). Dental plans will frequently not apply a deductible to diagnostic and preventive services in order to encourage appropriate utilization of these services. Other cost management features are typically used as well, such as:

- a) Frequency limitation (e.g., reimbursement for cleanings is limited to two times per year).
- b) Copayments (participant's share of the dentist's fee after the benefits plan has paid). Copayments for preventive care may be as low as \$5 or \$10 per procedure. As the procedures become more expensive, the copayment increases.

- c) **Predetermination of benefits**—Before beginning dental treatment, a plan participant may want to know how much he or she will be charged for the treatment and how much the plan will pay. The dentist can complete a predetermination-of-benefits form describing the proposed treatment and its cost. After review, the dental plan will advise the participant and the dentist of the amount the plan would pay. Some dental plans require this procedure when anticipated charges exceed a stated amount (e.g., \$200).
- d) **Alternative benefits**—Dental problems can often be successfully treated in more than one way to achieve the same outcome. When this situation occurs, many dental plans base payments on the least expensive treatment that is customarily used for the condition in question. For example, a decayed tooth may often be satisfactorily repaired with a crown or a filling. In this case, a dental plan with an alternative benefit provision bases its payment on the less costly filling. The participant and the dentist may proceed with the more expensive crown only if the participant agrees to pay the difference.

DHMOs have fewer benefit limitations. Premium costs are managed through provider discounts, limitations on access to specialists, and by pre-approval of high-cost services. Dentists in DHMOs typically receive a monthly capitation from the plan to provide basic services for each member. Although access to dentists is more restricted in this type of plan, DHMOs appeal to some plan participants because of their lower premiums and richer benefits.

Claims Payment

Payment of claims under an indemnity or network dental plan generally follows the same procedure as payment of claims under a group medical plan. The participant and/or the dentist fills out and submits claim forms. Payments for covered services may be sent to the dentist or to the participant. Increasingly, this claim submission process occurs electronically through the Internet.

Continuation of Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with dental plans to offer continued access to group dental insurance for former employees and their dependents.

Deciding on a Dental Care Plan

Ultimately, an employer offers a dental plan for the same reason it offers any benefit plan. The design and selection of a dental plan must balance the employer's financial limitations with its desire to offer an appealing benefit to current and prospective employees.

To balance cost and employee appeal, employers need to consider the following factors:

- Type of plan: indemnity, network, or DHMO.
- Benefit cost sharing: deductibles, copayments, and coinsurance.
- Reimbursement percentage for various services: e.g., 100 percent, 80 percent, 50 percent.
- Access to network dentists: how many dentists are near participants' homes and how many are accepting new patients?
- Maximums: annual and lifetime.
- Exclusions and limitations such as cosmetic services and age limitations for specific services such as sealants.
- Covered services: for example, orthodontia.
- Participant contributions to the premiums.

Employers electing a network dental plan also need to decide whether they want to create a plan design incentive for employees to choose in-network services over out-of-network services. Incentives could include lower deductibles and/or higher reimbursement amounts for in-network benefits.

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CHAPTER 23

VISION CARE PLANS

Introduction

Vision problems are common in the United States; more than one-half of the population requires optometric care. It is estimated that 54 percent of Americans wear corrective lenses, although only 41 percent receive an eye exam every year (Rosenthal and Soroka, 1998). Vision problems are often chronic and require regular attention. Although studies show that one in four school-age children have a vision problem, one national survey reveals that 48 percent of parents with children 12 years and younger have not taken their child to an eye care specialist for a comprehensive exam (VSP, 2002).

Except for medical and surgical treatment and, in some cases, contact lenses after cataract surgery, traditional health insurance plans have provided little or no vision care coverage. Employment-based vision care plans are designed to insure vision care services. Even so, vision care plans should attempt to fully integrate with the health care plan. Regular eye examinations can be the first clue to eye conditions—such as glaucoma, age-related macular degeneration, and cataracts—that, left untreated, can lead to blindness. Eye exams can also offer the first sign of significant chronic or systemic diseases, such as hypertension, atherosclerosis, alcohol abuse, cancer, diabetes, vitamin deficiencies, and nerve disorders.

Similar to most medical plans, vision care benefits are usually available to a group of covered employees after a nominal waiting period. In addition, most plans provide for coverage of employees' dependents. A variety of organizations offer vision care plans to employee groups. These include jointly managed funds, health maintenance organizations (HMOs), administrators of Blue Cross and Blue Shield plans, vision care corporations, optometric associations, closed-panel groups of vision care providers, and insurance companies. In addition, some employers self-fund and self-administer their plans.

The principal providers of vision care are:

- *Ophthalmologists*—Medical doctors specializing in eye examination, treatment, and surgery. Some ophthalmologists dispense eyeglasses and contact lenses.

- *Optometrists*—Health care professionals who are specifically educated and licensed at the state level to examine, diagnose, and treat conditions of the vision system. Optometrists may not operate on the eye and, in most states, may not administer therapeutic drugs. Most optometrists dispense eyeglasses and contact lenses.
- *Opticians*—Persons who make and/or sell lenses and eyeglasses.

Extent of Coverage

Vision plans may cover eye exams, eyeglasses, contact lenses, and orthopedics (exercises for the eye muscles). In 2006, 78 percent of large employers offered a vision plan (Hewitt Associates LLC, 2007).

Services

The typical vision care plan covers eye examinations, lenses, frames, and the fitting of eyeglasses. Eye examinations provide the information needed for lens prescriptions and may reveal eye diseases such as glaucoma or cataracts. (They may also reveal evidence of diabetes or high blood pressure.) Many plans cover some portion of the costs for contact lenses; however, other plans only cover contact lenses following cataract surgery.

Nearly all vision care plans impose limitations on the frequency of covered services and glasses. Typically, they limit participants to one eye examination within a 12-month period, one set of lenses within a 12-month period, and one set of frames within a 2-year period. Most plans do not cover the additional cost of oversized, photosensitive, or plastic lenses, nor do they cover prescription sunglasses.

Some employers, such as the U.S. Army, are embracing laser eye surgery as a way to improve employee performance on the job. After evaluating concerns about laser surgery, a Department of Defense medical panel recommended and the Congress approved \$15 million for the first phase of the program. As eyeglasses can interfere with the sophisticated weapons and gadgets that the military continues to employ, laser eye surgery offers an opportunity for soldiers to be more effective. Vision plans often provide a discount for laser eye surgery from a network of providers.

Payment of Benefits

Similar to other types of health insurance, vision care plans cover services in a variety of ways. For example:

- Some plans pay the full cost of services, provided they satisfy the *usual, customary, and reasonable* (UCR) cost criteria. In other words, the covered amount is the provider's usual fee for the service, the customary or prevailing fee for the service or product in that geographic area, and a reasonable amount based on the circumstances involved. A fee may be considered reasonable when circumstances necessitate extensive or complex treatment, even though it does not meet the usual, customary, and reasonable criteria.
- Sometimes vision care plan participants are required to pay *deductibles*. The deductible is a specified amount of vision care costs that the participant must pay before any costs are paid by the plan. Under a plan with a \$50 individual deductible, for example, a participant must pay his or her first \$50 in vision care expenses. The plan then pays for additional vision care expenses in accordance with other plan provisions.
- Plans may have a *coinsurance* arrangement in which the plan participant pays some portion of the vision care expenses and the plan pays the remainder. The plan participant, for instance, may pay 20 percent and the plan may pay 80 percent.
- Other plans specify a covered dollar amount for each service. Under the *schedule-of-benefits* approach, the plan participant pays any amount over the scheduled dollar limit. The schedule is usually adjusted at intervals to keep it consistent with changes in the cost of care.
- Vision care costs are often covered by employers through a so-called health flexible spending account. Under such arrangements, the employee chooses how much money to contribute to the account at the beginning of the year, and pretax contributions to the account are deducted from each paycheck. The employee pays for any medical expenses (including vision care) and is then reimbursed by the employer. Any unused balances are forfeited by employees at the end of the plan year.
- Plans may also use a *closed-panel arrangement*, in which a designated group (i.e., a closed panel) of vision care professionals provide services to an employee group. The full cost of services is paid when plan participants go to providers specified by the plan. Employers pay a premium for such services, which may cover a fixed cost per ben-

eficiary. The providers are reimbursed for their cost of materials plus a dispensing fee. If participants go to providers who are not in the closed-panel, the plan pays only a specified amount; the participant must pay any excess amount.

- Plans commonly use a combination of the approaches described above. A plan that covers services based on usual, customary, and reasonable charges may also require payment of a deductible or coinsurance. Coinsurance may also be included in a schedule-of-benefits approach.

Continuation of Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with vision and other health care plans to offer continued access to group health insurance for former employees and their dependents.

Deciding on a Vision Care Plan

When considering the cost of a vision care plan, a potential plan sponsor should be aware that such plans have a high incidence of claims in the first year because there may be a backlog of unmet needs in a newly covered employee group. An employment-based vision care plan should include a program to increase employee awareness and understanding of vision care and the plan; effective communication among all involved parties (i.e., employee, employer, and service providers); and an efficient claims filing and payment system. In order to fully evaluate the advantage of a vision care plan, employers should also consider the impact such a plan has on overall worker productivity. For example, an employer with employees spending most of their day working at a computer or driving may find added advantages to such a plan.

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CHAPTER 24

HEALTH PROMOTION AND DISEASE MANAGEMENT PROGRAMS

Introduction

Employers and employment-based group health plans use a variety of tools to manage the utilization of health care services and to control health care costs. In recent decades, employers have looked to managed care to help control costs. Along with negotiating reduced prices for health care services, managed care promised to focus on preventive care and managing demand for services by keeping members healthy. Through active management of group plan members' health and disease, managed care aims to reduce costs by preventing unnecessary utilization of health care services.

The purpose of managing demand for health care services is to lower expenditures on health care by reducing utilization through disease prevention and self-care medical programs (Fronstin, 1996). Various health management tools have been developed as a result of this effort, including health promotion and disease management. These tools are examples of preventive services. Employment-based group health plans generally include three levels of prevention activities, each of which responds to the needs of specifically targeted beneficiaries:

- *Primary prevention*—Activities are directed at all healthy plan beneficiaries with the goal of stopping the occurrence of disease before it starts. Primary prevention reduces the likelihood that individuals who do not have a specific disease will develop it in the future, e.g., routine immunizations of healthy children.
- *Secondary prevention*—Activities target health plan beneficiaries who are at high risk of disease but who lack symptoms. Some examples include PSA tests to detect early forms of prostate cancer, mammograms to detect early forms of breast cancer, smoking cessation programs for smokers without any current disease, and weight loss programs for obese individuals without any current disease. Employee assistance programs (EAPs) are common secondary prevention programs that group health plans use to address employees' physical and mental health. (See chapter on EAPs).
- *Tertiary prevention*—Directs services to symptomatic patients in order to reduce the negative consequences of their diseases. For example, it attempts to decrease the complications or severity of diabetes by care-

fully managing this condition in order to prevent vision, kidney, and nerve problems, and it offers smoking cessation programs for people with asthma.

This chapter focuses on two types of programs that relate to all three levels of prevention: health promotion programs and disease management programs.

Health Promotion Programs

Health promotion programs, also called wellness plans, emphasize prevention of physical and mental illness by using self-care and targeted strategies to encourage healthy lifestyles. Employment-based programs may be offered directly by the employer, through either an in-house or outside vendor or through an employment-based group health plan. Employers and health plans that offer health promotion activities and programs hope to motivate and educate employees to live healthy lives as well as provide opportunities for them to participate in healthy activities. Employers and health plans hope that by initiating these programs they will increase productivity and morale, reduce absenteeism and turnover, and manage health care costs.

The major lifestyle behaviors targeted by health promotion programs include smoking, nutrition, exercise, and stress. Health promotion programs range from modest efforts (e.g., the distribution of pamphlets on health issues or the provision of showers or changing facilities for employees who exercise) to individually targeted strategies for intervention and health improvement to major initiatives such as elaborate, well-equipped gymnasiums and a full package of physical fitness activities. Employers and health plans increasingly are using Internet and Intranet strategies to deliver health promotion programs. These may offer a cost-effective alternative to traditional approaches to communication, health assessment, and education (Hewitt Associates LLC, 2001a).

Objectives—Work-site health promotion and wellness plans often have several objectives, including improving and sustaining employees' health, increasing worker productivity, recruiting and retaining good employees, improving employee morale, reducing absenteeism due to illness, and reducing health care costs (Harris and Fries, 2002). The 1999 National Worksite Health Promotion Survey, conducted by the Association for Worksite Health Promotion (AWHP), William M. Mercer, Inc., and the U.S. Department of Health and Human Services' Office of Disease Prevention and Health Promotion (ODPHP) found the most common reason that employment-based group health plans sponsored these programs was to keep workers healthy (84 percent). Other reasons included improving employee morale

(77 percent), reducing health care costs (76 percent), and retaining good employees (75 percent) (Association for Worksite Health Promotion et al., 2000).

The Wellness Councils of America, a membership support organization for companies with wellness plans, lists six reasons for work-site wellness programs: (1) rising health care costs; (2) the prevalence of avoidable illnesses; (3) the expanding work week; (4) the technology revolution; (5) increased employee stress levels; and (6) increased work force diversity.

Prevalence of Health Promotion Programs—Ninety-six percent of very large companies offered some kind of health promotion program in 2005, up from 88 percent in 1995 (Hewitt Associates LLC, 2005). Of work sites with 50 or more employees, 90 percent sponsored at least one health-promoting activity in 1999. When programs offered through the companies' health plans were included, 95 percent of work sites offered some type of health promotion (Association for Worksite Health Promotion et al., 2000). Eighty-six percent of work sites with 50–99 employees offered at least one activity, while 98 percent of work sites with 750 or more employees did so (O'Donnell, 2002).

Using a definition of “health promotion program” that counted *programs* rather than *activities*, and did not include casual or sporadic attempts to inform or educate employees, 25 percent of small employers (15–99 employees) and 44 percent of larger employers offered health promotion programs (Wilson et al., 1999).

Impact and Effectiveness—The available data on the effectiveness of work site health promotion programs, while hindered by important methodological challenges, show a positive impact on employee health status, medical care costs, and key business efficiency measures such as absenteeism (Christensen, 2001). According to the 1999 National Worksite Health Promotion Survey, more than 50 percent of work sites have been able to demonstrate a return on their health promotion investment acceptable to senior management (Association for Worksite Health Promotion et al., 2000).

Employers cite various barriers and challenges to work site health promotion programs, including lack of employee interest (cited by 50 percent of work sites), lack of high-risk employee participation (39 percent), and inadequate resources (37 percent). Other challenges include tracking outcomes, management support, integration of programs, access to data, and confidentiality (Association for Worksite Health Promotion et al., 2000).

Incentives—Employers use a variety of incentives to encourage employee participation in health promotion programs. Some employers allow employees to use company time to participate in these programs (72 percent of work sites allow this) and/or allow the use of flex-time (45 percent) (U.S. Department of Health and Human Services, 1993). Others pay a portion

of the cost for employees to attend outside clinics to stop smoking or pay a higher percentage of medical expenses for employees who do not smoke or who regularly participate in an exercise program. Others set up competitions among employees, with prizes awarded to winners, or offer bonuses to employees who complete a specified number of hours of exercise. In some other cases, however, employees must pay a fee to participate in certain programs.

Some employers offer financial incentives for employees to participate in health promotion programs or to modify their health risks. Examples of these incentives include discounted health plan premiums and monetary bonuses. In 2005, 41 percent of very large firms offered programs with financial incentives or disincentives in their benefit plan designs (Hewitt Associates LLC, 2005). Among work sites with 50 or more employees, only 10 percent offered a financial incentive to encourage employees to participate in health-promoting activities (Association for Worksite Health Promotion et al., 2000). Certain financial incentives for participating in wellness plans are regulated by the nondiscrimination requirements of the Health Insurance Portability and Accountability Act (HIPAA).

Disease Management Programs

In addition to keeping employees healthy and preventing the onset of illnesses, employers and employment-based group health plans seek to prevent acute complications of chronic diseases among employees or members who have already been diagnosed. Through a process commonly referred to as disease management (DM), employers and health plans aim to reduce costs by guiding the patient in effectively navigating the complex medical care system, avoiding unnecessary utilization of health care services, and providing early and ongoing treatment. DM offers the possibility of saving money while improving health by reducing employees' need for expensive hospitalizations and other health treatments (Christensen, 2002).

DM is defined as a systematic approach to coordinated health care that seeks to identify individuals within populations who have—or are at risk of developing—certain targeted, mainly chronic, medical conditions such as diabetes, asthma, cardiovascular conditions, and depression. DM programs vary in the range of diseases targeted. A program may focus entirely on one condition or on a few specific diseases, such as asthma and/or diabetes. Or a program may manage the total health of persons with chronic conditions, since they often have comorbidities (i.e., more than one condition). Other programs focus more generally on the health of a population, in order to manage the health of current chronic disease sufferers and to prevent the onset of illness in members who are at high risk of developing chronic diseases.

DM supports the physician- or practitioner-patient relationship and course of treatment and emphasizes prevention of acute episodes and complications, utilizing evidence-based practice guidelines and patient empowerment strategies. DM is a proactive approach to treating chronically ill patients that places a heavy emphasis on educating patients and providers, promoting patient self-management, and building clinical support systems to aid providers.

The Disease Management Association of America (DMAA) identifies the necessary characteristics of a full-service disease management program as: (1) population identification processes; (2) evidence-based practice guidelines; (3) collaborative practice models to include physician and support-service providers; (4) patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance); (5) process and outcomes measurement, evaluation, and management; and (6) routine reporting/feedback loop (may include communication with patient, physician, and ancillary providers, and practice profiling).

The intensity of DM programs varies greatly, despite the comprehensive definition and program components endorsed by the DMAA. The Association uses the term *Disease Management Support Services* for programs that consist of fewer than all six of the components; however, in practice, programs of varying intensity routinely are labeled as DM programs. For example, one *program* may involve the simple provision of written materials on specific conditions or on-line health content, while another may provide intensive monitoring and management of the condition by health professionals. Some DM programs utilize electronic remote monitoring via computers or other devices. Increasing use of technology in health care is making it easier to manage disease from a distance. Some DM programs also conduct group activities for participants with the same condition.

DM programs may be owned and administered by various types of entities, including DM vendors that operate independently, health maintenance organizations (HMOs) and preferred provider organizations (PPOs) health plans, hospitals, pharmaceutical companies, and pharmacy benefit managers (PBMs).

Objectives—In light of the great expense involved in caring for persons with chronic illnesses, and in order to improve their health and quality of life, efforts are made to manage these illnesses rather than treating the periodic acute episodes of an unmanaged condition. Employer respondents to a survey conducted by Aon Corporation in 2000 ranked the reasons for using DM: (1) reduce health care costs; (2) improve clinical outcomes; (3) enhance employee satisfaction; (4) reduce disability costs; (5) increase worker productivity; and (6) retain workers (Aon Corporation, 2000).

Prevalence of Disease Management Programs—Advances in technology contribute to the growth in DM programs. Technologies are essential to the identification of candidates for DM programs, measurement of the programs' performance, and the operation of the programs. Internet and telephony devices allow participants in DM programs to transmit information, questions, and evaluations to care providers or medical databases. DM participants also have easier access to medical information at any time of day via the Internet or telephone. DM participants also may be able to utilize chat rooms, bulletin boards, and e-mail to communicate with care providers and others in the same programs. Some suggest that the cost savings associated with using such technologies will be so dramatic that in the future, when the technologies cost less, group health plans may provide DM participants with free computers as part of the DM program.

In 2005, 49 percent of very large employers provided DM programs to their employees. The vast majority of these programs were a function of, or were included in, the employer's health plan (68 percent of employers that offer DM programs in 2005). Very few were provided by an independent DM company contracting directly with the employer (Hewitt Associates LLC, 2005).

Data from the 1999 National Worksite Health Promotion Survey show that DM programs have become more prevalent, and that more employers plan to implement these types of programs in the near future. Among work sites with 50 or more employees, 42 percent offered programs for depression management, 35 percent for hypertension, 34 percent for cancer, 34 percent for diabetes, 33 percent for cardiovascular conditions, 27 percent for asthma, and 25 percent for obesity. For all types of programs included in the survey, employers expected to add more programs. By 2004, a majority of employment-based group health plans were expected to have DM programs for depression, hypertension, cancer, and diabetes. The responses indicate that much growth can be expected in DM programs: Less than 1 percent of employers said they would stop offering programs they currently offer. Also, among the work sites that intended to start new programs for managing chronic diseases, the majority said they would likely offer the programs through their group health plans, rather than directly at the work site (Association for Worksite Health Promotion et al., 2000).

In another survey, three-fourths (75 percent) of the responding employers provided some type of health promotion or wellness program to their employees to encourage healthy behaviors, and nearly all respondents (97 percent) thought DM could complement health promotion or wellness services (Aon Corporation, 2000). However, this survey also found that 43 percent of employers were concerned about the confidentiality of the health information collected and used by DM programs and were hesitant to

implement DM because of these concerns. (The applicability and impact of HIPAA privacy regulations on a particular DM program will depend on what type of entity administers the program and on the services the program provides.

Impact and Effectiveness—Research and case studies show positive results from individual DM programs, but there is no conclusive evidence that DM programs, in general, improve health or reduce costs in the long term. Improved health and cost-effectiveness may take from several months to a few years to become apparent in a DM program, and it would be difficult to prove that particular health outcomes were the result of a DM program. However, many employers and health plans have experienced improved health and decreased costs as a result of their programs, and growing numbers of employers are convinced that DM will help save money and are implementing the programs.

In a survey of very large employers, nearly half of employers with DM programs (47 percent) reported that the programs were too new to assess outcomes or return on investment (ROI). Only 10 percent reported being able to calculate or prove the ROI for their DM programs, and only about one-fourth reported having outcome reports for their programs (Hewitt Associates LLC, 2002).

In an effort to simplify the evaluation and selection of DM programs, work is under way to standardize the measurement of DM outcomes and returns on investment (Lewis, 2002). Three organizations known for advancing quality of care have begun accrediting DM programs: URAC (also known as the American Accreditation HealthCare Commission); The National Committee for Quality Assurance (NCQA); and The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO). Accreditation reviews generally evaluate the programs in such areas as organizational structure, program scope and objectives, performance and quality measurement, and program design. These standards and the subsequent accreditation of programs that meet them promise to aid employers in evaluating and selecting quality DM programs. Some DM program providers also take on financial risk by guaranteeing the purchaser improved participant health and a certain level of savings.

Conclusion

Various analyses and case studies show positive impacts of health promotion programs and disease management programs, including improved employee health and financial savings. Companies continue to collect data to assess the impact of their own programs. To establish whether these programs can be credited with health care cost savings, employers and

researchers must track a large number of employees over a long period of time. Regardless of the results, many employers believe that the mere existence of these programs is beneficial in that they demonstrate employers' concern for their employees and the value that they place on employees' well-being and good health.

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CHAPTER 25

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Introduction

The Global Burden of Disease, a publication of the World Bank and the World Health Organization, found that mental disorders account for more than 15 percent of the burden of disease in established market economies (Murray and Lopez, 1996). This is on a par with cancer and slightly less than cardiovascular conditions. In any given year, about 6 percent of adults have a major mental disorder, and between 5 and 9 percent of children suffer from a serious emotional disturbance (Kessler et al., 2005 and Friedman et al., 1996). Major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder are identified as among the top 10 causes of disability worldwide.

Spending on treatment for mental health and substance abuse disorders accounted for 7.5 percent of national health expenditures in the United States, amounting to \$121 billion of the \$1.6 trillion spent on health care (Mark et al., 2007). Between 1993 and 2003, spending for mental health and substance abuse disorders grew more slowly than health care spending in general, increasing by an average annual rate of 5.6 percent, compared with 6.5 percent for health care overall.

The government plays a larger role in the financing of mental health services than it does in the financing of overall health care. Public sources accounted for 58 percent of all mental health spending in 2003. At the same time, coverage for prescription drugs to treat mental illnesses has expanded dramatically. In 2007, the Substance Abuse and Mental Health Services Administration (SAMHSA), within the Department of Health and Human Services, found that expenditures for drugs prescribed to treat mental health disorders rose by 18.8 percent annually between 1993 and 2003.

Research seems to suggest that when individuals seek mental health treatment, they generally find their treatment to be both positive and helpful. For example, a 1995 *Consumer Reports* survey found that:

- Forty-four percent of people whose emotional state was “very poor” at the start of treatment said they now felt “good.” Another 43 percent who started out “fairly poor” also improved significantly.
- People who sought help from their family doctor tended to do well. But people who saw a mental health specialist for more than six months did much better.

Coverage of Mental Health and Substance Abuse Benefits

Most large employers provide coverage for mental health and substance abuse services, but even prior to the adoption of the Mental Health Parity Act of 1996 (MHPA) coverage for mental health and substance abuse was not as extensive as coverage for other medical care, according to an analysis of surveys conducted in 1989 and 1995 by Foster Higgins (Foster Higgins, 1989, 1995). In fact, since enactment of the Mental Health Parity Act, access to care and quality of care for mental health conditions have declined. Two RAND Corporation studies (Pacula and Sturm, 2000; Sturm and Wells, 2000) found that, among individuals with probable mental health disorders, more lost insurance coverage between 1996 and 1998 than gained it, and more reported decreases in health benefits. The studies found that individuals with worse mental health consistently report a deterioration of access to care compared with individuals with better mental health. Private-sector employment-based coverage of mental illness is less generous than it is for somatic illnesses. For example, most employment-based group health plans provide that the plan pays the costs above a certain out-of-pocket limit paid by the beneficiary. To protect the plan against potentially unlimited claims, however, annual or lifetime limits are imposed—typically \$1–\$3 million. Although more difficult under the MHPA, plans historically have often protected themselves against costly mental illness claims by setting lower annual or lifetime limits and imposing higher out-of-pocket costs on beneficiaries who access mental health services.

In 2003, the most common insurance restriction was an annual limit on inpatient days for mental illness. Seventy-seven percent of workers employed in private establishments with 100 or more employees were subject to a limit on inpatient days, while 74 percent were subject to a limit on outpatient days (U.S. Department of Labor, 2005). According to a 1998 report by the HayGroup (1998), the proportion of employment-based group health plans with day limits on inpatient psychiatric care increased from 38 percent to 57 percent between 1988 and 1997, and the proportion of plans with outpatient visit limits rose from 26 percent to 48 percent. Because of these changes, the HayGroup estimated that, from 1988 to 1997, the value of behavioral care benefits within the surveyed plans decreased from 6.1 percent to 3.1 percent as a proportion of the value of the total health benefit. Other studies also indicate that the gap in insurance coverage between mental health and other health services has been getting wider. The public mental health safety net as a chief provider of catastrophic coverage may encourage such practices. In addition, when Medicare and Medicaid were first introduced, they also limited coverage of long-term care of nervous

and mental illness disease to avoid shifting financial responsibility for these services (which were already performed by state governments) to the federal government.

Managed care processes associated with mental illness benefits have grown concurrently with those of other group health plan benefits, and include the same strategies, e.g., health maintenance organizations (HMOs), preferred provider organizations (PPOs), point-of service-plans (POS), exclusive provider organizations (EPOs), etc. A managed care device often used to deliver mental health and substance abuse benefits is Carve-out Managed Behavioral Health Care, typically provided by specialized vendors known as managed behavioral healthcare organizations (MBHOs). Carve-outs generally have separate budgets, provider networks, and financial incentive arrangements. Covered services, utilization management techniques, financial risk, and other features vary depending on the particular carve-out contract. Although about 75 percent of Americans with health insurance were enrolled in MBHOs, many are probably not aware of such an arrangement.

The shift to MBHOs has moved employment-based group health plans to more of a “supply-side” orientation (e.g., provider incentives) as opposed to the prominent strategy used before the emergence of managed care, which relied on “demand-side” controls (e.g., benefit limits). Utilization of behavioral health benefits is controlled in a managed care environment through a series of provider financial incentives and by using utilization management techniques to limit unnecessary care.

The National Committee on Quality Assurance’s (NCQA) Report Card for Managed Behavioral Healthcare Organizations (MBHOs) is an interactive tool that makes quality information about MBHOs more accessible to employers and unions, health plans, and consumers. NCQA, a private, nonprofit organization, is the leading accrediting body for the nation’s health care organizations (<http://hprc.ncqa.org/mbho/>). MBHOs that meet NCQA’s standards for the quality of care and service provided to their members receive NCQA accreditation. The standards cover seven categories: quality management and improvement; accessibility, availability, referral, and triage; utilization management; credentialing and re-credentialing; members’ rights and responsibilities (e.g., family support of adolescent counseling process); preventive behavioral health care services; and clinical evaluation and treatment records.

Managed care has demonstrably reduced the cost of mental health services (Ma and McGuire, 1998; Goldman, et al., 1998; Callahan et al., 1995; Bloom et al., 1998; Christianson et al., 1995; Coulam & Smith, 1990). The risk of such successful cost-containment is the possibility of undertreatment. This is particularly important because some evidence suggests that

limitations in mental health access affect people's well-being and result in decreased work performance, increased absenteeism, and increased use of medical services (Rosenheck et al., 1999).

A 1996 review of evidence on the efficacy of well-documented treatments (Frank et al., 1996) suggests that covered mental health services should include the following components:

- Hospital and other 24-hour services (e.g., crisis residential services).
- Intensive community services (e.g., partial hospitalization).
- Ambulatory or outpatient services (e.g., focused forms of psychotherapy).
- Medical management (e.g., monitoring psychotropic medications).
- Case management.
- Intensive psychosocial rehabilitation services.
- Other intensive outreach approaches to the care of individuals with severe disorders.

Another strategy used by employers (sometimes in conjunction with a union) that can affect the mental health quality and substance abuse level of their employee population is the employee assistance program (EAP), typically a voluntary program that can help employees and their family members obtain professional support in dealing with personal, emotional, family, or health problems. The EAP is designed to assist people who are facing such complex issues as marital crises, drug or alcohol dependency, single parenting, stress, financial uncertainty, or emotional distress. Sometimes people can effectively deal with these kinds of problems on their own. But when the problems are particularly serious and professional help is needed, locating assistance can be difficult. Also, a person "in crisis" may be unable to find help of the most appropriate kind. The EAP is meant to assist employees and their families to deal with these dilemmas.

Mental Health Parity

Inequities in insurance coverage between mental health and general medical care—the product of decades of stigma and discrimination—have prompted corrective efforts through legislation designed to produce financing changes and create parity. Parity calls for equality between mental health and other health care coverage. Where parity has been implemented, it appears that the cost increases have been negligible when the care has also been managed. Managed care techniques, because they focus on avoiding improper utilization of mental health services, allow parity to exist more effectively than did the traditional fee-for-service indemnity plan, which did

not employ utilization control techniques. Studies of state laws in Maryland, North Carolina, and Texas have shown that costs actually declined after parity was introduced when legislation coincided with the introduction of managed care. In general, the number of users increased, with lower average expenditures per user.

The MHPA, which was originally set to sunset on Sept. 30, 2001, has been extended a number of times and was finally permanently enacted into law in 2008. MHPA focuses on only one aspect of the inequity in mental health insurance coverage: catastrophic benefits. It prohibits the use of lifetime and annual limits on coverage that were different for mental and somatic illnesses. Specific dollar limits on mental health coverage that are lower than dollar limits on medical benefits would also violate MHPA. For example, a plan with a 50-visit per year limitation on mental health services, coupled with an absolute \$50 maximum payment per visit has a specific annual dollar limit on mental health benefits that is \$2,500 (50 visits times \$50) per year. If the plan has an annual dollar limit on medical benefits that is more than \$2,500, this violates MHPA.

MHPA covers employment-based group health plans, including private-sector self-insured group health plans otherwise exempted from state parity laws because of ERISA. In May of 2000, the General Accounting Office (now the Government Accountability Office) reported before the Committee on Health, Education, Labor, and Pensions of the U.S. Senate that although most employers are complying with the requirements of MHPA, it is having little or no effect on employees' access to mental health services. MHPA is limited in a number of important ways:

- Companies with 50 employees or fewer that offer no mental health benefit are exempt from provisions of MHPA.
- Disability plans that provide benefits for beneficiaries disabled due to mental health disorders are exempt from MHPA.
- Insurers and self-insured group health plans that experience more than a 2 percent rise in premiums and 1 percent in later years as a result of implementing parity could apply for an exemption from MHPA.
- Coverage sold in the individual (nongroup) market is not covered by MHPA.

State efforts at parity legislation have paralleled the MHPA. Some states like Texas target their parity legislation narrowly to include only people with severe mental disorders; others, such as Maryland, use a broader definition of mental illness for parity coverage, and include substance abuse. Maryland focuses on a broad range of insured populations, including employment-based group health plans that purchase health coverage for beneficiaries in the fully insured marketplace.

Confidentiality of Mental Health Information

As part of the Health Insurance Portability and Accountability Act of 1996, Congress committed the federal government to the creation of a national confidentiality standard. The Privacy Rule promulgated by the Secretary of Health and Human Services provides guidance on how the practices of providers, claim payers and clearinghouses, and plan administrators should be consistent with a patient's right to confidentiality, especially in regard to psychotherapy notes.

American law leaves little doubt that there is a broad legal protection for the principle of confidentiality. The U.S. Supreme Court in *Jaffee v. Redmond*, 1996, discusses the issue this way:

Effective psychotherapy... depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.

Public opinion polls support privacy of health care information; only 10 percent of those responding to one survey reported that they were extremely or very confident that electronic medical records would remain confidential.¹

Mental Health and Substance Abuse in the Work Place

The Americans with Disabilities Act of 1990 (ADA)—Each year, clinical depression alone causes a loss of some 200 million working days in the United States, according to a report released in October 2000 by the International Labor Organization. In fact, psychiatric claims were a leading type of claim filed by the Equal Employment Opportunity Commission, the agency responsible for enforcing the Americans with Disabilities Act (ADA) of 1990 during the first years after the legislation's enactment. Recent regulatory and court action, however, has made it much more difficult for employees with mental illnesses to prevail with an ADA claim. In order for such a claim to prevail, employees must generally prove that their mental illness substantially limits their abilities. Employers may still not need to accommodate an employee's mental illness if it causes undue hardship to

¹ www.ebri.org/surveys/hcs/2005/electronicMedicalRecords.pdf

do so. Employers also can't be accused of misconduct unless they knew the employee was disabled. Since most workers with mental illness don't disclose their problem until the illness shows up in bad behavior, this makes it difficult for employees to use ADA.

To further make it difficult for employees with mental illness to get help, disabilities that are correctable may not be covered by ADA. For example, if an antidepressant drug enables a depressed person to function normally, he or she may be considered to have a disability that is correctable and may not be able to use ADA. Some states have reacted to this perceived weakening of ADA as far as mental illness is concerned. For example, a September 2000 California law reaffirmed that state's broad definition of disability to include mental illness. Of course, many employers go further than required by ADA for sound business reasons, to be in compliance with more stringent state laws, and to avoid even the chance of becoming involved with an ADA claim.

Creating and Evaluating Drug-Free Work-Place Policy—The Substance Abuse and Mental Health Services Administration (SAMHSA) provides employers with advice on how to establish, monitor, and evaluate drug-free work-place policies and programs. The agency provides this advice in a report entitled, *Hallmarks of Successful Drug-Free Workplace Programs, Creating a Drug-Free Workplace Policy, and Evaluating a Drug-Free Workplace Program*. To view SAMHSA's employer tips, go to <http://ncadi.samhsa.gov> and <http://workplace.samhsa.gov>

Outlook

Many believe that no area of health care will see more change in the next 10 years than mental health. With sophisticated electronic imaging techniques that allow researchers to explore the brain more closely, scientists will discern areas of the brain that malfunction during specific illnesses and may soon be able to treat the targeted area more effectively. With the advance of genetic knowledge, clinicians will be able to treat patients with a new generation of psychotropic drugs that may offer hope for better outcomes for people with mental illnesses such as schizophrenia. The Internet is helping to overcome the stigma of mental illness by assuring anonymity while providing information about treatment options, current research, screening tests, online question and answer sessions with practitioners, and virtual support groups. New medications for the treatment of mental illness will continue to be advertised directly to millions of potential consumers, further changing the way they demand treatment. Many also believe that the further integration of behavioral health and physical health initiatives will contribute to a more responsive care delivery system from the patient's perspective.

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International Foundation of Employee Benefit Programs
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CHAPTER 26

RETIREE HEALTH BENEFITS

Introduction

Retiree health benefits were originally offered on a very limited basis in the late 1940s and 1950s. The number of employers offering these benefits expanded in the late 1960s in conjunction with the creation of the Medicare program. The benefits were provided as part of the health plan for active workers, generally without a separate premium structure or separate accounting. In subsequent years, the changing demographics of the work force, coupled with increasing life spans and rising health care costs, left many employers with higher retiree-to-active-worker ratios, increasing the costs and liabilities of retiree medical benefits.

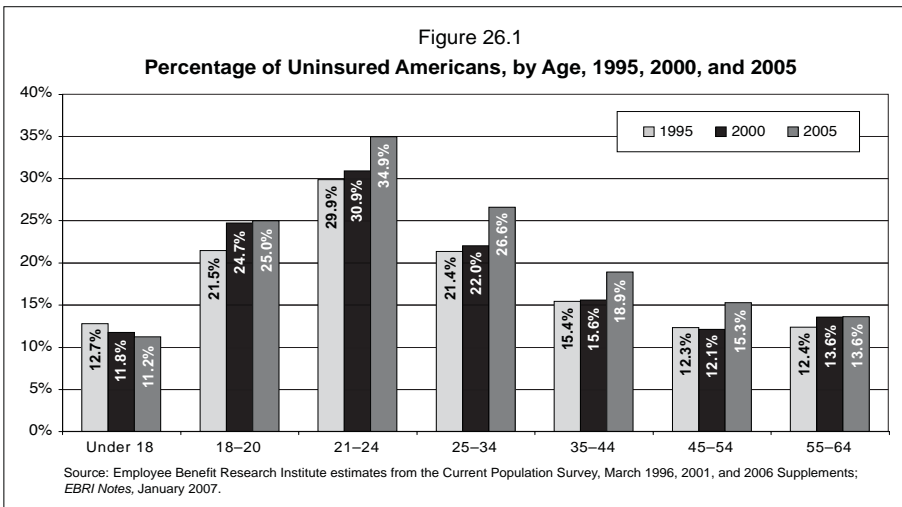
In 1989, the Financial Accounting Standards Board (FASB) issued Statement No. 106 (FAS 106), “Employers’ Accounting for Postretirement Benefits Other Than Pensions,” which required companies to account for these benefits and report liabilities for the future value of all promised benefits on their corporate balance sheets, beginning with fiscal years after Dec. 15, 1992. For the first time, the true cost of the benefits was understood (Employee Benefit Research Institute, 1988, 1989). Prior to FAS 106, companies were only required to disclose information on the existence of plans and amounts of benefit outflows. Governmental Accounting Standards Board (GASB) Statements No. 43 and No. 45 imposed new accounting standards upon public-sector sponsors of retiree health benefits that are similar to those required of private-sector employers under FAS 106. Under GAS 43 and 45, public-sector sponsors are required to accrue the cost of postretirement health benefits during the years of service as opposed to reporting the cost on a pay-as-you-go-basis.

As a result of FAS 106, and the increasing cost of providing retiree health benefits in general, many employers began a major overhaul of their retiree health benefit programs. Some employers placed caps on what they were willing to spend on retiree health benefits. Others added age and service requirements; moved to some type of “defined contribution” health benefit; completely dropped retiree health benefits for future retirees; or dropped benefits for current retirees, although this happened less frequently than other changes. While these changes do not appear to be having much impact on current retirees, they are likely to be felt most by future retirees who are not yet or may never become eligible for retiree health benefits, especially since an employer plan sponsor has an unqualified right to termi-

nate, modify, or amend unvested retiree health benefits if no commitment has been made to provide the benefit (Davis, 1991).

Retiree Health Participation and Cost

Since 1994, the percentage of persons ages 55–64 without health insurance generally has been fluctuating. Between 1994 and 1999, the percentage of the population ages 55–64 who were uninsured increased from 12.8 percent to 13.5 percent (EBRI estimates from the Current Population Survey). Since 1999, the percentage of Americans ages 55–64 without health insurance coverage remained rather stable, reaching 13.6 percent in 2005 (Figure 26.1). Recently, the percentage of persons ages 55–64 with employ-



ment-based health benefits decreased, from 68.1 percent in 2003 to 66.7 percent in 2005.

Coverage overall has been stable for workers. The percentage of workers ages 55–64 with no health insurance increased, from 11 percent in 1994 to 12.3 percent in 1999 (Fronstin, 2001), but decreased slightly to 11.9 percent in 2005. As the percentage of workers 55–64 with employment-based health insurance increases, the percentage with either coverage purchased in the individual market or public coverage declines. The percentage of workers ages 55–64 with employment-based health benefits increased, from 77.1 percent in 1994 to 79.1 percent in 2003. Since 2003, the percentage of workers 55–64 with employment-based health insurance has declined, reaching 77.6 percent in 2005. The percentage with insurance purchased directly

from an insurer declined from 9.4 percent in 1994 to 6.8 percent in 2005, and the percentage with public coverage declined from 8.6 percent in 1994 to 6.6 percent in 2003. After 2003, the percentage of workers ages 55–64 with public coverage increased to 8.5 percent in 2005.

Similar patterns can be seen in sources of coverage for retirees, although the trends are more pronounced. For example, the likelihood of a retiree age 55–64 being uninsured increased from 15.1 percent in 1994 to 17.8 percent in 2001, but declined to 16.6 percent in 2003. After 2003, the percentage of retirees ages 55–64 increased to 17.3 percent in 2005. In contrast, the percentage of retirees ages 55–64 with employment-based health benefits increased from 56.1 percent in 1994 to 57.2 percent in 2003. After 2003, the percentage of retirees ages 55–64 with employment-based health insurance declined to 54.4 percent in 2005. As the likelihood of a retiree having employment-based health insurance coverage declined from 2003–2005, the likelihood of having health insurance purchased in the individual market increased from 11.1 percent in 2003 to 13.0 percent in 2005.

The experience of the ill and disabled (persons not working for health reasons) is much different from that of workers and retirees. In general, the likelihood of an ill or disabled person being uninsured has been declining. In 1994, 14.1 percent of the ill and disabled were uninsured, compared with 6.5 percent in 2003. However, since 2003, the likelihood of an ill or disabled person ages 55–64 being uninsured increased sharply to 9.7 percent in 2005. The ill and disabled experienced an increase in the likelihood of being covered by either Medicare or Medicaid between 1994 and 2005. The variation in coverage from one year to the next among the ill and disabled is much greater than it is for workers and retirees. This may be the result of actual changes taking place, such as moving from one health insurance status to another. It also may be because this group is smaller than other groups.

Medicare

There are two basic designs for retiree health benefit plans: one for plans covering retirees under age 65 and one covering retirees age 65 and older. The reason for this age distinction is that eligibility for the Medicare program begins at age 65. For retirees under age 65, the benefit plan is usually based on the coverage they received while working, although, in recent years, the premium-sharing feature in programs for early retirees has increasingly differed from that in programs for active employees. For retirees age 65 and older, the benefit plan is coordinated with Medicare.

Medicare Basics—The Medicare program is the critical component of any employment-based retiree health benefit plan for Medicare-eligible retirees. Medicare is the primary payer of medical services for most Medicare

enrollees, except for active workers age 65 and older with employment-based health benefits. Most employer plans that extend health insurance coverage to retirees age 65 and older are coordinated with Medicare.

Medicare is currently composed of two parts. Part A covers hospital and post-hospital skilled nursing care facility services, and Part B covers physician and outpatient services and medical devices. Both parts cover home health care services. Part D covers out-patient prescription drugs. The following discussion highlights some of the services that Medicare does not cover and Medicare's deductibles and copayments.

An important service to the elderly not covered by Medicare is long-term care. Long-term care includes nonmedical services, such as help with activities of daily living that may nevertheless require the assistance of a medical professional.

Medicare's deductibles and copayments can become quite expensive. For a hospital stay of up to 60 days, the deductible was \$1,068 in 2009. Beyond the first 60 days in a hospital, Medicare beneficiaries are responsible for daily copayments. In 2009, a \$267 per day copayment during days 61–90, and \$534 per day during days 91–150 was required. Medicare provides all beneficiaries with 60 lifetime reserve days that can be used for hospitalizations longer than 90 days. Once these reserve days are all used, Medicare does not pay for any hospital days that exceed the 90-day limit. The copayment for the lifetime reserve days in 2009 was \$534 per day. There was also a copayment required of \$133.50 per day for services provided in a skilled nursing facility during days 21–100. For outpatient and physician services, Medicare required a \$135 deductible and a 20 percent copayment for most services, although there is 50 percent coinsurance for mental health care services.

Integration With Medicare—Because Medicare does not cover some vital medical services and the copayments and deductibles can become quite expensive, a continuation of health benefits into retirement can be a great financial bonus to a retiree age 65 and older. Employers use various methods to integrate their retiree health plans for retirees age 65 and older with Medicare. Some of the more common methods are:

- **Medicare carve-out**—With this method, Medicare's payment is subtracted from the employer plan's normal benefit.
- **Exclusion or nonduplication**—With this method, Medicare benefits are deducted from a covered expense before normal employer plan benefits are calculated.
- **Medigap**—With this method, the employer plan pays for some services not covered or reimbursed by Medicare, based on standardized coverage outlined by the government.

Medicare Advantage—Medicare has long provided an option designed to control the government’s costs while offering a wider array of services to beneficiaries who elect to deal with a preferred provider organization. Within this program, providers receive a fixed annual payment for each participating beneficiary, irrespective of the services required by the individual. Prior to 2004, this program was known as Medicare+Choice.

Proponents argued that, since health maintenance organizations (HMOs) had contracts with the government and agreed to care for beneficiaries for a fixed annual fee, they could deliver care more cheaply and thus afford to include added benefits at a lower total cost. But some argued that these plans would be attractive only to relatively healthy beneficiaries and would be ignored by the sick minority who are responsible for most of the costs.

Both sides agree that the critical calculation involves setting the HMO capitation rate at a level low enough to save the government money but high enough to be attractive to the HMOs. During the late 1990s and into early 2000, there had been a failure to reach this equilibrium point, and HMOs in many markets exited the program. As a result, during those years, this program was much more popular with beneficiaries than with providers. In an effort to revive the popularity of such plans, the 2003 Medicare Modernization Act included more generous reimbursement for a limited number of years.

FAS 106

In addition to issues concerning Medicare, employers are faced with Financial Accounting Statement No. 106 (FAS 106), which requires companies to accrue the cost of retiree health benefits and to record a liability for unfunded retiree medical costs explicitly on their financial statements. FAS 106 became effective starting with fiscal years beginning after Dec. 15, 1992. Many companies elected to recognize the “transition obligation” that FAS 106 created by reporting immediately and taking a one-time charge against earnings on their financial statements. Some companies instead elected to amortize the cost of the transition to the new accounting statement over time, spreading the cost over either a 20-year period or a period representing the future service to the participants at the date of transition. FAS 106 applies to current and future retirees, their beneficiaries, and qualified dependents. FAS 106 has forced employers to confront the issue of funding for their retiree health plans.

Other post-employment benefits (OPEB) obligations (including retiree health benefits) can be significant liabilities for individual companies. For example, in the automotive industry for the year ended Dec. 31, 2006,

each of the following companies recorded the following OPEB obligations (including medical, dental, life, and vision benefits), as reported in publicly available electronic copies of the annual reports filed with the Securities and Exchange Commission (SEC), in billions: Ford Motor Company, \$25.9 billion; and General Motors Corporation, \$64 billion.

Tax Planning

Prefunding the retiree health liability is one option open to employers, with some tax advantages and limitations. Funds must be segregated and restricted (usually in a trust) to be used as an asset against the FAS 106 liability. Vehicles that can be used for this purpose include Internal Revenue Code (IRC) Sec. 501(c)(9) trusts, also known as voluntary employees' beneficiary associations (VEBAs), and IRC Sec. 401(h) plans. Alternatively, other retirement plans can be used to help employers and employees set aside monies to help plan for the purchase of retiree health insurance, although these funds are not specifically reserved for this purpose. Such plans include 401(k) plans, corporate-owned life insurance, and employee stock ownership plans. Not all are tax-deductible means of funding or setting money aside, and each has specific limits. In addition, under IRC Sec. 420(c)(3), well-funded pension plans may be able to use excess pension assets in a defined benefit plan to finance payment of retiree health care claim costs by transferring some of the pension surplus to a retiree medical account established under IRC Sec. 401(h).

Although VEBAs are generally tax-exempt, unrealized business income tax (UBIT) applies to a VEBA's taxable income (e.g., investment income) to the extent the VEBA's assets exceeds its "account limit." The account limit for non-collectively bargained retiree health VEBAs is zero. Accordingly, UBIT generally would apply to taxable investment income from assets set aside to fund retiree health benefits. There are two important exemptions to the taxability of unrelated business income that are utilized by sponsors looking for ways to finance these benefits. They are:

- Employee-pay-all VEBAs.
- Collectively bargained VEBAs.

IRC Sec. 401(h) permits a qualified retirement plan to provide medical benefits to retirees, their spouses, and their dependents so long as such benefits are "subordinate" to the primary purpose of providing retirement income to the participants. Earnings in a 401(h) account are generally exempt from income tax. Unfortunately, a rule in the tax code requiring that 401(h) benefits be "subordinate" effectively eliminates the ability of many plan sponsors to accumulate funds in a Sec. 401(h) account.

IRC Sec. 420 allows surplus assets to be transferred from overfunded pension plans to pay retiree medical claims and expenses. To use this provision, the sponsor must set up a 401(h) account in the pension plan that has surplus assets. The Pension Protection Act of 2006 allows pension plans with assets above 120 percent of the plan's current liability (or funding target) to transfer two years or more of estimated retiree medical costs to the 401(h) account. The maximum amount that could be transferred is the lesser of 10 years of estimated retiree medical costs or assets in excess of 120 percent of current liability. For each year in which a transfer is made, the employer must make contributions that are sufficient to maintain the plan's 120 percent funding level or it must transfer assets back from the 401(h) account to the pension account. In addition, employers that want to transfer excess pension assets to a retiree health account must not reduce the number of people covered by retiree health benefits by more than 10 percent in any year, and by no more than a cumulative 20 percent over a five-year period. In certain cases, bigger reductions may be made by combining the per-person minimum-cost rule with the number-of-persons rule.

