Fundamentals of Employee Benefit Programs

SOCIAL SECURITY

HEALTH INSURANCE

RETIREMENT PLANNING

IRAs

401(K) PLANS

PENSION PLANS

CHILD CARE PLANS

EDUCATION ASSISTANCE

HEALTH CARE COST MANAGEMENT

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Through research, policy forums, workshops, and educational publications, EBRI and EBRI-ERF contribute to the expansion of knowledge in the field and to the formulation of effective and responsible health, welfare, and retirement policies. This work is intended to complement the research and education programs conducted by academia, the government, and private institutions.

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THIRD EDITION

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Foreword

Keeping pace with rapid and continuous change is a challenge each of us faces every day. Nowhere is this challenge more apparent than in the rapidly changing field of employee benefits. The Tax Reform Act of 1986 made the most comprehensive and dramatic changes in employee benefits since the landmark Employee Retirement Income Security Act of 1974. Some of these changes are effective in 1987; others take effect in 1988 and 1989.

Dramatic as these changes are, they are by no means the only sources of change in the employee benefit field. The employers that sponsor these benefit programs are now reevaluating their benefit packages in the wake of tax reform, and many will make decisions that will substantially alter their benefits package to keep them cost-effective and responsive to employer and employee needs. As people live longer, and continue to alter their lifestyles and their patterns of work, their expectations change about what they need to promote their economic security.

One of the biggest employee needs is the need for economic security. Promoting economic security is what employee benefits are all about. It is security during working years against the loss of family income because of ill health, disability, unemployment and premature death. In retirement years, economic security is the insurance against poverty and low income, and it is the assurance that one will have the ability to obtain the medical care that grows more important, and more expensive, as we age.

The United States has a long commitment to economic security of its citizens, based upon government-mandated programs, voluntary employer-sponsored programs and individual efforts that are often encouraged by the government and by employers. This combination of public and private programs has been so successful, and so pervasive, that many consumers take it for granted. But it is one of the most important components of a worker's total compensation. It is also an area that is subject to great change.

I am proud to introduce the third edition of the *Fundamentals of Employee Benefit Programs*, which has as its goal education about the

extent and the importance of employee benefits and the many changes being made by employers and by federal lawmakers.

In 1979, the Employee Benefit Research Institute (EBRI) began developing a series of educational pamphlets, which provided basic information about the primary employer-sponsored benefit plans. The pamphlets were drafted by employee benefit experts, and they were used widely for employee training and consumer education. In 1983, the pamphlets were updated and compiled into one volume, used by more than 10,000 individuals and widely acclaimed as a thorough, accurate and readable primer on the whole range of employee benefits.

Tax and pension law changes in 1984 and new federal regulations caused EBRI staff, in cooperation with benefit experts, to issue an expanded and updated second edition in 1985. Now, this third edition incorporates the many changes wrought by the Tax Reform Act of 1986. By popular demand, new chapters have also been added on Simplified Employee Pensions (SEPs), Preferred Provider Organizations (PPOs), Employee Assistance and Health Promotion Programs, and Guidance on Evaluating an Employee Benefit Package. Also, suggestions for additional information have been added to each chapter. The inclusion of a comprehensive index also makes this book an even quicker and more thorough reference guide.

This book is, however, a primer. It does not provide binding legal, investment or employee benefit plan design information. Due to constant economic, legal and regulatory changes, individuals should always seek specific legal, financial planning and employee benefit information from legal counsel, financial institutions and employee benefit professionals.

An advance word about the organization of this book: Each chapter is designed to be read as a freestanding piece, rather than to assume that the book is being read as a whole, which would require the reader to search for various definitions of terms; instead an editorial decision has been made to restate each term's meaning in each chapter as a convenience to the reader.

Appreciation is expressed to the sponsors of the Employee Benefit Research Institute, who generously made their benefit experts available to oversee the technical information in this project, and especially to the staff of EBRI, in particular, Frank McArdle, Chris Dolan, Anne Mayberry, Nancy Newman, Bonnie Newton, Cindy O'Connor, Stephanie Poe and Lisa Schenkel, whose dedicated efforts made this third edition possible.

DALLAS L. SALISBURY
President
June 30, 1987

I. Trends in the Provision and Taxation of Employee Benefits

Introduction

Employee benefit programs in the United States have a long history. They are part of a national commitment to provide economic security to active workers, displaced and disabled workers, and retirees and their families. Most American workers take the presence of employer-provided employee benefits for granted. They also take the current tax-favored treatment of these benefits for granted. Although many employee benefit plans are relatively young, the existence of such programs dates back to colonial times. Here is a list of landmark programs:

(1) Plymouth Colony settlers' military retirement program in 1636;

(2) Gallatin Glassworks' profit sharing plan in 1797;

(3) American Express Company's private-employer pension plan in 1875;

(4) Montgomery Ward Company's group health, life and accident insurance program in 1910;

(5) Baylor University Hospital's formalized prepaid group hospitalization plan in 1929.

Government involvement in employer-provided benefit plans began soon after that. In 1935, the U.S. Congress mandated the basic retirement income portion of Social Security and in 1965 established Medicare health insurance protection.

The tax treatment of these employee benefit programs has been relatively consistent over time. Health insurance contributions by employers are tax- exempt, and retirement and capital accumulation programs are tax-deferred.[1] Nearly all current American workers have experienced the present tax treatment of primary benefits (retirement, health, life and disability) for their entire careers. The law has changed over time to include nondiscrimination requirements such

[1]For more information, see Deborah J. Chollet, *Employer-Provided Health Benefits: Coverage, Provision and Policy Issues* (Washington, DC: EBRI, 1984) and Sophie M. Korczyk, *Retirement Security and Tax Policy* (Washington, DC: EBRI, 1984).

that benefits are now generally available to all workers. Minimum standards for retirement, capital accumulation and welfare programs ensure that benefit promises are kept. Recent tax reform legislation makes the nondiscrimination rules for pension and welfare benefits even more stringent.

The growth of employee benefits as a form of employee compensation has attracted increasing attention in recent years chiefly because of a concern that the growth of benefits occurs at the expense of growth in wage and salary income. Slower growth of wages and salaries, in turn, implies slower growth of the tax base. Erosion of the tax base affects the public sector's ability to finance government programs in general and the Social Security system in particular. In addition, growth of nontaxable benefits may generate an important redistribution of the tax burden across the population. These effects of growth in employee benefits, and in tax-exempt benefits in particular, merit careful attention.

What Are Employee Benefits?

Employee benefits represent virtually any form of compensation provided: (1) in a form other than direct wages; and (2) paid for in whole or in part by the employer, even if provided by a third party (e.g., the government, an insurance company or a health maintenance organization). Generally, news stories, cost surveys and government reports lump all benefits together. However, different benefits serve different social and economic needs.

Many benefits are required by law. These include employer contributions to Social Security, Medicare, unemployment insurance and workers' compensation insurance.

Other employee benefit programs are voluntary (discretionary). They serve different goals, and receive different tax treatment. Some of them are fully taxable (primarily, payment for time not worked). Other programs insure the employee against financial risks and are *tax-exempt* (including employer contributions for health coverage, for up to $5,000 of child care and the employer cost for the first $50,000 of group life insurance plans).

Certain benefits are designed primarily to help the *employee* meet special needs and are *tax-favored* for that purpose. Other tax-exempt benefits have traditionally been called "fringes" and are intended to meet *employer* needs (including employer provision of purchase discounts, job site cafeterias, special bonuses and awards, van pools, clubs and parking).

"Reimbursement account" benefit programs allow employees to have spending accounts—funded by the employer or through salary reduction—to pay certain expenses specified in the law. Monies allocated to reimbursement accounts are also tax-exempt (including health care reimbursement, dependent care reimbursement, etc.).

Retirement income benefit programs help protect employees against income loss at retirement. Taxes are deferred until benefits are received, but withdrawals before age 59 1/2 are generally taxed as ordinary income and an additional 10 percent penalty tax is imposed, unless the withdrawal meets one of several exceptions. Defined benefit (pension) plans are those in which the employee is promised a benefit and the employer bears the risk/reward of investment returns. Defined contribution (capital accumulation) plans are those in which the employee is promised a contribution and the employee bears the risk/reward of investment returns.

Other programs provide for the deferral of salary until termination of employment, and generally pay benefits as a lump sum (including contributions to some profit sharing plans, money purchase plans, employee stock ownership plans (ESOPs) and salary reduction plans). Again, taxes are deferred until benefits are received, but withdrawals before age 59 1/2 are generally taxed as ordinary income and an additional 10 percent penalty tax is imposed, unless the withdrawal meets one of several exceptions.

Why We Have Employee Benefits

The Congress, public- and private-sector employers and public- and private-sector employee representatives have historically shown concern for the welfare of workers, their dependents and their eventual survivors. This concern has created what some have described as a "social contract" between the government, employers and American workers and their families.

A formal employee benefit program can meet needs arising from death, disability, medical problems, or the desire to retire, in a fair, consistent, efficient and reliable way.

The nation benefits from employee benefits in many ways.

(1) Morale is improved if workers and their families are relieved of worry and fear over possible financial disaster from unexpected or *unplanned* events. Retirement, for example, may be unplanned if the individual does not save enough to afford retirement.

(2) Social Security retirement, employer-based pensions that pay lifetime benefits, employer-based pensions that provide for capital accumulation and individual retirement accounts (IRAs) have all been established to meet the national goal of allowing retirees to maintain preretirement lifestyles. Experience in this country and in other nations has shown that this "organized" savings effort is essential, particularly at low- and middle-income levels.

(3) Social Security disability, Medicare, Medicaid and employer-based health, life, and disability insurance programs have been established to protect the working, nonworking and retired against financial disaster.

(4) The nation achieves other work force objectives by providing employer-based employee benefit programs. For example, when workers can afford to retire, channels for promotion are kept open. If bad economic times require work force reductions, voluntary early retirements can be encouraged with employer-based pension programs. Employer-based profit sharing, employee stock ownership and stock purchase programs strengthen worker identification with the success of the company and thus enhance productivity, work quality and competitiveness.

(5) Experience in the United States and abroad has shown that a combination of social and employer-based programs is the most efficient and effective way to meet economic security needs and objectives. Social programs like Social Security, Medicare and Medicaid help the poor. They also give middle- and upper-income workers a basic level of support. Employer-based tax-favored employee benefit programs build upon these programs. These include, for example, health insurance programs for *both* active workers and retirees.

As pay-as-you-go social programs—such as Social Security and Medicare—age, and as the "return on contributions" continues to drop, popular support may be endangered. For these social programs to retain public support from the middle-class, employer-based programs that benefit middle-class beneficiaries must continue to be available, especially if the federal government makes further reductions in social program benefits to the middle class.

Employer-based benefits have now been a part of the work place for the entire working lives of most of those working today for government, unionized private employers, large nonunionized private employers and many small employers. Employee benefits are viewed by most workers as part of a contract that should and will not be abolished—by employers or the government. This attitude is the most likely explanation for survey results indicating that employees today take for granted a good benefit package and would strongly oppose government efforts to take away or tax employee benefits.

Tax Incentives Encourage Benefit Availability

Expanded employer pension and welfare plans over the past thirty years have significantly improved the income security of current workers and future retirees. This development has been encouraged by tax incentives. In 1985, the Social Security retirement and disability programs paid over $186 billion in benefits to over 37 million beneficiaries. Over 820,000 employer-based pension programs provided coverage to approximately 52 million workers and paid about $129 billion in benefits to more than 15 million beneficiaries. Medicare provided $70 billion in health protection, and privately administered group health insurance plans provided $106 billion.

Employer-Provided Pensions

Tax deferral of employer pension contributions and individual retirement savings provides an important incentive for employers and workers to provide for retirement income. Between 1950 and 1983, employee participation in employer-sponsored pensions rose by nearly 300 percent. Since 1960, 20 to 30 percent of the increase in employer pension contributions can be attributed to favorable tax incentives and the growth of real marginal tax rates (the amount of tax paid for each additional $1 of income, adjusted for inflation).

The increasing importance of pensions as a source of income for future retirees is the direct result of past growth in pension plan participation among workers. The future rate of pension recipiency among today's young workers (ages 25 to 34) is projected to be nearly 50 percent more than that of workers who are retiring today. Forty-eight percent of those now retiring (ages 55 to 64) who have families receive an average pension benefit of $7,100, whereas about 71 percent of today's young workers who have (or will have) families will receive an average pension benefit of about $13,000 (in inflation-adjusted dollars calculated using 1985 as the base year).

Employer-Provided Health Insurance

Employer group health insurance coverage for workers and their dependents has become the most common benefit offered to employees in the United States. Insurance coverage for major health care expenses and access to health care services has risen steadily among the U.S. population since 1960. In 1985, almost 132 million nonelderly civilian, nonagricultural workers and their family members reported coverage from an employer group health insurance plan, excluding

people employed in agriculture or the military and members of their families. Congress has made extensive private health insurance coverage a public policy goal.

Eliminating tax preferences for employer health insurance contributions might dramatically reduce coverage rates among low-income workers and their families, among workers and their dependents who experience unemployment during the year, and among persons who are eligible for Medicaid or Medicare.

An Employee Benefit Research Institute (EBRI) simulation of the probable pattern of coverage loss suggests that tax preferences for employer health insurance contributions strongly benefit low-income workers and their dependents, provide important economic security for workers with fragmented employment histories, and reduce the cost of public health care entitlement programs.

Tax preferences for employer health and pension contributions and individual saving for retirement are critical factors in determining worker participation and coverage. Nondiscrimination provisions in the tax code make tax benefits contingent on the breadth of the plan's coverage; that is, both high- and low-income workers must be included and receive comparable benefits from tax-qualified plans.

Employee Benefits Available at All Earnings Levels

Employee benefits are widely distributed among workers and their families at all income levels. In the United States, most workers have low and middle incomes. Reflecting this pattern, most workers who participate in employer pension and health insurance plans are low- or middle-income workers. In 1983, 76 percent of all wage and salary workers covered by an employer pension plan and 80 percent of workers covered by an employer group health plan earned less than $25,000.

The distribution of IRA savings among income groups also suggests distribution of IRA tax advantages at every income level. In 1982, 18 percent of all new IRA accounts and 14 percent of all additional IRA contributions were made by households with adjusted gross incomes less than $20,000. More than a third of all IRA contributions (34 percent) were made by households with adjusted gross incomes of less than $30,000. The share of total IRA contributions by lower- and middle-income workers will probably increase in the future, because of new restrictions on the eligibility of higher-paid workers contained in the Tax Reform Act of 1986.

Employer sponsorship increases availability of employee benefits. But there is no evidence that tax preferences for employer- and employee-based employee benefits favor only highly paid workers.

Pensions Provide Savings

Pension coverage constitutes the major source of savings for more than half of current pension participants. Of the 38.8 million persons (40.5 percent of the labor force) who had little or no savings of their own in 1983, 18.2 million (almost half) were covered by employer pensions. Since these persons had incomes just over half the size of those with some savings, it follows that employer-provided pensions distribute wealth more equally than would be the case in their absence. Federal tax law has been effective in encouraging retirement savings at lower income levels. Without such law, this lower-income saving could not otherwise be expected.

Total Cost of Employee Benefits

According to EBRI tabulations of U.S. Chamber of Commerce data, private- and public-sector employer contributions to fully taxable, tax-exempt and tax-deferred employee benefits exceeded 35.2 percent of wages and salaries in 1985. Nearly two-thirds of this figure (23.0 percent of wages and salaries) represented: (1) legally required employer payments (8.2 percent of wages and salaries); and (2) voluntary employer payments (14.8 percent of wages and salaries) that are fully taxable. Legally required employer payments include contributions for Social Security, unemployment compensation, workers' compensation and a variety of smaller public insurance programs.

Total voluntary employer contributions to benefits (i.e., *taxable* and *tax-favored* benefits) in the Chamber of Commerce data represented 27.0 percent of wages and salaries in 1985. Of this amount, over half (55 percent) were fully taxable both by Social Security and by the individual income tax. The fully taxable benefits reported in the data include employer payments for time not worked (paid vacations, holidays and sick leave) as well as paid rest periods, lunch periods and other paid employee time not directly spent in production. About one-third of the total level of employee benefits reported in the data (34.5 percent) represent voluntary tax-favored benefits paid by employers. In 1985, all tax-favored benefits totaled 12.2 percent of wages and salaries.

Size of Tax-Favored Benefits

Employer contributions to tax-favored benefits (those that are not taxed as current income to the employee) can be divided into two

groups: benefits on which taxes are *deferred* and benefits that are *tax-exempt*.

(1) *Tax-deferred* benefits primarily include employer contributions to private and public retirement income and profit sharing plans. These constituted about 7.2 percent of wages and salaries in 1985. Taxation of these benefits is deferred until the employee withdraws funds from the plan.

(2) *Tax-exempt* benefits include employer contributions to group health plans, life insurance (up to $50,000 face value) and a variety of smaller benefits that include dental insurance, dependent care, merchandise discounts and employer-provided meals. These benefits constituted 5.0 percent of wages and salaries in 1985.

Failure to distinguish among the growth of legally required employer payments, fully taxable employee benefits, tax-deferred benefits and tax-exempt benefits has greatly distorted the perception of the tax-base erosion that can be attributed to tax-favored and tax-exempt benefits.

The size of tax-favored benefits as a proportion of wages and salaries is much smaller than is commonly perceived. As shown in chart 1, voluntary, tax-favored employee benefits for private- and public-sector employees equal only 12.2 percent of wages and salaries.

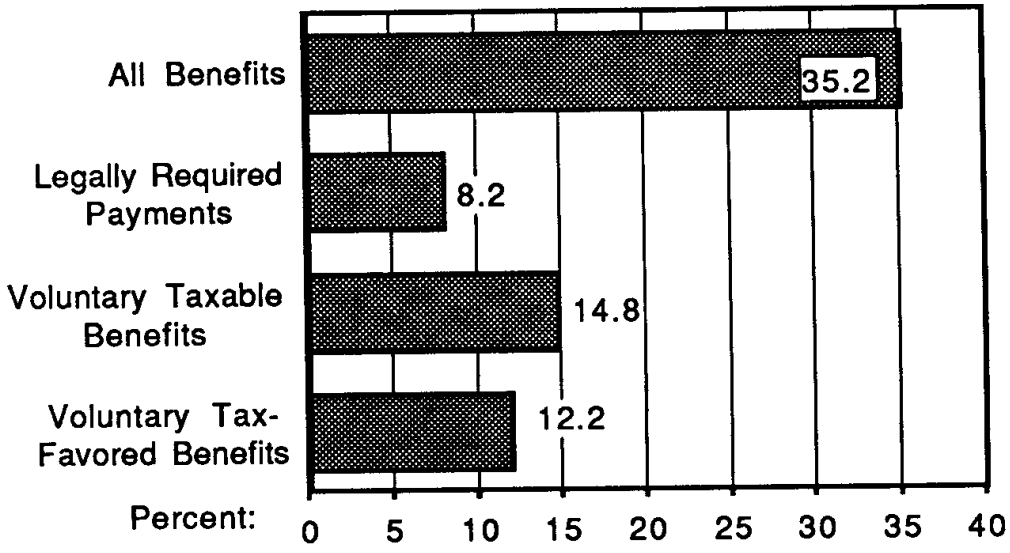
Growth of Tax-Favored Benefit Costs

Over the past thirty years, tax-favored employee benefit costs have grown more rapidly than wages and salaries, and slightly faster than legally required employer payments. Consequently, tax-favored benefits have absorbed a rising share of total compensation. Although there have been increasing tax incentives for tax-favored employee benefits, the growth of these benefits as a share of total compensation has been remarkably slow. Additionally, the rise in cost of tax-favored benefits appears to be slowing. Employers are increasingly concerned about controlling benefit and other costs that affect their competitive position in the marketplace.

Data compiled by the U.S. Department of Commerce indicate that employer contributions to all voluntary benefits as a fraction of wages and salaries increased at an average annual rate of 6.3 percent between 1960 and 1985.

The relatively faster growth of 15 percent a year in the early 1970s reflects several factors. The growth of pension contributions can be attributed to the slow growth of wages both before and during the

Chart 1
Employer Spending for Employee Benefits as a Percent of Wages and Salaries, 1985



Source: EBRI tabulations of U.S. Chamber of Commerce data.

1973-75 economic recession; employer efforts to improve pension funding in anticipation of—and in response to—the enactment of the Employee Retirement Income Security Act (ERISA) in 1974; and net growth in pension plan participation. The growth of health contributions can be attributed to growth in health plan participation and sudden increases in the employer cost of group health insurance benefits. The recent slower growth of employer pension contributions appears likely to continue, according to employer surveys.

Employer contributions to group health insurance are the fastest growing employee benefits. The expansion of worker and dependents' coverage under employer group health plans, the enhancement of benefits under these plans and persistent high inflation in health care costs have all contributed to the growth of employer contributions to health insurance as a share of compensation. Between 1950 and 1980, employer health insurance contributions as a percent of wages and salaries have risen at an average annual rate of 7.4 percent. Reflecting continued high inflation in health care costs since 1980, employer contributions to health insurance have continued to grow

at an average annual rate 4.2 percent faster than the growth of wages and salaries.

Benefit Cost Variation by Employer

The value of voluntary employee benefits varies significantly from employer to employer. During 1985, total value ranged from 10.7 to 34.4 percent of total compensation among Fortune 500 firms, and the expenditure would be lower for very young and small businesses. Significant variation is also found in industries. Among industries in 1985, average value ranged from 14.8 percent in retailing to 24.8 percent of total compensation in banks.

Benefit Cost Variation by Employee Age

Employee benefits, such as defined benefit pensions and health insurance, are almost always discussed as a flat-dollar cost per employee or as a level percentage of pay per employee. Employee representatives, employees, and employers have been content with this approach since the actual distribution of cost *does not* affect either the taxes to be paid by the employee or the employer. As a result, the only attention given to individual employee cost variation has been undertaken very recently to assess: (1) approaches to health care cost management; and (2) possible disincentives to hiring or retaining older workers. These recent studies show very significant cost variation by age. Workers age 30 to 44 cost the employer 80 percent of the average medical cost, whereas those age 55 to 59 cost 125 percent and those 65 to 69 cost 225 percent of the average medical cost.

New Forms of Employee Benefits

The growth of new tax-favored employee benefits has come under close scrutiny due to concern that these benefits might represent further erosion of the tax base. In fact, employers often have independent motivations for setting up these plans. The growth of new benefits—in particular, section 401(k) salary reduction arrangements and section 125 cafeteria plans[2]—generally represents an effort by employers to contain the employer cost of tax-favored employee benefits. Introduction of child care programs is an accommodation to the growing number of working mothers, particularly single heads

[2]For more information on section 401(k) arrangements and cafeteria plans, see chapters X and XXXI, respectively.

of households, who could not work if such programs were not available.

Rising employer pension costs have prompted several innovations in the design of retirement income plans. Section 401(k) arrangements, authorized by the Revenue Act of 1978, have become an increasingly popular tool for controlling employer retirement plan costs. Employees are able to supplement employer contributions to a section 401(k) arrangement with tax-deferred contributions of their own.

Section 401(k) arrangements—and other defined contribution plans—represent a way to provide employees with some inflation protection in retirement at a substantially lower cost to employers. Unlike defined benefit plans, which promise a fixed benefit, defined contribution plans are, in effect, better protected against inflation. The dollar value of the assets in the individual's account tends to rise along with the general price level.

Section 401(k) arrangements also meet the demand for retirement income security among mobile workers and workers with irregular labor force participation. Employee contributions to section 401(k) arrangements are, by law, fully and immediately vested.

The growth of cafeteria (or section 125) plans also reflects employers' efforts to control the cost of employee benefits. Generally, the primary motive of employers in establishing a cafeteria plan is the containment of employer contributions to health insurance and to make workers more sensitive to health costs. Cafeteria plans encourage employees to elect less generous health insurance coverage and substitute other benefits—both tax-favored and fully taxable benefits—for generous health insurance coverage. As do section 401(k) arrangements, cafeteria plans enable employers to meet the benefit needs of an increasingly diverse work force—including young workers, dual income families and single employees—while controlling total benefit costs.

Impact of Tax Reform

The recently enacted tax reform legislation makes dramatic changes in employee benefits both through the numerous provisions directly affecting benefits and through the overall reduction in individual income tax rates.

The changes in the pension and welfare benefit area are intended to produce more comparable employee benefit coverage of rank-and-file employees and of highly compensated employees. Pension changes

will increase the number of vested workers through faster vesting schedules, increase pension amounts for rank-and-file employees by limiting the coordination with Social Security benefits, and mandate broader and more comparable coverage of rank-and-file employees. Higher-paid employees, however, suffer potential losses in benefits: restrictions on 401(k) salary reduction contributions ($7,000 cap, tighter nondiscrimination rules and inclusion of all after-tax contributions as annual additions under the section 415 limits); a new limit of $200,000 on the amount of compensation that may be taken into account under all qualified plans; a new excess benefit tax of 15 percent on most annual distributions over $112,500; and sharply reduced maximum benefits payable to early retirees under defined benefit plans.

Changes in welfare benefit areas aim for the same effect: an intended broadening of benefits because of tighter nondiscrimination rules that also could reduce tax-favored benefits payable to the higher paid. Government staff has argued that reduced tax-favored benefits for the highly paid employees may be viewed as more comparable coverage of rank and file and highly paid when considered in terms of dollars, versus percent of compensation.

In all, the employee benefit changes are far less punitive than those originally contained in the 1984 Treasury proposal. Favorable tax treatment is retained for most benefits, except education assistance, group legal services and van pooling, which lose the income tax exclusion. Also, nondiscrimination rules for medical and group life insurance coverage are much more flexible than the original Treasury proposal, and permit a greater disparity between highly paid and rank-and-file employees.

Still, dramatic effects may be anticipated. The reduction in marginal tax rates will remove a significant force that historically contributed to the growth in employee benefits, and future growth will be slowed; coverage may not improve and may actually decline in the small business sector, where a top rate of 28 percent for the owners and a 15 percent rate for 80 percent of taxpayers may make cash more attractive than benefits, which are also more difficult to administer under the new rules. The desirability of deferring compensation for nonretirement purposes under qualified plans is also called into question, because of new penalties on early withdrawals and the expectation that future tax rates may be higher than current rates. Finally, because of the new restrictions on the higher paid, many employers will face the option of removing the higher paid from their general qualified benefit plans, which could result in deterioration

in benefits for rank-and-file employees. As more of their compensation is provided through nonqualified plans, the higher compensated might "lose their stake" in the general benefit plan. Obviously, whether nondiscrimination rules cause expanded and more comparable coverage of rank-and-file employees, or reduce tax-favored benefits for the highly paid, will differ from employer to employer.

Employee benefits will remain an important piece of total compensation, but the changes in their tax effectiveness may prompt a reevaluation of overall benefits and a return to the basic purposes employee benefits were intended to fulfill: the promotion of economic security and human resource needs.

Importance of Employee Communications

The recent, massive changes in the tax rules governing employee benefits brought about by tax reform will, among other things, require employers to communicate more to employees about the recent changes and the effects of the new rules.

The importance of effective communication to employees cannot be overstated. Focus groups consisting of older workers, in discussions sponsored by EBRI and the American Association of Retired Persons (AARP), emphatically demonstrated that most older workers delay their financial and retirement planning until age 50 or later, when it is more difficult to accumulate the additional savings needed for a comfortable and secure retirement. Most of the individuals lacked detailed knowledge of their benefit provisions, particularly the pension provisions, and some had made serious miscalculations of what their retirement income would be.

Among workers generally, a lack of understanding of employee benefit costs and provisions contributes to a lack of appreciation for what is provided by employers and the vast sums of money involved in providing economic security to workers. Clearly, employers and employees would both have much to gain if the full dimensions of employee benefits were better known and appreciated by employees. Likewise, public policy decisions, which are often made by legislators with an eye on the size of the potential constituency for these programs, would also more accurately reflect the widespread provision of benefits through the work place.

Fortunately, employers have increasingly begun to see the need for more effective employee communication on benefit issues, and some are taking bold new steps to enhance employee understanding. Comprehensive communication and education routinely take place, for

example, when a firm establishes a flexible compensation plan, and employees have to be educated in order to make the choices required of them as participants of a flexible benefit plan. Also health care cost management, which is now practiced by the vast majority of the nation's large employers, also requires education and communication to employees about elements in the redesign of health plans, and how, for example, reimbursement levels can vary depending on the type of plan selected and the type of provider.

Because financial planning has become more important (and more complicated), some employers are creating computerized benefit communications programs to make it easier for employees to plan their future. This advanced new communications practice helps employees understand the true value of all employee benefits offered, and it equips them with the information needed to make the many choices common in today's benefit packages.

Easy-to-use computer terminals and computer programs allow an employee access to his or her personal benefits record. They could show, for example, account balances in savings plans; covered services under health plans; life insurance available; and accrued pension benefits. And they could indicate whether any of the savings account balance is available for borrowing and how much loan repayment will affect take-home pay.

In flexible benefit arrangements, employees can visualize how different choices of benefits might work. The system could project what their future pension and Social Security benefits might be. It could also compare current taxable income and future retirement income if a specific percentage of salary is set aside in the company's savings plan. Repeating the same exercise with different contribution amounts can help employees decide how much of current pay can be used to meet future needs. Computerized communication systems promise to make financial planning through employee benefits simpler and more reliable.

Whether or not an employer can install computerized or videotaped employee communications packages depends a great deal on the size of the employer and the resources available for this purpose. But regardless of the method of communication chosen, more—and more effective—employee commmunication and education will represent a continuing trend in the future. Frequent changes in laws and regulations governing employee benefits, the desire of more employers to accommodate the request for a greater range of benefit choices by employees, and the continuing efforts of employers to redesign their employee benefit packages in the most cost-effective manner, all con-

tribute to make comprehensive employee communication an essential ingredient in virtually all employee benefit activities.

Conclusion

Tax laws favoring employee benefits were enacted in the belief that extensive coverage of workers and their families is desirable social policy. The growth of worker coverage by pensions and health insurance, in particular, has been strongly encouraged by the tax advantages given these plans and by the the needs of workers and their families for economic security. As we have seen, pensions and health insurance are broadly distributed among lower- and middle-income workers.

Women are gaining pension entitlement in greater numbers than ever before. Among those women meeting ERISA standards for plan participation, coverage expanded by 2.2 million workers between 1979 and 1983, and nearly 1.3 million more women became entitled to pension benefits at retirement.

This government policy to encourage employee benefits has been a success. This book describes the many different types of benefits that exist. Each must be carefully evaluated by workers, employers and the federal government. The favorable tax treatment may not be crucial to the existence of some benefits—but it is essential to the provision of employee benefits at all income levels.

Other nations now seek to duplicate the success of this nation in developing a true public- and private-sector partnership in meeting economic security needs. Were employer-sponsored benefits to disappear, one could expect higher rates of poverty among the elderly, greater demands on social programs, heightened strife among generations and tens of millions of surprised and disappointed Americans.

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II. Social Security

Introduction

Congress passed the Social Security Act in 1935, and it became effective on January 1, 1937. The original legislation has been amended many times since then, and has become a complex set of laws, rules and regulations governing and influencing the lives of all Americans in one way or another. This chapter represents a brief overview of Social Security, its benefits and its costs—present and future.

What Is Social Security?

Mention Social Security to a dozen people and they will conjure up a dozen different ideas—and for good reason. The *Social Security Handbook*, published by the federal government, contains close to 400 pages of explanation on the Social Security Act and refers the reader to thousands of additional pages of explanation contained in other volumes. In describing Social Security, the *Handbook* states:

> The Social Security Act and related laws established a number of programs which have the basic objectives of providing for the material needs of individuals and families, protecting aged and disabled persons against the expenses of illnesses that could otherwise exhaust their savings, keeping families together, and giving children the opportunity to grow up in health and security. These programs include:

(1) Old-Age Insurance (frequently referred to as Retirement Insurance);

(2) Survivors Insurance;

(3) Disability Insurance;

(4) Medicare for the Aged and Disabled;

  (a) Hospital Insurance (HI)—Part A;

  (b) Supplementary Medical Insurance (SMI)—Part B;

(5) Black Lung Benefits;

(6) Supplemental Security Income;

(7) Unemployment Insurance;

(8) Public Assistance and Welfare Services;

(a) aid to needy families with children;

(b) medical assistance;

(c) maternal and child-health services;

(d) services for crippled children;

(e) child welfare services;

(f) food stamps;

(g) energy assistance.

The federal government operates the first six programs listed above. The remaining programs are operated by the states with the federal government cooperating and contributing funds.

This chapter limits itself to a discussion of the first four programs: Old-Age, Survivors, Disability and Medicare, and refers to them collectively as Social Security. This is partly for simplicity, but largely because these four programs are: (1) financed primarily by the Social Security payroll taxes paid by employees, employers and self-employed persons; and (2) usually thought of by the public as Social Security. An exception to this financing method is the Supplementary Medical Insurance program, *Part B*, of Medicare. This program is financed by premiums paid by those electing to be covered by SMI and by general revenues.

Participation

Who is covered by Social Security; thus, who is eligible for Old-Age, Survivors, Disability and Medicare benefits? When Social Security took effect in 1937, it applied only to workers in industry and commerce—about 60 percent of all working persons. Since then, there has been a steady movement toward covering all workers.

The Social Security Act originally excluded all state and local government employees from Social Security coverage because of the question of whether the federal government could legally tax state employers. Workers for certain nonprofit organizations that are traditionally exempt from income taxes were also excluded. Federal government employees were excluded because of the existence of the Civil Service Retirement System established in 1920.

Coverage was extended substantially in the early 1950s to most self-employed, farm and household workers, and to members of the armed forces.

Legislation enacted in 1950 (and later) provided that employees of state and local governments and nonprofit organizations could be covered by Social Security on a voluntary basis under certain conditions. The Social Security Amendments of 1983 changed the law to *require* the coverage of employees of all nonprofit organizations. This legislation also mandated that state and local governments, which elected to become covered by Social Security, could not later withdraw from the program. Additionally, beginning in 1984, new federal government employees became covered by Social Security.

Mandatory coverage now extends to private-sector workers, nonprofit-sector workers, military personnel, 10 percent of all federal civilian employees who joined the government before 1984 and all federal civilian employees hired after December 31, 1983. Social Security presently covers about 95 percent of all United States workers.

Benefits

Because of the complexity of Social Security, this section gives only an overview of the program's benefits. For specific information concerning benefits that would be payable in a particular case, it is best to contact a local Social Security Administration office.

To assure that covered earnings are appropriately recorded on Social Security records, workers should review their past earnings records every three years. This can be accomplished by submitting *Form SSA-7004 (Request for Statement of Earnings)*. This form is available through local Social Security Administration offices. A response usually takes six weeks.

In a nutshell, Social Security replaces a portion of covered earnings that are lost as a result of a person's old age, disability or death; and it pays a portion of the medical expenses of aged and disabled persons. Social Security provides a much wider variety of benefits than is generally recognized. In fact, monthly cash benefits to retired workers represented about 50 percent of total Social Security benefits including Medicare for calendar year 1985.

Old-Age, Survivors and Disability Insurance—The benefits that are provided under the Old-Age, Survivors and Disability Insurance (OASDI) programs are:

(1) monthly benefits to those workers who are at least 62 years old and retired or partially retired; in addition, monthly benefits to their eligible spouses and dependents;

(2) monthly benefits to disabled workers, their eligible spouses and dependents;[1]

(3) a lump-sum death payment and monthly benefits to eligible survivors of deceased workers.[2]

Any person who is at least 62 years old in 1987 and who has earned at least 36 quarters of coverage in his or her lifetime, working at a job subject to the Social Security tax, is eligible to retire and receive a Social Security monthly benefit.

Persons age 62 or over who do not have a sufficient earnings record to get benefits on their own can nevertheless receive a spouse's benefit, provided the husband or wife is entitled to benefits on the basis of his or her earnings record and is drawing benefits. The spouse's benefit adds an extra 50 percent to the primary retiree's benefit if the spouse is 65 or over, but somewhat less if the spouse is between 62 and 65.

In cases where an individual is entitled to a benefit on the basis of his or her own lifetime earnings and also to a spousal benefit, the effect is that the person gets whichever is greater.

Starting in 1985, there was a new provision for divorced spouses. In the past, a divorced woman, for example, could get a spouse's benefit if she had been married at least ten years to her former husband, but only if he had retired and started receiving benefits of his own. This created severe problems in cases where the former husband did not retire; the ex-spouse could not get any benefit. Now, even if the former husband is not retired, the ex-spouse can receive the benefit if they both are at least 62, were married 10 years, have been divorced at least 2 years and the former husband worked under Social Security long enough to qualify for benefits.

Receipt of spouse's benefits by a former spouse does not take anything from a current spouse. Each could receive a spouse's benefit, although the current spouse would have to wait until the benefit earner retired.

The 1983 Social Security Amendments made significant changes in benefit eligibility. While reduced benefits will continue to be paid at age 62, the age for receiving full benefits, now available at age 65, will be increased in the future. The full benefit age will increase by two months a year for people reaching age 62 between the years 2000

[1]For more information on Social Security Disability Insurance, see chapter XXVII.
[2]For more information on Social Security survivor benefits, see chapter XXVI.

and 2005. The full benefit age will remain at 66 for people reaching age 62 in the years 2006 through 2016. The full benefit age will increase again by two months a year for people reaching age 62 between 2017 and 2022. It will remain at 67 for those who reach age 62 after 2022.

The early retirement benefit amount, which is payable at age 62, will be reduced over this period. The maximum reduction for early retirement benefits will increase from its present 20 percent to 30 percent for those who reach age 62 in 2022 or later.

Monthly benefit amounts are related to the average earnings on which a worker pays Social Security taxes throughout his or her career years. When computing benefits, a worker's average earnings are indexed to changes that have taken place in national average earnings over the worker's career years. To assist in achieving a *social adequacy* goal, benefits are higher (relative to preretirement earnings) for persons with low career earnings than for persons with high average earnings. Also, benefits are reduced or withheld altogether, if a participant under age 70 works after retiring and earns income that exceeds specified amounts.

Once monthly benefits begin, they are generally adjusted automatically each December to take into account Consumer Price Index (CPI) changes. Prior to 1986, these adjustments generally occurred only if the CPI increased by 3 percent or more since the last automatic adjustment. In 1986, Congress passed legislation that removed the 3 percent trigger for automatic adjustments, so that cost-of-living adjustments are tied to the rate of inflation.

Social Security benefits were not subject to federal, state or local income taxes (or to Social Security tax) prior to the 1983 Amendments. Beginning in 1984, however, up to one-half of Social Security benefits are included in taxable income for: (1) single taxpayers whose income exceeds $25,000; (2) married taxpayers filing jointly with a combined income of $32,000; and (3) all married taxpayers who lived with their spouses anytime during the tax year and file separately. For purposes of calculating these income levels, income includes: adjusted gross income, plus nontaxable interest income, plus one-half of Social Security benefits. For more details, please review Internal Revenue Service tax form instructions.

Social Security was not designed to meet all the financial needs that arise from a person's old age, disability or death. It is necessary to supplement Social Security with private savings and employer-sponsored retirement plans. This applies particularly to persons who earn higher than average incomes during their working years because

of the covered earnings limitation and the benefit formula which favors lower-paid workers.

During 1987, about 38 million persons in the United States will receive a Social Security OASDI benefit payment. In the same year, total cash benefit payments will reach about $205 billion.

Hospital Insurance and Supplementary Medical Insurance—The Medicare program has two parts: Hospital Insurance and Supplementary Medical Insurance. The Hospital Insurance program is automatic for those covered by Social Security or the Railroad Retirement plan. Additionally, all federal civilian employees were covered by HI beginning in 1983 and state and local government employees hired after March 31, 1986 were covered by HI beginning April 1, 1986. HI provides benefits for individuals: (1) age 65 or older; (2) receiving Social Security disability benefits for more than 24 consecutive months; and (3) disabled by chronic kidney disease that requires dialysis or a transplant. Those who are not automatically covered by Social Security may elect to be covered by the HI program at their own expense. HI helps to pay for inpatient hospital care and for certain follow-up care after leaving the hospital.

During 1987, approximately 28.4 million persons age 65 and over will be covered under HI (i.e., they will be eligible for HI benefits in the event of illness). This represented more than 95 percent of all persons age 65 and over in the United States and its territories. Another 3 million disabled persons under age 65 will be covered by HI.

The Supplementary Medical Insurance program is voluntary; it is offered to almost all persons age 65 and over and to those under age 65 who are covered by HI. Those who participate must pay a premium. Individuals not covered by Social Security or the Railroad Retirement program who elect HI must also pay for SMI. SMI coverage, however, can be elected independent of HI coverage. SMI helps to pay for doctor services and outpatient hospital services, as well as many other medical items and services not covered by HI.

Approximately 28 million persons age 65 and over were covered under SMI in 1987. Again, this represented over 95 percent of all persons age 65 and over in the United States and its territories. Another 3 million disabled persons who were under age 65 were covered by SMI.

Total Medicare benefit payments in 1987 are projected in Social Security's 1986 Annual Report at $76.2 billion; this represents approximately 50 percent of the total medical expenses of those participating in the two programs.

How Social Security Is Funded

Social Security is financed primarily by payroll taxes paid by employees, employers, and the self-employed. These taxes are held by special Social Security trust funds and can be used only to pay Social Security benefits and administrative expenses of the program. Any trust fund assets not needed to meet current costs are invested in U.S. government securities.

In 1987, participating workers pay Social Security taxes of 7.15 percent of earnings (subject to *maximum taxable earnings* of $43,800). The employer matches this amount. Payroll taxes account for about 97 percent of the total income for the Old-Age, Survivors, Disability and Hospital Insurance programs. Approximately 1 percent of the income for these programs comes from interest earnings on the trust funds; 0.4 percent is from general revenues and is used to finance special benefits. Beginning in 1984, OASDI began receiving income from the taxation of some Social Security benefits. General revenues from taxation benefits account for the remaining 1.6 percent of the total income for OASDI and HI. The general revenue contribution, however, will increase in the future as a result of the 1983 Amendments, which include a provision for shifting amounts equal to tax liabilities on Social Security benefits from the general fund to the Social Security trust funds. Also, general revenues will contribute amounts equal to the employer share of the Social Security tax with respect to coverage of federal employment.

The 1983 Social Security Amendments increased tax rates for employers, their employees and the self-employed. To lessen the burden of the tax increases, income tax credits (against Social Security tax liability) were provided to employees (in 1984 only) and to self-employed persons in 1984 to 1989.

The tax rates for employees and employers are scheduled to increase from 7.15 percent in 1986–1987, to 7.51 percent in 1988–1989 and 7.65 percent in 1990. The maximum taxable earnings will increase in future years at the same rate as the average earnings of all the nation's workers. This maximum is $43,800 in 1987.

Self-employed persons have the same maximum taxable earnings base as other workers; but they pay higher tax rates, since they do not have an employer with whom to share the total tax. The self-employed tax rate will be 14.3 percent in 1986–1987, 15.02 percent in 1988–1989, and 15.30 percent in 1990. An income tax credit of 2.0 percent in 1986–1989 is allowed the self-employed, offsetting their Social Security tax liability. Beginning in 1990, self-employed per-

sons will pay Social Security taxes on a reduced earnings base; in addition they will be allowed to deduct 50 percent of their Social Security tax as a business expense. To assess your eligibility for such tax treatment, check your income tax form instructions.

The 1983 Amendments were designed to improve the financial soundness of the Old-Age and Survivors Insurance program. That goal will be accomplished if the economic and demographic assumptions used by Congress prove to have been correct. The Medicare program, however, is in need of reform. Without changes, the program is projected to have insufficient funds around the turn of the century.