Retiree Health Benefits Design

Because of the limited tax preferences of the available funding vehicles, employers are looking to reduce their FAS 106 liability by redesigning their retiree health benefit plans. In general, the percentage of employers offering health benefits to future retirees seems to be declining. An annual survey of employers with 500 or more workers shows that the percentage that offer retiree health benefits on an ongoing basis (meaning employers planning to offer coverage at retirement for the foreseeable future, to both current and newly hired employees) declined from 46 percent in 1993 to 29 percent in 2006 for pre-Medicare eligibles and from 40 percent in 1993 to 19 percent in 2005 for Medicare eligibles (Mercer Human Resources Consulting, 2007). The percentage of employers offering health benefits to Medicare-eligible retirees today and planning to offer them to future Medicare eligible retirees is also declining.

Another survey of larger employers (most with 1,000 or more employees) also showed that the percentage offering retiree health benefits has declined. The likelihood of offering retiree health benefits to early retirees declined from 88 percent in 1991 to 52 percent in 2005 (Hewitt Associates LLC, 2005). The decline in the likelihood that an employer offered retiree health benefits is mainly due to two factors: (1) some employers are terminating existing benefits, and (2) new organizations are choosing not to offer retiree

health benefits at all. To some degree the data above overstate the extent to which employers are *dropping* retiree health benefits. When broad cross sections of employers are studied over time, it appears that employers are dropping retiree health benefits; however, new large employers most likely never offered these benefits. Thus, the cross sections that include these new employers are not examining employer behavior over time as much as they are providing snapshots of the availability of retiree health benefits.

In order to understand how employers that offer retiree health benefits are changing their benefit packages, it is important to examine a constant sample of employers. McArdle et al. (1999) examined a constant sample of employers between 1991 and 1998 and found that there had been a decline in the availability of retiree health benefits, but it was not as large as that found when examining a random cross section of employers. McArdle et al. (1999) shows the trend for the constant sample of employers and reports that there was a 7-percentage point drop in the likelihood that employers offered retiree health benefits to early retirees and a 9-percentage point drop for Medicare-eligible retirees.

Most employers that continue to offer retiree health benefits have made changes in the benefit package. Modifications to cost-sharing provisions are a common change, with employers asking retirees to pick up a greater share of the cost of coverage. In 2006, 43 percent of employers with 500 or more workers offering retiree health benefits to pre-Medicare eligible retirees required retirees to pay 100 percent of the premium for coverage, up from 31 percent of employers in 1997 (Mercer Human Resources Consulting, 2007).

Employers do not have to change the benefits package to control spending on retiree health benefits. Instead, they can tighten eligibility requirements, for instance, by requiring workers to attain a certain age and/or tenure with the company before they can receive any retiree health benefits. Overall, the percentage of employers requiring an age of 55 and a service requirement of 10 years increased from 30 percent in 1996 to 37 percent in 2005 (Hewitt Associates LLC, 2005). At the same time, some employers instituted a requirement of age 55 and 20 years service or age 60 and 10 years service for the first time. Employers have also instituted caps on the total amount of money they are willing to spend on retiree health benefits.¹ In 1993, 72 percent of employers with 1,000 or more employees did not have any type of cap on their total contributions, compared with 38 percent in 2005 (Hewitt Associates LLC, 2005).

Employers also are continuing to consider more changes to retiree health benefits. Seventy-four percent of employers said they were likely to increase

¹ Caps could work on a total aggregate spending basis or on a per-retiree basis.

the amount retirees are asked to pay, while 7 percent were likely to impose a cap on their contributions between 2005 and 2006 (McArdle et al., 2006).

Some employers have reduced the subsidy or eliminated benefits altogether for workers hired (or retiring) after a specific date. According to findings from the Kaiser/Hewitt Survey on Retiree Health Benefits, 13 percent of employers reported that they had terminated all subsidized health benefits for future retirees during either 2001 or 2002; 10 percent reported terminating all subsidized health benefits for future retirees in 2003; 9 percent reported doing so in 2004; and 11 percent between 2005–2006. It will be a few more years before sufficient data are available to explain how workers and retirees will be affected by cutbacks in retiree health benefits. Many workers may never qualify for retiree health benefits because their employers offer them only to workers hired before a specific date or because they may never reach the age and/or service requirements needed to qualify for benefits.

Employers should make any changes to a retiree health benefit plan with great care in order to avoid a class action lawsuit. Any ambiguity in plan documents can be interpreted in favor of retirees.

Retiree Medical Accounts (RMAs)

Some employers already have established retiree medical accounts (RMAs) for future and current retirees. These benefits are more similar to defined contribution (DC) or hybrid retirement benefits, such as 401(k) or cash balance plans, than DC health benefits would be for active employees. Like DC participants in a retirement plan, active employees with an RMA would typically accumulate funds in an account during their working lives. After retiring, they could use the funds in the account to purchase health insurance from their former employer or union, or directly from an insurer.

While working, each employee would have an account. The account might be funded or unfunded. Both employer and employees could contribute to the value of account balances. Employer contributions to the value of the account could be unfunded. If only employer contributions were made to the account, the employer could use a notional account similar to a cash balance pension plan, and could amend, modify, or even terminate the plan at any time for current and/or future retirees. If employee contributions were made to the account, an actual account would have to be established as the employees would “own” their contributions (i.e., such amounts would be fully funded), although they would not own the employer contributions.

One issue to consider when deciding who may contribute to the account is the tax treatment of contribution sources and of the resulting investment income. Employer contributions to the account could be designed so as not to

be treated as taxable income to the employee, either during working years or during retirement upon payout of insurance benefits. Active employee contributions, however, could not be excluded from taxable income like contributions employees make toward health benefits (through IRC Sec. 125 plans) during their working years, unless certain strict rules are met. If employer contributions are made to a funded, non-collectively bargained VEBA, the taxable income of the VEBA would generate unrelated business income tax. However, although employee contributions would be made on an after-tax basis, to the extent they are paid into an employee-pay-all VEBA, the investment income of that VEBA would not generally be subject to unrelated business income tax.

Another issue to consider in designing a plan is how to treat new employees who are older than the plan's entry age when they join the employer. A "lump-sum" or opening balance could be provided to employees who join the plan if they commence participation after entry age into the plan has passed.

Employers could require that employees meet an age and/or service requirement before being allowed to use the funds in the account to buy insurance during retirement. Employers could also vary their contribution to the accounts based on age and/or service requirements. Age requirements are common in defined benefit pension plans, in which an employee does not qualify for retirement benefits until he or she reaches a minimum age. As mentioned above, age requirements are also increasingly common for qualifying for retiree health benefits. It is likely that employers with both a defined benefit pension plan and retiree health benefits would consider using the same age qualifications across the benefit plans.

After retirement, retirees could use the funds accumulated in the account to buy health insurance. The insurance could be provided by the employer—meaning, the employer would continue to decide what benefits to offer and at what price or the employer could allow retirees to buy insurance on their own and pay an insurer of the retirees' choice directly.

Employers are interested in RMAs for a number of reasons. Prefunding an account could reduce future employer costs for retiree health benefits. By prefunding an account, an employer decides how much to contribute to retiree health benefits while a person is working. Contributions to the account could accumulate interest and the value of the contribution could grow over time or could vary with age or years of service, but it is possible that the value of the account would not grow as fast as the anticipated cost of providing retiree health benefits. Essentially, in this type of model the risk of unpredictable health benefit cost inflation is borne by employees.

Employers must also specify how the account could be used once an employee retires. As mentioned above, employers could continue to provide

the health benefit. This means retirees would be purchasing health insurance from their former employer using funds accumulated in the account. In contrast, employers might allow retirees to use the funds to purchase any health insurance, including policies sold directly by insurers. Account balances also could be used to pay out-of-pocket expenses, such as deductibles, co-payments, and health care services not covered by the benefit plan.

Whether retirees are allowed to use the funds accumulated in the account to purchase insurance on their own or as a spending account, they run the risk of depleting the assets in the account while money is still needed to purchase insurance. As a result, employers run the risk of losing a tool to manage the retirement process. If employees think that the balance of their account is not large enough to pay for retiree health benefits, they may postpone their retirement date until they are closer to being eligible for Medicare. Research already shows a strong link between a worker's decision to retire and the availability of retiree health benefits (Fronstin, 1999).

Hence, it will be an important exercise for retirees to predict how much it will cost them to purchase health insurance during retirement, and whether there will be enough assets accumulated in the account to purchase health insurance throughout their lifetimes. If a shortfall is expected, retirees may want to start saving additional funds for later years. They also may want to use some of their own money up front, rather than the funds in the account, if they expect the cost of insurance to increase faster than the gains on the assets accumulated in the account, or because health care cost inflation is typically higher than overall inflation and may outpace what the account earns over time. The decision to use personal assets, rather than the assets accumulated in an unfunded account, is highly complex and involves predicting the cost of health insurance, the composition of the benefits package, the rate of return on personal assets, the rate of return on the assets in the paper account, life expectancy, future income, other budget needs, and the ability of the plan sponsor to make good on its promise to fund the liability.

Because the RMA could be depleted before the death of a retiree, employers could consider allowing retirees to convert their account balance to an annuity. While the annuity may not provide enough funds to cover the full cost of health insurance, retirees would be guaranteed a stream of funds until their (or their spouse's) death. The annuity also could allow for different payouts before and after age 65, when the cost of health insurance falls substantially for retirees because they become eligible for Medicare. Annuities, however, may be taxable if the retiree has a choice between receiving money or health insurance.

Conclusion

FAS 106 triggered substantial changes to retiree health benefits. Some employers capped their spending on retiree health benefits. Others required employees to meet age and service requirements before becoming eligible for retiree health benefits. Still others moved to defined contribution health benefits, or completely dropped retiree health benefits.

However, the changes that employers have made to retiree health benefits have not yet had a huge impact on current retirees. Between 1994 and 2005, the percentage of retirees ages 55–64 with retiree health benefits from their own employer was unchanged at roughly 37 percent, although it is likely that many current retirees are paying more to maintain retiree health benefits.

The changes that employers have made to retiree health benefits will likely have a greater impact on future retirees. These changes may not have noticeable effects on trends in insurance coverage until a few years after the baby boom generation starts to retire. Retirement behavior patterns may also change as employees nearing retirement age postpone their decision to retire upon learning that, without a job, they may not be able to obtain health insurance coverage.

Public policymakers face the difficult task of trying to provide policy solutions for a system that is largely voluntary. By law, employers are under no obligation to provide retiree health benefits except to current retirees who can prove that they were promised a specific benefit. In the meantime, it is likely that employers will continue to make changes to retiree health benefits in response to future predicted health care costs and potential federal legislative initiatives.

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www.kff.org/content/2002/20021205a

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CHAPTER 27

COBRA CONTINUATION OF COVERAGE

Introduction

The continuation of coverage provision of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to make available continued health care coverage for a specified period to employees (and/or their qualified dependents) who terminate employment for reasons other than gross misconduct. While COBRA ensures that people who lose their health insurance coverage can continue it for up to 36 months in some cases, it does not require employers or unions to continue paying for this insurance; the entire health insurance premium may be paid by the persons electing COBRA. Those who utilize their right to COBRA coverage often find it to be surprisingly expensive.

Who Qualifies?

All employees and their dependents covered by an employment-based group health plan (provided by a private-sector employer with at least 20 employees) on the day before a qualifying event are eligible for COBRA. Employees covered by church plans are not necessarily covered by COBRA since their employer is not required to provide continuation of coverage. Employees of states and any political subdivision, agency, or instrumentality of such states are protected by COBRA, and federal employees (and their dependents) are covered by provisions similar to those of COBRA.

Under legislation that took effect in December 2002, certain people certified as having lost their jobs due to international trade, and who lost employment-based health coverage as a result, may be eligible for a new, second COBRA sign-up period (in addition to the traditional sign-up period described below), as well as tax credits covering 65 percent of the cost of their COBRA premiums.

What Constitutes a “Qualifying Event”?

For active employees and their dependents:

- Voluntary or involuntary termination of employment (other than for gross misconduct) or reduction in hours. (For example, a qualifying event

can occur because of a strike, lockout, layoff, or when an employee fails to work the minimum number of hours required for health plan coverage, for instance, because of a disability).

For retired employees and their dependents:

- The employer's filing for bankruptcy.

For dependents of active or retired employees:

- The employee's death.
- Divorce or legal separation.
- The employee's entitlement to Medicare benefits.
- A dependent child ceasing to be a dependent under applicable plan provisions.

Duration of Coverage

When a covered employee is terminated or his or her hours of work are reduced, the employee and qualified beneficiaries must be given the option of electing COBRA coverage for up to 18 months. In cases involving the employee's death, divorce, legal separation, Medicare entitlement, or loss of a child's dependency status, either initially or at any time during the continuation of coverage period, the qualified beneficiary must be allowed to elect COBRA coverage for up to a maximum of 36 months from the first qualifying event.

Only in the case of a retiree losing retiree health coverage in the event of a bankruptcy may the COBRA coverage period be longer than 36 months from the initial qualifying event for the retiree and his or her dependents.

Rights and Costs

COBRA coverage must be the same as that provided to other similarly situated employees covered under an employment-based health plan (except for medical savings accounts, long-term care plans, and in certain cases, flexible spending accounts) for whom a qualifying event has not taken place, and may not be conditioned on evidence of insurability. For example, if the employment-based health plan offers dental benefits as a separate plan option, a COBRA beneficiary must be allowed to separately elect dental coverage under the same conditions as active employees.

Each COBRA beneficiary (except for a new spouse of a COBRA eligible employee, as explained below) may elect his or her own health plan coverage at the time of each qualifying event and open enrollment season. COBRA

beneficiaries have the same right as active employees. For example, COBRA beneficiaries must be allowed to participate in all scheduled open-enrollment seasons and have the same coverage of benefits as active employees participating in the same health plan.

A new spouse of an employee on COBRA may receive the same coverage as the employee, but cannot make any elections on his or her own. The new spouse does not qualify for additional continuation of coverage (e.g., in the event of his or her spouse's death or a divorce from his or her spouse). In contrast, children who are born or adopted during the covered employee's continuation period are treated as qualified beneficiaries and may make separate elections at the time of their initial enrollment and during open enrollment. Such children are eligible for additional continuation-of-coverage availability should there be a subsequent qualifying event (e.g., death of employee, divorce, or separation of employee from his or her spouse).

A qualified beneficiary cannot be charged more than 102 percent of the employer's cost. In the case of individuals considered disabled for Social Security purposes, 150 percent of the employer's cost may be charged for the 19th month through the balance of the COBRA period for that individual and other family members who also qualify for this continuation of coverage.

Who Pays For COBRA?

People who pay for their own COBRA coverage typically experience “sticker shock.” That is because active employees (and dependents) typically pay only a portion of their entire health plan premium; employers pay for a significant portion of the premium. By contrast, COBRA beneficiaries often pay for the entire premium, plus an additional 2 percent. However, there may be certain situations in which a new employer or a hospital may want to pay for the COBRA coverage, as explained below:

- If a new employer hires a COBRA beneficiary, the new health plan might find a financial advantage in paying for COBRA premiums, especially if the new plan is self-insured and the person is in poor health. The difference between a few months of COBRA premiums and actual medical costs can be substantial.
- Hospitals may also find it advantageous to pay COBRA premiums for patients eligible for COBRA. A hospital can pay the premiums and then be reimbursed for the medical care it provides. This may be cheaper and easier than trying to collect for expensive medical care from an individual without health insurance.

Disability and COBRA

An employee or his or her dependent does not qualify for COBRA solely because of disability. An employee or dependent who otherwise qualifies for COBRA because of termination of employment or reduction in hours is entitled to an extension of COBRA if he or she is disabled (as determined by the Social Security Administration (SSA)) at the time of qualifying for COBRA or at any time during the first 60 days of COBRA coverage (see next section). The actual determination by SSA must occur within the initial 18 months of continuation coverage. Qualified beneficiaries are eligible for up to 29 months of continuation coverage from the time of the initial qualifying event. The 29 months of extended coverage is available to any nondisabled family members of the disabled individual who is entitled to COBRA coverage.

COBRA and Medicare

In instances in which a COBRA-covered employee also becomes eligible for Medicare (the federal health care insurance program for the elderly and disabled), COBRA coverage for spouse or dependent child can continue for at least 18 and as long as 36 months from the date of Medicare entitlement. A maximum of 36 months of coverage is allowed for the spouse or dependent of an employee who retires less than 18 months after becoming eligible for Medicare.

A special statutory rule provides the following: an active employee comes under Medicare coverage in Jan. 2007; his employer's plan continues to cover the employee and his wife (as required by law). In this example, because there is no loss of coverage, Medicare entitlement is not a qualifying event. However, when the employee retires on Jan. 1, 2008, his 62-year-old wife will lose coverage. His wife's COBRA coverage period is 36 months from the employee's Medicare entitlement date (Jan. 1, 2007) until Dec. 31, 2010, or a total of 24 months of actual continuation coverage instead of the 18 months normally extended for a termination of employment but less than the usual 36 months provided for dependents.

COBRA and FMLA

COBRA does not apply to employees taking leave under the Family and Medical Leave Act (FMLA). An employee on FMLA will have a qualifying COBRA event only if the event takes place in the following situations:

- On the last day of the FMLA, if the employee does not return to work.

- When the employer learns that the employee will not return from leave, even if the employee (or other qualified beneficiary) did not have health coverage during the leave.

COBRA coverage cannot be conditioned on the employee's repayment of health plan premiums that the employer paid during the FMLA. If the plan changes while the employee is on leave and not covered under the plan and there is a COBRA qualifying event, the employee would be entitled to the same type of coverage he or she was enrolled in immediately prior to the leave or to whatever coverage is available to employees in the COBRA beneficiary's employment group.

Employer Notification Requirements

The employer must notify the employee and his or her spouse of the right to continued coverage under COBRA when they are first covered under the plan and at the time of certain COBRA qualifying events. Model Notices have been published by the U.S. Department of Labor.

An employer whose health plan is not self-administered must notify the third-party administrator within 30 days of an employee's death, termination of employment, reduction in hours, Medicare entitlement for retired employees and their families, or of the employer's bankruptcy. The employee and spouse are responsible, as explained below, for notifying the employer of other qualifying events under COBRA. The third-party administrator has 14 days from the time it is notified of a qualifying event to notify the beneficiaries of their COBRA rights.

Employers that self-administer their own group health plans have 44 days to notify beneficiaries. Multi-employer plans have longer notification periods. Notice must be made to the beneficiary's last known address. Notice may be made by first-class mail, and does not need to be sent by certified mail in order to be in compliance.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a group health plan must provide certification of the period of creditable coverage under any applicable COBRA continuation provision and waiting period (if any) imposed on an individual. This certification must be provided when the individual ceases to be covered under the group health plan or otherwise becomes covered under a COBRA continuation provision, after any COBRA continuation coverage ceases, and on the request of an individual not later than 24 months after coverage ceased. At a COBRA qualifying event, certification of prior employer coverage may be provided along with the COBRA notification.

Employee/Dependent Notification Requirements

An employee or dependent must notify the plan administrator within 60 days of a divorce or legal separation or a dependent child ceasing to meet the plan's requirements for a dependent child.

Election Period

A qualified beneficiary also has at least 60 days to elect coverage after being notified by the plan administrator of the right to COBRA coverage. Premium payments for periods preceding the election cannot be required before 45 days after the election. This allows qualified beneficiaries great flexibility in determining whether to be covered by COBRA. If all permissible time periods reach their maximum length, a qualified beneficiary may have up to 149 days to decide to accept COBRA coverage after the qualifying event. If the qualified beneficiary chooses to not pay at the time due, nothing is lost except the coverage. Therefore, the qualified beneficiary can wait and see if the coverage is in his or her best interest; there is no downside to initially electing COBRA. Unless future health coverage is certain, it would be in the best interests of the qualified beneficiaries to delay the election of COBRA, and also to delay the actual payment of premiums, as long as the law allows.

New Tax Credits and Second COBRA Election Period

In addition to the extension of health coverage available under the traditional COBRA rules, certain people who lose their jobs because of increasing import competition, and their families, may be eligible for federal tax credits covering 65 percent of their COBRA premiums as well as a new, second 60-day COBRA election period. People qualify for the second COBRA election period if they:

- Receive federal trade adjustment assistance benefits (or would be eligible to receive such benefits except for the requirement that the person first exhaust unemployment benefits);
- Lost health coverage due to a termination of employment resulting in the person becoming eligible for trade adjustment assistance benefits; and,
- Did not elect COBRA coverage during the regular COBRA election period.

However, election of COBRA coverage under this second period must be made within 60 days beginning on the first day the person becomes eligible for benefits under the trade-adjustment legislation, but no later than six

months after the date a person lost coverage as a result of separation from employment that resulted in him or her becoming eligible for such benefits. (Also, coverage elected during the second COBRA election period is retroactive only to the beginning of that election period rather than to the date of the initial loss of coverage.)

Attempts to Evade Coverage

In certain cases, employers or employees may attempt to reduce or eliminate health insurance coverage in an attempt to evade COBRA. For example, if an employer eliminates health coverage in anticipation of an employee's termination, or if an employee cancels the coverage of his or her spouse in anticipation of a divorce or legal separation, COBRA must still be offered, effective on the date of divorce or legal separation (but not for any period before the date of the divorce or legal separation). Timely notification requirements for receipt of benefits still apply (such as notifying the employer/third-party administrator within 60 days of the divorce or legal separation).

Choices of COBRA Coverage

Each qualified beneficiary can elect coverage independently at the time of each qualifying event and at open-enrollment; however, a positive election by an employee is effective for the employee's spouse and children, and an election by a spouse (or an ex-spouse) is effective for all dependents. Thus, a spouse can elect coverage for dependent children, but the children can make their own elections if the parents decline coverage.

Each qualified beneficiary could be entitled to make a separate selection among types of coverage. Presumably, this would mean that an employee, spouse, and dependents all could choose different levels of coverage or that different choices could be made in a plan that offered various health care options (e.g., medical coverage is offered separately and also offered in conjunction with dental and vision coverage).

Termination of COBRA Coverage

COBRA coverage may be terminated when one of the following events occurs:

- The employer discontinues its group health coverage entirely.
- The qualified beneficiary fails to make timely payment of premium.
- The qualified beneficiary is covered under another group health plan.

- The qualified beneficiary first becomes entitled to and is covered by Medicare after the date of his or her COBRA election.

COBRA cannot be terminated because a person has other coverage and that coverage limits or excludes benefits for pre-existing conditions. Federal law now limits the circumstances under which a plan may impose a pre-existing condition waiting period on individuals. If a plan is prohibited from imposing a waiting period on an individual, COBRA continuation coverage may be terminated.

Conversion to Individual Policy

COBRA beneficiaries who exhaust their COBRA coverage must be offered an option to convert to an individual policy, if such an insurance policy is generally available. For example, individuals covered by a fully insured health plan (such as an HMO or other insurance product that assumes the full risk for claims incurred by the plan) would typically be able to convert their group coverage to an individual policy, whereas individuals covered by a self-insured health plan (such as an employer or union that assumes the risk for claim payment and does not purchase an insurance product to assume the full risk for them) would not typically be able to convert to an individual policy. Many individuals may switch from a self-insured health plan to a fully insured plan during open enrollment for this reason.

Alternatively, federal law now requires each state insurance market to offer individual health insurance products. Accordingly, a COBRA beneficiary at the end of his or her continuation of coverage period will need to weigh the benefits of converting the current health insurance coverage offered under COBRA against the coverage that may be available in the marketplace. The conversion of a COBRA health plan does not mean that the converted health plan will provide the same coverage that was available under COBRA. COBRA must be elected and exhausted in order to get guaranteed issue individual coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

COBRA Utilization

Charles D. Spencer & Associates has conducted extensive surveys regarding COBRA for the past several years. These surveys have found that about 20 percent of eligible beneficiaries elect COBRA coverage. The length of COBRA coverage has held relatively steady for the last six years: For 18-month qualifying events, the average length of coverage is between 10 and 11 months, while 36-month qualifying events have averaged around 21–23 months. Very few individuals on COBRA convert to individual policies.

On average, COBRA claims costs are around 1.5 times the cost of active-employee claim costs. Accordingly, COBRA beneficiaries do not cover the costs of the health care services rendered, since plans are typically allowed to charge such beneficiaries only 102 percent of active employee claim costs. As one would expect in any group health plan, active employees increasingly pay the cost of adverse claims experience under COBRA (through higher insurance premiums) because former employees and their families under COBRA are not paying the true cost of the coverage they are receiving.

Enforcement

Failure to comply with COBRA generally is not prosecuted if the problem is retroactively corrected to the extent possible and the COBRA beneficiary is made whole. The Employee Retirement Income Security Act of 1974 (ERISA), the major federal law governing employee benefits, provides that employees, qualified beneficiaries, or DOL may sue to enforce the COBRA coverage requirements. Governmental employees may sue under the Public Health Service Act provisions of COBRA. COBRA noncompliance has significant penalties associated with it. Many employers view the penalties for noncompliance as excessively large.

Additional Information

For more information about continuing health care coverage under COBRA, call the DOL Employee Benefits Security Administration's Toll-Free Employee and Employer Hotline, at (866) 444-3272.

Whether to elect COBRA coverage is an important decision for millions of Americans each year. In order to make that decision, people need to know about their rights under COBRA and a more recent law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). DOL offers information about some of the factors employees and their families should consider in "IRS Notice 98-12: Deciding Whether to Elect COBRA Health Care Continuation Coverage After Enactment of HIPAA," *Questions & Answers: Recent Changes in Health Care Law*, pages 49–64. The booklet can be found at www.dol.gov/ebsa/pdf/hippa.pdf

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CHAPTER 28

NONDISCRIMINATION AND HEALTH BENEFITS

Introduction

Internal Revenue Code (IRC) Sec. 105 and Sec. 106 permit employers to offer certain health benefits on a tax-free basis. However, these rules can be different for highly compensated employees (HCEs) if the health plan is self-insured and eligibility for benefits or benefits payable to the HCE is discriminatory. For purposes of IRC Sec. 105(h), an HCE (determined in the plan year for which the reimbursement was made) is:

- One of the five highest-paid officers.
- A shareholder owning (actually or constructively) more than 10 percent of the company's stock.
- Among the highest paid 25 percent of all employees.

IRC Sec. 105(h) applies to all employment-based health plans (medical, dental, and vision) in which the risk has not been shifted to an insurance company, including administrative services only (ASO) and cost-plus arrangements, possibly minimum premium plans, and medical reimbursement plans provided through an IRC Sec. 125 plan (collectively referred to as “self-insured health plans”). If such a self-insured health plan discriminates in favor of HCEs, the affected HCEs must include some or all of the value of the benefits received in their taxable income. This *imputed* income is subject to federal income taxes (but not to Social Security or Medicare taxes), and state tax liability if such liability is calculated pursuant to federal rules. Although employers are required to report such amounts on the HCEs' W2s, they are not required to withhold any taxes on these amounts. Obviously, discrimination in favor of an HCE in a self-insured health plan can result in large income tax liability exposure for the HCE. This tax liability can be avoided if the self-insured health plan is designed to avoid discrimination.

The IRC Sec. 105(h) discrimination rules do not apply to fully insured plans. When IRC Sec. 105(h) was enacted in 1978, most employee benefit programs were fully insured. Congress was concerned that self-insured health plans could potentially be used as devices for the benefit of shareholders, officials, or highly paid employees. Fully insured plans are able to protect employees from such discrimination because of the requirements imposed by state insurance laws. However, the Employee Retirement Income Security Act of 1974 (ERISA) prohibits states from regulating self-insured health plans. Accordingly, had Congress not acted to prohibit discrimination in

self-insured health plans, state law could not curtail discrimination in favor of HCEs.

The provisions of IRC Sec. 105(h) are only applicable to self-insured plans; thus the key indicator in determining applicability of IRC Sec. 105(h) is how the program is funded. The provisions also affect only persons who are current or retired HCEs. Accordingly, it is necessary to define: (1) which medical programs are subject to the discrimination rules of IRC Sec. 105(h), (2) when a program does in fact discriminate in favor of current or former HCEs, and (3) what amount of the benefit received by the HCE needs to be included in his or her income.

Programs Subject to IRC Sec. 105(h)

In essence, the IRC Sec. 105(h) requirements apply to all employment-based health plans (including health reimbursement arrangements) in which risk is not shifted to an unrelated third party. Thus, if the employer retains any of the financial risk of paying for the medical expenses incurred by employees or retirees (or their families), Sec. 105(h) may apply. An employment-based medical program is considered fully insured when the employer shifts the entire risk of medical expenses provided under the program to an unrelated third party (e.g., a state licensed insurance company). However, a plan that reimburses employees for premiums paid for fully insured plan health coverage is not subject to the nondiscrimination rules of IRC Sec. 105(h).

Discrimination—IRC Sec. 105(h) provides that a self-insured health plan may not discriminate in favor of HCEs with respect to either eligibility to participate or to benefits.

Eligibility Test—For a plan to be considered nondiscriminatory with respect to eligibility to participate, it must pass one of the three coverage tests:

- Seventy percent of all employees benefit under the plan.
- The plan benefits 80 percent of eligible employees and 70 percent of all employees are eligible.
- The plan benefits a nondiscriminatory classification of employees.

Employers who offer multiple medical options are unlikely to be able to pass either the first or the second test because employees are likely to be dispersed among the various medical options. This leaves the third test, which requires that the plan benefit a nondiscriminatory classification of employees. The IRS regulations indicate the test is conducted on the basis of plan participation (not merely eligibility to participate).

Although the IRS has not provided a definition of a nondiscriminatory classification for health plans, it would seem appropriate to use a methodology similar to the nondiscriminatory classification test that applies to qualified retirement plans (IRC Sec. 410(b) sets forth the minimum coverage requirements for qualified pension, profit-sharing, and stock-bonus plans).

Benefits Test—The IRS regulations indicate that the plan must provide the same benefits for both highly compensated and non-highly compensated employees. If a plan provides different benefits to different groups of employees (e.g., differences in waiting periods), each benefit structure is treated as a separate plan for purposes of the eligibility test described above.

A self-insured health plan discriminates as to benefits unless all benefits provided for participants who are HCEs are also provided to all other participants. All benefits for dependents of HCEs must also be available on the same basis for the dependents of all other employees. The self-insured health plan will also be considered discriminatory as to benefits if it covers HCEs and the type or amount of benefits subject to reimbursement is offered in proportion to compensation. The nondiscrimination test is applied to the benefits subject to reimbursement under the medical program and not to the actual payments or claims made. Further, a self-insured plan is not considered discriminatory just because HCEs utilize benefits to a greater extent than other participants.

If there are optional benefits available (e.g., vision and dental), these benefits will also be considered nondiscriminatory if all eligible employees can elect any of the benefits and either there is no required premium by the employee or the premium charged is the same for all employees.

An exception to the IRC Sec. 105(h) discrimination rules exists for programs that provide reimbursement for employee (but not for dependent) medical diagnostic procedures. Medical diagnostic procedures include routine medical examinations, blood tests, and X-rays; they do not include procedures for treatment, cure, or testing of a known illness or treatment or testing for an injury or symptom. Accordingly, an employer may provide for an executive “check-up” program without having to consider imputing its value to the HCE’s gross income.

Excludable Employees

In applying the rules set forth in the paragraph above, IRC Sec. 105(h)(3)(B) allows the employer to exclude the following groups of employees:

- Those who have less than three years of service at the beginning of the plan year.
- Those who are younger than age 25 at the beginning of the plan year.

- Part-time or seasonal employees.
- Those who are covered under a collective bargaining agreement.
- Nonresident aliens who receive no income from a U.S. source.

When applying the nondiscrimination test, all employees of a controlled group or affiliated service group, as defined in IRC Sec. 414, are treated as employed by a single employer.

Benefits Received and Taxable Income

If a benefit under the self-insured health plan is available to HCEs but not to other employees, the total amount of reimbursement to the HCE with respect to that benefit is an “excess reimbursement” and must be included in the HCE’s income taxes as imputed income. For example, if a self-insured dental program provides benefits only for HCEs, the value of the dental benefits paid to an HCE is imputed income to that HCE. In addition, if a plan provides maximum benefit limits subject to either the employee’s status as an HCE or based on a proportion of his or her compensation, the total value of the benefits provided to the HCE that is not provided to all other participants is an excess reimbursement subject to inclusion in the HCE’s wages as imputed income.

If the self-insured health plan discriminates in favor of HCEs as to eligibility to participate, the amount of the “excess reimbursement” that is taxable to the HCE who receives such reimbursement is computed as follows:

$$\frac{\text{Total reimbursement to HCE} \times \text{Total reimbursement to all HCEs in plan year}}{\text{Total reimbursement to all employees in plan year}}$$

For example, assume an HCE participates in a self-insured health plan that discriminates as to eligibility to participate. The HCE receives a reimbursement of \$120,000 for an open-heart surgery during the plan year. If the self-insured health plan made reimbursements of \$1 million to all HCEs in the plan year, and reimbursed all employees \$2 million in the plan year, the excess reimbursement to the HCE is \$60,000. This amount must be included on the HCE’s W-2 as imputed income (\$120,000 x \$1 million/\$2 million).

If a self-insured health plan is contributory, only that portion of the reimbursement attributable to employer contributions is subject to inclusion in the HCE’s income. All current and former employees, including current and former HCEs, are allowed to exclude benefits attributable to their own contribution under IRC Sec. 104(a)(3). Amounts attributable to employer contributions are determined in the ratio that employer contributions bear to total contributions over the three-year period prior to the year in which

the benefit was received (or, if the plan has been in effect for less than three years, the number of years the plan has been in effect). Note that the IRS treats pre-tax employee contributions like employer contributions. Thus, apportioning the taxable benefit amount for the HCE (including application of the three-year rule) applies only if the employee has made after-tax contributions to the health plan—which is unusual.

Personal Taxation Issues for the HCE

To cushion the tax liability blow slightly, HCEs may be able to deduct some of the value of qualified unreimbursed medical expenses from federal income tax on their individual tax returns, subject to IRC Sec. 213. To deduct a medical expense under IRC Sec. 213, taxpayers must determine their net unreimbursed medical expenses for the year by subtracting all reimbursements for medical expenses received from the total medical expenses paid for the year. They must then subtract 7.5 percent of his adjusted gross income from the net unreimbursed medical expenses and may deduct the balance, if any. IRC Sec. 68, which limits the overall amount of itemized deductions allowed for high-income taxpayers may also serve to reduce the HCEs' taxable income.

Taxation Issues for the Employer

The employer can deduct the full cost of medical treatment provided to employees and retirees through a program that is not fully insured as a business expense under IRC Sec. 162(a). Additional requirements apply to health programs that are provided through a welfare benefit fund, such as an IRC Sec. 501(c)(9) trust.

Conclusion

Employment-based health plans that are self-insured should be structured to avoid discrimination in favor of HCEs. The self-insured health plan must not discriminate as to eligibility to participate or as to benefits available to the HCE. Any discrimination in favor of an HCE will lead to tax consequences, specifically the inclusion of all or some part of the value of the benefits in the HCE's taxable income.

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Additional Information

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CHAPTER 29

MANAGING HEALTH CARE COSTS

Introduction

Health care spending in the United States has grown rapidly, increasing from \$73 billion in 1970, or 7 percent of gross domestic product (GDP), to \$2.0 trillion, or 16.0 percent of GDP, in 2005.¹ Expenditures are projected to reach \$4.1 trillion, or 19.6 percent of GDP, by 2016. Factors that have contributed to increased spending on health care services include the aging of the population, the comprehensiveness of insurance, increased income of employees, differential productivity growth from medical care, high administrative expense, provider-induced demand, and technological innovation (Newhouse, 1992, and Cutler, 1995).

In the United States, about two-thirds of the civilian population under age 65 received health insurance coverage through employment-based plans in 2005. Employers' contributions to employment-based health plans and Medicare on behalf of employees and their insured family members have risen dramatically, reaching nearly \$439.6 billion in 2005, up from \$12 billion (2 percent of compensation) in 1970 (Cowan and Hartman, 2005).

The use of cost management strategies in health care became more prevalent during the mid-1990s as a result of health care cost increases during the late 1980s and early 1990s. Employers have made sweeping changes in the operation of employment-based group health plans. While such measures are designed to contain individual employment-based group health plan spending, they also serve the broader goal of managing the increase in overall health care costs.

Changes in benefit design are the most often used means of managing health care costs because they are the easiest for employers to implement and manage. Design changes most commonly initiated by employers include imposing or increasing cost-sharing requirements such as deductibles, coinsurance, and the employee contribution to the premium; adopting utilization review (UR) techniques requiring that tests be performed prior to hospital admission and that approval be obtained before covering certain prescription drugs, i.e., drug utilization review (DUR); and requirements that plan participants and beneficiaries use lower-cost alternatives such as ambulatory surgical care, treatment in extended care facilities, home health and hospice care, case management, telemedicine, and wellness or health promo-

¹ Source: <http://cms.hhs.gov>

tion programs. Many employment-based group health plans also use demand management programs as an approach to provide health care benefits that are designed to help beneficiaries receive the appropriate level of care at the appropriate time (e.g., thru a 24/7 nurse advice line program).

Other plan design techniques used to manage health care costs include coordination of benefits (COB) and subrogation clauses. A COB provision regulates payments to eliminate duplicate coverage when a claimant is covered by multiple group plans. A subrogation procedure allows the health insurance plan to recover from a third party when the action resulting in medical expense (e.g., auto accident) is the fault of another person.

In addition to these changes within the framework of existing employment-based group health plans, some employers have initiated more sweeping reorganizations of their health insurance benefits. Other employers have more fundamentally reorganized their plans within the framework of flexible benefit or cafeteria plans. Employers have adopted flexible benefit plans to induce employees to share more of, and take greater responsibility for controlling, their health care costs.

Most employment-based group health plans have shifted plan participants and beneficiaries into managed care plans: 93 percent of workers with employment-based health plans were enrolled in some form of managed care in 2006 (Claxton et al., 2006). As recently as 1994, traditional indemnity plans were the most commonly offered type of health plan among employers that offered health benefits. As fewer employers offered traditional indemnity plans, participation in these plans declined and participation in managed care plans increased. In 2006, only 3 percent of employees participating in a health plan were enrolled in an indemnity plan, compared with 73 percent in 1988. During the same time period, enrollment in managed care plans increased from 27 percent to 93 percent. In addition to the decline in participation, the structure of fee-for-service indemnity plans has changed as employers and insurers added managed care features to these plans. Enrollment in health maintenance organizations (HMOs) grew from 9.1 million in 1980 to 33.6 million in 1990, a 269 percent increase. However, starting in the 1990s, the growth rate in HMOs has slowed and enrollment in the most restrictive types of HMOs has even declined.

One reason for the decline in staff and group model HMO enrollment may be the lack of flexibility afforded the employee. Employers offer health benefits as a form of compensation in order to recruit and retain qualified employees. Locking employees into a plan that limits choice and perhaps reduces their satisfaction may be less costly but may undermine an employer's recruitment and retention goals. Under independent practice association (IPA) and mixed-model HMOs, employees can switch to a plan with greater flexibility, and in many cases, retain their family physician or specialist.

A second reason for the decline in staff and group model HMO enrollment may be that employers' disappointment with expected cost savings has caused them to experiment with other plan types. And yet another reason may be that staff and group model HMOs were not as aggressive as IPAs and network plans at increasing market share because they were more likely to be owned by less aggressive nonprofit organizations.

Health Plan Type

Health plan designs can be arranged in a variety of ways according to the extent of financial control the payer (e.g., trust or employer) has over such plans and the extent of control such plans have over patient choice. At opposite ends of the spectrum is the traditional fee-for-service indemnity plan, with no managed care elements, and the staff model HMO, with the most. Between these two extremes lie fee-for-service plans with managed care features (known as managed indemnity plans), preferred provider organizations (PPOs), and HMOs that permit greater choice of physicians. Finally, as health care delivery systems have evolved and employers have become more involved in the design of corporate benefit plans, point-of-service (POS) plans have developed that combine elements of the HMO and PPO in an attempt to balance freedom of choice for the employee and financial control for the employer.

Health Maintenance Organizations—HMOs' basic functions are to provide comprehensive health care services to subscribers, contract with or employ physicians and other health care professionals who will provide the covered medical services, and contract with hospitals to provide covered hospital care (a few HMOs own and operate hospitals). Conventional insurance plans simply reimburse health care providers, usually under a fee-for-service arrangement. However, commercial insurers, self-insured employment-based group health plans, and Blue Cross and Blue Shield plans are increasingly using PPO and other managed care arrangements to encourage employee use of certain designated health care providers.

Until the mid-1980s, the typical HMO model was a staff or group model. The recent expansion in HMOs has been dominated by network model and IPA HMOs. Currently, there are five different HMO models: staff model, group model, IPA, network model, and mixed model. Each of these models differs with respect to its rules for patients and the financial incentives it imposes on health care providers to limit services and costs:

- **Staff Models**—In a staff model HMO, the health plan owns its health care facility and employs health care providers on a salaried basis. Patient choice is limited. Enrollees are restricted to network providers and are required to see a primary care physician first, who then refers

them to specialists within the HMO when it is considered medically necessary and appropriate.

- *Group Models*—A group model HMO is similar to a staff model HMO, but the group model HMO contracts with a single physician group to provide services to the HMO participants. The physician group is managed independently and is usually paid on a capitated basis. Group model HMO providers of health care usually spend most of their time serving HMO patients, but they may spend some time in private practice.
- *Independent Practice Associations*—IPAs are groups of physicians in private practice who provide services to HMO participants, but they primarily provide services to patients not enrolled in an HMO. In recent years, IPA providers working with HMOs have increasingly been paid on a fee-for-service basis. During the mid to late 1990s, many IPA HMOs reimbursed primary care physicians (PCPs) on a capitated basis. The advantage of an IPA is that contracting with physicians practicing in their own offices allows the HMO to offer services in a broader geographic area, requires less capital investment than a staff or group model HMO of similar size, and generally offers employees more choice among providers.
- *Network Model*—In the network model, HMOs contract with two or more independent physician groups that often provide specialty services as well as general services. The HMO typically pays these groups on a capitated basis, but these groups also spend some time in private practice on a fee-for-service basis.
- *Mixed Model*—A mixed model HMO will initially adapt one type of model, such as a network model, and then expand either its capacity and/or its geographic region at a later date by adding another type of model, such as an IPA.

The financial incentives within a health plan can affect physicians' decision-making process, how that process ultimately affects patients, and the cost of providing health care. Within the network-based models mentioned above, reimbursement schemes have evolved from a salaried or capitated basis to one in which physicians share less of the risk associated with treating patients. In addition, some HMOs use withholding accounts² and bonus programs based on quality of care or productivity to reimburse providers.

² In a withholding account arrangement, a percentage of the payment is withheld until the end of the year. Premiums are set aside in a referral fund that is used to pay for the services of primary care physicians, specialists, hospitals, and outpatient testing. If the referral fund runs a surplus, physicians receive the amount that accumulated in the withholding account. If the referral fund runs a deficit, nothing is returned to the provider.

Preferred Provider Organizations—PPOs are currently the dominant type of health plan. A PPO is a panel of health care providers who individually contract with insurance companies and/or employers to offer health care benefits to their members. PPO network physicians generally do not assume financial risk for the provision of health care services. Typically, PPOs reimburse their physicians on a negotiated fee schedule or a discounted fee-for-service basis. PPO plans choose physicians to fit geographic and specialty areas, often in response to employer requests. Enrollees can receive health care services from PPO (or in-network) providers or non-PPO (or out-of-network) providers, but they face higher cost-sharing requirements when receiving care from a non-PPO provider. While the PPO structure differs greatly from the HMO structure, they both combine three broad cost management strategies: a limited provider panel, negotiated fee schedules, and medical management.

Exclusive Provider Organizations—An exclusive provider organization (EPO) is a plan that limits coverage of nonemergency care to contracted health care providers. It operates similarly to an HMO plan but is usually offered as an insured or self-insured product. Typically, the plan only allows patients to choose medical care from network providers. A patient who elects to seek care outside of the network will usually not be reimbursed for the cost of the treatment. An EPO uses a network of providers and has primary care physicians serving as care coordinators. Typically, an EPO offers physicians financial incentives to practice cost-effective medicine by using a prepaid per-capita rate or a discounted fee schedule, and by providing a bonus if they meet cost targets.

Point-of-Service Plans—POS plans are essentially HMOs that allow participants to choose a provider from outside the list of network providers. Enrollees are required to select a primary care physician. The enrollee's cost-sharing responsibilities vary with the choice of provider—the highest cost sharing is associated with the use of non-network providers. The single major difference between POS plans and HMOs is that POS participants can seek non-network treatment and receive benefits from non-network providers as long as they are willing to accept higher cost-sharing responsibilities. Typically, the costs associated with receiving care from the “in-network” or approved providers are less than those incurred when care is rendered by noncontracting providers. Or the costs are less if the care is received from approved providers in either the HMO or PPO rather than “out-of-network” or “out-of-plan” providers. This is a method of influencing patients to use certain providers without restricting their freedom of choice too severely.

One of the distinguishing features of a network of providers is the way providers are selected. Some plans evaluate candidates against a set of predetermined selection criteria. Providers must be able to achieve the

network's goals for cost control and quality improvement by successfully managing health care delivery. In addition, most networks require providers to agree to accept UR procedures, refer patients only to other providers in the network, and accept the network's reimbursement procedures. Many networks also monitor their providers' practice patterns in order to identify unjustifiably high costs and then alter provider practice patterns through education and financial incentives.

Some employment-based plans use objective information provided by accrediting organizations on the quality of care to identify potential providers for their network. Employers contract with specific networks of health care facilities for high-cost procedures such as open-heart surgeries and transplants. These facilities, commonly known as Centers of Excellence, are selected according to a number of criteria, including experience, efficiency, effectiveness, and outcome measures such as mortality and morbidity rates. Providers have challenged the use of unadjusted outcome measures as criteria for selection because providers with sicker patients will appear to be of poorer quality. In response, health care organizations have developed systems to analyze medical records that attempt to adjust for the severity of case mix. The outcomes achieved by physicians and hospitals can potentially allow health plans and plan sponsors to objectively compare and assess the quality and cost effectiveness of care. Selectively contracting with providers using objective criteria such as these begins for the first time to directly reward providers for low-cost, high-quality health care. This may eventually lead to a reimbursement methodology that rewards population health improvement outcome as opposed to the current system in which rewards tend to be based merely on the amount of service provided.

Consumer-Driven Health Benefits

A number of health policy analysts have suggested that employers are rethinking their entire approach to managing employee health benefits (Fronstin, 2001a; Ogden and Strum, 2001; Salisbury, 1998; Salisbury, 1999; Scandlen, 2000). Terms such as *defined contribution*, *consumer-driven*, and *consumerism* have been used to describe a range of potential health benefit options available to employers. These terms generally refer to programs in which employees are intended to be treated more as *direct purchasers* of health coverage and health care services rather than as the *indirect beneficiaries* of purchases made by the employer. It is assumed that they will be more prudent purchasers and will be more satisfied if they make their own choices rather than having someone else choose for them.

Employers are interested in these health benefits for a number of reasons. First, they continually look for more cost-effective ways to provide

health benefits for their work force, and are concerned about future cost increases; these arrangements would allow them to set a monetary contribution for health benefits regardless of the size of cost increase for providing the benefit. Second, many employers sponsoring health plans are concerned that new restrictions or laws will entangle them in litigation. Employers could distance themselves from health care coverage decisions by limiting their involvement to only the contribution amount for health benefits and not the actual coverage or delivery of the health care services. Third, employers may be able to provide workers more choice, control, and flexibility through these arrangements.

Some employers have turned to, and many others are considering, a trend that started in the 1980s to give employees more choice among different types of benefit arrangements, while at the same time exposing them more directly to the cost of providing health benefits and health care services. These approaches typically expose consumers to more of the costs of their health benefits and the cost of the health care services they use. All strategies to increase consumer involvement in health care spending decisions have a common theme: to shift decision-making responsibility regarding some aspect of health care or delivery from employers to employees. The approaches fall along a continuum of options that employers could use to shift decision-making responsibility. At one extreme, employers can provide an array of plan designs from which employees can choose, as many companies now do. At the other extreme, employers could simply give employees an increase in cash wages and not offer any health plans, allowing the employees to determine how best to spend the money on health insurance and health care services. This section explores the spectrum of health benefit options—of which some are new and are being used, others are not being used, and still others have been used by employers for a number of years—and outlines the issues involved with these options.

Traditional Large-Employer Health Plan Choice Model—In the traditional large employer health plan model, employers usually offer several health benefit options and allow employees to choose among them.³ An employer may offer an HMO, PPO, POS, and consumer-driven health plan (CDHP), allowing employees to choose how they prefer to have the benefits administered, the size of the network of providers, the ability to receive benefits for health care services outside the network, out-of-pocket payments, and the level of premium contribution. Essentially, the employer chooses what plans to offer the employee, who then chooses the plan that seems best.

³The framework for the traditional large employer health plan choice model started in the 1980s with cafeteria plans.

Employers typically establish different employee contribution levels, depending on which options the employees choose and whether they select employee-only coverage or family coverage. According to one survey of employers, 28 percent of establishments surveyed paid a fixed-dollar amount for employee-only coverage for all health benefit options in 1997 (Marquis and Long, 1999). In other words, the employee was required to pay the full price difference between more costly and less costly options. Another 34 percent of employers paid a fixed percentage of the cost for each option, so an employee who chose a more costly option would pay only part of the difference in total cost between that option and a less costly option. Nearly 40 percent of employers fully subsidized the cost difference by either paying the full cost of employee-only coverage for all options or by setting a fixed-dollar contribution from the *employee* that did not vary across plan options.