Unlike the other Social Security programs we have discussed, SMI is not financed by payroll taxes. The cost of SMI was originally taken care of through premiums imposed on participants and matching payments from general revenues. At the present time, however, about 75 percent of SMI's total cost is paid from general revenues because, by law, premiums have not been permitted to rise as rapidly as program costs.

Outlook

Social Security's development is a continuing process. The program is a product of the decisions made by policymakers living in an ever changing social and economic environment.

Men and women under age thirty-nine comprise over 60 percent of today's population. When the bulk of these young persons approach retirement some 30 to 50 years from now, social and economic conditions are likely to be quite different than they are today or than they have been in the past. Accordingly, it is reasonable to expect society to begin now to make the changes necessary to assure that the Social Security program will be appropriate for the future social and economic environment.

Public understanding or misunderstanding will play a more important role in determining the future shape of the program than it did in the past when Social Security taxes were relatively low and the average worker was less questioning. One problem confronting Social Security is a lack of public understanding about the program—its basic rationale, the type and level of benefits it provides, the tenuous relationship between individual taxes paid and individual benefits received, its method of financing and the significance of its projected high future costs. The better we understand Social Security, the greater are our chances that the program will be modified to

coincide with our desires. Public acceptance will be necessary for a program that is scheduled to pay benefits, and to require tax collections amounting to trillions of dollars during the next 10 years.

The Social Security Administration has expanded its efforts to educate the public. In addition, a number of advisory groups and commissions regularly study the various aspects of Social Security. This attention and scrutiny may result in a certain amount of turmoil; in the long-run, however, it will improve the Social Security program.

Conclusion

The recent changes in Social Security legislated in 1983 have resolved the immediate financial difficulties that plagued the system. The latest actuarial estimates by the Social Security Board of Trustees generally project that OASDI benefits can be paid on time well into the next century, although some experts believe the system will still encounter difficulties in the long-term, as the large "baby boom" generation reaches retirement age.

The inadequate financing of the Medicare program is currently the major concern of the elderly and of public policymakers in general.

Social Security and Medicare are large, well established and recognized as an integral part of the national socioeconomic structure. Will the Social Security program and Medicare continue to grow? Will they grow in a way that best reconciles beneficiaries' economic needs and taxpayers' financial abilities? Or, will they be curtailed because of heavy financial burdens? The answers to these questions depend largely upon the dialogue among an informed citizenry.

Additional Information

For further information, contact your local Social Security office.

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III. Employee Retirement Income Security Act

Introduction

The Employee Retirement Income Security Act (ERISA) was signed by President Ford on Labor Day, September 2, 1974. It is the most comprehensive employee benefits legislation ever enacted in the United States. ERISA affects millions of working Americans who are covered by private-sector employee benefit programs. Although the law is frequently referred to as the Pension Reform Act, it affects almost all types of employee benefit plans.

ERISA has a long history. In 1962, President Kennedy appointed a committee to study corporate pension plans. The committee's report was released in 1965; it dealt with areas such as labor mobility, vesting, funding and the financial aspects of private retirement plans.[1] One of the committee's conclusions was that "private pension plans should continue as a major element in the nation's total retirement security program. Their strength rests on the supplementation they can provide to the basic public system." This report led to a series of investigations by various congressional committees and subcommittees, which resulted in the introduction of numerous bills to regulate private pension plans.

Congress found that the number of benefit plans was substantial, and that these plans were important to the well-being and security of millions of American workers and their dependents. Congress determined that there was insufficient employee information and there were inadequate safeguards for employee benefit plans. ERISA was passed because Congress believed that "minimum standards [should] be provided assuring the equitable character of such plans and their financial soundness."

Studies and congressional hearings leading to the passage of ERISA showed that most plans were operated for the benefit of participants and beneficiaries. However, the small proportion of exceptions were not to be tolerated. ERISA represents a strong commitment to protecting the rights of plan participants. This legislation has created a

[1]For a definition of vesting, see page 32.

greater awareness of the need to: (1) provide continuing attention to employee benefits; (2) protect plan participants and beneficiaries; and (3) realize employee benefit plan goals.

ERISA Overview

Employee benefit plan sponsors must design and administer their plans according to legal standards. Employees and beneficiaries must be given a *summary plan description* (SPD) and they must have access to plan financial information. These requirements are part of ERISA's *reporting and disclosure* provisions. Reporting requirements were expanded under ERISA to include almost all types of employee benefit plans. These requirements are intended to provide the information needed to determine whether participants' rights and benefits are protected.

Retirement plans must meet *minimum standards* in areas such as participation, vesting and benefit accrual. Certain retirement plans are subject to minimum *funding standards*, which are designed to ensure that money is available to pay benefits when participants retire.

ERISA's *fiduciary standards* apply to most plans. These standards require those who conduct the plan's business (i.e., fiduciaries) to do so for the exclusive benefit of plan participants and beneficiaries.

One of the most important features of ERISA is *plan termination insurance*. Through this insurance, the government guarantees some benefits if certain types of retirement plans terminate. The Pension Benefit Guaranty Corporation (PBGC) was established to administer the termination insurance program.

ERISA originally set limits on the benefit amounts that retirement plans could provide. Under defined benefit plans—these plans promise to pay a stated monthly benefit—the initial maximum benefit amount was $75,000 per year. Under defined contribution plans—these plans specify an employer contribution rather than a fixed benefit—the limit applies to the amount of money that can be contributed to a participant's account in any year.[2] The initial contribution limit was $25,000. Before 1983, the maximum benefit and contribution limits were adjusted annually to reflect increases in the cost of living. The 1982 Tax Equity and Fiscal Responsibility Act (TEFRA), however, imposed new benefit and contribution limits beginning in 1983, and

[2]For more information on defined benefit and defined contribution plans, see chapter VI.

froze them at these levels until 1985. The Deficit Reduction Act of 1984 (DEFRA) extended the freeze on cost-of-living adjustments until 1988. The Tax Reform Act of 1986 (TRA) made further changes. The annual benefit limit under a defined benefit plan is the lesser of $90,000 or 100 percent of the employee's average compensation for his or her three highest earning years; and the annual contribution limit under a defined contribution plan is the lesser of $30,000 or 25 percent of an employee's compensation. Under TRA, all employee after-tax contributions must be counted as part of annual additions. The defined contribution limit will remain unchanged until the defined benefit limit, which is indexed to the Consumer Price Index beginning in 1988, reaches $120,000. This 4:1 ratio will then be maintained in the future.

Certain plans are also required to use more accelerated vesting and to provide minimum benefits in years when the plan primarily benefits key employees.[3]

In addition to its impact on employee benefit plans, ERISA affected workers who were not covered by *employer* retirement plans. It created a means for such workers to save pretax earnings toward their own retirement (and their spouse's retirement) through individual retirement accounts.

Scope of ERISA

Although ERISA primarily applies to private retirement plans, almost all employee benefit plans are subject to some provisions of the act. The legislation affects welfare plans, such as those providing health insurance, group life insurance, sick pay and long-term disability income; and retirement plans, such as pension plans, profit sharing plans, thrift plans and stock bonus plans. There are no general exclusions based on employer or plan size. Other groups that sponsor benefit plans, for example, associations and labor organizations, are also affected.

Reporting and Disclosure

ERISA's extensive reporting and disclosure requirements are rooted in a belief that availability of information serves two important needs. First, adequate communications about the plan to participants can

[3]Key employees are company officers or other individuals meeting specified ownership and earnings criteria.

lead to realistic employee expectations of their benefits. Second, periodic government reporting enables officials to monitor legal compliance.

Reporting to Participants/Beneficiaries—The summary plan description is probably the most important document provided to plan participants and beneficiaries. It is required for all plans that are subject to ERISA. This summary must be:

(1) written so the *average* participant can understand it;

(2) accurate and detailed enough to reasonably inform participants and beneficiaries of their rights and obligations.

The law does not dictate the exact form the summary description should take. It does, however, require inclusion of specific information. For example, among other things, an SPD must include:

(1) the name and address of the employer or employee organization maintaining the plan;

(2) the name and/or title and business address of each trustee;

(3) plan requirements for participation and benefit accrual eligibility;

(4) a description of provisions for nonforfeitable pension benefits;

(5) information regarding credited service and breaks in service;

(6) a description of situations that may result in disqualification, denial, loss or forfeiture of benefits.

In addition to the summary plan description, each participant and beneficiary must have access to financial information about the plan. This information is provided in summary form; it is the summary of a more extensive annual report filed with the Internal Revenue Service (IRS). Such information enables participants and beneficiaries to gain an awareness of the plan's financial status and the types of financial transactions engaged in during the preceding year.

Participants are also entitled to see certain documents relating to the plan (e.g., complete annual report, personal pension benefits statement). A participant who requests such material and does not receive it within 30 days may file suit in a federal court. The court may require the plan administrator to furnish the materials, and it may impose a fine of up to $100 a day until the materials are received.

Certain events may generate the need for other reports. For example, a plan participant who terminates service with vested benefits

must be given a statement showing the amount of accrued and vested benefits. Once a year, participants and beneficiaries may request a written statement of accrued and vested benefits.

Government Agencies and Reports—Three government agencies administer ERISA: the Internal Revenue Service, the Department of Labor (DOL) and the Pension Benefit Guaranty Corporation. The IRS is concerned primarily with *qualified* retirement plans—those offering employers and employees favorable income tax treatment under a special section of the tax law. DOL's main responsibility is to protect participants' rights. If a defined benefit plan terminates, PBGC insures that *guaranteed* benefits are paid to participants.

Plan sponsors must file an annual report with the IRS. The IRS then sends the report to DOL. Additionally, some information from the report is sent to the PBGC. The report provides detailed information on the number of plan participants, distributions made to participants and beneficiaries, and the amount and nature of the plan's assets. (This information is available to participants and beneficiaries in the form of a summary referred to earlier.) Other reports must be filed when certain events occur. DOL, for example, must be notified when a new plan is established (the summary plan description serves this purpose). PBGC must be notified when defined benefit plans are terminated. Again, the reports are intended to help the government ensure that plans are operated according to the law and that participants' rights are protected.

Minimum Standards

Under ERISA, both the DOL and IRS are responsible for enforcing retirement plan participation, vesting and benefit accrual standards. The law also created funding standards for defined benefit pension plan sponsors, intended to protect plan participants. These standards represent minimum requirements; employers may adopt plans with more liberal provisions.

Participation—ERISA does not require employers to provide pension plans to all their employees. It is permissible, for example, to design retirement plans covering only hourly employees. If an employer sponsors a plan for all employees or for a specific group of employees, such employees must be covered by the plan after satisfying minimum age and service requirements.

In most situations, employees become eligible to participate in retirement plans when they reach age 21 and have completed one year of service. (Before the Retirement Equity Act of 1984 (REA)

became law, ERISA's minimum age requirement was 25.) An exception applies to plans with immediate vesting; such plans may require three years of service. In plan years beginning after December 31, 1988, the maximum service requirement is lowered to two years.) These minimum standards have made it possible for more employees to participate in retirement plans.

Vesting—Vested benefits are those that are earned by an employee and cannot be revoked by an employer. Employees attain vested rights to benefits after satisfying specific service, or age and service requirements. (REA reduced the age at which an employee begins earning vesting credits from 22 to 18.) Once vested, an employee's benefit rights cannot be revoked, even if employment with the plan sponsor is terminated. In some cases, participants who terminate employment after they are vested may receive their benefits immediately. In other cases, they may receive the vested benefits at some future date when they retire.

With respect to benefits attributed to employer contributions, pension plans generally must satisfy one of three alternative vesting formulas:

(1) *Ten-Year Service Rule*—An employee must receive nonforfeitable rights to all accrued pension benefits after 10 years of service.

(2) *Graded 15-Year Service Rule*—An employee must receive nonforfeitable rights to 25 percent of accrued pension benefits after five years of service. Vested rights must then increase by 5 percent in each of the next five years and 10 percent in each of the following five years. Thus, the employee is 25 percent vested after 5 years, 40 percent vested after 8 years, 50 percent vested after 10 years and 100 percent vested after 15 years of service with any one private plan sponsor.

(3) *"Rule of 45"*—An employee gains nonforfeitable rights to 50 percent of accrued pension benefits by satisfying one of two conditions: (a) 10 years of service with the plan sponsor; or (b) five or more years of service *and* age and length of service totaling 45 (e.g., age 37 with 8 years of service). After the employee has vested 50 percent, he or she will vest another 10 percent in each of the next 5 years.[4]

[4]Additionally, a different rule may apply to defined contribution money purchase, profit sharing and thrift plans where plans provide *class-year* vesting. Class-year vesting occurs when each year's contribution is vested after some period has expired (the law allows a five-year maximum). Under the class-year approach, the employee may not fully vest and may forfeit some employer contributions in the years prior to termination. In plan years beginning after December 31, 1988, class-year vesting that does not meet either of the two new minimum vesting schedules will not be permitted.

In plan years beginning after December 31, 1988, the 1986 Tax Reform Act requires employer contributions to vest according to one of two schedules: (1) 100 percent after five years of service or (2) 20 percent after three years of service and 20 percent after each subsequent year of service until 100 percent at the end of seven years of service. These vesting rules are applicable for employer contributions to private-sector, single-employer pension plans. Multiemployer plans can use different vesting schedules, but under TRA must fully vest employer contributions after a maximum of 10 years.

Full vesting also occurs at normal or early retirement and, in some plans, at death or disability. Loss or suspension of benefits occurs in some situations, however. If a participant and spouse have both waived the preretirement survivor option, the spouse will not be entitled to the vested benefit of the participant should he or she die before retirement. Additionally, benefits to retired participants may be suspended during reemployment. And, participants who take their own contributions out of the plan may—if they are not sufficiently vested—lose their rights to employer plan contributions.

In many cases, an employee who is not vested can have a break in service without losing credit for previous service. The *break-in-service* rules under REA require prior service to be reinstated unless the break is equal to, or exceeds, the greater of five years or the number of prior years of service.

Joint and Survivor Annuities—ERISA mandates that private employer retirement plans provide a qualified joint and survivor annuity option for retired married participants as the normal method of benefit payment. This provides the surviving spouse with a monthly income equal to at least half the amount of the employee's benefit. In return for this protection, the employee's benefit usually is reduced. In order to select a pension paid over the duration of the *participant's* life only, both the participant and the spouse must refuse the joint and survivor option in writing. (The spouses' signatures must be notarized or made before a plan administrator.)

Private employer plans may, but are not required to, make death benefits available to vested participants in the form of a life insurance contract or a cash distribution.

Preretirement Survivor Annuities—Prior to 1985, preretirement survivor benefits were available only after the participant was eligible for early retirement. Under REA, all spouses of vested participants who die before retirement are eligible for preretirement survivor benefits, payable at the plan's earliest retirement date.

Both the signature of the participant and spouse are required to opt out of this benefit.

These survivor benefit provisions must be explained to plan participants in detail. They are intended to assist a participant in assuring that the surviving spouse is provided with a pension at retirement age.[5]

Benefit Accrual—ERISA also imposes a standard for the rate at which benefits are accrued (i.e., earned) by participants. In general, benefits must be earned evenly over the period of a worker's plan participation. The law focuses only on the rate of benefit accrual; it does not specifically consider benefit levels.

Funding—To ensure that plans have the money necessary to pay benefits when participants retire, ERISA established minimum funding standards for defined benefit plans. Employers who sponsor these plans must make at least the minimum required plan contribution each year. If they do not make the necessary contribution without prior IRS approval, they are subject to a tax on the unpaid amount. Employers are able to get IRS funding waivers only in limited circumstances.

Fiduciary Standards

Employers who sponsored retirement plans before ERISA were subject to one general fiduciary standard: plans had to be operated for the exclusive benefit of participants and beneficiaries. ERISA expanded this principle and established fiduciary standards that apply to almost all employee benefit plans. Fiduciaries are defined as: (1) those who exercise control or discretion in managing plan assets; (2) those who provide investment advice to the plan; and (3) those who have discretionary authority in administering the plan. ERISA's fiduciary standards apply to most professionals who are involved in plan operation. For example, in an individual employer plan, the trustee, the plan administrator and the employer are normally considered fiduciaries.

Basic Standards—Plan fiduciaries must meet certain basic standards in fulfilling their responsibilities. A fiduciary must: (1) act in the exclusive interest of plan participants and plan beneficiaries; (2) manage the plan's assets to minimize risk of large losses; and (3) act in accordance with documents that govern the plan.

[5]For more information on survivor benefits under pension plans, survivor income plans and Social Security, see chapter XXVI.

Fiduciaries must act also "with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." This standard is frequently referred to as ERISA's *prudent man rule.*

Because the performance standard is so high, the prudent man rule can be translated to require the actions that a prudent *expert* would take. Fiduciaries must meet this test in performing all aspects of plan operation—from selecting the individual or institution that will handle plan asset investment, to setting investment objectives. Investments that were once acceptable may carry an element of risk that is too large to be considered prudent under current regulations.

Impact of Fiduciary Standards—A fiduciary who violates ERISA's standards is personally liable to cover any losses resulting from failure to meet responsibilities, and he or she must return any personal profits realized from his or her actions. Additionally, fiduciaries may be liable for the misconduct of other fiduciaries, if they know about such misconduct.

Enforcement of fiduciary standards permits certain penalties. Loss of favorable tax treatment may apply to some plans, but more extensive remedies are available to the government as well as to plan participants and beneficiaries. In some situations, the IRS may tax the person, such as the employer, who engages in a prohibited transaction; or the DOL may bring suit on behalf of participants in plans that do not satisfy ERISA's fiduciary standards.

Additional Employee Protection

Plans must provide an appeals procedure to participants whose claims are partially or completely denied. The reason for claim denial must be provided in writing to the participant, and the participant must have the right to request a reconsideration of the decision. If the claim is denied again, the participant can file suit in federal or state court to enforce his or her benefit rights.

ERISA prohibits anyone, including the employer, from discriminating against a participant who has exercised his or her legal rights. If a participant is fired or otherwise discriminated against for exercising his or her rights, he or she may seek assistance from the DOL, or may file suit in federal court.

Plan Termination Insurance

Plan termination insurance is probably ERISA's most innovative change. The Pension Benefit Guaranty Corporation, a governmental

body created by ERISA, insures payment of certain pension plan benefits in the event a covered plan terminates with insufficient funds to pay promised benefits. Employers (and jointly managed funds) with private, defined benefit plans are required to pay annual premiums to the PBGC to provide funds from which guaranteed benefits can be paid.

ERISA set the premium for single-employer plans at $1 per plan participant per year. The rate, which can only be raised after congressional approval, was raised to $2.60 for plan years beginning in 1978 and was raised again to $8.50 per plan participant for plan years after December 31, 1985. In 1987, PBGC again requested a premium increase. Multiemployer premium rates, originally set at $.50 per plan participant per year were raised by the 1980 Multiemployer Pension Plan Amendments Act (MPPAA) to $1.40 and are scheduled to increase to $2.60 over a nine-year period. PBGC can designate a more rapid multiemployer premium increase to protect the termination insurance program's financial soundness; however, premiums cannot be raised in excess of $2.60 without congressional approval.

Termination Policy—Terminations of single-employer plans are restricted to two cases: a "standard" termination and a "distress" termination. A standard termination is permitted only if the plan holds sufficient assets to pay all "benefit commitments" under the plan. Benefit commitments are defined as all PBGC guaranteed benefits, all benefits that would be guaranteed if not for maximum benefit limits or phase-in rules, and early retirement supplements and plant-closing benefits that were vested before termination. Thus, benefit commitments include virtually all accrued basic benefits vested before termination and some accrued nonbasic benefits vested prior to termination. Although under ERISA all accrued benefits become vested at termination, benefit commitments do not include benefits that become vested solely due to plan termination.

A plan that lacks sufficient assets to pay benefit commitments may be terminated only when the employer is in financial "distress." To terminate a plan in a distress situation, the plan administrator must show that: (1) a petition has been filed in bankruptcy or other state insolvency proceedings seeking liquidation of the employer; (2) a similar petition has been filed seeking reorganization of the employer and the bankruptcy court has approved the termination; (3) the employer will be unable to pay its debts when due; or (4) pension costs have become unreasonably burdensome due to a declining work force.

For multiemployer plans, which cover the workers of two or more unrelated companies under a collective bargaining agreement, PBGC

provided insurance coverage on a discretionary, plan-by-plan basis to participants of terminating plans until 1980. However, MPPAA established significant benefit guarantee provisions for all collectively bargained plans contributed to by "more than one employer."[6]

Covered Plans and Benefits—PBGC guarantees the retirement, death and disability benefits of those who are private-sector, defined benefit plan *beneficiaries* should a plan terminate. It also guarantees the vested retirement benefits of those who are private-sector, defined benefit plan *participants* should a plan terminate. Benefit guarantees are expressed in terms of straight life annuities that begin at age 65.

There are certain restrictions on the monthly benefit amount PBGC will pay. In general, payment is limited to a maximum dollar amount that is adjusted annually to reflect the increasing average wages of American workers ($1,857.95 in 1987). The limit applies to all plans in which a participant is covered—it is not possible to receive separate insurance protection under several plans and, thus, to increase the *total* guaranteed benefit.

For single-employer, defined benefit plans, insurance on new benefit provisions (i.e., benefits resulting from newly established plans or recent plan amendments) is phased in at 20 percent per year. Therefore, *full* insurance coverage applies only to benefit provisions that have been in effect for five consecutive years prior to plan termination. The guarantee pertains exclusively to benefits earned while the plan is qualified for favorable tax treatment. Additionally, benefits are guaranteed up to the stipulated maximum.

For multiemployer plans, MPPAA established a level of guaranteed benefits that is generally lower than single-employer plan benefit guarantees. *No* portions of multiemployer plan benefits are guaranteed until they have been in effect for five years; and the maximum amount guaranteed per year of service is 100 percent of the first $5 in monthly benefit rate plus 75 percent of the lesser of the next $15 or the accrual rate in excess of $5. Where plans seeking guarantees are insolvent, the guarantee's second tier is reduced from 75 percent to 65 percent.

Employer Liability to PBGC—In a distress termination, the terminating employer is liable to PBGC and to plan participants for unfunded benefit commitments up to a maximum limit, which is the

[6]Under ERISA's 1974 provisions, certain plans that were maintained by "more than one employer" were treated as single-employer plans. MPPAA allowed these plans to irrevocably elect—within one year of MPPAA enactment—to remain classified as single-employer plans.

sum of: (1) the full amount of unfunded PBGC guaranteed benefits up to 30 percent of net worth; (2) 75 percent of unfunded PBGC guaranteed benefits in excess of 30 percent of net worth; and (3) interest on the amount due calculated from the termination date.

The employer is additionally liable to plan participants for a portion of unfunded, nonguaranteed benefit commitments. That liability is limited to the lesser of: (1) 75 percent of the unfunded, nonguaranteed vested benefit commitments or (2) 15 percent of total vested benefit commitments.

Different rules apply for certain types of multiemployer plans. Because employers signatory to a multiemployer plan may withdraw from the plan—or reduce contributions to the plan—without termination, MPPAA imposes liability upon an employer for *withdrawal* from the plan. *Withdrawal liability* is a legal obligation requiring an employer, who discontinues or sharply reduces contributions to a multiemployer plan, to pay for its share of the plan's unfunded vested benefits. The employer must continue to make annual payments for 20 years or until the liability is satisfied, whichever occurs first.

Under MPPAA, *full withdrawal* occurs when an employer's contribution obligation to a plan permanently ceases, or if all of an employer's covered operations under a plan permanently cease. *Partial withdrawal* occurs when there is a gradual reduction in an employer's contribution base (i.e., if there is a 70-percent decline in the number of contribution units—for example, hours worked) continuing for three years. Partial withdrawal also results when an employer is no longer obligated to contribute: (1) under one of two or more collective bargaining agreements even though work continues that previously required contributions; or (2) because one or more (but not all) of an employer's facilities withdraws from a plan, although work continues at the withdrawing facility. PBGC assumes liability only when the entire plan is in financial difficulty. Thus, for multiemployer plans, plan insolvency, rather than plan termination, is the insured event. Plan trustees are responsible for: (1) identifying withdrawing employers; (2) calculating the amount of the withdrawal liability; and (3) collecting this liability.

Multiemployer plan trustees can: (1) adopt one of four methods set forth by PBGC for computing the employer's share of the unfunded vested benefits; or (2) develop their own computation method subject to PBGC approval. If plans do not choose a method themselves, MPPAA requires that withdrawing employers use the *presumptive rule*. This rule may be more complicated and more costly than some of the other calculation rules. Plan trustees, therefore, should carefully eval-

uate each of the withdrawal liability calculation methods to decide which is most practical for their individual circumstances.

Some limited exemptions from withdrawal liability apply to the building, construction, entertainment, trucking, moving and warehousing industries. A *de minimis* rule may also be used; under this rule, withdrawal liabilities may be waived for an employer whose share is less than $50,000 or .75 percent of the plan's total unfunded liability, whichever is smaller.

Unlike a single-employer plan termination where the employer's liability is limited to 30 percent of net worth, there is no limit on net worth for multiemployer plan withdrawal liability.

Conclusion

Since ERISA became law, thousands of plans have been amended to comply with its requirements. As areas that were initially overlooked or treated inadequately are identified, additional changes can be anticipated. The PBGC insurance program is a good example of a provision of ERISA that has undergone significant change. More changes can be expected, particularly for the single-employer termination insurance program.

Additional Information

The ERISA Industry Committee
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Coleman, Barbara J. *Primer on Employee Retirement Income Security Act.* Washington, DC: Bureau of National Affairs, Inc., 1985.

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IV. Pension Plans

Introduction

In 1759, the first pension plan was established in the United States to benefit widows and children of Presbyterian ministers. The first pension plan was established for United States' *workers* a century later when New York City created a fund for retired policemen. Only 15 percent of all privately employed nonfarm workers were covered by pension programs in 1930. Pension plans began to play a prominent role in providing retirement income security to American workers in the years after World War II. By 1983, employer-sponsored pension and profit sharing plans covered about 52 million people—more than half of the nation's work force.

Before the second World War, private pensions were considered to be employer gifts in recognition of long and faithful service. Typically, employers did not assume an obligation to provide retirement benefits to either retired or active employees. The *employer gratuity* philosophy evolved gradually into a theory of *human depreciation*. Since the employee's value as a worker depreciated over his or her working life, employers were thought to have a moral obligation to provide for employees when they were too old (and nonproductive) to continue in the labor force. The human depreciation theory has been supplemented by another theory holding that pensions represent *deferred employee wages*. Under this theory, an employee group is viewed as having a choice between immediate wage increases and a pension plan—if the employees choose the pension plan, the pension benefits are regarded as a form of deferred wages. Although this theory has some weaknesses, it is growing in popularity and has become the most prevalent view.

Qualified Plans

The Internal Revenue Code (IRC) was amended in 1942 to incorporate general guidelines for the design and operation of pension plans (as well as profit sharing and stock bonus plans). The amendments were intended to prevent discrimination in favor of the *prohibited group* (i.e., shareholders, officers and highly paid employees) with regard to pension plan coverage, benefits and financing. The

amendments were also intended to protect federal revenues against excessive tax deductions for contributions to these employee benefit plans. Except in the areas of participation, vesting and minimum funding, the 1974 Employee Retirement Income Security Act (ERISA) did not change significantly these basic plan qualification requirements.

The 1986 Tax Reform Act (TRA), however, made further changes in these rules, which are described in a later section, for plan years beginning after December 31, 1988.

Taxation

A tax-qualified plan offers advantages to both employers and employees: (1) the employer can claim an immediate income tax deduction for contributions to the plan; and (2) plan participants are not subject to current income taxation on employer contributions and the investment earnings on plan assets until benefits are received. Also, plan assets are held in tax-exempt trust funds, which do not pay taxes on the trust's investment earnings.

Additionally, a terminating employee who receives a lump-sum distribution from an employer pension plan may, within 60 days, roll over all or part of the distribution to another qualified plan or an individual retirement account (IRA). If the rollover occurs, the employee is not taxed on the amount transferred to the other plan or the IRA.[1]

The primary requirements for tax qualification are:

(1) The plan's provisions must be delineated in a written document.

(2) The plan must be established with the intent of being a permanent and continuing arrangement.

(3) The plan must provide coverage to employees in general—not just to a select group of employees.

(4) The plan's assets must be held separate from the employer's general assets.

(5) The plan contributions and benefits must not discriminate in favor of the prohibited group.

Numerous changes have been made to the tax treatment of qualified pension plans. TRA: (1) phased out capital gains treatment for lump-sum distributions over 6 years beginning on January 1, 1987;

[1]For more information on rollovers to an IRA, see chapter XIII.

and (2) eliminated 10-year forward averaging for taxable years beginning after December 31, 1986, and instead, permitted a *one-time* election of 5-year forward averaging for a lump-sum distribution received after attainment of age 59 1/2. Forward averaging is the ability to pay taxes on lump-sum distributions at a certain fraction of the marginal rate. Under a transition rule, a participant who attained age 50 by January 1, 1986, is permitted to make one election of 5-year forward averaging or 10-year forward averaging (at present-law rates) with respect to a single lump-sum distribution without regard to attainment of age 59 1/2, and to retain the capital gains character of the pre-1974 portion of such a distribution. Under the transition rule, the pre-1974 capital gains portion is taxed at a rate of 20 percent.

TRA provides significant penalties for most early distributions from qualified retirement plans. It applies a 10 percent additional income tax to all early distributions includible in gross income, regardless of the character of the contribution to which the distribution relates, from a qualified plan, qualified annuity plan, tax-sheltered annuity or IRA, made before death, disability or attainment of age 59 1/2 in taxable years beginning after December 31, 1986; but it does not apply to sec. 457 plans, which are plans commonly used by state and local governments.

The 10 percent additional tax does not apply to certain distributions: (1) in the form of an annuity payable over the life or life expectancy of the participant (or the joint lives or life expectancy of the participant and the participant's beneficiary); (2) made after the participant has attained age 55 and separated from service; (3) used for payment of medical expenses to the extent deductible under federal income tax (i.e., in excess of 7.5 percent of adjusted gross income); (4) received from an employee stock ownership plan (ESOP) before January 1, 1990; (5) received in a lump sum prior to March 15, 1987, if made on account of separation from service in 1986 if the recipient elects to be taxed on the distribution in 1986; or (6) made to or on the behalf of an alternate payee pursuant to a qualified domestic relations order (QDRO).

Employers may elect to sponsor *nonqualified* pension plans, which do not meet the requirements of the IRC and, as a result, suffer disadvantages from a tax standpoint. These plans, however, are not discussed in this chapter.

Plan Design

Pension plans can be classified into two major types: (1) single-employer plans; and (2) multiemployer plans. Single-employer plans

generally are established by the employer. Multiemployer plans generally cover union employees and are established by the participating employees and the union through the collective bargaining process. In both types of plans, there are certain decisions to be made. For example: Who will be covered? What benefits will the plan provide? Who will administer the plan? How will the plan be financed? All of these decisions will be made within the constraints of the employer's budget; and under the deferred wages theory of pensions, they are subject to trade-offs between retirement income and current wages.

Coverage—Even though ERISA and the IRC set minimum participation standards, there is some flexibility in deciding who will be eligible for plan membership. If an employee is in the group covered by a plan, once the employee reaches age 21 and completes one year of service, the employee must be eligible to participate in the plan (although there are some exceptions to this rule). More liberal standards may be set (e.g., employers could establish plans that cover all employees immediately).

Coverage may be extended to particular employee groups, provided certain restrictions of the IRC are satisfied. For example, the covered group may be defined in one or more of several ways: (1) on a pay basis (i.e., hourly or salaried employees); (2) according to job location (i.e., employees in certain divisions, plants or subsidiaries); or (3) on the basis of whether employees are union or nonunion. Employees may be required to make contributions in order to be covered. Some plans allow employees to elect not to participate.

In defining the covered employee group, the plan must not discriminate in favor of the prohibited group, and it must be established exclusively for the participants' benefit—rather than for the employer's benefit.

TRA provides new coverage rules for qualified plans that require one of the following tests to be satisfied:

(1) Seventy percent of all nonhighly compensated employees are covered by the plan.

(2) The percentage of nonhighly compensated employees covered by the plan is at least 70 percent of the percentage of highly compensated employees covered.

(3) The group of employees covered by the plan satisfies the present-law classification test, and the average benefit provided to all nonhighly compensated employees (as a percentage of compensation), including those not covered by the plan, is at least 70 percent of the average benefit provided to highly compensated employees (as a percentage of

compensation), including those not covered by the plan. In applying the third test, all plans maintained by the employer, including elective deferrals under a qualified cash or deferred arrangement, are taken into account.

The provisions of TRA are generally effective for plan years beginning after December 31, 1988. A special effective date applies to plans maintained pursuant to a collective bargaining agreement.

Under TRA, a plan is not qualified unless it benefits no fewer than the lesser of: (1) 50 employees or (2) 40 percent or more of all employees of the employer. The requirement may not be satisfied by aggregating comparable plans. In the case of a cash or deferred arrangement or the portion of a defined contribution plan to which employee contributions or employer matching contributions are made, for purposes of tests (1) and (2) above, an employee is treated as benefiting under the plan if the employee was eligible to make contributions to the plan.

TRA also provides a new uniform definition of the group of employees in whose favor discrimination is prohibited ("highly compensated employees") that generally applies for purposes of the nondiscrimination rules for qualified plans and statutory employee benefit plans (such as medical and group term life insurance). The new definition became effective for years beginning in 1987, except to the extent that the substantive rule to which it relates is effective at a later time (e.g., for 401(k) arrangements it is effective in 1987, but for minimum coverage rules it is effective in 1989).

An employee is treated as highly compensated with respect to a year if, at any time during the year or the preceding year, the employee: (1) was a 5 percent owner of the employer; (2) earned more than $75,000 in annual compensation from the employer; (3) earned more than $50,000 in annual compensation from the employer and was a member of the top-paid group of employees, the top 20 percent of employees by pay during the same year; or (4) was an officer of the employer and received compensation greater than 150 percent of the dollar limit on annual additions to a defined contribution plan ($45,000 in 1987). If for any year no officer of the employer received compensation in excess of 150 percent of the defined contribution plan dollar limit, then the highest-paid officer of the employer is treated as a highly compensated employee.

A special rule applies to new hires and to those with increases in compensation in the current year. Under this special rule, an employee who would be treated as highly compensated because the

employee meets one of these last three tests stated above is not included in the highly compensated group until the year after the year in which the employee satisfies one of these tests. This one-year delay does not apply in the case of a participant who is in the top 100 in pay of the employer.

Defined Contribution Plans—Under defined contribution plans, employers pay a specific amount into the pension fund for each participant. These payments accumulate, along with investment and interest earnings, in separate participant accounts. Employer contributions may be defined in some manner, such as either a percentage of salary or profits. Defined contribution plans may also provide for employee contributions, which may be either voluntary or mandatory. The retirement benefit under these plans is determined by the amount in the participant's account at retirement. As a result, the level of retirement benefits cannot be calculated exactly in advance. There are several types of defined contribution plans: (1) money-purchase pension plans; (2) profit sharing plans (including 401(k) arrangements); (3) thrift plans; and (4) ESOPs.[2]

Defined Benefit Plans—These plans differ from defined contribution plans. In defined benefit plans, the benefit is determined in advance, based on a benefit formula. The benefit formula is one of three general types: (1) a flat-benefit formula; (2) a career-average formula; or (3) a final-pay formula.

(1) *Flat-Benefit Formulas*—These formulas pay a specific dollar amount for each year of service recognized under the plan. They are most often seen in collectively bargained plans or plans covering hourly paid employees; sometimes flat-benefit formulas are used to provide a minimum benefit in plans covering salaried employees.

(2) *Career-Average Formulas*—There are two types of career-average formulas. Under the first type, participants earn a percentage of the pay recognized for plan purposes in each year they are plan participants; the normal retirement benefit is the sum of the yearly benefit amounts.

The second type of career-average formula totals and then averages the participant's yearly earnings over his or her period of plan participation. At retirement, the benefit equals a percentage of the career-average pay, multiplied by the participant's number of years of service. Sometimes, the percentage used in the calculation will be higher for career-average pay over a given pay breakpoint. Pay breakpoint formulas produce a more generous benefit where higher earnings are

[2]Profit sharing, thrift, 401(k) arrangements and employee stock ownership plans are discussed in greater detail in chapters VIII, IX, X and XI.

available during later years, which offset lower earnings in earlier years.

(3) *Final-Pay Formulas*—These plans base benefits on average earnings during a specified number of years at the end of a participant's career; this is presumably the time when an employee's earnings are highest. Benefits equal a percentage of the employee's final average earnings, multiplied by number of years of service. This formula provides the greatest inflation protection to the participant, but it also represents the greatest cost to the employer.

Career-average and final-pay formulas are most common in plans covering nonunion employees.

Under pay-related formulas, an employer has some discretion in defining *pay* for plan purposes. He may choose to: (1) recognize all compensation; (2) restrict the definition to base pay; or (3) choose a definition that is a compromise between (1) and (2). Under ERISA's minimum standards, there is also some leeway in determining what employment period will be recognized in the benefit formula. The benefit may reflect only the plan participation period; or it may be based on the entire employment period.[3]

Contribution Limits—ERISA originally set limits on the benefit amounts that retirement plans could provide. Under defined benefit plans, the initial maximum benefit amount was $75,000 per year. Under defined contribution plans, the limit applies to the amount of money that can be contributed to a participant's account in any year. The initial contribution limit was $25,000. Before 1983, the maximum benefit and contribution limits were adjusted annually to reflect increases in the cost of living. The 1982 Tax Equity and Fiscal Responsibility Act (TEFRA), however, imposed new benefit and contribution limits beginning in 1983, and froze them at these levels until 1985. The Deficit Reduction Act of 1984 (DEFRA) extended the freeze on cost-of-living adjustments until 1988. The Tax Reform Act of 1986 (TRA) made further changes. The annual benefit limit under a defined benefit plan is the lesser of $90,000 or 100 percent of the employee's average compensation for his or her three highest earning years; and the annual contribution limit under a defined contribution plan is the lesser of $30,000 or 25 percent of an employee's compensation. Under TRA, all employee after-tax contributions must be counted as part of annual additions. The defined contribution limit will remain unchanged until the defined benefit limit, which is indexed to the

[3]Defined benefit and defined contribution plans are discussed in greater detail in chapter VI.

Consumer Price Index beginning in 1988, reaches $120,000. This 4:1 ratio will then be maintained in the future.

Pension Plan Integration—Social Security benefits replace a greater proportion of preretirement earnings for lower-paid employees than for higher-paid employees. This is caused by two factors. Social Security taxes and benefits are based on earnings up to the *taxable wage base*, rather than on all earnings. In addition, the Social Security benefit formula produces higher benefits—relative to earnings—for lower-paid employees. Pension plan benefits can be coordinated with Social Security benefits to reflect the tilt in Social Security's benefit formula. Thus, to help compensate for Social Security's benefit tilt, employers are permitted to provide proportionately higher pension benefits to higher-paid employees than to lower-paid employees.

This benefit coordination, known as pension plan integration, can be accomplished in one of two ways: (1) by subtracting a portion of the Social Security benefit from the pension plan benefit; or (2) by providing a higher benefit on earnings above a stated amount and a lower benefit on earnings below that amount. The integration methods described here pertain to defined benefit plans and the integration rules for defined benefit and defined contribution plans have been substantially changed by TRA, effective for plan years beginning after December 31, 1988.[4]

Vesting—Pension plans are required to satisfy ERISA's minimum vesting provisions. Vesting occurs when a plan participant has earned a right to his or her benefit that is not dependent on additional requirements, such as continued employment. If a participant is vested and terminates employment, he or she retains the right to pension plan benefits. These benefits may be paid immediately or at some future date. As a result of the Retirement Equity Act of 1984 (REA), the vesting age has been reduced from 22 to 18.[5]

The vesting schedule may provide for: (1) immediate full vesting; (2) full vesting after a certain number of years of service; (3) accrual of a certain vesting percentage for each year of service; or (4) full vesting after the sum of service years, plus the participant's age, equal a specified amount. For plan years beginning after December 31, 1988, TRA shortens vesting schedules for most plans. Under the new schedules, a private-sector, single-employer plan must meet one of two tests: (1) 100 percent vesting after five years of service; or (2) 20

[4]Pension plan integration methods for defined benefit and defined contribution plans, as well as TRA changes, are discussed in chapter VII.

[5]ERISA's vesting requirements are discussed in greater detail on pages 32–33.

percent after three years of service, with an additional 20 percent for each subsequent year of service until 100 percent vesting is achieved at the end of seven years of service. A special rule is provided in the case of a multiemployer plan to require 100 percent vesting after 10 years of service.

Class-year vesting that does not meet either of the two new minimum standards is not permitted for plan years beginning after December 31, 1988, effectively repealing the special class-year vesting rule.[6]

TRA also provides that the current maximum waiting period for plan participation of three years for plans with full and immediate vesting is reduced to two years of service. If a plan requires an employee to complete more than one year of service as a condition of participation, the employee must be 100 percent vested when the benefit is accrued.

The above provisions of TRA are generally applicable for plan years beginning after December 31, 1988, with respect to participants who perform at least one hour of service after the effective date. A special effective date applies to plans maintained pursuant to a collective bargaining agreement.

Additionally, the 1982 Tax Equity and Fiscal Responsibility Act requires certain plans to use more accelerated vesting provisions once the plan becomes top-heavy (i.e., the plan primarily benefits key employees).[7]

Loans—Some plans permit employees to borrow a portion of their vested benefits. Generally, the employee repays the loan according to a specified repayment schedule. If loans are permitted, they must be: (1) available to all participants on a comparable basis; (2) adequately secured; and (3) made by the plan (i.e., not by a third party such as a bank). Loans from thrift plans must bear a reasonable interest rate. Recent legislation has placed further restrictions on loans.

(1) Loans for more than $10,000 may not exceed one-half of the present value of the employee's nonforfeitable accrued benefit, subject to an overall loan maximum of $50,000.

(2) Loans must be repaid under a level amortization schedule within 5 years, with payments at least quarterly.

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[6]For a definition of class-year vesting, see footnote on p. 32.

[7]Key employees are individuals meeting specified ownership and earnings criteria.

(3) The only allowable exception to the 5-year repayment rule is to acquire a primary residence of the employee.

Other Features—Many pension plans pay benefits when events other than normal retirement occur, e.g., early retirement, disability or death. Pension benefits may also be distributed to former spouses and children upon divorce under qualified domestic relations orders. Most of these additional benefits are not mandatory. The amount of such benefits is usually based on the participant's *accrued benefit* at the time of the event. ERISA generally requires that participants earn benefits evenly over their plan participation periods. (Some plans, however, use all periods of *employment* to satisfy the benefit accrual rules.) The accrued benefit is the benefit amount a participant has *earned* at a particular date. It may be either the full benefit produced by the benefit formula, or it may be a prorated benefit reflecting that a participant has not reached normal retirement age.

(1) *Early Retirement*—Early retirement benefits are generally payable when a participant satisfies certain age and service requirements. Less often, they are available based on age alone, years of service alone, or when the combination of age and service totals a required sum.

The early retirement benefit is usually the accrued benefit, reduced to reflect a participant's increased length of benefit receipt. Sometimes, to encourage early retirement, subsidized early retirement benefits are paid until the participant is eligible for Social Security benefits. This type of benefit may be limited to participants with long service or to those who are retiring because of a plant shutdown or staff reduction.

TRA requires that maximum benefits payable from a defined benefit plan must be actuarially reduced for retirees who claim benefits before the Social Security normal retirement age.