There are a number of advantages and disadvantages to giving employees more financial responsibility for purchasing more or less costly coverage in the manner discussed above. An advantage of the traditional model is that employees generally think that their employer can do a better job of picking the best available benefits. According to findings from the 2002 Health Confidence Survey, 46 percent of persons with employment-based health insurance were extremely or very confident that their employer had selected the best available health plan for its workers, while 17 percent were not too or not at all confident. In contrast, 37 percent were not too or not at all confident that they could choose the best available health insurance for themselves (Employee Benefit Research Institute et al., 2002).

One disadvantage of this model is that employees actually have little choice in health benefit options and little likelihood of seeing their purchase decision have any impact on the price. According to Claxton et al. (2006), among firms offering health benefits in 2006, 51 percent of covered workers had one plan type; 31 percent had two plan types to choose from; 18 percent had three or more plan types to choose from. Among employees in small firms (3–199 workers), 80 percent had one plan type; 19 percent had two plan types to choose from; just 2 percent had three or more plan types to choose from. In fact, some large employers and employer purchasing groups, such as the California Public Employees' Retirement System (CalPERS), have cut back on choice of health plans.⁴ Employers are making most of the choices for employees by deciding which insurance plans to offer and which benefits to cover in these programs, from the universe of choices available to them. In essence, the employer provides the employee with only “residual choice” to decide in which plan to enroll. Employees might have a greater

⁴ See www.calpers.com/index.jsp?bc=/about/press/archived/pr-2002/april/newhealthrate.xml for additional information on CalPERS.

array of health insurance choices if health insurance coverage were not tied to employment, although choice would vary quite substantially with location.

Another disadvantage of the traditional model, and employment-based health benefits generally, is that health insurance is not portable from job to job. To the degree that plans selectively contract with health care providers, employees and their families may have to change doctors when they change health plans. Employees sometimes forego job opportunities that could potentially increase their productivity, and rewards, in order to preserve existing health insurance benefits—a situation referred to as “job lock.”

There is another way to examine the impact of lack of health insurance portability. The patient-provider relationship may be disrupted if a health care provider leaves a network, forcing employees to change doctors even if they did not change their job or their health plan. The patient-provider relationship may be less of an issue today than it was in the recent past⁵ because health plans often offer out-of-network benefits. When given the choice of health plans, employees can often choose a PPO or POS plan that will pay for health care services provided by doctors not enrolled in the primary network. Employees usually have to meet a deductible before insurance will pay for any out-of-network services and may also be subject to higher coinsurance rates, after the deductible has been met, than when benefits are provided by in-network providers.

Out-of-Pocket Choice Model—Instead of choosing from among different types of health benefit options, employers can provide a standard set of benefits but offer options that vary based on out-of-pocket expenses. For the same benefits package, an employer could offer a combination of different deductible levels, different co-insurance rates for inpatient and outpatient services and for prescription drugs, and different maximum out-of-pocket limits. Employees would “buy” more comprehensive benefits (or reduced cost sharing) by paying a greater share of the monthly premium.

One advantage of this approach is that it allows employees to choose less comprehensive, and presumably, more affordable, benefit packages, without having to make decisions about what health care services are specifically included and excluded from coverage. This approach may result in more workers with *some* health insurance coverage that provides less comprehensive benefit options, such as high-deductible plans; is more affordable; and leads more employers to offer benefits and more employees to take health benefits when they are offered.

A disadvantage of this approach is that healthy employees may be the only ones who choose the less comprehensive benefits, resulting in adverse

⁵ Disruptions to the patient-provider relationship were not an issue at all until the managed care revolution in the 1990s.

selection. Some employees may hesitate to choose less comprehensive benefits if they are risk averse and do not want to incur potentially high out-of-pocket expenses. While employees could presumably take the savings gained from choosing a less comprehensive benefit package and use them when they do need health care services, current tax law does not allow them to save on a pre-tax basis. If it did, this would provide an additional incentive for employees to choose *less* comprehensive plans or plans with potentially higher out-of-pocket costs. Depending upon how employers price the various choices, their savings may not materialize if only non-users of health care services sign up for less comprehensive coverage.

Another disadvantage may be that some employees will be underinsured if they choose a plan with high out-of-pocket expenses. Employees who could not otherwise afford a high deductible may choose such a plan because the premiums are affordable. Enrollees in high-deductible plans may also choose to forgo necessary health care.

Tiered Provider Networks

To give employees more choice among types of health benefit arrangements and health care services, while at the same time exposing them more directly to the cost of those benefits and services, a few employers have turned to, and many others are considering, tiered networks for hospital and physician services. After a couple of years of experience with tiered co-payments and networks for prescription drug benefits, insurers and employers have begun to see the value in tiered networks for physician and hospital services as well. The impetus for tiered hospital networks came from the increased bargaining power that hospitals gained as the number of hospitals and hospital beds declined and the patient population grew. According to Robinson (2003), some hospitals are now willing and able to walk away from contracts with insurers unless reimbursement rates are increased and utilization review constraints are decreased. In fact, according to the American Hospital Association, the average number of managed care contracts per hospital declined between 1997 and 2001.

Under a tiered provider network benefit structure, employees pay different cost-sharing rates for different tiers of providers. For example, a provider may be in the lowest-priced tier if it is the lowest-cost provider, and may be in the highest-priced tier if it is the highest-cost provider. Tiers could also be assigned based on the size of the discount obtained from the provider. Quality measures may also be used to assign providers to various tiers. Tiered provider networks are essentially a variation of a long-standing practice of providing one level of benefits to employees who use in-network providers and another level of benefits for use of out-of-network providers.

Tiers make cost differences among providers more transparent to consumers and are a way to expose consumers to the actual cost of services, allowing them to decide whether a higher-cost provider merits the additional out-of-pocket expense (Yegian, 2003).

Insurers and employers can use tiers to distinguish among different types of hospitals or providers. Providers could be tiered according to the prices that they charge or the quality of care that they provide. One advantage of such an approach is to make employees more aware of the cost and quality implications of their decision to use providers in the various tiers. A disadvantage of this approach is that employees may choose the lowest-cost tier even when they may get better-quality health care services in a more costly tier.

Rather than threaten to exclude a hospital entirely from its health benefits program, an employer can offer tiered provider networks as a “next-generation” way to leverage favorable cost experience from hospitals. Since employees have the option to use the more expensive hospitals and providers (albeit under less favorable payment conditions for the employee), this type of approach may cause less friction with employees and providers than entirely excluding providers from a plan. Under a tiered provider network benefits package, health care providers are typically separated into different tiers, with the tiers being based on some combination of cost and quality.

For instance, under one scenario, tier 1 providers, thought to have the lowest cost and highest quality, would have the lowest cost sharing for health care services, while tier 2 would have much higher cost sharing. Differences in cost sharing could be applied to either per-day or per-visit copayments, overall coinsurance, or even deductibles. For example, with hospital tiers, employees may face a \$0 per day copayment for tier 1 hospitals and a \$200 per day copayment for tier 2 hospitals. Alternatively, employees may face 10 percent coinsurance for tier 1 hospitals and 30 percent coinsurance for tier 2 hospitals, or they may face no deductible for tier 1 hospitals and a \$1,000 deductible for tier 2 hospitals.

The tiered provider network concept is relatively new for hospital services, but employees may already be used to it, especially in preferred provider organizations (PPOs) and point-of-service (POS) health plans, which subject them to lower out-of-pocket expenses when they choose in-network doctors (or hospitals) over out-of-network doctors (or hospitals).⁶ However, from the point of view of insurers and employers, tiered provider networks are fundamentally different from the combined in-network and

⁶Traditional HMOs also provide a form of tiered benefits. HMOs typically provide very comprehensive coverage when employees use in-network providers. In contrast, there are usually no benefits when employees use unapproved out-of-network providers.

out-of-network benefit structures. Under a tiered provider network, all providers can have a contract with the insurer or health plan. The terms of the contract may differ depending upon the cost of providing care and other factors. In contrast, under a PPO or POS plan with out-of-network benefits, out-of-network doctors do not have a contract with the insurer or employer. This means that payers are billed at and responsible for paying prevailing charges at different benefit levels.

Employers and insurers are particularly interested in tiered networks to control spending on hospital services. While for many years hospitals had a major surplus in the number of available beds, today there is much less excess capacity because of consolidation, fewer hospitals, fewer beds, and population growth. As noted above, hospital bargaining power over prices has increased, resulting in higher costs to insurers and employers, and, ultimately, higher premiums. Some hospitals have used their clout, especially those in small markets dominated by a single facility or in large markets dominated by hospital systems, by threatening to walk away from contracts with managed care plans (Robinson, 2003).

Tiered provider networks allow employers and insurers to include all or most hospitals and health systems in their plan, thereby allowing them to move away from limited provider networks that are characteristic of many traditional HMOs. In the 1990s, employers attempting to attract and retain workers in a tight labor market characterized by increasing wages moved away from relatively more restrictive to less restrictive managed care plans. Since tighter-managed HMOs had to compete against more flexible PPOs, many of the more tightly managed plans opened their networks to more providers. In many areas, distinctions between plans could no longer be made by comparing the selection of providers in each network, since providers were contracting with nearly every network. Tiered provider networks are one way to make distinctions between providers when all or most have network contracts.

Similarly, tiered provider networks could also allow employers and insurers to address their concerns about any-willing-provider (AWP) laws. In a number of states, providers cannot be prohibited from joining a network if they are willing to accept the terms of the network. Tiered provider networks would allow employers and insurers to make distinctions between providers in states that have AWP laws.

Tiered provider networks can also benefit consumers by giving them more choice of providers, especially when it comes to hospital care. Hospitals formerly not in a network may now be included in the offering, but at higher cost sharing. In fact, one goal of tiered provider networks is to allow consumers to see any provider that they choose, with their out-of-pocket costs determined by their choice of provider.

In some sense, tiers build upon the selective contracting foundation of managed care and HMOs. One of the distinguishing features of a network of providers is the way the network selects its providers. Some networks evaluate candidates against a set of predetermined selection criteria. In the early HMO and managed care models, providers that met the predetermined selection criteria were able to be part of the network. Today, with tiered provider networks, all providers can be part of the network, but within the network, the predetermined selection criteria can be used to determine the providers' tier and, therefore, the consumers' cost sharing.

The introduction of tiered provider networks is part of a larger movement to sensitize employees to the real cost of health care. Many employers expect that consumerism generally will result in a decrease in their own health benefit costs.⁷ However, it is unrealistic to expect a decrease in health care costs to occur immediately. Twenty percent of the population accounts for 80 percent of the spending (Fronstin, 2002), and new benefit designs will need to focus on the highest-cost users to have an impact in the short run. It may be found that the tiered hospital network is better than other benefit package changes at controlling costs and utilization in the short run because it targets high-cost users more than it targets the general population. However, as mentioned above, modest out-of-pocket payment differences between tier 1 and tier 2 hospitals may have very little, if any, impact on consumer behavior. In the long run, data and information on prices and quality should be more readily available to the general population, and should begin to affect other aspects of health care utilization.

The extent to which tiering incentives will impact consumers' behavior is still unknown. It is clear that one of the goals of tiered provider networks is to provide financial incentives for consumers to use lower-cost and/or higher-quality health care providers. By exposing members to higher out-of-pocket expenses, they will have more of an incentive to become engaged in the process of provider and treatment selection. This may provide additional pressure on hospitals and physicians to disclose information about costs and performance. However, while there is little evidence that tiering has had an effect on consumer choice between in-network and out-of-network physician care and prescription drug choice, it is unknown how large the difference in out-of-pocket payments would need to be before a significant number of consumers factor price into their hospital choices (Robinson, 2003). In fact, the difference in out-of-pocket payments may need to be substantial to generate changes in consumer behavior because inpatient services tend to be

⁷ Mercer Human Resource Consulting (2002) reports that about one-half of employers responding to a recent survey reported that lowering health benefit costs was an important objective for offering a consumer-driven health plan.

price inelastic, although employers may realize some savings even if only a few consumers change their behavior and choose tier 1 providers. Consumers may be constrained by factors other than price from using certain hospitals. They rely heavily on their physicians for treatment advice and may be unwilling to use a hospital in a different geographic region, where their physician does not have admitting privileges, to save a modest amount of money.

It is also unknown how tiering will impact the behavior of providers. Tiered provider networks may result in providers renegotiating contracts if they are sensitive to being in the highest-cost tier. Some providers may view being in the higher-cost tier as driving patients to lower-cost providers and may take steps to renegotiate contracts to become tier 1 providers. Other providers may view being in the higher-cost tier as an indication that they are a high-quality provider and may use that to differentiate themselves from tier 1 providers. Tiered networks for hospitals, if associated with quality information, may also result in increasing physician knowledge about hospital quality differences, which may affect physician affiliations and recommendations of hospitals, thereby improving quality.

Tiered networks may also increase the amount of uncompensated care, such as bad debt and charity care that is provided by hospitals. As consumers' out-of-pocket expenses increase, there may be an increase in bad debt in the form of uncompensated care. Providers, especially hospitals, may look at ways in which they can collect a patient's out-of-pocket payment at the time of service. Hospitals and physicians may respond by reducing the amount of charity care that they provide in order to offset the increase in bad debt.

There may also be less integration of health care for consumers in tiered networks. Presumably, consumers will "shop" based on cost and quality. In some cases, this will mean that consumers will move among providers to contain their costs. This may increase total spending if, for example, consumers do not bring their medical records and the results of prior tests to new providers and those providers request new tests. Health spending may increase and quality of care may decrease if patients have less attachment to providers, and providers either do not know or have a history of a patient's total care and either request new tests or simply need more time to educate themselves about their new patients.

Finally, tiered networks may have unanticipated effects on academic medical centers (AMCs). AMCs provide medical education and training and conduct research on new medical practices and technologies. AMCs also provide health care services to the poor and medically indigent. This care is financed through cross-subsidies from private- and public-paying patients, and is also subsidized by state and local governments. AMCs have in the past provided twice as much uncompensated care (as a percentage of revenue) as nonacademic medical centers (Reuter and Gaskin, 1998). As a

result, AMCs are usually the most expensive source of health care and are unable to compete on price. Tiered networks based on cost will likely place AMCs in the higher-cost tier. This will drive private-pay patients toward lower-cost nonacademic medical centers. In turn, AMCs will see an increase in bad debt and charity care (as a percentage of revenue) and may put pressure on policymakers to increase public sources of financing. Tiered networks that essentially steer private-pay patients away from AMCs may therefore have the effect of increasing taxes, increasing the use of tax revenue for hospital services (at the expense of other services), or causing fewer uninsured patients to receive care, which may cost society more money in the long run.

Account-Based Health Plans

There are a number of accounts that employees and employers can contribute to, using pre-tax dollars, to save money for future health care bills. The theory behind these accounts is that by giving employees more control over funds allocated for their health benefits they will spend the money more responsibly, especially once they become more educated about the actual cost of health services. Prior research has shown that individuals respond to increased out-of-pocket payments by reducing their utilization of health care services, although according to Tollen and Crane (2002), these studies are dated and do not accurately reflect current employee responses to increased cost sharing and less comprehensive benefits. However, a recent study did find that Medicare beneficiaries will forgo medically necessary drugs when out-of-pocket costs for these drugs increase (Adams et al., 2001). This concept is known as *moral hazard*—meaning individuals demand a greater quantity of health care services when health insurance pays for at least part of the cost of receiving care. Whether health spending accounts provide an incentive for employees to consume health care services differently, and reduce the prevalence of moral hazard, is a subject of debate and is discussed further below.

Health Savings Account—A health savings account (HSA) is a tax-exempt trust or custodial account that an individual can use to pay for health care expenses. Contributions to the account are deductible from taxable income, even for individuals who do not itemize their taxes, and tax-free distributions for qualified medical expenses are not counted in taxable income. Tax-free distributions are also allowed for certain premiums.

HSAs are owned by the individual with the high-deductible health plan and are completely portable. There is no use-it-or-lose-it rule associated with HSAs, as any money left in the account at the end of the year automatically rolls over and is available in the following year. A bank, insurance company,

or other non-bank trustee approved by the Internal Revenue Service (IRS) must trustee the HSA.

HSAs were first introduced by a select number of insurers in January 2004. Employers waited for Treasury Department and IRS guidance (discussed in more detail below) before offering a plan. Many employers began to offer HSAs in 2006, as it was too late for most employers to design and implement a new plan in time for the 2005 open enrollment season during the fall of 2004.

High-Deductible Health Plan—In order for an individual to qualify for tax-free contributions to an HSA, the individual must be covered by a health plan that has an annual deductible of not less than \$1,100 for self-only coverage and \$2,200 for family coverage in 2008. Certain preventive services can be covered in full and are not subject to the deductible. The out-of-pocket maximum may not exceed \$5,600 for self-only coverage and \$11,200 for family coverage, with the deductible counting toward this limit. The minimum allowable deductible and maximum out-of-pocket limit will be indexed to inflation in the future. Network plans may impose higher deductibles and out-of-pocket limits for out-of-network services.

Contributions To an HSA—Both individuals and employers are allowed to contribute to an HSA. Contributions are excluded from taxable income if made by the employer, and deductible from adjusted gross income if made by the individual. The maximum annual contribution is \$2,900 for self-only coverage and \$5,800 for family coverage in 2008. Future contribution limits will be indexed to inflation.⁸

To be eligible for an HSA, individuals may not be enrolled in other health coverage, such as a spouse's plan, unless that plan is also a high-deductible health plan. However, individuals are allowed to have supplemental coverage without a high-deductible for such things as vision care, dental care, specific diseases, and insurance that pays a fixed amount per day (or other period) for hospitalization.⁹ Individuals enrolled in Medicare are not eligible to make HSA contributions, although they are able to withdraw money from the HSA for qualified medical expenses and certain premiums.¹⁰ Individuals also may not make an HSA contribution if claimed as a dependent on another person's tax return.

⁸The maximum annual contribution is actually the sum of the limits that are determined separately for each month. The monthly contribution limit is $\frac{1}{12}$ of the lesser of the annual deductible or the maximum annual contribution. If an individual first becomes covered by a high-deductible health plan mid-year, the annual contribution is pro-rated, and the monthly contribution limit is based on the number of full months of eligibility. As an example, an individual who enrolled in a plan on July 1 with a \$1,100 deductible would be eligible to contribute one-half ($\frac{6}{12}$) of the annual maximum contribution or \$550 to the HSA.

⁹Permitted insurance also includes workers' compensation, tort liabilities, and liabilities related to ownership or the use of property (such as automobile insurance).

¹⁰Only Medicare enrollees ages 65 and older are allowed to pay insurance premiums from an

Individuals who have reached age 55 and are not yet enrolled in Medicare may make catch-up contributions. In 2008, a \$900 catch-up contribution was allowed. A \$1,000 catch-up contribution will be phased-in by 2009.¹¹

Distributions From an HSA—Distributions from an HSA can be made at any time as long as the expense was incurred after the HSA was established. An individual need not be covered by a high-deductible health plan to withdraw money from his or her HSA (although the individual must have been covered by a high-deductible health plan at the time the funds were placed in the HSA). Distributions are excluded from taxable income if they are used to pay for qualified medical expenses as defined under Internal Revenue Code (IRC) Sec. 213(d). Distributions for premiums for COBRA, long-term care insurance, health insurance while receiving unemployment compensation, and insurance while eligible for Medicare other than for Medigap, are also tax-free. This means that distributions used to pay Medicare Part A or B, Medicare Advantage plan premiums, and the employee share of the premium for employment-based retiree health benefits are allowed on a tax-free basis.

Distributions for nonqualified medical expenses are subject to regular income tax as well as a 10 percent penalty, which is waived if the owner of the HSA dies, becomes disabled, or is eligible for Medicare.

Individuals are able to roll over funds from one HSA into another HSA without subjecting the distribution to income and penalty taxes as long as the rollover takes place within 60 days. Rollover contributions from Archer MSAs are also permitted. Earnings on contributions are also not subject to income taxes.

Health Flexible Spending Accounts (FSAs)

Health flexible spending accounts (FSAs) are a type of cafeteria plan benefit, authorized under Sec. 125 of the IRC as part of the Revenue Act of 1978. FSAs can be offered on a stand-alone basis or as part of a larger cafeteria plan, under which participants can choose among two or more benefits and cash. FSAs are perhaps the most well-known type of health spending account. Eighty-one percent of employers with 500 or more employees offered FSAs in 2006 (Mercer Human Resources Consulting, 2007). FSAs are a simple and inexpensive way of allowing employees to use pre-tax dollars to pay for health care services not covered by health insurance. Employers have often introduced or expanded these plans to soften the impact of a benefit reduction, such as an increase in the deductible or co-payments. FSAs do not

HSA. A Medicare enrollee under age 65 cannot use an HSA to pay insurance premiums.

¹¹The catch-up contribution is not indexed to inflation after 2009.

need to be paired with a high-deductible health plan. Individuals are eligible for an FSA only if an employer offers it as an option.

Contributions To an FSA—FSAs typically are funded through employee pre-tax contributions. Employees must designate their contribution in the year prior to the plan year. Once made, changes are allowed only for certain circumstances, such as a change in family status, plan cost changes, and plan coverage changes. Contributions to FSAs are withheld in equal amounts from each paycheck throughout the plan year, but employers must make the full amount available to the employee at the beginning of the plan year. For example, an employee who chooses to contribute \$1,200 to an account will have \$100 deducted from his or her paycheck each month, but will have access to the full \$1,200 at the beginning of the plan year. If an employee is reimbursed more than he or she has contributed to the account, and then leaves the job, the employer will lose money on the arrangement. This rule is a disincentive for a small employer to offer such an account. While there is no statutory limit on annual contributions to a health FSA, employers are allowed to set an upper limit, and usually do so to mitigate losses related to turnover.

Contributing to an FSA not only reduces salary for federal income tax purposes, but also reduces the wages on which Social Security and Medicare taxes are paid. As a result, employees with earnings below the Social Security wage base (\$97,500 in 2007) will also pay less in Social Security taxes, after the deduction is made for FSA contributions. Employees at all income levels will also pay less in Medicare taxes. The employer's share of Social Security and Medicare taxes will also be reduced, and this reduction may in fact be large enough to offset the cost of administering the benefit.

Distributions From an FSA—Distributions from an FSA can be made at any time during the plan year or, if the employer has adopted one, a grace period of up to 2½ months following the plan year's end. Distributions are excluded from taxable income if they are used to pay for qualified medical expenses as defined under IRC Sec. 213(d).

Employees forfeit any money left over in the FSA at the end of the plan year; this is known as the "use-it-or-lose-it" rule. Employers can keep the forfeited funds and use them for any purpose, except that the funds cannot be returned to employees who have forfeited them. Employers typically use the forfeited funds to offset losses or to offset the cost of administering the benefit. The forfeiture of unused funds may partially explain why only 19 percent of eligible employees participate in these plans (Mercer Human Resources Consulting, 2004).

Employees also tend to make conservative contributions when participating. In 2006, the average contribution was \$1,261 (Mercer Human Resources Consulting, 2007). While some would argue that the use-it-or-

lose-it rule provides an incentive for employees to spend the balance of their account on health care services to avoid losing the funds at the end of the year, this may not be the case, as it appears that employees are conservative in both their participation and contribution levels.

There is some evidence to suggest that much of an employee's FSA election amount is based on foreknowledge of expenditures. Cardon and Showalter (2001) examined 1996 data from an insurer and found that very few accounts had a substantial amount forfeited and also found that participants tend to use their accounts strategically, spending their election amount relatively early in the plan year.

Health Reimbursement Arrangements (HRAs)

A health reimbursement arrangement (HRA) is an employer-funded health plan that reimburses employees for qualified medical expenses. IRS Revenue Ruling 2002-41 and Notice 2002-45 (published in *Internal Revenue Bulletin* 2002-28, dated July 15, 2002) provide guidance clarifying the general tax treatment of HRAs; the benefits offered under an HRA; the interaction between HRAs and cafeteria plans, FSAs, and coverage under COBRA; and other matters under current law.¹² HRAs are typically combined with a high-deductible health plan, though this is not required. HRAs can also be offered on a stand-alone basis or with comprehensive insurance that does not use a high deductible. Employees are eligible for an HRA only when their employer offers such a health plan.

HRAs are typically part of a health benefits package that includes comprehensive health insurance after a deductible has been met. As an example, an employer may provide a comprehensive health insurance plan with a high deductible, for instance, \$2,000. In order to help employees pay for expenses incurred before the deductible is reached, the employer would also provide a HRA with \$1,000 that they would use to pay for the first \$1,000 of health care services. While the actual deductible is \$2,000, in this example, because the employer provides \$1,000 to an account, employees are subject only to the \$1,000 deductible gap—that is, the difference between the initial value of the HRA and the deductible level. After the employees' expenses reach the deductible, comprehensive health insurance would take effect. Employers can also set up an HRA to allow employees to purchase health insurance directly from an insurer. Generally, distributions are excluded from taxable income if they are used to pay for qualified medical expenses as

¹² See www.irs.gov/pub/irs-utl/revrul2002-41.pdf and www.irs.gov/pub/irs-drop/n-02-45.pdf (last reviewed July 2004).

defined under IRC Sec. 213(d), although employers can place restrictions on the use of an HRA.

Employers have a tremendous amount of flexibility in designing health plans that incorporate an HRA. For example, the amount of money that is placed in the account, the level of the deductible, and the comprehensiveness of the health insurance are all subject to variation. Employers often cover certain preventive services in full, not subjecting them to the deductible. Employers can offer comprehensive health insurance that covers 100 percent of health care costs after the deductible has been met or they may offer coverage with cost sharing after the deductible is met. If employers choose to pay less than 100 percent of health care expenses after the deductible has been met, they then have the option of designing the plan with or without a maximum out-of-pocket limit.

Employers can also vary employee cost sharing based on in-network visits and out-of-network visits. Employers may choose to pay 100 percent of health care consumed after the deductible has been met for employees who use network providers, but pay only 70 percent or 80 percent if employees use an out-of-network provider.

High-Deductible Health Plan—There is no statutory requirement that an employee have a high-deductible health plan in order to also have an HRA. However, it is standard practice among employers that an employee must also choose a high-deductible health plan in order to have an HRA. Overall, just 6 percent of large employers offered a plan with an HRA in 2006 (Mercer Human Resources Consulting, 2007), but offer rates were much higher among the largest employers, with 21 percent of those with 20,000 or more employees offering a plan in 2006, up from 7 percent in 2002. Since so few employers offer an HRA, there is not a wealth of data on deductibles and employer contributions. One study examined 128 plans to get a sense of the magnitude of deductibles and contributions and found that the median deductible for employee-only coverage was \$1,250 with a \$500 employer contribution to the HRA (Mercer Human Resource Consulting, 2007). This study found a median deductible of \$3,000 for family coverage with a \$1,500 employer contribution to the HRA. The study also found 32 percent of eligible employees enrolled in a CDHP with HRA among large employers.

Contributions To an HRA—HRAs are typically set up as notional arrangements and exist only on paper. Employees behave as if money were actually funding an account, but employers do not incur expenses associated with the arrangement until an employee incurs a claim. By contrast, were employers to set up the HRA on a funded basis, they would incur the full expense at the time of the contribution, even if an employee had not incurred any expenses.

Rollovers—HRAs can be thought of as providing “first-dollar” coverage until funds in the account are exhausted. Leftover funds at the end of each year can be carried over to the following year (at the employer’s discretion), allowing employees to accumulate funds over time, and, in principle, creating the key incentive for individuals to make health care purchases responsibly. Employers can place restrictions on the amount that can be carried over. One feature of HRAs is that when unused funds are carried over each year, employees may be able to accumulate enough funds in their accounts to satisfy their deductible in future years. In addition, as employees build account balances, they may be more likely to switch to higher deductible health plans in the future. However, employees may also choose to forgo necessary health care in order to accumulate funds in the account. Ultimately, the amount of money in the account will be a function of how long persons have had an account, use of health care, and the size of the annual contribution. Funds in the HRA can accumulate tax-free as long they remain employer-provided funds paid out only for qualified medical expenses.

Distributions From an HRA—Distributions from an HRA for qualified medical expenses are made on a tax-favored basis. Employers can also let employees use an HRA to purchase health insurance directly from an insurer. Since unused funds are allowed to roll over, employees are able to accumulate funds over time. Employers can allow former employees to use any leftover money in the HRA to continue to cover qualified medical expenses. Funds can be used for out-of-pocket expenses and premiums for insurance, long-term care, COBRA, and retiree health benefits. Employers are not required to make unused balances available to workers when they leave.

Medical Savings Accounts (MSAs)

A medical savings account (MSA) is a tax-exempt trust or custodial account that an individual can use to pay for health care expenses. MSAs were first authorized as a demonstration project under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Employees are eligible to set up an MSA if employed at a firm with 50 or fewer employees. The self-employed are also eligible. Both must be covered by a high-deductible health plan.

High-Deductible Health Plan—In order for an individual to qualify for tax-free contributions to an MSA, the individual must be covered by a health plan that has an annual deductible of between \$1,900 and \$2,850 for self-only coverage and between \$3,750 and \$5,650 for family coverage. Certain preventive services can be covered in full and are not subject to the deductible. The out-of-pocket maximum may not exceed \$3,750 for self-only

coverage and \$6,900 for family coverage. The allowable deductible range and maximum out-of-pocket limit are indexed to inflation.

Contributions To an MSA—Both employees and employers are allowed to contribute to an MSA, but both may not make contributions in the same year. Contributions are excluded from taxable income if made by the employer, and deductible from adjusted gross income if made by the individual. The maximum contribution for self-only coverage is 65 percent of the deductible in 2007. The maximum contribution for family coverage is 75 percent of the family deductible. Contributions cannot exceed annual earned income or net self-employment income.

Distributions From an MSA—Distributions are excluded from taxable income if they are used to pay for qualified medical expenses as defined under IRC Sec. 213(d). Distributions for premiums for COBRA, long-term care insurance, and health insurance while receiving unemployment compensation are also tax-free.

Distributions for nonqualified medical expenses are subject to regular income tax as well as a 15 percent penalty, which is waived if the owner of the MSA is age 65 or older, becomes disabled, or dies.

Connector/Exchange Model

Under a connector or exchange model, employers would provide employees with a voucher or fixed contribution to purchase health insurance coverage directly from an insurer. Vouchers would allow employees to continue to benefit from the tax-exempt status of employer spending on health care.

Employees would be able to choose from any health insurance offered in the individual market.¹³ An employee who chooses an insurance policy that costs more than the voucher value would have to pay the difference. If the employee chooses a plan that costs less than the value of the voucher, the difference could be “refunded” to him or her using after-tax dollars.

There are a number of advantages to a voucher model. It could potentially allow employees to choose from a wider selection of health insurance policies, and choose a policy that meets their needs. Policies could vary by their network of providers, the benefits covered, and cost-sharing arrangements. The degree of variation would be a function of how strongly states regulate the benefits package. If a state allows insurers to sell products with different benefit packages, for instance, by allowing insurers to offer products that exclude prescription drug, hearing, vision, or substance abuse benefits,

¹³ A voucher model could also apply to some type of non-employment-based group model. For more information about this arrangement and defined contribution health benefits, see Fronstin (2001a).

then employees would be able to choose from among those plans. However, in states with a relatively large number of benefit mandates, employees' choice among plans that cover different benefits would be limited. It is likely that they would have greater flexibility in choosing a combination of deductibles, co-insurance, and maximum out-of-pocket payments. The voucher model could also reduce job lock if many employers adopted it.

One obvious disadvantage of the voucher model is that, currently, individual health insurance is far more expensive and difficult to obtain than group health insurance obtained through employment (this is discussed further below). Another potential disadvantage is that marketing costs would be higher, driving up the cost of providing insurance to a level comparable with that offered in the group market. Employers might then have a difficult time convincing employees that the voucher is of more value than traditional health benefits. They might also feel obligated to adjust the value of the voucher by age and sex to reflect differential rates on the individual market, raising issues of equity in benefits. Another disadvantage is that while it might increase choice of *products*, a voucher model might not necessarily increase choice of *insurer*. While persons in large states and large metropolitan areas might be able to choose from 20 or more insurers, persons in small states could have very few options. For example, in some New England states, individual purchasers of health insurance have a handful of choices. In the state of Vermont, for example, one insurer offers HMO coverage in the individual market but two offer traditional indemnity coverage.¹⁴ While employees may not have a large choice of insurers or health plan options in the individual market today, were employers to move toward a voucher model, more insurers might consider offering coverage in the individual market.

The success of a voucher model in providing health insurance coverage to Americans would ultimately depend on a number of factors, including whether the voucher is large enough for employees to purchase a plan that they value and whether they would be able to pay the difference between the voucher amount and the cost of the health insurance. If employers provide vouchers that are large enough for employees to purchase health insurance that they value, employees likely would be generally satisfied with the program. If, over time, the value of the voucher erodes relative to the cost of purchasing health insurance, some employees would drop health insurance coverage. Ultimately, if employees face experience-rated premiums and employers offer community-rated vouchers, employees at high risk of

¹⁴ *Consumer Tips: Shopping for Individual or Small Group Health Insurance in Vermont, January 2007*, published by the Division of Health Care Administration. www.bishca.state.vt.us/HcaDiv/consumerpubs_healthcare/shopping_indiv-smallgroup_jan07.pdf (last reviewed June 2007).

needing health care services may not be able to afford to purchase health insurance coverage. In other words, if premiums vary by certain characteristics, such as age and health status, but vouchers do not vary by these same characteristics, then the premiums could greatly exceed the value of the vouchers for some employees. If voucher programs are seen as the cause of increases in the uninsured, policymakers might intervene with solutions that are less appealing to employers than simply offering comprehensive health benefits.

Massachusetts is currently making available a connector model for small business and other states are considering them, most notably California.

Conclusion

There is strong interest among employers (and unions) in redesigning health benefit programs in response to rising costs. Some employers (sometimes in conjunction with a union) have turned to, and many others are considering, a concept called *consumer-driven health benefits*, a term used to describe a wide range of possible approaches to give consumers more control over some aspect of either their health benefits or health care. A movement to consumer-driven health benefits has implications for health benefit costs, utilization of health care services, quality of health care, the health status of the population, risk selection, and efforts to expand health insurance coverage. Ultimately, the success or failure of the consumer-driven health benefits approach will be measured by its effect on the cost of providing health benefits and on the number of people with and without health benefits.

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PART FOUR
OTHER BENEFITS

CHAPTER 30

OVERVIEW OF OTHER BENEFITS

Introduction

Many employers offer employees a large array of benefits, in addition to retirement and health benefits, to meet the changing needs of the nation's work force. Some of these benefits, such as group life insurance, employee assistance programs, and paid leave, have been staples of the voluntary U.S. benefit system for decades. Employers have added others, including education assistance, group legal plans, and dependent care, as the nature of the U.S. work force has changed.

In addition to these voluntary benefits, the federal government requires employers to provide coverage for various services. Income in retirement is provided for retirees and their spouses through Social Security's Old-Age and Survivors' Insurance (OASI) program. Income protection for loss of income due to a disabling condition is provided through Social Security's Disability Insurance (DI) program. Provision of health insurance coverage for the elderly and disabled is provided through Social Security's Medicare program. Insurance against involuntary unemployment is required by the federal government through the unemployment insurance program.

Disability Benefits

In the event that an employee suffers an injury and is unable to perform his or her job for a period of time, there are a number of mandatory and voluntary disability insurance programs to help the employee through a financially difficult time.

Voluntary Programs—Employers offer two types of voluntary disability programs: short-term and long-term disability insurance. If an employee sustains an injury of short duration—typically up to six months—and is unable to perform the duties of his or her current position, a short-term disability program will replace a portion of an employee's predisability earnings. The typical replacement rate is anywhere from one-half to two-thirds of the employee's predisability weekly earnings. If the injury or illness is severe enough to keep the employee out of work for longer than six months, a long-term disability program will replace a portion of his or her predisability earnings. Most plans replace 60 to 70 percent of the predisability earnings. If the disability last more than two years, the definition of disability changes

to the inability to perform any occupation that the person is reasonably suited to do by training, education, and experience.

Mandatory Programs: Workers' Compensation—If an employee suffers an injury or illness while at work, and the condition is a direct result of performing his or her job duties, the workers' compensation program will cover the related medical expenses and provide income replacement while the employee is out of work. In exchange for these benefits, employees who receive workers' compensation benefits are generally not allowed to file lawsuits against their employers for damages of any kind.

Mandatory Programs: Social Security Disability—If a worker suffers a disability that is severely impairing, mentally or physically, such that he or she cannot perform any substantial gainful work, and the impairment is expected to result in death or to last for a continuous period of not less than 12 months, the worker will qualify for the Social Security disability program. Created in 1956, Social Security disability was originally open only to workers age 50 or older. The program was expanded over the years to cover all workers and dependents of disabled workers (U.S. Social Security Administration, 2006).

Group Life Benefits

Many employers provide death benefits for survivors of deceased employees. There are two types of plans designed specifically for this purpose: group life insurance plans, which normally make lump-sum payments to a designated beneficiary or beneficiaries, and survivor income plans, which make regular (usually monthly) payments to survivors. Additionally, benefits may be paid to survivors from other employee benefit plans (e.g., profit-sharing, thrift savings, and pension plans). Survivor benefits are also available through the Social Security program.

The contract between the insurance company and the employer is usually for *group term* life insurance. Many associations and multi-employer plans also provide group term life benefits.¹ The word *term* means that the coverage is bought for a specific time period (usually one year), with a renewable provision, and remains in effect only as long as premiums are paid. It also may be referred to as *yearly* or *annual renewable term*. Term insurance has no savings features and no buildup of cash value. It is pure insurance protection, paying a benefit only at death.

Group universal life programs (GULPs), first introduced in 1985, developed from individual universal life policies (UL). UL is issued on an

¹ Other major types of group life insurance are permanent forms, including paid-up and ordinary life insurance. For more information on these two other types, see Rosenbloom, 2005. Since term insurance is the most popular group coverage, this chapter will focus primarily on group term life insurance.

individual basis, whereas GULP coverage is available on a group basis. GULP plans may supplement a regular group term life insurance plan or may exist as stand-alone plans.

GULPs combine group term life insurance with a savings element or cash accumulation feature. This investment element can be used to create nontaxable permanent insurance or to accumulate savings. GULPs are made available to employees by an employer to which a master policy has been issued, and employees pay the entire premium.

Unemployment Insurance

The Social Security Act of 1935 created the Federal-State Unemployment Compensation Program. The program has two main objectives: 1) to provide temporary and partial wage replacement to involuntarily unemployed workers who were recently employed; and 2) to help stabilize the economy during recessions (U.S. Congress, 2004). The Federal Unemployment Tax Act of 1939 (FUTA) and titles III, IX, and XII of the Social Security Act form the framework of the system.

FUTA currently imposes a 6.2 percent gross tax rate on the first \$7,000 paid annually by covered employers to each employee. States may have a higher taxable wage base than the federal requirement of \$7,000. As of January 2008, 43 states had a taxable wage base higher than the federal level, ranging up to \$32,200 in Idaho (U.S. Department of Labor, 2008). Employers in states with programs approved by the federal government and with no delinquent federal loans may credit 5.4 percentage points against the 6.2 percent tax rate, making the minimum net federal unemployment tax rate 0.8 percent. Since all states have approved programs, 0.8 percent is the effective federal tax rate (U.S. Congress, 2004).

In 1976, Congress passed a surtax of 0.2 percent of taxable wages to be added to the permanent FUTA tax rate. Thus, the current effective 0.8 percent FUTA tax rate has two components: a permanent tax rate of 0.6 percent, and a surtax rate of 0.2 percent. The surtax has been extended five times, most recently by the Taxpayer Relief Act of 1997, which extended it through Dec. 31, 2007 (U.S. Congress, 2004).

In order for a worker to receive unemployment compensation, he or she must have earned a certain amount of qualifying wages. In most states, this is defined as earnings in the first four of the last five completed calendar quarters. The purpose of this requirement is to limit unemployment compensation to individuals with a current attachment to the labor force. Most states require a worker to meet a one-week waiting period before his or her first benefit payment. The worker must be able and available for work, actively seeking work, and free of any disqualifying event. A disqualifying

event is defined as quitting employment voluntarily, discharge for misconduct, refusal of suitable work, or being part of a labor dispute.

Paid Leave

Paid vacations allow workers a specified amount of leisure time to use at their discretion. The length of vacation time generally increases with tenure. Leave policies provide time off for holidays; enable workers to take leave for military-duty, funerals, and the birth or adoption of a child; and provide time off for workers who have short or long periods of illness.

To assist employees in balancing work/life conflicts and reduce their growing use of unscheduled leave, employers are increasingly turning to paid time off (PTO) banks. In short, a PTO bank combines separate vacation, personal, and sick leaves into one comprehensive plan that allows the employee the flexibility to use leave for any reason. This eliminates the stress an employee may experience when, for instance, he or she feels obliged to take sick leave inappropriately to deal with a personal situation such as attending a parent-teacher conference. According to Hewitt Associates, in 2006 between 22 percent and 32 percent of the surveyed programs are PTO banks (Hewitt Associates, 2006).

Lifestyle Benefits

As the evolution of the work force continues, lifestyle benefits, such as employee assistance programs, legal services, dependent care, and education assistance, have grown in popularity among workers and some employers.

Employee Assistance Programs (EAPs)—EAPs provide counseling services directed toward acute problems that affect job performance. These programs were originally designed to identify and address the problem of employee alcoholism (and later drug abuse). Today, alcoholism and drug abuse continue to be a major focus of many EAPs. However, counseling is also being offered on stress management, family and marital problems, work place violence, pressures from child and elder care responsibilities, and coping with the effects of company downsizing.

Group Legal Services—Employed persons usually do not qualify for legal aid or the services of public defenders. As a result, most employed people tend to postpone seeking legal information and assistance until their needs become acute and, typically, more costly, according to the American Bar Association (ABA).

Legal services plans primarily provide preventive assistance by making legal information and advice readily available to workers. By preventing disputes or simple legal matters from becoming serious problems, they offer

the potential for reducing legal expenses; in addition, plan members often receive discounted rates.

Dependent Care

Child Care—Studies show that when employees experience child care difficulties, the results are absenteeism, tardiness, decreased morale, and unproductive work time. Employers are beginning to respond to these problems as a way to increase productivity. Many employers have become involved in child care, especially those with a high proportion of younger employees, women, high turnover rates, and problems with absenteeism. Employment-based child care programs may take a variety of forms. Examples range from company-sponsored day care centers, to access to child-care information, to direct financial assistance, to flexibility in work scheduling.

Elder Care—As with child care, elder care encompasses a large group of benefits that some employers offer. Some of the services provided under elder care are similar to those provided under child care, such as in-house resources and/or referral services, contracted referral services, and dependent care flexible spending accounts. Other services and benefits, such as long-term care insurance, are unique to elder care.

Flexible Work Arrangements—Flexible work schedules are another form of child- and elder-care support. Flexible work schedules refer to any adjustment in the hours worked that is different from a traditional fixed daily schedule of five days per week. Certain flexible work schedule policies, such as flextime, job sharing, compressed work week, and part-time work, have become valuable to many working parents.

Education Assistance

Many individuals who cannot afford to finance their education in full look to federal loan or grant programs for financial assistance. However, some of these programs are only available to students who are enrolled at least half-time. Many part-time students, therefore, are not eligible to receive government assistance. For these individuals, there are three formal education assistance programs that employers may sponsor for their employees: tax-favored educational reimbursement programs (Sec. 162), educational assistance programs (Sec. 127), and qualified scholarship programs. In addition to these formal programs, employers may sponsor informal educational opportunities for their employees, for example, in-house training and courses involving continuing education, personal development, and literacy enhancement.

Sec. 529 Plans—States have begun developing their own aid programs to help residents meet the growing cost of a college education for their children, and Congress has provided these plans with special tax status under Sec. 529 of the Internal Revenue Code. These savings programs are established and administered by states for the purpose of setting aside savings for “qualified higher education expenses.”

There are two basic types of Sec. 529 plans: a savings plan and a prepaid plan. A prepaid plan allows individuals to prepay college education expenses at today’s prices, while the savings plan allows an individual to set aside some money and earn a variable rate of return on the assets.

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CHAPTER 31

LEAVE BENEFITS

Introduction

Leave time is perhaps the most commonly provided employee benefit. In 2008, paid vacations were offered to 78 percent of employees in private establishments and paid holidays were offered to 77 percent (U.S. Department of Labor, 2008a). In June 2008, paid leave (defined as vacation, holiday, and sick leave) accounted for 6.3 percent of private-sector employer costs for total compensation (U.S. Department of Labor, 2008b). Paid vacations allow workers a specified amount of leisure time to use at their discretion. The length of vacation time generally increases with tenure. Leave policies provide time off for holidays; enable workers to take leave for military duty, funerals, and the birth or adoption of a child; and provide time off for workers who have short or long periods of illness (sick leave is discussed later in this chapter; see also the chapter on short- and long-term disability for more information).

Holidays

Paid holidays are not mandated by law, but employers perceive them as a necessary business expense. After an employee has completed a probationary period, he or she becomes eligible for paid time off on holidays. The most commonly offered paid holidays are:

- New Years Day.
- Memorial Day.
- Independence Day.
- Labor Day.
- Thanksgiving Day.
- Christmas Day.

According to a Hewitt Associates survey, workers were offered an average of 11 paid holidays and personal days in 2007, whether or not they were exempt from the Fair Labor Standards Act (FLSA), the major federal law setting minimum wage and workweek standards (Hewitt Associates, 2007a). (FLSA “nonexempt” means hourly workers, while “exempt” means wage and salary workers.)¹ When a holiday falls on a Saturday or Sunday,

¹ FLSA exempts from its basic rules employees who require minimal supervision and exer-

another day off is substituted, most commonly Friday or Monday. For FLSA nonexempt employees (hourly workers), a general requirement for employees to receive pay for a holiday is that they must work the day before and after the holiday. If an employee takes an unscheduled leave of absence, he or she must provide medical documentation or forfeit pay for the holiday (Rosenbloom, 2005).

Vacation Leave

Like paid holidays, vacation leave requires the employee to complete a service requirement before he or she becomes eligible for the benefit. According to the U.S. Bureau of Labor Statistics, in 1997, 87 percent of full-time employees in medium and large private establishments were required to meet a service requirement (U.S. Department of Labor, 1999) to qualify for vacation. Thirty-three percent had a service requirement of six months or less, and 43 percent had a service requirement of seven months to one year. Additional vacation leave time is granted with increasing years of service. According to Hewitt Associates, after an employee has completed five years of service, the average number of days of vacation leave was 15.3; after 15 years, 20.5 days; and after 25 years, 24.0 days (Hewitt Associates, 2007a). Hewitt Associates found no significant difference between exempt and non-exempt employees (hourly vs. wage and salary) with regard to the number of vacations days allowed as tenure increases.

Employees accumulate vacation days on an annual basis. Hewitt Associates found that, at year-end 2005, 39 percent of employers placed a limit on the number of vacation days that can be carried over but no limit on the number that may be accrued; 21 percent placed a limit on the number of vacation days that may be accrued but no limit on the number that may be carried over; and 25 percent required that all time accrued must be used in that year or forfeited (Hewitt Associates, 2006b).

Only 10 percent of employers allow employees to sell unused vacation days. The most prevalent practices for selling vacation days are: selling back only once per year at the end of the year (47 percent), selling back between 8–40 hours (37 percent), and selling back at 100 percent of value. Upon termination, 87 percent of employers pay out for unused vacation time (Hewitt Associates, 2006b).

cise much discretion in performing their duties. According to the U.S. Department of Labor, the exact terms and conditions of an exemption must be related to the employee's actual duties and not be merely a designation of the position as nonexempt. The ultimate burden of supporting the actual application for an exemption rests with the employer. The act also exempts specific categories and businesses.

Personal Leave

Some employers offer personal days as time off for an employee to deal with personal situations that arise, such as needing to wait at home for a delivery. Employers offer this type of leave to reduce the number of unscheduled leaves of absence. In 2006, employers offered a median of two personal days to employees (Hewitt Associates, 2006b).

Military Leave

Military leave is granted to individuals who are in the National Guard or reserve component of the armed forces and who need leave time to maintain their military status. According to the U.S. Bureau of Labor Statistics, 48 percent of employees were eligible for paid military leave in 2008 (U.S. Department of Labor, 2008a).

In times of war (such as the Persian Gulf War) or military conflict (such as the 1999 Kosovo air strikes), the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994 states that veterans, reservists, and National Guard members who are on active duty or in required training must be allowed up to five years of excused absences for their military service. This leave is allowed so long as advance notice is given, when possible, and the employee returns to work in a timely manner (Rosenbloom, 2005).

Sick Days

Nearly all employers provide sick days either as a stand-alone plan or as part of a paid time off bank (Hewitt Associates, 2006b). Sick days are a benefit that allows the employee to call in sick for a minor illness such as a cold or flu. For illnesses that last longer than two weeks, some employers provide short-term disability insurance (see the chapter on disability insurance). Half of employers surveyed by Hewitt track the usage of sick leave days by both exempt and nonexempt employees.

Paid Time Off Banks

To assist employees in balancing work/life conflicts and reduce their growing use of unscheduled leave, employers are increasingly turning to paid time off (PTO) banks. In short, a PTO bank combines separate vacation, personal, and sick leaves into one comprehensive plan that allows the employee the flexibility to use leave for any reason. This eliminates the stress an employee may experience when, for instance, he or she feels obliged to take sick leave inappropriately to deal with a personal situation such as attend-

ing a parent-teacher conference. According to Hewitt Associates, 24 percent of employers offered a PTO bank in 2007 (Hewitt Associates, 2007b).

In 2000, nearly 90 percent of employers surveyed reported that the PTO bank was effective in helping to attract and retain talented employees. When making the transition from traditional leave plans to a PTO bank, nearly all employers provided the same amount or more vacation leave. With regard to sick days, 60 percent of employers that did not offer health care coverage reduced the number of sick days employees were entitled to before implementation of a PTO bank (Hewitt Associates, 2001).

Among employers that offer a PTO bank, a median of 19 PTO bank days were provided for an employee (exempt and nonexempt) with one year of service; after five years of service, 23 days; after 15 years of service, 28 days; and after 25 years of service, 31 days (Hewitt Associates, 2007b). Nearly all employers with a PTO bank allow employees to carry over unused PTO bank days, but most limit the number of days that can be carried over into the next year.