(2) *Disability Benefits*—Disability benefits may also be tied to age and/or service requirements, and they are usually contingent on satisfying the plan's definition of *disability*. For plan purposes, disability may be linked to the definition of disability under Social Security.

The benefit may be a flat-dollar amount that continues until the participant's normal retirement date (assuming he or she remains disabled); then, at normal retirement date (usually age 65), the normal retirement benefit would become payable. Or, the plan may pay the participant the unreduced, accrued benefit during the period before he or she reaches normal retirement age. Under yet a different method, the plan may reduce the participant's accrued benefit to reflect that benefits are paid before normal retirement. In some plans, disabled participants continue to accrue benefits from the time they become disabled, through their normal retirement age. Where an employer also provides a long-term disability (LTD) plan, the pension plan ben-

efit is usually postponed until the LTD benefit stops, to avoid duplicate payments.[8]

(3) *Late Retirement Benefits*—Amendments to the Age Discrimination in Employment Act prohibit employers from forcing employees to retire because of age. The majority of pension plans specify 65 as the normal retirement age for plan participants; these plans must reflect how benefits will be calculated for participants who remain employed beyond age 65. As a result of legal changes and recent court decisions, a plan must now recognize earnings and/or service after age 65 for pension contribution and benefit purposes.

(4) *Death Benefits Before Retirement*—There is a considerable amount of flexibility in designing death benefit provisions under pension plans. Where plans offer early retirement benefits, REA requires that participants must be provided with an *early survivor annuity*. Written spousal consent is needed to elect out of the coverage. Such an annuity would be payable to a surviving spouse, if the worker dies before retirement. The annuity must be equal to at least half of the participant's accrued benefit at the time of his or her death. To reflect the cost of providing survivor protection, the law permits employers to provide a lower benefit to the participant.

(5) *Death Benefits After Retirement*—ERISA requires that retirement benefits to married persons must be paid as a *qualified joint and survivor annuity, unless the participant gets written spousal consent to receive his or her benefits in some other form.* Under a joint and survivor annuity, the participant receives a benefit during retirement years; benefits then continue to be paid, after his or her death, in the same amount or in a lesser amount to the surviving spouse. The participant's benefit is usually reduced to reflect the cost of survivor protection. Some plans, however, pay an unreduced amount to the participant.

Typically, any employee contributions are refunded to a beneficiary if a participant dies before receiving his or her benefits.[9]

Plan Administration

Under ERISA, an employer must name a plan administrator. Administrative responsibilities are frequently delegated to an *administrative committee*. Administrative committees are typically made up of representatives from personnel, finance and top management, as well as union representatives if the plan is collectively bargained. Record keeping for the plan may be incorporated into the personnel

[8]For more information on disability benefits under pension plans, disability plans and Social Security, see chapter XXVI.

[9]Death benefits under pension plans, survivor income plans and Social Security are discussed in chapter XXVI.

function, or it may be assigned to another area. Responsibilities of the administrative committee may include:

(1) filing the various governmental reports necessary for legal compliance;

(2) ensuring that reports to participants and beneficiaries are prepared and distributed;

(3) determining eligibility for plan participation;

(4) determining eligibility for and calculation of plan benefits;

(5) explaining plan provisions to employees;

(6) interpreting plan provisions;

(7) making investment decisions regarding plan assets.

The committee should keep a written record of its meetings and actions. Since the plan may not discriminate in favor of the prohibited group, a written record is helpful—it can assist in ensuring nondiscriminatory treatment.

The plan administrator, the administrative committee and certain other parties involved in the plan's operation are considered to be *fiduciaries*. Under the law, a fiduciary must:

(1) act solely in the interest of plan participants and beneficiaries, and for the exclusive purpose of providing benefits and defraying reasonable administrative expenses;

(2) manage the plan's assets to minimize the risk of large losses;

(3) act in accordance with the documents governing the plan.

In some instances, violation of fiduciary standards will cause the pension plan to lose IRS *qualified* status. The Department of Labor may bring suit on behalf of participants in plans that are not operated according to ERISA's fiduciary standards. Other penalties also exist.

Funding

To be eligible for IRS tax-qualification provisions, plan assets must be held apart from the employer's general assets. A plan may be funded through one of a number of vehicles. For example, a trust agreement with a bank or similar institution may be used. In this case, the trustee holds the plan's money in a separate account, and the employer does not have access to the funds.

Under another arrangement, a plan may be funded through an insurance company. The funding may be through either an allocated or unallocated funding instrument. If an allocated arrangement is used, separate accounts are established for each plan participant and total contributions are divided among participants. Under an unallocated arrangement, a pool of funds is established and benefits are paid from this pool. Pension plans may also be funded through individual policies issued on each participant's life.

Combinations of trust funds and insured plans may be used to gain a greater degree of flexibility in plan funding.

To ensure that pension plans have the funds to pay benefits when participants retire, ERISA established *minimum funding standards*. These funding standards are generally more applicable to defined benefit plans than to defined contribution plans. ERISA requires that a minimum contribution must be made each year. If funding requirements are not met, a penalty tax may be imposed on plan sponsors. In limited situations, the IRS may issue a funding waiver enabling the employer to postpone his annual contribution.

Pension plans retain the services of *actuaries* (i.e., individuals skilled in the mathematics of pension plans and insurance) to determine the amount of the minimum contribution. The actuary certifies that plan contributions are sufficient to satisfy the minimum funding standards. The Financial Accounting Standards Board (FASB) is an independent, private authority that establishes U.S. accounting principles and guidelines, which often affect calculations of pension assets and liabilities.

Plan Termination

Even though pension plans are established with the intent that they will be permanent, employers can and do reserve the right to terminate their plans. ERISA introduced plan termination insurance to protect participants' benefit rights in the event of plan termination.

The Pension Benefit Guaranty Corporation (PBGC) is a governmental body that insures payment of plan benefits when qualified defined benefit plans terminate without sufficient assets to pay certain of their promised benefits. Defined benefit pension plan sponsors pay annual premiums to PBGC. These premiums are used to provide the funds needed to pay guaranteed benefits.

There are certain restrictions and limitations on the benefit amounts PBGC will guarantee. In general, payment is limited to a dollar amount; this amount is adjusted annually to reflect the increasing average

wages of the American work force. To be fully insured, benefits must have been vested before the plan terminated; and the benefits must be attributable to plan provisions that have been in effect for five years.[10]

Conclusion

Over the last 30 years, the number of employer pension plans has grown dramatically. This historical growth, combined with the increasing labor-force participation of women and the maturing of baby boom workers, suggests that employer plans will continue to play an increasing role in providing retirement income security.

Additional Information

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Stamford, CT 06905

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[10]For more information on pension plans and government regulations affecting these plans, see chapters IV, VI and VII.

V. Multiemployer Plans

Introduction

A multiemployer plan is an employee benefit or pension plan that covers the workers of two or more unrelated companies, in accordance with a collective bargaining agreement. Contributions to support such plans are negotiated at the initiative of a labor union or a group of labor unions representing the workers of a number (frequently hundreds) of employers in a given geographic area. The workers are usually engaged in the same kind of employment (e.g., a skilled craft like carpentry or acting).

Multiemployer plans are generally of two types. The first, a benefit or welfare plan, may provide group life insurance, disability insurance and coverage for hospitalization, surgical and medical costs. The other, a pension plan, provides retirement income security. The multiemployer concept can also be used to provide other benefits; its collective approach has been used effectively in areas such as employee training.

Multiemployer plans are governed by employer and union representatives who comprise the plan's board of trustees. Employer representatives must equal the number of union representatives on the board.

The first multiemployer plan was probably an employer-sponsored pension plan initiated in 1929 by Local 3 of the Brotherhood of Electrical Workers and the Electrical Contractors Association of New York City. Subsequently, certain negotiated plans developed in the 1930s and 1940s in industries such as the needle trades and coal industries. True growth of multiemployer pension plans did not begin until after World War II. By 1950, negotiated multiemployer pension plans covered one million people. Coverage under these plans rose to 3.3 million workers in 1960, and an estimated 7.2 million active workers were participating in 1979.

Multiemployer Plan Characteristics

Number of Plans—There are an estimated 2,500 multiemployer pension plans; these plans cover an estimated 8.5 million active and retired participants and involve over 700,000 employers. There is

probably an equal number of multiemployer welfare plans, which provide life, medical, dental and disability insurance to employees and their dependents. There is also a growing number of multiemployer plans that provide annuity funds, supplementary unemployment insurance and legal benefits.

Of the nation's 8.5 million multiemployer pension plan participants, the majority are covered by large plans. In 1982, the latest year for which data are available, there were 149 plans with 10,000 or more active participants, covering 4.2 million persons. All the other plans provided combined coverage for only 4.3 million participants. The United States Department of Labor (DOL) has produced figures indicating that each of ten unions—Carpenters, Electrical Workers (IBEW), Food and Commercial Workers, Hotel and Restaurant Employees, Laborers, Ladies Garment Workers, Mine Workers, Operating Engineers, Plumbers and Teamsters—had over 250,000 members covered by multiemployer pension plans in 1979.

Industries Covered by Multiemployer Plans—Multiemployer plans tend to be found in certain industries. With some exceptions, they are common in industries where there are many small companies, each too small to justify an individual plan. They are also found in industries where, because of seasonal or irregular employment and high labor mobility, few workers would qualify under an individual company's plan (if one were established). For example, construction workers are commonly hired by a given contractor for only a few weeks or months. When the job is completed, the worker may be unemployed until another contractor needs his particular skills or talent.

Substantial numbers of multiemployer plans exist in the following manufacturing industries, as defined by the Labor Department:

(1) food, baked goods and kindred products;

(2) apparel (or needle trades) and others;

(3) printing, publishing and allied industries;

(4) finished textile products;

(5) leather and leather products;

(6) lumber and wood products;

(7) furniture and fixtures;

(8) metalworking.

In nonmanufacturing industries, multiemployer plans are common in:

(1) mining;

(2) construction;

(3) motor transportation;

(4) wholesale and retail trades;

(5) services;

(6) entertainment;

(7) communication and public utilities.

Construction is the industry with the most multiemployer plans. In 1979, construction accounted for about 1,500 multiemployer pension plans or roughly one-half of all multiemployer pension plans in the United States. In addition, construction accounted for nearly 28 percent of all employees participating in multiemployer pension plans.

Multiemployer plans also appear among companies and in industries where single-employer plans are feasible. Breweries, dairies, large bakeries and metal fabricating companies are some typical examples.

Benefits—According to the Pension Benefit Guaranty Corporation, in 1976, multiemployer plans paid benefits totalling $2.5 billion to about 1.3 million retirees. In the same year, multiemployer retirement plan assets exceeded $21.6 billion. Multiemployer pension plan benefit payments increased to $4.5 billion by 1981, according to DOL, while the number of retirees grew to about 1.8 million. Multiemployer retirement fund assets are estimated to have been $56.8 billion in 1981, and $107.4 billion as of September 30, 1986.

Investment Performance of Plan Funds—According to the Employee Benefit Research Institute's (EBRI) *Quarterly Pension Investment Report (QPIR)*, for four years ending September 30, 1986, multiemployer retirement plan investment portfolios produced an average annual rate of return of 16.6 percent, based on market value. This overall result reflected annual earnings of 23.3 percent on equities and 16.1 percent on fixed income holdings. These equity and fixed income results compared favorably with broad stock and bond market averages over the four-year period. In the first three quarters of 1986 alone, the funds earned 13.8 percent overall, with 16.0 percent and 15.0 percent on the equity and fixed income portions, respectively. These rates reflect the bulk of the funds' assets but exclude certain

nonmarketable holdings, such as insurance company investment contracts.

As of September 30, 1986, the invested assets covered by *QPIR* were 27 percent invested in equities (i.e., common stocks and convertible securities), 45 percent in bonds, 5 percent in cash and 23 percent in other investment vehicles. Multiemployer fund trustees tend to follow conservative investment policies; this is at least partly because plan contributions are fixed by collective bargaining agreements.

Funding

Plan contributions are normally made by the employers participating in the collective bargaining agreement. Occasionally, employees are required or permitted to make additional contributions to welfare plans (e.g., during short unemployment periods). The employer's contribution amount is determined through negotiations (e.g., $1 for each hour worked by each employee). All the contributions are pooled in a common fund that pays for the benefits provided. Investment earnings augment the fund. A multiemployer plan, by virtue of its size, often can undertake certain forms of investment that are not available to a small fund or a plan established by a single company employing only a few workers.

Companies participating in the same multiemployer plan usually make equal contributions. However, some large, national multiemployer plans provide several levels of benefits that require different levels of employer contributions. As a result of special circumstances, a company may be required to make higher contributions than other participating companies or its employees may receive lower benefits. For example, a company with a large number of older workers may join an established multiemployer pension plan. Such a company might be required to make higher contributions because of the substantial past service liabilities of its older workers who are approaching retirement.

Establishing the Plan

Once a union and various companies agree to set up a multiemployer plan, the first step is usually to negotiate how much each employer will contribute to the plan. Then, employer and union representatives, with an attorney's assistance, adopt a trust agreement (equivalent to a constitution) that: (1) establishes a board of trustees; (2) defines the board's powers and duties; and (3) covers the affairs

of both the trustees and benefit or pension plan. An attorney and an accountant will assist in establishing a trust fund to accept company contributions. Benefit and actuarial consultants will assist the trustees in working out plan details and determining a supportable benefit level. The trustees will probably retain a professional investment advisor or portfolio manager to ensure competent fund management. The trustees will also hire a salaried plan administrator and staff—or retain an outside administration firm—to manage the plan and handle day-to-day details, such as: (1) the collection of employer contributions; and (2) employee claims, payments and inquiries. Finally, the trustees must publish a booklet in lay language informing employees of plan benefits, eligibility rules and procedures for filing benefit claims.

Administrative Differences Between Multiemployer and Single-Employer Plans—The administration of a multiemployer plan differs from that of a single-employer plan. Multiemployer plans must establish procedures for obtaining information from all contributing employers. A central system for collecting contributions and maintaining employee records must be set up, and procedures must be established to flag delinquent contributors. For pension plans, a method of verifying all creditable past service must be devised.

Plan Administrators

Like a corporation's board of directors, a board of trustees sets overall plan policy and gives direction to the plan's activities. As previously mentioned, the trustees employ an administrator and various advisors (e.g., lawyers, accountants, actuaries and consultants) to assist them. These experts provide the technical information that the trustees need to make informed policy decisions.

Trustees are responsible for proper fund management. Trustees may delegate certain of their duties and functions, including the management of plan funds; but they bear ultimate responsibility for all actions taken in their names. Fund management is a serious responsibility, since vast sums of money may be involved and pensions or other benefits of hundreds or thousands of people are at stake. Trustees are bound by rigid rules of honesty and performance. They are required by law to act on behalf of plan participants as any prudent person familiar with such matters (i.e., financial affairs) would act. These same requirements apply to any advisors who manage plan funds.

Industry Practices

There is frequently more than one multiemployer plan within each large industry. Multiemployer plans may cover industry employees on a national, regional or local basis.

Transferral of Pension Credits—Normally, pension credits cannot be transferred from one multiemployer plan to another in the same industry, unless the trustees of the various plans have negotiated reciprocity agreements. Under such agreements, a worker can shift from employer to employer and among different plans without losing pension credits.

About 75 percent of the workers covered by health, welfare and pension programs in the construction industry were covered by reciprocity agreements in 1983. Many other multiemployer plans are also industrywide in nature. Still others are adopting reciprocity agreements at an accelerating rate as international unions continue to encourage these arrangements.

Multiemployer plans generally have benefit patterns that are similar to the patterns negotiated by large international unions like the United Auto Workers or Steelworkers. Benefits are normally defined in terms of a dollar amount that is related to an employee's length of service (e.g., $15 per month, per year of service). Often there is a maximum on the number of years of service credited (e.g., twenty-five or thirty years). In the example cited, a thirty-year employee would be entitled to $450 per month (i.e., $15 × 30).

About 75 percent of multiemployer plans (with 65 percent of multiemployer plan workers) base benefits on length of service and do not base benefits on earnings level. This is partly because the range of earnings for workers covered by multiemployer plans tends to be narrower than for workers covered by single-employer plans. Under multiemployer plans, the need to keep individual earnings records is eliminated; the contribution rate for all employees is usually identical.

Vesting—The provision in the Tax Reform Act of 1986 that requires either five-year vesting or seven-year graded vesting, effective in 1989, makes an exception for multiemployer plans. Instead, multiemployer plans are only required to provide 10-year cliff vesting.

Normal Retirement Age Under Multiemployer Plans—A DOL study disclosed that about 98 percent of those covered by multiemployer plans must reach a specific age to qualify for a retirement benefit. Nearly 75 percent were in plans where normal retirement was at age 65; nearly 20 percent were in plans where normal retirement was

before age 65. Five out of eight participants were in plans that allowed retirement after 15 years of service, providing participants also met the age requirements.

Early Retirement Options—Virtually all multiemployer plans provide an option for early retirement. Employees who choose this option will usually receive a reduced pension benefit. A few multiemployer plans allow workers to retire after working a stated length of service, such as 30 years, regardless of age. A person whose coverage under a *service* plan begins at 24 could, therefore, be eligible to retire with full benefits at 54—an earlier age than under a conventional multiemployer or single-employer plan.

Restrictions—Most multiemployer plans restrict retirees in their jurisdictions from working in the same trade or industry while receiving pensions. The restriction is to prevent retirees from competing for jobs with active workers or practicing their skills in the nonunion sector of the industry. Under rules issued by the DOL, a multiemployer plan may suspend benefits for a retiree who completes forty or more hours of service in a month:

(1) in an industry where other employees covered by the plan were employed and accrued benefits under the plan, at the time benefit payments commenced or would have commenced, if the retired employee had not returned to employment;

(2) in a trade or craft where the retiree was employed at any time under the plan;

(3) in the geographic area covered by the plan, at the time benefit payments commenced or would have commenced, if the retired employee had not returned to employment.

Advantages of Multiemployer Plans

Employee Advantages—Multiemployer plans provide certain advantages to employees. First, because so many companies contribute to multiemployer plans, they are less likely to terminate than single-employer plans. Consequently, multiemployer plans may provide greater assurance of permanence than single-employer plans. Moreover, recent legislation requires generally that employers continue contributions to multiemployer pension plans, even if the employers withdraw from the plan. Withdrawing employers may have to pay for a prorata portion of any unfunded vested benefits.[1]

[1]See discussion of *withdrawal liability* on page 38.

Second, multiemployer plans offer attractive portability features. Employees may carry pension credits with them as they move from company to company. Thus, they can earn pensions based on all accumulated credits, even if some of their former employers have gone out of business or stopped making plan contributions. Similarly, continuity of coverage can be assured for other benefits (e.g., medical insurance) when the worker switches jobs within the same industry.

Third, multiemployer plans provide an incalculable advantage to employees of small companies; these employees might not receive benefits if multiemployer plans did not make benefit programs affordable for small employers.

Fourth, the favorable tax treatment of health and pension benefits under single-employer plans also applies to the benefits employees receive under multiemployer plans. In many cases, single-employer plans cannot achieve the same results as multiemployer plans. Consider a highly mobile industry such as entertainment. An actor might work for the same employer for weeks or months, but probably not for the years needed to qualify for a pension. If the actor's various employers contributed toward a multiemployer pension fund, their contributions would eventually finance his or her pension coverage. Single-employer plans cannot accomplish this.

Employer Advantages—There are several advantages for employers who participate in multiemployer plans. First, economies can be achieved through group purchasing and simplified administration. Second, benefit and labor costs throughout a region or even an industry may be stabilized. This can help reduce employee turnover, because workers will not be attracted to other jobs by the promise of better benefits elsewhere. As with all benefit plans qualified by the Internal Revenue Service, company contributions to a multiemployer plan are tax deductible.

The economies for administration and group purchasing are substantial. If a single, small company were to sponsor a plan, the administrative costs might be 15 to 20 percent of total costs. For a typical multiemployer plan, the administrative costs generally amount to less than 5 percent. In addition to lowering administrative costs, a multiemployer plan reduces the per capita costs for consulting, actuarial, legal, accounting and investment advisory services.

Sometimes, competing companies participate in the same multiemployer plan. In fact, it is more common for competitors to participate in such plans than it is for miscellaneous firms. In certain highly competitive industries, such as garment manufacturing, par-

ticipation in a multiemployer plan is considered a distinct advantage to each company.

There is no maximum limit on the number of companies or workers who can participate in a multiemployer plan. There must be at least two companies and at least two employees, but there is no upper limit. Multiemployer plans may cover a small number of employees or as many as 500,000 employees; there may be thousands of participating companies.

Some plans are industrywide within a region (e.g., several states, a city or a county), and some cut across several related industries (e.g., crafts or trades in just one geographic area). Industrywide plans often cover a trade or craft rather than a national industry. However, some plans that embrace whole industries or a large part of an industry include those of the American Federation of Television and Radio Artists, Communication Workers of America, National Maritime Union, International Ladies Garment Workers Union, United Paperworkers International Union and Amalgamated Clothing Workers.

Nonnegotiated Plans—There is also a nonnegotiated multiemployer plan. These plans have been established by certain employers who have chosen on their own initiative to provide their employees with a benefit package. Nonnegotiated plans are quite common in the nonprofit area among religious, charitable and educational institutions.

Conclusion

Multiemployer plans have grown: (1) to meet the needs of people who seek pension security; (2) to assist in paying the medical expenses associated with illness or off-the-job accidents; and (3) to provide financial protection against untimely death. The years of explosive multiemployer plan growth are probably over. In the future, only incremental coverage growth will occur with relatively small numbers of new workers coming under multiemployer plan protection.

Multiemployer plans can be expected to grow, however, in certain industries. Dynamic industries such as entertainment, where employees work irregularly, offer favorable prospects for multiemployer plan growth. Additionally, small manufacturers, the retail trades and transportation—particularly mass transit—may experience substantial growth. Over the long term, service industries also offer potential opportunities for multiemployer plan expansion. In addition, some authorities have suggested that government unions might negotiate

benefits under a multiemployer plan setup that includes small municipalities.

There are also a few industries where the number of multiemployer plans is declining. Since passage of the 1974 Employee Retirement Income Security Act, some plans have terminated in the millinery, printing and milk delivery industries.

Additional Information

National Coordinating Committee for Multiemployer Plans
815 16th Street, NW
Suite 603
Washington, DC 20006

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VI. Defined Benefit and Defined Contribution Plans: Understanding the Differences

Introduction

Employers generally try to meet the retirement income needs of their employees by adopting either a defined benefit plan, a defined contribution plan or both.

Defined Benefit—In this type of plan, each employee's *benefit* is predetermined by a specific formula. Usually, the promised benefit is tied to the employee's earnings, length of service or both. For example, an employer may promise to pay each *vested* participant a pension equal to 1 percent of the employee's final five-year average salary, times number of years of service at retirement.[1]

Defined Contribution—There are several types of defined contribution plans (e.g., money-purchase pension, profit sharing (including 401(k) arrangements), savings or thrift and employee stock ownership plans).[2] In these plans, the employer's plan *contributions* are predetermined each year and allocated to individual accounts for employees. The allocation is usually determined by a percentage of each employee's earnings. The benefit payable at retirement is based on money accumulated in each employee's account. Such accumulated money will reflect employer contributions, employee contributions (if any) and investment gains or losses. The accumulated amount may also include employer contributions forfeited by employees who leave before they become fully vested, to the extent such contributions are reallocated to the accounts of employees who remain.

To illustrate the basic differences between the two approaches, the following discussion will focus on the major considerations involved in an employer's selection of the type of plan to be used.

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[1]For a definition of vesting, see pages 32–33.

[2]For more specific information on profit sharing, thrift, 401(k) and employee stock ownership plans, see chapters VIII, IX, X and XI.

The Major Differences

The important factors for understanding the differences between defined benefit and defined contribution plans include:

(1) achievement of retirement income objectives;

(2) plan cost;

(3) ownership of assets and investment risk;

(4) ancillary benefit provisions;

(5) postretirement benefit increases;

(6) employee acceptance;

(7) employee benefits and length of service;

(8) plan administration;

(9) taxes.

Achievement of Retirement Income Objectives—Many (perhaps most) employers feel that the primary objective in adopting a retirement plan is to provide future retirement income to employees. In addition, they have an interest in seeing that retirement income programs help to maintain organizational efficiency and vitality. Such goals require plans to be available for long periods of benefit accumulation. For career employees who do not change jobs frequently, the defined benefit plan provides a known result without employee risk. Defined benefit plans calculate the employee's ultimate retirement benefit based upon formulas. Examples of such formulas are:

(1) *Flat-Benefit Formula*—$12 a month per year of service;

(2) *Career-Average Formula*—1 percent of the employee's earnings up to the Social Security taxable wage base, plus 2 percent of earnings in excess of the Social Security taxable wage base for each year of service (or plan participation);

(3) *Final-Pay Formula*—1.5 percent of the employee's final five-year average earnings, times years of service (or plan participation), minus one-half of his or her primary Social Security benefit.[3]

Flat-benefit formulas are most frequently found in union-negotiated plans. Career-average and final-pay formulas are more

[3]For more information on these benefit formulas, see pages 46–47; also, see chapter VII.

often found in plans for salaried employees. Today, final-pay formulas are the most commonly used.

Employer-sponsored retirement plans do not guarantee that each employee's benefits will be sufficient to fully support the employee and/or his or her dependents throughout retirement. Defined benefit plans, however, provide employers with the ability to design plans that attempt to satisfy stated retirement income objectives.

Defined contribution plans are not designed specifically to provide stated retirement benefit levels. Instead, they prescribe the rate of employer and/or employee contributions and how these contributions are to be allocated to individual employee accounts. Such plans may rely totally upon employer contributions, or they may include the combined contributions of employees and employers. Here are some representative examples:

(1) *Defined Contribution Savings or Thrift Plan*—The employee may contribute up to 6 percent of his or her earnings each year, and the employer contributes an additional amount equal to one-half of the employee's contributions.

(2) *Defined Contribution Profit Sharing Plan*—Each year, the employer's total plan contribution is based on profits. This contribution is divided among employees in proportion to their respective earnings.

(3) *Defined Contribution Money-Purchase Pension Plans*—The employer contribution to the plan is stated as a percentage of employee salary. The plan may be integrated with Social Security by stating a lower percentage of salary up to the taxable earnings base, and a higher percentage above the base.

Under defined contribution plans, there is no way of knowing in advance the exact amount of assets that will be in the employee's account at retirement. The size of the account will be affected by the amounts contributed, the impact of investment gains or losses and the value of reallocated benefit forfeitures.

Employers adopt defined contribution plans:

(1) as a step toward achieving employees' retirement income security;

(2) to supplement an existing defined benefit plan;

(3) to avoid the long-term funding and liability commitments, as well as the more burdensome regulations of defined benefit plans;

(4) to create a program that provides benefits for short-term workers;

(5) as a tool to attract qualified employees or to control an excessive employment turnover rate.

Plan Cost—The employer who adopts a defined benefit plan accepts an unknown cost commitment. Numerous factors determine the cost of promised benefits, including the: (1) rates of return on investment; (2) number of employees working until retirement; (3) nature of future government regulatory changes; and (4) future employee pay levels.

The unknown cost aspect of defined benefit plans is often considered a deterrent. Employers minimize the unknown cost by projecting future interest earnings, mortality rates, personnel turnover and salary increases; thus, they attempt to establish a reasonably level funding pattern. Moreover, the plan's assets and liabilities are evaluated periodically (usually annually), and contribution adjustments can be made on a regular basis. Within legal limits, the employer is permitted to vary contributions from year to year. Therefore, defined benefit plan sponsors have a certain contribution flexibility; however, flexibility is not as great as it is under certain defined contribution plans.[4]

Defined contribution plan sponsors generally know the plan's true cost on a yearly basis. The employer pays an established amount on a regular basis; he does not have to be concerned about future costs. This cost control feature appeals to many employers—particularly to newer and smaller employers and to nonprofit educational institutions. Additional funding flexibility is possible by basing employer contributions on profits (i.e., through a defined contribution profit sharing plan) and, thus, permitting the employer to forego contributions in times of economic hardship.

Ownership of Assets and Investment Risk—The ownership of plan assets differs between defined benefit and defined contribution plans. In a defined contribution plan, contributions can be viewed as a deferred wage once an employee has become vested. The full vested value of each participant's account can be considered *owned* by the employee. Vested benefits are often distributable to employees upon employment termination. Defined contribution plan sponsors may be committed only to paying a stipulated contribution each year. It is the employee who bears the investment risk thereafter. Favorable investment results will increase benefits; unfavorable results will decrease benefits.

In a defined benefit plan, vested benefits can again be viewed as a deferred wage. It is here, however, that the difference in risk becomes important. Defined benefit plan sponsors assume an obligation for paying a stipulated future benefit. Consequently, the employer ac-

[4]For more information on contribution limits, see chapter IV.

cepts any investment risk involved in meeting this obligation. If the pension fund established to provide promised benefits earns a lower-than-expected yield, or if it suffers capital losses, the employer will have to make additional contributions. Because defined benefit plan sponsors are at risk for paying promised benefits, regardless of investment gains or losses, the employers can be viewed as owning the plan assets.

Ancillary Benefit Provisions—Although retirement plans are intended first and foremost to provide retirement income, they must, by law, make some provision for paying benefits in the event of a participant's death or preretirement termination. Most plans provide early retirement and disability benefits as well. To receive ancillary benefits, employees may be required to satisfy certain eligibility requirements; the law places limits on such requirements.

Under most plans, employees must work a specified length of time before they qualify for vesting. Defined benefit plans normally require longer waiting periods than defined contribution plans. Defined contribution thrift and profit sharing plans usually pay a vested employee's individual account balance in full upon death, employment termination, retirement or disability. Defined benefit and defined contribution pension plans frequently distribute the vested benefit as a stream of level monthly payments for life beginning at the time the employee retires—early, at the normal age or later.

Defined benefit plans can coordinate ancillary benefits with similar benefits from other types of plans. For example, if the employer has a three-times-pay group life insurance plan, or a long-term disability plan providing 60 percent pay continuance, a defined benefit pension plan can be designed to reflect such life insurance and disability protection.

Defined contribution plans also can be coordinated with other plans; but coordination is more difficult, and the *total* benefit in any given circumstance may be more or less than is intended or needed.

Postretirement Benefit Increases—During periods of inflation the pensioner's financial plight is brought into sharp focus. In such periods, retired employees living on fixed pensions, or on incomes derived from investing lump-sum retirement distributions, have been affected by the dollar's declining value. Automatic Social Security benefit increases have helped; but they frequently have not provided total retirement income increases comparable to inflationary increases for above-average earners.

Most employers are concerned about their retired workers' financial problems. Few, however, can afford to provide automatic cost-

of-living adjustments under their plans. Where automatic cost-of-living increases are provided, the initial benefit is generally reduced to balance the indexing feature's cost. If resources are available, many employers are willing to voluntarily grant periodic benefit increases after retirement to help offset inflationary effects; such ad hoc adjustments generally can be made easily.

Defined contribution thrift and profit sharing plan sponsors usually provide for lump-sum distributions at retirement, and defined contribution money-purchase pension plans may require that pension benefits be taken in the form of a fixed and/or variable annuity. Where lump-sum distributions are provided for, the employees may purchase fixed and variable annuities, or partially indexed annuities, with the latter usually requiring a reduction in the initial benefit amount.

Employee Acceptance—By nature, defined benefit plans are complex. Numerous government regulations—intended to protect employee rights—have added to the complexity.[5] Ironically, as a result of the complexity, many employees do not understand their plans; therefore, they do not value or appreciate them. Promised benefits often seem remote, and the current dollar value of benefits is not apparent.

As employees approach retirement, however, they may come to understand and appreciate their defined benefit plans. In some cases, though, employers conclude that defined benefit plans are too expensive; and they do not generate a fair return in terms of overall employee motivation and retention.

Defined contribution plans can also be complex. However, their complexity is less apparent. Defined contribution plan participants have individual accounts; their accounts have known values expressed in dollars—rather than benefit formulas. Benefit accumulations under thrift and profit sharing plans are usually payable in lump sums upon a vested participant's death, disability, employment termination or retirement. Instinctively, employees may prefer a $50,000 lump-sum cash payment to a $400 monthly benefit payment—even though the latter form of payment may produce an equal or greater value than the lump-sum payment. Defined contribution plans also offer flexibility. They can permit the employee to choose his or her benefit distribution among a variety of options (e.g., an annuity, a cash payment or a combination of both).

[5]For more information on such regulations, see chapters III and VII.

Employee Benefits and Length of Service—Defined contribution plans offer distinct benefit advantages to employees who change jobs frequently. Vesting provisions in these plans are generally liberal. Defined contribution plans usually provide at least partial vesting after two or three years of service. Additionally, vested benefits under thrift and profit sharing plans are normally paid in a lump sum at employment termination, but under pension plans may be required to be taken as a lifetime annuity. Prudent employees will be able to avoid the 10 percent additional income tax on preretirement distributions by rolling over the lump-sum distribution into an individual retirement account or another qualified retirement plan.

Alternatively, defined benefit plan participants usually do not become fully vested until they have completed 5 to 10 years of service. Instead of receiving vested benefits at employment termination, they receive deferred monthly income after they retire. The benefit amount is usually frozen at termination, and the employee is exposed to future inflationary effects.

Vesting provisions for private-sector, single-employer plans were changed, however, under the Tax Reform Act of 1986 (TRA) for plan years beginning after December 31, 1988. TRA requires faster vesting schedules for private-sector, single-employer plans. A plan can choose to meet one of two tests: (1) 100 percent vesting after five years of service; or (2) 20 percent after three years of service, with an additional 20 percent for each subsequent year of service until 100 percent vesting is achieved at the end of seven years of service.

Defined benefit plan benefit formulas frequently anticipate late-age hirings; some are designed to provide adequate retirement benefits for employees with as few as 20 or 25 years of service. This offers an advantage for the employee making a permanent job commitment relatively late in his or her career years (e.g., at age 40 or 45). Under defined contribution plans, employees hired at age 40 or 45 are less likely to accrue adequate benefits.

Plan Administration—Both defined benefit and defined contribution plans can be complex to administer; they usually require trained internal staffs as well as outside advisors. Defined contribution plans offer some administrative advantages over defined benefit plans. First, defined benefit plans require the use of complicated actuarial techniques, but defined contribution plans do not.

Second, provisions of the tax code and the Employee Retirement Income Security Act (ERISA) have less effect on defined contribution plans than on defined benefit plans. For example:

(1) Defined benefit plans must satisfy minimum funding standards. Generally, defined contribution plans do not have to satisfy these standards.

(2) Defined benefit plans must calculate and pay insurance premiums to the Pension Benefit Guaranty Corporation (PBGC) to protect employee benefits in the event of plan termination. Defined contribution plans are by nature fully funded; therefore, they do not present the risks of defined benefit plans and are not subject to the pension insurance program. This also makes it administratively easier to terminate a defined contribution plan because approval by the PBGC is not necessary.

(3) Defined benefit plans usually must provide more detailed and complicated actuarial disclosure reports than defined contribution plans, although now many defined contribution filings are as detailed and complex. Individual recordkeeping, especially where loan and withdrawal rights exist, can also pose complications for defined contribution plan administration.

Since the passage of ERISA, the administrative advantages of defined contribution plans have been considered significant by many employers and have influenced their selection of a defined contribution plan.

Taxes—For employers, the tax considerations under defined benefit and defined contribution plans are essentially the same. Under either plan, employer contributions—subject to certain statutory limits—are a deductible business expense in the year paid or accrued.[6]

For employees, too, the tax considerations associated with each plan are essentially the same. Employees do not pay taxes on employer contributions, investment income or capital gains of retirement plan assets until they receive benefits.

Employees, however, have traditionally paid taxes on their own plan contributions in the year such income was earned. Most private-sector, defined benefit plans do not require employee after-tax contributions, but public-sector, defined benefit plans commonly do require employee after-tax contributions.

Employee elective deferrals to qualified 401(k) salary reduction arrangements generally are not treated as current income to the employee and are not taxed until distribution. In such plans, an employee may take a pretax reduction in salary up to the plan's maximum allowable deferral (in no case more than $7,000), contribute the amount to the plan and thus reduce his or her gross income by the amount

[6]For more information on the statutory contribution limits, see pages 28–29.

of the deferral. Where a 401(k) arrangement also accepts employee after-tax contributions in addition to elective deferrals, the after-tax contributions are treated differently for tax purposes.

Under defined benefit and defined contribution plans, benefits are subject to tax when received by the employee.

If employees receive benefits in the form of monthly income—this is typical under defined benefit plans—ordinary income tax rates apply. The advantage here is that traditionally the employee has been in a lower-income tax bracket when retired than during his or her working years although this has become less likely under tax reform's two tax brackets (15 percent and 28 percent).

For employees receiving lump-sum distributions—this is more typical under defined contribution plans—the tax options have changed. TRA: (1) phases out capital gains treatment for lump-sum distributions over six years beginning on January 1, 1987; and (2) eliminates 10-year forward averaging for taxable years beginning after December 31, 1986, and instead, permits a *one-time* election of 5-year forward averaging for a lump-sum distribution received after attainment of age 59 1/2. Forward averaging is the ability to pay taxes on lump-sum distributions at a certain fraction of the marginal rate. Under a transition rule, a participant who attained age 50 by January 1, 1986, is permitted to make one election of 5-year forward averaging or 10-year forward averaging (at 1986 rates) with respect to a single lump-sum distribution without regard to attainment of age 59 1/2, and to retain the capital gains character of the pre-1974 portion of such a distribution. Under the transition rule, the pre-1974 capital gains portion would be taxed at a rate of 20 percent. TRA also imposes a 15 percent excise tax on distributions to an individual in excess of specified limits (currently up to $150,000 in a year, or $750,000 if a lump sum).

The tax consequences depend on the form of benefit payment—not on the type of plan. Lump-sum distributions are treated the same, for example, whether paid from a defined benefit or a defined contribution plan.

Income distributions that are attributable to employee contributions are not taxed in retirement if such contributions were made from after-tax income.

Conclusion

In the past, defined benefit plans were generally adopted as the primary vehicle for meeting employees' retirement income needs.

More recently, due to changes in legislation, in public attitudes and in the economy, the emphasis appears to be shifting to defined contribution plans. An increasing number of employers believe that the most effective retirement program combines the two types of plans—making maximum use of the particular cost and benefit advantages of each.

An employer could, for example, adopt a defined benefit plan that provides a modest level of benefits and supplement these benefits with a defined contribution thrift, profit sharing or salary reduction plan. The employer's cost risk under the defined benefit plan is minimized, while the two plans combine benefits to satisfy income adequacy standards.

An employer with a defined contribution plan could adopt a defined benefit plan; the latter plan would guarantee a minimum level of retirement benefits (e.g., 40 percent of final pay). In this case, the defined benefit plan is called a *floor plan*. Its purpose is to counteract potential benefit deficiencies in the primary plan (i.e., the defined contribution plan). Under this approach, minimum benefit objectives can be met with certainty, but cost control is reduced. Slight deficiencies in expected benefit levels under the defined contribution plan can result in sharp cost increases under the floor plan.

Employers might also choose just one plan that incorporates characteristics of both defined benefit and defined contribution plans. For example, cash balance pension plans are defined benefit plans offering features common to defined contribution plans, and target benefit plans are defined contribution plans doing just the opposite.

Defined benefit and defined contribution plans offer distinct advantages for employers and employees. Individual circumstances will determine which type of plan is adopted.

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VII. Integrating Pension Plans With Social Security*

Introduction

The majority of private pension plans and a significant number of public plans coordinate their benefits with Social Security. This coordination is known as integration. Through integration, employers can design pension formulas that: (1) take into account Social Security benefits; and (2) produce a combined pension and Social Security benefit that attempts to replace a desired portion of preretirement income.

The requirements for integrated plans will change substantially for plan years beginning after 1988. This chapter describes the integration of plans prior to that time. A final section describes the 1989 requirements under the Tax Reform Act of 1986 (TRA).

Table 1 shows Social Security benefits for workers at four earnings levels. It also gives these workers' *Social Security replacement rates* (i.e., the portion of final year's gross income that is replaced by Social Security benefits).

The Social Security benefit formula is weighted to favor low-income workers. This produces the higher replacement rates shown for the lower earners in table 1. The replacement rate is 52 percent for workers with final average annual earnings of $8,000; it is 22 percent for those with final average annual earnings of $37,500. Integrated pension formulas are designed to help close such replacement rate gaps. For example, some pension plans use an *offset* integration formula.

Offset Plans

Offset integration formulas are used with defined benefit plans. In offset plans, employers: (1) calculate an employee's pension benefit based on the plan's benefit formula; and (2) subtract an amount (traditionally a portion of the employee's Social Security benefit) from

*This chapter draws heavily from James H. Schulz and Thomas D. Leavitt, *Pension Integration: Concepts, Issues and Proposals* (Washington, DC: EBRI, 1983).

TABLE 1
Social Security Benefits and Replacement Rates for Workers Retiring at Age 65[1]

	Average Annual Earnings[2]	Final Year's Earnings	Social Security Benefit	Social Security Replacement Rate[3]
Worker A[4]	$ 8,000	$ 8,958	$4,644	52%
Worker B[4]	16,000	17,916	7,284	41
Worker C[5]	37,500	42,000	9,228	22
Worker D[6]	112,500	126,000	9,228	7

Source: Donald S. Grubbs, Jr., F.S.A., Grubbs and Company, Inc., Silver Spring, MD.
[1] Assumed to retire at the beginning of 1987.
[2] Average of highest five years of earnings, which in these hypothetical examples are the last five years.
[3] Benefit divided by final year's earnings.
[4] Annual earnings are assumed to increase at a rate of 6 percent per year.
[5] Worker earns the taxable wage base in all years.
[6] Worker earns three times the taxable wage base in all years.

his or her calculated pension benefit. This determines the actual employee pension.

Table 2 illustrates an offset plan's impact on long-term workers. It uses a benefit formula that first calculates a benefit equal to 50 percent of final average earnings. In a second step, the formula subtracts 50 percent of the employee's Social Security benefit from the pension benefit calculated in the first step.

The offset's effect is apparent in column (5). As earnings increase, the pension plan replaces a greater portion of preretirement earnings. Note, however, that the *combined* Social Security and pension benefit replacement rate—shown in column (7)—remains significantly higher for lower-income workers.

All replacement ratios shown in this chapter are based on the final year's gross pay. If these replacement ratios were adjusted for taxes to determine the percentage of after-tax pay that is replaced, all percentages would be higher and the differences between the high-paid and low-paid employees would be less.

Under pre-1989 Internal Revenue Service (IRS) regulations, a worker's normal retirement benefit may be reduced by a maximum offset of 83 1/3 percent of his or her Social Security primary insurance

TABLE 2

Pension Benefits, Pension Replacement Rates and Total Replacement Rates for Workers in a Pension Plan with a 50 Percent Offset[1]

	Gross Benefit Prior to Offset (1)	Social Security Benefit (2)	Offset = (2) × .5 (3)	Final Pension Benefit = (1) − (3) (4)	Pension Replacement Rate[2] (5)	Total Benefit (2) + (4) (6)	Total Replacement Rate[3] (7)
Worker A	$ 4,000	$4,644	$2,322	$ 1,678	19%	$ 6,322	71%
Worker B	8,000	7,284	3,642	4,358	24	11,642	65
Worker C	18,750	9,228	4,614	14,136	34	23,364	56
Worker D	56,250	9,228	4,614	51,636	41	60,864	48

Source: Donald S. Grubbs, Jr., F.S.A., Grubbs and Company, Inc., Silver Spring, MD.

[1] Calculations assume workers retired at age 65 on January 1, 1987. Calculations also assume that plan provides a benefit equal to 50 percent of final average earnings, minus 50 percent of Social Security benefits. Final average earnings represent the average of the highest five years, which in these hypothetical cases are the last five years. See table 1 for the value of the high-five average and final year's earnings in each case.

[2] Benefit divided by final year's earnings.

[3] Social Security and final pension benefit divided by final year's earnings.

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amount (the benefit payable at age 65 with no reductions for early retirement). The most commonly used offset, however, is 50 percent. Sometimes, offset formulas result in no pension benefits below certain earnings levels.

Employers can also integrate pension benefits with Social Security benefits by using *excess* and *step-rate excess* integration formulas.

Excess Plans

Excess formulas are used with both defined benefit and defined contribution plans. Unlike offset plans, excess plans do not directly deduct Social Security benefits in calculating pension benefits. Instead, in determining employer benefit accrual or contribution rates, *pure* excess plans give no credit to lower earnings. This is intended to counteract the effects of Social Security, which gives more credit to lower earnings than to higher earnings. Pure excess plans do not provide pension benefits for workers with earnings below a certain level. Benefits are based on a percent of earnings above the *maximum integration level.* Pure excess plans will not be permitted after 1988.

Maximum Integration Level—The maximum integration level is the highest earnings level that the IRS will allow a qualified pension plan to exclude for benefit accrual or contribution purposes. This level increases each year with changes in the *taxable wage base.* The taxable wage base is the maximum amount of earnings on which Social Security taxes and benefits are paid. For pension plans that base benefits on a percentage of each year's *actual* annual compensation, the maximum integration level is the current Social Security taxable wage base. The 1987 taxable wage base is $43,800. In defined benefit plans that base benefits on a percentage of final *average* salary, the maximum integration level is known as *covered compensation.* For each employee, covered compensation is the average of taxable wage bases beginning in 1959 (or age 30 if later) and ending with the year the employee reaches age 64. In this case, the maximum integration level is $15,732 for persons reaching age 65 in 1987. The IRS also allows rounding of the covered compensation level to the nearest multiple of $600. In 1987, this alternative produces a maximum integration level of $15,600, which is used in the examples in this chapter.

The integration level may be static or dynamic. If it is static, it remains at a fixed level despite changes in the taxable wage base. If it is dynamic, it changes in response to increases in the taxable wage base. In inflationary times, plans with static integration levels become less integrated each year. This happens because the benefit

accrual or contribution rate is applied to a greater portion of earnings each year.

Integration Percentage—The integration percentage is the percent applied to earnings above the integration level, which is used to calculate benefits or contributions in an excess or step-rate excess plan. IRS imposes a maximum limitation on integration percentages.

Defined Benefit Excess Plans—Two types of excess formulas are used in defined benefit plans: (1) *Flat-Benefit Excess;* and (2) *Unit-Benefit Excess*.

(1) *Flat-Benefit Excess Plans*—Flat-benefit excess plans must be based on an average earnings period. Originally, five years was the minimum period that could be used in averaging earnings. It is now permissible to use four or three consecutive years for averaging earnings. The maximum integration percentage, however, must then be reduced by 5 and 10 percent, respectively.

In flat-benefit excess plans, up to 37½ percent of average earnings above the integration level may be paid to participants with at least fifteen years of service. For participants with less than 15 years of service, the maximum percentage is 2½ percent for each year of service. Thus, the maximum for a participant with twelve years of service is 30 percent (i.e., $12 \times 0.025 = 0.30$).

Table 3 shows pension and total replacement rates produced by a fully integrated flat-benefit excess formula for four hypothetical workers. Since this plan does not provide benefits to people with average earnings below $15,600, Worker A receives no pension benefit. As with fully integrated offset plans, however, *total* replacement rates decline with increasing average earnings.

(2) *Unit-Benefit Excess Plans*—Unit-benefit excess plans determine benefit accrual in terms of *each year* of credited service. Benefits may be based on *actual* earnings each year. In this case, up to 1.4 percent of earnings above the integration level may be paid to a participant. Alternatively, benefits may be based on *average* earnings. If benefits are based on earnings averaged over at least five years, up to 1 percent of earnings above the integration level may be paid. Table 4 illustrates benefits for 30-year workers in a fully integrated unit-benefit excess plan, which uses average earnings.

For a worker with 37½ years of credited service, the unit-benefit formula used for table 4 becomes equivalent to the flat-benefit formula in table 3. However, these formulas produce markedly different results for workers with fewer years of service. For example: A worker with 20 years of service, who participates in the unit-benefit excess plan, will receive a benefit equal to 20 percent of average earnings above the integration level. If the same worker participates in the flat-benefit excess plan, he or she will receive a benefit equal to 37½ percent of average earnings above the integration level.

TABLE 3

Pension Benefits, Pension Replacement Rates and Total Replacement Rates for Workers in a Flat-Benefit Excess Plan[1]

	Average Annual Earnings (1)	Integration Level (2)	Pension Benefit = [(1)−(2)] × .375 (3)	Pension Replacement Rate[2] (4)	Total Replacement Rate[3] (5)
Worker A	$ 8,000	$15,600	$ 0	0%	52%
Worker B	16,000	15,600	150	1	41[4]
Worker C	37,500	15,600	8,213	20	42
Worker D	112,500	15,600	36,338	29	36

Source: Donald S. Grubbs, Jr., F.S.A., Grubbs and Company, Inc., Silver Spring, MD.

[1] Calculations assume workers retired at age 65 in 1987 with at least 15 years of service. Calculations also assume that plan provides a benefit equal to 37½ percent of final average earnings above an integration level of $15,600. Final average earnings represent the average of the highest five years, which in these hypothetical cases are the last five years. See table 1 for the value of the high-five average and final year's earnings in each case.

[2] Benefit divided by final year's earnings.

[3] Social Security and pension benefit divided by final year's earnings.

[4] Does not add to sum of column (4) and Social Security replacement rate in table 1 due to rounding.

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TABLE 4
Pension Benefits, Pension Replacement Rates and Total Replacement Rates for Workers in a Unit-Benefit Excess Plan[1]

	Average Annual Earnings (1)	Integration Level (2)	Pension Benefit = .01[(1)−(2)]×.30 (3)	Pension Replacement Rate[2] (4)	Total Replacement Rate[3] (5)
Worker A	$ 8,000	$15,600	$ 0	0%	52%
Worker B	16,000	15,600	120	1	41[4]
Worker C	37,500	15,600	6,570	16	38
Worker D	112,500	15,600	29,070	23	30

Source: Donald S. Grubbs, Jr., F.S.A., Grubbs and Company, Inc., Silver Spring, MD.

[1] Calculations assume workers retired at age 65 with 30 years of service in 1987. Calculations also assume that plan provides a benefit equal to 1 percent of final average earnings per year of service above an integration level of $15,600. Final average earnings represent the average of the highest five years, which in these hypothetical cases are the last five years. See table 1 for the value of the high-five average and final year's earnings in each case.

[2] Benefit divided by final year's earnings.

[3] Social Security and pension benefit divided by final year's earnings.

[4] Does not add to sum of column (4) and Social Security replacement rate in table 1 due to rounding.

Plan sponsors may, therefore, choose among integration formulas in order to achieve particular business and social goals. A sponsor interested in retaining skilled workers for the longest possible period may prefer to use a unit-benefit excess formula. He or she may choose this formula because it provides a higher percentage of average earnings for each additional year of service. On the other hand, a sponsor interested in quickly maximizing benefits to higher-paid workers may choose a flat-benefit excess formula. This formula can provide full benefits after just 15 years of service.

Defined Contribution Excess Plans—In a defined contribution excess plan, benefits are based on the accumulated value of employer and/or employee contributions. Employer contributions to these plans cannot exceed 5.7 percent of an employee's earnings above the integration level. The limit is based on the Old-Age, Survivors and Disability Insurance (OASDI) payroll tax rate. This rate equals the Social Security (FICA) tax (7.15 percent in 1987) minus the amount attributable to Medicare Hospital Insurance, which is 1.45 percent in 1987.

Step-Rate Excess Plans

Step-rate excess plans are similar to the excess plans just described. Unlike pure excess plans, however, the benefits of step-rate plans may accrue or contributions may be made on earnings *below* as well as *above* the integration level. In step-rate excess plans, *all* participants receive a pension benefit.[1]

In one sense, a step-rate excess plan is two plans: (1) it is a non-integrated plan providing proportionately equal benefits to all workers with earnings below the integration level; and (2) it is an excess plan providing additional benefits to those with earnings above the integration level. Restrictions on benefit accrual and contribution percentages apply *only to the excess* part of the formula. They are related to the limits in pure excess plans.

In flat-benefit step-rate formulas, the accrual rates on average earnings above the integration level may be up to 37½ percent more than the accrual rates on average earnings below the integration level. Similarly, maximum accrual rates on earnings above the integration level may be up to: (1) 1.0 percent greater than accrual rates on earnings below the integration level in unit-benefit plans using av-

[1]Even a pure excess plan would provide benefits to all participants if they all had earnings above the integration level.

erage earnings; (2) 1.4 percent greater than accrual rates on earnings below the integration level in unit-benefit plans using each year's actual annual compensation; and (3) 5.7 percent (OASDI rate) greater than contribution rates on earnings below the integration level in defined contribution plans.

Table 5 shows benefits and replacement rates for workers at various earnings levels in a fully integrated, unit-benefit step-rate excess plan, using average earnings.

Adjustments to Maximum Integration Percentages

In deriving maximum integration percentages and offsets, the IRS has assumed that the employer-funded portion of Social Security benefits (i.e., primary and ancillary) is equal to 37½ percent of final earnings for workers at the Social Security taxable wage base. The basic assumption underlying the concept of integration is that an employer should be able to fund a proportionate annuity for workers whose earnings are above the taxable wage base. However, the provisions of many integrated plans—if used in conjunction with maximum integration percentages—would raise the value of benefits above the 37½ percent limit. Consequently, the use of these provisions requires downward adjustment of maximum integration percentages. Six types of provisions require such adjustment:

(1) normal retirement at ages lower than 65;

(2) early retirement with benefit reductions that are less than actuarial reductions;

(3) integrated disability benefits payable before age 65;

(4) employer-paid, integrated preretirement death benefits;

(5) normal forms of annuities other than straight life;

(6) earnings periods that are averaged over less than five years in excess plans.

Upward adjustment of maximum integration percentages for excess plans is allowed if the plan has integrated employee contributions.

TABLE 5
Pension Benefits, Pension Replacement Rates and Total Replacement Rates for Workers in a Unit-Benefit Step-Rate Excess Plan[1]

	Average Annual Earnings (1)	Integration Level (2)	Benefit on Earnings below Integration Level = .01 × [lower of (1) or (2)] × 30 (3)	Benefit on Earnings above Integration Level = .02 × [(1) − (2)] × 30 (4)	Pension Benefit (3) + (4) (5)	Pension Replacement Rate[2] (6)	Total Replacement Rate[3] (7)
Worker A	$ 8,000	$15,600	$2,400	$ 0	$ 2,400	27%	79%
Worker B	16,000	15,600	4,680	240	4,920	27	68
Worker C	37,500	15,600	4,680	13,140	17,820	42	64
Worker D	112,500	15,600	4,680	58,140	62,820	50	57

Source: Donald S. Grubbs, Jr., F.S.A., Grubbs and Company, Inc., Silver Spring, MD.

[1] Calculations assume workers retired at age 65 with 30 years of service in 1987. Calculations also assume that plan provides a benefit equal to 1 percent of final average earnings below an integration level of $15,600 per year of service and 2 percent of final average earnings per year of service above that level. Final average earnings represent the average of the highest five years, which in these hypothetical cases are the last five years. See table 1 for the value of the high-five average and final year's earnings in each case.

[2] Benefit divided by final year's earnings.

[3] Social Security and pension benefit divided by final year's earnings.

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Top-Heavy Plans

Top-heavy plans must provide minimum, nonintegrated benefits or contributions to plan participants who are not key employees.[2] The minimum benefit for nonkey employees in defined benefit plans is 2 percent of average annual compensation for each year of service—not to exceed 20 percent of average annual compensation. The minimum contribution for nonkey employees in defined contribution plans is the lesser of 3 percent of compensation or the highest contribution rate for a key employee.

Tax Reform Act of 1986

TRA changes all of the rules for integrated plans for benefits earned in 1989 and later. The general thrust of the changes is to reduce the permitted disparity between the percentage of benefits or contributions for higher-paid and lower-paid employees.

For defined contribution plans, in addition to the old limit of 5.7 percent (the OASDI rate) in the contribution level above and below the integration level, there is a new requirement. The contribution percentage below the integration level must be at least half the contribution percentage above the integration level. Thus, pure excess plans will no longer be permitted. Also, the additional contribution percentage above the integration level is limited to the greater of the Social Security Old Age Insurance payroll tax rate at the beginning of the plan year (less than 5 percent in 1987) or 5.7 percent.

At the time of this writing, several aspects of the new requirements for integration of defined benefit plans depend upon technical corrections or regulatory clarification.

For defined benefit excess plans, the benefit percentage below the integration level must be at least half the benefit percentage above the integration level. In addition, the difference between the percentages of benefits above and below the integration level may not exceed 0.75 percent of pay times years of service (maximum 26.25 percent after 35 years). But this maximum allowable integration at age 65 is reduced for participants born after 1937, so that the 0.75

[2]Defined benefit plans are considered top-heavy when the present value of accumulated accrued benefits for key employees exceeds 60 percent of the present value of accumulated accrued benefits for all employees. Defined contribution plans are top-heavy when the sum of key employees' account balances exceeds 60 percent of all employees' account balances. Key employees are company officers or other individuals meeting specified ownership and earnings criteria.

percent factor becomes 0.65 percent for participants born in 1960 and later. The maximum integration level is limited to the Social Security wage base ($43,800 in 1987), with the maximum allowable integration being further reduced if the plan's integration level exceeds covered compensation.

For offset plans, the changes are more radical, and there is more uncertainty about the exact requirements at the time of this writing. The amount of allowable offset will no longer be determined as a percent of the Social Security primary insurance amount, but will be 3/4 percent of three-year-final-average pay for each year of service. The allowable percentage will vary with the level of compensation. In addition, the maximum allowable offset may not exceed one-half the amount of the benefit prior to the offset.

Unlike prior law, no adjustment in the maximum allowable integration is required to account for the form of annuity, death benefits, disability benefits or employee contributions. However, adjustments must still be made for early retirement if less than the actuarial reductions is applied.

Conclusion

With the escalating costs of employee benefits, Social Security and public assistance programs, concern over integration has expanded. The public has become more aware of private and public benefit program costs and their effects on our national productivity. Concern now focuses on equity, affordability and efficiency issues as well as on benefit adequacy.

Most employers believe integration is necessary to: (1) control total employer retirement income costs; and (2) design efficient retirement income programs that help correct overpensioning and underpensioning problems.

Additional Information

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VIII. Profit Sharing Plans

Introduction

A profit sharing plan is a type of *defined contribution plan*;[1] it plays a unique role in filling employee benefit planning objectives. Through these plans, employees share in their companies' profits; this may provide a strong incentive for increased employee productivity. Depending on plan design, profit sharing arrangements can provide supplemental income to employees and their families at death, disability, retirement, employment termination or at other times for personal use. This flexibility is another very attractive feature of profit sharing.

About 100 years ago, Pillsbury Mills and Procter & Gamble each established a *cash* (defined below) profit sharing plan. In 1916, Harris Trust & Savings Bank (Chicago) established the first *deferred* (defined below) profit sharing plan. In 1939, legislation clarified the tax status of deferred plans. This legislation and the World War II wage freeze resulted in rapid growth of profit sharing plans in the 1940s. Another major increase in the growth of profit sharing plans was caused by the 1974 Employee Retirement Income Security Act (ERISA). Since ERISA imposed less burdensome regulations on profit sharing plans than on pension plans, there was a substantial increase in pension plan terminations and in profit sharing plan creations.

Today, profit sharing plans continue to increase in popularity. The Profit Sharing Research Foundation estimates that by 1984, there were approximately 360,000 companies practicing deferred or combination profit sharing. Deferred plans cover approximately 20 percent percent of private, nonfarm employment. Plans exist in approximately 25 percent of manufacturing companies, 30 percent of retailing and wholesaling companies and in about 40 percent of banks.[2] Qualified deferred plans cover about 20 million employees; cash plans cover about 2 million employees. A substantial portion of deferred plans provide for some direct cash payments to participants.

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[1]Defined contribution plans are discussed in chapter VI.

[2]This includes thrift plans, which share many characteristics of profit sharing plans. Thrift plans are discussed in chapter IX.

Types of Profit Sharing Plans

There are three basic types of profit sharing plans:

(1) *Current or Cash Plan*—At the time profits are determined, benefits are paid directly to employees in the form of cash, checks or stock. (Typically, benefits are paid at the end of a fiscal year.)

(2) *Deferred Plan*—Contributions are credited to employee accounts and paid out as benefits at retirement or at the time of other specified events (e.g., death, disability or employment termination).

(3) *Combination Plan*—A portion of the benefit is paid in cash and another portion is placed in an account until the employee's retirement or other specified event.

For tax purposes, Internal Revenue Service (IRS) qualification of profit sharing plans is restricted to deferred or combination profit sharing plans. Therefore, the remainder of this chapter will focus primarily on these two types of profit sharing arrangements.

Plan Design

To satisfy government regulations[3] and employee benefit objectives, profit sharing plans must be designed with the following questions in mind: Who is covered? How will employer contributions be determined? How will contributions be allocated? How and when will benefits be paid?

Vesting—Deferred profit sharing plans must define employee vesting rights. The Tax Reform Act of 1986 (TRA) requires that profit sharing plans satisfy one of two vesting rules: (1) 100 percent vesting after five years of service, or (2) 20 percent after three years of service, with an additional 20 percent for each subsequent year of service until 100 percent vesting is achieved at the end of seven years of service.

TRA also provides that the current maximum waiting period for plan participation of three years for plans with full and immediate vesting will be reduced to two years of service. If a plan requires an employee to complete more than one year of service (aside from a waiting period that a plan may require prior to an enrollment date) as a condition of participation, the employee must be 100 percent vested when the benefit is accrued.

[3]See chapter IV for details.

Plans with class-year vesting[4] will not meet qualification standards of TRA unless, under the plan schedule, the participant's total accrued benefit becomes nonforfeitable as rapidly as under one of the previously described two vesting schedules.

All of the tax reform provisions discussed above are generally applicable for plan years beginning after December 31, 1988, with respect to participants who perform at least one hour of service after the effective date. A special effective date applies to plans maintained pursuant to a collective bargaining agreement.[5]

Coverage—Qualified profit sharing plans that have age and service requirements must meet ERISA's minimum standards (i.e., the plan must cover all employees who are age 21 with one or more years of service). Depending on plan characteristics, participation may be limited to specific employee groups, providing it satisfies nondiscrimination requirements that have been revised under TRA.[6]

Employer Contributions—When employers establish profit sharing plans, they must intend for the plan to be permanent. Although employers can amend or terminate plans, if a plan is terminated shortly after its inception for other than business reasons, IRS may construe that the plan was not established for the benefit of all employees. This could result in tax consequences.

Allocation of Employer Contributions

Plans must define how employer contributions will be allocated to employee accounts. The allocation formula is generally based on compensation. Allocations may be determined by calculating the proportion of each employee's compensation, relative to the total compensation of all plan participants. For example, if the employee earns $15,000 annually and total annual compensation for all participants is $300,000, he or she will receive 5 percent of the employer's annual contribution.

Some plans base their allocations on compensation *and* service credits. These plans must be very careful to assure that the wage/service formula does not result in discrimination in favor of the pro-

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[4]See footnote on page 32 for a definition.

[5]Under a collective bargaining agreement ratified before March 1, 1986, the amendments are not effective for plan years beginning before the earlier of: (1) the later of (a) January 1, 1989, or (b) the date on which the last of the collective bargaining agreements terminates; or (2) January 1, 1991. Extensions or renegotiations of the collective bargaining agreement, if ratified after February 28, 1986, are disregarded.

[6]See chapter IV for coverage rules.

hibited group. Whether a plan uses compensation or compensation and service in determining allocations depends on an employer's objectives. If employee retention is a primary goal, this can be reflected in a pay-and-service allocation formula. Allocation formulas may be integrated with Social Security, within prescribed limits.

For the present, dollar limits under section 415—the lesser of $30,000 or 25 percent of compensation for annual additions to defined contribution plans—along with combined plan limits, have been retained under TRA. TRA modified the provision of tax law that regulates the maximum amount that an employer may contribute for employees and deduct for federal tax purposes. If a company has both a profit sharing and a defined benefit pension plan covering the same employees, the combined tax-deductible contributions to both plans generally cannot exceed 25 percent of all covered employees' compensation.

Also, an employer's contribution to a profit sharing plan for plan years beginning after December 31, 1985, is not limited to the employer's current or accumulated profits (this provision applies without regard to whether the employer is tax-exempt, although tax-exempt employers who did not adopt a cash or deferred arrangement before July 2, 1986, are no longer allowed to do so under TRA). Treasury may require defined contribution plans to contain provisions that specify whether they are pension or discretionary contribution plans.

TRA repeals the limit carryforward for profit sharing and stock bonus plans effective for employer tax years beginning in 1987. Accordingly, if an employer's contribution for a particular year is less than the maximum amount for which a deduction is allowed, the unused limit may not be carried forward to subsequent years as under prior law. TRA does not change the rules relating to deduction carryforwards of contributions in excess of the deduction limit for a particular year. Any amount paid into a profit sharing or stock bonus trust in excess of the 15 percent deduction limit for the year may be deductible in succeeding taxable years to the extent allowed. Such contributions, however, may subject to the 10 percent nondeductible excise tax that TRA imposes on excess contributions to a tax-qualified pension, profit sharing, stock bonus, or annuity plan for employer taxable years beginning after December 31, 1986. Excess contributions are defined as the sum of: (1) total amounts contributed for the taxable year over the amount allowable as a deduction for that year; and (2) the amount of excess contributions for the preceding year, reduced by amounts returned to the employer during the year, if any, and the portion of the prior excess contribution that is deductible in

the current year. In other words, if an excess contribution is made during a taxable year, the excise tax would apply for that year, and for each succeeding year to the extent that the excess is not eliminated. Excess contributions for a year are determined at the close of the employer's taxable year and the tax is imposed on the employer.

Employee Contributions

Pure profit sharing plans do not require employee contributions, but many profit sharing plans do permit voluntary employee contributions. Employee contributions in the form of a salary reduction arrangement are becoming increasingly popular. This is a result of the 1978 Revenue Act (and subsequent regulations in 1981) that permit employee contributions with pretax income to profit sharing plans.[7] TRA makes extensive changes in what can be contributed to qualified plans, although for most low- and moderate-income individuals saving for retirement, these changes will not have a major effect. For highly compensated individuals, they could have a major effect.

Again, the maximum amount of combined tax-deductible contributions that may be made to defined contribution plans generally cannot exceed the lesser of 25 percent of compensation for the year, or $30,000. Also, any after-tax employee contributions now count dollar-for-dollar as annual additions under this limit; they also must comply with special nondiscrimination rules.[8] Adjustments to the $30,000 limit will begin when the current defined benefit dollar limit of $90,000 has been increased, due to cost-of-living increases, to $120,000.

A new limit for most plans on includible compensation will have the effect of isolating a greater portion of executives' benefit expectations from those of the rank and file. TRA imposes a limit of $200,000 on the amount of compensation that can be used to determine allowable contributions and benefits, and for the nondiscrimination rules starting in 1989. The $200,000 limit will be indexed to track the defined benefit plan limits beginning in 1990.

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[7]Profit sharing plans that utilize the salary reduction approach are known as 401(k) arrangements. Salary reductions are treated as employer contributions for tax purposes and must satisfy Internal Revenue Code regulations applicable to such arrangements.

[8]The special nondiscrimination rules for employee after-tax contributions are the same as the nondiscrimination rules for 401(k) arrangements (see chapter X).

Investments

Profit sharing funds may be invested in a wide variety of vehicles including corporate stocks, bonds, real estate, insurance products and mutual funds. Unlike qualified pension plans, profit sharing plans may invest more than 10 percent of their assets in employer securities. Therefore, contributions are frequently invested in employer securities. This practice may give participants an increased interest in the firm's success.

Plan assets can be held in one fund or in several funds. The plan sponsor usually has responsibility for developing broad investment policies. The trustee (e.g., bank) is usually responsible for the actual investment of plan assets.

Investment risk is assumed by the participant since employers do not guarantee benefit levels in profit sharing plans. Some employers permit participants to select among two or more investment options.

Distributions

Retirement, Disability and Death Benefits—The law requires that participants' account balances fully vest at retirement. In addition, plans generally provide for full benefits upon death and disability. The plan's vesting provisions determine whether an employee will receive full or partial benefits upon other types of employment termination. However, if the plan is *contributory* (i.e., employees make contributions), the employee will always receive the benefits that are attributable to his own contributions.

Profit sharing plans typically give retiring participants and beneficiaries of deceased participants a choice of up to three benefit payment options: (1) annuities; (2) installments; or (3) lump-sum distributions. Usually, those who terminate employment for reasons other than retirement, death or disability receive lump-sum distributions, although if the benefit exceeds $3,500, the participant cannot be forced to take an immediate lump-sum distribution.

Withdrawals—Although withdrawal provisions are more common in thrift plans, some profit sharing plans provide for partial account withdrawal during active employment. Plans allowing participants to elect account withdrawals impose certain conditions; these conditions vary widely. Withdrawal provisions must be designed with care, or they may defeat the plan's major objectives (e.g., whether the plan is intended to provide for retirement income or capital accumulation). Permissible withdrawal amounts are usually the value

of employee contributions or employee and vested employer contributions. Withdrawal provisions are also likely to change because of the recent modification of their tax treatment, and, in particular, the pro rata recovery of employee contributions discussed below.

TRA phases out capital-gains treatment for lump-sum distributions over five years beginning January 1, 1987, and eliminates 10-year forward averaging, replacing it with a one-time election of five-year forward averaging for lump-sum distributions received after attainment of age 59½.

TRA provides significant penalties for early distributions from qualified plans. It applies a 10 percent additional income tax to most early distributions made before death, disability, or attainment of age 59½. The 10 percent additional tax does not apply to certain distributions: (1) in the form of an annuity or installments payable over the life or life expectancy of the participant (or joint lives or life expectancy of the participant and the participant's beneficiary); (2) made after the participant has separated from service on or after age 55; (3) used for payment of medical expenses deductible under federal income tax rules; (4) received in a lump-sum before March 15, 1987, if made on account of separation of service in 1986 if the recipient elects to be taxed on the distribution in 1986; or (5) made to or on the behalf of an alternate payee pursuant to a qualified domestic relations order. A distribution rolled over to an IRA or to another qualified plan will not be subject to additional tax.

Minimum distribution rules were also established under TRA, whereby distributions must begin by April 1 of the calendar year following the calendar year in which the individual attains age 70½. There are also rules about the minimum distribution required during a taxable year. A 50 percent nondeductible excise tax will be imposed in any taxable year on the excess of the amount that should have been distributed over the amount that actually was distributed. The tax will be imposed on the individual required to take the distribution.

Additionally, there are certain legal restrictions on withdrawal provisions. For example, employees cannot generally make withdrawals of employer contributions that have been held in the fund for less than two years. Profit sharing plan sponsors must design withdrawal provisions that consider administrative costs, satisfy IRS qualification requirements and comply with the new tax law.

TRA imposes a 15 percent excise tax on the aggregate amount of annual distributions (excluding basis recovery and rolled-over amounts) to an individual in excess of $112,500 in 1987, or 1.25 percent of the indexed defined benefit plan limit. Under a complex transition rule, the

tax will either not apply to "excess" benefits accrued before August 1, 1986, or the applicable dollar threshold will be increased to $150,000. A separate limit is used for a lump-sum distribution where 5-year or 10-year forward averaging treatment is used for income tax purposes. For such a lump sum, a 15 percent excise tax applies if the lump sum exceeds five times the annual threshold in effect the year in which the distribution is received (e.g., 5 × $150,000 = $750,000).

TRA also: (1) modifies present-law basis recovery rules for amounts distributed prior to a participant's annuity starting date to provide pro rata recovery of employee contributions; this means employees can no longer withdraw nontaxable employee contributions only; (2) eliminates the special three-year basis recovery rule of present law; (3) modifies the general basis recovery rules for amounts paid as an annuity to provide that each distribution is treated in part as recovery of employee contributions and in part as payment of taxable employee contributions; and (4) restricts rollovers of partial distributions to distributions due to separation from service. The new basis recovery rules do not apply to employee contributions made prior to January 1, 1987, to the extent that, on May 5, 1986, such contributions were available for distribution under a plan before separation of service.

TRA also includes a "separate contract rule" that applies to plans accepting both pretax and after-tax contributions. The rule allows the employee's after-tax contributions, and the earnings on those contributions, to be treated as a separate "plan" for purposes of the pro rata rule. Thus, only the percentage represented by earnings on the after-tax contribution would be taxable.

Loans—Some plans permit employees to borrow a portion of their vested benefits. In general under TRA, the employee must repay the loan according to a level amortization schedule with payments made at least quarterly. If loans are permitted, they must be available to all participants on a comparable basis, and they must bear a reasonable interest rate. (The 1982 Tax Equity and Fiscal Responsibility Act included additional loan requirements for qualified profit sharing plans, and TRA precludes a deduction for loan interest paid on loans made to a key employee.)[9]

Taxation

In general, taxation of distributions from qualified profit sharing plans is the same as taxation of distributions from qualified pension

[9]For a detailed description of loan provisions for qualified plans, see chapter IV.

plans.[10] Employer contributions are tax deductible to the employer. Employer contributions and investment earnings or gains on employee/employer contributions are not taxed to the employee until actually received. Employee contributions may be made from after-tax or pretax income.

There are also limits on the amounts that an employer can contribute annually for individual participants. These limits only affect highly paid employees.[11]

Integration of Profit Sharing Benefits With Social Security Benefits

Profit sharing plan benefits can be integrated (i.e., coordinated) with Social Security benefits through one of two methods: (1) a pure *excess* formula; or (2) a *step-rate excess* formula.[12] In an excess formula, contribution allocations are provided only to employees who earn income above the maximum Social Security taxable wage base ($43,800 in 1987). In a pure excess formula, the maximum allowable employer contribution is currently 5.7 percent of each participant's compensation above the taxable wage base. Employer contributions, as well as the reallocation of benefits forfeited by nonvested terminating participants, must be included in the 5.7 percent maximum.

Under a step-rate excess formula, all employees participate in the profit sharing plan, but a larger percentage of compensation is allocated relative to earnings above the integration level than to earnings below the taxable wage base. The maximum difference in the permitted contribution to the two groups is 5.7 percent. For example, if an employer contributes 5 percent of each participant's earnings below the taxable wage base, the maximum contribution that can be made on each participant's earnings above the wage base is 10.7 percent. In a step-rate excess plan, the reallocated benefits forfeited by terminating employees are *not* included in the 5.7 percent contribution differential.

When the contribution formula is expressed as a percentage of profits, rather than of compensation, a variation of the excess or step-rate excess integration methods is used. Additionally, if an employer has a profit sharing and a pension plan, the combined integration under the two plans cannot exceed 100 percent of the permitted in-

[10]For information on taxation of pension plan distributions, see pages 42–43.
[11]See discussion on ERISA's contribution limits for defined contribution plans, pages 28–29.
[12]For a more detailed discussion of these integration formulas, see chapter VII.

tegration of one plan. Integrated profit sharing plans, however, are rare.

For plan years beginning after December 31, 1988, TRA provides that a plan is not to be considered discriminatory merely because the contributions and benefits under the plan favor highly compensated employees, if the plan meets new disparity limits. Under TRA, the contribution percentage below the integration level must be at least half the contribution percentage above the integration level. Thus, pure excess plans will no longer be permitted. For step-rate excess plans, a defined contribution plan meets the disparity limits for integrated plans only if the excess contribution percentage above the integration level does not exceed the base contribution by more than the lesser of either (1) the base contribution percentage, or (2) the greater of 5.7 percentage points or the percentage equal to the Social Security Old Age Insurance payroll tax rate (currently less than 5 percent).

Conclusion

From the employee's point of view, a cash profit sharing plan is a form of contingent bonus. If profits are good, benefits are paid. Plan sponsors should understand, however, that after several years of successful plan performance, there is some danger employees could view their benefits as a certainty and *spend* anticipated benefits before they materialize.

Deferred plans are more complex. They are generally intended to supplement other benefit plans. They sometimes attempt to fill many needs; and in doing so, they may not succeed in satisfying specific goals. For example, a plan that permits liberal withdrawals can result in modest capital accumulation or retirement benefits.

Profit sharing provides unique incentives for employee productivity. It helps raise employee awareness about the importance of profits; thus, employees may work harder and more effectively to enhance the company's success. Profit sharing plans may create a favorable attitude among employees, greater job satisfaction and work force stability.

In profit sharing plans, employer costs need be incurred only when (and to the extent that) profits are substantial enough to justify benefits. In deferred plans, the company's financial commitment ends with its contribution and with prudent investment of plan assets.

Because of their advantages to both employees and employers, profit sharing plans will continue to play an important role in employee benefits planning.

Additional Information

Profit Sharing Council of America
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IX. Thrift Plans

Introduction

A thrift plan is a type of *defined contribution plan.*[1] The Internal Revenue Code (IRC) considers thrift plans to be a type of profit sharing plan.[2] Thus, what are commonly called profit sharing plans and thrift plans are very similar. Differences between the two plans include:

(1) Thrift plans generally *require* employees to make contributions in order to be a participant—profit sharing plans do not.

(2) Since thrift plans often require employee contributions, they normally cost the employer less than profit sharing plans.

Employees generally make periodic contributions to thrift plans. Employee contributions are often matched (completely or in part) by employer contributions. These contributions are placed in a trust fund and invested. For record-keeping purposes, each participant's savings and investment earnings are assigned to an individual account.

Matching employer contributions provide a strong incentive, and employees have found thrift plans to be an attractive way of saving. In addition, the tax-favored treatment of employer contributions and investment gains makes these plans effective capital-accumulation vehicles.

Coverage, Participation and Vesting

Thrift plans, as qualified retirement plans, must comply with minimum coverage, participation and vesting standards. The 1986 Tax Reform Act (TRA) made major changes in these rules generally beginning in 1989.

Coverage rules are designed to ensure that a retirement plan does not disproportionately cover and benefit employees who are officers,

[1]Thrift plans are also known as savings and investment savings plans. Defined contribution plans are discussed in chapter VI.
[2]Profit sharing plans are discussed in chapter VIII.

shareholders or highly compensated. TRA standardized the rules for all types of qualified retirement plans.[3]

Participation in a plan must be allowed to employees who have attained age 21 and have one year of service. Plans with full and immediate *vesting* may require as many as three years of service before participation begins. In plan years beginning after December 31, 1988, the maximum service requirement is lowered to two years. In actual practice, participation usually depends on some minimum service requirement. Employees are usually able to participate after a short service period, such as six months or a year. Maximum age requirements are not permitted.

Until December 31, 1988, employer contributions may vest according to one of three standards under the Employee Retirement Income Security Act (ERISA): (1) 10-year rule; (2) 5-to-15-year rule (sometimes called the graded 15-year rule); or (3) rule of 45.[4] Additionally, the 1982 Tax Equity and Fiscal Responsibility Act requires certain plans to use more accelerated vesting and to provide minimum contributions in years when the plan primarily benefits key employees.[5] Most plans practice more liberal policies and permit employees to fully vest upon retirement, death or disability regardless of age and service. (A plan must provide full vesting at normal retirement age.) As in other qualified employee benefit plans, employee contributions are always fully vested. If a participating employee terminates without full vesting, the forfeited employer contributions may be reallocated among employees, or they may be used to reduce employer contributions.

Beginning with plan years after December 31, 1988, employer contributions must vest according to one of two schedules: (1) 100 percent after five years of service or (2) 20 percent after three years of service and 20 percent after each subsequent year of service until 100 percent vesting is achieved at the end of seven years of service.[6]

Employee Contributions

Most thrift plans are *contributory*; to participate, eligible employees agree to make voluntary contributions. Employee contributions to

[3]A detailed description of coverage rules for qualified plans is in chapter IV.
[4]For a definition of these vesting rules, see pages 32–33.
[5]Key employees are company officers or other individuals meeting specified ownership and earnings criteria.
[6]The vesting rules are applicable for employer contributions to most qualified plans. Multiemployer plans may satisfy different vesting standards: the 1986 Tax Reform Act requires ten-year vesting. See chapter V for more information on multiemployer plans.

thrift plans are of two types: (1) *basic contributions*, which are matched by employer contributions; and (2) *supplemental contributions*, which are not matched by employer contributions. Depending on the plan's structure, the employee's contributions can be made from after-tax income or through pretax income in the form of a salary reduction.[7] Employee contributions are generally made through payroll deductions.

Sometimes the employer requires participants to contribute a specified percentage of pay. More often, however, employees are permitted to choose a contribution level of between 1 percent and 6 percent of pay. Supplemental employee contributions above the maximum basic contribution level may also be allowed. The law permits supplemental employee contributions of up to 10 percent of pay, plus the lowest rate of basic employer contributions.

After providing reasonable notice to the employer, employees may be permitted to change or suspend contributions. Most plans restrict the frequency of such changes (e.g., they may be limited to once a year). When employees suspend contributions, the suspension is often limited to a six-month period.

Employer Contributions

Employers can make contributions to a thrift plan through a number of arrangements. Employer contributions usually are defined as a fixed percentage of each dollar of basic employee contributions, although they can be defined as a flat-dollar amount. The matching percentage may be the same for all employees, or it may increase with years of service or participation. The most common employer contribution is 50 percent of the basic employee contribution; however, many employers provide either lower or higher contribution amounts. Under a different approach, employers may provide: (1) a contribution matched (partially or fully) to an employee's contribution; and (2) a supplemental contribution based on profits. Under a relatively uncommon approach, employer contributions are based entirely on profits. The level of the employer's matching contribution

[7]Thrift plans that utilize the salary reduction approach are commonly referred to as 401(k) arrangements. Contributions made through salary reduction are treated as employer, not employee, contributions. There are special rules governing these arrangements, which are discussed in chapter X.

appears to be the most important factor in influencing eligible employees to elect to participate.[8]

Investments

Most thrift plans offer more than one investment option and are allowing the participant flexibility in choosing among options. In some cases, employer contributions must be placed in a designated investment vehicle, and flexibility is permitted only with regard to employee contributions. Popular investment vehicles include company stock, fixed-dollar investment accounts, guaranteed investment contracts through insurance companies and equity funds.

Many plans permit employees to change their investment elections. Where permitted, such a change may be limited to investment of future contributions or it may apply to both past and future contributions. An employee generally is permitted to change his or her election at the time investment funds are valued. The question of whether to provide investment alternatives depends on the plan's objectives and its role in the company benefit package.

Distributions

Retirement, Disability and Death Benefits—The law requires that participants' account balances fully vest at the plan's normal retirement age. In addition, plans generally provide for full benefits upon death and disability.

Thrift plans typically give retiring participants and beneficiaries of deceased participants a choice of up to three payment options: (1) annuities; (2) installments; or (3) lump-sum distributions. Usually, those who terminate employment for reasons other than retirement, death or disability receive lump-sum distributions, although if the benefit exceeds $3,500, the participant cannot be forced to take an immediate lump-sum distribution.

Withdrawals—Some plans provide for account withdrawals during active employment. Plans that allow such account withdrawals impose certain conditions, which vary widely. Withdrawal provisions must be designed with care, or they may defeat the plan's major objectives (e.g., whether the plan is intended to provide for retirement income or capital accumulation). Permissible withdrawal amounts

[8]Bankers Trust Company, *Bankers Trust Company 1977 Study of Employee Savings and Thrift Plans* (New York, 1977), p. 15. Other important factors influencing participation are vesting provisions and the degree of investment flexibility.

are usually the value of employee contributions or employee and vested employer contributions. Withdrawals prior to age 59½ (with some exceptions) are subject to a penalty tax. (See "Taxation" section below for a more detailed description.)

Additionally, there are certain legal restrictions on withdrawal provisions. For example, employees generally cannot make withdrawals of employer contributions that have been held in the fund for less than two years. Thrift plan sponsors should design withdrawal provisions that consider administrative costs and satisfy Internal Revenue Service qualification requirements.

Loans—Some plans permit employees to borrow a portion of their vested benefits. Generally, the employee repays the loan according to a specified repayment schedule. If loans are permitted, they must be: (1) available to all participants on a comparable basis; (2) adequately secured; and (3) made by the plan (i.e., not by a third party such as a bank). Loans from thrift plans must bear a reasonable interest rate. Recent legislation has placed further restrictions on loans.[9]

(1) Loans for more than $10,000 may not exceed one-half of the present value of the employee's nonforfeitable accrued benefit, subject to an overall loan maximum of $50,000.

(2) Loans must be repaid under a level amortization schedule within 5 years, with payments at least quarterly.

(3) The only allowable exception to the 5-year repayment rule is to acquire a primary residence of the employee.

Taxation

Qualified thrift plans are regulated by the IRC and ERISA. If the plan is qualified, employer contributions are tax-deductible to the employer. Employer contributions and investment earnings or gains on employee/employer contributions are not taxed to the employee until actually received. In plans with after-tax employee contributions, distributions are taxable on a pro rata basis. Distributions made before the annuity starting date will be allocated in the same proportion that the individual's total after-tax employee contributions bear to the total value of his accrued benefit or account balance.

[9]For a detailed description of restrictions on loans from thrift plans and all qualified plans, see chapter IV.

Withdrawals before age 59½ are subject to a 10 percent additional tax unless the distribution is (1) in the form of an annuity or installments payable over the life or life expectancy of the participant (or the joint lives or life expectancy of the participant and the participant's beneficiary); (2) made after the participant has separated from service, on or after age 55; (3) used for payment of medical expenses to the extent deductible under federal income tax rules; (4) received in a lump sum prior to March 15, 1987 if made on account of separation from service in 1986 and the recipient elects to treat the distribution as paid in 1986; or (5) made to or on behalf of an alternate payee pursuant to a qualified domestic relations order. A distribution that is rolled over to an individual retirement account or to another qualified plan will not be subject to this tax.

The maximum amount that an employer may contribute for all employees and deduct for federal tax purposes is 15 percent of compensation. If a company has both a thrift plan and a defined benefit pension plan covering the same employees, the combined tax-deductible contributions to both plans cannot exceed 25 percent of all covered employees' compensation.

There are also limits on the amounts that an employer can contribute annually for individual participants.[10]

Plan Administration

The administrative complexity of a thrift plan depends on its design. Individual participant account records must be maintained, and annual account statements must be provided to employees. Administrative complexity varies with the number of employee options (e.g., contribution rates, investment vehicles and the frequency of permitted changes). Larger plans usually use computerized record systems—sometimes these are internal, at other times they are provided by an outside consulting, financial or administrative service organization. Administrative responsibilities are often divided between the employer and an outside organization. As a plan matures and its trust fund grows, it is frequently necessary to hire an investment manager and an internal liaison.

Conclusion

Thrift plans can play a major role in a firm's total benefit program. They may function as the principal retirement income vehicle, or

[10]See discussion on ERISA's contribution limits for defined contribution plans, pages 28–29.

they may provide supplemental retirement income. In the past, thrift plans could also provide savings to be used in financing a house or a vacation; the flexible characteristics of thrift plans offered employees and employers freedom to adapt the plan to their needs. Now, because of tax reform changes imposing a tax penalty on lump-sum withdrawals before 59½ and requiring pro rata recovery of employee after-tax contributions, use of thrift plans to generate nonretirement savings will be less desirable.