Family and Medical Leave Act (FMLA) of 1993

FMLA is a federal law that requires employers with 50 or more workers to provide employees with leave for certain medical and family-related reasons. It took effect on Aug. 6, 1993, and is administered by the U.S. Department of Labor. It covers private employees, state employees, and federal government employees who work for an employer with 50 or more employees within 75 miles of a given work place (Society of Human Resource Management, 2000). The law requires that, to be eligible for FMLA leave, an employee must have worked at least 12 months for the employer and for 1,250 hours in the past year.

Employees are allowed to take up to 12 weeks of unpaid job-secure (or job-equivalent) leave during any 12-month period for the following reasons:

- Birth of a child.
- Adoption or foster care of a child.
- Caring for a spouse, child, or parent with a serious health condition.
- The serious health condition of the employee.

Leave for the birth or placement of an adopted or foster child must be completed within a one-year period from the date of the birth or placement of the child. A serious health condition is defined as one requiring inpatient care at a hospital, hospice, or residential medical care facility, or continuing care by a doctor of medicine or osteopathy (Society for Human Resource Management, 2000).

FMLA allows employees to take the leave intermittently (such as a day here or there as needed) or use the leave to reduce the workweek or workday. Intermittent leave for the birth or adoption of a child must be based on an arrangement worked out between employer and employee. Intermittent leave related to a serious health condition does not need the employer's approval provided it is medically necessary.

FMLA allows an employer to require that an employee use up all available paid leave (e.g., vacation, personal, sick, or family) before taking unpaid leave. The employee is required to give 30 days notice prior to taking the leave, or as much notice as is practical.

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Society for Human Resources Management
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www.shrm.org

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division
Compliance Assistance—Family and Medical Leave Act (FMLA)
www.dol.gov/esa/whd/fmla/#faq

CHAPTER 32

UNEMPLOYMENT INSURANCE

Introduction

The Social Security Act of 1935 created the Federal-State Unemployment Compensation Program. The program has two main objectives: 1) to provide temporary and partial wage replacement to involuntarily unemployed workers who were recently employed; and 2) to help stabilize the economy during recessions (U.S. Congress, 2004). The Federal Unemployment Tax Act of 1939 (FUTA) and titles III, IX, and XII of the Social Security Act form the framework of the system.

Funding

FUTA currently imposes a 6.2 percent gross tax rate on the first \$7,000 paid annually by covered employers to each employee. States may have a higher taxable wage base than the federal requirement of \$7,000. As of January 2008, 43 states had a taxable wage base higher than the federal level, ranging up to \$32,200 in Idaho (Department of Labor, 2008). Employers in states with programs approved by the federal government and with no delinquent federal loans may credit 5.4 percentage points against the 6.2 percent tax rate, making the minimum net federal unemployment tax rate 0.8 percent. Since all states have approved programs, 0.8 percent is the effective federal tax rate (U.S. Congress, 2004).

In 1976, Congress passed a surtax of 0.2 percent of taxable wages to be added to the permanent FUTA tax rate. Thus, the current effective 0.8 percent FUTA tax rate has two components: a permanent tax rate of 0.6 percent, and a surtax rate of 0.2 percent. The surtax has been extended five times, most recently by the Taxpayer Relief Act of 1997, which extended it through Dec. 31, 2007 (U.S. Congress, 2004).

States may also *experience rate* employers' tax rate. This allows states to assess a higher tax rate to employers with a high turnover rate. This experience rate assessment ranges from a minimum of 0.0 percent in 14 states (Colorado, Florida, Hawaii, Iowa, Michigan, Missouri, Montana, North Carolina, South Dakota, Tennessee, Texas, Virginia, West Virginia, and Wyoming) to three states with higher than 10 percent (Georgia, Pennsylvania, and South Dakota) (U.S. Congress, 2004).

Covered Work Force

When FUTA was first created in 1939, it imposed a uniform federal tax on the payrolls of industrial and commercial employers that employed eight or more employees for at least 20 weeks per year. The Employment Security Amendments of 1970 and the Unemployment Compensation Amendments of 1976 broadened this coverage to include all private employers in industry and commerce that employ one or more individuals for at least 20 weeks during the current year or pay \$1,500 or more in wages and salaries during any calendar quarter. Agricultural and domestic employees face slightly modified eligibility standards. Eligibility for benefits is generally determined by an unemployed worker's previous attachment to the labor force as evidenced by a specified amount of work or earnings in covered employment and by the unemployed worker's ability and willingness to work.

Eligibility for Benefits—In order for a worker to receive unemployment compensation, he or she must have earned a certain amount of qualifying wages. In most states this is defined as earnings in the first four of the last five completed calendar quarters. The purpose of this requirement is to limit unemployment compensation to individuals with a current attachment to the labor force. Most states require a worker to meet a one-week waiting period before his or her first benefit payment. The worker must be able to and available for work, actively seeking work, and free of any disqualifying event. A disqualifying event is defined as quitting employment voluntarily, discharge for misconduct, refusal of suitable work, or being part of a labor dispute.

In general, benefits are based on a percentage of an individual's earnings over a recent 52-week period—up to a state maximum amount. Benefits can be paid for a maximum of 26 weeks in most states. Additional weeks of benefits may be available during times of high unemployment. Some states provide additional benefits for specific purposes. Benefits are subject to federal income taxes and must be reported on an individual's federal income tax return. A benefit recipient may elect to have the tax withheld by the state unemployment insurance agency (U.S. Department of Labor, Unemployment Insurance Fact Sheet).

The Tax Reform Act of 1986 made all unemployment compensation benefits taxable after Dec. 31, 1986.

Extended Benefits

Extended benefits are available to workers who have exhausted regular unemployment insurance benefits during periods of high unemployment. The basic extended benefits program provides up to 13 additional weeks of benefits when a state is experiencing high unemployment. Some states have also

enacted a voluntary program to pay up to seven additional weeks (20 weeks maximum) of extended benefits during periods of extremely high unemployment. Extended benefits may start after an individual exhausts other unemployment insurance benefits. Not everyone who qualifies for regular benefits qualifies for extended benefits. The state agency advises individuals of their eligibility for extended benefits (U.S. Department of Labor, Extended Benefits Fact Sheet).

Disaster Benefits

Disaster Unemployment Assistance provides financial assistance to individuals whose employment or self-employment has been lost or interrupted as a direct result of a major disaster declared by the president of the United States. Before an individual can be determined eligible for Disaster Unemployment Assistance, it must be established that the individual is *not* eligible for regular unemployment insurance benefits (either state or federal benefits). The program is administered by states as agents of the federal government.

Disaster Unemployment Assistance is available to unemployed U.S. nationals and qualified aliens who have worked or have been self-employed if they:

- Worked or were self-employed in an area declared to be a federal disaster area, or were scheduled to begin work or self-employment in an area declared to be a federal disaster area.
- Can no longer work or perform services as a direct result of a disaster.
- Establish that the work or self-employment they can no longer perform was their primary source of income.
- Do not qualify for regular unemployment insurance benefits from any state.
- Cannot perform work or self-employment because of an injury or because they were incapacitated as a direct result of the disaster.
- Became the breadwinner or major support of a household because of the death of the head of the household.

Suffering a monetary loss due to damage of property or crops does not automatically entitle an individual to Disaster Unemployment Assistance.

Disaster Unemployment Assistance is available to individuals for weeks of unemployment beginning after the date the major disaster began and for up to 26 weeks after the major disaster was declared by the president, as long as their unemployment continues to be a result of the major disaster. The maximum weekly benefit amount is determined under the provisions of the state law for unemployment insurance in the state where the disaster occurred (U.S. Department of Labor, Disaster Unemployment Assistance Fact Sheet).

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CHAPTER 33

VOLUNTARY DISABILITY INCOME PLANS

Introduction

Unexpected illness or injury can result in a person's inability to work, creating serious financial problems for the individual and his or her family. The costs of necessary medical treatment can exacerbate these financial problems. Health insurance plans may help to pay for medical care costs, while private and public disability income plans may replace a portion of a disabled worker's lost income.

Industry and government studies suggest that total disability-related costs now represent 6 percent to 12 percent of payroll for the average company. In 2004, the Bureau of Labor Statistics reported there were a total of 1.3 million injuries and illnesses in the private sector which required time away from work for recuperation. The median days away from work was seven (U.S. Department of Labor, 2006).

A survey by the U.S. Bureau of the Census found that, in 2002, 4.8 percent of persons age 15 and over—including 3.1 percent of those ages 25–64 and 16.3 percent of those age 65 and over—needed personal assistance with one or more activities of daily living (ADL) or instrumental activities of daily living (IADL) (U.S. Department Of Commerce, 2006). The survey also found that the proportion of women of all ages with disabilities was 19.5 percent, compared with 16.7 percent for men of all ages. The difference occurs largely because women outnumber men in the elderly age groups. Among people aged 16–64, the report indicated that 11.8 million, or 6.4 percent, were limited in the kind or amount of work they could do.

In the past, many employers offered informal pay-continuation arrangements to disabled employees—especially salaried employees. In 2008, 30 percent of workers were participating in a long-term disability insurance program and 38 percent were participating in a short-term disability program (U.S. Department of Labor, 2008). Virtually all jobs are covered by mandatory public disability plans (e.g., Social Security and workers' compensation). Public- and private-sector disability income plans cover short-term and long-term disabilities.

Overview

Individual employers, jointly managed (Taft-Hartley) trust funds, and employer associations may offer private disability income plans. Before a

private plan is adopted, a number of plan design and administrative questions must be answered. For example: What benefit level should be provided? How long should benefits be provided? What portion of the benefits should be paid by employers and what portion should be paid by employees?

Employers are legally required to contribute to the public disability plans (see chapters on Social Security Disability Insurance and workers' compensation). To avoid costly duplication, private plan sponsors should recognize all sources of disability income when determining benefit levels. This is usually accomplished by a *benefit integration provision*. Integration is intended to limit combined disability benefits to a reasonable income replacement level (i.e., the portion of a worker's income prior to disability that is replaced after disability occurs).

There are two primary types of private disability income plans: short-term disability plans (in which benefit payments usually are provided for 26 weeks or less) and long-term disability plans (in which benefit payments are usually provided after short-term benefits have ended).

Short-Term Disability

A short-term disability is usually defined as an employee's inability to perform the duties of his or her current position. Paid sick leave and short-term disability plans protect workers against loss of income during temporary absences from work due to illness or accident. Sick leave is provided to most employees and short-term disability or sickness and accident insurance to a significant but smaller number of workers. Some workers have both sick leave and short-term disability plans, with the two benefits coordinated. The duration of short-term disability benefits ranges from 13 weeks to 52 weeks, although most workers are covered for up to 26 weeks. Short-term disability plans usually specify when successive periods of disability are considered to be separate disabilities and when they are considered to be a continuous disability.

Often, paid sick leave is available to the employee without any waiting period, and it may be used during the interim before sickness and accident insurance payments begin. Under most sickness and accident insurance plans, the disability must exist for at least one week before a worker becomes eligible for benefits. This waiting period is intended to control plan costs and simplify plan administration.

Sick leave usually provides 100 percent of a worker's normal earnings, and the plan frequently specifies a number of covered days each year that are permitted for paid sick leave (e.g., 13 days). Other plans provide sick leave benefits (e.g., 30 days) per illness instead of per year. When used in conjunction with sick leave plans, sickness and accident plans provide bene-

fits after sick leave benefits are exhausted. The level of sickness and accident benefits for short-term disability may be expressed as a flat dollar amount or as a percentage of employee earnings. The level and duration of benefits may increase with service. Generally, benefits replace between one-half and two-thirds of a person's predisability gross weekly income. Many believe that a higher replacement rate would create a disincentive for employees to return to work.

Employers usually pay for short-term disability plans. These plans may be financed under a group insurance contract with a private insurance carrier, an employer self-insurance arrangement, an employer-established employee benefit trust fund, a Taft-Hartley multiemployer welfare fund, or general corporate assets (e.g., for a sick leave plan). Short-term disability plans may be administered by an employer, an insurance carrier, or the board of trustees of a Taft-Hartley plan.

Data from the Bureau of Labor Statistics (BLS) indicate that in 2008, 38 percent participated in a short-term disability or sickness and accident insurance program (U.S. Department of Labor, 2008).

Long-Term Disability

In most long-term plans, disability for the first two years is defined slightly differently from disability under short-term plans (e.g., an employee's inability to perform the duties of his or her occupation vs. the duties of his or her current position). If the disability continues for more than two years, the definition of disability usually changes to the inability to perform any occupation that the person is reasonably suited to do by training, education, and experience. Some plans use the payment of Social Security disability benefits as the sole test for ascertaining whether a participant should receive long-term disability benefits under the plan.

Private sources of long-term disability benefits include disability provisions under long-term disability plans, group life insurance, employment-based pension plans, and other insurance arrangements (e.g., individual insurance protection). Like short-term benefits, long-term disability benefits are integrated with benefits from other sources to produce reasonable replacement rates and to control costs.

Long-term benefits generally begin after short-term disability benefits (sick leave and sickness and accident insurance) expire. Most plans provide benefits for the length of a disability, up to a specified age (e.g., age 65, when Social Security and employment-based retirement benefits usually begin). Under the 1986 Amendments to the Age Discrimination in Employment Act, which abolished mandatory retirement, plans that provide disability benefits cannot impose an upper age limit on active employees' eligibility for these

benefits. The benefits may be paid to employees age 65 or over who become disabled, based on age-related cost considerations. Employers must either provide equal benefits to employees regardless of age, or—as is usually the case—provide benefits that are equal in cost to employees of all ages. Because disability costs rise with age, this means that employees who are disabled at older ages may be paid disability benefits for a shorter duration or lower benefits for the same duration, relative to younger employees.

Typically, long-term disability plans pay benefits amounting to approximately 60 percent of a person's predisability monthly pay. However, some plans provide as much as 70 percent of predisability pay. Additionally, some plans contain a provision stating that private-sector long-term disability benefits, plus Social Security disability benefits, cannot exceed a stated amount (e.g., 75 percent of predisability salary). Most plans set a limit on monthly payments, e.g., between \$4,000 and \$10,000. The cost of long-term disability benefits may be financed by employer contributions, employee contributions, or employer/employee cost sharing.

Similar to short-term disability plans, long-term plans usually specify when successive periods of disability are considered to be separate disabilities and when they are considered to be a continuous disability. Also, some long-term plans provide for continued payment of at least some disability benefits when long-term disabled persons engage in rehabilitative employment.

BLS data indicate that in 2008, 30 percent of workers in private establishments had long-term disability insurance (U.S. Department of Labor, 2008).

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CHAPTER 34

GROUP LIFE INSURANCE PLANS

Introduction

Many employers provide death benefits for survivors of deceased employees. There are two types of plans designed specifically for this purpose: *group life insurance plans*, which normally make lump-sum payments to a designated beneficiary or beneficiaries, and *survivor income plans*, which make regular (usually monthly) payments to survivors. Additionally, benefits may be paid to survivors from other employee benefit plans (e.g., profit-sharing, thrift, and pension plans). Survivor benefits are also available through the Social Security program (see Social Security chapter). This chapter discusses group life insurance plans.

The concept of *individual* life insurance was developed centuries ago, but *group* life insurance developed more recently. In 1911, the first known group life insurance contract was created at the Pantasote Leather Company in Passaic, NJ. The contract was called the *yearly renewable term employees' policy* and included many features that are standard in today's group term life policies. According to the American Council of Life Insurers (ACLI), by the end of 1920, there were 6,000 group life insurance master policies¹ in force, providing total coverage of \$1.6 billion; by 1940, there were 23,000 master policies providing total coverage of \$15 billion; and by 1945, there were 31,000 master policies providing total coverage of \$22 billion (American Council of Life Insurers, 2002).

The wage freeze of World War II spurred a boom in group life insurance. Employees, knowing they could not get wage increases, requested additional benefits. Employment-based life insurance coverage was one of the most-demanded benefits. As a result, by 1950 there were approximately 56,000 group life insurance master policies in force, providing total coverage of \$48 billion.

Employment-based life insurance has continued to grow. At the end of 2005, 167.1 million group life insurance certificates were providing \$7.1 trillion of coverage to Americans—most of it employer sponsored. This group coverage accounted for 44.9 percent of the face value of *all* life insurance in force in the United States at the end of 2005 (American Council of Life Insurers, 2006).

¹ A master policy is a policy issued to an employer or trustee establishing a group insurance plan for designated members of an eligible group.

In 2006, 50 percent of employees in private industry participated in employer-provided life insurance protection (U.S. Department of Labor, 2006).

The Insurance Contract

The contract between the insurance company and the employer is usually for *group term* life insurance. Many associations and multiemployer plans also provide group term life benefits.² The word *term* means that the coverage is bought for a specific time period (usually one year), with a renewable provision, and remains in effect only as long as premiums are paid. It may be referred to as *yearly* or *annual renewable term*. Term insurance has no savings features and no buildup of cash value. It is pure insurance protection, paying a benefit only at death.

The cost of providing group life coverage varies, depending on the insurer and the covered group. For small groups, charges usually are taken from a *standard rates table*. Monthly premiums typically range from \$0.08 per \$1,000 of coverage for employees under age 30 to \$1.17 per \$1,000 of coverage for employees in their early 60s. For large groups, the initial premium might also be taken from a standard rates table; however, in the second and subsequent years of coverage, plans are often designed such that the premium varies according to the group's claims experience. After the first year, the net premium for a large group is essentially the sum of claims incurred plus the insurer's administrative costs and an amount to provide for profit and risk.

Plan Provisions

Eligibility—Most group term life plans allow permanent full-time employees to be eligible for coverage on the first day of active employment. Some plans require that participants work a minimum period (typically one to three months) to qualify for the plan.

Amounts of Insurance—Employers provide varying levels of coverage. The amount of coverage can be based on one or more factors (e.g., occupation and/or salary). According to the Bureau of Labor Statistics (BLS), the most common method of determining basic coverage for employees in private industry in 2003 was the *multiple-of-earnings* benefit. Fifty-seven percent of employees in the BLS survey had a basic life insurance plan determined by the multiple-of-earnings method. A *dollar amount* benefit, which occasionally

² Other major types of group life insurance are *permanent* forms, including *paid-up* and *ordinary* life insurance. For more information on these two other types, see Rosenbloom, 2005. Since *term* insurance is the most popular group coverage, this chapter will focus primarily on group *term* life insurance.

varies with earnings or service, was the other prevalent means of providing life insurance protection. Thirty-eight percent of employees in the BLS survey had basic life insurance determined by a flat dollar amount (i.e., not varying with earnings or service), often \$5,000–\$15,000. Although it typically provides smaller amounts of insurance than earnings-based formulas, flat-amount coverage has improved considerably over the years (U.S. Department of Labor, 2005).

Employee Cost—Employers typically pay the entire cost of basic life insurance. When life insurance benefits are offered as part of a cafeteria plan or reimbursement account, employee contributions may be required. Another form of employee contribution is a specified flat dollar amount (e.g., \$0.20 per \$1,000 of coverage per month). In supplemental plans, the cost is usually paid entirely by the employee. Supplemental coverage is more prevalent for employees who have their basic insurance determined by a multiple-of-earnings formula than for those with a flat dollar amount of coverage.

Dependent Life Insurance—As part of the group life insurance plan, some employers offer insurance coverage for dependents. The cost of dependent coverage is usually paid by employees who elect such protection. Dependent life insurance usually provides a flat dollar benefit for a worker's spouse and an equal or smaller benefit for children (usually between the ages of 14 days and 19 years), although the benefit may vary by employee option or may be a percentage of employee coverage. Spousal coverage typically provides benefits of \$5,000 or more, while coverage for children usually offers benefits of \$1,000, \$2,000, or \$5,000 per child.

Accidental Death and Dismemberment (AD&D) Insurance—Frequently, group life insurance plans include AD&D insurance. This insurance provides additional benefits if a worker dies in an accident or loses an eye or a limb in an accident. In the case of accidental death, the AD&D benefit commonly equals the basic life insurance benefit, whereas in the case of dismemberment, the AD&D benefit is usually equal to only a portion of the basic life insurance benefit.

Beneficiary Provisions—Under a typical group plan, employees may designate and change the beneficiaries who are to receive their group life insurance proceeds. At an insured employee's death, the stipulated benefit is paid directly to the named beneficiary. If payment cannot be made to a designated beneficiary, group contracts usually permit payment by the insurance company to one or more of a group of the employee's surviving relatives.

Benefits for Retired Persons and Older Active Workers—Most group life policies are designed to cover active employees. Coverage for active older employees can be reduced to reflect the increase in the cost of life insurance as a result of age. This practice will not violate the Age Discrimination in Employment Act as long as the reduction for an employee of a particular age

is justified by the increased cost of coverage for that employee's specific age bracket, encompassing no more than five years. Plans that reduce coverage typically make their first reduction at age 65 or 70. Many plans reduce coverage for older workers only once, but other plans reduce coverage in several stages. At retirement, basic life insurance coverage may continue (often for the rest of the retiree's life), but the amount of the benefit is usually reduced at least once during retirement.

Conversion Privileges—If an employee's insurance ceases under certain situations (e.g., employment termination or retirement), the employee may convert his or her group coverage to an individual policy. Under state law, the employee is generally permitted to obtain an individual ordinary life insurance policy of an amount equal to the amount of the employee's previous coverage. Application must be made in writing and a premium (based on the employee's age, type of insurance, and the class or risk involved) paid within 30 days after termination of group coverage (Mamorsky, 1992).

A second conversion situation exists when the group master policy itself is terminated or amended so as to terminate the insurance on all employees or on the class of employees to which the employee belongs. In this situation, the conversion privilege is available for employees who have been insured at least five years, and the maximum amount that may be converted on any one life is \$2,000 (Rosenbloom, 2005).

Disability Benefits—Group plans generally continue to provide some life insurance protection for a covered employee who becomes totally and permanently disabled. Although group term life plans contain three basic types of provisions regarding the continuation of coverage in the event of a covered person's disability, the most common is a *waiver-of-premium disability benefit*.³ Under such a provision, coverage is continued at no cost to the disabled employee, providing:

- The employee is under a specified age (such as 60 or 65) at the onset of disability.
- The employee is covered under the plan at the onset of disability.
- Disability continues until death.
- Proof of total and continuous disability is presented as required by the plan.

Optional Forms of Payment—The standard payment method for group life insurance claims is a lump-sum distribution. However, virtually all insurers permit other settlement arrangements at the insured employee's

³The two other provisions are a *maturity value benefit* and an *extended death benefit*. For more information on these provisions, see Rosenbloom and Hallman, 1991.

option (or the beneficiary's option, if the employee did not make an election before death). Alternative payment arrangements include installment payments and life income annuities.

Taxation

The employer's premiums for group term life insurance are tax deductible as a business expense, and the benefits paid to beneficiaries are exempt from federal income taxation up to a limit. However, the proceeds are generally subject to estate taxes.

Employees may receive up to \$50,000 in employer-provided life insurance coverage without paying income tax on the amount. On coverage beyond \$50,000, the employee is taxed on the cost⁴ of the balance. In cases where an employee contributes toward the cost of the insurance, that part of the contribution is credited to any coverage in excess of \$50,000.

Group Universal Life Programs

Group universal life programs (GULPs) were first introduced in 1985 and developed from individual policy universal life (UL) programs. UL is issued on an individual basis, whereas GULP coverage is available on a group basis. GULP plans may supplement a regular group term life insurance plan or may exist as stand-alone plans.

GULPs combine group term life insurance with a savings element or cash accumulation feature. This investment element can be used to create nontaxable permanent insurance or to accumulate savings. GULPs are made available to employees by an employer to which a master policy has been issued, and employees pay the entire premium. According to ACLI, in 2000, life insurance companies issued 981 certificates for group universal life insurance, and 8,048 certificates for group universal life insurance were in force in 2000 (American Council of Life Insurers, 2002).

Participation by employees is voluntary. A formula in the plan is used to establish the amount of life insurance coverage available to employees (e.g., one or two times compensation). Employees may choose to contribute only to the cost of term protection and administrative expenses, but many also contribute to the savings element. All employee contributions (including those to the cash value) are withheld from after-tax pay, although the investment earnings on the cash value are not taxed until coverage is surrendered or until the cash values are taken as income or withdrawn. This tax-deferred buildup of the cash values is an attractive feature for the employees.

⁴ A table in the Internal Revenue Code determines cost, although this cost may differ somewhat from the actual cost of the insurance.

Another feature important to employees is the portability of GULPs. When a participating employee terminates employment (e.g., to change jobs or to retire), he or she may make premium payments directly to the insurance company and hence continue coverage. Employees may withdraw cash values at any time and may take loans against their cash values.

Some GULPs limit coverage to employee life insurance, but others allow employees to include accidental death and dismemberment insurance and dependent coverage for spouses and children. Children are usually only covered for term insurance, whereas spouses may be able to accumulate cash values. Some plans also allow employees to add coverage payable in the event of the employee's disability.

Premium rates for the term insurance portion of each employee's group coverage are stated in the plan and usually increase with the employee's age. These rates are usually guaranteed for some amount of time (e.g., one, three, or five years) and may be lower than individual term rates. The interest credited to cash values is set periodically by the insurance company. Once a rate is set, it may be guaranteed for a limited period of time (e.g., one year). There is also a guaranteed minimum interest rate that is set for purposes of state insurance and federal tax laws.

Living Benefits

Living benefits, also known as *viatical* settlements, allow the insured to receive the proceeds payable on death while still living. The amount received is the actuarially discounted value based on the individual's expected remaining lifetime and is paid by a third party (a living benefits company) rather than by the insurance company that issued the life insurance policy. The living benefit company typically takes an irrevocable absolute assignment of the life insurance policy and in return pays (in cash) 50 percent to 80 percent of the face amount of an individual life insurance policy of a terminally ill individual (and sometimes of an individual who has attained a specified age, such as 83 or over). As terminally ill patients reach lifetime health benefit limits in an employment-based health benefit plan, they may find living benefits attractive since they allow individuals to access the cash value of the life insurance policy while still living, usually to help pay medical bills.

Conclusion

The death of a worker can be financially devastating to his or her family. Employer-sponsored life insurance benefits can ease the ensuing financial difficulties. The number of employer-sponsored life insurance plans

has grown significantly, attesting to their importance. To design effective programs and to ensure an adequate amount of compensation for family members in the case of the covered employee's death, employers and employees should consider how these plans fit in with other potential private and public sources of life insurance, survivor benefits, and death benefits.

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CHAPTER 35

WORKERS' COMPENSATION

[This chapter is excerpted with permission from the National Academy of Social Insurance, Workers' Compensation: Benefits, Coverage, and Costs, 2006, www.nasi.org]

Introduction

Workers' compensation pays for medical care, rehabilitation and cash benefits for workers who are injured on the job or who contract work-related illnesses. It also pays benefits to families of workers who die of work-related causes. Each state has its own workers' compensation program.

The lack of uniform reporting of states' experiences with workers' compensation makes it necessary to piece together data from various sources to develop estimates of benefits paid, costs to employers, and the number of workers covered by workers' compensation. Unlike other U.S. social insurance programs, state workers' compensation programs have no federal involvement in financing or administration. And, unlike private pensions or employer-sponsored health benefits that receive favorable federal tax treatment, no federal laws set standards for "tax-qualified" plans or require comprehensive reporting of workers' compensation coverage and benefits.¹ The general lack of federally mandated data means that, states vary greatly in the data they have available to assess the performance of workers' compensation programs.

Workers' compensation is an important part of American social insurance. As a source of support for disabled workers, it is surpassed in size only by Social Security disability insurance and Medicare. Workers' compensation programs in the 50 states, the District of Columbia, and federal programs paid \$54.7 billion in benefits in 2006. Of the total, \$26.5 billion paid for medical care and \$28.2 billion paid for cash benefits (calculated from Figure 35.1).

Workers' compensation programs are undergoing changes. Total benefits rose at double-digit rates in the 1980s, and then declined in absolute dollar amounts and relative to wages of covered workers in the 1990s. Benefits and

¹ A new reporting requirement was enacted in 2007, Sec. 111 of S 2499 (now Public Law No. 110-173) that workers' compensation claims administrators must report to CMS (Centers for Medicare & Medicaid Services) information about workers' compensation recipients who are entitled to Medicare.

costs relative to covered wages fell for the second consecutive year in 2006 (Figure 35.2)

Workers' compensation differs from Social Security disability insurance and Medicare in important ways. Workers' compensation pays for medical care for work-related injuries beginning immediately after the injury occurs; it pays temporary disability benefits after a waiting period of three to seven days; it pays permanent partial and permanent total disability benefits to workers who have lasting consequences of disabilities caused on the job; in most states it pays rehabilitation and training benefits for those unable to return to pre-injury careers; and it pays benefits to survivors of workers who die of work-related causes. Social Security, in contrast, pays benefits to workers with long-term disabilities from any cause, but only when the disabilities preclude work. Social Security also pays for rehabilitation services and in addition pays for survivor benefits to families of deceased workers. Social Security begins after a five-month waiting period and Medicare begins 29 months after the onset of medically verified inability to work. In 2006, Social Security paid \$91.7 billion in cash benefits to disabled workers and their dependents, while Medicare paid \$52.2 billion for health care for disabled persons under age 65 (Social Security Administration, 2007, and Centers for Medicare & Medicaid Services, 2007).

Paid sick leave, temporary disability benefits, and long-term disability insurance for non-work-related injuries or diseases are also available to some workers. About 70 percent of private-sector employees have sick leave or short-term disability coverage, while 30 percent have no income protection for temporary incapacity other than workers' compensation. Sick leave typically pays 100 percent of wages for a few weeks. Private long-term disability insurance that is financed, at least in part, by employers covers about 30 percent of private sector employees and is usually paid after a waiting period of three to six months, or after short-term disability benefits end. Long-term disability insurance is generally designed to replace 60 percent of earnings and is reduced if the worker receives workers' compensation or Social Security disability benefits.

Recent Developments

Total cash benefits to injured workers and medical payments for their health care were \$54.7 billion in 2006, a 1.5 percent decline from \$55.4 billion in 2005 (Figure 35.1). Medical payments slightly increased to \$26.5 billion, while cash benefits to injured workers declined by 3.5 percent, to \$28.2 billion from \$29.2 billion in the prior year (Figure 35.2).

Costs to employers fell by 1.5 percent in 2006 to \$87.6 billion. Costs for self-insured employers are the benefits they pay plus their administrative

Figure 35.1

WORKERS' COMPENSATION, 2006 SUMMARY

	2005	2006	Percentage Change
Covered Workers	128,140,998	130,322,233	1.7%
Covered Wages (in \$ billions)	\$5,212	\$5,543	6.3
Workers' Compensation Benefits Paid (in \$ billions)	\$55.5	\$54.7	-1.5
Percentage of Benefits Paid for Medical Care	47.3%	48.4%	2.3
Employer Costs for Workers' Compensation (in \$ billions)	\$88.9	\$87.6	-1.5
Benefits per \$100 of Covered Wages	\$1.07	\$0.99	7.4
Employer Costs per \$100 of Covered Wages	\$1.71	\$1.58	-7.6
Benefits per Covered Worker	\$433	\$420	-3.0
Employer Costs per Covered Worker	\$694	\$672	-3.2

Source: National Academy of Social Insurance.

costs. For employers who buy insurance, costs are the premiums they pay in the year, plus benefits they pay under deductible arrangements in their insurance policies. From an insurance company's perspective, premiums received in a year are not expected to match up with benefits paid that year. Rather, the premiums are expected to cover all future liabilities for injuries that occur in the year.

The National Academy of Social Insurance (NASI) measures of benefits and employer costs are designed to reflect the aggregate experience of two stakeholder groups—workers who rely on compensation for work-place injuries and employers who pay the bills. The NASI measures are not designed to assess the performance of the insurance industry or insurance markets. Other organizations analyze insurance trends.²

For long-term trends, it is useful to consider workers' compensation benefits and employer costs relative to aggregate wages of covered workers. In a steady state scenario, one might expect benefits to keep pace with covered wages. This would be the case with no change in the frequency or severity of injuries and if wage replacement benefits for workers and medical payments to providers tracked the growth of wages in the economy generally. However, in reality, benefits and costs relative to wages vary significantly over the years.

² Rating bureaus, for example, assess insurance developments in the states and advise regulators and insurers on premium changes.

In 2006, aggregate wages of covered workers rose by 6.3 percent. This increase was the combined effect of a 1.7 percent increase in covered workers—due to job growth in the economy—and a 4.6 percent increase in the workers' average wages. In 2006, workers' compensation covered an estimated 130.3 million workers, an increase of 1.7 percent from the 128.1 million workers covered in 2005. In 2006, employment increased for the third year in a row after declining between 2000 and 2003.

When measured relative to the wages of covered workers, both employer costs and benefits for workers fell in 2006 (Figure 35.1). Total payments on workers' behalf fell by eight cents to \$0.99 per \$100 of covered wages: Medical payments fell from \$0.50 per \$100 of wages in 2005 to \$0.48 in 2006, while wage-replacement benefits fell by five cents per \$100 of wages to \$0.51. The cost to employers fell by 13 cents per \$100 of covered wages, to \$1.57 in 2006 from \$1.70 in 2005.

Figure 35.2 shows the trends in employer costs and in cash and medical benefits combined as a share of covered wages over the past 18 years. Benefits and costs declined sharply from their peaks in the early 1990s, reached a low in 2000, rebounded somewhat after 2000, and then declined in the last few years. As a share of covered wages, benefits in 2006 were at their lowest point in the last 18 years at \$0.99 per \$100 of wages in 2006.

A total of 5,840 fatal work injuries occurred in 2006, which is a 1.8 percent increase from the number reported in 2005 and which continues a general trend of increasing work-place fatalities since 2002. Transportation incidents continued to be the leading cause of on-the-job fatalities in 2006, accounting for 42 percent of the total. Contact with objects and equipment, falls, and assault and violent acts (homicides, and self-inflicted injuries), were the other leading causes of death, accounting for 17 percent, 14 percent, and 13 percent, respectively (U.S. Department of Labor, 2007a).

Longer Trends in Workers' Compensation Benefits and Costs

The absolute dollar amount of workers' compensation benefits fell for the second consecutive year in 2006. The increases in benefits in 1997 through 2004 occurred after dollar benefits had fallen for three years (from 1995 through 1997). Employer costs fell in 2006 for the first time since 1998 (Figure 35.3). The increase in employer costs in 1999 through 2005 occurred after employer costs had declined for five straight years (from 1994 through 1998).

Possible Reasons for Changes in Total Benefits and Costs

Fluctuations in payments for workers' compensation over the last two decades are influenced by policy developments and the role of workers' compensation in the broader health care and disability income systems. Opinions often differ about the main causes of changes in spending.

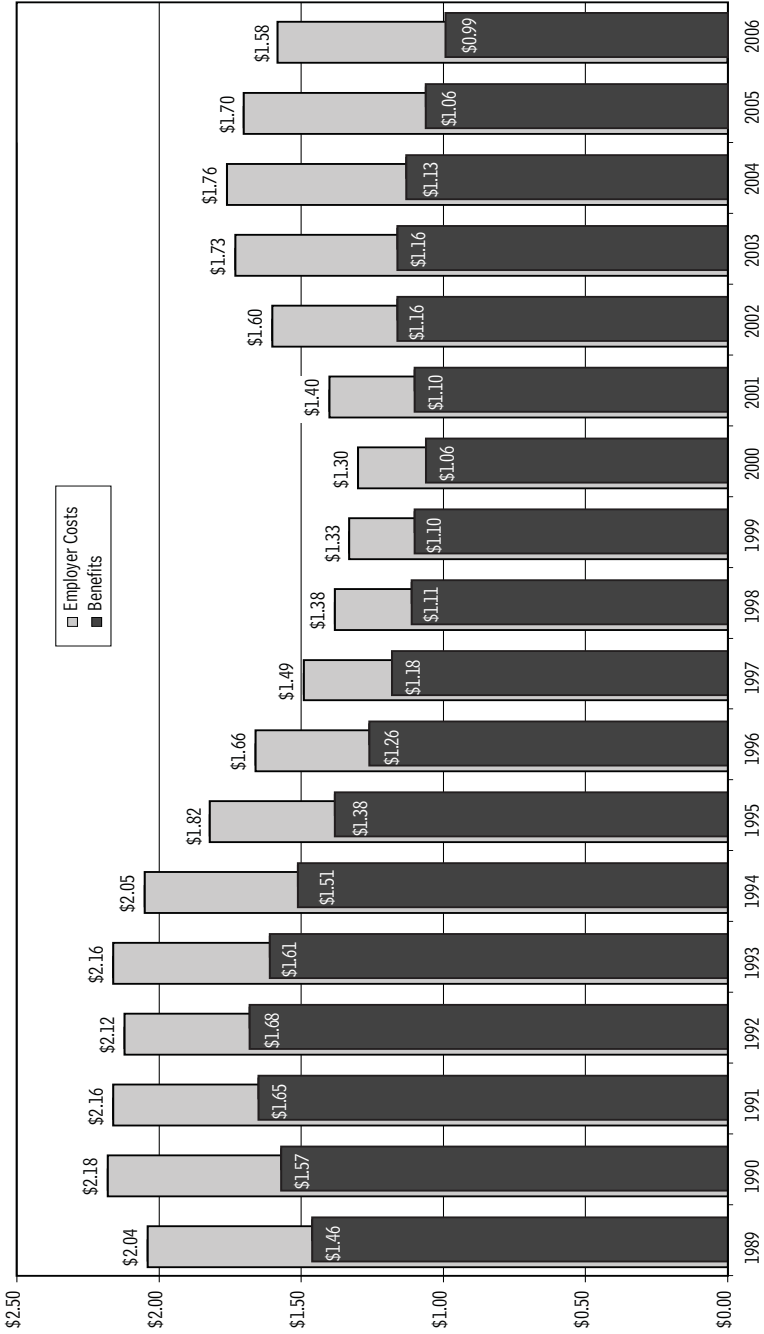
In the second half of the 1980s, workers' compensation benefits and costs grew at double-digit rates and payments for medical treatment were a growing share of total payments. Some believe that rising workers' compensation medical benefits and costs reflected cost-shifting away from employment-based health insurance to workers' compensation as the regular health insurance system introduced managed care and other forms of cost controls in the 1980s (Burton, 1997).

The decline in workers' compensation benefits in the mid-1990s may have been caused by many factors. In response to rising workers' compensation costs in the late 1980s and early 1990s, employers and insurers expanded the use of disability management techniques with the aim of improving return-to-work rates for injured workers and lowering workers' compensation costs. At the same time, workers' compensation systems followed the general health care system in introducing managed care and other cost controls to reduce the growth in medical spending.

While employer costs are affected by benefit payments to workers, shifts in employer costs as a share of payroll also reflect broader developments in the insurance industry and financial markets. Declining workers' compensation benefits and costs in the mid-1990s, combined with a vibrant economy and high financial market returns, enabled insurance companies to earn more from invested premiums. The combination of improved underwriting results and higher returns on reserves led to high profits by historical standards within the workers' compensation insurance industry (Burton, 2007).

A decline in work-place accidents would also contribute to a decline in aggregate payments in the 1990s. The Bureau of Labor Statistics reports a total of 4.1 million nonfatal work-place injuries and illnesses in private industry work places during 2006, resulting in a rate of 4.4 cases per 100 full-time equivalent workers (U.S. DOL, 2007c). Many of these cases involved relatively minor injuries that did not result in lost workdays. The frequency of reported non-fatal occupational injuries and illnesses has declined every year since 1992. A total of 1.2 million work-place injuries or illnesses that required recuperation away from work beyond the day of the incident were reported in private industry in 2006 (U.S. DOL, 2007b). The rate of such reported injuries or illnesses per 100 full-time workers declined from 3.0 in 1992 to 1.3 in 2006. Boden and Ruser (2003) find that between 7.0 and 9.4 percent of the decline in injury rates measured by the Bureau of Labor

Figure 35.2
WORKERS' COMPENSATION COSTS AND BENEFITS PER \$100 OF COVERED WAGES, 1989-2006



Source: National Academy of Social Insurance estimates.

Statistics (BLS) between 1991 and 1997 is an indirect result of tighter eligibility standards and claims filing restrictions for workers' compensation. The primary impact of such restrictions is likely to be on workers' compensation claims. Still, fewer cases entered into the workers' compensation system could result in fewer injuries reported to the BLS. The National Council on Compensation Insurance (NCCI) reports on the frequency of workers' compensation claims for privately insured employers and some state funds in 41 states (NCCI, 2007). These data show declining trends similar to national trends in workplace injuries reported by the BLS.

Interaction with other disability benefit programs could also affect overall system benefits and costs. Social Security disability benefits grew rapidly in the early 1970s and then declined through the late 1980s, after policy changes in the late 1970s and early 1980s reduced benefits and tightened eligibility rules. From 1990 to 1996, Social Security benefits again rose as claims and allowances increased, particularly during the economic recession of 1990–1991. Between 1996–2001, disability insurance benefits relative to covered wages leveled off and then rose again following the recession of 2001.

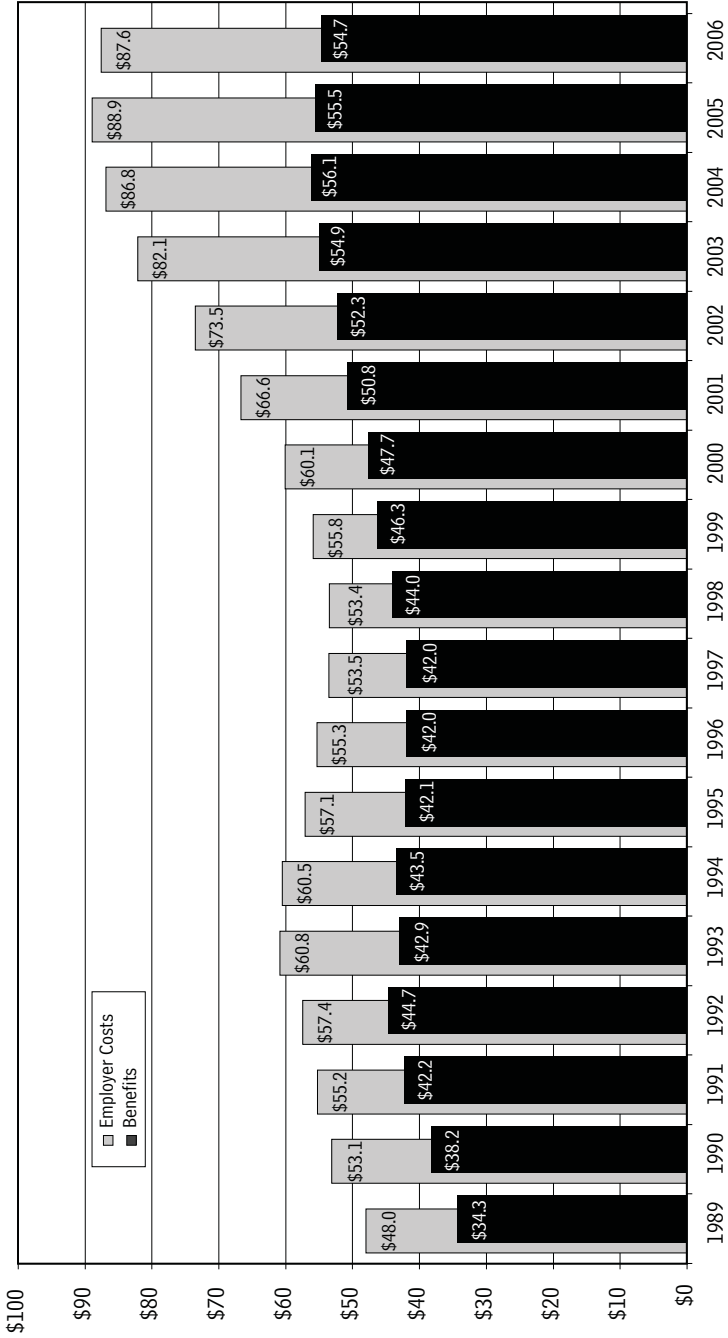
The trend in workers' compensation benefits as a share of covered wages followed a different pattern. Total workers' compensation benefits (cash and medical combined) were less than Social Security disability benefits during the 1970s, but grew steadily throughout the 1970s and surpassed Social Security disability benefits in the mid-1980s. When Social Security benefits flattened out during the mid-1980s, workers' compensation payments continued to grow at a rapid rate. Then, as workers' compensation payments declined as a share of covered wages in 1992–2000, Social Security benefits rose.

The opposite trends in workers' compensation and Social Security disability benefits during much of the last 25 years raise the question of whether retrenchments in one program increase demands placed on the other, and vice versa. The substitutability of Social Security disability benefits and workers' compensation for workers with severe, long-term disabilities that are, at least arguably, work related, or might be exacerbated by the demands of work, has received little attention by researchers and is not well understood (Burton and Spieler, 2001). A recent study finds that work-related disabilities are much more common than might previously have been thought, both among older persons in general and among recipients of Social Security disability benefits in particular (Reville and Schoeni, 2006). Based on reports in the 1992 Health and Retirement Study, more than one third (36 percent) of 51 to 61-year-olds whose health limits the amount of work they can do became disabled because of an accident, injury, or illness at work. Of those receiving Social Security disability insurance, a similar portion (37 percent) attributed their disability to an accident, injury or

Figure 35.3

WORKERS' COMPENSATION BENEFITS AND COSTS, 1989-2006

(\$ billions)



Source: National Academy of Social Insurance estimates.

illness at work. The study also finds that the 51 to 61-year-olds who attribute their disabling conditions to their jobs are far more likely to receive Social Security disability insurance (29.0 percent) than to report ever having received workers' compensation (12.3 percent).

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www.census.gov/compendia/statab/

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National Academy of Social Insurance
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Washington, DC 20036
(202) 452-8097
www.nasi.org

National Council on Compensation Insurance
901 Peninsula Corporate Circle
Boca Raton, FL 33487
(800) 622-4123
www.ncci.com

National Safety Council
1121 Spring Lake Drive
Itasca, IL 60143
(630) 285-1121
www.nsc.org

Social Security Administration

Office of Public Inquiries
Windsor Park Building
6401 Security Boulevard
Baltimore, MD 21235
(800) 772-1213
www.ssa.gov

U.S. Bureau of Labor Statistics
Postal Square Building
2 Massachusetts Avenue, NE
Washington, DC 20212
www.bls.gov

Workers' Compensation Research Institute
955 Massachusetts Avenue
Cambridge, MA 02139
(617) 661-9274
www.wcrinet.org

CHAPTER 36

DEPENDENT CARE

Introduction

The U.S. labor force changed dramatically in the 20th century, primarily as a result of the increase in the number of working women. In 1900, only 20.6 percent of women were in the labor force. Fifty years later, in 1950, 31.4 percent of women had become workers; in 1970, this portion had risen to 42.6 percent; and by 2005, it was 59.4 percent (U.S. Department of Commerce, 1975 and 2006). The increasing labor force participation among women means that men are no longer the sole wage earners in many families. Differences in employment patterns for women according to marital status and the presence and age of children have almost disappeared.

In 1950, 54.5 percent of all families were supported by one earner. This percentage declined steadily to 37.1 percent in 1970, and to 27.5 percent in 1990; it increased slightly, to 29.4 percent, in 2005 (U.S. Department of Commerce, 1975, 1992, and 2006). The number of working mothers with children has also increased. In 1970, 39.7 percent of married women with children were in the labor force. This percentage increased to 68.1 percent by 2005. Fifty-two percent of single women with children were in the labor force in 1980, increasing to 72.6 percent in 2004 (U.S. Department of Commerce, 2006).

At the same time, the U.S. population aged during the 20th century. In 1900, 4.1 percent of the U.S. population was age 65 or older. This percentage increased to 8.1 percent in 1950, 9.9 percent in 1970, and to 12.4 percent in 2005 (U.S. Department of Commerce, 1975 and 2006). The growth of the elderly population will be even more dramatic with the aging of the baby boomers, and is projected to reach 20.7 percent of the total population by 2050 (U.S. Department of Commerce, 2006). In 2003, it has been estimated that 15 percent of the work force may be actively involved in providing care for an older family member or friend. Studies of caregiving in the general population found that 1 out of 3 caregivers is male while 2 out of 3 are female (Metropolitan Life Insurance Company, 2003).

In response to changing work force and family patterns, dependent care—both child and elder—is emerging as a valuable employee benefit that is offered by a growing number of employers.

Children of Working Parents

The types of child care arrangements available to working parents vary by locality but often include in-home care, an arrangement in which a person, sometimes a relative, comes to the child's home; family care, in which a child is taken to another home where the provider often takes care of several children; or child care centers, which are organized facilities that care for many children. Most children ages 3–5 are cared for in a center-based program (56.4 percent in 2001). Center-based care includes day care centers, Head Start programs, preschools, prekindergartens, and nursery schools. In 2001, 22.8 percent of children ages 3–5 received care from a relative and 15.9 percent received care from a nonrelative. In 2001, 26.1 percent of children ages 3–5 received care only from a parent (U.S. Department of Commerce, 2006).

Child Care and the Employer

Studies show that when employees experience child care difficulties, the results are absenteeism, tardiness, decreased morale, and unproductive work time. Employers are beginning to respond to these problems as a way to increase productivity. Many employers have become involved in child care, especially those with a high proportion of younger employees, women, those with high turnover rates, and problems with absenteeism.

Types of Assistance—Employment-based child care programs may take a variety of forms. Examples range from company-sponsored day care centers to access to child care information to direct financial assistance to flexibility in work scheduling.

- *Child care centers* at or near the work place are the most visible form of assistance. They usually are company-operated or contracted out. Sometimes employers contract with other employers or municipal governments to establish facilities. However, start-up costs for centers are high, and continuing labor costs can be higher.
- *Community child care programs* are supported by some firms. When an employer chooses to finance a community day care center rather than to create an on- or near-site service, the employees of the participating company may receive preferential admission, reduced rates, or a reserved space in the day care center in exchange for the employer's financial support of the center. In this way, the employer avoids the administrative and legal responsibilities but still offers support services. However, support or maintenance of child care centers is not as common as other forms of employment-based assistance. Among 989 firms sur-

veyed by Hewitt in 2007, 10 percent offered employer-arranged discounts with local child care providers (Hewitt Associates LLC, 2007).