Additional Information

The Wyatt Company. *Top 50: A Survey of Retirement, Thrift and Profit-sharing Plans Covering Salaried Employees at 50 Large U.S. Industrial Companies as of January 1, 1986*. Washington, DC: The Wyatt Company, 1986.

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X. 401(k) Cash or Deferred Arrangements

Introduction

A qualified cash or deferred arrangement (CODA), under section 401(k) of the Internal Revenue Code (IRC), allows an employee to elect to have a portion of his or her compensation (otherwise payable in cash) contributed to a qualified profit sharing, stock bonus or pre-ERISA money-purchase pension plan. The employee contribution is treated not as current income, but most commonly as a pretax reduction in salary, which is then paid into the plan by the employer on behalf of the employee. In some cases, an employer may contribute a portion of the company's profits to the plan on behalf of the employee. Whatever portion is not contributed to the plan may be taken in cash. In both instances, the employee defers income tax on the 401(k) contribution until withdrawal.

Various forms of deferred compensation have existed for years. As early as the mid-1950s, cash or deferred option profit sharing plans using pretax employee contributions were permitted by the Internal Revenue Service (IRS) as long as at least half of the participants electing to defer were in the lowest paid two-thirds of all plan participants. The primary advantage of these plans is the employee's ability to defer tax on a portion of income until a future time, when he or she might be able to pay tax at a lower marginal rate.

The IRS, departing from general tax principle — which treats income as taxable when it is *constructively received*, or made available, to an individual whether or not the individual actually received the income—determined that cash or deferred compensation would not be considered constructively received, and thus not currently taxed. This basic rule continued until late 1972, when the IRS issued a proposed regulation that would have reversed its prior position on constructive receipt and effectively eliminated tax-deferred income. There were a number of CODAs in existence at that time, so Congress, through the Employee Retirement Income Security Act (ERISA) of 1974, allowed the tax treatment of CODA plans in existence before June 28, 1974, to continue. New plan formation, however, was frozen

until Congress could study the use of cash or deferred compensation and its preferential tax treatment.

The Revenue Act of 1978 sanctioned cash or deferred arrangements (effective January 1, 1980) through the addition of section 401(k) to the Internal Revenue Code—hence the commonly used reference to this type of arrangement as a "401(k)" plan. Proposed regulations issued in November 1981 delineated new and more restrictive coverage and nondiscrimination requirements beyond ERISA's minimum standards for qualified benefit plans.

Although final IRS regulations are not published, the Internal Revenue Service has announced that employers can rely on the proposed regulations as guidelines in qualifying their 401(k) plans. The proposed regulations, however, leave open the interpretation of some distribution and coverage rules, and because of this, some employers have been reluctant to establish a 401(k) plan without final regulations. Nevertheless, there has been a significant growth in 401(k) plans since 1981. Forty-six of the nation's "top 50" companies had 401(k) plans in 1985,[1] although the incidence of salary reduction is probably greater in larger companies. A survey of medium and large firms by the Department of Labor[2] shows that 31 percent of full time workers in 1986 were eligible to make 401(k) contributions, up from 26 percent in 1985.

Types of 401(k) Arrangements

Although other forms of cash or deferred arrangements currently exist and may evolve in the future, there are four principal types of benefit plans to which section 401(k) is applicable: (1) thrift plans; (2) profit sharing plans; (3) "stand alone" salary reduction plans; and (4) as a part of cafeteria plans.[3]

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[1]The Wyatt Company, *Top 50: A Survey of Retirement, Thrift and Profit-sharing Plans Covering Salaried Employees of 50 Large Industrial Companies as of January 1, 1986.* Other surveys on the design features and plan experience of 401(k) plans include: Massachusetts Mutual Life Insurance, *401(k) Survey Report* (June 1985); Hewitt Associates, *Survey of Plan Design and Experience in 401(k) Salary Reduction Plans*, 1985; Towers, Perrin, Forster & Crosby, *What Makes 401(k) Plans Appealing? A Survey of Design Features and Plan Experience, January 1986.* See also the discussion of the Federal Reserve Bank of Atlanta survey, in Retirement Plans: Deferred Compensation's Popularity Soars," *Economic Review*, (October 1983): 34-43.

[2]U.S., Department of Labor, Bureau of Labor Statistics, "BLS Reports on Employee Benefits in Medium and Large Firms in 1986," USDL 87-130, March 31, 1987.

[3]These plan types are descriptive only. A plan utilizing section 401(k) must be part of a profit sharing, stock bonus or pre-ERISA money-purchase pension plan.

401(k) Thrift Plans—A thrift plan with a 401(k) feature is virtually identical in design to a typical conventional savings, or thrift, plan: the employee contributes a percentage of pay and the employer may provide a matching contribution.[4] The funds are held in trust and invested. In terms of taxation, however, the two plans are quite dissimilar. In a conventional thrift plan, contributions made by the employee are not tax deductible, although no tax is assessed to the employee on employer contributions or on the investment earnings of the plan account until benefits are paid from the plan. In a 401(k) thrift plan, an employee contributes a portion of pretax earnings through a salary reduction, and therefore, he or she can exclude the contribution to the plan from taxable income. The tax savings from this type of plan can be quite significant.

Profit Sharing Plans—Under a profit sharing plan[5] with a 401(k) feature, the employer generally makes an annual contribution derived from current or accumulated profits, although they are no longer necessary under the 1986 Tax Reform Act (TRA). Each eligible employee is allocated a portion of the total contribution generally based on the employee's compensation as a percentage of the total employer plan contribution. The employee has the option of taking the contribution, or some specified portion of it, in cash or contributing it to an individual account where it is held and invested until distribution. Any compensation taken in cash is currently taxable. Many plans also allow an employee to defer a portion of his or her monthly salary and contribute it to the account, thereby reducing taxable income. These "deferrals" are not taxed until distribution.

"Stand Alone" Salary Reduction Plans—Plan sponsors may set up a qualified savings plan funded solely through a salary reduction agreement with no employer contributions. This type of plan is sometimes referred to as a "stand alone" salary reduction plan, because it can be established with employee salary reductions exclusively. A "stand alone" plan allows an employee to defer a percentage of pretax earnings each year and the funds are held in trust until distribution. A conventional plan requires only employee contributions, but the most prevalent type of plan includes employer matching contributions.

Cafeteria Plans—Section 401(k) arrangements may be part of a qualified cafeteria plan, authorized under section 125 of the IRC. A cafeteria plan allows an employee to choose among a variety of benefit

[4]For more information on thrift plans, see chapter IX.
[5]For more information on profit sharing plans, see chapter VIII.

options (taxable and nontaxable). Typically, a plan includes benefits such as life insurance, medical/dental, disability, legal services, child care and cash. The employee is not taxed on the nontaxable benefits selected, but is taxed on the value of any taxable benefits he or she has chosen.

An employer who maintains both a 401(k) and a cafeteria plan may allow any cash paid from the cafeteria plan to be transferred to a 401(k) plan on a tax-sheltered basis. In addition, through a salary reduction arrangement, cafeteria plans may permit employees to purchase additional coverage with their own pretax dollars.[6]

Contributions

Contributions to a 401(k) plan can be of four types:

(1) Elective contributions—tax-excludible *employee* contributions (made by the employer on behalf of the employee) in the form of a salary reduction.

(2) Nonelective contributions—contributions made by the *employer* from employer funds. Sometimes these are made to help satisfy nondiscrimination tests (see below).

(3) Matching contributions—employer contributions that "match" employee contributions, although the employer does not always provide a full dollar-for-dollar match.

(4) Voluntary contributions—after-tax *employee* contributions not made through a salary reduction.

In general, each year the 401(k) plan participant can direct his or her contribution to a menu of investment choices that most often includes three fund options: (1) a fixed (or guaranteed investment) fund, which invests in a guaranteed interest contract with an insurance company; (2) a balanced fund, which is designed to provide stability as well as growth through an investment mix of stocks and bonds; and (3) an equity fund, which may have the most potential growth, but also the most risk. Investments in this fund are made only in stocks. The different funds allow the participant the option to direct investments toward his or her individual retirement planning goal. Other options include bond funds, money market funds,

[6]For more information on cafeteria plans, see chapter XXXI.

fixed income securities, real estate and company stock. The most prevalent investment choice appears to be guaranteed income funds.[7]

Employee elective contributions made with pretax dollars to a 401(k) plan are limited to $7,000 and are coordinated with elective contributions to simplified employee pensions, state and local government plans, tax-sheltered annuities and section 501(c)(18) trusts. Beginning in 1988, the $7,000 cap is adjusted for inflation by reference to percentage increases in the dollar limit under a defined benefit plan.[8]

The limits on total employer and employee contributions to a qualified 401(k) plan are governed by the same rules as other defined contribution plans (IRC section 415). In general, the sum of the *employer's* contribution (including the amount the employee elected to contribute through salary reduction plus any employer "matching" contributions) and any *after-tax employee* contribution may not exceed the lesser of 25 percent of an employee's compensation or $30,000. Before TRA, only a portion (6 percent) of the employee's after-tax contribution was counted in these limits. TRA also applies a limit of $200,000 on compensation that may be taken into account in determining the limit.

Distributions

The employee's ability to withdraw funds from a 401(k) plan is restricted. In general, distributions may be made before age 59½ only in the case of retirement, death, disability, termination of employment, plan termination (or sale of a subsidiary or substantially all the business' assets) or limited distributions for financial "hardship."[9] Distributions from a 401(k) plan can be in the form of an annuity in installments, in a lump sum or through a plan's loan provision.

Special Legal Requirements

Because a 401(k) arrangement is a qualified retirement plan, it must comply with coverage, participation, vesting and distribution rules.

Coverage—Section 401(k) arrangements must satisfy coverage rules designed to insure that highly compensated employees do not dis-

[7]See "Retirement Plans: Deferred Compensation's Popularity Soars" and Massachusetts Mutual, *401(k) Survey Report*, for a percentage breakdown of 401(k) funds among types of investment vehicles.

[8]For greater detail on inflation adjustments for defined benefit and defined contribution limits, see chapter IV.

[9]A more thorough discussion of 401(k) hardship rules follows later in this chapter.

proportionately benefit from the plan. TRA standardized coverage rules for all qualified retirement plans, effective for plan years after December 31, 1988.[10] In general, the rules require a plan to cover a specified percentage of employees who are not "highly compensated" as defined under the new law. In addition, TRA added a minimum participation rule that qualified plans must satisfy.

An employee is defined as "highly compensated" under TRA if at any time during the year or the preceding year, the employee: (1) was a 5 percent owner of the employer; (2) earned more than $75,000 in annual compensation from the employer; (3) earned more than $50,000 in annual compensation from the employer and was a member of the top-paid group of employees, the top 20 percent of employees by pay during the same year; or (4) was an officer of the employer and received compensation greater than 150 percent of the dollar limit on annual additions to a defined contribution plan ($45,000 in 1987). The $50,000 and $75,000 thresholds are indexed in the same manner as the indexation of the dollar limit for defined benefit plans under IRC section 415. Under a special rule designed for those who are newly hired or who receive increases in compensation, if an employee is not a 5-percent owner the top 100 employees by compensation during the current year and not highly compensated during the preceding year, then that employee is not treated as highly compensated for the year, but will be considered highly compensated for the following year if the employee otherwise falls within the definition of highly compensated.

Section 401(k) arrangements must also satisfy special nondiscrimination rules[11] that restrict the amounts the most highly compensated elect to defer—as a percentage of compensation—with the amounts deferred by the remainder of eligible employees. The rules are satisfied through a set of tests that must be run annually.

The test works this way: The eligible group of employees (defined as those employees who are eligible for employer contributions under the plan for that year) is divided into the highly paid and the lower paid. Then, within each group, the percentage of compensation that each employee is contributing to the plan is determined. The per-

[10]A detailed description of coverage rules for qualified plans as amended by TRA is in chapter IV.

[11]TRA modified the rules generally effective for plan years after December 31, 1986. In collectively bargained plan agreements ratified before March 1, 1986, the amendments are not effective for plan years beginning before the earlier of (1) January 1, 1989 or (2) the date on which the last of the agreement terminates (determined without regard to any extensions in the agreement).

centages for each employee are totaled and averaged to get an "actual deferral percentage" (ADP) for the group. The ADP for the high-paid group is then compared with the ADP for the low-paid group.

The actual deferral percentage test may be satisfied in one of two ways:

Test 1: The ADP for the eligible highly compensated may not be more than the ADP of the other eligible employees multiplied by 1.25.

Test 2: The excess of the ADP for the highly paid over the lower paid may not be more than 2 percentage points, and the ADP for the highly paid may not be more than the ADP of the lower paid multiplied by 2.

For example, if the actual deferral percentage for the lower paid group is 4 percent and the actual deferral percentage for the higher paid group is 6 percent, are the nondiscrimination rules satisfied?

Test 1: Because 6 percent (the ADP of the higher paid) is greater than 5 percent (4 percent x 1.25), test 1 is *not* satisfied.

Test 2: Because 6 percent (the ADP of the higher paid) is not more than 2 percentage points more than 4 percent (the ADP of the lower paid) *and* 6 percent is not more than 8 percent (the ADP of the lower paid multiplied by 2), test 2 *is* satisfied.

Because one of the tests has been satisfied, the special nondiscrimination rules are, therefore, satisfied.

The following table illustrates the maximum ADPs allowed for the top-paid employees, assuming various ADPs for the lower paid:

If the Average ADP and any Employer Contribution for the Lower Paid Is:	**The Maximum Average ADP (Including Any Employer Contribution) for the Top Paid Will Be**	
	Test 1	Test 2
½%	⅝%	1%
1	1¼	2
2	2½	4
3	3¾	5
4	5	6
5	6¼	7
6	7½	8
7	8¾	9
8	10	10
9	11¼	11
10	12½	12

"Fail Safe" Devices—A 401(k) plan may be designed to include a "fail-safe"mechanism, which allows plan sponsors to meet the special nondiscrimination tests using nonelective employer contributions.[12] This provision allows the use of employer contributions to ensure that the ADP tests are satisfied. These contributions must not circumvent the basic antidiscrimination rules applicable to qualified plans. In addition, such amounts, unlike regular nonelective employer contributions, must be 100 percent vested and subject to 401(k) withdrawal restrictions.

Such a provision must be used with care, however, because the excess amounts included in the ADP computation may cause the contributions to exceed the statutory employer deductible and individual participant limits.

Vesting and Participation—Under a qualified 401(k) plan, an employee's right to the portion of his or her accrued benefit (based on any elective contribution and any employer contributions used to satisfy the ADP tests) must be immediately and 100 percent nonforfeitable. Nonelective employer contributions that are not used to satisfy the ADP tests, however, do not need to be immediately and 100 percent vested. They must, however, vest in accordance with ERISA requirements.[13] Beginning in 1989, a plan cannot require, as a condition of participation, that an employee complete a service period greater than one year.

Distributions—One of the rules that has most concerned many employees and caused much discussion among employers is the limitation on withdrawals from a 401(k) plan. In a regular profit-sharing plan, generally, employer contributions held in trust for at least two years may be distributed to participants (but such distributions would be subject to income tax and possibly to an additional 10 percent tax if made before age 59½). Amounts deferred and held in trust in a 401(k) plan may not be distributed to participants or beneficiaries until the participant's retirement, death, disability, attainment of age 59½, termination of employment or financial "hardship."

The IRS proposed regulations define "hardship" as an "immediate and heavy financial need." In determining whether a plan participant has an "immediate and heavy need," there must be: (1) a heavy and immediate financial expense and (2) no other resources reasonably

[12]Employer contributions made for this purpose must be fully vested and satisfy the withdrawal limitations applicable to elective deferrals.
[13]ERISA vesting rules are described on pages 32–33.

available to satisfy that expense. The proposed regulations offer no additional explanation of the hardship rules, although final regulations, scheduled for release in 1987, will include a precise definition. Beginning in 1989, TRA limits hardship withdrawals to an employee's elective contributions made through salary reduction (not including income thereon).

Taxation

Contributions—Elective and nonelective contributions to a qualified section 401(k) arrangement are excludible from the employee's gross income until distribution. The employee thus defers federal income tax until the time he or she withdraws his or her benefit. The deferral of taxation applies also to most states and municipalities.[14] Voluntary employee contributions (i.e., those not made through a salary deferral), however, are presently taxable, and are limited to 10 percent of total salary. Any earnings generated by these contributions (elective, nonelective and voluntary) are also not taxed until withdrawal.

Until the end of 1983, employer contributions and employee contributions made through a salary reduction to a 401(k) plan were not considered wages for the purposes of Social Security (FICA) and unemployment (FUTA) taxes. The employee, therefore, was not currently taxed for FICA or FUTA on the contribution amount, and the employer incurred less payroll tax. The 1983 Social Security Amendments imposed FICA and FUTA taxes on 401(k) plan contributions made from salary deferrals.

The employer's total 401(k) plan contribution may be claimed as a deductible business expense up to the statutory limits defined under IRC section 404. Amounts contributed to the plan—elective and nonelective—may not exceed 15 percent of total participant compensation.

Distributions—The new rules governing withdrawals from a 401(k) plan may be a disincentive for some employees to contribute to the plan. Withdrawals before age 59½ are subject to a 10 percent additional tax unless the distribution is: (1) in the form of an annuity or installments payable over the life or life expectancy of the participant (or the joint lives or life expectancy of the participant and the par-

[14]State and local income tax law changes from year to year. For a list, albeit incomplete, of 401(k) income tax withholding rules for states and municipalities, see Commerce Clearing House, Tax Aspects of 401(k) Plans," *Pension Plan Guide*, Number 426, Part II, May 23, 1983.

ticipant's beneficiary); (2) made after the participant has separated from service on or after age 55; (3) used for payment of medical expenses to the extent deductible under federal income tax rules; (4) received in a lump sum prior to March 15, 1987 if made on account of separation from service in 1986 and the recipient elects to treat the distribution as paid in 1986; or (5) made to or on behalf of an alternate payee pursuant to a qualified domestic relations order. A distribution that is rolled over to an individual retirement account or another qualified plan will not be subject to this additional tax.

Beginning with plan years after December 31, 1988, hardship withdrawals are limited to the employee's elective deferrals (but not including income on those deferrals). As discussed earlier in the chapter, distributions may be in the form of a lump sum, an annuity, installments, or through a loan provision. The form of the distribution determines the tax treatment of the funds.

If the distribution is in the form of a lump sum, it may qualify for five-year averaging if received after age 59½. Distributions in the form of an annuity and partial distributions while a participant is still employed are taxed as ordinary income.

Five-Year Income Averaging—A one-time election of five-year averaging for a lump-sum distribution received after attainment of age 59½ is permitted. If a participant attained age 50 by January 1, 1986, he or she may make one election of five-year averaging or ten-year averaging (at 1986 tax rates) with respect to a single lump-sum distribution. Five-year income averaging allows an employee to separate the distribution into fifths, compute the income tax on one-fifth, and multiply the result by five. In effect, the employee is allowed to pay the tax on the distribution as if he or she had received it over five years, disregarding any other income he may receive during those years. The five-year forward income averaging rule can result in tax savings.

The following requirements must be met for a 401(k) distribution to qualify for five-year averaging:

(1) The employee has been a participant in the plan for five years (except in the case of death).

(2) The distribution is from a qualified plan.

(3) The distribution comes from all the employer's profit-sharing plans in which the employee had funds and constitutes the full amount credited to the employee.

(4) The distribution is paid in a single tax year.

(5) The distribution is paid for death, attainment of age 59½, termination of employment, or disability.

Rollovers—In general, distributions from a 401(k) plan may be rolled over to another qualified plan or to an IRA, if the transaction takes place within sixty days of the participant's receipt of the distribution. The entire distribution or any portion may be rolled over. No tax is paid on the portion rolled over until withdrawal from the IRA. Once a distribution is rolled over to an IRA, however, it cannot qualify for ten-year averaging.

Loans—Although withdrawals from a 401(k) plan are limited, some plans permit an employee to borrow a portion of their vested benefits. The rules governing loans from a 401(k) are the same as those for other qualified plans.[15] However, under TRA, no deduction for interest paid on loans secured with 401(k) elective contributions is allowed.

Plan Operation

The installation and operation of a qualified 401(k) plan can be a complex procedure and can be a drawback for some employers. The proposed regulations set forth specific requirements for the administration of each plan participant's 401(k) account. Under the regulations, a 401(k) plan must maintain separate accounting between the portion of the employees accrued benefit that is subject to the special vesting and withdrawal rules and any other (after-tax) benefits.

In each participant's account, depending on the structure of the plan, there may need to be a separate record for deductible employer contributions (elective and nonelective), nondeductible "voluntary" employee contributions, and vested and nonvested company contributions. Special rules exist for contributions made before 1980. The proposed regulations do not provide a detailed accounting method to be used, but they state that the accounting must allocate investment gains and losses on a reasonable pro rata basis and adjust account balances for withdrawals and contributions.

401(k) Arrangements, Worker Mobility and Cost Containment

In today's mobile society, 401(k) arrangements help meet the retirement income needs among workers who change jobs frequently

[15]For a detailed description of loan restrictions from qualified plans, see chapter IV.

and workers with intermittent labor force participation. Employee elective contributions to section 401(k) plans are, by law, fully and immediately vested. When employees terminate employment or change jobs, they can "roll over" the accumulated contributions and earnings of the plan into an IRA or another qualified plan. As a result, 401(k) arrangements may particularly benefit young workers with high labor-force mobility, and women who may leave the labor force for a protracted time.

Section 401(k) arrangements have also been used by employers as a way to provide additional retirement security for their employees without increasing overall pension costs. This has been accomplished by supplementing the employer's primary pension plan with a 401(k) arrangement that has little or no employer contribution. However, because TRA restricts preretirement withdrawals, employer contributions may become more common as a way to encourage employee participation.

Conclusion

401(k) plans provide a unique vehicle for accumulating retirement income. Their current preferential tax status makes them popular with employees, who can defer income tax on contributions until withdrawal. Employer contributions make 401(k)s even more attractive to employees. For many employees, however, the new restrictions on access to funds and the 10 percent additional tax on distributions before age 59½ may be a disincentive to use these plans for short-term savings, as opposed to saving for retirement.

As with other qualified retirement plans, employers can deduct contributions to a 401(k) plan as a business expense on their income tax. In addition it appears that employers view provision of a 401(k) plan as a way to maintain a competitive employee benefit package.

Recognizing the limitations of a 401(k) plan is essential to the consideration of adopting or participating in the plan. From the employee's standpoint, the major drawback is the restriction on withdrawals. The employer must deal with several issues, some unresolved and awaiting final regulatory action: (1) additional record-keeping procedures depending on the structure of the plan and the method used in satisfying the nondiscrimination rules; (2) provisions, if any, for a hardship distribution; and (3) loan provisions, if any.

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XI. Employee Stock Ownership Plans

Introduction

The employee stock ownership plan (ESOP) is an innovative way for employers to share company ownership with employees without requiring the employees to invest any of their own money. Since ESOPs are unique among employee benefit plans in their ability to borrow money, they are also being used with growing frequency as a technique of corporate finance. Because of tax benefits Congress has granted, ESOPs can provide the employer with a tax-favored financing vehicle that can significantly lower the cost of financing transactions, while providing employees with a significant equity position in the company.

Louis O. Kelso is generally credited with the creation of the ESOP concept. Kelso believed that ESOPs, by providing employees with access to capital credit, would broaden the distribution of wealth through free enterprise mechanisms. By making employees owners of the productive assets of the business where they work, Kelso reasoned that they would benefit from the wealth produced by those assets and would thus acquire both a capital income as well as an incentive for being more productive.

Kelso attracted a powerful ally in Sen. Russell Long (D-LA), who used his influence to spearhead the legislative efforts to promote ESOPs. Political support for the ESOP concept has grown steadily and Congress has encouraged ESOPs through a number of legislative initiatives, including the: (1) 1974 Employee Retirement Income Security Act (ERISA); (2) 1975 Tax Reduction Act; (3) 1976 Tax Reform Act; (4) 1978 Revenue Act; (5) 1981 Economic Recovery Tax Act (ERTA); (6) 1984 Deficit Reduction Act (DEFRA); and (7) the 1986 Tax Reform Act (TRA).

Leveraged ESOPs

A typical leveraged ESOP (an ESOP that involves borrowing funds to acquire stocks) usually works in the following way:

(1) The company adopts the plan, which must be designed to invest primarily in company stock.

(2) The company sets up an ESOP by creating a trust fund, managed by a trustee (e.g., a bank or other financial organization).

(3) A loan is arranged between the lender and the ESOP. The company guarantees repayment of the ESOP loan.

(4) The loan is used to purchase company stock at fair market value. The stock is pledged as collateral for the loan.

(5) The company seeks IRS approval of the plan, which certifies that the plan's provisions are in line with current law. For example, the plan cannot discriminate in favor of shareholders, officers and highly paid employees.

(6) The company makes regular contributions to the ESOP, which are used to repay the loan.

(7) Participants are allocated shares of stock. Each year, as company contributions are used to pay the loan, the stock originally purchased by the trust is allocated to participants, and it no longer acts as security for the loan.

(8) The shares are usually distributed to participants at retirement, death or job termination.

Other ESOPs

Some companies offer ESOPs that are not leveraged. These ESOPs do not use debt; the employer makes contributions to a trust that in turn invests in the company stock. Maximum employer contributions to an ESOP that is not leveraged are limited to 15 percent of covered compensation. When the employer also offers a pension plan, the maximum tax-deductible employer contribution to both plans cannot exceed 25 percent of covered compensation.

ESOPs that are not leveraged but which can be leveraged have been called "leverageable ESOPs."

Another class of ESOPs that are not leveraged is the tax credit ESOP, including Tax Reduction Act stock ownership plans (TRASOPs) and payroll-based employee stock ownership plans (PAYSOPs). TRA eliminates the tax credit that employers received for contributions to these plans for compensation paid or accrued after December 31, 1986, but a special transition rule is provided. Many of these plans will be maintained by employers as wasting trusts, or converted to other types of defined contribution plans, including non-tax-credit ESOPs.

Plan Design

As with all tax-qualified employee benefit plans, ESOPs must establish a trust to receive the employer's contributions to the plan and the plan must be created exclusively for the benefit of employees. ESOPs are a type of *defined contribution* plan,[1] and such plans allow a company flexibility in determining the amount of contribution that should be made to the plan each year. ESOPs that are not used to borrow money are generally qualified with the IRS as a *stock bonus plan* or a *combination stock bonus/money-purchase pension plan*.[2] Stock bonus plans may receive as much as 15 percent of payroll as an annual deductible contribution from the employer. With a leveraged ESOP, however, the deduction limit can be as much as 25 percent and more to allow an ESOP to repay its debt more quickly.

General pension rules[3] governing minimum coverage requirements, nondiscrimination, vesting and the taxation of employee benefits also apply to ESOPs, although there are several specific exceptions, as will be explained, provided to ESOPs that distinguish them from other types of employee benefit plans. The two key features that make ESOPs unique are their ability to borrow money and the requirement that the ESOP trust be invested primarily in the securities of the sponsoring employer. Other plans may be fully invested in employer securities, but ESOPs *must* be primarily invested in employer securities. The latter requirement is generally interpreted to mean that the ESOP should be at least 50 percent invested in the stock of the sponsoring employer on an ongoing basis.

Allocations to individual employee accounts are usually determined by calculating the proportion of each employee's compensation relative to the total compensation of all plan participants. Plan participation generally begins when the employee reaches age 21 and has completed at least one year of service with the company. Each participant's account is held in the ESOP trust until the employee leaves the company. Employees approaching retirement age (age 55) must be given an option of directing that up to 25 percent of their account balance be invested in diversified investments other than the

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[1] Defined contribution plans are discussed in chapter VI.

[2] Employees sometimes make contributions to ESOPs with pretax dollars in the form of salary reduction arrangements. ESOPs that utilize the salary reduction approach are known as 401(k) arrangements and must satisfy Internal Revenue Code regulations applicable to such plans.

[3] For more information on these pension rules, see chapters III and IV.

stock of the employer. Alternatively, the ESOP can distribute the amount that could be diversified.

The value of the ESOP stock in publicly traded companies is determined by the market price. Closely held companies[4] must have their stock valued on at least an annual basis by an independent appraiser.

ESOP participants in publicly traded companies must be given the right to vote their stock on all issues. Closely held companies are required to pass through voting rights to employees on major corporate issues, such as a sale of the company, refinancing, merger, etc.

Distribution Requirements

Distributions to departing employees must begin no later than one year after an employee retires or becomes disabled, or five years after an employee terminates for other reasons, unless the employee elects to defer the commencement of benefits. All or part of an employee's account may be payable, depending on years of service and the plan's vesting provisions. In the case of publicly traded companies, the employer may distribute stock which the employee may then sell on the open market.

In closely held companies for which there is no recognized market, employees must be given a put option on their stock which requires the employer to redeem the stock in cash. The put option requires the employer to purchase the stock back from the former employee in substantially equal terms over a period not to exceed five years. This period may be extended in the case of particularly large distributions.

Usually the employee has the right to receive his or her account value in as many whole shares of stock as possible, with the value of any fractional shares paid in cash. However, some plans allow the employee to take the entire amount in cash. In either case, payments can be made in a lump sum or in installments.

An employee who receives stock has all the ownership rights associated with that class of stock. Some plans of closely held companies *require* employees to give the company an opportunity to buy their shares at fair market value before selling such shares to anyone else. Some plans of closely held companies must provide the employee

[4]Closely held companies are generally those owned by a small number of people whose securities are not registered on a recognized exchange.

with the right to *demand* that the employer purchase the stock; therefore, the employee is assured of a market.

Dividends can be: (1) paid to participants in cash; (2) kept in the ESOP; or (3) used to repay the loan.

Taxation

ESOPs offer considerable tax benefits for both employer and employee. Companies can make tax-deductible contributions of up to 25 percent of covered employees' annual pay to repay loan principal, plus receive an unlimited deduction to repay interest. Contributions in excess of the deductible limits may be deductible in later years, within the maximum limits. If an employer provides both an ESOP that is not leveraged and a pension plan, the maximum tax-deductible contribution to both plans generally cannot exceed 25 percent of covered compensation.

Under a leveraged ESOP, the loan payments (both the principal and interest portions) are tax deductible to the employer, because they are treated as contributions to an employee benefit plan. These tax savings must be weighed against the increased cost to the employer of repaying the loan, if the employer is not the lender. However, since the passage of DEFRA, certain lenders may exclude from their taxable income 50 percent of the interest they receive on loans to ESOPs. Their savings may be passed along to the company in the form of lower interest charges.

Employers can also claim a tax deduction for dividends on ESOP stock paid directly in cash to participants or used to repay the ESOP loan. Dividend payments paid in cash to a participant are fully taxable to the employee. However, dividends retained in the trust are not taxed until they are paid out. Also, employer contributions to ESOPs are not taxable to employees until benefits are distributed.

To encourage the use of ESOPs to broaden corporate ownership, the law provides a number of tax incentives to encourage companies to adopt these plans. The most significant ESOP incentives are as follows:

(1) Qualified lenders to ESOPs may deduct from their taxes 50 percent of the interest income they earn on loans to ESOPs. As a result of this benefit, lenders are able to pass some of their savings on to the borrower, resulting in lower interest rates on ESOP loans.

(2) Major shareholders of stock in a closely held company can defer all taxes on the sale of stock to an ESOP if, upon the completion of the sale, the ESOP owns at least 30 percent of the company and the seller

reinvests the proceeds from the sale in qualified domestic securities within one year. This provision allows owners of closely held businesses who are approaching retirement age to, in essence, create a market for their stock and to diversify their investments while providing their employees with a significant benefit and assuring the continued independence of the business.

(3) Employers may take a tax deduction for dividends paid on ESOP stock to the extent that the dividend is used to repay the principal on the ESOP loan, or paid in cash to ESOP participants within 90 days. This provision allows companies to accelerate the repayment of the ESOP loan, thereby accelerating the transfer of stock to individual employee accounts, or to provide employees with current benefits from their stock ownership rather than deferring the entire benefit until they leave the company.

(4) Estates that sell stock to an ESOP may exclude from their taxes 50 percent of the proceeds they receive on the sale. This provision is available only on sales enacted prior to January 1, 1992, and is the likely subject of legislation designed to curb abuses. In addition, an ESOP may assume an estate's tax liability in exchange for an equivalent amount of stock. The ESOP may then pay the taxes on favorable terms.

(5) Finally, TRA provided temporary exemptions for ESOPs from two excise taxes imposed on other pension plans. Through December 31, 1988, corporations may avoid the 10 percent excise tax imposed on the excess assets recovered from terminated defined benefit pension plans to the extent that the excess assets are contributed to an ESOP. In addition, lump-sum distributions to ESOP participants prior to January 1, 1990, are exempt from the 10 percent excise tax to employees who have not yet attained age 59½. The tax may also be avoided by rolling the distribution over into another qualified retirement plan or an individual retirement account.

Conclusion

ESOPs can provide employees with substantial financial benefits through stock ownership while providing companies with attractive tax advantages and a powerful financial tool. By making employees part-owners of the business, companies also may realize productivity improvements, since workers benefit directly from corporate profitability and are thus working in their own interest. The U.S. General Accounting Office (GAO) estimates that as of March 1986, there were about 4,800 active ESOPs and an additional 2,400 similar stock bonus plans. As of 1983, GAO estimates that ESOPs covered more than 7 million workers and held nearly $19 billion in assets.

Although the advantages of ESOPs are attracting growing numbers of companies in virtually every type of industry, there are also risks

that should be considered. Because the ESOP is invested primarily in employer securities, the success of the ESOP depends on the long-term performance of the company and its stock. There is therefore a greater degree of risk involved since the employees' capital is invested mainly in one company. In addition, especially for closely held companies, the tax benefits that ESOPs provide should not divert attention from the company's repurchase liability—the requirement that the company redeem the shares of departing employees. This repurchase liability can be significant, particularly in companies that have realized growth in the value of their stock.

An ESOP is not appropriate in every circumstance, but the many benefits of employee ownership and ESOP financing for companies and employees alike merit close consideration of this innovative concept.

Additional Information

Employee Stock Ownership Association of America
1725 DeSales Street, NW, Suite 400
Washington, DC 20036

National Center for Employee Ownership
426 17th Street
Suite 650
Oakland, CA 94612

Employee Benefit Research Institute. "Estimated Revenue Losses Soar for New ESOP Provision." *Employee Benefit Notes* (February 1987).

Case, John. "Every Worker an Owner?" *Inc.* (May 1987):14–16

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XII. Tax-Sheltered Annuities

Introduction

A unique type of tax-sheltered retirement arrangement is available to certain nonprofit organizations and public schools. Since 1942, the Internal Revenue Code (IRC) has permitted such employers to purchase tax-sheltered annuities (TSAs) for their employees.[1] However, it was not until 1958 that Congress established the ground rules for today's TSAs. Through the Technical Amendments Act of 1958 and a later series of IRC amendments, Congress has encouraged retirement savings through TSAs.[2]

The tax-sheltered annuity is a tax-deferred arrangement defined under section 403(b) of the IRC. This arrangement allows an employee of a qualified charitable organization or a public school system, to exclude from gross income, contributions to a tax-sheltered annuity. Although the savings are intended for retirement purposes, such amounts are available for emergencies and can provide a source of income in the event of death or disability.

Retirement savings to such plans are excluded from reportable income at the time they are set aside. During the savings accumulation period, investment earnings on these funds are also sheltered from current taxes. Later, when the employee withdraws funds, the withdrawals are reported as ordinary income for federal tax purposes. However, the ultimate tax impact may be reduced for employees who make withdrawals at age 65, and whose yearly retirement incomes are lower than working-year incomes. Additionally, an increased standard deduction applies to most citizens who are over age 65.

Eligibility

Examples of the nonprofit, tax-exempt organizations that are eligible to offer TSAs include: hospitals, educational institutions, charitable institutions and social welfare agencies. A number of nonprofit,

[1]Tax-sheltered annuities are also known as tax-deferred annuities, 403(b) annuities or 403(b) plans.

[2]There are a variety of other tax-sheltered arrangements available to most people, including investments in oil, cattle and land. These arrangements, however, should not be confused with the tax-sheltered *annuities* discussed in this chapter.

tax-exempt organizations, however, do not qualify under section 403(b) and cannot offer their employees TSAs. Ineligible organizations include some federal, state and local government offices, civic leagues, labor organizations, recreational clubs, fraternal societies, credit unions, business leagues and cooperatives.

Until 1989, employers may adopt a TSA for one or more employees on a selective basis; unlike qualified retirement plans, there are no nondiscrimination rules applicable until after this date. The Employee Retirement Income Security Act's (ERISA's) age and service standards, however, may apply. Additionally, the IRC states that a plan must be established exclusively for the benefit of employees.

In plan years beginning after December 31, 1988, tax-sheltered annuities (except those programs maintained by churches) must satisfy essentially the same nondiscrimination and participation rules as qualified retirement plans (as changed by the Tax Reform Act of 1986 (TRA)). In addition, special nondiscrimination rules will apply to elective contributions made by employees through salary reduction.[3] These rules will effectively require the extension of a salary reduction TSA to most employees if any employee has the opportunity to participate in such a TSA.

Since many organizations (e.g., hospitals) have contracts with professional people, TSA sponsors must determine the true employer/employee relationship. If the employer is not paying Social Security taxes and is not withholding federal income taxes for a particular employee, the individual is not considered to be an employee eligible for a TSA. Radiologists, pathologists and anesthesiologists working at a hospital may fall into this category.

Funding

Originally, TSA contributors were required to purchase an annuity contract or life insurance policy from a life insurance company. The IRC has been modified and now allows mutual funds investment. TSA plans include: (1) individual and group fixed and variable annuity contracts; (2) endowment and retirement income contracts; and (3) custodial accounts held by banks, credit unions, investment companies and loan associations. Many employers specify funding arrangements; others have no restrictions and permit employees to select the type of arrangement they prefer.

[3]For detailed information on pension coverage and nondiscrimination rules, and the changes made by the 1986 Tax Reform Act, see chapter IV.

Plan Operation

Types of Plans—There are two basic types of TSA plans. Under one arrangement, employers make all contributions to a plan for covered employees. This approach permits a qualified nonprofit organization to provide retirement benefits through TSAs for at least some employees. This arrangement, however, is relatively uncommon. Instead, TSAs are usually of the second type, where plans are funded with *employee* contributions through a salary agreement.

Salary Agreement—Under the second arrangement, the employee and the employer enter into an agreement to reduce the employee's salary by an amount determined by the employee. This is known as a *salary reduction agreement*; it is a characteristic common to *contributory* (i.e., employees make contributions) employee benefit plans. The employer then remits these contributions to an insurance company, custodian or mutual fund.

Instead of reducing *current* pay, employee contributions may be derived from what otherwise would have become a *pay increase*. In this case, the employee agrees to forego the pay increase in lieu of plan contributions. In either situation, the language in the agreement must specifically state: (1) the level of the contribution; (2) the date the contribution will become effective; and (3) the investment vehicle in which the contribution will be placed.

Specific requirements of the salary reduction agreement include the following:

(1) It must be in writing.

(2) Contributions can be derived only from money earned *after* the date of the agreement.

(3) The employee can make only one agreement with the employer during a taxable year.

(4) The reduction amount can be either a specified dollar amount or a percentage of pay.

Contributions—Annual contributions to a TSA cannot exceed a maximum limit referred to as an exclusion allowance. The exclusion allowance is generally equal to 20 percent of the employee's includible compensation from the employer multiplied by the number of the employee's years of service with that employer, reduced by amounts already paid by the employer to purchase the annuity. If an employee elects to make plan contributions through a salary reduction, the maximum allowable contribution is one-sixth of the employee's earn-

ings. In addition to the limit imposed by the exclusion allowance, TRA limits employee contributions made through salary reduction to $9,500 annually, coordinated with contributions to a 401(k) plan. The limit applies until the $7,000 annual limit for 401(k) plans, indexed for cost-of-living adjustments, reaches $9,500, at which time the TSA limit will also be indexed in the same manner as 401(k) plan limits. If an employee is required to contribute a set percentage of compensation to a tax-sheltered annuity as a condition of employment, the contribution does not count toward the annual limit.

A special annual catch-up election is available for employees of educational organizations, hospitals, home health agencies, health and welfare service agencies, or churches or conventions of churches. Under this provision, any eligible employee who has completed 15 years of service with the employer is permitted to make an additional salary reduction contribution equal to the lesser of the following:

(1) $3,000;

(2) $15,000 reduced by the total amount of prior contributions that, in any year, exceed $9,500; or

(3) $5,000 multiplied by the number of years of service the individual has with the employer, minus an individual's lifetime elective deferrals under a 401(k) and 403(b) arrangement and a simplified employee pension plan.

ERISA's overall limits on defined contribution plans under section 415 of the IRC also apply to amounts that can be contributed on behalf of each employee in any one year.[4]

Employee Rights—A TSA participant has a wide variety of rights and privileges. The employer who adopts a TSA will usually place reasonable limits on its operation, but the employee enjoys a flexibility not found in some other retirement programs. Some important employee rights include:

(1) the right to determine the contribution amount and date when the contribution will begin;

(2) the right to the account balance (i.e., the employee's contributions cannot be forfeited);

(3) the right to select the investment vehicle (depending on the terms of the plan);

[4]For a more detailed description of ERISA's limits for defined contribution plans, see pages 28–29.

(4) the right to select from a variety of settlement options at termination, including lump-sum cash withdrawals, annuities or installment refunds;

(5) the right to transfer the account balance to an individual retirement account (IRA) or the TSA of a new employer;

Other rights and options may be offered within the framework of the plan and the investment vehicle.

Taxation

Social Security—Employees' contributions that are attributable to voluntary salary reduction agreements are subject to Social Security taxes, even though they are excluded from employees' federal income taxes. Future Social Security benefits, however, will be based on higher income; thus, retired employees will not receive lower Social Security benefits as a result of participating in a tax-sheltered annuity.

Distributions—Except where an employee rolls a lump-sum distribution into another tax-sheltered annuity or into an IRA, distributions will be taxed as ordinary income in the year received. Lump-sum distributions do not qualify for capital gains treatment, but five-year income averaging may be applicable. Also, for benefits accrued after December 31, 1986, a TSA must comply with the standard distribution rules governing timing and payouts applicable to qualified retirement plans.

Early Distribution Tax—As of January 1, 1987, a 10 percent additional tax will be imposed on "early" distributions (those made before age 59½) from all tax-sheltered annuity and custodial account (mutual fund) accumulations, regardless of when the contributions to which the accumulation is attributable were made. The additional tax is equal to 10 percent of the portion of the amount distributed that is includible in gross ("taxable") income. The total taxable amount distributed will still be taxed as ordinary income for the year in which it is received. The 10 percent tax will not apply for payments made in the form of an annuity and payments pursuant to the death, disability, early retirement (age 55), or extraordinary medical expenses of the covered worker (to the extent deductible under the Internal Revenue Code).

Early Distribution Restrictions—Withdrawals from tax-sheltered annuities will be allowed at any age, for any reason, until January

1, 1989. (However, a 10 percent additional tax may apply to a distribution after December 31, 1986, as explained above.)

As of January 1, 1989, participants may not make early withdrawals prior to age 59½ from annuity accumulations attributable to salary reduction contributions except on account of separation from service, financial "hardship," death, or disability. These restrictions currently apply to mutual fund custodial accounts. The restrictions will apply to all distributions attributable to salary reduction contributions, regardless of when the contributions to which the accumulations are attributable were made. Withdrawals on account of hardship are limited to salary reduction contributions only—no earnings on these contributions may be withdrawn.

Financial "hardship" is not statutorily defined (as of January 1, 1987), but proposed IRS regulations defining hardship under 401(k) arrangements apply to tax-sheltered annuities, according to the Conference Report of the 1986 Tax Reform Act. In the proposed regulations the IRS defines "hardship" as an "immediate and heavy financial need" of the employee that cannot reasonably be met through other resources. Final regulations are expected in 1987.

Death Benefits—Under TSAs, payments made to the beneficiary of a deceased employee are usually fully taxed as ordinary income. However, except for employees of public schools and certain other nonprofit organizations, the $5,000 death benefit exclusion may apply.

Employer Responsibilities

Unless the plan is an employer-pay plan, the employer's responsibilities are to: (1) make the plan available to certain or all employees; (2) enter into an agreement with each participating employee; (3) make appropriate payroll deductions; and (4) remit proper amounts to the insurance company, custodian or mutual fund organization. The employer must comply with various regulations set forth by the IRC and ERISA.[5]

Conclusion

Tax-sheltered annuities play an important role in providing retirement income for eligible employees. They can supplement an employee's pension plan, personal savings and other investments intended to provide retirement income. The unique value of a TSA lies, not

[5]Exemption from ERISA is often possible.

only in the personal tax advantages, but also in *forced savings* through payroll deduction.

Additional Information

Teachers Insurance and Annuity Association
College Retirement Equities Fund
730 Third Avenue
New York, NY 10017

Employee Benefit Research Institute. "Tax Reform and Employee Benefits." *EBRI Issue Brief* 59 (October 1986).

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XIII. Individual Retirement Accounts

Introduction

The 1974 Employee Retirement Income Security Act established individual retirement accounts (IRAs). In establishing IRAs, Congress intended to offer workers who did not have employer-sponsored pension coverage an opportunity to set aside tax-deferred compensation for use in retirement. The 1981 Economic Recovery Tax Act (ERTA) extended the availability of IRAs to all American workers (i.e., even those who already had employer-sponsored pension coverage). The Tax Reform Act of 1986 (TRA) retained tax-deductible IRAs for those who are not "active participants" in an employer-sponsored plan but restricted the tax deduction among those who are active participants in an employer-sponsored retirement plan to taxpayers with incomes below specified levels. TRA adds two new categories of IRAs: nondeductible contributions that accumulate tax free until distributed; and partial, deductible contributions, which are fully deductible contributions for a maximum amount that is less than the $2,000 maximum contribution otherwise allowable.

Financial institutions have promoted IRA availability. Advertising has emphasized the future value of IRAs. Varying interest rates and varying rates of return on stocks and bonds, however, will have a significant impact on the value of IRAs at retirement. Those purchasing IRAs that have high current-year rates of returns should understand that these rates could fluctuate over their working years. Fluctuating returns, combined with inflationary changes, will affect an IRA's ultimate real value.

Individuals who are considering IRA investment should understand how IRAs work—particularly their tax implications. This chapter discusses IRA: (1) eligibility; (2) contribution limits; (3) distributions; (4) rollovers; (5) taxation; and (6) investment options. It also discusses employer-sponsored IRAs.

Eligibility

There are five primary types of IRA owners:

(1) *Those individuals not active participants in an employer-sponsored retirement plan who establish IRAs with a direct contribution from current*

earnings—Regardless of income level, any part-time or full-time worker who is younger than age 70½ and not an active participant in an employer-sponsored plan can establish and contribute to a personal IRA. An individual is considered an "active participant" if that person is covered by a retirement plan. The individual is covered by a retirement plan if an employer or union has a retirement plan under which money is added to the individual's account or the individual is *eligible* to earn retirement credits. An individual is an active participant for a year even if the individual is not yet vested in a retirement benefit. In certain plans, the individual may be an active participant even if the individual was only with the employer for part of the year.

IRA investors must have *earned* income, which can include: (a) wages, salaries, tips, professional fees, bonuses and other amounts received for personal services; (b) commissions and income generated through self-employment; (c) payments from the sale or licensing of property created by authors, inventors, artists and others; and (d) alimony. (Unearned income derived from real estate rents, investments, interest, dividends or capital gains cannot be used as the basis for IRA contributions.)

(2) *Those taxpayers who are active participants in an employer-sponsored plan whose adjusted gross income (AGI) falls below $25,000 (single taxpayers) or $40,000 (married taxpayers filing jointly)*—These taxpayers can make a fully deductible IRA contribution. Again, contributions can only be made from earned income.

(3) *Active participants in an employer-sponsored plan with AGIs between $25,000 and $35,000 (single taxpayers) and between $40,000 and $50,000 (married taxpayers filing jointly)*—These taxpayers can make a fully deductible IRA contribution of less than $2,000 and a nondeductible IRA contribution for the balance, as follows. The $2,000 maximum IRA deduction is phased out by losing one dollar of deductible contribution for each five dollars of income between the AGI limits. For example, a single taxpayer with an AGI of $30,000 could make a $1,000 deductible IRA contribution and a $1,000 nondeductible contribution. Under a special rule, the deductible amount is not reduced below $200 if a taxpayer is eligible to make any deductible contributions at all. Again, contributions can only be made from earned income.

(4) *Active participants in an employer-sponsored plan with earnings of $35,000 and above (single taxpayers) and $50,000 and above (married taxpayers filing jointly)*—These taxpayers can only make nondeductible IRA contributions of up to $2,000; earnings on the nondeductible contribution are tax deferred until they are distributed to the IRA holder. Again, contributions can only be made from earned income.

(5) *Those IRAs established as a roll-over vehicle for a lump-sum distribution from an employer-sponsored pension plan or another IRA*—A worker who receives a distribution from his or her employer-sponsored retirement plan or an IRA or Keogh plan can generally place all of the distribution in a roll-over IRA without tax penalty or current taxation.

IRA Eligibility Test			
Adjusted gross income		Covered by pension plan? (You or your spouse)	Type of contribution ($2,000 maximum)
Joint Tax Return	Individual		1987
$40,000 and under	$25,000 and under	*Yes*	Fully Deductible
$40,000 and under	$25,000 and under	*No*	Fully Deductible
Between $40,000–$50,000	Between $25,000–$35,000	*Yes*	Partially Deductible
Between $40,000–$50,000	Between $25,000–$35,000	*No*	Fully Deductible
Above $50,000	Above $35,000	*Yes*	Nondeductible
Above $50,000	Above $35,000	*No*	Fully Deductible
Source: Employee Benefit Research Institute.			

Contribution Limits

Maximum Contributions

(1) *Single Workers*—Single workers can contribute up to $2,000 or 100 percent of earned income (whichever is lower) per year if they are not active participants in an employer-sponsored plan or if they are covered and have an AGI of less than $25,000. For those with an AGI of between $25,000 and $35,000, the deductible IRA is prorated (see (3) under *Eligibility*).

(2) *Two-Earner Couples*—Where a husband and wife both earn income, each may contribute up to $2,000 or 100 percent of earned income (whichever is lower) per year. This means that a two-earner couple could then make a combined annual contribution of up to $4,000. Where a husband and wife file a joint tax return and *either* spouse is covered by an employer-sponsored plan, both are restricted in their eligibility to make deductible IRA contributions under the rules that apply to their combined AGI. In other words, they are each allowed full $2,000 contributions if their combined AGI is below $40,000; a deductible IRA contribution of less than $2,000 and a nondeductible IRA contribution for the balance of the $2,000 if their combined AGI is between $40,000 and $50,000; and no deductible IRA if their AGI is

$50,000 and above ($2,000 nondeductible IRA contribution would be allowed for each working spouse).

If a married individual files a separate tax return, then the spouse's active participation does not affect the individual's eligibility to make deductible IRA contributions. But if a married person files separately, the phase out of the $2,000 deduction begins with $0 and ends at $10,000. In other words, every five dollars of income above $0 will reduce the maximum $2,000 IRA deduction by $1.00, or 20 percent. For example, if a married person is an active participant, has $3,000 of compensation and files a separate return, the maximum allowable IRA deduction would be $1,400 (i.e., $2,000–$600 (0.20 × $3,000)). If the same individual had compensation of $10,000 or more, no deductible IRA contribution would be allowed.

(3) *One-Earner Couples*—A married worker with a nonworking spouse can contribute up to $2,250 or 100 percent of the employed spouse's earned income (whichever is lower) per year, only if the worker is not an active participant in an employer-sponsored plan or is an active participant but has an AGI below $40,000. (A spousal IRA can also be established if a spouse has some small amount of earned compensation but elects to be treated as earning no compensation and makes no IRA contribution.) *Spousal* IRAs can be set up as a single IRA with a subaccount for the spouse, or they can be set up as separate IRAs for each spouse. The dollar limit on deductible contributions to spousal IRAs is phased out (i.e., reduced) for active pension plan participants in accordance with the same rules that apply to nonspousal IRAs (i.e., a 20 percent reduction in the IRA $2,000 maximum for each $1.00 between the AGI limits). The maximum amount that can be placed in either spouse's account is $2,000 (i.e., the entire $2,250 cannot be placed in one spouse's account). Those contributing $2,250 must file a joint tax return in the year the contribution is made.[1] If the worker is covered by a pension plan, one-earner couples with AGIs above $40,000 but less than $50,000 could make partial, deductible spousal IRA contributions and partial, nondeductible IRA contributions; one-earner couples with AGIs of $50,000 and above could only make a nondeductible spousal IRA.

(4) *Nonworking Divorced Persons*—All taxable alimony received by a divorced person is treated as compensation for purposes of the IRA deduction limit, and the regular IRA eligibility rules apply.

Minimum Contributions

IRA regulations do not require minimum contributions; nor do they require contributions in every year. The IRA deduction limit is not

[1]When the working spouse reaches age 70½, deductible contributions to spousal IRAs are no longer permitted—even if the nonworking spouse is younger. If the working spouse is younger, deductible contributions are not permitted for the nonworking spouse after he or she reaches age 70½; the working spouse, however, may continue to make contributions to his or her own separate IRA.

reduced below $200 if the individual is otherwise eligible to make any deductible contribution.

Employer-Sponsored IRAs

An employer can contribute to an IRA that has been set up by the employee, or the employer himself can set up an IRA for an employee.[2] The employee's interest must be nonforfeitable, and separate records showing the employee's contributions and the employer's contributions must be maintained. Although regular IRA contribution limits apply, the employer is also permitted to pay reasonable administrative expenses associated with the IRA.

Employers can also offer employee IRAs through payroll-deduction arrangements. Automatic deductions from employees' earnings would be deposited in IRAs that are set up by the company. Some employers permit employees to select among a wide variety of investment options; others place greater restrictions on such options.

Distributions

IRA distributions must begin by April 1 of the calendar year following the calendar year in which the individual reaches age 70½ and must meet certain minimum distribution rules to ensure full payout over the individual's expected life. The penalty for failure to comply with the minimum distribution rule is a 50 percent excise tax on the amount by which the minimum required distribution exceeds actual distributions during the tax year. The 50 percent tax is imposed on the individual required to take the distribution. Distributions can be paid in the following ways:

Lump-Sum Payments—The entire account balance is distributed in one sum.

Periodic Certain—The account balance is paid in a predetermined number of fixed payments over a specified period of time.

Life Annuity—Monthly payments are made to retirees for their remaining lifetimes. These payments cease at death.

Joint and Survivor Annuity—Monthly payments are paid for the IRA holder's remaining lifetime. After the IRA holder's death, the surviving spouse continues to receive monthly payments. The survivor usually receives only a portion (e.g., 50 percent) of the amount

[2]Note that this arrangement is not a simplified employee pension, which allows greater employer contributions and pretax employee contributions. See chapter XIV.

paid to the primary IRA holder. In addition, the monthly income to the primary holder will be lower than under an individual life annuity; this reflects the additional cost of insuring income over two lifetimes rather than just one.

To repeat, distributions that fail to meet the minimum distribution rules are subject to a 50 percent penalty tax imposed on the individual. Also, IRA distributions are included along with distributions from all qualified plans in determining whether total annual distributions exceed a threshold amount—in which case a 15 percent excise tax on the excess is imposed on the individual with respect to whom the excess distributions are made. The threshold for the excise tax is the greater of $112,500, indexed for inflation, or $150,000.

Rollovers

The law permits individuals to roll over account balances from: (1) one IRA to another; and (2) a qualified employer plan to an IRA. To avoid tax penalties, the transfer of assets from one account to another must be completed within 60 days.

Rollovers Between IRAs—Under this arrangement, the individual can roll over his or her account balance from one IRA to another. This provision offers individuals greater investment flexibility. This type of rollover can occur only once annually. A transfer of IRA funds from one trustee to another, either at the individual's request or at the trustee's request, is *not* a rollover. It is a transfer not affected by the one-year waiting period.

Rollovers Between Employer Plans and IRAs—Where employer pension and profit sharing plans provide lump-sum distributions, the amounts corresponding to tax-deferred employee and employer contributions may be transferred to a roll-over IRA. Roll-over IRAs were established specifically to provide a savings vehicle for lump-sum distributions without imposing a tax penalty. Rollovers of lump-sum distributions can be made at any age. However, if the individual is 70½ or older, distributions must begin in the roll-over year. Lump-sum distributions from employer plans paid to a surviving spouse after an employee's death can also be rolled over into an IRA without penalty.

Taxation

IRA taxation rules reflect the basic purpose of an IRA (i.e., to provide retirement income security). Use of IRA savings for purposes

other than retirement income, therefore, is discouraged through tax penalties. For retirement purposes, IRA distributions may begin as early as age 59½, but *must* begin by April 1 of the calendar year following the calendar year in which the individual attains age 70½. In the case of death or disability, distributions can begin prior to age 59½ without penalty. Distributions are considered income in the year received and are subject to applicable marginal income tax rates.

Income Taxes—Each year, tax-deductible contributions to new or existing IRAs must be made by the tax return filing date. Contributions can be made in one full payment, or they can be made in installments throughout the year. Income taxes on these contributions are deferred until IRA savings are distributed. The distributions are taxed as ordinary income in the year received, except for the portion of the total IRA distribution that is attributable to *nondeductible* contributions, which are excludable from gross income. All IRAs (including roll-over IRAs and simplified employee pensions (SEPs)) are treated as a single contract, and all distributions in any taxable year are treated as a single distribution.[3] If an individual withdraws an amount from an IRA and had previously made both deductible and nondeductible IRA contributions, the amount excludable from gross income is determined by multiplying the withdrawal by a fraction, where the numerator is the individual's total nondeductible contributions and the denominator is the total balance (at the close of the calendar year) of *all* the individual's IRAs. For example, if an individual held four IRA accounts with a total value of $10,000, and $2,000 was the amount of the nondeductible contributions, then a withdrawal of, say, $4,000 would be considered to consist of $800 attributable to excludable, nondeductible contributions (i.e., $4,000 x [$2,000/$10,000 or 0.2]) and $3,200 fully taxable as ordinary income and subject to any early withdrawal penalty.

IRA lump-sum distributions are *not* eligible for five-year income averaging.

Estate Taxes—The entire value of a lump-sum distribution is included in the deceased participant's gross estate.

Penalties—Under certain circumstances, tax penalties apply:

(1) Contributions in excess of the maximum limitations described above are not deductible from taxable income. Additionally, a 6 percent excise tax will be imposed on any excess contribution for each year it remains in the account. (If an individual contributes more than the permissible

[3]For more information on SEPs, see chapter XIV.

amount, he or she can avoid the 6 percent tax penalty by withdrawing the excess plus its earnings by the tax return due date in the year the contribution is made.)

(2) Distributions are not permitted without penalty before age 59½, unless they are taken in the form of a life annuity or the IRA owner dies or becomes disabled. Early withdrawals that are not rolled over to another IRA are subject to income tax in the year withdrawn plus a 10 percent penalty tax. The portion of an early withdrawal that is attributable to nondeductible contributions is not taxed and is not subject to the penalty.

(3) Regular distributions must begin prior to April 1 of the calendar year following the year in which a participant reaches age 70½. Such distributions may be made in a lump sum or in installments, providing the payment schedule does not exceed the individual's life expectancy. In the case of a joint and survivor annuity, the payment schedule must not exceed the life expectancies of the worker and spouse. A 50 percent excise tax is levied on any excess in accounts that do not satisfy this criterion.

Investments

IRA savings can be invested in retirement accounts and retirement annuities. The institutions that offer IRA investment vehicles include banks, brokerage houses, insurance companies, savings and loan associations, credit unions, mutual fund companies, other investment management organizations and the federal government. IRA contributions can be placed in more than one account, provided the total annual contribution limits are not exceeded. (Collectibles such as art, antiques, rugs, stamps, wines and coins—other than certain U.S.-minted gold or silver coins—are not permissible IRA investments.)

An IRA investor should understand the risks and limitations of the various investment options. Financial institutions are required to explain how their IRAs work and their financial ramifications. There has been tremendous competition among financial institutions for IRA business. Before choosing an IRA, some important questions should be analyzed and answered. For example:

(1) What are the investor's retirement income needs? Should he or she invest in low-risk options, or can he or she afford to gamble on higher risks that may produce higher returns?

(2) What are the administrative fees or commissions charged on the type of IRA under consideration?

(3) Is there a minimum deposit requirement?

(4) What is the interest rate and how is it computed? Is it likely to fluctuate over the worker's career years?

(5) Can the investment be quickly converted into cash in an emergency? What penalty charges (in addition to tax penalties) will be imposed for an early withdrawal?

(6) Should IRAs be purchased early or late in the tax year? (If money is invested early, it accumulates interest longer. If money is invested late, individuals have use of their money throughout the year. Additionally, they may have a better idea about how much of a deductible contribution they are eligible to invest in an IRA.)

Conclusion

IRAs can be an important addition to retirement savings opportunities. They are particularly useful for: (1) persons who do not have employer pension coverage; or (2) highly mobile workers with minimal pensions or no pensions due to limited service in any one job. The amount of retirement income generated by an IRA will depend on factors such as: (1) contribution amounts; (2) a participant's age when the IRA is established; (3) rates of investment return; and (4) a participant's age at retirement.

Additional Information

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XIV. Simplified Employee Pensions

Introduction

Many small businesses have been reluctant to establish a retirement plan for their employees because of the legal and administrative burdens of setting up and maintaining a plan and by the costs of complying with federal regulations.

In the Revenue Act of 1978, Congress sought to remove these obstacles for small businesses through the introduction of a new tax-favored retirement plan that was aimed primarily at small employers—the simplified employee pension (SEP).

SEPs are arrangements under which an employer establishes and finances (in part or wholly) an individual retirement account (IRA) for each eligible employee. The employee generally controls the investment of the money in which he or she is immediately vested.

These arrangements are sometimes called SEP-IRAs. A principal difference between a SEP and an employer-sponsored IRA is the larger annual contribution that can be made by an employer and an employee to the SEP—$30,000 or 15 percent of compensation, whichever is less. Some SEPs must also meet coverage and nondiscrimination requirements that do not exist for employer-provided IRAs.[1]

However, SEPs offer employers an alternative to more complex and costly qualified pension plans. Paperwork, recordkeeping and reporting requirements are kept to a minimum.

But acceptance of SEPs has been slow. To increase their attractiveness, Congress added a salary reduction feature in the Tax Reform Act of 1986 (TRA). Employees in small firms may elect to have a portion of their pretax salary contributed to a SEP. This option may be offered only in companies with 25 or fewer employees. Salary-reduction SEPs are not available to tax-exempt organizations or to state or local governments.

SEPs can be set up by corporations, unincorporated businesses and partnerships and self-employed persons. Although companies of any size may create SEPs, the simplicity of the arrangement was expected to interest small businesses. In large companies economies of scale

[1]Individual retirement accounts are discussed in greater detail in chapter XIII.

make establishing qualified pension plans less expensive than for small firms.

Participation

Employer contributions must be made for each employee who has reached age 21 (and those over age 70½), has worked for the employer in at least 3 of the preceding 5 years and has received at least $300 in compensation from the employer during the year. The $300 figure is indexed to increases in the cost of living beginning in 1988.

Any period of service during a year, even if only one day, qualifies as work for the year. The employer must also contribute for employees who worked some period during the year even if they have left the company by the time the employer makes the contribution.

Employees covered by collective bargaining agreements and nonresident aliens may be excluded from eligibility.

All eligible employees must participate in the SEP, including eligible part-time employees. If one eligible employee elects not to participate, the employer may not contribute to accounts for the other employees.

Contributions

Employers—Under the Revenue Act of 1978, the maximum an employer could contribute for each employee was $7,500 or 15 percent of compensation, whichever was less. The limit on compensation that could be considered for calculating the annual contribution was $100,000.

The dollar limit on contributions to SEPs was raised to $15,000 and the compensation limit to $200,000 by the Economic Recovery Tax Act of 1981. The Tax Equity and Fiscal Responsibility Act of 1982 raised the dollar limit on contributions to $30,000. The limit includes the amount an employee elects to contribute through salary reduction.

Contributions must be made according to a formula that does not discriminate in favor of officers, shareholders or highly compensated employees. Employer contributions will be considered discriminatory unless the same percentage of compensation (not in excess of $200,000) is allocated to all eligible employees. In plans integrated with Social Security, there is a limited disparity permitted (see "Plan Design," below).

An employer may contribute to a SEP in addition to contributing to other qualified pension plans. However, the contribution to the SEP will count in the total deductible limit imposed on employer contributions to all qualified plans.

One of the most flexible features of a SEP for an employer is that there is no required annual contribution. If the company has a poor year and profits are low, the employer can simply make no contribution that year or decrease the amount of contribution.

Employees are fully and immediately vested in the employer's contributions and the investment earnings on the contributions. This means that even if the employee leaves the job, the employer contributions belong to the employee.

Employees—When SEPs were first created, if the employer contribution was less than the maximum contribution permitted for IRAs that year, the employee was permitted to make up the difference with a tax-deductible contribution to the SEP. In addition, an employee could also contribute up to the maximum tax-deductible level to his or her own IRA. Under TRA, an employee covered under a SEP may not be able to make deductible contributions to his or her own IRA unless his or her adjusted gross income falls below $25,000 (single) or $40,000 (married) (see chapter XIII for more detail).

TRA considerably broadened the possibilities for employee participation in a SEP by providing the salary reduction option. The option is available only to employees in firms with 25 or fewer employees and only if 50 percent of all eligible employees in the company elect to have amounts contributed to the SEP.

Employees may elect to defer up to $7,000 annually. The $7,000 limit is reduced by any salary deferral made to a 401(k) cash or deferred arrangement or tax-sheltered annuity (403(b) plan). Beginning in 1988, the $7,000 is indexed to reflect cost-of-living increases.

TRA also includes a special nondiscrimination test for elective deferrals to a SEP. The deferral percentage for *each* "highly compensated" employee cannot exceed 125 percent of the average deferral percentage for all other eligible employees. Thus, if all employees of a firm on average contribute 10 percent of their pay to a SEP, the owner of the firm cannot contribute more than 12.5 percent of compensation to his own account (not to exceed $30,000).

The definition of "highly compensated" employees is the same as provided for all qualified plans by TRA: (1) 5-percent owners; (2) employees who earned more than $75,000 in annual compensation; (3) employees who earned more than $50,000 in annual compensation

and were members of the top 20 percent of employees by pay; or (4) officers who received compensation greater than 150 percent of the defined contribution plan dollar limit (i.e. $45,000 in 1987).[2] The $50,000 and $75,000 are indexed beginning in 1988.

Excess contributions made by highly compensated employees are subject to a 10 percent excise tax on the employer if they are not distributed within 2 1/2 months following the plan year in which the excess was deferred. Any excess contribution distributed to an employee is includible in the employee's taxable income for the year in which the contribution is made.

Distributions

From their inception, SEPs have been subject to the same penalties on premature withdrawals that have applied to IRAs. A 10 percent penalty is imposed on any lump-sum amounts withdrawn before age 59 1/2. Exceptions from the 10 percent penalty are made for payments in the form of an annuity and payments pursuant to the death or disability of the covered worker. SEP distributions must begin by April 1 of the calendar year following the calendar year in which an individual attains 70 1/2. All distributions are fully taxable.

Taxation

Until the end of 1986, employees had to include in gross income on their tax returns the amounts contributed by their employers to a SEP account and then claim an offsetting deduction for the amount. The employer included the contributions on W-2 forms sent to employees. TRA changed the tax treatment of SEP contributions. Employer contributions and employees' elective deferrals to a SEP are now excluded from employee's taxable income. Contributions and earnings in the SEP accumulate tax free until withdrawn.

Employer contributions to a SEP are not subject to Social Security (FICA) taxes or to unemployment (FUTA) taxes, but employee elective deferrals are included as wages for FICA and FUTA purposes.

An employer may elect to operate a SEP on the basis of a calendar year or the employer's taxable year. Contributions for a taxable year may be made no later than the due date (including extensions) for filing the return for that taxable year.

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[2]Contribution and benefit limits for defined benefit and defined contribution plans are discussed fully in chapter IV.

Plan Design

Integration—Until 1989 employers are permitted to take Social Security taxes paid by the employer for each employee into account in calculating the SEP contribution for the employee. That is, the employer can subtract the Social Security tax paid in a given year from the SEP contribution. This enables employers to make higher percentage SEP contributions for higher-paid employees because the Social Security tax is a smaller percentage of their total compensation than it is of the compensation for lower-paid workers.

Beginning in 1989, TRA prescribes new integration rules for defined contribution plans that also apply to the nonelective portion of SEP contributions. These rules permit a limited disparity between the percentage contribution above and below the Social Security wage base.[3] A SEP may not be integrated with Social Security, however, if any other qualified plan of the employer provides for integration.

Plan Operation—The Internal Revenue Service (IRS) provides a short model form (5305-SEP) that constitutes an agreement between employer and employee. Instructions for completing the form and questions and answers are included with it. (The model form may not be used if the SEP is to be integrated with Social Security or if the employer maintains any tax-qualified pension, profit sharing or stock bonus plan.)

The model form is not filed with the federal government. The employer retains the form and furnishes a copy with explanatory material to each employee.

The employer also must draw up a "written allocation formula" that explains the percentage of salary used for making contributions. Employees may designate the kind of investment vehicle they want to use for the SEP contribution, such as stocks, bonds, mutual funds, certificates of deposit and other similar types of investment vehicles. Employees are also free to change the investment vehicles. Employers themselves might select the investments but most leave the decision to the employees.

The employer then forwards the contributions directly to the SEP fiduciary, which is generally a bank, insurance company or investment firm.

The employer does not have to file detailed annual reports with the Department of Labor that are required for other qualified pension plans. But the employer must keep track of the names of the em-

[3]For more information on pension plan integration, see chapter VII.

ployees for whom contributions are made, the amounts of the contributions and the institutions to which the amounts have been paid.

An employer may also set up a nonmodel SEP. In this case, an employer must either file form 5306-SEP with the IRS or adopt a prototype plan sponsored by banks or insurance companies and approved by the IRS.

Conclusion

In businesses with 25 employees or less, only 1 in 7 workers is covered by a company-sponsored pension plan. Only 23 percent of workers in firms with fewer than 100 employees have pension coverage. This is considerably lower than the 58 percent rate for firms with 100 to 500 workers and the nearly 83 percent rate for workers in larger firms.

Despite attempts by Congress since 1978 to stimulate interest in SEPs by increasing contribution limits, many of the very firms to whom SEPs are targeted know little about them.

Among the employers who have heard of SEPs, interest in flexibility of contributions and simplicity of administration may be tempered with concern about the nondiscrimination requirements. The employer must make contributions on behalf of employees who may not remain long with the employer, thus diverting funds the employer might wish to use to reward longer-service employees.

Because employees vest immediately in employer contributions, employers may feel that such a retirement arrangement does little to encourage employees to remain with the employer.

Employees have the advantage of immediate vesting, but they face penalties and taxation if they withdraw the contributions and earnings before age 59 1/2. Employees also have the opportunity to contribute to their SEPs through salary reduction, but the requirement for 50 percent participation by eligible employees may limit this option.

Additional Information

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XV. Retirement Plans for the Self-Employed

Introduction

The self-employed are covered under the Social Security program and become entitled to benefits in the same manner as other employees.

In addition, self-employed individuals—with respect to a business in which personal services of the individual are a material income-producing factor—and noncorporate employers can now establish supplementary retirement plans on a basis virtually identical to corporate employers.[1] Prior to the passage of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), pension plans for the self-employed, or Keogh plans, were subject to more stringent limitations on contributions and benefits than were corporate plans. In removing the more stringent limitations on Keogh plans and imposing some Keogh-type rules on other qualified plans, TEFRA completed two decades of legislative effort aimed at putting corporate and noncorporate employers on the same footing for pension purposes.

Keogh plans originated in the Self-Employed Individuals Tax Retirement Act of 1962. Prior to that time, as tax-qualified pension plans spread, many small business people found that their employees could benefit by being included in a tax-qualified pension plan, but the employers themselves, could not. Self-employed individuals without employees also could not participate in a tax-qualified plan. Furthermore, where two people operated similar businesses and realized similar profits—but one was a sole proprietor and the other was incorporated—the corporate operator could benefit from a pension plan even though he or she was the only employee of the corporation, but the sole proprietor could not.

Various bills were introduced in Congress to remedy this situation. The number H.R. 10 was assigned to an early bill and was retained in succeeding bills until enactment of the Self-Employed Individuals Tax Retirement Act of 1962. Today these retirement plans are often

[1] In addition to Keogh plans, the self-employed are also eligible for simplified employee pensions, discussed in chapter XIV.

referred to as H.R. 10 plans or Keogh plans (named for Representative Eugene J. Keogh of New York, who sponsored the legislation).

The purpose of the act was to enable self-employed individuals to participate in a tax-qualified retirement plan, if they chose to do so, in much the same way as employees could. Various restrictions and limitations, however, were included in this 1962 legislation. For example, prior to passage of the Employee Retirement Income Security Act of 1974 (ERISA), self-employed people who established a Keogh plan were limited to a contribution of $2,500 per year, while there was no limit imposed on corporate plans. This provision led to otherwise unnecessary incorporation by self-employed persons solely for the purpose of obtaining the tax benefits for retirement savings. To achieve greater equity vis à vis corporate plans, ERISA increased the annual limit for deductible contributions to Keogh plans to 15 percent of earned income or $7,500, whichever was lower. The act also provided a new minimum deduction for those with adjusted gross income from all sources of $15,000 or less, based on the lesser of 100 percent of earned income or $750.

1981 Legislative Changes in Keoghs

In 1981 Congress reviewed the Keogh provisions of ERISA at the same time that it expanded eligibility for individual retirement accounts (IRAs). The 1981 law retained the ERISA limit of 15 percent of compensation, but effective January 1, 1982, it increased the maximum deduction for employer contributions to a defined contribution Keogh plan from $7,500 to $15,000.

1982 Legislative Changes in Keoghs

As part of TEFRA, Congress established parity between corporate and noncorporate retirement plans. To this end, most of the special rules applicable to Keogh plans were eliminated. Maximum limits for a defined benefit or defined contribution Keogh plan are the same limits as for corporate plans. For a defined contribution plan, the maximum contribution each year is the lesser of $30,000 or 25 percent of compensation. For a defined benefit plan, the maximum is the lesser of the amount needed to fund a $90,000 annual benefit or 100 percent of the employee's average compensation for the three highest years. The combined effect of treating Keogh plans and corporate plans under the same pension rules is to increase the pension tax incentives under Keogh plans and to mitigate the tendency for profes-

sionals to incorporate simply to take advantage of the higher amounts that were tax-deductible under prior law.

Tax Reform Act of 1986

The Tax Reform Act of 1986 (TRA) made numerous changes in the rules governing all qualified plans, including Keoghs (see chapter IV).

Eligibility

Technically, in contributing to these Keogh plans, the self-employed individual is treated for tax purposes as an employer as well as an employee. In addition, the self-employed individual must make contributions to the plan on behalf of his or her employees.

H.R. 10 plans may be classified as either defined contribution or defined benefit plans. As explained in chapter VI, defined contribution plans are those in which the contributions are predetermined, and the eventual benefit depends on the total amount of contributions and their investment performance. As a result, under a defined contribution plan, the level of retirement benefits cannot be calculated exactly in advance. On the other hand, defined benefit plans specify, in advance, a benefit level upon retirement based on a mathematical formula.

Self-employed individuals are also eligible to contribute to an IRA instead of the H.R. 10 plan. But they can only contribute to an IRA *and* a Keogh plan if their taxable income is below the levels established for IRAs under TRA (see chapter XIII).

Contribution and Benefit Limits

Keogh plans are subject to the same contribution and benefit limits as other corporate retirement plans. The maximum annual addition to a defined contribution plan may not exceed the lesser of 25 percent of the employee's compensation (earned income)[2] or $30,000 per year. The maximum annual benefit to a participant under a defined benefit plan is $90,000 or 100 percent of the participant's average compen-

[2]The Internal Revenue Service defines compensation of the self-employed as net earnings from self-employment, *which take into account the deduction for employer contributions to qualified employee retirement plans (including Keogh plans)"* [emphasis added]. Earned income can be calculated using the following formula: Gross profits minus (−) business expenses equals (=) net income. Net income minus (−) retirement plan contributions equals (=) *earned income.*

sation for his or her three highest consecutive earning years. The defined benefit dollar limits will remain at this level until 1988, when a cost-of-living adjustment is scheduled in the law.

The limit on annual additions to defined contribution plans will be frozen at current levels until they equal one-fourth of the defined benefit limit; from that point on, they will also be adjusted for inflation.

Keogh plans are subject to the same top-heavy rules as other tax-qualified pension plans. A top-heavy plan is defined as a plan under which more than 60 percent of the present value of accrued benefits (or account balances) is provided for key employees.

Special requirements for top-heavy plans include accelerated vesting schedules and a minimum benefit. Full vesting is required after three years of service, or, alternatively, graded vesting may be used, beginning with 20 percent after two years of service, increasing by 20 percent each year so that 100 percent vesting is attained at the end of six years of service.

The minimum *benefit* required of a top-heavy defined benefit plan is 2 percent of pay multiplied by the employee's years of service (not to exceed 20 percent). A contribution of 3 percent of pay is required for each nonkey employee in a defined contribution top-heavy plan, or, if less, the highest contribution rate for any key employee. These minimum benefit/contribution requirements are applicable only to years in which a plan is top-heavy.

Distributions

Keogh plan distributions can be paid in the same manner as other plans, namely in a lump-sum payment (where the entire account balance is distributed in one sum) or in periodic distributions from accumulated reserves as an annuity. The annuity can be in the form of a *life* annuity—in which monthly payments are made to retirees for their remaining lifetimes and cease upon the retiree's death—or joint and survivor annuities can be paid, in which the surviving spouse continues to receive monthly payments after the retiree's death. Plan distributions can also be paid out in regular installments for a fixed number of years.

If a participant takes a lump-sum distribution from a Keogh plan before age 59 1/2, it is subject to a 10 percent penalty tax in addition to ordinary income tax—unless the distribution meets one of a limited number of exceptions. The exceptions are for death, disability, age 55 and early retirement under the plan, and large medical ex-

penses to the extent they are deductible from income tax. The tax can be avoided if the entire lump sum is rolled over to an IRA or another qualified plan.

Rollovers

Prior to the Deficit Reduction Act of 1984 (DEFRA), tax-free rollovers of lump-sum distributions could not be made by a self-employed individual from a Keogh plan to a corporate or another Keogh plan. DEFRA changed prior law to permit a tax-free rollover from one qualified plan to another of a distribution attributable to contributions made on behalf of a participant while he or she was self-employed.

Tax-free rollovers of Keogh plan distributions can also be made to an IRA. If an amount otherwise eligible for the lump-sum tax treatment is rolled over into an IRA, however, the special income-averaging tax treatment is *not* available upon subsequent distribution from the IRA.

Taxation

Contributions made by self-employed individuals are not currently taxable to the self-employed individual, and the contributions by the self-employed individual on behalf of his or her employees are not currently taxable to the employees. Earnings on contributions are also not taxable during the preretirement period.

Voluntary after-tax contributions up to 10 percent of compensation are also allowed, even where only owner-employees participate. These after-tax contributions, which are still subject to the overall limit of 25 percent of compensation or $30,000, generate nontaxable investment gains during the preretirement period.

During retirement, employees are taxed on benefits recovered. If the individual is in a lower tax bracket in retirement or if five-year income averaging of lump sums applies, it may result in benefit receipt on a tax-preferred basis. Lump-sum distributions may qualify for the special income-averaging tax treatment only in the case of death, disability or the attainment of age 59 1/2. Distributions of account balances to self-employed individuals from Keogh plans other than for death or attainment of age 59 1/2 are not eligible for lump-sum treatment. The first $5,000 of a lump-sum death benefit paid under a Keogh plan can be excluded from federal income tax.

Conclusion

Over the past two decades, Congress has passed numerous pieces of legislation designed to provide substantial tax incentives for self-employed individuals to supplement retirement income in addition to their Social Security benefit.

Despite these incentives, the unincorporated self-employed have not participated in Keogh accounts at a very high rate. Based on a May 1983 survey jointly sponsored by the Employee Benefit Research Institute and the U.S. Department of Health and Human Services, only 4.8 percent of approximately 9.1 million unincorporated self-employed people in the United States contributed to a Keogh account.

The larger maximum deductions allowed since TEFRA may expand participation somewhat. A greater number and variety of plans can be expected. But, historically, the self-employed have been more inclined to invest in their own businesses than in separate plans earmarked for retirement income.

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XVI. Planning for Retirement

Introduction

Retirement is a relatively new phenomenon. Until a few decades ago, most men and many women worked throughout their lives. Those who were unable to continue working were either sustained by their family or a public facility for destitute people. Since Social Security retirement benefits were first paid in 1940, age 65 has become the *normal retirement age*.[1] The growth of employer pension plans and increased life expectancy have also contributed to present retirement trends.

On average, men and women who reach age 65 today can expect to live to ages 79½ and 84, respectively. Expanded life expectancy brings with it a new awareness of the aging process. Retirement is increasingly an important part of one's total life. Unfortunately, many still view their retirement years as a time of crisis. Retirement is a challenging period that can bring rewards and new experiences. A happy and satisfying retirement, however, requires an adjustment period that is greatly aided by thoughtful, effective planning in earlier working years.

Ideally, one should begin planning for retirement at age 30 to 40. Planning at a later age, however, is better than no planning at all. A survey of nonretired Americans conducted in 1985 for the American Association of Retired Persons by Yankelovich, Skelly and White revealed that 71 percent believe it is important to plan for retirement; more than half, however, reported difficulty saving for retirement on their present incomes, and 40 percent said they are worried their retirement income will be inadequate. In 1978, the University of Michigan's Department of Gerontology conducted a survey of early retirees. The findings indicate that 75 percent of those who planned ahead were enjoying retirement. Those who did not plan were gen-

[1]Under Social Security, the normal retirement age will be increased from age 65 to age 67. This age increase will be phased in, in gradual steps beginning in the year 2000. See pages 20–21.

erally less content. Advance planning can minimize the financial and psychological problems that sometimes accompany retirement.[2]

The first part of this chapter identifies some areas that need attention by those who are preparing for retirement. It is not intended to provide all the necessary information. Instead, it poses certain questions that need early consideration. Discussion is provided on: (1) financial planning; (2) preventive health; (3) health care costs; (4) living arrangements; (5) use of leisure time; (6) interpersonal relationships; and (7) estate planning. The second part of the chapter will look at the potential role of employers in helping employees to prepare for retirement.

Considerations for the Employee

Financial Planning—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. Workers should be saving and investing the largest 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? What are my assets and liabilities now? What will they be at retirement? How can I cope with inflation? If I should die before my spouse, will my family be left with an adequate income?

(1) *Social Security*—Social Security provides a monthly benefit to retired, blind or disabled workers who have contributed to the system during their working years. Various requirements must be met before benefits are payable. For those who qualify, benefits are paid to workers and their nonworking 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 does not provide income sufficient to satisfy all retirement needs. Social Security must be supplemented by private pensions, personal savings and other investments.

[2]Lee Butcher, *Retirement Without Fear* (Princeton, NJ: Dow Jones & Company, Inc., 1978), p. 5.

How Much Do You Have to Save?

Column A	Forms of Payment	
	Column B	Column C
years of saving	one lump-sum payment	15 annual payments
5	0.216	2.79
10	0.112	1.45
15	0.077	1.00
20	0.060	0.77
25	0.049	0.63
30	0.041	0.53
35	0.035	0.46

You can use this chart to determine how much you must save at the end of each year to accumulate a specific amount of money (adjusted for inflation). These calculations assume a 6 percent annual rate of return on savings and a 4 percent annual rate of inflation.

Step 1: Decide how much money you want to receive and choose the form of payment desired: one lump-sum payment (Column B) or 15 equal annual payments (Column C). Write the amount you want to receive here _____.

Step 2: Look under Column A and find the number of years you plan to save. Then find the corresponding number under Column B or Column C (depending on the form of payment you chose) and write the number here _____.

Step 3: Multiply the number you get resulting from Step 2 by the amount of money you want to receive (Step 1). This will give you the amount you must save at the end of each year to reach your target amount (adjusted for inflation) _____.

Example 1: To determine how much you must save at the end of each year to accumulate one lump-sum payment of $50,000 (adjusted for inflation)* after 10 years, multiply $50,000 by 0.112. You will need to save $5,600 at the end of each year. *The actual sums accumulated will vary because the target of $50,000 is calculated in terms of today's values. Therefore, these numbers show what you will have to save to accumulate, in the future, the equivalent of $50,000 in today's dollars. At the assumed 4 percent annual rate of inflation, your actual lump-sum payment in 10 years would be $74,012 in nominal dollars.

Example 2: To determine how much you must save at the end of each year to finance 15 annual payments of $20,000 each (adjusted for inflation)* starting after 25 years, multiply $20,000 by 0.63. You will need to save $12,600 at the end of each year. *The actual sums accumulated will vary because the target amount is calculated in terms of today's values. Therefore, these numbers show what you will have to save to finance the target amount in today's dollars. At the assumed 4 percent annual rate of inflation, your actual first payment in 25 years would be $55,449 in nominal dollars, and the last payment would be $96,020 in nominal dollars. The total amount accumulated would be $691,293 in nominal dollars.

Source: Employee Benefit Research Institute.

Today, most workers qualify for reduced retirement benefits at age 62 and full benefits at age 65. Social Security has no minimum age or service criteria, thus all covered workers are also program participants. *Vesting* (i.e., rights to benefits that cannot be revoked due to job termination) occurs when employees have at least one quarter of coverage for every year between 1950 (or, if later, the year after reaching age 21) and the time they reach age 62. Individuals retiring at age 62 in 1987 need 36 quarters of coverage. Workers with $1,920 or more in 1987 covered earnings will earn four quarters of Social Security coverage. For those reaching age 62 after 1990, 40 quarters (the maximum) will be required. Social Security vesting is relatively lenient; an overwhelming majority of the work force ultimately qualifies for benefits. Social Security payments are not automatically provided; workers must apply for full benefits three months before retirement (two months if they retire early, i.e., at age 62).

Workers should determine whether they will qualify for Social Security benefits. They should also obtain an estimate of the dollar amount of these benefits. Answers to questions concerning Social Security can be obtained from local Social Security Administration offices. The address and phone number are in your telephone book under "Social Security Administration."[3]

(2) *Private Pension Programs*—Approximately 70 percent of the full-time work force can expect to receive income from employer pension plans.[4] Some people, however, will not become eligible for such pensions. This often results from short service with individual employers. Although vesting in a defined contribution plan is shorter, vesting in a defined benefit plan commonly occurs after 10 years of service with any one organization. Beginning in 1989, however, most plans will vest workers after five years of service, under provisions of the Tax Reform Act of 1986.