- *Resource and referral services* are more common. These services can help parents obtain information on child care and, in many cases, refer them to the most appropriate form in their community. Most companies that offer child care services contract with an existing federal referral agency in the community; others have an in-house hotline capacity. A growing number of employers sponsor educational seminars on parenting issues. Although this form of assistance may not include access to a child care center, it can help the employer estimate the potential demand for child care services before investigating other forms of child care support. Among 989 firms surveyed by Hewitt in 2007, 45 percent offered resource and referral services (Hewitt Associates LLC, 2007).
- *Direct financial assistance* with child care expenses is typically provided through employers' flexible benefit plans. Sometimes called "cafeteria plans," these arrangements allow employees to choose among a variety of benefit options paid for by employer contributions, employee contributions, or both. There are various approaches to design, but flexible benefit plans often provide credits that employees can use to purchase benefits of their own choice. When child care benefits are offered in this type of arrangement, those employees who need and want them can purchase them; those who do not may choose other benefits. Flexible benefit plans allow employers flexibility to meet the needs of different lifestyles and at the same time satisfy equity considerations within a diverse work force.
- *Flexible spending accounts*—also known as *reimbursement accounts*—provide a way to finance child care and other benefits, either within flexible benefit plans or separately as stand-alone plans. These accounts are funded by employee salary reduction arrangements, employer contributions, or both. Under a salary reduction arrangement, the employee makes a pretax contribution to a spending account, which reduces the amount of salary subject to federal income and Social Security taxes. Employees must determine how much they wish to contribute in advance and forfeit any unused dollars at the end of the year. Among 950 firms surveyed by Hewitt in 2007, 96 percent offered a dependent care reimbursement account (Hewitt Associates LLC, 2007). (See chapter on long-term care insurance.)

Elder Care

As with child care, elder care encompasses a large group of benefits that employers offer. Forty-eight percent of 989 employers surveyed in 2007 offered elder care benefits (Hewitt Associates LLC, 2007). Some of the services provided under elder care are similar to those provided under child care. For example, in-house resources and/or referral services were provided by 8 percent of surveyed firms, contracted referral services by 36 percent, and dependent care flexible spending accounts by 83 percent (Hewitt Associates LLC, 2007). Other services and benefits that are unique to elder care—such as long-term care insurance—were offered by 11 percent of surveyed firms in 2007 (Hewitt Associates LLC, 2007).

Costs to Employers—A 1997 study by Metropolitan Life Insurance Company estimated that U.S. businesses lost \$11.4 billion per year in lost productivity due to caregiving (Metropolitan Life Insurance Company, 1999a). The cost estimates were broken out as follows: \$4.9 billion to replace employees who quit due to caregiving needs; \$0.9 billion in absenteeism; \$3.8 billion in work-day interruptions; \$1.1 billion due to elder-care crises; and \$0.8 billion due to supervisors' time lost to dealing with employee caregivers' concerns (Metropolitan Life Insurance Company, 1999b).

Stresses Involved With Caregiving—With many women postponing childbearing until later in life, individuals who are caring for minor children are increasingly also caring for an elderly relative. Caregivers for the elderly must face additional emotional and psychological issues not associated with child care: the elderly individual needing the care is most likely a parent and the caregiver must now reverse life roles with the parent. Unlike a child, who is growing and developing, the elderly infirm person is in a declining stage of life that will end only in death. Added to these emotional and psychological issues is the burden of distance. Unlike child care, where the child lives with the parent, an elderly relative may live in another city. The caregiver must therefore arrange for care from a long distance. Frequently, an employed caregiver must make these arrangements during work hours, adding to his or her stress.

Coordination With Other Benefits—Employees who are caring for an elderly individual may be able to use employee assistance programs (EAPs) and other benefit programs that can alleviate their emotional stress. Because stress takes its toll on an individual's physical health, the use of health promotion programs provided through a health plan also may be helpful. Other benefit options for caregivers include flexible work arrangements, family and medical leave, and dependent care flexible spending accounts. These options are discussed in greater detail below.

Flexible Work Options

Flexible work schedules have become another form of child and elder care support. Flexible work schedules refer to any adjustment in the hours worked that is different from a traditional fixed daily schedule of five days per week. Certain flexible work schedule policies such as flextime, job sharing, compressed work week, and part-time work have become valuable to many working parents. According to Hewitt Associates LLC, 88 percent of employers offered flexible work arrangements in 2007. Of those employers that offered flexible work arrangements, “flextime” (early or late arrivals and departures, as long as a full day of work is provided) was the most prevalent option, with 60 percent of employers offering this benefit (Hewitt Associates LLC, 2007).

A study conducted for the MetLife Mature Market Institute by the National Alliance for Caregiving and Towson University’s Center for Productive Aging found that nearly all employees value and/or use flexibility in scheduling when offered by an employer (93 percent of women and 85 percent of men, Metropolitan Life Insurance Company, 2003).

Flextime—This work schedule allows employees to vary the times their work day begins and ends. Variations can occur in the number of hours worked each day or the total number of hours worked each week or pay period. Flextime plans usually have a required core time each day or specified days of the week. For instance, federal government agencies tend to offer their workers flextime in order to help ease commuter traffic in the Washington, DC, metropolitan area.

Part-Time Workers—Part-time workers are those who work on a temporary basis or those who work part-time on a continuous or so-called permanent basis. Temporary part-time work helps employers meet their peak time or seasonal needs but generally offers employees lower wages, a somewhat lower job status, and no company benefits. However, some employers may prefer to hire someone they know and trust on a permanent part-time basis rather than hire a new full-time employee. In some cases, permanent part-time workers are offered some benefits as well. Despite the loss of some traditional benefits, permanent part-time employment may afford the worker advantages similar to those offered by flextime. In 2007, 78 percent of surveyed employers offered part-time employment (Hewitt Associates LLC, 2007).

Job Sharing—Job sharing refers to a structured arrangement that merges the efforts of two or more (part-time) workers into one job. Employees involved in the sharing usually complement each other by having different strengths. The incidence of workers actually using this scheduling practice is low relative to other types of flexible benefits. In 2007, 27 percent

of surveyed employers offered job-sharing arrangements (Hewitt Associates, LLC, 2007).

Telecommuting—Telecommuting makes it possible for employees to work at home, with a computer, fax line, fax machine, and other necessary equipment. In a telecommuting situation, the employee and employer agree on the work to be done and on the time frame. The employees may need to come to the office for staff meetings, client presentations, and other occasions that require their presence. This arrangement works well for knowledge- or information-based workers who work primarily on computers or telephones, as opposed to manufacturing or service workers whose physical presence at a work site is essential to the performance of their job. In 2007, 38 percent of surveyed employers offered a telecommuting option (Hewitt Associates LLC, 2007).

Compressed Work Weeks—Compressed workweeks consist of several long workdays on a fixed or rotating basis. Many federal government agencies offer employees the option of working nine hours a day for eight days in a two-week period, followed by one eight-hour day and then the next day off. This scheduling provides a day off every other week. In 2007, 27 percent of surveyed employers offered compressed work schedules (Hewitt Associates, LLC, 2007).

Taxation

The Economic Recovery Tax Act of 1981 (ERTA) provided tax incentives for employment-based child and dependent care benefits. Dependent care assistance programs (DCAPs), qualified by the Internal Revenue Service under Internal Revenue Code (IRC) Sec. 129, provide tax incentives to both employers and employees.¹

Employers may deduct from income tax the cost of providing child care benefits. Employees may exclude the value of these benefits from taxable income. The cost of service is not treated as part of employee wages, so neither the employee nor the employer pays FICA or other payroll taxes on this amount. (The maximum exclusion an employee (single or married) is allowed is \$5,000 (\$2,500 for a married individual filing separately) but the amount of dependent care assistance cannot exceed the earned income of the worker or spouse, whichever is lower.) The limits are applicable to the taxable year in which the service occurs, not the year in which the employee is billed or reimbursed. Eligible expenses are limited to dependents under age 13, disabled spouses, and disabled dependents.

¹ Sec. 21 of the tax code, passed by Congress in 1976, provides a tax credit on the individuals' federal income tax liability. In addition, it defines terms such as *dependent* and *employment-related expense*, both of which are important for Sec. 129.

To qualify for tax-free status under IRC Sec. 129, the program, regardless of the type—child care center, direct payment to a child care provider, or resource and referral service—must be available to all employees and cannot discriminate in favor of employees who are officers, owners, or highly compensated.

An employer must also prepare a written plan setting forth eligibility requirements and the method of payment. Eligible employees must be notified of the plan's availability and terms. On or before Jan. 31 of each year, the employer must give each employee a written statement showing the amounts paid or expenses incurred by the employer in providing dependent care assistance to the employee during the previous calendar year.

IRC Sec. 21 permits a federal income tax credit for qualified child care expenses not covered or paid for by an employment-based DCAP. A credit is allowed for eligible children when both spouses work full time or when one spouse is a student and the other is employed. A single parent must be employed or be a student. Qualified expenses are limited to \$3,000 for one qualifying individual and \$6,000 for two qualifying individuals and cannot exceed the earned income of the individual, if single, or the income of the lesser-earning spouse of a married couple in taxable years beginning after Dec. 31, 2002, and beginning before Jan. 1, 2011. A tax credit is provided equal to 20 percent to 30 percent (depending on the taxpayer's adjusted gross income) of eligible expenses against a person's individual income tax (Internal Revenue Service, 2006).

Employees claiming a tax credit or excluding employer DCAP expenses must provide the name, address, and Social Security number or other taxpayer identification number of the care provider on their tax forms. Non-profit 501(c)(3) organizations, such as day care centers operated by nonprofit religious or educational organizations, are not required to provide a taxpayer identification number.

An employee may not combine the employment-based DCAP tax savings with the dependent care tax credit. The employer may assist the employee in determining which would give the employee more tax saving but the employee must choose one or the other.

The Family and Medical Leave Act

The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide up to 12 weeks of unpaid, job-protected leave each year to eligible employees for the birth or adoption of a child or for the serious illness of the employee or the employee's child, parent, or spouse. Employers are required to maintain the same health care coverage for the duration of the employee's leave that was provided when he or she was actively employed. Employers

with fewer than 50 employees are exempt from the law. Although the law requires only unpaid leave, it does allow the employer to offset that unpaid leave with paid leave that the employee has accrued. In 2005, 73 percent of surveyed employers offset the unpaid family and medical leave with all paid leave offered, 12 percent of employers offset it with sick leave or disability only, and 10 percent had no offset provision (Hewitt Associates LLC, 2005).

The Pregnancy Discrimination Act (PDA) of 1978 requires employers that choose to offer disability insurance plans to treat pregnancy and childbirth as any other disability, with the same employee benefit programs. PDA covers employers with 15 or more employees.

Adoption Benefits

Adoption benefits include direct financial assistance or reimbursement for expenses related to the adoption of a child and/or the provision for paid or additional unpaid leave (other than what is required by the Family and Medical Leave Act of 1993) for the adoptive parent employee. Such benefits are increasing in popularity but are available in only a limited number of companies. In the Hewitt Associates LLC survey, 47 percent of employers offered employees financial adoption assistance. Among those offering this assistance, 98 percent reported placing a dollar limit on the benefit provided. The amounts ranged from \$500 to \$10,630, with the average being \$4,099 and the median \$4,000 (Hewitt Associates LLC, 2005).

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www.catalystwomen.org

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(212) 465-2044
www.familiesandwork.org

National Council on the Aging
409 Third Street, SW, Suite 200
Washington, DC 20024
(202) 479-1200
www.ncoa.org
(NCOA sponsors a free service that identifies federal and state assistance programs for older Americans: See www.benefitscheckup.org)

U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
(866) 487-2365
(This Web site provides information on compliance assistance with FMLA: www.dol.gov/dol/compliance/comp-fmla.htm)

CHAPTER 37

EDUCATION ASSISTANCE BENEFITS

Introduction

During the last 50 years, participation has grown in higher education in the United States. One reason has been the demand for more skilled workers to meet the challenges of high technology industries. Another factor was passage of the World War II GI bill, which entitled World War II veterans to a higher education—previously virtually impossible for low-income veterans. In the late 1950s and in the 1960s, higher education also became more accessible to minorities and low-income individuals as a result of government grants and job and loan programs, most of which were established under the Higher Education Act of 1965.

Higher education is more expensive today than it has been during any previous period in U.S. history. College tuition inflation in the past 30 years has averaged approximately 2–3 percentage points higher than general price inflation and is showing no signs of slowing down (Ma and Fore, 2002). Many individuals who cannot afford to finance their education in full look to federal loan or grant programs for financial assistance. However, some of these programs are only available to students who are enrolled at least half time. Many part-time students, therefore, are not eligible to receive government assistance. For these individuals, there are three formal education assistance programs that employers may sponsor for their employees: tax-favored educational reimbursement programs, educational assistance programs, and qualified scholarship programs. In addition to these formal programs, employers sponsor informal educational opportunities for their employees, for example, in-house training and courses involving continuing education, personal development, and literacy enhancement. These informal courses are focused on expanding or improving an employee's job-related functions, and as such are part of normal business operations and do not require a separate tax-advantaged account or other structure to be established.

Educational Reimbursement Programs

Educational reimbursement programs (ERPs) are the most commonly offered education assistance programs by employers. These programs are also known as *tuition reimbursement* programs or *tuition assistance* programs. ERPs are designed to assist employees with the cost of tuition, books,

and fees. Employers usually pay for ERPs from their organizations' general revenues on a pay-as-you-go basis.

Taxation of Benefits—Employers may reimburse employees for any type of educational expense, provided that it meets either of the two following “job-related” criteria, as specified under Sec. 162 of the tax code: The education must maintain or improve the skills that employees are required to perform on their jobs, or the education is required by the employer or by law for the employees to remain in the occupation or to keep the same status or rate of compensation. These benefits are considered “working condition fringe benefits” by the Internal Revenue Service (IRS), and are therefore excludable from an employee’s gross income and deductible for employers as ordinary and necessary business expenses. These expenses also are exempt from income tax withholding and payment of employment taxes (FICA and FUTA) (International Foundation of Employee Benefit Plans, 2000a).

In addition, working condition fringe benefits are exempt from nondiscrimination rules. Employers may reimburse all employees or discriminate in favor of certain categories of employees (information technology workers, for instance), but if they do, they need to be aware of potential morale issues within their work force.

Plan Design—Employers usually limit their benefit costs in some way: by reimbursing less than 100 percent of expenses, by setting a dollar maximum on the reimbursement, or by limiting the number of courses an employee may take per semester or year. Many employers require the employee who receives educational assistance to obtain a certain grade upon completion of the course he or she is taking before the cost will be reimbursed. Others reimburse a greater proportion of the cost for a higher grade. Some employers require the employee to stay with the firm for a certain number of years after completing the course or to repay the course costs.

An employer may elect to pay some of the expenses directly, such as paying tuition expenses to the institution where the classes were held, or indirectly by reimbursing the employee in cash. If the employee is reimbursed in cash, the expenses must be substantiated with receipts.

Educational Assistance Programs

Educational assistance programs were originally legislated through the Revenue Act of 1978, Internal Revenue Code (IRC) Sec. 127. An educational assistance program is a separate written plan that provides educational assistance only to employees of the organization. The program qualifies only if all of the following tests are met (Internal Revenue Service, 2006a):

- The program is required to be a “separate written plan of an employer for the exclusive benefit of the employees to provide such employees with educational assistance.”
- The plan cannot discriminate in favor of officers, shareholders, or the highly compensated.
- No more than 5 percent of annual educational assistance benefits can be paid out to shareholders or owners (or their dependents) who own more than 5 percent of the company.
- A plan cannot provide employees with a choice between educational benefits and other taxable benefits.
- Reasonable notification must be provided to the employees regarding the terms and availability of the program.

Eligible Employees—In addition to current employees, a former employee who is retired, left on disability, or was laid off is eligible to participate in a Sec. 127 educational assistance program. Leased employees are eligible to participate provided they performed services on a substantially full-time basis for at least a year if the services are performed under the primary direction and control of the employer. A sole proprietor, and a partner who performs services for a partnership, are also eligible participants.

For purposes of Sec. 127 nondiscrimination rules, a highly compensated employee is defined as an employee who meets one of two tests: (a) the employee was a 5 percent owner at any time during the year or preceding year; (b) the employee received more than \$100,000 in pay for the preceding year and was among the top 20 percent of employees when ranked by pay for the preceding year (Internal Revenue Service, 2006).

Taxation of Benefits—The Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) made permanent the exclusion from income for employment-based educational assistance benefits under Sec. 127. EGTRRA extended the exclusion to graduate level and well as undergraduate level courses for courses beginning after Dec. 31, 2001. Any amounts provided over \$5,250 are taxable to the employee. When an employee has multiple jobs, the annual limit applies to educational assistance from all employers (Internal Revenue Service, 2006).

Plan Design—Educational assistance expenses include tuition, fees, books, certain supplies, and equipment. Education expenses do not include meals, lodging, transportation, or the cost of tools or supplies (other than textbooks) that the employee is allowed to keep at the end of the course. Expenses do not include the cost of a course or other education involving sports, games, or hobbies, unless the education:

- (a) Has a reasonable relationship to the business, or
- (b) Is required as part of a degree program.

Scholarship Programs

Although scholarship programs are not a commonly offered benefit, some employers establish them for the dependent children of active employees, the active employees themselves, and/or their spouses. Employers can place limitations on this benefit, such as service requirements, annual dollar limits, and number of yearly awards. These scholarships can cover tuition, fees, books, supplies, and necessary equipment. The scholarships are excludable from income for the employee provided that they are outside the pattern of employment, meaning they cannot be compensation for past, present, or future employment services. The scholarships cannot be confined to areas of study or research primarily benefiting the employer.

Sec. 529 Plans

States have begun developing their own aid programs to help residents meet the growing cost of a college education for their children, and Congress has provided these plans with special tax status under Sec. 529 of the Internal Revenue Code (IRC), from which the plans take their name. These savings programs are established and administered by states for the purpose of setting aside savings for “qualified higher education expenses.”

There are two basic types of Sec. 529 plans: a savings plan and a prepaid plan. A prepaid plan allows individuals to prepay college education expenses at today’s prices, while the savings plan allows an individual to set aside some money and earn a variable rate of return on the assets.

Tax Status—Although Sec. 529 plans were first established in 1988 by the state of Michigan (Michigan Education Trust), it was not until 1996 that Sec. 529 was added to the federal tax code to clarify the plans’ federal tax treatment (Ma and Fore, 2002). Prior to enactment of EGTRRA, contributions to a Sec. 529 plan were not deductible from federal income tax although the earnings were allowed to grow tax-deferred until withdrawn to pay for college-related expenses. Since states sponsor these plans, they have included incentives such as making the contributions deductible against state income tax and/or exempting the earnings from state income tax.

Under EGTRRA, starting on Jan. 1, 2002, the earnings on qualified withdrawals from state sponsored plans have been exempt from federal income tax. It is believed most states will go along with the federal tax provisions. The Pension Protection Act of 2006 made permanent the exclusion of 529 plans. Under current law, these provisions are due to expire in 2010. At that

time (assuming no other changes to Sec. 529 have occurred), the federal tax status of Sec. 529 plans will revert to pre-Jan. 1, 2002, status (Ma and Fore, 2002).

Prepaid Plans—Participation in Sec. 529 plans is not subject to income limitation. The only limitation placed on participation in prepaid plans is state residency: Most of these plans require participants to be residents of the sponsoring state. The beneficiary of a prepaid plan can be anyone, even the individual making the contributions. Contribution limits to prepaid plans generally are set at the purchase of up to four years' worth of tuition at certain in-state schools. The assets of prepaid plans may be used to pay for tuition, fees, room and board, books, supplies, and equipment at almost any college or university (Ma and Fore, 2002).

Savings Plans—Participation in savings plans is open to any individual, with no residency requirement. As with prepaid plans, the beneficiary can be anyone, even the individual making contributions, and the assets may be used to pay for tuition, fees, room and board, books, supplies, and equipment at almost any college or university. Savings plans are subject to a lifetime limit on contributions per beneficiary, on account balances (the sum of contributions and earnings less fees and expenses), and in some cases on gross contributions. Lifetime contribution limits vary widely among states. Currently, the lowest limit on gross contributions is \$100,000 and the highest is \$251,000. The lowest limit on account balances is \$122,484 and the highest is \$265,620 (Ma and Fore, 2002).

Transfers from one Sec. 529 plan to another are permitted once every 12 months without having to change the beneficiary. (Before the tax law changes, if an account owner decided to transfer assets from one 529 plan to another, he or she could do so only by changing the beneficiary.) EGTRRA also allows for the transfer of account balances from one cousin to another (in addition to sibling to sibling transfers, as were previously permitted)—a benefit to grandparents who contribute to 529 plans for their grandchildren. Nonqualified withdrawals are subject to regular income tax plus a 10 percent penalty (Ma and Fore, 2002).

In response to EGTRRA, employers are seeing Sec. 529 plans as a new employee benefit. In an e-mail survey conducted by Hewitt Associates LLC in November and December 2001 (in which more than 160 companies participated), 19 percent of surveyed employers plan to assist employees to save for college expenses through payroll deductions or direct contributions to Sec. 529 plans. An additional 46 percent of surveyed employers were considering such moves (Hewitt Associates LLC, 2001).

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Additional Information

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(703) 683-8100
www.astd.org

College Savings Plan Network
Affiliate of the National Association of State Treasurers
P.O. Box 11910
Lexington, KY 40578
(859) 244-8175
www.collegesavings.org

Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224
(202) 622-5000
www.irs.gov

National Institute for Work and Learning
1875 Connecticut Avenue, NW
Washington, DC 20009
(202) 888-8186
www.niwl.org

CHAPTER 38

EMPLOYEE ASSISTANCE PROGRAMS

Introduction

Employee assistance programs (EAPs) are increasingly being used by employers as a health care cost management measure and as a tool for improving employee productivity, morale, and job satisfaction; reducing absenteeism and turnover; and improving the corporate image.

EAPs provide counseling services directed toward acute problems that affect job performance. These programs were originally designed to identify and address the problem of employee alcoholism (and then drug abuse). Today, alcoholism and drug abuse continue to be a major focus of many EAPs. However, counseling is also being offered on stress management, family and marital problems, work place violence, pressures from child and elder care responsibilities, and coping with the effects of company downsizing.

In 2008, 42 percent of workers in private establishments were eligible for an EAP (U.S. Department of Labor, 2008). Employers concerned with their employees' physical and mental health may offer in-house or outside counseling services and/or provide information on such problems as substance abuse, smoking, and stress through seminars, classes, or written materials.

Employers often provide coverage in their company medical plans for the treatment of substance abuse and mental health problems in addition to offering EAPs. Often, this coverage is provided within the framework of an integrated program that includes an EAP as well as a network of behavioral health providers.

Like health promotion programs, EAPs are being developed and offered by employers to address three basic issues: rising health care costs, increasing concern about how employees' personal problems affect job productivity, and growing awareness of the benefits of good health and fitness. EAPs offer employees, and in most case their families, the opportunity to receive confidential professional counseling and assistance. (See Chapter on health promotion programs.)

Types of EAPs

There is no single EAP model to suit all employers. A basic EAP may offer informational pamphlets, while a more comprehensive EAP may offer diagnostic, counseling, and referral services.

EAPs can be provided internally or externally. An internal EAP is an in-house program that offers employees direct assistance through the employer's own staff counselors. Most EAP counseling services that are provided in-house are free of charge to the employee. An external EAP provides its services by contracting with specialists, such as psychologists, counselors, or social workers, to provide services for their employees. Employers may also contract with a community agency to provide services to employees. An employee who is referred to an outside counselor may be required to pay a fee. Both internal and external EAPs utilize telephone hotlines. Employees can use the hotlines to talk with trained counselors, who make assessments and provide referrals to sources of professional help or services.

According to data from William M. Mercer, in 2000, most employers that offered an EAP (71 percent) used a separate external EAP vendor. Twelve percent of employers providing an EAP used an internal EAP staff and 18 percent used the same organization that administers the mental health and substance abuse benefits (William M. Mercer, 2000).

Today, in addition to addressing the "traditional" problems such as alcoholism and drug abuse, EAPs offer a broad range of services. Some of the services currently being offered by EAPs include divorce or other family discord issues, stress management, crisis intervention, dependent care issues, and retirement counseling. One of the most popular services, offered by 53 percent of EAPs today, is a legal services plan (DeMent 1998).

Planning an EAP

If employees are to seek out the services of an EAP, the program must be structured to guarantee confidentiality and trust. Communication with employees about the program needs to emphasize the EAP's role in assisting those who need help. Employers may face legal liability for the actions taken by the EAP and therefore need to make sure that their liability insurance covers actions taken by both internal and external EAP counselors. The following are some types of situations for which an employer may be legally liable: malpractice, misdiagnosis, negligent referral, defamation or other harm to the employee's reputation, and inappropriate relationships, such as sexual involvement between an EAP counselor and an employee (Panszczyk, 1997).

Confidentiality of records is very important. Employees need to be assured that, by participating in the EAP, they are not jeopardizing their jobs. Because of the vital importance of confidentiality to the functioning of an EAP, employers should take some or all of the following precautions (Panszczyk, 1997):

- Locate the EAP offices either off the company's premises or at an out-of-the-way location on the company's premises.
- Maintain EAP records separately from human resource records.
- Take steps to ensure that EAP participant records cannot be identified.
- Both paper and computerized records should be secure, with limited access.
- Make assurances that the details of treatment are confidential.
- Require written consent before releasing information.

Evaluating an EAP

As is the case with any other employee benefit program, evaluating the effectiveness of an EAP is important in determining whether it is providing the quality of services needed by the employees in a cost-effective manner. In order to evaluate the performance of an EAP, an employer should ask for data on the following topics:

- The number of calls or visits.
- The nature of the calls.
- The recommendation for care.
- The amount of time spent with each individual.
- The time of day of the call or visit.
- The follow-up with the individual or supervisor who refers the employee.
- What price differentials exist that influence the decision?

Measuring the cost savings that an EAP provides is more difficult to do. Some areas that may be useful in evaluating the cost savings associated with an EAP are:

- The number of lost workdays.
- The number of accidents and errors.
- Morale and productivity.
- The use of medical benefits.

Employers should look at each of these areas and determine whether there is improvement between the period before the EAP was introduced and a year following its introduction (Panszczyk, 1997).

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Oakbrook, IL 60523
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www.esmassn.org

CHAPTER 39

LEGAL SERVICES PLANS

Introduction

Employed persons usually do not qualify for legal aid or the services of public defenders. Most people tend to postpone seeking legal information and assistance until their needs become acute and, typically, more costly, according to the American Bar Association (ABA). Thus, wills go unwritten and legal documents go unchecked. Legal services plans can provide affordable legal representation and consultation for many who would otherwise not obtain such services.¹

Legal services plans are arrangements between a group of people and one or more lawyers to obtain legal assistance. Although such plans have been in existence since the late 1800s, their development was hindered well into the 1900s by bar associations, which opposed the plans on grounds that they constituted a form of client solicitation. However, four U.S. Supreme Court decisions between 1963 and 1971 recognized the constitutional right to obtain legal advice, and the court ruled that bar associations could not interfere with the establishment of legal services plans. Hewitt Associates LLC reports that 24 percent of private employers provided group legal services to their employees in 2007 (Hewitt Associates LLC, 2007).

Legal services plans primarily provide preventive assistance by making legal information and advice readily available. By preventing disputes or simple legal matters from becoming serious problems, they offer the potential for reducing legal expenses; in addition, plan members often receive discounted rates.

Plan Design and Cost

Legal services plans encompass a broad spectrum of designs and costs, ranging from plans that offer free consultations and discounts to those that cover a wide range of legal services. Most plans are group plans.

Plan Types—*Access plans* provide members access to legal advice and services. They typically include in-office or telephone consultation with a lawyer; follow-up services, such as correspondence; a review of legal documents; self-help counseling; referrals to participating attorneys for further legal assistance; and fee discounts for more complex matters.

¹ Legal services plans are sometimes known as prepaid legal services plans or group legal services plans.

In addition to the services provided in the access plans, *comprehensive plans* provide other services such as legal representation for domestic matters; will and estate planning; traffic matters; and consumer, debt, and real estate issues.

Enrollment—In group plans, enrollment may be *automatic* or *voluntary*. In an automatic enrollment plan, all members of the group are automatically members of the plan. In a voluntary enrollment plan, only those members who choose to enroll are covered, on a prepaid basis. Household members typically are also covered.

Delivery of Benefits

The structures for delivering legal services plan benefits are as varied as those related to health insurance plans, but they can be classified under three broad categories: open panel plans, closed panel plans, and modified panel (or combination) plans.

Open Panel Plans—Under open panel plans (the least common), a member may use any licensed attorney. Payment for services is usually made according to an established fee schedule, with fees varying depending on the type of service provided. The plan participant is responsible for attorney fees in excess of the scheduled amount. Open panel plans may also use legal services trust funds.

Open panel plans offer advantages and disadvantages. While a participant is able to choose his or her own attorney, the attorney selected is never obligated to accept the case, particularly if the attorney's caseload is heavy or the case is outside his or her area of expertise. Administrative costs are generally higher in open panel plans. Since the sponsoring employer has no control over the attorneys' fees, sponsors often restrict coverage to selected services and/or impose maximum coverage limits.

Closed Panel Plans—There are two types of closed panel plans: staff plans and participating attorney plans. *Staff plans* provide benefits through a full-time, salaried staff of lawyers who are hired specifically to handle the group's needs. In *participating attorney plans*, a plan sponsor contracts with one or more law firms to provide access to legal services to a group of participants who are geographically dispersed. A closed panel can pay lawyers a per capita amount or pay according to a fee schedule. The plan usually pays the entire cost, but some plans may allow the client to be billed for costs in excess of a certain amount or require a percentage payment by the client, as in many health plans.

Administrative costs under closed panel plans are generally lower than those under open panel plans. Since a smaller number of attorneys are involved, there are fewer records to manage and payments for services may

be easier. The lawyers in a closed panel plan often acquire special expertise in areas associated with the covered group's most common problems. Unions usually favor closed panel plans, under which they are able to control the quality of the legal work by controlling the selection of attorneys. Closed panel plans frequently can offer more efficient legal services at lower rates than open panel plans.

Scope of Services

Types of Services Covered—Four broad service categories that may be covered under a comprehensive service plan are consultation, general nonadversarial, domestic relations, and trial and criminal.

- ***Consultation***—Legal services plans are used most frequently for legal information and advice (most legal matters require no more). They may deal with virtually any type of legal issue, including consumer matters, landlord-tenant disputes, and domestic disputes (e.g., overdue child support payments and visitation rights). Here, the attorney counsels the participant, either by telephone or in the office, on appropriate legal action or may provide self-help information so the plan participant can resolve the problem on his or her own.
- ***General Nonadversarial***—These services are generally performed in an attorney's office. They deal with such matters as review of documents, wills, and adoption papers; guardianship; name changes; personal bankruptcy; real estate transfers; estate closings; and Social Security, unemployment, and other benefit claims.
- ***Domestic Relations***—Legal separations and divorces are the most frequently used services covered by legal services plans. Most plans that cover these services also cover the costs of modifying divorce and separation agreements (such as changes in the terms of child custody agreements, visitation agreements, child support, or separate maintenance arrangements). Due to the high cost that is often associated with domestic relations legal problems, many plans limit these types of services.
- ***Trial and Criminal***—This type of service includes adversarial legal matters, such as contested adoptions and guardianship, civil suits, and contested domestic relations matters, and minor criminal matters such as suspension or revocation of driver's licenses, juvenile court proceedings, and misdemeanors. Although infrequently utilized, these services usually incur the highest plan cost per claim; thus, many plans do not cover them.

Exclusions and Limitations—In order to avoid excessive attorney fees and unnecessary services, plan sponsors may build in cost controls by excluding coverage for certain types of services such as actions against employers and unions; services for legal problems existing before the plan’s effective date; lawyers’ contingency fees; and court expenses such as fines, court costs, filing fees, subpoenas, assessments, penalties, and expert witness fees.

Plans may also use closed lists of eligible procedures, which automatically exclude some legal services from the schedule of benefits; limit the number of hours or dollar amount of services rendered; limit the frequency of coverage for a particular service over a specified time; or place maximum limits on the attorneys’ hourly fees, which are usually less than the prevailing rate.

Taxation

Initially, legal services plan contributions were counted as gross income to the employee. However, employers were allowed to take a tax deduction for their contributions. Subsequent legislative changes removed many of the initial deterrents to the establishment of these plans, particularly their explicit exclusion from taxation under the Tax Revenue Act of 1976, which added Sec. 120 to the Internal Revenue Code (IRC). The original law expired at the end of 1981, but subsequent tax laws in 1981, 1984, 1986, 1988, 1989, and 1990 extended the tax exclusion, sometimes retroactively. The extension included in the 1990 law expired on June 30, 1992. Currently, the tax exclusion for legal services plans under IRC Sec. 120 is still “expired”; however, there is active lobbying to make it a permanent part of the tax code. Some observers believe that the impermanence of the tax exclusion for legal services plans may discourage their widespread development and use.

In the past, in a qualified plan under IRC Sec. 120, employer contributions for legal services benefits of up to \$70 per year were excludable from income tax. To qualify for favorable tax treatment, the plan had to meet the following requirements:

- An application for qualification must be filed with the Internal Revenue Service.
- The employer must establish a separate written plan for the exclusive benefit of employees (and their spouses or dependents); the plan must provide only legal services.
- The plan must provide personal legal services; it cannot provide legal services related to an employee’s trade or investment property.
- The plan cannot discriminate in favor of shareholders, officers, or highly paid employees. In determining whether the plan is discriminatory,

certain employees may be excluded from consideration—specifically, those covered under an agreement determined by the Secretary of Labor to be a collective bargaining agreement, providing there is evidence that group legal services benefits were the subject of good faith bargaining. Certain limits also apply to contributions made on behalf of shareholders and owners who have more than a 5 percent interest in a firm.

- The employer must transmit its plan contributions to designated recipients (e.g., insurance companies, tax-exempt trusts, or authorized service providers).

All legal services plans maintained by a private employer or employee association are classified under the Employee Retirement Income Security Act of 1974 (ERISA) as employee welfare plans and are subject to certain requirements. Legal services plans sponsored by public employers are not subject to ERISA.

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American Prepaid Legal Services Institute
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www.aplsi.org

National Resource Center for Consumers of Legal Services
6596 Main Street
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Gloucester, VA 23061
(804) 693-9330
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CHAPTER 40

DOMESTIC PARTNER BENEFITS

Introduction

Domestic partner benefits are benefits that an employer voluntarily chooses to offer to an employee's unmarried partner, whether of the same or opposite sex. An employer wishing to implement a domestic partner program needs first to identify what constitutes a domestic partner. The most common definitions contain some or all of the following core elements (Hewitt Associates, 2000):

- The partners must have attained a minimum age, usually 18.
- Neither person is related by blood closer than permitted by state law for marriage.
- The partners must share a committed relationship.
- The relationship must be exclusive.
- The partners must be financially interdependent.
- The partners must have resided together a minimum period of time.
- The relationship must be registered as a domestic partnership with a government agency.

An employer also must decide whether the domestic partner program is to cover same-sex couples only or include opposite-sex couples. Documentary proof of a domestic partner relationship can take many forms; it is up to the employer to determine the appropriate one. Some employers are satisfied with the partners signing a written statement of their relationship. Others may require proof of a financial relationship such as a joint lease or mortgage or copies of tax returns showing financial interdependence. Whatever documentation is required must be germane to the issue of validating a domestic partnership, or it could lead to claims of invasion of privacy.

Benefits Offered

Most employers that offer domestic partner benefits offer a range of only low-cost benefits, such as family/bereavement/sick leave, relocation benefits, access to employer facilities, and attendance at employer functions. However, public attention has focused on employers who offer health insurance coverage to domestic partners.

According to a 2007 survey by Hewitt Associates, 54 percent of surveyed firms offered coverage for domestic partners. Seventeen percent of firms offered domestic partner coverage to same-sex couples only; 1 percent of firms offered coverage to opposite-sex couples only; 32 percent of surveyed firms offered coverage for same or opposite-sex couples (Hewitt Associates, 2007). According to a 2005 Hewitt Associates study, of those employers that offered domestic partner benefits, 83 percent offered the coverage to dependents of domestic partners. These numbers represent a significant increase since 2002, when 19 percent of surveyed firms offered domestic partner benefits (Hewitt Associates, 2005).

According to the Human Rights Campaign Fund, which claims to be the largest national lesbian and gay political organization in the United States, as of August 14, 2008, 9,374 employers had been identified as offering domestic partner benefits.¹

Reasons for Offering Domestic Partner Benefits

Many employers believe that offering benefits to legally married partners of employees and not offering the same benefits to the partners of non-legally married partners of employees discriminates on the basis of sexual orientation and/or marital status. Sixty-four percent of employers had a formal policy against discrimination on the basis of sexual orientation in 2000, according to Hewitt Associates (Hewitt Associates, 2000). The decision to offer domestic partner benefits communicates to employees that the employer is committed to its stated policy.

Many employers also offer domestic partner benefits in order to recruit and retain workers. The relatively high value that employees place on employment-based comprehensive health benefits is well documented (Christensen, 2002). In a tight labor market, designing a benefits package that appeals to a diverse work force enables an employer to maintain a recruitment edge and demonstrates that the employer values diversity. Employee morale and productivity have been found to improve in work environments where individuals believe the employer demonstrates that it values its employees. According to a 2005 Hewitt Associates study, the number one reason for offering domestic partner benefits was to attract and retain employees (cited by 71 percent of organizations offering benefits to same-sex couples and 69 percent to opposite-sex couples) (Hewitt Associates, 2005).

¹ A listing of firms that offer full health insurance coverage to domestic partners is posted by the Human Rights Campaign at www.hrc.org/worknet/dp/index.asp

Costs of Domestic Partner Benefits

Cost is the primary concern for employers, since extending coverage to more individuals increases the cost of health benefits. Two components drive the cost issue:

- How many new enrollees the plan can expect to receive; and
- What risks are likely to be associated with these individuals?

In a 2000 study of domestic partner benefits, Hewitt Associates found that 90 percent of employers that offer domestic partner benefits reported that less than 3 percent of all employees offered the coverage actually elected to take it, and 58 percent reported less than 1 percent acceptance (Hewitt Associates, 2000). In the planning stage, many employers had anticipated an enrollment rate of 10 percent. Employers that allow only same-sex couples to enroll domestic partners in the health plan reported a lower enrollment rate, compared with those that allow opposite-sex couples to enroll. Hewitt found that employers are no more at financial risk when adding domestic partners than when adding spouses.

Experience has shown that the costs of domestic partner coverage are lower than anticipated. There are several reasons for this: The employees eligible for domestic partner coverage tend to be young, and, as a result, healthier; enrollment in domestic partner coverage is low, primarily because most domestic partners already have coverage through their own employers; any increased risk of AIDS among male same-sex couples appears to be offset by a decreased risk among female same-sex couples; and same-sex domestic partners have a near-zero risk of pregnancy. Most recent estimates (1996) of the lifetime costs of treating a person with HIV disease range from \$71,143 to \$424,763. By way of comparison, the cost of a kidney transplant can be as high as \$200,000, and the cost of premature infant care can run from \$50,000 to \$100,000. In 2005, Hewitt Associates found that 88 percent of employers that offer domestic partner benefits reported that they amount to less than 2 percent of total benefit costs (Hewitt Associates, 2005).

Domestic Partner Benefits and Federal Law

The Internal Revenue Service (IRS) has addressed the issue of domestic partner coverage in several private letter rulings. According to those rulings, employment-based health benefits for domestic partners or nonspouse cohabitants are excludable from taxable income only if the recipients are legal spouses or legal dependents. The IRS also states that the relationship must not violate local laws in order to qualify for tax-favored treatment. The IRS leaves the determination of marital status to state law. Currently, three

states recognize same-sex marriages: California, Connecticut, and Massachusetts. Some cities (i.e., San Francisco and New York City) allow domestic partners to register their relationship with the city, but these registries do not provide legal status as marriage or common-law marriage.

With regard to opposite-sex couples, there are 11 states plus the District of Columbia that recognize common law marriages and all states recognize common law marriages legally contracted in those jurisdictions that permit them (see http://topics.law.cornell.edu/wex/table_marriage for more information). Opposite-sex couples in those jurisdictions that recognize common-law marriage do receive the tax-favored treatment for spousal coverage in an employment-based plan. However, an employer that contributes to the cost of health benefits for domestic partners must report the premium (or premium equivalent for self-insured plans) of the employer-provided portion as imputed income on the employee's W-2 form.

Sec. 125 Flexible Benefits and Spending Accounts—Employee flexible allowances that include extra money or credits toward providing coverage for a domestic partner are treated as taxable income, and employee contributions for domestic partner coverage cannot be taken on a pretax basis. Flexible spending account benefits may not be provided to a domestic partner because, generally, they do not qualify as employees' dependents under the tax code.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)—A domestic partner may not make an independent election for COBRA coverage. This is because COBRA specifies that only covered employees, their spouses and children are considered "qualified beneficiaries." A domestic partner may be part of an employee's election if the plan provisions extend continuation coverage to domestic partners for some or all COBRA events.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)—Domestic partners may not be dependents and therefore technically are not covered by some portions of HIPAA. However, an employer that provides health insurance to domestic partners will need to include them in the certification procedure and health nondiscrimination provisions of HIPAA, if they are covered by the plan. Employers may want to apply the other HIPAA requirements for consistency in administration.

Defense of Marriage Act of 1996 (DOMA)

For purposes of federal tax law and benefits, DOMA established federal definitions of (a) "marriage" as a legal union only between one man and one woman as husband and wife; and (b) "spouse" as a person only of the

opposite sex who is a husband or wife. Because of DOMA's provisions, if a state extends marriage to same-sex couples, same-sex partners would not be treated as spouses for federal tax and employee benefit purposes.

Because marriages are granted through state law, DOMA also gives states the choice to recognize same-sex marriages legally performed in other states. The law does not specifically outlaw same-sex marriage, and states remain free to recognize same-sex marriage if they so choose. But by making one state's recognition of another state's legal acts optional in this instance, DOMA essentially creates an exception to the Full Faith and Credit Clause of the U.S. Constitution, thus raising constitutional questions concerning the validity of the law. Because Vermont created a parallel civil union rather than sanctioning same-sex marriage, the new law does not create an opportunity to challenge DOMA's constitutionality. Since the enactment of DOMA in 1996, the issue has not come before the U.S. Supreme Court for a decision.

State and Local Governments and Domestic Partner Benefits

Benefits generally are regulated at the federal level through the Employee Retirement Income Security Act of 1974 (ERISA), and private employers that choose to offer domestic partner benefits must follow federal law. Most recent legal activity concerning domestic partner benefits has involved state and local governments acting in their capacity as employers but subject to local political and legal circumstances. As a result, some jurisdictions have taken very different approaches to the issue.

Connecticut Supreme Court, Elizabeth Kerrigan et al. vs. Commissioner of Public Health et al.—On October 10, 2008, the Connecticut Supreme Court in a 4–3 ruling found that failing to give same-sex couples the full rights, responsibilities, and name of marriage was against the equal protection clauses of the state constitution and ordered that same-sex marriage be legalized. The ruling is to take effect October 28, 2008. www.jud.state.ct.us/external/supapp/Cases/AR0cr/CR289/289CR152.pdf

California Supreme Court, In re: Marriage Cases—May 15, 2008, the California Supreme court ruled by 4–3 that marriages between people of the same sex are legal, thereby overturning an existing statutory ban on same-sex marriage. The ruling went into effect June 14, 2008. See www.courtinfo.ca.gov/opinions/documents/S147999.pdf for the decision.

The “Limit on Marriage” (Proposition 8) proposed constitutional amendment is an initiative to put before the voters of California in November 2008 an amendment to the state constitution that would ban same-sex marriage, thereby overturning the state Supreme Court's decision. Gov. Arnold Schwarzenegger is opposed to the proposed constitutional amendment. On November 4, 2008, California voters voted in favor of Proposition 8.

Supreme Judicial Court of Massachusetts, Hillary Goodridge & others vs. Department of Public Health & another—The Massachusetts Supreme Judicial Court held Nov. 18, 2003, that “barring an individual from the protections, benefits, and obligations of civil marriage solely because that person would marry a person of the same sex violates the Massachusetts Constitution.” The court stayed the entry of judgment for 180 days “to permit the Legislature to take such action as it may deem appropriate in light of this opinion.” <http://caselaw.lp.findlaw.com/scripts/getcase.pl?court=ma&vol=sjcslip/sjcNov03c&invol=1>

The Massachusetts State Senate asked the court for an advisory opinion as to whether legalized civil unions would be sufficient for same-sex couples. The court ruled on Feb. 6, 2004, that they would not, saying, “Because the proposed law by its express terms forbids same-sex couples entry into civil marriage, it continues to relegate same-sex couples to a different status. The history of our nation has demonstrated that separate is seldom, if ever, equal.”

The state court’s decision providing state recognition of same-sex marriages went into effect on May 18, 2004. On March 29, 2004, the state legislature narrowly passed a state constitutional amendment ballot measure that would overturn Goodridge. The amendment had to be approved a second time in the 2005–2006 session of the legislature. On June 14, 2007, the effort to ban same-sex marriage by amending the state constitution was defeated.

At this point it is unknown what impact the Massachusetts action might have on the federal Defense of Marriage Act, although it is speculated that a challenge arising out of a Massachusetts same-sex marriage (if one occurs) ultimately will test the legality of DOMA before the U.S. Supreme Court. In November 2004, the U.S. Supreme Court refused to hear a case trying to overturn the Massachusetts decision.

San Francisco City Marriages—On Feb. 12, 2004, San Francisco Mayor Gavin Newsom ordered the city to begin approving same-sex marriages, and since then city clerks have conducted hundreds of same-sex marriage ceremonies. While state law and a voter-approved referendum passed in 2000 (Proposition 22) define marriage as a union of a man and a woman, Newsom maintains that the state constitution’s broad equal protection clause pre-empts those laws. Legal challenges to the city’s action currently are underway.

Vermont’s Civil Union Law for Same-Sex Couples, Effective July 1, 2000—On April 26, 2000, Vermont’s governor signed into law H. 847 (Act 91) establishing a system of civil unions for same-sex couples, effective July 1, 2000. Couples entering into a civil union in Vermont will have the same

state-guaranteed rights and privileges (and obligations) as married couples, even though they will not be considered “married” under state law.

The highly controversial law stemmed from a unanimous ruling Dec. 20, 1999, by the state Supreme Court (*Stan Baker et al., vs. State of Vermont et al.*), which held that there was no state constitutional reason for “denying the legal benefits and protections of marriage to same-sex couples.” The case could not be appealed to a federal court because the ruling was based on Vermont’s constitution, so federal law did not apply.

The Vermont Supreme Court did not give permission for legalizing same-sex marriages, but instead ordered the state legislature to come up with some method for implementing its decision. Because the legislature created a domestic partnership equivalent to marriage, employers are expected to be able to retain more design flexibility over their benefit plans, and ERISA will shield self-funded employers from being forced to cover “domestic partners” of Vermont employees.

Benefit Provision: Because ERISA pre-empts state law provisions that relate to employee benefit plans, private employers will not be required to recognize civil unions as marriages for the purposes of employee benefit plan design. The exception to this is with regard to state family leave benefits and workers compensation benefits, which are not ERISA-covered programs.

Insurers in Vermont are required to offer coverage to parties in civil unions and their dependents if they offer such coverage to spouses and dependents. It appears that employers are not required to purchase such policies for their employees. The insurance provisions of the law took effect on Jan. 1, 2001.

Who Is Eligible for a Civil Union and What Are the Rights and Benefits?—Civil unions are available to two unrelated persons of the same sex who:

- Are at least 18 years old.
- Are competent to enter a contract.
- Are not already married or in a civil union.
- Have a guardian's written permission if they are under a guardianship.

There is no residency requirement, but to dissolve a civil union the parties must follow the same procedures required for divorce.

Parties to a civil union have exactly the same rights and obligations as married couples and are subject to the state domestic relations laws regarding support, custody, property division, and dissolution of the relationship.

Reciprocal Beneficiary Relationships: Related persons who cannot marry or enter into a civil union (i.e., siblings) can now enter into a “reciprocal beneficiary” relationship. This relationship will entitle them to more limited

spousal-type rights than civil unions. Generally, these rights relate to health care decisions, hospital visits, and durable power of attorney for health care (Hawaii has had a similar reciprocal beneficiary law since 1997).

The following states have enacted civil union laws which provide all the same rights and responsibilities as marriage:

- Connecticut (www.jud.ct.gov/lawlib/Notebooks/Pathfinders/CivilUnions.htm). See above on Connecticut and same sex marriage.
- New Hampshire (www.gencourt.state.nh.us/legislation/2007/HB0437.html).
- New Jersey (www.njleg.state.nj.us/2006/Bills/A4000/3787_I1.pdf).

San Francisco Nondiscrimination in Contracts-Benefits Ordinance, Effective Jan. 1, 1997—The Air Transport Association of America successfully sued the City of San Francisco, claiming airlines do not have to comply with the city’s ordinance because the airlines’ benefit packages are governed by federal law, specifically ERISA, which pre-empts state and local laws with regard to employee benefits. In an April 10, 1998, ruling, the U.S. District Court for the Northern District of California upheld the San Francisco ordinance *except* with regard to airlines. In her ruling, Judge Claudia Wilkens stated that the city acts as a “market participant” in dealing with city contractors—other than airlines—and the law therefore does not violate the ERISA pre-emption provisions. However, in the city’s dealing with airlines at the city-owned airport, the city acts as a regulator, and not a market participant, so therefore the ordinance is pre-empted by ERISA with regard to the airlines, the judge ruled. The ruling applies the “market participant” standard to situations where the city wields no more power than an ordinary consumer in its contracting relationships.