Full pension benefits are offered at a specified age—frequently age 65. It is usually possible to retire early with reduced pension benefits. Under tax reform, however, pension payments received in a lump-sum prior to age 59½ will generally be subject to a 10 percent penalty if not transferred to an individual retirement account (IRA).

The 10 percent tax does not apply, however, to certain distributions (a) made in the form of an annuity payable over the life or life expectancy of the participant (or the joint lives or life expectancies of the participant and his or her beneficiary); (b) made after the participant has attained age 55, separated from service, and satisfied the conditions for early retirement under the plan; (c) used for payment of medical expenses to the extent deductible under federal income tax rules; (d) received from an employee stock ownership plan (ESOP) before January 1, 1990; or (e) made to or on behalf of an alternate

[3]For more information on Social Security, see chapter II.
[4]For more information on pension plans, see chapter IV.

payee pursuant to a qualified domestic relations order.

Most pension plans do not provide automatic cost-of-living adjustments. 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 result in higher retirement income.

Under the 1974 Employee Retirement Income Security Act (ERISA), employer plans automatically provide benefits to surviving spouses of retired workers, unless an employee rejects this option in writing. The Retirement Equity Act of 1984 (REA) requires that an employee may reject surviving spouse's benefits only with the written consent of the spouse.[5] Survivors' benefits are provided through a joint and survivor annuity. Before retirement, workers and their spouses should confirm the status of their survivor benefits.

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 benefit provisions and financial and operations information to plan participants and beneficiaries. Reports to participants must be written in a manner "calculated to be understood by the average participant or beneficiary."[6]

(3) *Federal Pensions*—Civil service employees are covered by their own retirement income program. Full civil service pension benefits are generally provided to retirees who satisfy one of several possible age and service criteria: (1) age 55 with 30 years of service; (2) age 60 with 20 years of service; or (3) age 62 with 5 years of service. Pension benefits are automatically adjusted for inflation.

Changes in the federal pension program were implemented as a result of the 1983 Social Security Amendments. Effective January 1, 1984, Social Security participation became mandatory for all newly hired federal employees. Before the 1983 Amendments, federal employees generally did not participate in Social Security.

These recent federal hires are also covered by a new pension system. Full benefits are payable at age 57 with 30 years of service; benefits paid after age 62 are indexed to inflation, and participants who work beyond age 62 continue to accrue benefits. Workers also have the option of taking part in a capital accumulation plan, to which they and the government contribute.

For more information on civil service pensions, contact the United

[5]ERISA, as modified by REA, also provides that vested employees must be given the option to take a survivor benefit through their plan. For more information on survivor benefits under Social Security and employer-sponsored plans, see chapter XXVI.
[6]For more information on ERISA, see chapter III.

States Office of Personnel Management, 1900 E Street, NW, Washington, DC 20415.

(4) *Military Plans*—The Military Retirement System has traditionally provided higher lifetime benefits than almost any other employer plan. For active-duty military personnel with 20 years of service, the system offers very early retirement with an immediate and continuing lifetime benefit. Military personnel do not contribute to their pension plans. Their retirement benefits are automatically adjusted with inflation, unless Congress intervenes. Military plans, however, do not provide vesting of nondisability retirement benefits for those with fewer than 20 years of service. Military retirees who are age 62 or older are also entitled to Social Security benefits. For long-service retirees, the combined military and Social Security benefits often have produced a retirement income exceeding 100 percent of preretirement take-home pay.

The Military Retirement Reform Act of 1986, however, implemented a new pension plan for anyone entering the armed forces after August 1, 1986. Under the old system, military personnel who retired after 20 years of service received annual benefits of one-half of their base pay for the three highest-earning years. Benefits rose 2.5 percent for every additional year of service up to 30, when benefits peaked at 75 percent. Persons entering the military after August 1, 1986, retiring with 20 years of service will receive 40 percent of their base pay for the three highest years; those retiring with 30 years of service will receive 75 percent. Benefits for early retirees are adjusted for each year of service less than 30 years.

(5) *Veterans' Pensions*—Veterans with service-connected disabilities may be eligible for compensation from the Veterans Administration if they have wartime service. Veterans without service-connected disabilities may be eligible for veterans' pensions. To qualify, veterans must be: (1) totally and permanently disabled; or (2) age 65 or older; and (3) have income below a specified amount.

More detailed information can be obtained by contacting a local Veterans Administration office.

(6) *Keogh Plans and Individual Retirement Accounts (IRAs)*—Keogh plans and individual retirement accounts are voluntarily established by employers and individuals. Keoghs and IRAs offer tax savings on personal contributions and their investment earnings.[7] Each year, those eligible for IRA participation can contribute up to $2,000 ($2,250 for those with nonworking spouses) or 100 percent of earned income (whichever is lower). Persons eligible to deduct IRA contributions may claim the deduction for the tax year in which contributions are made. The tax reform law, however, restricts the deductibility of IRA con-

[7]For more information on IRAs and Keoghs and how they are treated under the revised federal tax code, see chapters XIII and XV, respectively.

tributions for taxpayers who are covered by an employer-sponsored retirement plan and have income above specified levels. Distributions from IRAs are taxed in the year they are received, with a 10 percent penalty imposed on lump-sum distributions received before age 59½, unless the distribution meets one of the exceptions included in the tax code.

The self-employed covering themselves and any of their employees in an unincorporated business can save for retirement through Keogh plans. The annual contribution maximum for a defined benefit plan is the lesser of the amount needed to fund a $90,000 annual benefit or 100 percent of the employee's average compensation for the high three years. For a defined contribution plan, the annual contribution maximum is $30,000 or 25 percent of compensation, whichever is less. Distributions from Keoghs are taxed in the year they are received, with a 10 percent penalty imposed on those who take a lump-sum distribution before age 59½, unless the distribution meets one of the exceptions included in the tax code.

(7) *Homeownership*—Most individuals accumulate their largest share of personal wealth in home equity; many older families do not have outstanding mortgages. At retirement, they can convert their home value into income-generating assets, or they can continue living in their homes and enjoying the financial and personal advantages of owning residential property.

A relatively new concept available in some states, the *reverse mortgage* (RM), allows individuals to convert home equity into a steady income while retaining residence. An RM is a loan secured by property; the homeowner typically receives payments from the loan on a monthly basis. There may also be an option to receive a larger lump-sum payment, which can be used to purchase an annuity or fund property maintenance or repair.

There are two types of RMs. *Term RMs* may be attractive to an individual who needs cash for a certain number of years—while waiting to be accepted into a continuing care community, for example. At the end of the term, the person would then be in a position to sell his or her home, pay the loan balance plus interest, and move to the community. *Open-ended RMs* allow the homeowner to receive monthly payments for as long as he or she is alive and residing in the home.

Since RMs enable older people to live at home, they increase the opportunity for self-reliance while decreasing the likelihood of institutionalization. Despite their potential benefits, however, there are some important concerns associated with RMs. They reduce mobility, and the income generated may disqualify older persons from public assistance programs.

For more information on home equity conversion, contact a savings and loan institution or the National Center for Home Equity Conversion, 110 East Main Street, Madison, WI 53703.

(8) *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. The rate of return on savings invested in some policies, however, may be relatively lower than that of other investment alternatives.

Workers may purchase individual life insurance and pay premiums out of personal income. Sometimes employers pay group life insurance premiums for active as well as retired employees. Workers should inquire whether employer plans will continue to provide coverage after retirement.

(9) *Other Savings Alternatives*—There are many other types of investment instruments that can 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.

(10) *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. In 1987, a 65-year-old person with $8,160 or less in earnings can continue to work and receive all of the Social Security benefits. Those who retire early are permitted to earn up to $6,000. For every two dollars in earnings above the limit, Social Security will withhold one dollar of benefits. Beginning at age 70, however, there is no limit on the amount that can be earned without penalty.

Beginning in 1990, one benefit dollar will be withheld for every three dollars in earnings above the limit for those 65 and older. Some employment agencies now specialize in placing older workers, and some employers sponsor job-search seminars for retiring workers.

(11) *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.

(a) *Supplemental Security Income* (SSI) is a federally administered program implemented in 1974. It provides cash assistance to low-income aged, blind and disabled adults who have assets below specified limits. Benefits are indexed to cost-of-living increases. Additionally, many states supplement the basic federal benefit. Income from other sources reduces available SSI benefits; however, the benefit calculation disregards the first $20 of unearned monthly income (regardless of source), plus the first $65 of earned income, as well as one-half of earnings above $65.

More information can be obtained by contacting your local Social Security Administration office.

(b) *The Food Stamp Program* was enacted in 1964. The federal government finances 50 percent of administration costs and 100 percent of benefit costs. The benefit amount varies with household size and income, and is inflation-adjusted.

For more information on food stamps, contact your local or county social services offices.

Preventive Health Care—Many diseases associated with old age result from years of poor health habits. To enhance the chances of good health in later years, doctors recommend eating properly, exercising and having regular physical examinations.

A number of special programs have been developed to encourage good health habits at affordable prices. Programs that provide low-cost nutritional meals to older people can be located by contacting an area senior center. To encourage exercise, the YMCA and other athletic facilities offer reduced membership rates for people over age 65.

Health Care Costs—Health care costs have risen dramatically. It has become imperative to plan ahead for potential large costs associated with unexpected illness. Without insurance assistance, few people have adequate financial resources to cover catastrophic illnesses, particularly for long-term care associated with a chronic illness.

(1) *Medicare*—Medicare is the federal health insurance program under Social Security. Medicare consists of two parts: *Part A* (hospital insurance) helps pay for inpatient hospital care and certain follow-up care; *Part B* (medical insurance) helps pay for doctors' services, outpatient hospital services and other medical supplies and services not covered by Part A. Medicare offers public health insurance protection to all persons age 65 or older who are entitled to receive Social Security (as well as the severely disabled under age 65), whether or not they actually receive Social Security benefits.

Medicare coverage is not automatic. Application may be made three months before reaching age 65. Those who are enrolled in Part A are automatically enrolled in Part B, unless they choose not to be. There is a moderate monthly charge for Part B. Those who are not covered by Social Security may pay to participate in Parts A and B or Part B alone.

Since Medicare does not cover all expenses, it is important that workers planning their retirement develop a sound understanding of what is and is not covered by Medicare. Workers should also ascertain whether their group health coverage will continue after retirement. If not, many

retirees purchase additional health insurance coverage on their own. Employer group plans sometimes can be converted to individual policies. If this option is not available, some policies (known as Medicare supplement, or "Medigap," policies) are designed specifically to fill in the gaps not covered by Medicare. To assure that major medical expenses will be covered, retirees must understand their private insurance coverage and how it coordinates with Medicare.

(2) *Health Maintenance Organizations (HMOs)*—Participants in an HMO make fixed monthly payments to the HMO. In turn, the HMO provides most or all of the needed health care services. Such fixed-price arrangements permit retirees to estimate future health care costs more accurately. Many Medicare beneficiaries receive all Medicare-covered health services through enrollment in HMOs.[8]

(3) *Medicaid*—Medicaid, created in the mid-1960s, offers health assistance to people with low incomes. It is jointly financed by federal and state governments. Each state that elects to participate administers its own program. Medicaid reimburses health care providers for specified services rendered to older and disabled persons, as well as members of families with dependent children, who satisfy income tests. Covered services and the amount of deductibles (i.e., an amount an individual is required to pay before receiving any Medicaid payments) differ from state to state, but medical services are free to most SSI recipients.

(4) *Long-Term Care*—Many chronically ill and functionally impaired older persons require ongoing health and social services, known as long-term care. An estimated 9.3 million Americans age 65 and older will need long-term care by the year 2000. Care for debilitating chronic conditions is expensive and can rapidly deplete a lifetime's savings, yet is not covered by Medicare or most supplemental insurance policies. Nursing home insurance is available in some parts of the country, but premiums increase with the age of the policyholder. Research and test-marketing efforts undertaken by the public and private sectors may in the future lead to better options for financing and delivering long-term care.

Even as they approach their own retirement, many persons are confronted with the prospect of providing financial, emotional and often physical support to their parents and other older relatives. This added responsibility, sometimes referred to as *eldercare*, can make it difficult to plan for retirement effectively. Some individuals may be forced to delay their retirement or to postpone travel or relocation plans.

Living Arrangements—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

[8]For more information on health insurance and HMOs, see chapters XVII and XIX, respectively.

example, an elderly family 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. Many older people choose to share homes with others as an alternative to living alone. These decisions should be based upon financial considerations as well as individual needs and desires.

(1) *Financial Considerations*—Capital gains on sale of a home that has been a principal residence are offered as a once-in-a-lifetime tax break for older homeowners. If a homeowner is age 55 or over, and if the home has been his or her principal residence for at least three of the last five years, he or she may sell the home and enjoy a one-time exemption from taxes on profits of up to $125,000.

For more information, contact your local Internal Revenue Service office.

(2) *Housing Assistance*—Under the 1937 Housing Act and subsequent amendments, several programs have been developed to provide direct and indirect housing assistance to older people. Such assistance can be separated into four basic categories: homeownership, rental, rental subsidy and nursing home/intermediate care facility programs. There are often long waiting periods for housing assistance, so inquire and apply early. These programs are subject to change, and interested parties should keep abreast of new developments.

More information can be obtained through your local housing authority or social services offices.

(3) *Physical and Social Considerations*—Before moving to a new home, consider such issues as the accessibility of public transportation. A time may come when driving a car is not possible. Older persons should be in close proximity to grocery stores, doctors' offices and other frequently used places. Isolation and loneliness are common concerns for older people; 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 who are 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. It is solely the responsibility of a retiree to structure his or her time and to invest it in satisfying activities. Retirement frequently provides an opportunity for more active involvement in the community, travel, an avocation and/or further education.

A newly retired person can begin by exploring community resources. Public libraries can be a good source of information about community programs. Free adult education courses are offered by many community colleges. Recreational activities are sponsored by various organizations (e.g., area senior centers, the YMCA and local recreation departments). Opportunities for part-time and/or volunteer work may be available.

Interpersonal Relationships

(1) *Friends*—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. Again, those who develop strong friendships and family relationships in earlier years usually have a happier, more productive retirement.

(2) *Spouses*—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 concerns the problems associated with 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.

Estate Planning—A decedent's estate is made up of assets minus liabilities at death. Many people put off estate planning because they do not want to face the unpleasant thought of death. Lack of qualified legal assistance in estate planning can cause unnecessary hardship and expense to a decedent's surviving family and friends. Those who die without a will leave the distribution of their property to the state. No estate is so small that it eliminates the need for a formalized will.

Wills should be prepared by a lawyer. To ensure legality, they must be properly witnessed and signed. Handwritten or spoken wills are usually not valid. States have differing probate laws; therefore, it is advisable to have all important documents reviewed by a lawyer when relocating to another state. If there is a major change in family circumstances, such as a death, divorce or marriage, the will should again be reviewed by a lawyer.

Considerations for the Employer

This chapter has stressed the worker's responsibilities in planning for retirement. Employers can also play an important role in helping employees prepare for retirement. The number of companies that are

taking steps to assist employees in this way is increasing steadily. The remainder of this chapter will focus on employer-sponsored retirement planning programs.

Retirement planning programs have varied widely. Some employers have offered programs since the 1960s. After ERISA, more employers began to provide retirement planning assistance to retiring employees. The more assistance employees receive in preparing for retirement, the more likely they will adapt successfully.

Results of a 1984 study of *Fortune* 500 firms indicate that employers recognize a need for retirement counseling programs. Of 142 respondents, nearly 51 percent indicated they have such programs—26 percent more than reported having them in a 1977 study. Fifty-six percent of the firms without programs reported they plan to implement one within the next few years. About one-half of eligible employees take advantage of the counseling programs each year, according to those firms with programs.

Interest in Retirement Planning Programs—Reasons for the increased interest in retirement counseling programs include:

(1) Retirees are living longer and represent the fastest-growing segment of our population. There is a growing appreciation of their problems. The 1978 Amendments to the Age Discrimination in Employment Act have heightened awareness of the importance of the decision to retire.

(2) The 1974 Employee Retirement Income Security Act has resulted in greater dissemination of information about benefit plans. As more information becomes available, interest in retirement planning programs is increasing.

(3) Concerns about high rates of inflation have contributed to employees' uneasiness about their financial security during retirement. They have been forced to recognize the problems of living on a fixed income.

(4) Employees nearing retirement age often experience feelings of insecurity and anxiety; this can lead to a reduction in productivity. By offering retirement counseling, employers have learned they can alleviate anxieties and reduce the decline in productivity. Research shows that employees who believe their employers care about them tend to produce a better quality of work.

(5) Studies show that employees who receive employer retirement counseling adapt better to retirement. By providing retirement counseling, employers invest in the goodwill of their workers as well as a positive public image.

(6) Loyal employees have helped organizations succeed, and most employers want to help them prepare for a satisfying retirement.

Program Content—Retirement planning programs generally include counseling in some or all of the following areas:

(1) *Financial Planning*—coping with inflation, investment options, estate planning, insurance and the roles of Social Security and pensions;

(2) *Health*—the importance of nutrition, exercise, health maintenance and health care;

(3) *Interpersonal Relationships*—interaction with friends and spouses;

(4) *Living Arrangements*—the importance of financial and geographical considerations in choosing a new home;

(5) *Leisure Time*—the need for recreational activities, hobbies, community involvement and education;

(6) *New Careers*—the types of available opportunities for employment and volunteer work, and guidance in brushing up on job-hunting skills.

Program Design—Individual counseling is a popular way of providing benefit information to employees. Some organizations, however, combine individual interviews with group sessions, or they conduct only group meetings. Much of the retirement planning information is similar for all employees, and group meetings can be efficient. Although attendance is encouraged, participation is usually voluntary.

Employers can purchase packaged programs from firms with retirement planning expertise. Some employers use a combined approach, starting with a packaged program and conforming it to their employees' needs. Other methods of retirement planning include the use of expert speakers, printed materials and audio/visual aids. The majority of counseling seminars enlist the assistance of outside professionals to hold sessions on topics such as real estate, health care, Social Security and psychological adjustment.

Timing and Length of Counseling Sessions—Topics can be covered in separate weekly sessions; however, a session of two to three consecutive days may be preferable. Most firms hold sessions during nonworking hours. Participants should be encouraged to devote sole attention to the retirement counseling session; the session should not be interrupted by work. If a weekly format is adopted, two-hour sessions are generally advisable. Usually, in this period of time, one retirement topic can be discussed with a question-and-answer period.

Group Size—Because the success of a counseling program depends on attendee participation in group discussions, it is wise to limit attendance at each meeting to 40 participants. Assuming that most

employees bring a spouse or friend, 20 to 25 employees should be invited.

Who Should Attend—Employees, their spouses and other close family members or friends generally attend retirement planning meetings. Inclusion of spouses and friends helps to alleviate an employee's anxieties about retirement. Additionally, it provides the employee with access to other informed persons. These persons can discuss future problems with the employee if and when they occur.

Participants' Ages—Generally, employees who are age 55 and over are invited to participate in retirement planning programs. The 10-year period before normal retirement age is an appropriate time for an employee's financial and attitudinal preparation.

Conclusion

Increased life expectancies make the need for retirement planning even more crucial than in the past. Through individual and company retirement planning efforts, employees can prepare more effectively for a happy, healthy and productive retirement.

Additional Information

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1909 K Street, N.W.
Washington, DC 20049

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XVII. Health Insurance

Introduction

Nearly 75 percent of all United States workers are covered by an employer-sponsored health insurance plan. Depending upon the nature of an illness and the medical benefits provided, an employee's financial well-being could be jeopardized by unanticipated medical expenses. Although employees also value other types of employee benefits (e.g., pensions, profit sharing plans and group life insurance), medical benefits have a unique value; these benefits are received on a current rather than a future basis.

There are two primary types of health plans that may be offered by an employer: (1) prepaid plans, such as those provided through health maintenance organizations (HMOs);[1] and (2) postpaid plans, which are the traditional fee-for-service plans offered by insurance companies and many self-insured employers. This chapter will describe postpaid plans, including basic medical and major medical insurance.

Some of the important events in the development of health insurance in the United States include:

(1) As far back as 1798, a health plan for members of the merchant marine was established.

(2) Montgomery Ward & Co., Inc., instituted an insured health contract in place of its *employee establishment fund* in 1910.

(3) The first collectively bargained health and welfare plan was established in New York City's garment industry in 1917.

(4) The first citywide Blue Cross plan to insure against hospital costs was established in 1932. The first Blue Shield plan to insure against physician costs was established in 1939.

(5) Group medical expense benefits were introduced by *private* insurers in 1943.

(6) During World War II, when limits were placed on wage increases, many employers established medical care programs to attract and retain

[1]For more information on HMOs, see chapter XIX.

workers. Medical care benefits spread rapidly after World War II. Labor law changes and favorable court decisions accelerated this trend.

(7) Major medical benefits to supplement basic medical benefits were introduced in 1949.

Employee Participation

Many employers cover all eligible employees under a single health plan. Others have one plan for union members and another plan for nonunion members. Most employees are covered at the time they are hired or after satisfying a waiting period (e.g., three months).

Most plans cover employees and their dependents. The cost of the employee's coverage is usually paid by the employer. In some plans, family coverage is provided only if the employee pays some or all of the cost of such coverage. Under such plans, payment for family coverage is made through payroll deduction.

Continuation of Employer-Provided Coverage—The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with health insurance plans to offer continued access to group health insurance for former employees and their dependents:

(1) for 18 months if the worker becomes unemployed for any reason other than gross misconduct or if there is a reduction in the number of hours worked; or

(2) for 36 months to dependents of deceased workers, to the former spouse of a worker who is divorced, to dependent children who cease to be dependent, or if the active employee becomes eligible for Medicare.

The coverage offered must be identical to that available prior to the change in a worker's employment status. The qualifying employee or dependent may be required to pay up to 102 percent of the premium. At the end of the 18- or 36-month period, the employer must offer conversion to an individual policy if the group plan includes a conversion privilege (an option required in some states). The law is effective for plan years beginning on or after July 1, 1986; collectively bargained plans must be amended by the later of (1) the termination of the currently bargained plan or (2) January 1, 1987.

Group health plans for public and private employers with fewer than 20 employees are excluded from these provisions, as are church plans (as defined in section 414(e) of the Internal Revenue Code), the District of Columbia and any territory, possession or agency of the U.S.

Technical corrections to these provisions were included in the Tax Reform Act of 1986 (TRA). The Omnibus Budget Reconciliation Act of 1986 (OBRA) further amended COBRA to make a firm's entering into Chapter 11 bankruptcy proceedings on or after July 1, 1986, a quali-

fying event allowing any retired employee to purchase employer coverage until he or she dies or becomes covered under another plan. The retiree's spouse would be able to continue purchasing the coverage for an additional 36 months.

Plan Operators

A variety of sources offer health insurance: (1) commercial insurance plans; (2) Blue Cross/Blue Shield plans; (3) self-funded plans; (4) HMOs;[2] and (5) public programs such as Medicare.[3]

(1) *Commercial Insurance Plans*—Insurance companies are a major source of health insurance. Generally, the premium for such insurance protection is calculated to cover the: (a) benefits that will be paid; (b) administrative costs; (c) insurance sales commissions; (d) state premium taxes; (e) surplus (i.e., profit); and (f) risk charges. Generally, for employee groups of 50 or more, the insurer maintains separate claims records and periodically adjusts the premium to reflect the group's claims experience (called experience-rated plans).

(2) *Blue Cross/Blue Shield Plans*—These plans are also a major source of health insurance coverage. Blue Cross covers hospital services and Blue Shield covers medical and surgical services. Participating doctors and hospitals agree to accept a predetermined specified fee from Blue Cross/Blue Shield as payment in full for each service. Thus, if a plan member visits a nonparticipating doctor or hospital, and if the charge is above the scheduled Blue Cross/Blue Shield fee, the patient will be responsible for paying the difference. (Most doctors and hospitals are participating members.) Most Blue Cross/Blue Shield plans directly pay the health care service provider.

Although many plans operate under the Blue Cross/Blue Shield name, each plan is independent; each generally operates in a specific geographic area, and the various plans may offer different benefit structures.

Blue Cross/Blue Shield plans must comply with certain standards of the Blue Cross and Blue Shield Association (e.g., these plans must enroll all applicants regardless of health; they must operate as nonprofit organizations; and they must offer terminating employees conversion privileges).

(3) *Self-Funded Plans*—Some employers self-fund (i.e., self-insure) and self-administer their medical plans. Other employers self-fund their plans but purchase *administrative services contracts* to take care of their administrative needs. Additionally, some insurers offer *stop-loss* coverage

[2]For more information on HMOs, see chapter XIX.
[3]For more information on Medicare, see chapter II.

to employers, which covers catastrophic health expenses above a maximum and, therefore, limits a self-funded plan's liability.

Health Insurance Benefits

Postpaid Plan Benefits—Medical benefits may be provided through several approaches: (1) usual, customary and reasonable (UCR);[4] (2) fixed; or (3) combination.

(1) Under the UCR approach, all covered services considered to be usual, customary and reasonable are recognized in full. The range of covered services depends upon the plan's design.

(2) Under the fixed approach, covered services are recognized only up to a fixed dollar amount. This limit can take many forms; for example, a plan may limit hospital benefits to $100 per day and reimburse surgical charges according to a specified schedule of payment by procedure.

(3) The combination approach includes elements of each of the first two approaches. An example would be a hospital plan that recognizes the UCR amount for room and board and a scheduled amount for surgical procedures.

In recent years, the UCR approach has become the most popular among postpaid plans.

Prepaid Plan Benefits—Whereas postpaid plans reimburse insured persons for covered charges they incur, prepaid plans promise to deliver needed health care. This requires that care be obtained from a prepaid plan provider. Because care is paid for in advance, as opposed to having the cost of care reimbursed after it is provided, there are no UCR or fixed dollar limitations. However, for certain highly elective services, such as outpatient psychiatric care, benefits might be limited.

Refer to chapter XIX for a discussion of health maintenance organizations.

Deductibles, Coinsurance and Maximum Coverage Limits—Major medical plans incorporate deductible, coinsurance and maximum coverage limits. These plan features are intended to: (1) reduce plan costs; (2) encourage employee cost consciousness; and (3) reduce administra-

[4]Usual, customary and reasonable means that the charge is 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.

tive expenses. In 1985, 90 percent of plan participants in medium and large establishments had a deductible and/or copayment provision for hospital room and board coverage and nonhospital physician care.

A *deductible* is a specified amount of *initial* medical costs that each plan participant must pay before any expenses are reimbursed by the plan. Deductibles typically range from $100 to $500. 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. The plan then pays for additional health care expenses according to other plan provisions.

The deductible must be satisfied generally every calendar year by each individual participant. However, many plans contain a three-month carry-over provision. If so, any portion of the deductible that is satisfied during the last three months of the year can be applied toward satisfaction of the following year's deductible.

Under a *coinsurance* arrangement, the plan participant pays a portion of recognized medical expenses and the plan pays the remaining portion. The employee commonly pays 20 percent, with the plan paying the remaining 80 percent of recognized charges. Most major medical plans incorporate both deductible and coinsurance features. Thus, once the plan participant pays the deductible (e.g., the first $200 in medical expenses), the plan pays up to 80 percent of all other covered charges.

Because 20 percent of a large medical claim poses an undue financial burden for many individuals and families, most plans contain a limit on out-of-pocket expenditures. In this case, once an individual has reached the out-of-pocket maximum, covered expenses are reimbursed in full for the remainder of the year. The out-of-pocket limit is usually renewed at the start of the calendar year for each individual participant.

Most major medical plans impose a *maximum dollar limit* on the amount of health insurance coverage provided. Plans that impose limits may do so on an episode basis such as per hospital admission or per disability. Or, plans may impose an annual or lifetime maximum reimbursement amount for all covered services. Individual lifetime maximums are set usually at very high levels, such as $250,000 or $1 million. Separate lifetime maximums, typically $25,000, are often set for high-risk coverages such as psychiatric care.

Basic Health Insurance

Basic health insurance plans primarily cover health care services that are associated with hospitalization. There are three major cat-

egories of health coverage under basic plans: (1) hospitalization; (2) physician care; and (3) surgical.

Room and board, physician care and surgery are paid generally on a fixed basis, often at relatively low levels. Other hospital benefits are recognized in full. Basic services are sometimes covered on a first-dollar basis (i.e., there is no deductible or coinsurance).

Hospitalization—This type of coverage pays for inpatient hospital charges, such as: (1) room and board; (2) intensive care expenses; (3) necessary medical supplies; (4) general nursing services; and (5) other hospital expenses. Some outpatient services may also be covered (e.g., emergency treatment as a result of an accident, or preadmission testing). Room and board benefits are often limited on a daily basis, total hospital benefits may be limited on a per-admission basis, and treatment for psychiatric care or substance abuse may have separate, stricter limits.

Physician Care—This type of coverage pays for in-hospital visits by a physician. Medical care obtained in a physician's office or at home is usually excluded from the basic plan. A major medical plan will cover these types of services. Benefit limits often apply, such as a dollar amount per visit or a limited number of visits per calendar year.

Surgical—This type of coverage pays for surgical procedures performed by a licensed physician. The surgery can be performed in a hospital, outpatient facility or physician's office. Additionally, the services of an assistant surgeon, anesthesiologist and anesthetist may also be covered. Surgical procedures often are reimbursed according to a fee schedule.

Major Medical Insurance

There are two types of major medical plans: (1) *supplemental* and (2) *comprehensive*. Supplemental plans are intended to cover services excluded under basic plans. Comprehensive plans provide the combined coverage of both a basic plan and supplemental plan. Unlike basic medical plans, both types of major medical plans cover a broad range of health care services and are designed to protect against large and unpredictable medical expenses.

Supplemental Plans—Supplemental major medical plans cover medically necessary services excluded under basic plans, as well as charges that exceed any basic plan fixed-dollar limitations. Typical covered services include inpatient and outpatient hospital care, special nursing care, outpatient prescription drugs, medical appliances,

and outpatient psychiatric care. These plans include deductible, coinsurance, and maximum benefit features.

Comprehensive Plans—Comprehensive major medical plans provide coverage for the same types of services covered under basic and supplemental plans combined. In fact, basic/supplemental plans are being rapidly replaced by comprehensive plans. Most comprehensive plans incorporate deductible and coinsurance features, although several variations exist. Many plans may provide first-dollar coverage for emergency accident benefits. Or they may waive any out-of-pocket expenses altogether for certain types of benefits.

Other Health Care Plans

Medical plans generally exclude services that are not considered medically necessary. These services include most 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.[5]

Retiree Health Insurance

Continued health insurance coverage for retirees is a common provision among medium and large employer plans. In 1985, 72 percent of participants in such plans had coverage continued after early retirement; 66 percent had coverage continued after retirement at age 65. Most of the cost of this coverage is usually paid by the employer.

Employer plans that continue health coverage for retired workers typically maintain benefits at preretirement levels, although coverage under the employer plan usually is secondary to that provided under Medicare (i.e., benefits covered by the employer plan are reduced by the amount Medicare pays).

Nondiscrimination Rules

Nondiscrimination rules are intended to ensure that nonhighly compensated employees are not discriminated against, in relation to highly compensated employees, in the benefits they receive under an employer-provided health plan.

TRA revised the nondiscrimination rules for self-funded group health plans and extended them to insured plans. The nondiscrimination

[5]For more information on dental, prescription drug and vision care plans, see chapters XXI, XXII and XXIII, respectively.

rules generally are effective for the later of (1) plan years beginning after December 31, 1987, or (2) the earlier of (a) plan years beginning at least three months following the issuance of Treasury regulations or (b) after December 31, 1988.

Employers must meet both an eligibility test and a benefits test, or an alternative test.

The eligibility test stipulates that the employer satisfy three requirements. The first is that nonhighly compensated employees must constitute at least 50 percent of the group of employees eligible to participate in the plan. This requirement can be satisfied if the percentage of highly compensated employees who are eligible to participate is not greater than the percentage of nonhighly compensated employees who are eligible. This allowance is important to smaller firms where more than 50 percent of the workers are defined as highly compensated. In such cases, 100 percent of the nonhighly compensated would have to be eligible in order for the plan to pass the test.

The second requirement is that at least 90 percent of the employer's nonhighly compensated employees are eligible for a benefit that is at least 50 percent as valuable as the benefit made available to the highly compensated employee with the most valuable benefits.

The third requirement provides that a plan may not contain any provision relating to eligibility to participate that suggests discrimination in favor of highly compensated employees.

The benefits test requires that the average employer-provided benefit received by nonhighly compensated employees under all plans of the employer of the same type is at least 75 percent of the average benefit received by the highly compensated employees under all of the employer's plans of the same type. The average employer-provided benefit is defined as the aggregate employer-provided benefits received by the highly or nonhighly compensated group divided by the number of employees in the respective group, whether or not they were covered by any of the plans.

An alternative to the eligibility and benefits tests allows an employer to meet the nondiscrimination rules if the plan benefits at least 80 percent of the employer's nonhighly compensated employees. Only individuals who receive coverage under a plan will be considered as benefiting from the plan—eligibility to receive coverage is not sufficient.

There is a penalty if a plan fails to comply with the new nondiscrimination rules: All highly compensated employees in the plan will be taxed on the value of the discriminatory portion of the benefit. The discriminatory excess for health insurance arrangements is de-

fined as the amount of employer contributions and elective deferrals required to have been made as after-tax employee contributions by the highly compensated employees if the nondiscrimination tests were to have been satisfied. TRA language implies that this is determined by reducing the value of the benefits attributable to employer contributions (beginning with employees receiving the greatest benefits) until the plan is not discriminatory. The value subtracted is the discriminatory excess.

Employers who fail to report in a timely manner that a plan is discriminatory are liable for an excise tax at the highest individual tax rate on the total value of benefits, unless reasonable cause for failure to report is demonstrated.

Conclusion

For many decades, health insurance plans have played a significant role in employee benefit planning. Modern medical technology, increased longevity and a growing emphasis on good physical and mental health make these plans even more important today. The development of HMOs, PPOs, 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.[6] Future innovative efforts in plan design will be influenced strongly by the continuing need for health care cost management as well as new government regulations.[7]

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[6]For more about employee assistance and health promotion programs, see chapter XXIV.

[7]Many aspects of employer-provided health insurance plans are affected by government regulations such as the Employee Retirement Income Security Act (ERISA). For more information on ERISA's impact on medical care plans, see chapter III.

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XVIII. Managing Health Care Costs

Introduction

Health care costs in the United States have grown rapidly, reaching $425 billion in 1985. This growth has occurred because of several factors, including advances in medical technology; population growth; increased life expectancy; lower infant mortality; and inflation.

The health care costs of employers, who provide health insurance coverage to 75 percent of the nation's workers, reached $105 billion in 1985, up from $51 billion in 1979. Health care spending as a percentage of wages and salaries also rose, from 2.2 percent in 1970 to 4.9 percent in 1985.

In recent years, virtually all employers offering health insurance coverage to their employees have taken steps to manage costs. A 1984 survey of 1,115 firms conducted by The Wyatt Company found that 97 percent had changed their health plans in response to rising health care expenditures. While these measures are designed to contain individual employer spending, they also may serve the broader goal of controlling overall health care costs.

The variety of plan design changes that have been adopted by employers can be grouped into three categories:

(1) *Changes that increase employee incentives to use health care more economically*—These include imposing higher deductibles and coinsurance levels for all or some services covered by the plan, as well as expanding the scope of covered services to include less-expensive alternatives to inpatient hospital care.

(2) *Changes that specifically restrict the use of some services*—These include requiring a formal review of hospital utilization, as well as case management and second-opinion and same-day surgery requirements.

(3) *Changes that restructure the delivery of health care services to persons covered by the plan*—These include incentives for employees to select prepaid health plans (HMOs), and the establishment of "preferred providers" for services covered by conventional health insurance plans.

Changes most commonly initiated by employers include imposing or increasing cost-sharing requirements; requiring that tests be performed prior to hospital admission; and coverage of ambulatory sur-

gical care, treatment in extended care facilities, and second surgical opinions. Other changes, although less common, include coverage of home health and hospice care, case management and utilization review programs, coverage of annual physical examinations, wellness programs and coverage through PPOs or HMOs.[1]

In addition to these changes within the framework of existing employer health insurance plans, some employers have initiated a much more sweeping reorganization of their health insurance benefits. In some cases, this reorganization involves simply offering more than one health insurance plan option to employees with the same employer contribution to health insurance coverage under each plan option. Other employers have more fundamentally reorganized their health insurance plans within the framework of flexible benefit or "cafeteria" plans.[2] Most employers adopting flexible benefit plans try to induce employees to share more of, and take greater responsibility for controlling, their health care costs.

Improving Incentives for Economic Health Care Use

Plan design changes that encourage employees to use health care services more economically include increasing employee cost sharing and redesigning service coverage under the plan. Raising the level of cost sharing required by the plan refers to the portion of the cost—called the copayment or coinsurance[3]—paid by the employee for services actually used. Cost sharing under employer group plans may be increased by raising deductibles and coinsurance levels for all or some services covered by the plan, and by raising employee premiums for their own or for dependents' coverage.

Because changes in the range of services covered reduce real compensation levels by raising employees' out-of-pocket health care costs, they have been generally resisted by employees, particularly by those with collectively bargained health insurance plans. It is important, therefore, for employers to effectively communicate to employees the reasons that changes are being made in their health plans, and for

[1]Robert B. Friedland, "Private Initiatives to Control Health Care Expenditures." In Frank B. McArdle, ed., *The Changing Health Care Market* (Washington, DC: Employee Benefit Research Institute, 1987). For more about health insurance, wellness programs, PPOs and HMOs, see chapters XVII, XXIV, XX and XIX, respectively.
[2]For more information on flexible compensation plans, see chapter XXXI.
[3]Copayment refers to a flat payment (e.g., $10 per office visit) and coinsurance refers to a percent of payment (e.g., 20 percent of total cost).

employees to fully understand their role in the health care partnership—that of being *efficient* consumers of health care.

Despite some employee resistance to greater cost sharing, many employers report having raised the deductible provisions of their group health plans in recent years. As a result, "first-dollar" coverage for inpatient hospital expenses has become much less common. First-dollar coverage pays initial expenses (a specified amount, depending on the plan) for hospital care, with no deductible or coinsurance provision on the "first dollar" of care delivered.

Changes in the range of services covered by the plan may redirect patient use of health services toward less expensive substitutes for inpatient hospital care. For example, employers have expanded the range of group health plans to include coverage of home health care services, hospice services and outpatient hospital care. Outpatient care covered by employer group plans usually includes preadmission testing, outpatient surgery or surgery performed in free-standing surgical centers. Coverage of these services is aimed at discouraging the unnecessary use of inpatient hospital care or prolonged hospital stays.

Restricting Use of Benefits

Another technique for controlling employer health care costs is to restrict the use of certain benefits under the plan. For example, coverage for inpatient hospital care by plan participants may depend on: (1) complying with a case management or hospital utilization review program; or (2) obtaining a second confirming surgeon's opinion before undergoing elective surgery.

Hospital utilization review assesses the appropriateness of hospital admission, inpatient hospital services and hospital discharge. Individual employers or insurers may conduct their own programs or they may contract with peer review organizations (PROs) to evaluate hospital use. Hospital utilization review may be conducted prospectively (before hospital admission), concurrently (during the patient's hospital stay) or retrospectively (after hospital discharge).

The use of prospective, or preadmission, review is increasing rapidly. Insurers, particularly Blue Cross organizations, are increasingly conducting such reviews using their own employees. Often, however, the review process is subcontracted to an organization in each locality that conducts reviews for a number of third-party payers. Some of the prospective review programs also provide concurrent monitoring and require re-authorization for hospital stays that exceed the originally agreed-upon duration.

Plans that require or pay for a second or third medical opinion before elective surgery have become common. Second-opinion surgery provisions are often enforced either by refusing payment or by imposing greater cost sharing for expenses related to surgery performed without a second opinion.

Same-day surgery provisions eliminate unnecessarily early hospital admissions and the higher cost of hospital room and board. Plans that do not require same-day surgery may not cover hospital room and board charges for nonemergency weekend admissions, unless surgery is scheduled for the following morning.

Restructuring Service Delivery

The emergence of preferred provider organizations (PPOs, sometimes called preferred provider arrangements) is an important development. A PPO is a contractual arrangement between providers and buyers of health care services. Under the arrangement, providers may agree to grant discount rates to those paying (e.g., employers) in return for faster payment, a patient base, or both. In addition, the PPO may cooperate in utilization review to monitor and control the growth of health service use and plan costs. As an incentive for plan participants to use the services of the PPO, plan coverage is often greater for PPO services than for services delivered by other providers. Greater coverage for PPO services might be achieved by waiving the deductible or by decreasing the employee's coinsurance for services delivered by the PPO.

The number of PPOs has consistently grown over the last several years. (For more about PPOs, see chapter XX.)

Adopting Flexible Benefit Plans

A flexible benefit or "cafeteria" plan is an employee benefit plan that gives employees some choice among cash or nontaxable benefits provided by the employer.

Flexible benefit plans typically include two or more health plans. They may also include, for example, dental coverage, group life insurance, dependent-care benefits, and a cash account—sometimes called a "reimbursement account"—from which employees may reimburse themselves on a pretax basis for out-of-pocket health care or dependent care expenditures.

Employer goals in establishing a flexible benefit program are complex. They often include:

(1) managing the cost of group health benefits by inducing employees to share more of the health care costs covered by the plan;

(2) offering employees new, specialized benefits tailored to the needs of individuals in a demographically changing work force, without substantially raising total benefit costs;

(3) enhancing employee perceptions of the value of employer-provided benefits.

A cash reimbursement account in a flexible benefit plan may be helpful in reducing health care costs paid by both employers and employees under the plan. Employees may be more willing to "trade down" to a less generous health insurance plan option if they can pay out-of-pocket expenses with pretax dollars. Reimbursement accounts offer employees this opportunity. Employees must decide at the beginning of the plan year how much they wish to contribute to the reimbursement account. Any unused reimbursement account balances are forfeited by employees at the end of the plan year.

Despite restrictions on the use of reimbursement accounts, flexible benefit plans still offer employers an opportunity to reduce their health insurance costs—and reduce total health care expenditures. That is, employers are able to fix their contribution to health insurance benefits—either absolutely or as a percentage of a lower-cost health insurance option—rather than automatically raise their contribution as plan costs rise. In addition, a flexible benefit plan gives employees an incentive to use fewer health care services, with or without a reimbursement account. The choice of a more generous, and more costly, health insurance plan reduces the employee's ability to elect alternative benefits (including pretax savings) or higher cash earnings.

Adjusting the price of alternative health insurance plans offered in a flexible benefit program is important to its success in controlling health insurance costs. Employers providing more than one health plan anticipate "adverse selection" by employees. That is, employees who foresee few medical needs during the year are most likely to choose a low-cost, less generous health insurance plan. Employees remaining in the most generous—and most costly—health insurance plan are likely to have greater health care costs, on average, than employees who choose a less generous health plan. The average cost of the most generous plan is likely to rise much faster than the average cost of the least generous plan. Employers would, therefore, like to adjust or "reprice" the health plans to reflect the cost history subsequent to the initial offering of the alternative plans.