In November 1999, Los Angeles and Seattle joined San Francisco in enacting an ordinance that requires private employers that contract with the cities to provide benefits to the domestic partners of workers.

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Additional Information

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919 18th Street, NW, Suite 800
Washington, DC 20006
(202) 628-4160

HRC WorkNet is a national source of information on workplace policies and laws surrounding sexual orientation and gender identity.
www.hrc.org/worknet/dp/index.asp

San Francisco's City Ordinance on Equal Benefits for Domestic Partners and Spouses: www.sfgov.org/site/sfhumanrights_index.asp?id=4584

PART FIVE
PUBLIC SECTOR

CHAPTER 41

THE PUBLIC-SECTOR ENVIRONMENT

Introduction

More than 21 million individuals are employed by public jurisdictions in the United States. These public entities include the federal government; state, county, and municipal governments; school districts; and a host of other special-purpose districts and authorities. Approximately 16 percent of the employed labor force, or nearly 1 in 6 working Americans, works for a public entity.¹

Nearly all of these public employees are covered by employee benefit programs. While there is enormous diversity among the programs, taken together, they exhibit a certain family resemblance and differ in important respects from private-sector programs. This chapter highlights these differences and provides an overview of the current status of employee benefits in the public sector.

Many of the differences between public-sector and private-sector benefit plans stem from the different environments in which they operate. Indeed, these environmental differences are important enough that some discussion of them is necessary to provide a context for understanding the differences in individual benefits.

Centrality of the Political Process

The single largest difference between public- and private-sector benefit programs lies in their relationship to the law and the legislative process. All qualified private-sector plans with tax-incentive features are regulated by the federal government (primarily by the Employee Retirement Income Security Act of 1974 (ERISA)), but public-sector plans are not subject to all ERISA provisions. Within these constraints, private-sector plan sponsors are relatively free to establish, maintain, and modify their plans as regulated by ERISA.

By contrast, the basic features of public employee plans—eligibility, contributions, types of benefits, etc.—are often spelled out in statutes or in local ordinances. Even where collective bargaining over benefit issues is allowed,

¹ Data are preliminary for October 2006 from U.S. Department of Labor, Bureau of Labor Statistics.

the legislatures generally retain some measure of control. Furthermore, public employee programs usually exist within a highly structured personnel system that is itself prescribed, often in great detail, in public law. In addition, because they are legislative products, public employee benefit plans necessarily reflect the interplay of political (rather than economic) forces. Where public employee benefit plans are concerned, the interest group activities can usually extend far beyond the public administrators and employees (and their unions and associations) that are directly affected, and often include provider groups, insurers, the business and financial community, and taxpayer organizations.

The influence of organized labor on public employee benefits is particularly strong. In 2006, approximately 40.1 percent of public employees were represented by labor unions, compared with 8.1 percent of private employees (U.S. Department of Commerce, 2008). This influence is exercised directly where bargaining over benefit issues is allowed, but it is also exercised indirectly through the legislative process.²

Relationship to Federal Law

A second fundamental difference in the environment of public employee plans as opposed to those sponsored by private companies is the role played by federal tax and benefits law and regulation. The taxing power of the federal government has been used to encourage the provision of employee benefits by private business since 1916, when corporations were first allowed to deduct payments to retired employees, their families, and dependents as ordinary and necessary expenses (Graebner, 1980). The federal government's taxing power has also been used to compel certain behavior (e.g., participation in Social Security) by the levying of payroll taxes. However, approximately one-fourth of all full-time workers in state and local defined benefit plans are not covered by Social Security (Fore, 2001; Eitelberg, 1999).³

Regarding federal taxation, it should be recognized that a qualified private-sector pension plan and its participants enjoy three tax benefits. First, the employer's contributions are immediately deductible. Second,

² There continues to be quite a range of union influence or lack thereof—on one end there are states that have public-sector collective bargaining with binding arbitration where benefits are on the table and the other end of the spectrum would be right-to-work states or states that simply have “meet and confer” statutory provisions. Regardless of the union influence, the legislative process through which benefit provisions are established has much in common with the collective bargaining process.

³ Among general coverage statewide retirement systems, 43 systems participate in Social Security. The delineation between states with systems under Social Security and those outside the system is not entirely clean, however, since there are both large and small retirement programs not covered by Social Security that operate in states where the general retirement programs are covered.

earnings on the plan investments are exempt from taxation. Third, the benefits in the pension plan that accrue to participants are tax-deferred until the participant takes a distribution. By contrast, because state and local governments are not subject to federal tax, the first benefit is inapplicable to them. In the second benefit, earnings on plan investments may or may not be tax-deferred—depending on whether the plan invests in tax-exempt state and local government investments (in which case there would be no tax benefit) or any other taxable investment (in which case the earnings would be exempt from taxation until distributed). Therefore, the only benefit applicable is the third one that defers a participant's liability for federal tax on the pension accrual until he/she takes a distribution. Since public jurisdictions are not taxpaying entities, their behavior cannot be influenced by opportunities to reduce federal tax on their revenues.

State and local jurisdictions also co-exist with the federal government in a system of federalism, and while the powers and prerogatives of the various levels of government have changed over time, the balance among them is always a politically delicate issue. The federal government has at times formally asserted that its tax laws and benefits regulations do apply to benefit plans for public-sector employees, but occasionally its enforcement has been slow. However, public-sector plans share with qualified private-sector plans a common source of rules under the federal Internal Revenue Code (IRC), which has been expanded in recent years. Attention to public plans has increased in the last several years, however (see chapter on defined benefit plans). For reasons unrelated to federalism, the federal government has also chosen to exclude its own employees' benefit programs from major parts of the law applicable to private plans. The special status of governmental plans can be seen most readily in their relationship to two landmark pieces of federal legislation, the Social Security Act of 1935 and ERISA.

Benefit Systems

The pension area for state and local jurisdictions is characterized by a relatively small number of large systems and a large number of small systems. According to the U.S. Census Bureau, there were 2,654 state and local retirement systems in the United States as of 2006, with the 221 state-administered systems accounting for 90 percent of the total covered population (U.S. Department of Commerce, 2006). At the federal level, most civilian employees are covered by the Civil Service Retirement System (for civil servants entering the federal government before 1984) or the Federal Employees Retirement System (for new hires brought in after 1983). Those in the military services are included in the Defense Department's military retirement system. Approximately another 30 relatively small groups—e.g.,

staff employed by the Foreign Service and Federal Reserve and other bank systems—have their own, entirely separate, arrangements.

Health and life insurance plans are likely to be operated by each jurisdiction for its own employees and, unlike pension plans, they are often collectively bargained. However, New York and California operate statewide health benefit programs in which local government employees can elect to participate. Where they exist, state-run long-term disability and sickness and accident insurance plans may also be open to local government entities.

Occupational Divisions

Another salient feature of public employment for benefit purposes is that the work force in some states is subdivided along certain occupational lines. In many jurisdictions, law enforcement and firefighting employees have their own programs apart from those for other public employees. Alternatively, they may participate in a general system but in plans that take into account their unique career patterns. Public school teachers also sometimes have separate plans or separate arrangements, whether they participate in a state-run or a local plan. The special status of these occupational groups is partly historical (they were among the first to obtain pension coverage), partly a consequence of the occupations' characteristics and requirements, and partly a reflection of their ability to protect their interests in the political arena.

One characteristic of private-sector plans that is extremely rare in the public sector is the provision of separate benefits for executives. In the public sector, benefit provisions tend to apply equally to all levels of the work force. Even where separate "executive services" have been recognized, separate benefit provisions are rare. However, this egalitarian tradition does not extend to members of the judiciary, the legislature, or elected members of the executive branch. Since careers for legislators and elected officials may encompass a much shorter period of time than for other categories of employees, plan provisions for these occupations may allow benefits to accrue at a faster rate. Judges almost always have their own separate pension plans, typically with higher benefit accrual rates, while legislators enjoy faster pension vesting, eligibility, and computation provisions. The judges' plans are justified on the grounds that the judiciary must be provided a sufficient measure of security to allow them to carry out their responsibilities in an impartial, disinterested way and also because they typically enter the system at a late age. The special provisions for legislators and elected officials are justified by the uncertain nature of their tenure.

Key Distinguishing Characteristics

It is quite unusual for private-sector employees to contribute to defined benefit retirement plans. While not universally true, a common characteristic of public-sector pension plans is the requirement that members, as a condition of employment, must contribute to the cost of their defined benefit retirement benefits. The typical approach is to require that a certain percentage of payroll be contributed. A provision of the IRC, which is applicable only to public-sector plans, allows for the establishment of an arrangement whereby member contributions may be made with before-tax dollars—an arrangement that has been widely embraced in the public sector.

Another distinguishing characteristic is public employee participation in Social Security. While private-sector employees are universally covered by Social Security, public-sector employee participation is dependent on whether or not the state in which they work has an agreement with the federal government for state and/or local government employee coverage. In a few states, no public-sector employees participate in Social Security, and in many states certain segments of the public-sector work force (such as teachers, police, and fire employees) are excluded, while the balance of the public employee work force participates.

Commonalities

For all the differences between public- and private-sector employee benefit plans, there also are numerous commonalities. In a competitive marketplace, all employers need to attract and retain workers and to maintain a healthy and vigorous work force. To the extent that benefit programs serve these needs, they are based on common motives and directed at common goals. Furthermore, while public pension systems developed early and more or less independently of private business practice, the later addition of health and welfare plans was often a response to the availability of such benefits in private employment. Indeed, in determining many aspects of compensation for public employees, legislators have looked to practices prevailing in the business community. Thus, many developments in private-sector employee benefit plans eventually surface in public employee programs, albeit in a form tailored to the public entity's traditions and circumstances.

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National Association of State Retirement Administrators
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National Council on Teacher Retirement
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National Education Association
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National Conference on Public Employee Retirement Systems
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CHAPTER 42

BENEFIT COST COMPARISONS BETWEEN STATE AND LOCAL GOVERNMENTS AND PRIVATE-SECTOR EMPLOYERS

Introduction

The proposal in 2005 by California Gov. Arnold Schwarzenegger (R) to end that state's public employee defined benefit pension plan focused attention on the disparate compensation costs between public-sector workers and private-sector workers. This chapter examines some of the causes of the differences in total compensation costs between state and local government employers and private-sector employers, using various datasets.¹

Total Compensation Costs

In September of 2007, overall total compensation costs were 51.4 percent higher among state and local government employers (\$39.50 per hour worked) than among private-sector employers (\$26.09 per hour worked) (calculated from Figure 42.1).

Total compensation costs consist of two major categories: wages and salaries and employee benefits. For both of these categories, state and local government employers' costs were higher than those of private-sector employers: 42.6 percent higher for wages and salaries and 72.8 percent higher for employee benefits (calculated from Figure 42.1).

Work Force Comparisons

One of the primary reasons for differences in total compensation costs between state and local government employers and private-sector employers is the composition of their respective work forces. This section looks at two components of the work force: industry groups and occupation groups. (Readers should note that the term "service" is not the same in the industry

¹ The datasets used are as follows: For compensation costs, the Bureau of Labor Statistics (BLS), *Employer Costs for Employee Compensation*; for private-sector benefit participation, the BLS, *National Compensation Survey, Employee Benefits in Private Industry in the United States, March 2006*; and for state and local government employers, BLS, *Employee Benefits in State and Local Governments, 1998*. Employment by industry group data are from BLS, *Employment and Earnings, October 2006*; and employment by occupation data are from Employee Benefit Research Institute tabulations of the March 2006 Current Population Survey by the U.S. Census Bureau.

Figure 42.1

EMPLOYER COSTS FOR EMPLOYEE COMPENSATION AND PERCENTAGE OF FULL-TIME EMPLOYEES PARTICIPATING^a IN EMPLOYEE BENEFIT PROGRAMS: STATE AND LOCAL GOVERNMENTS AND PRIVATE SECTOR

Employee Benefit Program ^b	State and Local Governments			Private Sector		
	Total compensation costs (\$ per hour worked)	Percentage of total compensation costs	Participation (Sept. 2007)	Total compensation costs (\$ per hour worked)	Percentage of total compensation costs	Participation (March 2007)
Total Compensation Costs	\$ 39.50	100.0%	c	\$ 26.09	100.0%	c
Wages and Salaries	26.26	66.5	c	18.42	70.6	c
Total Benefits	13.24	33.5	c	7.66	29.4	c
Paid leave	3.07	7.8	c	1.76	6.8	c
vacations	1.08	2.7	61%	0.90	3.5	77%
holidays	0.99	2.5	69	0.58	2.2	77
sick	0.76	1.9	87	0.22	0.8	57
other	0.24	0.6	c	0.06	0.2	c
Supplemental pay	0.35	0.9	c	0.78	3.0	c
overtime and premium ^d	0.18	0.4	c	0.27	1.0	c
shift differentials	0.07	0.2	c	0.07	0.3	c
nonproduction bonuses	0.10	0.3	30	0.44	1.7	47
Insurance	4.50	11.4	c	1.99	7.6	c
life	0.07	0.2	78	0.04	0.2	56
health	4.35	11.0	72	1.85	7.1	52
short-term disability	0.03	0.1	23	0.05	0.2	38
long-term disability	0.04	0.1	34	0.04	0.1	30

continued on next page

Figure 42.1, continued from previous page

Employee Benefit Program ^b	State and Local Governments			Private Sector		
	Total compensation costs (Sept. 2007) (\$ per hour worked)	Percentage of total compensation costs	Participation (Sept. 2007)	Total compensation costs (Sept. 2007) (\$ per hour worked)	Percentage of total compensation costs	Participation (March 2007)
Retirement and savings defined benefit	3.04	7.7	86	0.92	3.5	51
defined contribution	2.73	6.9	79	0.43	1.7	20
Legally required benefits	0.31	0.8	18	0.49	1.9	43
Social Security and Medicare	2.29	5.8	c	2.21	8.5	c
OASDI ^e	1.75	4.4	c	1.55	5.9	c
Medicare	1.34	3.4	c	1.24	4.8	c
federal unemployment insurance	0.41	1.0	c	0.31	1.2	c
state unemployment insurance	f	9	c	0.03	0.1	c
workers' compensation	0.05	0.1	c	0.16	0.6	c
	0.49	1.2	c	0.48	1.8	c

Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employer Costs for Employee Compensation-September 2007* (Washington, DC: U.S. Department of Labor, 2007) www.bls.gov/nsc/ect; *National Compensation Survey, Employee Benefits in State and Local Governments in the United States, September 2007* (Washington, DC: U.S. Government Printing Office, 2008) and *National Compensation Survey: Employee Benefits in Private Industry in the United States, March 2007* (Washington, DC: U.S. Department of Labor, 2007) www.bls.gov/nsc/ebs/

Note: Because of rounding, sums of individual items may not equal totals.

^a Includes workers covered but not yet participating due to minimum service requirements. Does not include workers offered but not electing contributory benefits.

^b Includes only benefit programs that are partially or wholly paid by the employer.

^c Data not available.

^d Includes premium pay for work in addition to the regular work schedule (such as overtime, weekends, and holidays).

^e Stands for Old-Age, Survivors, and Disability Insurance.

^f Cost per hour worked is \$0.01 or less.

^g Less than 0.05 percent.

groupings and occupation groupings: Data for these two are not identical because not all service workers are employed in the service industries.)

Industry Groups—State and local government workers are highly concentrated in the education sector. This sector includes teachers and university professors, two categories of employees with relatively high levels of education, unionization rates, and compensation costs. In September 2007, 52.7 percent of all state and local government employees were employed in this sector and total compensation costs for this sector were \$42.48 per hour worked (Figure 42.2).

By contrast, private-sector industry groups with the largest number of workers were services and trade, transportation, and utilities. In September 2007, services accounted for 47.9 percent of all private-sector workers, and trade, transportation, and utilities accounted for 22.7 percent. Total compensation costs for these two industry groups were \$22.41 per hour for trade, transportation, and utilities industries and \$24.91 per hour for services.

Another factor affecting total compensation costs is union membership. Union presence in an industry is positively correlated with total compensation costs. In 2006, 7.4 percent of private-sector workers were members of a union, compared with 36.2 percent of workers in state and local governments (Figure 42.2).

Occupation Groups—As with the industry groupings, the concentration of occupations among state and local government employers was quite different from that of private-sector employers. A large percentage of state and local government employees were concentrated in teachers (27.0 percent) and in service occupations (31.8 percent) (Figure 42.3). Teachers had the highest total compensation costs among state and local government employers, \$53.39 per hour worked in September 2007. By comparison, the largest percentages of private-sector workers were among sales and office occupations (27.3 percent) and service occupations (25.7 percent). Compensation costs for these occupations were relatively low: \$20.86 for sales and office occupations and \$13.00 service occupations.

The largest gap in compensation costs between state and local government and private-sector workers was among service occupations. In September 2007, the total compensation costs for these workers in state and local governments was \$30.74 per hour, compared with \$13.00 per hour in the private sector. This difference is a function of the type of occupations in the services category. Among state and local governments, the BLS categorizes police and firefighters among the service occupations, positions that involve a high degree of physical risk and generally require above-average skills and physical ability. Among private-sector employers, occupations such as waiters/waitresses and cleaning and building services functions are categorized as service occupations, and these jobs traditionally have low wages.

Figure 42.2

EMPLOYMENT AND TOTAL COMPENSATION COSTS, BY INDUSTRY GROUP AND UNION MEMBERSHIP, STATE AND LOCAL GOVERNMENTS AND PRIVATE SECTOR

	<u>State and Local Governments</u>		<u>Private Sector</u>	
	<i>Employment</i>	<i>Total compensation costs^a</i>	<i>Employment</i>	<i>Total compensation costs^a</i>
	<i>(Sept. 2007)</i>	<i>(Sept. 2007)</i>	<i>(Sept. 2007)</i>	<i>(Sept. 2007)</i>
Total	19,391,200	\$ 39.50	Total	116,348,000 \$ 26.09
Education	52.7%	42.28	Construction	6.7% 29.39
Hospitals	5.4	33.62	Manufacturing	12.1 30.82
General administration	31.1	36.53	Trade, transportation, & utilities	22.7 22.41
Local government utilities	1.2	b	Information	2.6 39.11
Local government transportation	1.3	b	Financial activities	7.2 34.95
Other	8.2	b	Services	47.9 24.91
			Professional & business services	15.6 30.44
			Education & health services	15.8 27.55
			Leisure & hospitality services	11.9 11.59
			Other services	4.7 21.87
Members of a Union ^c	36.2	45.00	Members of a Union ^c	7.4 35.92
Non-union workers ^c	63.8	34.50	Non-union workers ^c	92.6 24.94

Source: EBRI tabulations of data from U.S. Department of Labor, Bureau of Labor Statistics, *Employment and Earnings December 2007* (Washington, DC: U.S. Department of Labor, 2008). www.bls.gov/ces/home.htm
Employer Costs for Employee Compensation-September 2007 USDL: 07-1883 (Washington, DC: U.S. Department of Labor, 2007) www.bls.gov/ncs/lect/, and U.S. Department of Commerce, Bureau of the Census, *Statistical Abstract of the United States, 2008* (Washington, DC: U.S. Government Printing Office, 2008) www.census.gov/statab/www/

^a Data are expressed as dollars per hour worked.

^b Data not available.

^c Data are for 2006.

Employee Benefits

As noted above, benefit costs of state and local government employers were 72.8 percent higher than those of private-sector employers in September 2007. Many factors contribute to this gap.

Benefit Costs—The two most important voluntary benefit programs an employer provides are health insurance and a retirement savings plan. There is great cost disparity in these benefits between state and local government employers and private-sector employers. In September 2007, the average cost per employee per hour worked for health insurance benefits for state and local government employers (\$4.35) was 135 percent higher

than for private-sector employers (\$1.85) (calculated from Figure 42.1). The disparity was even larger for retirement and savings plans: These cost state and local government employers \$3.04 per hour worked in September 2007, 230 percent higher than the \$0.92 cost for private-sector employers.

Participation—One of the primary reasons for the difference in benefit costs is that state and local government employees are more likely than their private-sector counterparts to participate in employee benefit programs. Health insurance participation rates among all employees in state and local governments (72 percent in September 2007) were significantly higher than rates among all employees in the private sector (52 percent in March 2007) (Figure 42.1). The disparity was even larger for retirement and savings plans. In September 2007, 86 percent of all employees in state and local governments participated in some type of retirement and savings plan, compared with 51 percent of all employees in the private sector in March 2007.

Factors Behind the Differences—As the data illustrate, there are many factors that drive the disparity in benefit cost between the private and public sectors:

- **Job Characteristics:** Public-sector jobs are more service-oriented and a different nature (primarily education) than private-sector jobs (primarily trade). In many cases, such as teaching and public safety, these are jobs that require special skills or training, have higher pay grades, and offer different benefit structures that are specifically designed to attract and retain workers who have those specialized skills (for instance, many police and fire positions offer faster pension accrual or early retirement due to the demanding physical requirements and risks related to the work).
- These differences also make it difficult to compare benefit plan designs between the sectors: For instance, in state and local governments, workers are generally required to contribute to their own defined benefit pension, but in the private sector, employers typically pay all defined benefit pension contributions. Conversely, almost half (45 percent) of state and local workers received automatic cost of living adjustments for their defined benefit plan payments, compared with about 8 percent of private-sector workers, according to the Bureau of Labor Statistics.
- **Pension participation:** About 79 percent of all state and local government workers participated in a defined benefit pension plan as of September 2007, compared with about 20 percent of private-sector workers (Figure 42.1) (participation in a public-sector defined benefit plan usually is mandatory for permanent full-time employees).
- **Pension costs:** Defined benefit pension plans typically are more expensive for private plan sponsors to operate than defined contribution plans (such as 401(k)s). The growing administrative cost of operating a defined

Figure 42.3

EMPLOYMENT AND TOTAL COMPENSATION COSTS IN STATE AND LOCAL GOVERNMENTS AND PRIVATE SECTOR, BY OCCUPATION GROUP, AGE 16 AND OLDER

	<i>State and Local Governments</i>		<i>Private Sector</i>	
	Employment	Total compensation costs ^a	Employment	Total compensation costs ^a
	(2006)	(Sept. 2007)	(2006)	(June 2006)
Total	18,476,664	\$ 39.50	118,348,553	\$ 26.09
Management, professional and related	13.4%	48.35	18.0%	46.22
Professional and related	7.2	47.95	9.3	43.21
Teachers ^a	27.0	53.39	2.2	39.28
Sales and office	14.1	27.00	27.3	20.86
Service	31.8	30.74	25.7	13.00
Natural resources, construction, and maintenance	5.3	34.34	18.8	29.57
Production, transportation, and material moving	3.1	30.86	6.9	22.64

Source: EBRI tabulations of data from the Current Population Survey March 2007 Supplement; U.S. Department of Labor, Bureau of Labor Statistics, *Employer Costs for Employee Compensation-September 2007* USDL: 07-1883 (Washington, DC: U.S. Department of Labor, 2007) www.bls.gov/ncs/lect/

^a Includes postsecondary teachers; primary, secondary, and special education teachers; and other teachers and instructors.

benefit plan is cited by many private-sector plan sponsors as a major disincentive to operating this type of retirement plan (see *EBRI Issue Brief* no. 232, April 2001, p. 5). ERISA, the federal law governing most private-sector benefits, generally does not apply to public-sector pension plans, and the cost of administering a public-sector defined benefit plan is decidedly less than a defined contribution plan.

- **Unionization:** State and local government workers have significantly higher unionization rates than do private-sector workers. In 2006, 36.2 percent of state and local government employees were members of a union compared with 7.4 percent among private sector employees (Figure 42.2). Workers who are union members tend to have both higher pay and more generous benefits.

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Additional Information

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CHAPTER 43

REGULATION OF PUBLIC-SECTOR RETIREMENT PLANS

(This chapter was written by Melanie Walker and Cathie Eitelberg of The Segal Company)

Introduction

Like their private-sector counterparts, public-sector retirement plans—representing federal, state, and local jurisdictions—are extensively regulated by the federal Internal Revenue Code (IRC), the common source of rules governing the deferral of taxation for each type of pension plan.¹ In fact, this regulation has been significantly expanded in recent years. In exchange for the deferral of taxation and for certain other favorable tax treatment, the IRC sets forth certain retirement plan requirements some of which apply to both public-sector and private-sector plans and others from which public-sector plans are exempt.²

In addition to IRC regulations, public-sector plans operated for employees in state and local jurisdictions are extensively regulated and governed by state constitutional, statutory, and case law. These plans are highly regulated, and in the past three decades the states have voluntarily adopted regulations, procedures, and practices—legal, actuarial, accounting, administrative, and investment—that have led to strong, responsible, and effective public employee retirement systems (PERS) across the country.

Because of their well-developed benefit programs, the significant size of assets (approximately \$2.9 trillion at the end of 2006, according to the Census Bureau), and their large numbers of active and retired members (18.5 million individuals), public-sector pension plans are naturally the subject of interest to all stakeholders involved in their operation, including public employers; employer associations; plan members and employee organizations; taxpayers; legislators on the state, local, and federal level; and, last but not least, beneficiaries.

¹ Public-sector pension plans, known as *governmental plans* in ERISA, refer to plans established or maintained for employees of the federal government and of states and their political subdivisions. While other organizations (e.g., international organizations) are included under this heading, the discussion in this chapter is limited to federal, state, and local jurisdictions. See chapter one of Calhoun and Moore (2002) for more details.

² For background on federal law regarding the taxation of public retirement systems, see Calhoun and Moore (2002).

Federal Regulation of State and Local Plans

Public-sector retirement plans operated for federal employees are largely exempt from practically all of the rules applicable to other plans. Somewhat different are public-sector retirement plans operated at the state and local levels, which are regulated largely by state and local law, but federal regulation of these plans has been evolving. State and local plans are governed by state constitutions and laws that historically provided public-sector workers with guarantees comparable with those found in the private sector. States protect retirement benefits of public employees through some combination of the following: statute, common law, and/or constitution.

Passage of the Employee Retirement Income Security Act of 1974 (ERISA) required private-sector retirement plans to satisfy minimum coverage, participation, vesting, funding, and fiduciary requirements as a means of improving retirement income security for plan participants. When ERISA was enacted, Congress intentionally excluded public-sector retirement plans from certain sections of the act "... in order that additional information might be obtained regarding whether a need exists for further regulation" of these plans (U.S. Congress, 1978). ERISA called for a congressional study of several aspects of public-sector retirement plans, including the adequacy of their financing arrangements and fiduciary standards. That study, *The Pension Task Force Report on Public Employee Retirement Systems*, was completed four years later and reported certain deficiencies in public plans in the areas of funding, reporting and disclosure, and fiduciary practices.³ Later that same year, the federal government imposed reporting and disclosure requirements on retirement plans for its own employees (Employee Benefit Research Institute, 1997).

Nearly three decades later, however, state and local government plans still enjoy a general exemption from many requirements of ERISA. ERISA includes a group of provisions under the IRC, of which all apply to private plans and many apply to public-sector plans. It also has provisions enforced by the Department of Labor, from which state and local government plans are exempt. But while many ERISA provisions do not always apply to retirement plans of state and local governments,⁴ those requirements may indirectly influence plan design and administration in areas ranging from investment and fiduciary standards to pension rights of surviving spouses.⁵

³ See U.S. Congress (1978). The 1985 Public Employee Pension Plan Reporting and Accountability Act (PEPPRA) was a similar (but unsuccessful) attempt to create a public-sector version of ERISA.

⁴ Where ERISA rules do not apply, comparable state laws do, such as in the case of vesting and funding.

⁵ Sections of ERISA that do apply to public-sector plans include Title III and significant sections of Title II. Government plans are exempt from most of ERISA's reporting, disclo-

Moreover, although public-sector plans are excluded from several sections of ERISA, these plans are required to comply with pre-ERISA requirements of the IRC. These pre-ERISA requirements thus continued to shape the plan qualification rules for both private- and public-sector plans in the years following the establishment of ERISA.⁶

Some observers continue to believe that state and local plans would benefit from the federal imposition of ERISA-like standards. Underfunded plans can be found, although state and local public pension systems have traditionally been generally well financed. According to the National Association of State Retirement Administrators' 2007 Public Fund Survey, for the first time since FY 2001, aggregate public pension funding levels rose in FY 2007 from 85.7 percent to 86.1 percent (National Association of State Retirement Administrators, 2008).

Tax Laws and Public-Sector Plans

After the passage of ERISA, the enactment of a series of tax and other federal laws, beginning in the mid- and late-1980s, further affected the legal framework of employment-based benefit plans (Crane, 1999; Harris, 2000). Unlike ERISA, many of these provisions do apply to state and local plans. This expansion into the operations of state and local retirement plans, found in many federal tax and civil rights protection laws by 1990, began to lessen the ERISA-nonERISA distinction.

For example, the IRC Sec. 401(a)(17) limit on compensation was enacted under the Tax Reform Act of 1986 (TRA '86). However, such a compensation limit was not clearly imposed on public-sector plans until the passage of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). The regulations governing the IRC Sec. 401(a)(17) annual compensation limit (reduced from \$200,000 to \$150,000 by OBRA '93) generally took effect on January 1, 1996. Public-sector plans were permitted to grandfather the prior compensation limit for individuals who were participants in the plan on such effective date, either at the \$200,000 pre-OBRA amount, as indexed, or an unlimited compensation amount, if no compensation limit had been imposed prior

sure, and funding requirements (Title I) and plan termination insurance (Title IV). See Chapter 1 of Calhoun and Moore (2002) for details.

⁶ When Congress enacted the Taxpayer Relief Act of 1997 (TRA '97), which provided full relief from the nondiscrimination rules for state and local governments, it continued a tradition dating back to 1977. In 1999, the Internal Revenue Service (IRS) issued Notice 99-40, which provided relief from compliance with the nondiscrimination rules for certain governmental plans *other* than plans maintained by a state or local government (e.g., federal government agencies, international agencies, and Indian tribes) until January 1, 2001. IRS Notice 2001-46 extended this compliance date until the first day of the plan year beginning on or after January 1, 2003.

to OBRA. As indexed, this limit was raised to \$170,000 in 2001 and then increased in 2002 to \$200,000 under the Economic Growth and Tax Relief Reconciliation Act (EGTRRA) of 2001 (Calhoun and Moore, 2002). For 2009, the compensation limit has now been indexed to \$245,000 or \$360,000, for public-sector plan members under a grandfathered limit (Segal, 2008).

Most public employee retirement plans are contributory, and the Tax Reform Act of 1986 (TRA '86) replaced a special "three year recovery" of contributions rule that had applied primarily to public employees. Where public employees had earlier been granted up to three years of tax-free benefit payments to recover their own post-tax investment in pension plans, TRA '86 stipulated that their benefits were to be treated as partly taxable and partly tax free, based on an "exclusion ratio." Furthermore, if those employees received a preretirement starting date distribution, even if the distribution equaled their accumulated contributions, it would be treated as partly a tax-free return of contributions and partly a taxable distribution. The ratio of the tax-free to the taxable part of the distribution would reflect the ratio of the total employee contributions to the total value of the plan's expected benefits. Today, however, in the majority of public-sector pension plans employees make contributions on a pre-tax basis under the employer pick-up rules of IRC Sec. 414(h).

TRA '86 also recognized that public-sector plans provide normal retirement benefits at an earlier age, on average, than most private-sector plans due to the inclusion of public safety employees. Therefore, the IRC Sec. 415(b) benefit limitations have clearly applied to public-sector pension plans since the enactment of TRA '86,⁷ but with special protection for public employees. Specifically, public-sector pension plans were allowed to remain under pre-TRA '86 IRC Sec. 415 limits regarding maximum benefits and actuarial reductions for retirement before a specified age.⁸ Since retirement at younger ages is common in the public sector, compliance with the new, more severe IRC Sec. 415 rules would have forced some public jurisdictions to reduce benefits to current employees below promised amounts, violating pension plan law and in some cases constitutional law that prohibits cutbacks in public employees' benefits. Special IRC Sec. 415 rules were also enacted for police and firefighters, who typically retire at younger ages than other public workers. In addition, because some state and local plans had promised benefits even beyond those allowed under pre-TRA '86 limits, an additional option was provided under the Technical and Miscellaneous Revenue Act of 1988. This law allowed jurisdictions to "grandfather" and

⁷ The Small Business Job Protection Act of 1996 modified the Sec. 415 limits in such a manner that the 100 percent of compensation limit does not apply to governmental plans.

⁸ See Harris (2000) for a discussion of the history and development of Sec. 415 limits and their relationship to public-sector plans.

excuse any IRC Sec. 415 violations resulting from benefit payments made to employees who became plan members before January 1, 1990, although the jurisdiction had to apply the new IRC Sec. 415 limits applicable to private plans to all future plan members.

A series of federal laws since TRA '86 have continued a trend toward extending coverage of federal legislation to state and local pension plans. For example, the Omnibus Budget Reconciliation Acts (OBRA) of 1990 and 1993 required employees not covered by a retirement plan to be covered by Social Security, and imposed mandatory 20 percent withholding and direct roll-over rules, respectively. Also, the Small Business Job Protection Act of 1996 (SBJPA '96) required IRC Sec. 457 plan assets and income to be held in a trust, custodial account,⁹ or an annuity, and modified IRC Sec. 415 to permit public-sector plans to establish excess benefit arrangements that provide benefits in excess of the IRC Sec. 415 limits and eliminated the 100 percent of average compensation limit for public-sector pension plans under IRC Sec. 415(b). Another federal law, the Taxpayer Relief Act of 1997 (TRA '97), established rules regarding the purchase of permissive service credit and treatment of contributions for service purchase under IRC Sec. 415 limits for public-sector plans, granted a permanent moratorium on the application of IRC nondiscrimination rules for state and local plans, and permitted in-service distributions of amounts of \$5,000 or less (increased from \$3,500) payable from an IRC Sec. 457(b) plan under certain conditions.

EGTRRA also had a substantial impact on public-sector plans. First, EGTRRA enhanced the portability of benefits in public-sector plans in a number of ways. For example, beginning in 2002, it permitted the use of IRC Sec. 403(b) and Sec. 457 plan assets to purchase service credits in public-sector defined benefit (DB) plans through the transfer of funds (direct trustee-to-trustee exchange) to a public-sector DB plan.¹⁰ Also, EGTRRA

⁹ Legislative interest in Sec. 457 plans was sparked in 1994 by the losses of 457 plan participants in Orange County, CA, in the country's largest municipal bankruptcy in history. Authorities arbitrarily reduced employee retirement accounts by 10 percent—permitted at the time because plan accounts were managed by the county and technically considered county property—to resolve a severe budget shortfall, leading to a lawsuit filed by county employees. This well-publicized event led to a SBJPA '96 requirement that all amounts deferred by a state or local government employer be held in a trust (or custodial account or annuity contract) for the exclusive benefit of employees (Olsen, 1996). This requirement gave 457 plan participants the same protections as 403(b) and 401(k) plan participants. Prior to that time, the funds deferred by governmental employees into a 457 plan were subject to the claims of employer creditors. Noneducation 457 plan participants were ineligible for coverage under 403(b) plans and also state and local governments were prohibited from creating new 401(k) plans after TRA '86. Thus, noneducation state and local government employees had no way to save for retirement on a supplementary basis except through a 457 plan, which lacked the protections of similar plans.

¹⁰ Under state and local law, employees are commonly allowed to purchase service credit as a means to boost pension benefits and recover credit for years of work that would otherwise

eased restrictions for eligible rollover distributions (but only through a direct rollover) among qualified retirement plans, Sec. 403(b) annuities, individual retirement accounts (IRAs), and governmental Sec. 457 plans, including the rollover of after-tax amounts. Surviving spouses are also able to roll over distributions from their spouses' plans to a qualified plan, 403(b) annuity, or 457 plan in which they participate, as well as to an IRA. In addition, the law repealed the "same desk rule" for 401(k), 403(b), and 457(b) plans—replacing the words "separation from service" in Sec. 401(k)(2)(B) with "severance from employment"—thereby allowing employees to roll over their accounts in their prior employer's plan to their new employer's plan or to an IRA. EGTRRA also required that involuntary cashouts of amounts more than \$1,000 (disregarding rolled-over amounts) be automatically rolled over to an IRA unless the recipient elects otherwise, effective March 2005.

A second area influenced by passage of EGTRRA dealt with contribution and benefit limits. The law increased the annual elective deferral dollar limits for 401(k) plans, 403(b) annuities, and 457 plans to \$11,000 in 2002, \$12,000 in 2003, \$13,000 in 2004, \$14,000 in 2005, and \$15,000 in 2006, and indexed the limits thereafter (indexed to \$16,500 for 2009). EGTRRA also allowed catch-up contributions to 401(k), 403(b), and governmental 457 plans for participants who are age 50 or older, up to \$1,000 in 2002, \$2,000 in 2003, \$3,000 in 2004, \$4,000 in 2005, \$5,000 in 2006, and indexed thereafter (indexed to \$5,500 for 2009) (Segal, 2008). It also affected compensation-based defined contribution (DC) plan limits by increasing the dollar limit on annual additions under IRC Sec. 415(c) from \$35,000 to \$40,000, indexing them in \$1,000 increments thereafter (indexed to \$49,000 for 2009); and increased the 25 percent of compensation limit on DC plans to 100 percent. In addition, EGTRRA repealed the 403(b) maximum exclusion allowance applicable to contributions to IRC Sec. 403(b) annuities; henceforth, such annuities are subject to the limits applicable to tax-qualified plans. The law also increased the 33⅓ percent of compensation limits on deferrals under 457 plans to 100 percent. Finally, EGTRRA repealed the coordination of IRC Sec. 415 and Sec. 457 limits.

Regarding compensation-based DB plan limits, EGTRRA increased the IRC Sec. 415(b) DB dollar limits from \$140,000 to \$160,000 at age 62, with late-retirement adjustments for benefits starting after age 65, and indexed in \$5,000 increments thereafter. Also, the law increases the IRC Sec. 401(a)(17) compensation limit, applicable to both DB and DC plans, to \$200,000 from \$170,000 and indexed the limit thereafter in \$5,000 increments.

be lost because the employee was not eligible to receive a benefit at work. For example, at the state level, most public school teachers can purchase out-of-state teaching service. Interstate as well as intrastate reciprocity, where retirement systems are authorized to transfer participants' credit to other retirement systems, is sometimes available (Moore, August 1999).

A third area affected by passage of EGTRRA concerns IRAs. EGTRRA increased the annual dollar IRA contribution limits from the old limit of \$2,000 to \$3,000 in 2002, to \$4,000 in 2005, and \$5,000 in 2008. Beginning in 2003, 401(k), 403(b), and 457(b) plans are allowed to permit employee contributions to separate accounts or annuities and to elect to treat the contributions as IRAs or Roth IRAs; then, beginning in 2006, 401(k), and 403(b) plans are permitted to allow participants to designate a portion of their elective deferral as an after-tax Roth contribution.

Other pension provisions were also affected by EGTRRA. First, a federal income tax credit became available to low-to-moderate-income individuals that matches part of the salary-reduction contribution of individuals with incomes below \$50,000. This includes those who participate in 401(k), 403(b), or governmental 457 plans, or in IRAs, of up to \$2,000 with the size of the credit declining from 50 percent to 10 percent as income increases. Another EGTRRA provision addressed the tax treatment of 457 plan assets in divorce proceedings. The provision applies the tax rules for qualified plan distributions, according to a qualified domestic relations order (QDRO), to 457 plans, and clarified that the plan does not violate any restrictions on distributions when making payments to an alternate payee under a QDRO. EGTRRA also eliminated some special distribution requirements for 457 plans, such as the nonincreasing rule for periodic payments and the 15-year limit on payment to survivors, instead applying the required minimum distribution rules under IRC Sec. 401(a)(9) in a similar manner as applicable to qualified plans. EGTRRA also allowed for the exclusion from the employee's gross income for tax purposes of any retirement planning services generally provided to employees by an employer maintaining a qualified employer plan.

All EGTRRA provisions were set to expire after December 31, 2010. However, the Pension Protection Act of 2006 (PPA) made permanent all provisions of EGTRRA relating to retirement plans and IRAs. Although most of the provisions of PPA focus on funding rules for private-sector pension plans, PPA also included significant retirement plan provisions that affect public-sector plans. Continuing with a theme of EGTRRA, PPA added new rules that enhance the portability of benefits in retirement plans, such as requiring eligible retirement plans to allow rollover into a Roth IRA (effective in 2008) and permitting nonspouse beneficiaries to roll over distributions into an inherited IRA (effective in 2007). The new law also permits hardship distributions to participants in 401(a) or 403(b) plans or unforeseeable emergency distributions to participants in governmental 457(b) plans on behalf of a hardship experienced by a designated beneficiary.

PPA also made two important changes to distribution rules applicable to public safety employees. First, effective in 2007, public safety officers who retire due to disability or normal retirement may direct up to \$3,000

annually of their retirement income to be paid tax free for health care or long-term care premiums. The payment must be made directly from the retirement plan, including a 401(a), 403(b), or governmental 457(b) plan, to the insurer or self-insured plan. Second, effective in August 2006, public safety employees are no longer subject to the 10 percent early withdrawal penalty if they separate from service after age 50, reduced from the existing age 55 requirement. In addition, PPA provided specific relief for all employees in public-sector plans from various minimum distribution rules by treating public-sector plans as complying with these rules if they satisfy a reasonable, good-faith interpretation of IRC Sec. 401(a)(9), thereby eliminating the need for public-sector plans to comply with detailed regulations on minimum distributions. PPA also added a phased retirement provision which permits certain plans, including 401(a) DB plans, to make in-service distributions to employees who are at least age 62, effective in 2007.

The PPA made a number of important clarifications to the rules regarding purchase of permissive service credit in public-sector pension plans, such as allowing participants who are no longer employees to purchase service credit and not subjecting service purchased via transfer from a 403(b) or 457(b) plan to the “air time” limit of five years of service. In addition, PPA provided specific rules for automatic contributions to DC plans, including a refund provision that allows a public-sector plan to return contributions to a participant who opts out of the automatic contribution arrangement within 90 days of the first contribution being made, beginning in 2008. However, public-sector plans cannot take advantage of the ERISA provisions in PPA that facilitate automatic contribution arrangements, such as regulations on a default investment option that provides fiduciary protection for investment of automatic contributions and ERISA pre-emption of state laws that prevent automatic deductions from wage payments. Finally, PPA clarified the legality of cash balance plans and other hybrid plans, but imposed certain restrictions on such plans under age discrimination rules, including restrictions on the interest rate applied to account balances under these plans.

Another important development for public-sector retirement plans came in the form of extensive regulations on IRC Sec. 403(b) plans in 2007, the first of such regulations since 1964. The 403(b) regulations, which are generally effective January 1, 2009, were designed to shape 403(b) plans in the mold of private-sector 401(k) plans. A 403(b) plan is governed by IRC Sec. 403(b) and is restricted to certain types of public-sector employers, mainly public schools, including higher education institutions. These plans are DC plans like 401(k) plans but may only be funded through annuity contracts and custodial account agreements. One of the major requirements under 403(b) regulations is that 403(b) plans must adopt a written plan, which is a new requirement for public-sector plans. Sec. 403(b) plans often operate with

multiple investment providers, and the new regulations require that the employer ensure that the providers coordinate certain transactions, such as hardship withdrawals, loans and distributions after termination of employment, similar to requirements for 401(k) and 457(b) plans. In addition, the 403(b) regulations impose new restrictions on withdrawals from the plan and contract exchanges between providers. These regulations are likely to cause public-sector employers to become more involved in the administration of their 403(b) plans, and this in turn will have a substantial impact on the market environment for these plans. For more information, see chapter on 403(b) arrangements.

Recently, the IRS has increased its scrutiny of public-sector pension plans to ensure these plans are complying with the federal tax laws described above. Federal legislators are also taking a close look at public-sector plans to determine whether additional federal regulation of these plans is needed. One important result of this increased scrutiny is the recognition that additional federal regulation of public-sector plans may conflict with existing state and local regulation of these plans. That is, where state and/or local laws in the form of constitutional or statutory rules guarantee a certain level or type of benefit for public employees, any federal regulation that requires a reduction in benefits or affects the rights of participants in a retirement plan may not be able to be implemented in a public-sector plan.

State and Local Regulation

As mentioned, any analysis of state and local retirement programs must begin with a recognition that these systems operate in a legal environment that is partially subject to state rules and regulations but often fall under federal law and regulations.¹¹ Although federal initiatives in regulation have occurred, the development of plan features and management of plan operations still rely extensively on state and local laws and regulations. Constitutional and contractual law guarantees, which may be expressed in state statutes and decisional law, afford members of public employee retirement plans many of the protections granted to members of ERISA-regulated

¹¹ A qualified private-sector pension plan and its participants enjoy three tax benefits: First, the employer's contributions are immediately deductible. Second, earnings on the plan investments are exempt from taxation. Third, the benefits in the pension plan that accrue to participants are tax-deferred until the participant takes a distribution. By contrast, because state and local governments are not subject to federal tax, the first benefit is inapplicable to them. In the second benefit, earnings on plan investments may or may not be tax-deferred—depending on whether the plan invests in tax-exempt state and local government investments (in which case there would be no tax benefit) or any other taxable investment (in which case the earnings would be exempt from taxation until distributed). Therefore, the only benefit applicable is the third one, which defers a participant's liability for federal tax on the pension accrual until he or she takes a distribution.

plans by federal statutory law. In fact, it is safe to say that public employees have protection that is comparable with that of private-sector employees today, although from different sources. A private-sector company can—subject to Pension Benefit Guaranty Corporation and IRS rules—freeze, merge, or terminate its retirement plan. This seldom happens in the public-sector because of the strong legal guarantees in place against diminishment of benefits.

In those instances where ERISA and or IRC rules are not applicable to public plans, such as reporting and disclosure, it is interesting that legislative bodies have enacted protections similar to ERISA on a voluntary basis. In addition, state statutes often spell out benefit formulas, age and service requirements, and vesting and contribution rules, and typically include ancillary provisions such as disability and death benefits. In effect, these statutes constitute a “plan document” that contains the plan provisions of a private-sector plan.

Many states have also established pension commissions. In fact, New York had established a successful commission as early as 1971, and by the late 1980s permanent pension commissions and legislative retirement committees had been formed in 21 states, temporary commissions had been formed in three states, and legislative committees with pension activities had been formed in three states. These commissions and committees were formed for the purpose of providing guidance to public executives, administrators, and legislators in developing public retirement objectives and principles, identifying problems and areas of abuse, projecting costs of existing systems and modifications to those systems, and designing and implementing pension reform programs (Foster Higgins, 1988). In some cases, the pension commissions also oversee nonpension benefit programs (e.g., by studying the costs of providing postretirement medical coverage for public employees) and serve as a buffer between the legislature and special interest groups. States without a separate retirement or pension committee tend to handle these issues under the jurisdiction of the state finance or ways and means committees. According to the National Conference on State Legislatures, approximately 21 states operated permanent pension committees in 2002.

Governance and Funding

Administrative responsibility of public-sector plans varies by level of government. In the federal government, the primary civilian retirement systems (the Civil Service Retirement System and Federal Employees Retirement System) are administered by the Office of Personnel Management with assistance from federal agencies, while the retirement

system for the military services is administered by the Department of Defense. Among state and local jurisdictions, a board of trustees establishes the overall policy for administering pension plans, which can include adopting actuarial assumptions (DB plans), establishing procedures for financial control, and reporting and setting investment policy.

Investment policy also varies with the level of government. Among most state and local jurisdictions, the investment policy for the \$2.2 trillion in assets managed by these retirement systems is governed by state or local statute. Most states incorporate “prudent expert” rules, which require that investments be made with the care of a prudent expert, solely in the interest of plan participants, echoing ERISA’s definition of the prudent expert principle. A number of states also have lists of permissible or prohibited investments (including recently developed policies on investments prohibited due to social concerns in a particular geographic region, e.g., Sudan), percentage limits on certain types of investments, or rules covering diversification of pension assets. For example, some permit allocation of a percentage of assets to in-state investments. Other common investment restrictions include limiting the maximum amount of assets that can be placed in one company, in foreign stocks or bonds, in alternative investments, or in real estate. During the past two decades, many jurisdictions have broadened permissible investment opportunities for their pension plans, allowing them to prudently pursue a higher return for participants. While public pension funds invested 95 percent of their assets in bonds (fixed income) in 1950, this share had declined to 33 percent in 2001 and to 26.6 percent in 2007 (National Association of State Retirement Administrators, 2008). Meanwhile, the investment in equities increased from 0 percent in 1950 to 57 percent in 2001 and to 63 percent in 2007 (Employee Benefit Research Institute, 2008).

Public pension plans have been largely successful in increasing returns through these changes. With a notable pool of assets, public plans are facing issues such as the propriety of using public pension fund investments to further social goals. More recently, states and local funds have begun to concern themselves with the governance of the companies in which they invest. Such investor activism can be viewed as another strategy by pension trustees to ensure that plan participants enjoy higher returns for the associated risks (Useem and Hess, 1999). A related issue is the active encouragement of certain types of investments within the same jurisdiction as the retirement system. Anticipated benefits from such economically targeted investments (ETIs) include job creation, infrastructure, and the like.

Conclusion

Public pension plans have been substantially strengthened by federal, state, and local laws and regulations over the past several decades. In many instances, these new rules have applied to both public-sector and private-sector plans. Due to their strong constitutional and statutory guarantees on the state level, employees' rights and benefits likely have protection today in the public sector that is comparable with the ERISA protections available for workers in the private sector. This backdrop of legal statutes, governance, and tradition all combine to play a role in defining a public-sector culture shaped by the continued presence of professional pension administrators, informed legislators, and government administrators involved in the public pension policymaking process. For these reasons, defined benefit plans in the public sector have generally continued to thrive and serve as a major source of retirement income for public employees, while the number and total assets of defined benefit plans in the private sector have steadily decreased over the past several decades.

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CHAPTER 44

DEFINED BENEFIT PENSION PLANS IN THE PUBLIC SECTOR

Introduction

One significant difference between civilian public-sector and private-sector retirement systems is that public-sector employees are more likely to be covered by defined benefit (DB) pension plans.¹ For example, while nearly all (98 percent) full-time employees in state and local governments participated in one or more employment-based retirement plans in 1998, 91 percent of them participated in a DB pension plan, compared with 50 percent of private-sector employees in medium and large private establishments in 1997 (U.S. Department of Labor, 1999 and 2000). At the federal level, nearly all eligible federal employees are covered by two components, the Civil Service Retirement System (CSRS) and the Federal Employee Retirement System (FERS), which offer DB pension plans (U.S. Office of Personnel Management, 2008). Until 2001, the military retirement system operated exclusively on a defined benefit basis.²

This chapter discusses public-sector DB plans, covering both civilian and military retirement systems. It describes system features related to such issues as funding, coverage, benefit eligibility, contributions, benefit computation, forms in which benefit payments are offered, adjustments for changes in the cost of living, and governance issues.

Federal Civilian Retirement System

The vast majority (more than 90 percent) of U.S. federal civilian employees participate in CSRS, which covers employees hired before 1984, or FERS, which covers those hired after 1983.

CSRS was enacted in May 1920 by the Civil Service Retirement Act and implemented the following year. It was based on an existing arrangement

¹ Other characteristics that set public-sector plans apart from those operated in the private sector include the requirement in many public plans that employees contribute toward the cost of the DB plan and the prevalence of cost-of-living adjustments (COLAs) in most public plans but few private plans.

² With the enactment of P.L. 106-398, the National Defense Authorization Act for FY 2001, uniformed military service personnel on active duty or in the ready reserve could participate in the federal Thrift Savings Plan (TSP).

under the Civil Service Act of 1883, which protected federal employees from arbitrary dismissal for any reason, including age (U.S. Office of Personnel Management, 2008; Husted and Husted, 1999). By 1920, there were many federal employees age 70 or older who could not be separated from service because of existing legal protections. CSRS offered a legal basis for separating those employees and providing the income necessary to support them in retirement. Since 1920, the CSRS has been amended by subsequent acts of Congress. CSRS is a stand-alone retirement system intended to provide reasonable benefits for long-service federal employees and is administered by the U.S. Office of Personnel Management (OPM).

FERS was established in June 1986 by Congress, partly as a result of the expansion of Social Security to federal workers beginning in 1984.³ It is a three-part pension program that became effective Jan. 1, 1987. Using Social Security as a base, it provides an additional defined benefit and a voluntary thrift savings plan. Only the defined benefit portion of FERS is administered by OPM. The Thrift Savings Plan is administered by a separate independent agency. (For further discussion of the Federal Thrift Savings Plan, see chapter on supplemental savings plans in the public sector.)

Financing—The Civil Service Retirement and Disability Fund (CSRDF) finances the operation of CSRS and FERS. By law, the entire fund is available for payment of either CSRS or FERS benefits.⁴

Coverage—Both CSRS and FERS include as members appointed and elected officers and employees in or under the executive, judicial, and legislative branches of the U.S. government, except those excluded by law or regulation. In 2007, there were 2.8 million participants in CSRS and 2.4 million in FERS (includes actives, retirees and survivors) (U.S. Office of Personnel Management, 2008).

CSRS covers most federal employees hired before 1984 and is closed to new members. FERS generally covers those employees who first entered a covered position on or after Jan. 1, 1984. Employees who were hired after Dec. 31, 1983, with less than five years civilian service under CSRS were automatically converted to FERS coverage on Jan. 1, 1987. An interim plan, created under the Federal Employees' Retirement Contribution Temporary Adjustment Act, was in effect from Jan. 1, 1984, through Dec. 31, 1986. Any employee hired during that period received credit for all service toward FERS. Employees covered by CSRS had the opportunity to transfer to FERS from July 1, 1987, through Dec. 31, 1987.⁵ This was the first of two opportu-

³ For further discussion of Social Security coverage of public employees, see the chapter on Social Security and Medicare.

⁴ A summary description is available in U.S. Office of Personnel Management (2004).

⁵ For CSRS employees who met special criteria, there was an extended open season from January 1, 1988, through June 30, 1988.

nities, or “open seasons,” during which CSRS employees were permitted to transfer out of CSRS and into FERS. A second open enrollment period available to CSRS employees occurred from July 1, 1998, through Dec. 31, 1998.

CSRS-Offset is an option available to employees who were originally hired before 1984 and covered by CSRS, but who left federal service and were rehired after 1983 (Federal Employees News Digest, 2001). Workers whose prior employment spanned at least five years of creditable service under CSRS have the right to re-enter that retirement system upon re-employment. Congress created a special category of coverage, known as the CSRS-Offset, in order to eliminate the overlap in the DB portion of deferred compensation associated with CSRS and Social Security. Under this provision, money from contributions ordinarily intended for CSRS is divided between the CSRS retirement fund and the Social Security trust fund.⁶

Eligibility for Retirement, Disability Retirement, Early Retirement, and Death Benefits

CSRS—CSRS provides a full range of pension benefits and wage insurance protections, including annuities for employees who meet age and service criteria for voluntary retirement, annuities for employees whose jobs are terminated after they have reached certain specified levels of age and/or service, benefits to employees who become unable to perform in their positions because of a disabling condition, and benefits to deceased employees’ and deceased retirees’ survivors who meet certain conditions.

Employees covered by CSRS qualify for normal retirement benefits (full annuity) at age 55 with 30 years of service, age 60 with 20 years of service, or age 62 with five years of service. According to the OPM’s Office of the Actuary, in 2001, the mean CSRS retirement age was 58.3 (median age was about 58 years). Federal employees under CSRS may be able to leave their jobs with an immediate (but possibly reduced) annuity, even though they have not met the normal age and service requirements during times of downsizing or agency reorganization. Such benefits for involuntary separation from service is permitted at any age after 25 years of service or at age 50 with 20 years of service. Disability retirement is permitted at any age with five years of creditable civilian service.

An employee’s widow or widower and children may qualify for a survivor annuity if the employee’s death occurs while the employee is employed and a member of the retirement system, provided the employee has completed at least 18 months of creditable civilian service.⁷ A retiree’s widow, widower,

⁶ For more detail about the CSRS-Offset, see *Federal Employees News Digest* (2001).

⁷ For more information on survivors’ eligibility for benefits, see *Federal Employees News Digest* (2001).

or former spouse will receive benefits in the event of the death of the retiree, provided the retiree elected a survivor annuity when he or she retired. Election of a survivor annuity at retirement will result in a reduction of the full retirement annuity in order to offset part of the cost of the additional protection afforded survivors.

FERS—Like CSRS, FERS provides benefits for normal retirement or early retirement due to involuntary separation, disability, and death. In addition, FERS provides reduced benefits for early retirement, an option that is typically not available under CSRS. Certain FERS retirees are also eligible for an annuity supplement until age 62.

FERS provides for full retirement benefits at the minimum retirement age (MRA) with 30 years of service, age 60 with 20 years of service, or age 62 with five years of service. The MRA is 55 for those born before 1948 and increases gradually to age 57 for those born in or after 1970.⁸ Workers may retire at the MRA with only 10 years of service, but those who do so receive reduced benefits. According to the OPM's Office of the Actuary, employees in FERS retired, on average, at age 57.2 in 2001 (median age was approximately 59 years). Deferred retirement benefits are payable at age 62 with at least five years of service or at age 55 with at least 10 years of service. In cases of involuntary separation, full immediate benefits are payable at age 50 with 20 years of service or at any age with 25 years of service. Disability benefits are payable at any age with 18 months of service.

In general, the same conditions required for survivors of CSRS participants to be eligible for benefits must be met in order for survivors of FERS participants to be eligible for benefits.

A special annuity supplement is payable until age 62 to certain eligible retirees. Those eligible include employees who retire at the MRA with 30 years of service or at age 60 with 20 years of service, or those on involuntary retirement. The supplement approximates the Social Security benefit earned while the retiree was employed under FERS and is subject to reduction if earnings exceed a specified amount. The supplement was created in order to bring FERS benefits nearer to those of CSRS participants.⁹

⁸ The minimum retirement age (MRA) was age 55 until 2002, when it began to climb by two months per year in coordination with the gradual rise in the normal retirement age under Social Security. The MRA reaches age 56 in 2009, where it remains until the year 2020. The MRA begins rising again by two months per year in 2021 and reaches age 57 in the year 2026.

⁹ For more information on the special annuity supplement, see *Federal Employees News Digest* (2001).

Computation of Benefits

CSRS—The CSRS benefit formula uses an average salary that is based on the highest three years of salary (high-3 average salary). The general retirement annuity formula provides 1.5 percent of high-3 average salary for the first five years of service, 1.75 percent of high-3 average salary for the next five years, and 2 percent for any remaining years, up to a maximum of 80 percent of high-3 average salary. This annuity will be reduced if the retiree elected the survivor annuity.¹⁰

In the case of deferred retirement, the computation of benefits is performed as if the former employee is retiring from his or her former federal job at that point, using the highest three years of salary at the time of separation. Former employees under CSRS are eligible for an annuity at age 62 if they have completed at least five years of creditable service and were covered by CSRS for at least one year within the two-year period immediately preceding separation.

In the case of involuntary retirement, if the retiring employee is under age 55, the general retirement annuity rate is permanently reduced by one-sixth of 1 percent for each full month (2 percent a year) the retiree is under age 55.

For disability retirement, the annuity payable is the lesser of either 40 percent of high-3 average salary or the amount computed under the general formula using service projected to age 60. The general formula for annuity computation will be applied if a larger annuity would result.

The law also contains more generous eligibility and computation requirements for annuity and disability benefits of plan participants who fall into one of the following categories: certain law enforcement officers, firefighters, air traffic controllers, congressional employees, members of Congress, and certain other groups.

In the case of death, qualifying widows and widowers of deceased annuitants typically receive 55 percent of the annuity unless the employee annuitant waived provisions of a survivor benefit or elected to provide less than a full survivor benefit. Children of deceased annuitants and employees receive a flat monthly amount. In the case of single individuals with no dependent children or former spouse eligible for benefits, there would be no monthly survivor annuity benefit payable. In that case, a lump sum would be paid to the survivors under the order of preference.

FERS—The average salary used in FERS benefit computations is also based on the highest three years of salary. The general annuity formula provides one percent of high-3 average salary times the years of creditable

¹⁰ For more information on the amount of the reduction, see *Federal Employees News Digest* (2001).

service. If retirement is at age 62 or later with at least 20 years of service, a factor of 1.1 percent is used rather than one percent. For workers who choose the reduced benefit option (i.e., workers who retire at the MRA with 10 years of service), the reduction is 5 percent for each year the employee is under age 62 at retirement.

In the case of deferred retirement, separated workers will have benefits computed as if they are retiring from their former federal jobs at that point. For separated workers who elect the deferred benefit at age 55 with at least 10 years of service, the benefit computation will include the applicable reductions of 5 percent for each year of age under age 62.

For FERS participants retiring under the involuntary separation rules, benefits are not reduced. However, the annuity supplement referred to earlier is not payable until the employee reaches the MRA (age 55–57).

In the case of disability, annuitants in the first year of retirement generally receive 60 percent of their high-3 average salary minus 100 percent of any Social Security benefits payable. After the first year, annuitants receive 40 percent of the high-3 average salary, minus 60 percent of any Social Security benefit payable. At age 62, FERS disability benefit will be recomputed.¹¹

For annuity and disability benefits, the law also contains special eligibility and computation requirements for certain law enforcement officers, firefighters, air traffic controllers, congressional employees, members of Congress, and military reserve technicians.

In the case of the death of a worker with at least 18 months but less than 10 years of service, qualifying widows and widowers of deceased employees receive an annually indexed lump-sum payment (\$25,537.58 in 2005) plus one-half of the deceased worker's final annual pay rate or one-half of the employee's high-3 average pay. If the employee had at least 10 years of service, the surviving spouse also receives an annuity equaling 50 percent of the accrued basic retirement benefit. If the surviving spouse is under age 60, a FERS supplement is added to the FERS survivor benefit. Children of deceased annuitants and employees receive a flat monthly amount, minus the amount of Social Security benefits payable to them.¹²

Employees who transferred from CSRS to FERS will have part of their annuities computed using the CSRS general formula.¹³

¹¹ For the retirement recomputation, the period of disability would be credited toward years of service, and average pay would be increased to reflect COLAs applicable during that period (*Federal Employees News Digest*, 2001).

¹² See *Federal Employees News Digest* (2001) for more details.

¹³ For more information on the benefits of employees who transferred from CSRS to FERS, see *Federal Employees News Digest* (2001).

It should be recognized that married employees who retire under either CSRS or FERS are allowed to decline a joint-and-survivor annuity only if both the employee and his/her spouse decline the joint-and-survivor annuity in writing. In addition, under both CSRS and FERS, survivor annuities terminate if the surviving spouse remarries before age 55.

Employee Contributions and Refunds of Contributions

CSRS and FERS both require contributions from employees, which constitute part of the eligibility criteria that must be met to qualify for benefits. Except in certain special circumstances, amounts contributed have no bearing on amounts received. The contributions are deducted from an employee's gross pay and are included in taxable income.

CSRS—Most employees covered by CSRS pay 7 percent of their basic pay to participate in the program.¹⁴ Basic pay includes salaries for regularly scheduled work.¹⁵ These involuntary contributions are credited to the program under the employee's name. Employees who separate from government service or transfer to a position not covered by CSRS are eligible for a refund of their accumulated contributions. Under CSRS, contributions withdrawn by former employees with more than one year but less than five years of service at separation are refunded with interest, computed at 3 percent. Withdrawn amounts for separating employees with more than five years of service do not include interest. A separating employee who exercises the right to withdraw contributions waives the right to collect further benefits from CSRS, although participants can restore their lost rights under the program after returning to a covered position in the federal government by repaying the withdrawn amounts, plus interest.

CSRS also allows for voluntary contributions by participants. Employees covered by CSRS who want to receive a larger annuity than would be payable based on salary and service may make voluntary contributions.¹⁶ Annuities based on voluntary contributions are not increased by cost-of-living adjustments (COLAs). Total contributions may not at any time exceed 10 percent of the accumulated base pay the employee has received during federal service. Since 1985, voluntary contributions earn a variable interest

¹⁴ Employees in certain special categories, such as law enforcement categories and firefighters, contribute 7.5 percent.

¹⁵ Exclusions include pay for special services such as night duty as well as for bonuses, allowances, overtime, and lump-sum payments for unused leave.

¹⁶ Voluntary contributions cannot be deducted from an employee's salary. An employee may make voluntary contributions whenever he or she chooses, and contributions must be in multiples of \$25.

rate,¹⁷ based on the average yield of new investments purchased by CSRDF during the previous fiscal year, as determined by the U.S. Department of the Treasury.

FERS—Employees covered by FERS are also required to make contributions as a matter of employment. FERS participants pay at a rate of total basic pay that, combined with the employee Old-Age, Survivors, and Disability Insurance (OASDI) portion of Social Security taxes, equals 7 percent (6.2 percent for Social Security and 0.8 percent for FERS). Employees who separate from government service or transfer to a position not covered by FERS are eligible for a refund of their contributions. Participants who receive refunds of their contributions at separation are not able to recapture the lost service in the event that they return to federal employment.

There are no voluntary contributions for FERS participants, due to the existence of the Federal Thrift Savings Plan.

Cost-of-Living Adjustments

CSRS—In accordance with the Omnibus Budget Reconciliation Act of 1983, civil service retirees and survivor annuitants receive annual COLAs. Initial COLAs for newly retired employees (or their survivors) are prorated, depending on the month in which the annuity begins. The COLA reflects the percentage change as determined by the average Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) for the third quarter of each year over the third quarter average CPI/W index of the previous year.

FERS—In general, retirees ages 62 and older receive COLAs. Survivors, disabled retirees, and certain other special groups (e.g., law enforcement officers, air traffic controllers, etc.) receive COLAs regardless of age. Annuities are adjusted annually to reflect the percentage change as determined by the average Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) for the third quarter of each year over the third quarter average CPI/W index of the previous year.¹⁸ Initial COLAs of retiring employees (or survivors of an employee) are prorated based on the number of months the employee is in receipt of an annuity prior to the effective date of the increase. The annuity supplement for retirees is not increased by COLAs, but the supplement for survivors is increased.

Coordination With Social Security—Since (except for totally and permanently disabled workers) FERS benefits are added to Social Security

¹⁷ For 2001, the interest rate was 6.38 percent.

¹⁸ If the CPI-W increase is 3 percent or more, the COLA is one percentage point less than the CPI-W increase. If the CPI-W increase is greater than or equal to 2 percent but less than 3 percent, the COLA is 2 percent. If the CPI-W increase is less than 2 percent, the COLA is equal to it.

benefits, the FERS defined benefit plan is coordinated with Social Security. When the CSRS began in the early 1920s, Social Security had not yet been established. When Social Security did become effective in 1937, CSRS employees were excluded from Social Security. As Social Security expanded the type and generosity of benefits over the years, CSRS made appropriate changes so that coverage for federal workers and coverage for other workers remained roughly comparable.

Military Retirement System

Historically, military pension plans preceded those established for public employees, going back to colonial times. In 1636, Plymouth colony provided that any man sent forth as a soldier and returned maimed should be maintained by the colony during his life. (U.S. Department of Defense, 2006). The first pension law, August 26, 1776, promised 50 percent pay for life, or during disability, to the disabled. Following the Revolutionary War, most claims were settled for less than face value and at considerable controversy. From 1818 to 1836, as tax revenues increased, Congress passed measures to expand benefits for veterans and extend coverage to widows of veterans.

The first major nondisability retirement act was enacted in 1861 at the start of the Civil War, when there arose a need to replace the aging military population with a young and active force. After the war, Congress enacted legislation to reduce the overall size of the military by providing retiring officers with benefits worth 75 percent of pay at 30 years of service regardless of age. This fundamental design of 2.5 percent accrual per year of service—2.5 percent times 30 years equal to 75 percent—is still in effect.

Legislation enacted between 1920 and 1949 shaped the distinction between disability benefits that continued to be administered by the Department of Veterans Affairs (VA)¹⁹ and separate disability and nondisability benefits transferred to the Department of Defense (DoD) (Hustead and Hustead, 1999). DoD military retirement system benefits, including nondisability, disability, and survivor benefits, are offset by any benefit amounts paid by the VA. In 1957, military service personnel were brought under Social Security, when OASDI benefits were simply added to existing military and VA benefits. In 1980, following the termination of the draft and an increase in military pay designed to make it competitive with the private sector for candidates for the all-volunteer force, the benefits system was

¹⁹ The disability compensation benefits administered by the VA are not a part of the military retirement system. Unlike DoD disability benefits, these benefits do not depend on a worker's ability to continue service, but rather are awarded for changes in health status between entry and departure from the military. VA compensation is awarded for combat disabilities, other accidents that take place during a military career, and natural diseases acquired in the military.

revised for new entrants. This resulted in two different retirement benefit structures: one for those hired prior to 1980 and the other for those hired since that time. Further changes took place in 1986 with the result that a third member population could be identified as being eligible for nondisability benefits in the military retirement system—those first entering the armed services on or after August 1, 1986. As of the end of FY 2006, there were 1.4 million active duty personnel and full-time active duty reservists, 754,515 selected reservists, 1.8 million nondisability and disability retirees, and 283,939 surviving families in the military retirement system (U.S. Department of Defense, 2007).

Financing—Prior to 1984, the military retirement system was operated on a pay-as-you-go basis, with amounts paid out to retirees in a given year coming directly from the DoD budget. A decision was taken to switch to a funded system in 1984 because actuaries projected that retiree payments would soon begin to increase rapidly over normal cost payments, and charging DoD with only the accruing liability of the current force would lower the cost of the retirement obligation in the military budget.²⁰ As a consequence, the Military Retirement Fund was created under P.L. 98-94 to move the military retirement system from a pay-as-you-go to a funded system (U.S. Department of Defense, 2008).

Coverage—The military retirement system applies to members of the Army, Navy, Marine Corps, and Air Force.²¹ It serves as part of an integrated pay, benefits, and allowance system used by DoD to recruit, retain, motivate, and ensure a young and vigorous active-duty force.²² Retiree and survivor benefits differ across the three populations within the military retirement system (mentioned above), according to the individual's first entry date into military service. Military personnel are full participants in the Social Security system.

Eligibility for Nondisability Retirement, Reserve Retirement, Disability Retirement, and Death Benefits—The military retirement system provides nondisabled retiree benefits for active duty personnel retiring after 20 years of service at any age and for reservists (part-time military

²⁰ See U.S. DoD (2006) for details on financing the military retirement system.

²¹ Most provisions apply as well to retirement systems for members of the Coast Guard (administered by the Department of Transportation), officers of the Public Health Service (administered by the Department of Health and Human Services), and officers of the National Oceanic and Atmospheric Administration (administered by the Department of Commerce).

²² It can be argued that military retirement benefits should be considered only one of several components of military compensation (Hustead and Hustead, 1999). Most new entrants serve less than six years, taking advantage of education and other separation benefits designed to recruit and temporarily employ them. This turnover pattern results in a force where the majority of all members have less than seven years of service at any given time and an average age for active-duty personnel of 29 years.

members) at age 60 with 20 years of service²³ (U.S. Department of Defense, 2008).²⁴ In addition, the system provides disability annuities when a member can no longer fulfill the duties of the job. A disabled military member is entitled to disability retirement pay if the disability is at least 30 percent (according to a standard VA rating schedule for disabilities) and either (1) the member has at least eight years of service; (2) the disability results from active duty; or (3) the disability occurred in the line of duty during a time of war, national emergency, or certain other time periods (U.S. Department of Defense, 2008). The system also pays annuities to survivors of service personnel who die while on active duty with over 20 years of service or who elect an annuity benefit at retirement. As full participants in the Social Security system, military members and their families are entitled to the same benefits as civilian employees under the OASDI program.

Computation of Benefits—There are three distinct nondisability benefit formulas related to the three populations within the military retirement system described above (U.S. Department of Defense, 2008). The key difference separating them is the definition of basic pay used in the calculation. The first category is referred to as *final pay*: Retirees who first entered military service before September 8, 1980, receive retirement benefits equal to terminal basic pay times a multiplier. The multiplier equals 2.5 percent times years of service and is limited to 75 percent. A second category is referred to as *High-3*: If the retiree first became a member of the armed services on or after September 8, 1980 (but before August 1, 1986), the average of the highest 36 months (i.e., three years) of basic pay is used instead of terminal basic pay. The benefit calculation is otherwise performed the same way. A third category is referred to as *Redux* (i.e., as in brought back): Individuals first entering the armed services on or after August 1, 1986, are subject to a penalty if they retire with less than 30 years of service until age 62. The penalty reduces the multiplier by one percentage point for each full year of service below 30 years. At age 62, retirement pay is recomputed without the penalty. Provisions in the FY 2000 Defense Authorization Act now allow military retirement system members in the Redux category to choose between (a) receiving High-3 benefits or (b) staying under the Redux formula and receiving a lump-sum payment of \$30,000. This decision is made during the fifteenth year of service. Unless they complete 20 years of continuously active service, individuals selecting the lump-sum option must forfeit a portion of the amount received.

Under disability retirement, service personnel receive retirement pay equal to the larger of (1) the accrued nondisability retirement benefit or

²³ Of the 20 years of “creditable” service required, the last eight must be in a reserve component (U.S. DoD, 2006).

²⁴ See Husted and Husted (1999) for further detail on reservists.

(2) base pay (determined by entry date into the military) multiplied by the rated percentage of disability.²⁵ However, the benefit cannot exceed 75 percent of base pay. Only the excess of (1) over (2) is subject to federal income tax. Military retirement service members whose disabilities are not necessarily permanent are placed on a temporary-disability retired list and receive disability retirement pay as if they were permanently disabled, and the benefit amount can be no less than 50 percent of base pay. The calculation for temporary disability benefits is performed just like that for permanent disability. Temporary disability benefit recipients must be examined every 18 months for any change in disability status with a final determination made within five years.

At retirement, military members have the option to have a portion of retired pay continue to their dependents upon the retiree's death in return for a reduction in retirement pay to cover the expense. Prior programs before 1972 required military members to bear the entire cost of this benefit. After 1972, the Survivor Benefit Plan (SBP) was enacted for new retirees, and those retired under the old system were given an option to convert to the SBP. The government subsidizes the SBP benefit—directly by paying for benefits in excess of revenues and indirectly by exempting retired pay from SBP premiums.²⁶ Benefits paid to survivors are a percentage of the base amount previously elected by the retiree, which cannot exceed the retired pay benefit or be less than \$300. Reductions in the premium (subsidy) are also based on the elected base amount selected upon retirement. SBP annuities equal 55 percent of the base amount if the annuitant is under age 62, and 35 percent of the base amount if he or she is older—a two-tiered benefit structure mirroring the age requirements for Social Security benefits. Since 1992, retirees electing the maximum base amount can eliminate all or a portion of the reduced second tier by paying the full cost of this added benefit through increased premiums.

Members of the military retirement system who die on active duty after 20 years of service are assumed to have retired on their date of death and to have selected survivor benefits for their surviving spouses and/or children. As with retirement pay, all SBP annuities are offset by survivor benefits awarded by the VA, but any past retiree premium payments related to the reduction are returned to the survivor.

Reservists are eligible to elect SBP at age 60, when they begin to draw retirement pay. Those reservists accumulating 20 years of service prior to age 60 can elect to participate in the Reserve Component Survivor Benefit

²⁵ Husted and Husted (1999) provide more detail on disability benefits.

²⁶ According to Husted and Husted (1999), the total subsidy averages about 34 percent. Retirement pay is reduced before taxes for the member cost of SBP (U.S. Department of Defense, 2006).

Program (RCSBP), which provides survivor benefits in the event of death before age 60.²⁷

Relationship With Veterans Administration Benefits—The VA provides compensation for service-connected and certain non-service-connected disabilities. While such benefits can replace or be provided in combination with DoD retirement pay, they cannot be additive (U.S. Department of Defense, 2006). It may be to the advantage of the individual to elect VA benefits, since they are exempt from federal income taxes. VA benefits also overlap survivor benefits through the Dependency and Indemnity Compensation (DIC) program.²⁸

Cost-of-Living Increases—Retiree and survivor benefits are automatically adjusted each year. Benefits received by members who first entered the military service before August 1, 1986 are adjusted by the percentage increase in the average CPI.²⁹ Benefits associated with members entering on or after August 1, 1986, are annually increased by the percentage change in the CPI minus 1 percent. At age 62, the military member's benefits are restored to the amount that would have been payable had full CPI protection been provided. Cost-of-living increases and other adjustments for survivors are applied as they would have been to the retiree, depending upon which of the three military service groups the deceased member belonged to.

Governance—The military retirement system is administered by the Department of Defense, and trust fund assets are invested by an investment fund manager employed by DoD.³⁰ P.L. 98-94 established an independent three-member DoD Retirement Board of Actuaries. The DoD Chief Actuary serves as the Executive Secretary of the Board and the Office of the Actuary provides all technical and administrative support to the Board.

State and Local Government Plans

The New York City police force is recognized as the first group of civilian employees at the state or local level to be covered by a public employee retirement system in the United States (1857). By the end of the 19th century, employers in both public and private sectors were seeking ways to provide economic welfare for employees at the conclusion of their careers. Many of these early systems covered only teachers or workers in public safety occupations, such as firefighters and police officers—groups still

²⁷ The additional cost of this benefit is borne by the serviceman or servicewoman through additional reductions in retirement pay and survivor annuities (Hustead and Hustead, 1999).

²⁸ See U.S. Department of Defense (2006) for further details on this relationship.

²⁹ This is referred to as full CPI protection (U.S. Department of Defense, 2006).

³⁰ Hustead and Hustead (1999) provide details on how this works.

covered in occupation-specific pension plans operated at the state and local levels.

Over the next 50 years, numerous retirement plans in state and local jurisdictions came into existence. The first state employee retirement system was established by Massachusetts in 1911 for general service employees. By 1930, 12 percent of the larger state-administered pension systems currently in existence had been established. Between 1931 and 1950, half of the largest state and local plans in the country were established (U.S. Congress, 1978). From 1941 to 1947, the remaining 22 states began to offer pension plans to their work force (Munnell and Connelly, 1979).

The percentage of full-time state and local government employees participating in a defined benefit pension plan has remained constant. In the 1990s, approximately 9 of 10 such employees were defined benefit pension plan participants (U.S. Department of Labor, 1996 and 2000). PERS plans range in size from those with hundreds of thousands of participants to plans covering fewer than five employees (e.g., plans in townships or boroughs).

According to the U.S. Census Bureau, total membership in state and local government retirement systems was approximately 18.5 million in fiscal year 2006. There are 221 state-administered systems and 2,433 locally administered systems, for a total of 2,654 public employee retirement systems. State systems had 12.9 million active members, while local systems had 1.7 million active members. Benefit payments totaling \$152.1 billion were made to 7.3 million persons, with an average monthly payment of \$1,736 per beneficiary (U.S. Department of Commerce, Bureau of the Census, 2006).

Funding—Retirement systems at the state and local levels are funded through a combination of tax revenues, employee contributions, and investment income. A majority of state and local retirement systems are supported by both employer and employee contributions. Employee contributions provide a steady source of income to public employee retirement systems. Contributions of public-sector employers are subject to the approval of the legislature (or other financing agency). Employer contributions can also be funded by special taxes or levies.

To reduce the need for additional contributions to fund retirement benefits, state and local employee retirement systems earn supplemental income by investing the funds collected. Investments by retirement systems are subject to state and local laws, which has not prevented state and local funds from achieving good returns over time (Zorn, 2000). In recent decades, state and local retirement systems have increased their already substantial share of total retirement market assets relative to other major institutional investor categories—including private trustee pension funds, federal government

plans, private life insurance pension funds, and individual retirement accounts (Rajnes, 2001).

Coverage—Plans may cover all types of employees, but benefit formulas and other plan provisions may be different for certain categories of employees (i.e., general employees, teachers, firefighters, police officers, judges, legislators, and elected officials). Such differences may result from historical distinctions or varying retirement policies. For example, public school teachers may have plans different from those for general employees, often because the system for teachers preceded that for general employees. Firefighters and police officers are often permitted to retire with full benefits at a younger age than most other employees, since such positions often require youth and physical exertion. For judges, legislators, and elected officials, a career may encompass a much shorter period of time than for other categories of employees, so plan provisions may allow for accrual of benefits at a faster rate.

Eligibility for Retirement, Disability Retirement, and Death Benefits—Participants in defined benefit plans can receive full benefits after they meet the plan's normal retirement requirements, which typically involve completing a service requirement. One out of four participants could receive full benefits at any age once a service requirement was met. In addition, an age requirement for normal retirement was imposed on 56 percent of defined benefit plan participants, while a sum-of-age-plus service requirement was imposed on 19 percent. Thirteen percent of defined benefit plan participants could retire at age 55, but more than half of them had to have more than 30 years of service. Nine percent could retire at age 60; of those, two-thirds had to have at least 10 years of service. (U.S. Department of Labor, 2008).

In 2007, 92 percent of employees were in defined benefit plans that permitted them to retire early and receive an immediate but reduced pension. Almost all plans that permit early retirement do so at the employee's option, but a few plans require employer approval. Early retirement is generally available only to participants with a certain number of years of service. Plans permitting early retirement at age 55 generally require at least 10 years of service; plans permitting early retirement prior to age 55 also require more than 10 years of service.

Almost all state and local government employees are covered by disability retirement benefits. Participants must often meet a service requirement (e.g., five or 10 years) in order to be eligible for disability retirement benefits.

Preretirement survivor benefits (i.e., annuity and/or lump-sum benefits for the survivors of a state or local government employee who dies before retirement) were provided to 98 percent of state and local government employees in 2007. Generally, participants must be vested before preretire-

ment survivor benefits are available. Post-retirement survivor benefits (i.e., annuity and/or lump-sum benefits provided to the survivors of a state or local government employee who dies after retirement) were available to all state and local government pension plans participants in 2007.

Computation of Benefits—For normal retirement, the nearly universal defined benefit formula is the terminal earnings-based formula (96 percent of all employees in 2007), which typically pays a flat percentage of earnings (an average of 2.0 percent in 2007) per year of service, based on earnings in the final years of employment. For example, an employee who worked for 30 years and is covered by a plan that pays 1.5 percent per year of service would earn annual benefits equal to 45 percent of terminal earnings. For 56 percent of participants in 2007, terminal earnings were defined as a three-year average (often an employee's highest average earnings for three consecutive years). Some plans have alternative formulas that are used to provide a minimum level of benefits for individuals with short service or low earnings. The alternative formula may be a second terminal earnings formula or a formula that pays a flat dollar amount per year of service.

The amount of an early retirement pension is reduced to reflect the earlier age at which benefits begin and the fact that they are expected to be paid over a longer period of time. The early retirement benefit is generally calculated by reducing the normal retirement benefit by a percentage for each year between the early and normal retirement ages. For example, if a plan's normal retirement age is 62 and the reduction factor is 5 percent, a person retiring at age 60 would receive 90 percent of the normal retirement benefit. The reduction factor may be uniform (e.g., 3 percent, 5 percent, or 6 percent for each year of early retirement) or may vary by age or service.

Plans often have two types of disability benefits. Short-term disability payments or long-term disability payments are often provided to employees who are expected to recover within a reasonable period from their disability. Disability retirement benefits are provided to vested employees who meet a more stringent disability standard (e.g., totally and permanently disabled). Employees who receive disability retirement benefits are often subject to periodic reviews of their disability status until they have attained the age set by the plan for normal unreduced retirement. In 1998, 39 percent of full-time state and local government employees were in plans with an unreduced normal retirement (or service retirement) formula. Benefits to these disabled employees were based on the same retirement formula used to calculate benefits to employees retiring under normal circumstances. Some disability retirement calculations include additional years of service projected to the age or service level at which the employee would have met the plan's normal retirement requirement. Other disability retirement calculations are based on years of service actually completed. Other methods of calculating

disability benefits include flat amount benefits, dollar amount formulas,³¹ percentage of unreduced normal benefits less Social Security, and percentage of earnings formula both with and without Social Security offsets. In 1998, 12 percent of state and local government pension plans provided deferred disability retirement benefits. The workers in these plans are often given long-term disability insurance benefits that typically provide 50 percent, 60 percent, or 67 percent of earnings at the time of disability. Once the long-term disability benefits cease, disability retirement benefits begin.

According to the BLS, of those state and local government employees with a preretirement survivor annuity provided in 2007, 71 percent had plans in which the surviving spouse would receive an annuity equivalent to the amount payable if the employee had retired (early retirement is usually assumed) on the day prior to death, with a joint-and-survivor form of payment in effect (U.S. Department of Labor, 2008). For those with preretirement survivor annuities based on early retirement, the most common annuity was 50 percent of the deceased employee's pension. Most state and local government employees with a post-retirement survivor annuity have plans with an annuity that provides income during the lifetime of both the retiree and the surviving spouse. Many participants are in plans that give them a choice of two or more alternative percentages (usually 50 percent, 67 percent, or 100 percent) to be continued to the spouse. Reductions in the retiree's annuity are made, depending on the alternative percentage chosen. The few participants not in the plans noted above are in plans that provide the survivors with between 50 percent and 100 percent of the retiree's pension. For those participants in plans without the joint-and-survivor annuity, survivor benefits are typically a portion of the retiree's accrued benefit, in which case there is no reduction to the employee's pension to account for survivor benefits.

Employee Contributions and Refunds of Contributions—In 2007, 77 percent of employees in state and local governments were required to make a contribution to the defined benefit plan. Of those participants required to make a contribution, the most common type of contribution was a fixed percentage of earnings, with a median percentage of 6.4 percent (U.S. Department of Labor, 2008). Among defined contribution plan participants, 57 percent were required to make a contribution to the plan.

Public employees in a contributory system who terminate employment before becoming eligible for retirement benefits may be entitled to a refund of their own contributions. Such refunds usually include credited interest that may be established by statute or may depend on the fund's earnings or on current economic conditions. Many systems allow employees to reinstate service credit that was forfeited after a break in service. Reinstatement of

³¹ Dollar amount formulas specify a flat dollar amount times years of service.

service credit may be allowed only after the employee has repaid the contributions that were withdrawn (with interest sometimes required from the date contributions were originally credited), although some systems allow the employee to repay on an installment basis.

Employee contributions that were made on an after-tax basis are not subject to income tax or penalties when refunded, although the portion of the refund that has not yet been taxed (e.g., credited interest or picked-up contributions) is taxable and may also be subject to the 10 percent penalty under IRC Sec. 72(t).³²

The refund of contributions to employees who terminate employment with limited service is generally in the form of a lump sum. Employees of most systems also have the option of deferred vested benefits, provided they terminate employment after meeting certain service or age and service requirements. Service-related qualifications for vesting are typically five years.

Forms of Benefit Payments—Defined benefit pension plans typically pay their benefits in the form of annuities covering the life of the retiree and spouse, while some plans offer an option in the form of a lump-sum payment that provides the employee with the actuarial equivalent of the annuity.³³ In 2007, lump-sum payments were available to 49 percent of state and local employees. In many of these plans, a partial lump sum with annuity was available, in which case the participant generally received a reduced annuity for the remainder of his or her life. The participant receives no further benefits from the pension plan if a full lump-sum distribution is taken.

In an effort to add benefit flexibility for plan participants without increasing costs, a growing number of public safety and other public-sector employers are considering delayed/deferred retirement option plans (DROPs).³⁴ DROPs are optional payment forms under DB plans similar to the traditional or partial lump-sum options that allow participants to elect to receive a lump sum in exchange for a reduced monthly benefit for life, thereby permitting long-term employees to eventually leave their job with both a traditional annuity and a lump-sum amount as in a DC plan. An

³² This tax is imposed unless the refund occurs following death, disability, attainment of age 59½, or separation from service after age 55. This tax burden may be overcome if the employee rolls over the contributions into an individual retirement account.

³³ Payments from defined benefit plans may be in the form of a straight-life annuity, joint-and-survivor annuity, percentage of unreduced accrued benefit, or a lump sum. See U.S. Department of Labor (2000) for further details.

³⁴ These plans originated chiefly in local public safety pension plans, where members could retire with full benefits at an early age. Employers realized the benefit of retaining a valued employee versus the expense and disruption of recruiting and training an inexperienced one. Use of the DROP also enabled public-sector employers to predict with greater accuracy future employment needs (Perdue, 2000).

employee electing to participate in a DROP will continue to work for the employer but cease to accumulate further credits toward retirement—the future DB annuity is thus frozen at enrollment—in exchange for credits placed by the employer into a personal retirement account. DROP account balances are then managed as part of the DB plan total portfolio. When the employee terminates employment, both the DROP contributions and the annuity are received as a retirement benefit. The use of DROPs at the state level is growing. In 2002, 28 percent of public pension programs offered a DROP (Mann Bragg, 2003).

Cost-of-Living Increases—Public employee plans are widely known for their COLAs, a feature not often seen in the private sector.³⁵ COLA provisions represent an effort on the part of public-sector employers to compensate retirees for the loss of purchasing power due to inflation. Inflation in the 1970s caused many public pension plans to adopt COLAs to protect annuity purchasing power (Wisconsin Legislative Council, 2005). Some plans specify automatic cost-of-living increases, usually based on changes in the Consumer Price Index (CPI), while other plans provide discretionary (ad hoc) increases to adjust retiree benefits for inflation. Nearly all general-coverage state systems provide some form of cost-of-living adjustment for retired workers in 2006, and there is an automatic procedure in 34 of these states (Workplace Economics, Inc. 2006). Of those that offer an automatic adjustment, 13 have some form of fixed percentage and 21 others tie changes to the CPI, although the adjustment may be limited to some maximum percentage or proportionate change.

Purchase of Service Credit—In the absence of full portability of benefits, an opportunity to purchase credits for past service as a public employee can mean the difference between being eligible and not being eligible for retirement, especially for public-sector workers in several retirement systems. In 2007, 83 percent of state and local employees were allowed to purchase credits for prior government service, according to government statistics (U.S. Department of Labor, 2008). Plan provisions for teachers, for example, can differ as to the type of prior service available for purchase (e.g., from another state system), the amount paid for the purchase, and the payment options available (National Education Association, 2000b). Public-sector plans' service credit purchase provisions have taken on increased importance in the education area, given the shortage of teachers in many states. As of 1998, 47 out of 50 statewide retirement systems (that include teachers) allowed some or all participants to purchase out-of-state teaching service credit.

³⁵ The public sector—which comprises more or less permanent entities that rely on the tax base rather than on operating results for their resources—has historically been more willing than the private sector to commit to postretirement benefit adjustments.

Social Security Coverage and Integration—The initiation of a national retirement income policy took place with passage of the Social Security Act of 1935. Public-sector employees were originally excluded from coverage, partly due to constitutional concerns about the federal government’s right to tax state and local governments and partly because many state and local employees were already covered under public retirement systems (Crane, 2001).

The following decades witnessed a series of legal changes that brought many state and local pension plans into the Social Security system. In the 1950s, public-sector employers without a retirement plan were allowed to elect Social Security coverage by entering into “Sec. 218 Agreements” with the Social Security Administration.³⁶ Employers could identify groups of employees for possible addition to Social Security under this arrangement, with the result that employers might have none, some, or all of their employees participating in the federal program (Harris, 1998). In practice, public-sector employers were thus able to opt into and out of Social Security even if their employees were covered by an in-state retirement system. However, changes to the Social Security law in 1983 barred public-sector employers from leaving the Social Security system.³⁷ In 1991, Congress extended mandatory Social Security coverage to state and local government employees not covered by a public pension plan. At present, new employees enrolling in existing public-sector retirement plans, which operate outside Social Security, are not covered under the Social Security system.

About one-fourth of all full-time workers in state and local DB plans are not covered by Social Security (Fore, 2001; Eitelberg, 1999). Examining employees participating in DB plans, the proportion not covered by Social Security is fairly consistent across all occupational groups at around 10 percent, although a little lower for white-collar employees. Among general coverage statewide retirement systems, 43 systems participate in Social Security. The remaining seven states with general coverage retirement systems not participating in Social Security include Alaska, Colorado, Louisiana, Maine, Massachusetts, Nevada, and Ohio. The delineation between these two groups is not exactly clear, however, since there are both large and small retirement programs not covered by Social Security in states where the general retirement programs are covered by Social Security.³⁸

³⁶ Named after that section of the Social Security Act permitting voluntary participation.

³⁷ More specifically, the law stipulated that once social security coverage was extended to any group of employees, the employer could not remove them (Harris 1998).

³⁸ For example, teachers in Connecticut, Kentucky, Illinois, Missouri, Texas, and California do not participate. Moreover, certain teachers in Rhode Island, Georgia, Oklahoma, and Minnesota also do not participate.

In general coverage statewide systems, where employees receive both a state pension and a Social Security benefit, five states offered some kind of coordinated or integrated plan in 2006 (Workplace Economics, Inc., 2006).³⁹ Government data indicate that integrated formulas are generally uncommon in such plans, accounting for 7 percent or less of the total. There are usually significant differences between the benefits received by employees from their government-sponsored retirement plan, depending on whether or not they are also covered by Social Security. Higher benefit formulas typically apply to employees without Social Security coverage in order to make up for the absence of those postretirement benefits. According to data from a survey of state and local government employee retirement systems conducted by the Public Pension Coordinating Council in 2000, the average annual unit benefit (percentage of final average salary used in the benefit formula for the first 10 years of service) of plans without Social Security coverage was 2.38 percent, compared with 2.08 percent for plans with Social Security coverage (Zorn, 2000).

Plans that are integrated with Social Security typically use either an offset approach or an excess formula. Under the offset approach, an employee's retirement benefits are reduced by part of his or her Social Security benefit. For example, the pension benefit of an employee who has worked for a state or local government for 30 years may be reduced by 30 percent of his or her Social Security benefit (1 percent times each year of service). The maximum offset is usually limited to 50 percent of the Social Security payment. Under an excess formula, a lower pension benefit rate is applied to earnings below the integration level, and a higher rate is applied to earnings above that level. The integration level is typically equal to the Social Security taxable wage base (\$102,000 in 2008). Benefit accrual rates applied to earnings below the integration level may range from 0.75 percent to 2.0 percent; rates applied to earnings above the integration level may range from 1.5 percent to 2.5 percent.⁴⁰ A final approach, known as a pure excess formula, provides that earnings below the integration level are disregarded. Social Security integration may also reduce disability benefits by the amount of benefits received from Social Security, workers' compensation, or both.

³⁹ Integrated plans are those that explicitly recognize Social Security coverage in the plan design by using "offsets" or "step-up formulas." "Offset" provisions subtract some part of the Social Security benefit from the state-provided retirement plan annuity upon Social Security retirement. By contrast, "step-up formulas" apply lower pension benefit rates to an employee's earnings up through a specified earnings level (for example, the Social Security taxable wage base) and then apply higher rates above that level.

⁴⁰ See Zorn (2000).

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CHAPTER 45

PUBLIC-SECTOR LIFE INSURANCE AND RELATED PROTECTION

Introduction

Most public jurisdictions make group life insurance coverage available to their employees, and many pay all or a portion of the cost. According to the Bureau of Labor Statistics, in 2007, 78 percent of state and local government employees participated in group life insurance funded wholly or partly by their employers (U.S. Department of Labor, 2008). Another survey covering only state employee benefits, indicates that 43 states provide at least a basic life insurance benefit at no cost to the employee (Workplace Economics, Inc., 2006). Approximately 90 percent of active and retired federal employees participated in the basic federal group life insurance program in fiscal year 2004 (U.S. Office of Personnel Management, 2006).¹

Federal Program

The Federal Employees' Group Life Insurance (FEGLI) Program was established by the Federal Employees' Group Life Insurance Act of 1954 and was significantly modified by the Federal Employees' Group Life Insurance Act of 1980 (U.S. Office of Personnel Management, 2000). Modifications included an increased level of insurance under basic life insurance (discussed below), introduction of new optional forms of coverage, and a more competitive premium structure. Prior to the FEGLI Program, life insurance coverage was offered to groups of federal employees by beneficial associations. There were 27 such associations in 1954. Under the FEGLI Act of 1954, the Civil Service Commission was authorized to purchase a qualified life insurance policy to insure all or portions of the agreements assumed from the beneficial associations. Beneficial association insurance still has members, although it is closed to new enrollment.

Coverage—With few exceptions, all federal civilian employees are eligible to participate in the FEGLI Program. Those covered by the FEGLI Program include the president, members of Congress, federal government employees, Gallaudet University² faculty, and others not excluded by OPM

¹ Participation in the basic program by both active and retired federal employees has held consistently at 90 percent since the program was expanded and revitalized in 1981.

² Gallaudet University is a private four-year institution in Washington, DC, with under-

statute or regulation. As of 2003, the program covered more than 4 million federal employees and retirees, as well as many of their family members, and was the largest group life insurance program in the world.³

Administration—The insurance program is administered by OPM, but each federal agency is responsible for daily program operations with respect to its own employees.

Basic Life Insurance—During employment, the group policy provides both life insurance and accidental death and dismemberment (AD&D) insurance. The basic life insurance benefit equals the employee's annual pay rounded upward to the next thousand, plus \$2,000. For employees earning \$8,000 or less annually, the minimum amount of insurance coverage was \$10,000 (U.S. Office of Personnel Management, Federal Employees Group Life Insurance Program). Additional benefits at no additional cost are provided for employees under age 45.⁴ The AD&D benefit provided to employees is twice the basic life insurance benefit in the case of accidental death and one-half the basic life insurance benefit for the loss of one limb or sight of one eye. (The full amount is paid for two or more such losses.)

Basic insurance cost is shared by the employee and the government (as employer). The employer pays one-third of the cost (contributed from agency appropriations or other funds available to pay salaries), and the employee pays two-thirds (withheld from his or her salary).⁵ Unless eligible employees state in writing that they do not want basic insurance, they are automatically covered.

Basic life insurance enrollment is a prerequisite for enrollment in any of the following optional life insurance coverage.

Standard Optional Life Insurance (Option A)—Federal employees under the basic life insurance program have the option of purchasing additional insurance known as standard optional life insurance. Standard life provides \$10,000 of life insurance and an equal amount of AD&D coverage. The full cost of standard life is paid by the employee and is dependent on his or her age. The premium is withheld from the employee's salary. The monthly withholding ranges from \$0.30 per \$10,000 of coverage for employees under age 35 to \$6.00 per \$10,000 of coverage for employees age 60 or

graduate programs open only to deaf individuals. The university was federally chartered in 1864 and continues to receive a portion of its funding from the federal government.

³ Office of Personnel Management, Introduction to the FEGLI Program, www.opm.gov/insure/life/intro.asp (last reviewed July 2003).

⁴ Additional benefits range from 2 times the basic life insurance benefit for employees age 35 or younger to 1.1 times the basic life insurance benefit for employees at age 44.

⁵ The employee paid \$0.155 per \$1,000 of basic coverage in 2000 (Federal Employees News Digest, Inc., 2001).

over. (U.S. Office of Personnel Management, Federal Employees Group Life Insurance Program).

Additional Optional Insurance (Option B)—Additional optional insurance is also available to employees covered by the basic life insurance program. Additional life is offered in amounts equal to one, two, three, four, or five times annual basic pay (after the pay has been rounded to the next higher \$1,000).⁶ The full cost of additional life is paid by the employee and is dependent on his or her age. The premium is withheld from the employee's salary. Unlike standard life, AD&D coverage is not included in additional life. The monthly withholdings for additional optional insurance range from \$0.03 per \$1,000 of coverage for employees under age 35 to \$0.70 per \$1,000 of coverage for employees age 60 and over (U.S. Office of Personnel Management, Federal Employees Group Life Insurance Program).

Family Optional Insurance (Option C)—Federal employees covered by the basic life insurance program also have the option of purchasing insurance to cover eligible family members (spouse and unmarried dependent children). Family optional insurance is offered with \$5,000 coverage for a spouse and \$2,500 coverage for each child under age 22.⁷ The full cost of family optional insurance is paid by the employee and is withheld from his or her salary. The premium depends on the employee's age. Monthly withholdings range from \$0.27 for employees under age 35 to \$3.40 for employees age 70 and over. Family optional insurance does not include AD&D coverage (U.S. Office of Personnel Management, Federal Employees Group Life Insurance Program).

Coverage after Retirement—Basic life insurance continues into retirement, with three elections offered to annuitants (U.S. Office of Personnel Management, Federal Employees Group Life Insurance Program).⁸ The first option is a reduction in basic life insurance coverage of 2 percent a month after age 65 (maximum reduction of 75 percent of the basic policy face value), with no additional cost to the retiree. The second option is a lesser reduction of 1 percent a month after age 65 (maximum reduction of 50 percent of the

⁶ The maximum amount of basic pay used in this calculation was set at \$143,000 in 1999 (U.S. Office of Personnel Management, 2000).

⁷ This coverage may include children age 22 and over, provided the child is incapable of self-support due to a mental or physical disability that existed prior to age 22 (U.S. Office of Personnel Management, 2000).

⁸ Provided the employee is retiring on an immediate annuity and he or she either had been covered by the basic life insurance during either of (1) the five years of service immediately preceding the starting date of the annuity or (2) if less than the full five years, the full period or periods of service during which the basic insurance was available to the individual (U.S. Office of Personnel Management, Federal Employees Group Life Insurance Program). (Note: The AD&D benefit provided to employees under basic life insurance does not continue into retirement.)

basic policy value). In 2005, the additional premium for this lesser reduction was \$0.925 a month per \$1,000 of basic insurance coverage until age 65 and \$0.60 a month per \$1,000 for coverage thereafter (U.S. Office of Personnel Management, Federal Employees Group Life Insurance Program). The final option is no reduction in basic life insurance coverage after age 65, with a larger premium charge. In 2005, the additional premium required for no reduction in the amount of basic insurance was \$2.155 a month per \$1,000 of basic insurance until age 65 and \$1.83 a month per \$1,000 after age 65 (U.S. Office of Personnel Management, Federal Employees Group Life Insurance Program). If either of the last two elections is canceled, the amount of life insurance is computed as if the retiree had originally elected the 75 percent reduction.

The FEGLI Act of 1980 requires that employees who retire before reaching age 65 make a supplemental contribution in order to continue their basic life insurance coverage. This supplemental coverage applies regardless of which of the three postretirement options the retiree has elected. The supplemental contribution ceases when the retiree reaches age 65, at which point the elected option becomes effective. The optional insurance programs (standard, additional, and family) may also be continued into retirement (at the same cost to the retiree as when he or she was employed), although the cost and coverage change when the retiree reaches age 65.

Retirees age 65 and over do not pay premiums for standard optional life insurance. However, the \$10,000 standard optional insurance begins to decline at the rate of 2 percent per month until it reaches \$2,500 (i.e., one-fourth of the face value). Similarly, premiums for additional optional insurance and family optional insurance are no longer required of retirees who have reached age 65. However, the amount of coverage will begin to decline at the rate of 2 percent per month for 50 months, at which point coverage ends.

State and Local Programs

Generally, the cost of basic life insurance in state and local government plans is paid entirely by the employer. In 2007, for example, 89 percent of life insurance plan participants were in plans that were wholly employer financed; the remainder were in plans that were partly employer financed (U.S. Department of Labor, 2008). Workers in plans requiring employee contributions generally pay a dollar amount based on coverage. Some plans, however, require a set contribution that covers more than one benefit.

Coverage—Among all state and local government employees who were full-time life insurance participants in 1998, 30 percent were required to work a minimum period (commonly one or three months) to qualify for the

plan; 68 percent were in plans with no service requirement, and 2 percent were in plans for which the service requirement was not determinable. Minimum age requirements were rare (U.S. Department of Labor, 2000).

Basic Life Insurance Benefit Formulas—For employees of state and local governments, the most common method (51 percent) of determining basic life insurance is a flat-dollar amount of coverage. Flat-dollar insurance amounts up to \$25,000 accounted for 67 percent of life insurance participants in 2007 (U.S. Department of Labor, 2008).

The second-most common method (38 percent) of determining the amount of basic life insurance is to base it on a fixed multiple of earnings. Earnings-based coverage provides a level of protection that automatically increases with pay. The most prevalent method of tying life insurance to pay is to multiply the employee's annual salary by one or two and then round the result to the next higher \$1,000. For example, an employee whose annual pay is \$43,600 would receive \$88,000 of coverage under a plan providing two times pay.⁹ Some plans place limits on the amount of life insurance available; such limits are typically in the range of \$50,000–\$250,000. According to a 2006 state employee benefits study, 27 states vary the amount of insurance based on an employee's salary, 14 states vary the insurance amount by age, and 22 states provide a fixed amount (Workplace Economics, Inc., 2006).

Accidental Death and Dismemberment (AD&D) Coverage—Accidental death and dismemberment (AD&D) insurance was available to 65 percent of state and local government life insurance plan participants in 1998. AD&D insurance provides additional benefits if a worker dies or loses an eye or a limb in an accident. For most workers, the benefit is equal to the basic life insurance benefit in the case of accidental death and a portion of that benefit for dismemberment, although a few workers receive a flat amount of AD&D coverage. Some states provide optional AD&D coverage at the employee's expense.

Supplemental Benefits—The typical supplemental plan provides term life insurance in multiples of one to three times annual pay, at the employee's option. Supplemental benefits are more common among state and local employees who have their basic life insurance determined by a flat-dollar amount than among employees with a multiple of earnings formula. Among the 59 percent of state and local government employees with the option of supplemental benefits in 1998, about 52 percent were required to pay the full premium for such benefits.

Coverage for Dependents—Of the 51 percent of state and local government employees with dependent life insurance coverage in 1998, 39 percent were required to pay the entire premium to obtain coverage; the remainder

⁹ The annual pay of \$43,600 is multiplied by two, which yields \$87,200. This amount is then rounded up to \$88,000.

had coverage paid either partly or entirely by the employer. The most prevalent method used to provide dependent coverage is a flat-dollar amount, and the employee often has the option to select specific benefits.

Survivor Benefits—Life insurance plans providing a monthly benefit to surviving members of a state or local government employee's family are rare. When survivor income payments are available, they are generally either a percentage of the employee's pay or a flat-dollar amount. Survivor benefits usually continue for 24 months, although some plans provide benefits until the surviving spouse either remarries or attains age 65 or until surviving children reach a specified age.

Coverage for Older Active Workers—In some life insurance plans, coverage of older active workers is reduced to account for the increased cost of insuring older workers. Coverage may be reduced once or in several stages. Plans with reduced coverage typically make the first reduction at age 65 or 70. If coverage is reduced only once, it is typically reduced to 50 percent of the original life insurance amount. For plans that reduce coverage in several stages, a common provision is to reduce coverage to 65 percent at age 65 and then to 50 percent at age 70. In 1998, 34 percent of participants were in plans in which older active workers faced reduced benefits.

Coverage for Retirees—Plans that extend basic life insurance coverage into retirement almost always continue coverage for the remainder of the retiree's life. However, the amount of the benefit is usually reduced at least once during retirement. Some plans require that premiums for continued coverage be paid fully by the retiree. In 1994, 46 percent of the full-time participants in state and local governments had basic life insurance that continued into retirement.

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CHAPTER 46

EMPLOYMENT-BASED HEALTH BENEFITS IN THE PUBLIC SECTOR

Introduction

Public-sector employers offer health benefits to their employees for the same reasons as private employers offer them: to provide workers and their families with access to health care and with protection from financial losses that can accompany unexpected serious illness or injury. Employers also offer health benefits in order to promote health, to increase worker productivity, and as a form of compensation to recruit and retain qualified workers. A key difference is that while private-sector employment-based health benefits are offered on a voluntary basis, public-sector plans are offered under state or municipality law. Public-sector employees receive health benefits, unlike their ordinary wage income, on a pre-tax basis in the same manner as private sector employees.

According to EBRI estimates of data from the Current Population Survey, March 2006 Supplement, in 2005, 76.3 percent of federal government workers, 74.9 percent of state government workers and 73.9 percent of local government workers were covered by their employer's health plan. This compares with 54.0 percent of private-sector workers. The uninsured rate among government workers is low, 6.3 percent to 6.5 percent, compared with 20.1 percent among private-sector workers.

Employment-based public-sector group health plans typically provide comprehensive health benefits, including mental health and substance abuse treatment coverage—although these benefits are subject to limitations. Most public employees also receive dental care benefits (U.S. Department of Labor, 2000). One salient characteristic of public-employee group health plans is that employees usually become eligible to participate immediately on being hired. This is true at the local, state, and federal levels. In situations in which waiting periods apply, they tend to be three months or less (U.S. Department of Labor, 1996).

Starting in 2002, long-term care insurance for persons unable to care for themselves was offered to federal employees, annuitants, and their families, including but not limited to nursing home care, assisted living facility care, formal and informal care in the home, hospice care, and respite care (Dore and Helwig, 2001). In fiscal year 2004, there were more than 205,000 enroll-

ees in the federal long-term care insurance program (U.S. Office of Personnel Management, 2006). This benefit is already available to some public-sector workers, including 43 percent of employees at the state level and 21 percent of employees at the local level (U.S. Department of Labor, 2008).

Types of Insurance Program Operators

Although the Employee Retirement Income Security Act of 1974 (ERISA) does not cover public-sector employment-based group health plans, provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (see chapter on COBRA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which amended ERISA, do apply. Because ERISA does not generally apply to public-sector employment-based group health plans, states are free to regulate these plans in ways that they cannot regulate private-sector plans, which are subject to ERISA pre-emption. Therefore, states may mandate how public-sector group health plans operate (e.g., funding requirements, benefits offered, employee and dependent appeal rights, disclosure requirements, etc.).

In 2002, among state plans, Segal Company found 19 percent of workers were enrolled in an indemnity plan, 16 percent in a point-of-service (POS) plan, 33 percent in a preferred provider organization (PPO) and 32 percent in a health maintenance organization (HMO) (The Segal Company, 2003). In 1999, approximately 39 percent of federal civilian employees participating in the Federal Employees' Health Benefits Program were enrolled in plans offered by Blue Cross and Blue Shield, 22 percent were in employee organization plans (which are sponsored by employee organizations or unions and are only open to employees or annuitants who are members of the sponsoring union or organization), while the rest were in health maintenance organizations (HMOs), preferred provider organizations (PPOs), point-of-service (POS) arrangements and other managed care programs not sponsored by Blue Cross and Blue Shield or a union (U.S. Office of Personnel Management, 2000).

The combination of public policy favorable to HMOs and the inherent political difficulty involved in limiting the number of HMOs that can participate in the public sector has led to a strong representation of these organizations in public-sector programs. However, the number of HMOs offered by public plan sponsors varies greatly. According to a 1999 survey, the number of HMO/POS plans offered among state governments ranges from none in two states to 10 or more in 15 states (The Segal Company, 1999). According to the Office of Personnel Management's Office of Actuaries, the federal government offered approximately 167 HMOs during 2002.

Over the past few years, there has been a dramatic increase in the number of full-time state and local employees covered under PPOs. According to BLS, 35 percent of state and local employees were covered by PPOs in 1998, compared with 30 percent in 1994 and 7 percent in 1987 (U.S. Department of Labor, 1988, 1996, and 2000).

Contributions

Among full-time workers in state and local plans, it is common for the public-sector employer to pay the entire premium for the employees' coverage but to require a contribution from employees who elect coverage for their dependents. The 1998 BLS survey showed that 51 percent of participants contributed to their own coverage, whereas 75 percent made a contribution for dependents (U.S. Department of Labor, 2000). However, the incidence of noncontributory coverage for the worker may be declining as state and local jurisdictions, like all other employers, seek to manage their health care costs. For federal employees, the federal government pays 72 percent of the average premium and not more than 75 percent of the total premium of any plan.

Cost Management

During the past two decades, many employers sponsoring employee group health plans have struggled with the problem of how to manage what appear to be ever-escalating costs. In 1982, the federal employee health benefits program introduced mandatory coinsurance and deductibles in all health program offerings in an effort to curb utilization and, consequently, costs. Public employers have tried many of the same strategies that private employers have used to eliminate unnecessary service and to control costs. These strategies include utilization review, case management, disease management, larger out-of-pocket responsibilities for use of out-of-network providers, and specialty networks of physicians, hospitals, diagnostic centers, transplant services, pharmacy (including mail order), and vision and dental providers, etc. HIPAA places some restrictions on how public-sector employment-based group health plans may use a pre-existing condition limitation provision in order to curtail costs.

Health care costs have continued to rise for both private and public employers. Recently, some employers in both sectors have attempted to curb utilization and price by using managed care arrangements. For example, many public entities have adopted POS programs under which the method of service delivery is selected at the time of treatment, with the expectation that patients will respond to financial incentives to use more cost-effective

HMO or PPO arrangements. Other public-sector group health plans are encouraging employees to opt for HMOs by providing relatively greater financial support to those making this choice. Some larger entities that self-insure the cost of health coverage, and possibly self-administer by negotiating favorable arrangements directly with providers of medical care and administrative services, are also big consumers of stop loss insurance. One thing is certain: Most public-sector employment-based group health plans have ceased to offer traditional indemnity coverage altogether, relying instead exclusively on managed care arrangements.

Post-Employment Coverage

COBRA—State and local employers are subject to the continuation of coverage provisions of COBRA, as amended. While the federal government, as an employer, was not originally subject to the act, similar requirements were subsequently imposed on federal agencies by separate legislation.

Retiree Coverage—In 2006, all states provided health insurance for pre-Medicare retirees and 48 provided it to Medicare-eligibles. (Workplace Economics, 2006). Federal workers enrolled in a plan under the Federal Employees Health Benefits Program for the five years immediately preceding retirement may continue coverage during retirement with the same level of employer-paid premiums as active workers. Where postretirement coverage exists in public plans, it almost always continues for the retiree's lifetime. Depending on the specific terms of the plan, coverage may also continue for the survivor's lifetime. In most cases, the level of coverage for retirees is the same as that for active workers, although employment-based benefits are usually coordinated with Medicare for retirees age 65 and over. Government entities, like private-sector employers, must account for post-employment benefit obligations, including retiree health care costs, on their financial accounting statements.

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CHAPTER 47

LEAVE PROGRAMS IN THE PUBLIC SECTOR

Introduction

Leave, or paid time off from work, is a particularly significant benefit for public-sector workers. These workers are entitled to slightly more paid holidays and vacations on average than their private-sector counterparts, and annual and sick leave often play a somewhat different role in their total benefits package.

Sick Leave

Public employees rely on accumulations of paid sick leave to provide income during periods of illness and temporary disability. In 2007, 87 percent of employees had access to paid sick leave (U.S. Department of Labor, 2008). All federal government employees have access to paid sick leave (U.S. Office of Personnel Management, 2008). By contrast, 57 percent of employees in private industry had access to paid sick leave benefits (U.S. Department of Labor, 2007). Most public employees accrue sick leave on an annual basis (the rate of accrual may vary by service) and sometimes are entitled to carry forward unused sick leave balances. Although most cumulative plans have a limit on the number of days that can be carried over to the following year, long-service employees who have enjoyed reasonably good health can have large sick leave accumulations during the later years of their careers.

In some jurisdictions, employees are compensated for their unused sick leave on termination of employment. However, a more common practice is to compensate them for this unused leave at the time of retirement. This compensation can take several forms. Some states and the federal Civil Service Retirement System (CSRS) credit unused sick leave for purposes of calculating their service credits used in computing retirement annuities. Except for individuals who transferred to the Federal Employees Retirement System (FERS) with a CSRS annuity component, this sick leave credit does not apply to annuity calculations of federal employees covered by FERS (*Federal Employees News Digest Inc*, 2001)

Annual Leave

Annual leave (vacation time) is generally accrued according to length of service, with average accruals in 2006 for state employees of 12.6 days after one year of service, 18.4 days after 10 years of service, 23.0 days after 20 years of service (Workplace Economics, 2006). Federal employees accrue 13 days of annual leave during their first three years of employment, 20 days during years three through 14, and 26 days thereafter (*Federal Employees News Digest Inc.*, 2001). This compares with 8.8 days at one year of service, 16.0 days at 10 years of service, 18.3 days at 20 years of service, and 19.1 days at 25 years of service that workers in the private-sector accrued in 2003 (U.S. Department of Labor, 2005).

Unused annual leave can usually be carried forward to subsequent years, although the amount that can be carried forward is generally subject to a maximum. Most federal and state and local employees are able to carry over 30 days of annual leave. Three states (Indiana, Louisiana, and Mississippi) allow leave to be carried over without limit. Among states specifying a maximum, Hawaii allows the greatest accumulation, at 90 days. Accumulated leave is generally cashed out on termination or retirement, although the cashout may be subject to a limit that is different from that imposed on accumulation (Workplace Economics, 2006).

Leave Sharing/Leave Banks, and Compensatory Time

Since public employees often have accumulation in excess of their own needs, some jurisdictions have undertaken programs whereby employees can transfer leave to colleagues in need. Nineteen states currently maintain some form of “sick leave pool.” In addition, other states allow employees to donate their annual leave to fellow employees in need of sick leave, subject to specific limitations under certain guidelines (Workplace Economics, 2006).

The federal government also has several leave-sharing programs. Under the Federal Employees Leave Sharing Amendments Act of 1993, all federal agencies are required to operate a leave-transfer program. The act also allows agencies to establish leave banks at any time. Employee participation in either program is strictly voluntary (Federal Employees News Digest Inc., 2001).

Under the leave-transfer program, employees who have exhausted all of their leave and are in need of additional leave (due to medical or family emergencies) can accept annual leave donations from fellow employees.

Under the leave bank program, employees who are in need of additional leave and who have previously become leave bank members by contributing a portion of their own annual leave to the agency’s leave bank are eligible to apply for a withdrawal of annual leave from the bank, should a medical

or family emergency arise. Banked leave can also be distributed to fellow employees in much the same way as under the leave transfer program.

Compensatory time (“comp-time”) is another form of leave used in the public sector. It is a method employers in the public sector can use to compensate employees for overtime work. Under the Fair Labor Standards Act, public employers are able to provide compensatory time off instead of monetary overtime compensation, providing there is an agreement between the employer and the employee. When compensatory time off is provided as an alternative to overtime pay in the federal government, the amount of “comp time” authorized is computed at the rate of one hour of compensatory time for each hour of overtime worked.

Family and Medical Leave

Paid Leave—Apart from annual and sick leave accumulations—leave that may be used expressly to care for children is rare in the public sector. However, under the federal Family and Medical Leave Act of 1993, employers are required to provide 12 weeks of unpaid, job-protected leave each year to eligible employees for the birth or adoption of a child or for the serious illness of the employee or the employee’s child, parent, or spouse. In addition to the federally mandated Family and Medical Leave Act, most states have their own family leave laws that apply to public-sector workers (Federal Employees News Digest Inc., 2001). For example, many states provide up to a year of unpaid parental leave, while other states provide employees with some paid parental leave. In 2006, 48 states reported that some amount of paid parental leave is available for mothers, and in 40 states, for fathers. Many states allow either parent to use accumulated annual leave, personal leave, compensatory leave, or other accrued paid leave. All states now report that adoption leave is available (Workplace Economic, 2006).

Military Leave—Military leave is granted to individuals who are in the National Guard or other reserve components of the armed forces. Such employees may need leave time to maintain their military status. In 2006, all states provided paid military leave to their employees (Workplace Economics, 2006). The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) provides that an employee is entitled to a leave of absence to perform military service, and re-employment following the service, so long as the person provides advance notice (unless impossible to do so or precluded by military necessity). In addition, the cumulative period of service may not exceed five years, the nature of the service is not dishonorable or otherwise disqualifying, and the person returns to work or applies for re-employment in a timely manner following completion of the service. There are several specified types of military duty that do not

count toward the five-year limit, including required training performed by guard and reserve members, and duty during a war or because of various contingencies, including the current mobilization for Operations Noble Eagle (a multi-agency effort within the borders of the United States to uncover terrorists and their plans for disruption), Enduring Freedom (all anti-terrorism military operations underway outside the borders of the United States), and Free Iraq (the war in Iraq).

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Additional Information

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CHAPTER 48

DEFINED CONTRIBUTION AND SUPPLEMENTAL RETIREMENT SAVINGS PLANS IN THE PUBLIC SECTOR

Introduction

The availability and use of defined contribution pension plans in the public sector differs from their availability and use in the private sector and has evolved over the years to address a variety of retirement and deferred compensation objectives of employers. In response, in large part to work force and demographic changes and certain changes in federal law, public-sector entities have begun to incorporate and integrate defined contribution and other tax-deferred savings vehicles into their overall compensation and benefits structures. Increasingly, public-sector entities are developing overall retirement benefits strategies that include the creative use of both defined benefit and defined contribution approaches that allow flexible participation in both plan types during their employees' working careers. Examples of creative uses of defined contribution plans include:

- Using Internal Revenue Code (IRC) Sec. 401(a) or Sec. 403(b) plans to receive matching contributions for elective employee contributions to Sec. 457, 403(b) or 401(k) plans.
- Using 401(a) or 403(b) plans to receive employer contributions of the value of unused accumulated employee annual vacation and sick leave payments.
- Allowing 457 and 401(a) plan participants to transfer all or a portion of their account balances to purchase service credit under their defined benefit pension plans.

Public-sector entities are also finding creative ways to help employees save for post-retirement health coverage costs by establishing a variety of defined contribution retiree health savings plans. Some of these plans include tax-advantaged arrangements under Sec. 501(c)(9) Voluntary Employee Benefits Association trusts (VEBAs), Sec. 115 or integral governmental trusts, and Sec. 401(h) medical subaccounts of Sec. 401(a) retirement plans.

The Federal Thrift Savings Plan

The Federal Thrift Savings Plan (TSP) is a key component of the three-part Federal Employees' Retirement System (FERS) that became effective on Jan. 1, 1987,¹ and covers those employees who first obtained coverage on or after January 1, 1984. The TSP is a tax-deferred defined contribution retirement savings and investment plan that contains features typically found in private-sector 401(k) plans. Employees in both the Civil Service Retirement System (CSRS) and FERS may participate in the TSP, although the TSP is only a supplement to CSRS, and the contribution rules are different.

According to a Congressional Research Service (CRS) report, Congress included the TSP as a part of FERS for three reasons: (a) to increase retirement income replacement rates under FERS, especially for higher paid employees for whom Social Security replacement rates are low; (b) to provide a portable benefit and thereby reduce retirement income penalties associated with changing jobs, and (c) to replicate benefits available to private-sector workers (Merck, 1994). As of December 31, 2005, thrift savings fund accounts were maintained for more than 3.6 million participants (Federal Retirement Thrift Investment Board, 2006).

Administration—The Federal Retirement Thrift Investment Board, an independent federal agency, manages the TSP. The board consists of five members who are nominated by the president and must be confirmed by the Senate. The board members serve part time and appoint a full-time executive director of the agency (Federal Retirement Thrift Investment Board, 2006).

Open Seasons—Open seasons occur twice a year: May 15 to July 31 and Nov. 15 to Jan. 31. During open seasons, employees may begin or terminate contributions, alter contribution amounts, and change the way future contributions are invested. In late May and November, employees receive participant statements showing employee and employer contributions and gains or losses due to investment experience.

Employer and Employee Contributions—TSP participants may contribute either a percentage of basic pay each pay period or a fixed dollar amount. All contributions must be made through payroll deductions; lump-sum contributions are not permitted. Employee contributions to the TSP reduce the individual's taxable income for federal (and usually state and

¹ The three-part Federal Employees Retirement System (FERS) program uses Social Security as a base and provides an additional defined benefit and the voluntary Thrift Savings Plan (TSP). Since the FERS program did not become effective until Jan. 1, 1987, an interim plan was in effect from Jan. 1, 1984, through Dec. 31, 1986. Any employee hired during that period received credit for all service toward FERS. (For further discussion of the Social Security and defined benefit components of the FERS program, see the chapter on defined benefit pension plans in the public sector.)

local) income tax purposes. FERS employees may contribute up to 15 percent of basic pay on a pretax basis; CSRS and uniformed service employees may contribute up to 10 percent of basic pay on a pretax basis.² All participants are also subject to the annual deferral limit set by IRC Sec. 402(g)—the same limit as for 401(k) deferrals. The limit is subject to annual adjustment and was set at \$15,500 in 2007. Employees may change their contribution rates only during the open seasons (Federal Retirement Thrift Investment Board, 2006).

The government (acting in the role of employer) automatically contributes 1 percent of basic pay for all eligible FERS participants, regardless of whether the employees make personal contributions. For FERS participants who choose to make their own contributions, the government matches the first 3 percent of employee contributions at 100 percent and the next 2 percent of employee contributions at 50 percent. As noted, CSRS participants may make tax-deferred contributions to the plan, but there are no automatic or matching employer contributions for CSRS participants.

Eligibility to Make Personal Contributions and to Receive Employer Contributions—FERS participants newly hired in any month from January to June become eligible to participate in the TSP the first full pay period starting the next January. They begin to receive the automatic 1 percent employer contribution, and, if they elect to contribute, the employer matching contribution. FERS participants newly hired July through December become eligible to participate the first full pay period starting the next July. They begin to receive the automatic 1 percent employer contribution and, if they elect to contribute, the employer matching contributions. CSRS participants can begin making contributions to the TSP during any open season. An employee may stop contributing at any time. If a participant stops during an open season, he or she may resume making contributions the next open season. If a participant stops outside an open season, he or she must wait until the next open season to resume making contributions (Federal Retirement Thrift Investment Board, 2006).

Vesting—All TSP participants (both CSRS and FERS employees) are immediately vested in their own contributions and investment earnings on those contributions. FERS enrollees are also immediately vested in the government matching contributions, plus associated investment earnings. Most FERS participants vest in the automatic 1 percent employer contribution and its earnings after three years of federal civilian service. However, members of Congress, congressional staff, and certain political appointees to the Executive Branch vest in the automatic 1 percent employer contribution after two years of such service. If an employee leaves federal service before

² Basic pay for TSP purposes is defined by law. The definition does not include things such as awards or many forms of premium pay.

vesting, the automatic 1 percent employer contribution and its earnings are forfeited. In the case of death, vesting is immediate (Federal Retirement Thrift Investment Board, 2006).

Investment Options—There are five TSP investment funds: the Government Securities Investment Fund (G Fund), the Common Stock Index Investment Fund (C Fund), the Fixed Income Index Investment Fund (F Fund), the Small Cap Fund (S Fund), and the International Stock Index Fund (I Fund). Individuals who choose to invest in other than the G Fund are required to sign a statement saying that they understand and accept the risk of investing in these funds. If a FERS participant does not submit an investment election form, the automatic 1 percent employer contribution is invested in the G Fund. During open seasons, an employee may change his or her investment allocations for *new* contributions. For FERS employees, the investment allocations chosen apply to personal contributions and to agency automatic and matching contributions. Interfund transfers of previously contributed amounts are permitted in any month (Federal Retirement Thrift Investment Board, 2006).

The G Fund consists of investments in short-term nonmarketable U.S. Treasury securities specially issued to the TSP. By law, all investments in the G Fund earn interest at a rate equal to the average of market rates of return on U.S. Treasury marketable securities that are outstanding with four or more years to maturity. The G Fund is managed by the Federal Retirement Thrift Investment Board. The C, F, S, and I Funds are managed by BZW Barclays Global Investors, N.A. (Barclays). The C Fund is invested primarily in the Barclays Equity Index Fund, a stock index fund that tracks the Standard & Poor's 500 (S&P 500) stock index.³ The F Fund is a bond index fund invested primarily in the Barclays' U.S. Debt Index Fund, which tracks the Lehman Brothers Aggregate (LBA) bond index. The S Fund is invested in a Willshire 4500 index fund. The I Fund is invested in an EAFE (Europe, Australasia, Far East) stock index fund⁴ (Federal Retirement Thrift Investment Board, 2006).

Plan Loans—Those eligible for the TSP Loan Program include current employees with a TSP account that has at least \$1,000 in employee contributions and investment earnings. TSP loans are available for purchase of a primary residence, educational expenses, medical expenses, and financial hardship. The interest rate charged is the G Fund rate in effect at the time the loan application is received. Repayment is made through payroll deduc-

³ The C fund also includes temporary investments in the G fund and certain other short-term securities pending purchase of stocks. These temporary investments also cover liquidity needs such as loans and withdrawals from the plan.

⁴ The F fund may also have temporary investments in the G fund and in certain other short-term securities pending purchase of notes and bonds and for liquidity requirements.

tions. To obtain a TSP loan, FERS employees must obtain spousal consent, and the spouses of CSRS employees must be notified of the loan application by the TSP (Federal Retirement Thrift Investment Board, 2006).

Withdrawal of a TSP Account Balance—Employees who separate from federal service are eligible to withdraw their TSP accounts. An individual must be separated from federal service for 31 or more full calendar days before the TSP account can be paid out. Withdrawal options include a TSP life annuity, a single payment, or a series of monthly payments. A participant may choose to have the payment(s) begin immediately or at some future date.⁵ A participant may also request that the TSP transfer all or a part of a single payment to an individual retirement account (IRA) or other eligible retirement plan. (In some cases, a series of monthly payments can be transferred.) Participants also have the option of leaving their accounts with the TSP on separation and making a withdrawal decision later. Amounts paid to participants from TSP accounts are considered taxable income for federal income tax purposes in the year in which payment is made. Payments not subject to these rules include TSP annuity purchases and direct transfers by the TSP to IRAs or other eligible retirement plans, since such payments are not made directly to the individual. The withdrawal option known as the TSP annuity is a monthly benefit paid for life. A participant can request a single life annuity (with level or increasing payments), a joint life annuity with his or her spouse, or a joint life annuity with someone other than a spouse. As with the single life annuity, a participant with a joint life annuity can choose to have level or increasing payments. For participants with TSP account balances of at least \$3,500, an annuity can be purchased from the TSP's annuity provider. If an account balance is less than \$3,500, the participant can request an annuity with a specific future date (the account must be at least \$3,500 before the annuity can be purchased). Annuity payments will be taxed as ordinary income in the years in which they are received (Federal Retirement Thrift Investment Board, 2004).

Another withdrawal option is the single payment option, which is simply a withdrawal of the entire TSP account balance in a single payment. If the amount withdrawn in a single payment is paid directly to the participant (and is not transferred to an IRA or other eligible retirement plan), the payment is subject to mandatory 20 percent withholding. In addition to the ordinary income tax an individual must pay on money received directly from the TSP account, the Internal Revenue Service (IRS) imposes a 10 percent penalty tax on amounts received from the TSP if the individual separates or retires before the year he or she reaches age 55 and receives the money

⁵ An individual cannot choose a future date that is later than April 1 of the year following the year in which he or she attains age 70½.

before age 59½.⁶ In this case, the individual is subject to the penalty tax on all amounts received before age 59½ (Federal Retirement Thrift Investment Board, 2004).

The third withdrawal option is a series of monthly payments. Participants may choose the *number* of monthly payments they want to receive. Another option available to participants is to choose a specific dollar amount for each monthly payment (Federal Retirement Thrift Investment Board, 2004).

A final alternative is for participants to have monthly payments computed by the TSP based on an IRS life expectancy table. As with the single payment option, an individual who chooses the monthly payments option (unless the payments are based on life expectancy) is subject to a 10 percent penalty tax on all amounts received before age 59½ if he or she separates or retires before the year he or she reaches age 55. Individuals who reach age 70½ and are receiving a series of monthly payments from their TSP accounts are subject to IRS minimum distribution requirements. Participants with vested account balances of \$3,500 or less are subject to automatic cash-out procedures. Under the automatic cash-out procedure, the account balance is automatically paid directly to the participant unless the participant makes another withdrawal election or chooses to leave the money in the TSP. An automatic cash-out is subject to the same taxes as other cash payments from the TSP (Federal Retirement Thrift Investment Board, 2004).

Transferring TSP Accounts—On termination of federal employment, an individual may transfer all or a portion of a TSP account to an IRA or other eligible retirement plan. If this option is chosen, the participant continues to defer taxes on the amounts transferred, and savings continue to accrue tax-deferred earnings until the money is withdrawn (Federal Retirement Thrift Investment Board, 2004).

Leaving Money in a TSP Account—After a participant terminates employment with the federal government, he or she may leave the entire TSP account balance in the TSP (only until age 70½). Accounts continue to accrue investment earnings, and individuals can continue to change investment allocations among the three TSP funds by making interfund transfers (Federal Retirement Thrift Investment Board, 2004).

Death Benefits—A participant may designate beneficiaries (including a surviving spouse, children, parents, or other named beneficiary) to receive the TSP account balance if the participant dies. Payments to spouses of deceased participants are subject to 20 percent mandatory federal income tax withholding. The withholding tax cannot be waived, although spouses of deceased participants can avoid the withholding by having the TSP transfer

⁶ For individuals separating or retiring during or after the year in which they reach age 55, or for individuals who retire on disability, the withdrawal is not subject to the penalty tax.

all or a portion of the payment to an IRA (but not to another eligible retirement plan). Payments to beneficiaries other than a spouse are subject to 10 percent withholding, which *may* be waived. Payments to nonspouse beneficiaries cannot be transferred to an IRA or other plan (Federal Retirement Thrift Investment Board, 2004).

State and Local Government Plans

In contrast to the private sector, the overwhelming majority of state and local government employees continue to participate in defined benefit pension plans. According to a survey by the Bureau of Labor Statistics (BLS), 79 percent of state and local government employees participated in defined benefit plans in 2007, down from 1994, when 91 percent participated in defined benefit plans. BLS data also show that the share of state and local government employees in defined contribution plans has increased to 18 percent from 9 percent in 1994, indicating that an increasing number of governmental employers have been expanding their defined contribution plan offerings. Money purchase pension plans cover more state and local government employees than any other form of defined contribution plan (70 percent of defined contribution plan participants in 2007). Profit-sharing plans, providing discretionary employer contributions, are made available by some governments but to a much lesser extent.

Money Purchase Plans—In contrast to the prevalence of 401(k) plans in the private sector, the principal public-sector defined contribution pension plans are 401(a) money purchase plans and, to a much lesser extent, target benefit and other “hybrid” plans. These plans are used as primary defined contribution pension plans.

Contributions—Employers must annually make fixed, determinable contributions that are typically specified as a percentage of the worker’s pay. Employees may be required to make contributions and may be allowed to make voluntary, after-tax contributions. The IRC allows annual maximum contributions of 100 percent of a participant’s includable compensation or \$40,000 a year (indexed for inflation), whichever is less.

Taxation of Contributions—Employer contributions are not subject to Social Security (if applicable), federal, and most state taxes. Employee contributions may be made on an after-tax or pre-tax basis if “picked-up” by the employer. Pick-up contributions are mandatory employee contributions that are treated as though they were made by the employer for federal income tax purposes. An IRC provision specific to governmental plans allows the pick-up contributions to be pre-tax through salary reduction arrangements or offsets against future salary increases. Pick-up contributions made through salary reduction arrangements are subject to Social Security taxes, if applicable.

State tax treatment of employee contributions varies by state, although most states follow the federal rules.

Distributions—Vested plan assets may be withdrawn at separation from service due to retirement, resignation/termination, death, or disability. In-service withdrawals of voluntary after-tax amounts may be permitted. Distribution must begin by April 1 following the calendar year in which the participant attains 70½ or retires, whichever is later. Hardship withdrawals are not permitted from money purchase plans.

Taxation of Distributions—At the time of distribution, all amounts received from the money purchase plan not previously taxed are subject to federal and perhaps state taxes. This includes withdrawals of employer contributions, picked-up contributions, and associated earnings. Money purchase plan distributions eligible to be rolled over to another eligible retirement plan or an IRA that are not directly rolled over are subject to 20 percent withholding. Distributions may be subject to early distribution, minimum distribution, and excess distribution penalty taxes. Plans receiving eligible rollover contributions may need to separately account for such amounts in order to facilitate different distribution eligibility rules under the plan and early withdrawal penalty requirements. Distributions of after-tax contributions are also eligible for rollover; however, only 401(a) defined contribution plans and IRAs are eligible rollover plans for this purpose.

Direct Rollovers—An employee separating from service may make a direct rollover of his or her eligible rollover distributions to an IRA or another eligible retirement plan, including 401(a), 403(b), 457(b) and 401(k) plans. As long as the transfer is made between plans and not through the employee there is no current taxable income to the employee. Amounts not directly rolled over are subject to a 20 percent withholding tax and may be subject to the early distribution tax.

Loans—If permitted by the employer's plan, active participants may borrow assets from the vested portion of their accounts.

Administration and Regulation—As qualified plans, governmental money purchase plans must comply with numerous sections of the IRC. Unlike private-sector plans, governmental plans are exempt from the Employee Retirement Income Security Act of 1974 (ERISA) and associated provisions of the IRC. While private-sector plans are required to follow strict guidelines when establishing, for example, vesting schedules, governmental employers have a great deal more flexibility. Despite this, many governments establish plans that conform to ERISA guidelines.

Private-sector employers must comply with nondiscrimination rules to maintain the qualified status of their plans. The Taxpayer Relief Act of 1997 placed a permanent moratorium on the enforcement of these nondiscrimination rules on state and local government plans.

Profit-Sharing Plans—State and local governments that adopted profit-sharing plans with 401(k) features prior to May 6, 1986, are eligible to offer the 401(k) feature allowing participants to elect the amount of their voluntary pre-tax contributions on an individual basis. Even though the 401(k) feature can no longer be adopted by state and local governmental employers, IRC Sec. 401(a)(27) specifically permits profit-sharing plans for employers who do not have profits and are tax exempt. The profit-sharing and money purchase plans established by governments are similar in most respects. The principal difference is that in the money purchase plan employers must make fixed, determinable contributions, while in the profit-sharing plan employer contributions are discretionary and are not required to be made in the same amount or made every year. However, the IRC provides that contributions to a profit-sharing plan must be “substantial and recurring.” Two other distinctive features are that profit-sharing plans may provide for withdrawal at age 59½ and/or in cases of hardship.

Notwithstanding the fact that state and local governmental employers are not permitted to establish new 401(k) arrangements, the IRS has taken a liberal view in recent years and allowed expansion of existing public-sector 401(k) plans to cover new public-sector entities.

Defined Contribution Plans of State and Local Governments—State and local governments have continued to consider defined contribution plans as an alternative to traditional defined benefit plans. These efforts are largely motivated by a combination of policy and fiscal reasons, including a desire to improve portability of retirement benefits, and a desire to shift investment power and responsibility, as well as the investment and funding risk, to the participants. A number of government employers have already established defined contribution retirement plans for their employees to complement or replace existing defined benefit pension plans. There are a number of ways by which governments can “convert” from a defined benefit to a defined contribution plan. The three basic conversion types are: 1) *complete* conversion; 2) *partial* conversion; or 3) *new employee-only-conversion*. Under a *complete* conversion, the employer’s defined benefit plan is terminated, and all current and future employees are enrolled in a defined contribution plan. Current employees are typically given credit for the greater of the present value of their accrued benefit in the defined benefit plan or their individual contributions. In a typical *partial* conversion, all new employees are enrolled in the defined contribution plan, and current employees have the option of enrolling in the defined contribution plan. Current employees enrolling in the defined contribution plan are normally credited with the present value of their accrued benefit from the defined benefit plan. The defined benefit plan is retained for retirees and for current employees who elect not to participate in the defined contribution plan. As

its name implies, under a *new-employee-only* conversion, all new employees are enrolled in the defined contribution plan, while all existing employees remain in the defined benefit plan. It is interesting to note that in recent partial conversion scenarios, only a relatively small portion of existing employees has chosen to leave the defined benefit plan in favor of the new defined contribution plan.

Sec. 457 Plans—Congress enacted IRC Sec. 457 as a part of the 1978 tax act, primarily in response to the IRS's effort to tax elective deferred compensation in the year in which it was *deferred* rather than in the year in which it was *received*. Sec. 457 allows state and local government entities to establish deferred compensation arrangements for their employees. Sec. 457 deferred compensation plans are not qualified plans but must meet a separate set of requirements under the IRC. These plans are similar to 401(k) plans for private-sector employees, although there are several important differences. As a result of the TRA '86, deferred compensation arrangements of other tax-exempt organizations are now subject to 457. Examples of eligible tax-exempt organizations include civic organizations and local associations of employees; religious, charitable, scientific, literary, and educational organizations; business leagues; certain credit unions; nonprofit hospitals; trade associations; and mutual insurance funds. Eligible participants include employees of the governments or tax-exempt organizations previously noted as well as independent contractors of eligible employers. As a practical matter, only key management and highly compensated employees of non-governmental tax-exempt employers may benefit from 457 plans due to the applicability of ERISA to nongovernmental plans.

Trust Requirements—Prior to the Small Business Job Protection Act of 1996, governmental deferred compensation plan assets (as a condition for receiving favorable tax treatment for nonqualified plans of this nature) were required to be treated as general assets of the employer subject to the claims of creditors. As a result of the bankruptcy of a large county government in the 1990s, this requirement was repealed and now all governmental 457 plans must meet the following basic trust and exclusive benefit requirements:

- The plan assets must be held in trust or in IRC Sec. 401(f) annuity contracts or custodial accounts. Sec. 403(b) tax-sheltered annuity plans can only be held in IRC Sec. 401(f) annuity contracts or custodial accounts.
- The plan assets must be held for the exclusive benefit of participants and beneficiaries.
- Assets of the plan may not be diverted or used for other than plan purposes.

- The benefits of the plan generally may not be assigned or alienated or transferred by the participant to another person or entity.

Other tax-exempt entities must continue to hold plan assets as employer assets subject to the claims of general creditors of the employer.

Contributions—Employees may defer up to the applicable dollar limit or 100 percent of includable compensation,^{7,8} per year, whichever is less. The applicable dollar amount for each calendar year was modified by the Economic Growth and Tax Relief and Reconciliation Act of 2001 (EGTRRA) to be the same for all 457(b), 401(k), and 403(b) plans and is as follows:

Year	Applicable Dollar Amount
2002	\$11,000
2003	\$12,000
2004	\$13,000
2005	\$14,000
2006	\$15,000

For years after 2006, the \$15,000 applicable dollar amount will be adjusted upward in \$500 increments based on cost-of-living formulas announced by the Secretary of the Treasury.

The applicable dollar limit is applied annually on a per-person basis. That is, an individual must aggregate all of his or her 457 plans from all employers during a particular year to determine if the applicable dollar limit has been exceeded. The applicable dollar limit applies not only to any elective deferrals to the plan but also to any nonelective deferrals the employer contributes to the plan. However, the 100 percent of includable compensation test only applies on a per-plan basis. The deferral limits for 457 plans are not coordinated with an employer's 401(k) or 403(b) plans in which the employee may also participate. Compensation may be deferred only if an agreement to defer has been made before the beginning of the month in which it is deferred, except for new employees who may participate in the month of hire.

A catch-up contribution provision may be included to increase the deferral limit during the three-year period preceding a participant's normal

⁷ Includable compensation is defined in the IRC as compensation for service performed for the employer that is currently includable in gross income (taxable in the current year), plus elective salary reduction amounts to an employee's 401(k), 457, 403(b), and 125 cafeteria plans.

⁸ Since Sec. 457 plans are not subject to any nondiscrimination tests, employers may set eligibility criteria that might not be permitted in qualified plans.

retirement age. Plans providing for catch-up must specify the catch-up deferral ceiling, which can be no greater than the lesser of:

- Twice the applicable dollar limit for the current year, or
- The sum of the current year's regular deferral limit plus any prior years' unused deferral limits.

Normal retirement age, if specified in the plan, must be after the earliest retirement age at which unreduced benefits can commence under the employer's pension plan, but not later than age 70½. If not specified, normal retirement age is the later of age 65 or the normal retirement age specified in the employer's basic pension plan. Note that a plan may also permit a participant to elect his or her normal retirement age that triggers the three-year catch-up period. An individually elected normal retirement age may not be later than the retirement plan's mandatory retirement age or the age at which the participant actually separates from service.

A special catch-up contribution provision for participants age 50 or older may be included. For these older participants the plan may allow an additional deferral equal to the greater of the current year's regular deferral applicable dollar limit, plus an additional amount as follows:

<u>Calendar Year</u>	<u>Age 50+ Additional Deferral Amount</u>
2002	\$1,000
2003	\$2,000
2004	\$3,000
2005	\$4,000
2006	\$5,000

For later years, the age 50-plus additional catch-up amount will be adjusted upward in \$500 increments for cost-of-living as determined by the secretary of the Treasury.

According to 457 regulations, an individual will be able to use the greater of the regular catch-up deferral amount or the age 50-plus catch-up amount if both are available.

Some state and local plans have a minimum deferral requirement (e.g., \$21.00–\$24.00 per month). According to the 2003 NAGDCA survey of 457 plans, the average annual participant deferral for 2003 ranged from \$3,573 for state employee participants to \$4,686 for local employee participants, among the 58 plans that reported a figure. Most 457 plans do not have matching employer contributions. Sec. 457 plans typically allow participant-directed investments. Loans to employees are permitted under the same IRC 72(p) loan rules as apply to qualified plans.

A 457 plan may accept rollover contributions from eligible retirement plans, including other 457 plans, 401(a) defined benefit and defined contribution plans, 403(b) TSAs, and IRAs. Rollover contributions from plans other than other 457 plans must be separately accounted for and must remain subject to any applicable early withdrawal penalty tax under IRC Sec. 72(t). Sec. 457 plans may not accept rollovers of the after-tax portion of any otherwise eligible rollover distribution

The amount set aside in a 457 plan through payroll deduction and any increase from investment earnings is excluded from income subject to current federal income taxation until paid or otherwise made available to the participant.

Participation—According to the 2003 NAGDCA survey, over 4.2 million state and local government employees were eligible to participate in the 60 plans that provided an eligibility figure. The average participation rate in combined state and local plan is 29 percent. Unless participation is limited to a specific defined group by an adopting resolution or personnel policy,⁹ the plan is available to all employees.

Distributions—Deferred amounts and income may be distributed on separation from service, retirement, death, attainment of age 70½, or an unforeseeable emergency.¹⁰ An employee separating from service may transfer his or her account balance (tax free) to another 457 plan. As long as the transfer is made directly between the plans—and not to the employee—there is no current taxable income to the employee. (This is similar to the trustee-to-trustee transfer requirements for qualified plans.) Participants receiving eligible rollover distributions must be permitted to make direct rollovers of such amounts to eligible retirement plans and IRAs as required under IRC Sec. 401(a)(31).

If permitted by state law, a plan may include a provision to establish a separate account for a former spouse pursuant to a “conforming equitable distribution order” under the state’s domestic relations order laws. EGTRRA provided clarification that the alternate payee and not the participant will be required to pay any applicable federal income taxes on domestic relations order payments he or she receives.

A plan may include a provision allowing participants who are still in active service the opportunity to withdraw their account from the plan if it totals less than \$5,000, if there have been no contributions to the account

⁹ Sec. 4(b) of the Employee Retirement Income Security Act of 1974 excludes governmental plans, church plans, and certain other types of plans from Title I.

¹⁰ The Teachers Insurance Annuity Association-College Retirement Equities Fund (TIAA-CREF) also provides eligible employees with tax-deferred annuity (supplemental retirement annuity) plans for additional (elective) retirement savings as well as individual and group life insurance, group long-term disability income plans, and long-term care insurance.

for two full years, and if the participant has received no other such distributions from the plan. Sec. 457 plans that provide hardship withdrawals must define “unforeseeable emergency” as severe financial hardship to a participant resulting from the sudden and unexpected illness or accident of the participant or his or her dependents, the loss of a participant’s property due to casualty or other similar extraordinary and unforeseeable circumstances that result from events beyond the control of the participant. If the hardship may be relieved through reimbursement, compensation, or insurance; liquidation of assets; or ceasing deferrals, then the 457 plan is prohibited from making a distribution. The emergency withdrawal is limited to what is reasonably required to satisfy the emergency need.

If distribution begins prior to a participant’s death, the amount must be over the single life expectancy of the participant or joint life expectancy of the participant and a designated beneficiary, subject to certain restrictions. Distributions *must* begin no later than April 1 following the calendar year in which the employee either attains age 70½ or retires, whichever is later. Any amount not distributed to the participant by the time of his or her death must be paid in a manner at least as rapidly as the method of distribution being used at the date of death. However, if the beneficiary is the spouse, then payments may be made over the spouse’s life expectancy.

Taxation of Distributions—A distribution from a 457 plan is taxed as ordinary income; there is no special tax treatment such as 10- or five-year forward averaging. A 457 plan may accept rollover contributions from eligible retirement plans, including other 457 plans, 401(a) defined benefit and defined contribution plans, 403(b) TSAs, and IRAs. Rollover contributions from plans other than other 457 plans must be separately accounted for and must remain subject to any applicable early withdrawal penalty tax under IRC Sec. 72(t). Sec. 457 plans may not accept rollovers of the after-tax portion of any otherwise eligible rollover distribution.

The following taxes are not applicable to distributions from 457 plans: other early distribution penalty taxes, excess contribution taxes, excess distribution tax, or prohibited transaction excise tax. Amounts deferred under 457 plans are subject to Social Security (FICA) taxes in the year the amounts are deferred. Rollover accounts from other non-457 plans are subject to applicable early distribution taxes.

Administration and Regulation—Participants in state and local 457 plans are usually given a variety of investment options. The assets may be invested by insurance companies; banks and savings and loan institutions; mutual fund companies; or credit unions, brokerage firms, in-house managers, and other independent money managers. The Small Business Job Protection Act of 1996 requires that all amounts deferred under a 457 deferred compensation plan of state and local governments be held in trust

for the exclusive benefit of employees (effective on date of enactment, but allows for establishment of a trust by Jan. 1, 1999, for amounts deferred before the date of enactment). Sec. 457 plans for *governmental* employers are not subject to the discrimination tests to which 401(k) plans must comply. Minimum vesting or participation standards and disclosure requirements are also not applicable to 457 plans for *governmental* employers, since these plans are nonqualified plans exempt from Title I of ERISA.¹¹

Sec. 403(b) Plans

Sec. 403(b) plans are deferred tax arrangements (similar to a 401(k) cash or deferred plan) available to employees of certain types of organizations. Participants can set aside a portion of their compensation for retirement purposes. The employer may also make contributions on behalf of the employee. Public school systems, colleges, universities, and certain state and local hospitals that are tax exempt under IRC Sec. 501(c)(3) are eligible to set up 403(b) plans.

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