Effectiveness of Plan Redesign

Evidence of the effectiveness of alternative plan design changes is scarce. Available data (1982 National Association of Employers for Health Care Alternatives survey of employers) indicate that adding or increasing coinsurance requirements may be very effective in reducing plan cost. Raising deductibles or the level of employee contributions to the plan have apparently been less successful strategies for controlling health plan costs. A 1986 survey by Hewitt Associates of companies offering flexible benefit plans indicates that when employees are given a choice from among a variety of medical coverage options, overall health care costs are reduced over time.[4]

A 1983 survey done by the Equitable Life Assurance Society of the United States reflects views of corporate benefit officers in companies experienced with specific cost-containment programs. They see the following strategies as "very effective" in health care cost containment:

(1) requiring employees to pay a part of their health insurance premiums;

(2) preventing people in families where more than one person has employer-provided health insurance from filing duplicative insurance claims for the same medical services;

(3) utilization reviews conducted by third-party payers to discourage the use of expensive treatment alternatives and/or inessential procedures;

(4) insurance plans that encourage the care and treatment of the chronically ill at home instead of in hospitals and nursing homes;

(5) a system that encourages the use of nurse practitioners, midwives and physician's assistants rather than the sole use of physicians.

Prospective Medicare Pricing

Since the passage of the Social Security Amendments of 1983, Medicare payments to hospitals have been based on prospective pricing, a specific allowance for each patient based on 468 diagnosis-related groups (DRGs).

Patients with similar diagnoses are categorized into a specific DRG. Medicare pays a hospital a fixed amount, based on the cost history of the DRG. Since spokesmen for the hospital industry criticized the original proposal as too rigid, Congress allowed regional variation in Medicare rates for the first three years of the new system. However,

[4]For more about flexible benefit programs, see chapter XXXI.

starting October 1, 1987, the Medicare rates are to be standard around the country, with one set of rates for urban areas and another for rural areas. New Jersey, Maryland and U.S. territories are exempt from the DRG plan because they have their own cost-control systems using a different form of prospective payment for all hospital patients, including those covered by private insurance carriers. In addition, Medicare has exempted specific hospitals extensively involved in cancer treatment and research, psychiatric facilities, children's hospitals and other specialized providers of care. These facilities continue under the old system of cost-based Medicare reimbursement.

Prospective pricing for hospital care is intended to encourage more cost-effective hospital use. If the cost of care exceeds the Medicare payment, the hospital is responsible for the remaining cost. On the other hand, if the Medicare payment exceeds the cost of care, the hospital still receives the full payment. Before the DRG plan, hospitals had few incentives to cut the cost of serving Medicare patients, since they were paid for all services provided. With the installment of DRGs, a specific amount is paid, regardless of any excess care administered. If a hospital utilizes its facilities inefficiently, it loses money. Therefore, hospitals now have a strong incentive to provide more efficient care. Medicare requires that hospitals cooperate with local PROs to monitor the quality of care. Medicare's implementation of DRG-based payment for hospital care has apparently been effective in reducing hospital admissions and hospital costs for Medicare patients.

Conclusion

Recent changes in employer group health plan design have received considerable publicity. Although no nationally representative data document the extent of those changes or their impact, private industry's survey evidence suggests that some employer initiatives are effective in controlling health care costs.

The changes initiated by employers are notable because they have occurred in a relatively undramatic, gradual fashion—and without legislation that would either encourage or require such change.

Strategies used by employers to control the cost of their health insurance plans often rely on making employees more aware of their own health care costs. Many who would reform the nation's health care delivery system see the lack of consumer awareness of health care costs as a major source of health care cost inflation. Health care cost inflation itself has forced employers to consider major changes

in their health insurance benefits. These changes offer promising ways to manage the rising cost of health care for all payers.

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XIX. Health Maintenance Organizations

Introduction

Critics of the United States health care delivery system point to traditional fee-for-service payment for health care as a major contributor to health care cost inflation. They assert that this payment-for-services method offers little incentive for controlling costs. Health maintenance organization (HMO) advocates believe HMOs offer a greater potential for controlling health care costs while providing high-quality medical care.

HMOs are organizations of physicians and other health care professionals that provide a wide range of services to subscribers and their dependents on a prepaid basis. Subscribers purchase HMO coverage for a contract period by paying a fixed periodic fee. HMOs generally emphasize *preventive care* and *early intervention*. Because HMOs are contractually obligated to provide all covered medical services for a fixed dollar amount, they have an incentive to provide care early, before illnesses become more serious. At the same time, HMO members tend to have lower rates of hospitalization than persons covered by traditional fee-for-service insurance plans.

The first HMO was established in 1929. The number of HMOs has risen dramatically since then. By January 1, 1987, according to the National Association of Employers on Health Care Alternatives, there were an estimated 720 HMOs covering about 26.5 million people—about 11 percent of the United States population. As of September 1986, some 980,000 older Americans were enrolled in HMOs through Medicare.

How HMOs Work

HMOs both finance and deliver health care services. Instead of paying a health care provider each time a service is delivered, HMO subscribers agree to pay periodic fees. In turn, HMOs provide for virtually all of their subscribers' health care needs. (Subscribers may be required to make a modest copayment for some HMO services.) Each HMO develops its own rates and benefits, although federally qualified HMOs must provide at least the basic health services required by law. HMOs accept the risk of providing covered health care

services at a cost that does not exceed subscriber rates. Thus, they have an economic incentive for monitoring utilization and costs.

HMOs' basic functions are:

(1) providing comprehensive health care services to subscribers;

(2) contracting with or employing physicians and other health care professionals who will provide the covered medical services;

(3) contracting with one or more hospitals to provide covered hospital care (a few HMOs own and operate hospitals).

The role of an HMO is different from that of a commercial insurer or Blue Cross/Blue Shield plan. HMOs finance *and* provide health care services. Conventional insurance plans reimburse health care providers—whom the patient has to locate—usually under a fee-for-service arrangement, although commercial insurers, self-insured employers and Blue Cross/Blue Shield plans increasingly are using preferred provider organizations (PPOs) and other managed care arrangements to encourage employee use of certain designated health care providers.

Types of HMOs

There are three primary types of HMOs: (1) *group-model plans* (sometimes called *prepaid group practice plans*); (2) *staff-model plans;* and (3) *individual practice associations* (IPAs).

(1) Group-model HMOs contract with physician groups to provide services to HMO subscribers. They usually reimburse physicians on a capitation basis (i.e., at a fixed rate per HMO patient). Group-model HMO physicians spend most of their professional time serving HMO subscribers; the rest of their time may be spent in their private practices. Group-model HMOs may contract with multiple-specialty physician groups as well as general practitioners or other primary care physicians. Group-model HMOs may own one or more hospitals, or they may contract with local hospitals to provide services to subscribers.

(2) Staff-model HMOs are similar to group-model plans. Under a staff-model plan, however, physicians and other health care professionals are directly employed by the HMO (i.e., they are members of the HMO's staff).

(3) Individual practice associations are groups of physicians in private practice who provide some services to HMO subscribers, but primarily provide services to patients who are not subscribers. These physicians do not operate from a central facility. The HMO, however, monitors the appropriateness and quality of care provided to subscribers, as well as utilization of services. Typically, the IPA physician shares in

the financial loss when the cost of providing covered health services to HMO subscribers exceeds total subscription fees. IPAs have grown faster than other types of HMOs. As of June 1986, there were about 345 IPAs with total enrollment of nearly 8.5 million people.

The 1973 Health Maintenance Organization Act

The 1973 Health Maintenance Organization Act was intended to encourage the growth of HMOs. In addition, it established requirements that have to be satisfied by an entity seeking designation as a federally qualified HMO. Under these requirements, HMOs must offer certain benefits and satisfy federal regulations for administrative, financial and contractual arrangements. The Department of Health and Human Services administers the act and oversees HMO qualification.

Some HMOs are not federally qualified because they do not meet the act's requirements or because they have not applied for qualification. All HMOs must, however, be state certified.

As of September 1986, 412 HMOs were federally qualified; these HMOs provided health care services to more than three-fourths of all HMO subscribers.

HMOs generally provide more comprehensive services than are covered by commercial insurance plans or Blue Cross/Blue Shield plans. For example, federally qualified HMOs must provide routine examinations. They also have limits on allowable copayment amounts.

Services that must be provided by federally qualified HMOs include: (1) primary and specialty physician care; (2) inpatient and outpatient hospital care; (3) emergency care; (4) short-term outpatient mental health care; (5) medical treatment and referral for alcohol/drug abuse and addiction; (6) diagnostic laboratory services; (7) diagnostic and therapeutic radiology services; (8) home health care; and (9) preventive health care.

At its discretion, a federally qualified HMO may also provide a broad range of *supplemental* health care services such as: (1) intermediate and long-term care (e.g., institutional or home health care); (2) adult vision care; (3) dental care; (4) long-term or inpatient mental health care; (5) long-term physical therapy and rehabilitation services; and (6) prescription drugs.[1] These supplemental services can be offered on a fee-for-service basis.

The federal HMO law and regulations also provide:

[1]For more about vision care, dental care and prescription drug plans, see chapters XXIII, XXI and XXII, respectively.

(1) Under certain circumstances, employers must offer at least two health care plan options—the employer's regular health plan and an HMO. This provision, known as the *dual choice* option, applies only if: (a) an HMO representative approaches an employer and requests that the employer offer the HMO as an option; (b) the employer already offers and contributes to a health plan; and (c) the employer has 25 or more employees living in the HMO service area. The HMO would then be offered to employees as an alternative to the employer's regular health plan.[2]

(2) The HMO solicitation must be in writing; it must be directed to a managing official at the solicited location. The written request must be extended at least 180 days before renewal or expiration of the employer's regular health benefit contract or collective bargaining agreement. Additionally, the HMO must satisfy other requirements before it will be considered as an optional employer plan (e.g., information must be available on the HMO's ownership and control, facilities, operation hours, service areas and rates). In actual practice, most employers who offer HMOs do so voluntarily (i.e., not as a result of the formal solicitation process).

(3) An employer who offers an HMO plan must contribute an amount to the HMO for each subscriber-employee that is as large as the individual participant contribution made to the regular group health plan, but no greater than the HMO premium. If the HMO premium is greater than the employer contribution, an employee who chooses to subscribe may be required to pay the difference.[3]

(4) Employers who offer HMOs must provide for annual group enrollment periods, where employees can choose either the HMO or the regular

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[2]Two or more qualified HMOs may offer services in the same geographic area. Employers that are approached by more than one qualified HMO are required to offer one medical group or staff plan and one IPA plan (assuming more than one *type* of HMO solicits the employer). If 25 or more employees live in each of a number of service areas, and if the employer is solicited by HMOs from each area, the employer may have to offer more than one of each HMO type. Even when an employer offers coverage under a nonqualified HMO, the employer is still required to offer qualified HMO coverage if approached by a qualified HMO.

Other rules apply to union employees. The HMO alternative is subject to collective bargaining and can be accepted or rejected by the union employees. If the union rejects the HMO option, the option must still be offered to nonunion employees.

Employees who select the HMO option may not lose eligibility for dental, vision or prescription drug benefits if they are offered under employer plans separate from the regular health plan. This assumes that the HMO does not include the same services.

[3]The U.S. Department of Health and Human Services, which regulates federally qualified HMOs, has proposed no longer requiring employers to pay the same per-employee premium for HMO coverage as for traditional health insurance. Instead, employers and qualified HMOs would be permitted to negotiate premiums and make adjustments based on the composition of a given work force with relation to age, sex, marital status and average family size. See *Federal Register* 52, no. 8, January 1987, pp. 1343–44, for the proposed regulation.

health insurance plan without waiting periods, exclusions or restrictions due to health status.

Rate Requirements

The HMO Act requires that federally qualified HMOs *community rate* their services. A community rating system determines rates based on the HMO's total membership experience rather than on the experience of each subscriber group.[4] HMOs may vary rates within subscriber groups for individual and family coverage and among subscriber groups depending on the amount of coverage offered to each group.

The 1981 Amendments to the HMO Act further refined the federal HMO rating requirements. Now, federally qualified HMOs may use factors such as age, sex, marital status and family composition to establish classes of subscribers and group rates (community rating by class).

Conclusion

Since the passage of the 1973 HMO Act, there has been evidence that HMOs have been an important influence in restructuring our health care system and slowing rising health care costs. The growth of HMOs until recently was relatively slow. This slow growth reflected several factors. Physician reluctance to break from fee-for-service medical practice and to affiliate with HMOs has been an important obstacle to HMO development. Additionally, there was some initial confusion over the 1973 Act. The 1976, 1978 and 1981 amendments, however, attempted to clarify the original act and strengthen the competitive position of HMOs.

A 1978 Comptroller General report concluded that there was a shortage of persons trained to develop, operate and manage HMOs. Additionally, the group health plan marketplace is very competitive. It requires an intricate coordination of marketing, underwriting, actuarial and management skills.

Some changes are now occurring. Sustained growth in HMO membership suggests increasing employer and consumer interest in HMOs. Some employers make HMO enrollment mandatory for new employees for a trial period. Since 1982, national HMO membership has grown by more than 15 percent annually. Employers, unions and insurance companies have been more involved as direct sponsors and

[4]HMOs can separately rate public employees and Medicare or Medicaid subscriber groups.

organizers of HMOs. Involvement of business and labor leaders has brought needed management skills. Also, hospital managers and private-practice physicians have become more interested in HMOs as well as other types of alternative health care delivery systems.

An indication of the importance attached to HMO competition in the health care marketplace is the program enacted as part of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The program is intended to encourage HMO participation in Medicare by paying HMOs in a manner consistent with their cost efficiency. Medicare is authorized to pay HMOs in advance at a preset rate per enrollee, regardless of the amount or type of services rendered. Previously, Medicare would retrospectively pay HMOs, based on the "reasonable" cost of providing specific services to beneficiaries. Under final regulations issued by the Department of Health and Human Services in January 1985,[5] cost control becomes a financial incentive, which may lead to increased savings and enable more HMOs to offer expanded benefits, such as dental care, eyeglasses and prescription drugs.

TEFRA also defined competitive medical plans (CMPs) and authorized them to enter into contracts with the federal government to provide Part A and B services to Medicare beneficiaries. CMPs may be hospitals, large group practices, preferred provider organizations, non-federally qualified HMOs or any other organized group that has met certain financial solvency requirements. As of September 1986 there were 21 CMPs in the U.S.

Despite HMOs' growth, some observers regard them as a less attractive means of stemming rising health care costs. Employers may get at least a one-time saving for each employee joining an HMO, but it is less apparent that costs will subsequently increase any more slowly than those for conventional fee-for-service health insurance coverage. As a greater variety of providers and insurers compete for a share of the health care market, the future role of HMOs in the market becomes difficult to predict.

Additional Information

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624 9th Street, NW
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[5]For more information on the HHS regulations, see the *Federal Register*, January 10, 1985, p. 1344.

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304 Key Executive Bldg.
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XX. Preferred Provider Organizations

Introduction

Preferred provider organizations (PPOs) are contractual arrangements generally between health care providers and an employer or insurance company to provide fee-for-service health care at a prenegotiated rate. The term *PPO* covers a variety of arrangements and agreements between employers and organizations providing the health care services.

Providers (e.g., physicians and hospitals) agree to prenegotiated rates to those who contract for the services (e.g., employers and insurance companies) in return for an increased pool of patients, faster claims processing or both. There are various ways to determine the discount. Some arrangements have been based on a percent of charges, on a specific cost per day, or on the cost to treat specific diagnostic groups.

In most cases, employees covered by a PPO (subscribers) are free to choose any physician or hospital they wish, but are given financial incentives to use the services of *preferred* providers. These incentives include expanded benefits and lower costs for certain services.

Financial incentives for employees might include no deductibles and only minimal copayments, while employees who choose nonparticipating physicians may have to pay a deductible and larger copayments. For example, subscribers who use a preferred provider might have no deductible and a copayment of only $5 or $10 on office visits, plus extra services such as well-baby care and diabetes tests. Those who use nonparticipating physicians might be subject to a $100 or $200 deductible, 20 percent copayments and no extra coverages.

PPOs have emerged in response to employer concern over rising health care costs and to provider concern about growing competition from alternative health delivery systems, such as health maintenance organizations (HMOs), that promise lower-cost services. PPOs not only offer reduced prices for health care services, but they contend that they can reduce costs by selecting cost-efficient providers and through utilization review and control.

The American Association of Preferred Provider Organization's 1987 directory lists 674 operational PPOs, the majority of which have been

formed since 1983. According to the association, in 1985, the total number of covered persons grew from 1.3 million to 5.8 million, and in 1987, 37 million employees were estimated to have a PPO option available to them.

Types of PPOs

There are three primary types of PPOs: (1) provider-based, (2) entrepreneur-based; and (3) purchaser-based.

(1) Provider-based PPOs include hospitals, physician groups, joint hospital/physician arrangements, dentists, podiatrists and other health professionals.

(2) Entrepreneur-based PPOs include private investors, third-party administrators and utilization review organizations.

(3) Purchaser-based PPOs include Blue Cross/Blue Shield plans, commercial insurers, employers and community groups.

A similar arrangement to a PPO is an exclusive provider organization (EPO), established by self-insured employers. In an EPO, employees *must* use EPO providers to receive coverage; PPOs merely offer a financial incentive to employees to use the preferred providers. PPOs are subject to state insurance regulations, unless established by self-insured employers. Such employers consequently can establish EPO arrangements, agreeing to reimburse only for services of the exclusive providers.

Another type of PPO is known as a negotiated provider agreement (NPA), which allows employers to tailor their health insurance arrangement to their specific needs. An employer can negotiate pricing and determine how health care utilization will be monitored.

Most of the original PPOs were formed by hospitals, physicians and investors, but the more recent arrangements have been sponsored by Blue Cross/Blue Shield plans and commercial insurers.

Relatively few employers have organized their own PPOs, although some employers in the same geographic area have created associations that sponsor a PPO. Employers sometimes use insurance carriers as middlemen with a PPO.

Physicians who provide services to a PPO might have their own practice, be in small groups that belong to an independent practice association (IPA) or belong to a multispecialty group practice. The PPO might contract with a combination of these physician arrange-

ments and offer subscribers a choice among groups. PPOs usually include both primary care and specialists.

In a large metropolitan area, a PPO could have agreements with as many as 10 or 15 hospitals and thousands of physicians.

Differences Between HMOs and PPOs

HMOs and PPOs are both relatively new developments in alternative health care delivery systems, but there are major differences between them:

(1) HMOs are prepaid systems while PPOs operate on a fee-for-service basis.

(2) HMO members must use the services of HMO physicians and affiliated hospitals while PPO subscribers are not restricted to preferred providers.

(3) HMOs must bear the financial risk for their operations, while the purchaser, not the provider, bears the risk in most PPOs.

As new variations of PPOs emerge, however, many PPOs are assuming characteristics of HMOs. For example, risk-sharing between provider and purchaser is taking place in some PPOs. Also, some PPOs have begun to require primary care physicians to refer patients only to specific hospitals or specialists.

Managing Costs

PPOs can be effective in managing costs only through medical practices that carefully use health care resources. This means that physicians and hospitals are expected to avoid unnecessary tests, x-ray examinations and other procedures; to consider alternatives to hospitalization; and in general to practice efficient medicine.

Utilization review with feedback to the provider is a critical component of a PPO's cost containment strategy. PPOs might monitor claims, require prior authorizations for certain types of treatment and examine physician case records. Effective utilization review might also incorporate assurance for quality.

Utilization review is often handled within the PPO itself, as is the case with many hospital-provider PPOs, or by using an outside professional peer review organization. Hospitals or physician groups that conduct their own internal reviews are susceptible to the criticism that it is difficult for organizations to police themselves.

Employers who set up their own PPOs or insurance carriers who act as purchasers of services for employers must often set up their own monitoring systems to ascertain that they are receiving cost-efficient services from the providers with whom they contract.

Self-insured employers who want to reduce their risk for large losses are in many cases able to negotiate risk-sharing agreements with providers. Risk sharing includes splitting costs in catastrophic cases, paying bonuses to health care specialists for keeping costs under certain limits and setting fees for certain procedures. If the procedure turns out to be more costly, the hospital absorbs the difference.

In provider-based PPOs that accept responsibility for a share of financial risk, targets might be set on expenditures. If expenditures fall below the target, the savings might go to the physicians or be shared by the physicians and the employer. If expenditures exceed the target, the losses might be shared by the PPO and the employee or by the PPO, but only up to certain limits.

Legal Issues

Questions as to the legal status of PPOs have impeded their development in some states. Some forms of these arrangements have been found in violation of antitrust laws as horizontal price-fixing arrangements (*Arizona v. Maricopa County Medical Society*, 1982) or as arrangements potentially in restraint of trade (*Group Life and Health Insurance Company v. Royal Drug Company*, 1979).

Although PPOs in general are open to legal review, their dramatic growth is expected to continue. State laws may, however, restrict this growth somewhat. Illinois requires PPOs to have higher financial reserves, for example, and New Hampshire and Utah require that nonpreferred providers be paid at least 75 percent of the levels set for preferred providers.

There are also liability concerns. Questions have been raised about employer liability if an employee is directed to a particular doctor because of lower costs, and then malpractice occurs.

Conclusion

The changes in health care delivery systems present employers with new possibilities for cost containment. The rapid surge of PPOs in the 1980s suggests that they are finding acceptance with employers who are searching for alternatives to traditional indemnity plans that will help them control rising health care costs.

PPOs are seen as having the potential to bring about price competition among providers. But they also hold out the promise that they can provide more than discounted prices. To ensure both cost-effective and quality care, however, they must be energetic in searching out efficient and competent providers, and vigilant in discouraging excessive or inappropriate treatment by those providers.

Few scientific studies yet exist to support PPO contentions that they are successful in holding down health care costs. Many PPOs have been in existence too short a time for conclusive data to be available.

There are trends, however, that favor the continued growth of PPOs, including the increasing surplus of physicians and excess of hospital beds.

PPOs also may find greater acceptance by employees because they offer a choice of physicians in comparison to HMOs and other managed care plans. Some PPOs, however, are moving closer to the HMO model by using a primary care physician as a so-called "gatekeeper" who controls referral to specialists and hospitals.

In today's changing medical marketplace, different models of PPOs continue to emerge in response to the competitive marketplace and the search for successful cost containment strategies. If studies show that PPOs are succeeding in keeping health care costs down, they will certainly continue to expand.

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XXI. Dental Care Plans

Introduction

Health authorities agree that the dental care of many Americans could be improved substantially. Among the deterrents to better care are: (1) the public's perception that dental costs are high; and (2) the fact that correction of many dental problems can be postponed for long periods. Dental insurance has grown rapidly, and now covers over 80 million Americans. In 1986, nearly three workers in four employed by medium and large firms had employer-sponsored coverage for dental care.

A sound dental insurance plan has two primary objectives: (1) it helps pay for dental care costs; and (2) it encourages people to receive regular dental attention—thus, potentially serious problems can be detected and prevented.

Dental coverage may be provided to employees and their eligible dependents. In most situations, the plan sponsor (i.e., employer, union or joint fund) pays the employee's entire dental insurance premium, with some contribution to the dependents' premiums. In some cases, the employee and the plan sponsor share the cost.

A variety of organizations offer dental care plans: (1) insurance companies; (2) dental service corporations; (3) those administering Blue Cross/Blue Shield plans; (4) health maintenance organizations; and (5) *closed-panel* groups of dental care providers. In addition, some employers self-fund and self-administer their plans.

Services

The plan should specify the types of dental services that are covered and those that are not. Services that are usually covered include:

(1) diagnostic procedures—evaluating existing conditions and determining necessary treatment (e.g., oral examinations, regular checkups and x-rays);

(2) preventive procedures—cleaning, polishing and scaling teeth as well as fluoride treatment;

(3) restorative procedures—repairing teeth (e.g., fillings and crown work);

(4) oral surgery—operations performed in the mouth;

(5) endodontics—root canal therapy (i.e., treating teeth that have diseased roots);

(6) periodontics—treating gum diseases;

(7) prosthodontics—replacing missing teeth with fixed or removable prostheses (e.g., bridgework, partial removable dentures or full dentures);

(8) orthodontics—correcting malpositioned teeth.

Services that are not usually covered include:

(1) hospitalization due to necessary dental treatment;[1]

(2) cosmetic dental work (e.g., closing a gap between two front teeth);

(3) cleaning and examinations performed more often than twice a year;

(4) services covered by workers' compensation or other insurance programs.

Payment of Benefits

The most common types of dental plans are:

(1) *Nonscheduled Plans*—Typically, these plans cover dental costs based on *usual, customary and reasonable* charges. Usual, customary and reasonable charges are those that are: (a) the usual fee charged by the dentist; (b) the customary or prevailing fee charged by other dentists in the same geographic area for the same treatment; and (c) a reasonable amount based on the circumstances involved.

(2) *Scheduled Plans*—These plans use a schedule of benefits; this schedule provides a flat-dollar amount for each service. If a dentist charges more than the scheduled amount, the participant is responsible for the difference.

(3) *Combination Plans*—Some dental plans combine the usual, customary and reasonable payment method with the schedule-of-benefits payment method. For instance, a plan may pay for diagnostic and preventive services under the usual, customary and reasonable method, but it may pay for other services under the schedule-of-benefits method.

(4) *Closed-Panel Plans*—In a closed-panel arrangement, a designated group of dentists (i.e., a closed panel) provides services to an employee group.

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[1]Hospitalization for dental treatment as well as other dental services may be covered under another health insurance plan. For more information on other types of health insurance, see chapter XVII.

> The full cost of services is paid when employees go to providers specified by the plan. Employers pay a premium for such services; premiums are used to pay dentists' salaries, or they cover a fixed cost per beneficiary. If employees go to providers who are not in the closed panel, the plan will pay only a specified amount; the employee must pay any excess.

Dental plans may also require payment of a *deductible* (i.e., an amount a participant must pay before receiving any insurance payments).

Dental plans are increasingly part of flexible compensation plans—either as one or more of the types discussed above, or as part of a reimbursement account.[2]

Other Dental Plan Features

Predetermination of Benefits—Before beginning dental treatment, a plan participant may want to know how much he or she will have to pay for the treatment and how much the plan will pay. A plan may require the participant's dentist to fill out a predetermination-of-benefits form. The dentist would list the proposed treatment and its cost. He would then send the form to the claims office. The claims office, in turn, advises the participant and dentist of the benefit amount the plan will pay. Some plans require this procedure in cases where anticipated charges exceed a stated amount (e.g., $100).

Alternative Benefits—Dental problems often can be treated successfully in more than one way. When this situation arises, many dental plans base payments on the least expensive treatment that is customarily used for the condition. For example, a decayed tooth may often be satisfactorily repaired with either a crown or a filling. In this case, a dental plan bases its payment on the filling, which is the less expensive treatment. The participant and the dentist may proceed with the more expensive crown, providing the participant pays the dollar difference.

Cost Sharing—Most dental plans are designed with cost-sharing features, which require the participant to pay some portion and the plan to pay the remaining portion of charges for dental services. Two common features are deductibles and *copayments*.

As noted earlier, a deductible is an amount a participant must pay before receiving any insurance payments. Deductibles usually must be satisfied once each year, depending on the plan's design. Consider

[2]For more about flexible compensation plans, see chapter XXXI.

an example where a participant's first dental bill for the year is $75; the bill covers the filling of several cavities. The yearly deductible under this hypothetical plan is $50. Thus, the participant pays the first $50. The remaining $25 is covered, either partially or fully, by the plan. No other deductible is required of this individual in this year. Another $50 deductible, however, will have to be satisfied in the following year.

If a plan has a coinsurance feature, the plan and the participant share the costs of each covered dental service. The plan pays a specified percentage of covered services (e.g., 80 percent), and the participant pays the balance (in this case, 20 percent). Additionally, a plan may offer a number of coinsurance schedules depending on the treatment. For example, a plan may pay 80 percent of a dentist's bill for filling a cavity, but only 50 percent of a bill for orthodontic work.

In some plans, coinsurance is used in conjunction with a deductible. Under such a plan, after the yearly deductible (e.g., $50) has been paid by the participant, the plan will pay some stated percentage (e.g., 80 percent) of additional incurred dental expenses.

Some plans that require a deductible for some types of treatment do not require a deductible for preventive care services. Similarly, some plans that require coinsurance for some types of treatment do not require coinsurance for preventive care services. These features are intended to encourage regular dental visits and preventive care.

Benefit Limits—Most dental plans set maximum limits on the amount they will pay for each participant (e.g., $1,000 per person per calendar year). Separate maximum limits may apply for different treatments (e.g., an annual maximum of $1,000 per person for all dental services other than orthodontics, with orthodontics limited to a $750 lifetime maximum).

Claims Payment—Payment of claims under a group dental plan generally follows the same procedure as payment of claims under a group medical plan. The participant and the dentist fill out and submit claim forms. Payment for covered services may be sent to the dentist or to the participant. Dental plans usually experience heavy claims the first year due to a backlog of unmet dental needs in a newly covered employee group.

Effective and economical use of a group dental plan requires close interaction between the employee, employer and service provider. It requires that all parties work together to achieve the plan's goal of maintaining good dental health at a reasonable cost.

Nondiscrimination Rules

Employer-sponsored dental care plans are subject to the nondiscrimination rules for health and welfare plans mandated by the Tax Reform Act of 1986. (For an explanation of these rules, see chapter XVII.)

Conclusion

The first comprehensive group dental insurance plan was written nearly 25 years ago. Today, these plans can be found in almost every major industry (e.g., auto, steel, communications), and are increasingly found among outside companies that do business with these major industries. An abundant supply of dentists also has led to an increase in preferred provider arrangements, in which dentists provide care to covered employees for a discounted fee. Some believe that dental plans will be as common as health and life insurance plans by the end of this decade.

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XXII. Prescription Drug Plans

Introduction

Prescription drug plans were first introduced in 1964. Coverage for prescription drugs is intended to encourage the beneficiary to complete prescribed drug therapy so as to avoid more costly medical complications later. The average price of prescription drugs has risen nearly 40 percent since 1980. Although most major medical plans cover prescription drugs, many employers and joint funds prefer to provide separate drug plans because:

(1) Employees may not otherwise know that their medical plans cover the cost of prescription drugs.

(2) Participants covered under medical care plans that require payment of large or separate deductibles may not submit prescription claims.

(3) Employees may be confused by the paperwork of a typical medical plan (e.g., saving drugstore receipts and filing claims).

(4) The influx of prescription drug claims at the end of a medical plan year can cause administrative problems for the plan.

Prescription drug plans are simple in design. Usually, a plan will cover the employee after a brief employment period and pay the employee's premium. In addition, most plans cover employees' dependents. Some employers pay the full cost of dependent coverage; others require employee payroll deductions to pay for part or all of the cost.

A variety of organizations offer prescription drug plans: (1) insurance companies; (2) those administering Blue Cross/Blue Shield plans; (3) health maintenance organizations; and (4) labor unions. In addition, some employers self-fund their plans. Drug plans also are available through such organizations as the American Association of Retired Persons, often on a mail-order basis. (See (3) under "Payment of Benefits.")

Services

Prescription drug plans provide coverage for out-of-hospital prescription drugs. They usually cover *legend* drugs. " 'Legend' drugs

state on the label that federal law prohibits their being dispensed without a prescription."[1]

Generally, prescription drug plans do not cover proprietary medicines, appliances or devices, nonprescription drugs, in-hospital drugs, blood and blood plasma, immunization agents and any drugs or medicines lawfully obtained without a prescription, except insulin. Plans may also specifically exclude contraceptive drugs.

Many plans place limits on the quantity of a drug that may be dispensed at any one time. A typical limitation is a 34-day supply or 100 doses, whichever is greater. Frequently, a higher limitation applies to maintenance drugs. Most plans do not place a maximum on the overall covered quantity of a drug.

> [Prescription drug] plans typically apply only a small copayment (deductible) charge, such as $1 to $5 per prescription, on the covered person for drugs provided under the plan. So the relatively large deductible (such as $25 to $100), the coinsurance percentage, and the reasonable and customary charges provision, of traditional major medical plans, do not apply in the case of these basic prescription drug plans.[2]

Payment of Benefits

The most common types of plans include: (1) *open-panel plans*; (2) *closed-panel plans*; (3) *mail-order plans*; and (4) *nationwide-panel plans*.

(1) Open-panel plans permit employees to go to pharmacies of their choice. Participants pay for prescriptions and send the receipts with claim forms to the plan administrator for reimbursement. If the plan has a deductible (i.e., an amount a participant is required to pay before receiving any insurance payments), receipts usually are accumulated until they satisfy the deductible and then are submitted to a claims office at one time.

(2) Closed-panel plans generally employ a number of pharmacies—the number may range from a few to several thousand. The panel pharmacies dispense drugs to plan members at prices agreed upon by the plan provider and the pharmacy. Sometimes the price is the pharmacy's cost plus a dispensing fee. The plan administrator pays the panel pharmacies directly. Plan members pay only the applicable deductible and are not required to submit claim forms. If a plan partic-

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[1]Jerry S. Rosenbloom and G. Victor Hallman, *Employee Benefit Planning* (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1981), p. 197.
[2]Ibid.

ipant uses a nonpanel pharmacy (e.g., in an emergency situation), he must submit a claim form as though he were in an open-panel plan.

(3) In a mail-order plan, employees send their prescriptions to specified mail-order firms. Because of volume, mail-order pharmacies frequently price prescriptions at lower prices than other pharmacies. This arrangement usually works well, because 80 percent of prescription drugs are for maintenance or long-term medication; the other 20 percent are for emergencies. Costs can be reduced under the mail-order arrangement because all claims are processed at one location; thus, the use of a claim form is eliminated 80 percent of the time. Door-to-door service also makes this plan attractive. This plan is not designed for drugs that are needed immediately.

(4) Nationwide-panel plans, also known as prescription card service plans, are popular. They use a network of pharmacies, usually through a *prepaid drug plan administrator* (i.e., a firm administering plans for insurance companies, employers, joint funds and others) and negotiate price discounts. Also, nationwide-panel plans provide participating employees with a *credit card,* which is used to purchase prescription drugs. The administrators use computers to process claims and to control costs and claims abuses. Sometimes, a nationwide-panel plan includes a mail-order option; this approach achieves savings on maintenance drugs while maintaining a community-pharmacy convenience for emergency situations.

In addition, many pharmacy chains negotiate discounts with employers in a type of preferred provider arrangement.

Conclusion

After more than 20 years, prescription drug plans are now mature and have grown in number. Coverage may be decreasing, however, as plan deductibles are increased in an attempt to contain overall health plan costs. A few plans have encountered problems, especially at the start. For example, under certain plans, there has been the potential for credit card misuse. Also, since prescription drugs do not have stated *reasonable and customary charges*,[3] some pharmacists may have charged inflated prices because a third party paid the bill. In fact, prices for prescription drugs have risen faster than those for hospital care in recent years. Despite the small incidence of the problems cited here, these plans now work reasonably well and appear to be popular with many individuals.

[3]Reasonable and customary charges are those that are considered reasonable based on the circumstances and those that are customarily charged for drugs in a particular geographic area.

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XXIII. Vision Care Plans

Introduction

Vision problems are common. Over one-half of the United States population requires optometric care. Approximately 12 percent of children who are age 6 require vision care services; however, 96 percent of persons who are age 70 require such services. The need for eye care becomes pronounced at about age 40. Vision problems are often chronic and require regular attention.

Except for medical or surgical treatment and, in some cases, contact lenses after cataract surgery, traditional health insurance plans have provided little or no vision care coverage. Employer-sponsored vision care plans are designed to insure vision care services. In 1985, about 34 percent of workers in medium and large firms had vision care coverage through their employer.

Similar to most medical plans, vision benefits are usually available to a group of covered employees after a nominal waiting period; the employer usually pays the cost for employee coverage. In addition, most plans provide for coverage of the employee's dependents. This can be accomplished in a number of ways: (1) the employer may pay the full cost of dependent protection; (2) the employee may pay for dependent protection; or (3) the employer and the employee may share the cost.

A variety of organizations offer vision care plans. These include: (1) jointly managed funds; (2) health maintenance organizations; (3) those administering Blue Cross/Blue Shield plans; (4) vision care corporations; (5) optometric associations; (6) *closed-panel* groups of vision care providers; and (7) insurance companies. In addition, some employers self-fund and self-administer their plans.

The principal providers of vision care are:

(1) *Ophthalmologist*—A medical doctor specializing in eye examination, treatment and surgery. Some ophthalmologists dispense glasses and contact lenses.

(2) *Optometrist*—A health care professional who is specifically educated and licensed in each state 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 glasses and contact lenses.

(3) *Optician*—A person who makes or sells lenses and eyeglasses.

Services

The typical vision care plan covers eye examinations, lenses, frames and fitting of glasses. 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 cost for contact lenses; however, some plans only cover contact lenses when vision cannot be corrected to a stated level with conventional lenses (e.g., following cataract surgery).

Nearly all vision care plans impose limitations on the frequency of covered services and glasses. Typical limitations include: (1) one eye examination within a 12-month period; (2) one set of lenses within a 12-month period; and (3) 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.

Payment of Benefits

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

(1) Some plans pay the full cost of services, provided it satisfies the *usual, customary and reasonable* cost criteria. In other words, the covered amount is: (a) the provider's usual fee for the service; (b) the customary or prevailing fee for the service or product in that geographic area; and (c) a reasonable amount based on the circumstances involved. A fee may be considered reasonable when special circumstances necessitate extensive or complex treatment, even though it does not meet the usual, customary and reasonable criteria.

(2) Sometimes vision care plan participants must pay *deductibles*. The deductible is a specified amount of vision care costs that the plan participant must pay before any costs are paid by the plan. Under a plan with a $50 individual deductible, a participant must pay his or her first $50 in vision care expenses. The plan then pays for additional vision care expenses according to other plan provisions.

(3) Plans may have a *coinsurance* arrangement. Here, the plan participant pays some portion of the cost of vision care expenses, and the plan pays the remaining portion. The plan participant, for instance, may pay 20 percent and the plan may pay 80 percent of vision care costs.

(4) 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 usually is adjusted at intervals to keep it up-to-date with current charges.

(5) Plans may also use a closed-panel arrangement. A designated group (i.e., a closed panel) of vision care professionals provides 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 beneficiary. 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 will pay only a specified amount; the participant must pay any excess.

(6) 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 it may require coinsurance payments. Coinsurance may also be included in a schedule-of-benefits approach.

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. Additionally, an employer-sponsored vision care plan should include: (1) a program to increase employee awareness and understanding of vision care and the plan; (2) effective communication among all involved parties (i.e., employee, employer and service providers); and (3) an efficient claims filing and payment system.

Nondiscrimination Rules

Employer-provided vision care plans are subject to the nondiscrimination rules for health and welfare plans as mandated in the Tax Reform Act of 1986. (For an explanation of these rules, refer to chapter XVII.)

Conclusion

Although some vision care plans were established more than 30 years ago, vision care coverage is presently available to only a small portion of the population. With the increasing emphasis on comprehensive employee health care, however, the growth in vision care benefits may continue.

Additional Information

Finkel, Madelon Lubin. *Health Care Cost Management*. Brookfield, WI: International Foundation of Employee Benefit Plans, 1985.

Rosenbloom, Jerry S., ed. *The Handbook of Employee Benefits: Design, Funding and Administration*. Homewood, IL: Dow Jones-Irwin, 1984.

XXIV. Employee Assistance and Health Promotion Programs

Introduction

Employee assistance and health promotion programs are increasingly being utilized by employers as health care cost management measures and as tools for improving employee productivity, morale and job satisfaction. While the two types of programs often have similar goals, their structures and components are quite dissimilar.

Employee assistance programs (EAPs) are generally counseling services directed toward acute problems that affect job performance, such as drug and alcohol abuse and emotional and financial problems. Health promotion programs, on the other hand, emphasize prevention of physical and emotional illness through healthier lifestyles. Many health promotion programs are called "wellness" or "fitness" programs.

Today, more and more employers are offering both types of programs. In showing concern for employees' physical and mental health, employers may: (1) offer in-house or outside counseling services; (2) provide information on such problems as substance abuse, smoking and stress through seminars, classes or written materials; and (3) set up programs to assist employees in changing patterns of behavior that can lead to poor health.

In many cases, an employer provides coverage in the company medical plan for treatment of substance abuse and mental health problems, and also offers an EAP and a health promotion program.

Employee assistance and health promotion programs are being developed and offered by employers to address three basic issues: (1) rising health care costs; (2) increasing concern about how employees' personal problems affect job productivity; and (3) growing awareness of the benefits of good health and interest in participating in fitness programs.

Since both types of programs are relatively new employer-sponsored benefits, there have been few opportunities for employers or researchers to study the results over a long period of time. There have been few conclusive studies on the direct impact of the programs in reducing health care costs. If properly structured and communicated

to employees, however, the programs demonstrate employer concern and commitment for employee well-being.

EAPs offer employees, and in most cases their families, the opportunity to receive confidential, professional counseling and assistance. Generally there is little, if any, cost to the employee. Health promotion programs, on the other hand, provide extra benefit options to employees through activities at the work place or at easily accessed facilities. Depending on the program's design, employees may pay a fee for participation in certain activities.

The programs are finding wide acceptance among employers and employees, and appear to be on the rise. The Health Research Institute surveyed the 1,500 largest employers in the United States in 1985 and found:

(1) The proportion of respondents offering EAPs increased from 37 percent in 1983 to 50 percent in 1985.

(2) Smoking cessation programs rose from 28 percent in 1983 to 44 percent in 1985.

(3) The proportion of employers providing on-site exercise facilities rose from 17 percent in 1983 to 28 percent in 1985.

Employee Assistance Programs

Types—Some employers contract with specialists such as psychologists, social workers or alcoholism counselors to provide services for employees who are referred through the EAP, while other employers offer direct assistance through their own staff counselors. An employer also might contract with a community agency to provide services to employees.

The problem areas that are generally covered in an EAP include: (1) alcoholism and drug abuse; (2) emotional problems; (3) marital and family relations; and (4) legal or financial issues. The most prevalent problem covered in EAPs is substance abuse. A 1986 survey by Hewitt Associates of 293 companies—47 percent of which sponsored EAPs—also revealed coverage for such additional areas as job performance, eating disorders, employment termination and retirement.

Many employers include coverage for mental health services and treatment for substance abuse in the company medical plan. The 1985 Employee Benefits Survey conducted by the U.S. Department of Labor found that insured plans were somewhat more likely than self-insured plans to provide coverage for alcoholism and drug abuse treatment (required of insured plans in 28 states for alcoholism treat-

ment and in 14 states for drug abuse treatment). In 1985, 69 percent of participants in insured plans had coverage for alcohol abuse treatment and 62 percent had coverage for drug abuse treatment. By comparison, among participants in self-insured plans, 64 percent had coverage for alcohol abuse treatment and 57 percent for drug abuse treatment.

Many companies cover mental health care under their medical plans, but with limitations on inpatient and outpatient coverage. Many companies also include substance abuse treatment under mental health coverage.

Setting Up a Program—If employees are to seek out the services of an EAP, it must be structured to guarantee confidentiality and trust. Communications with employees about the program need to emphasize the EAP's role in assisting employees who need help with problems.

The program generally begins with an assessment of all employees' needs. This can be done by reviewing claims for mental health treatment, absenteeism rates, accident rates and employee interest in programs that deal with issues such as stress and caring for elderly relatives. Initial steps in setting up a program also involve deciding whether to develop an in-house program or contract out for services.

Supervisors and managers must be formally trained on how to effectively refer an employee to the EAP for problems that are affecting job performance. Supervisors who label employees as alcoholics or drug abusers and who try to force or coerce employees into treatment programs could cause legal problems for the employer.

Confidentiality of records makes the collection of information for evaluation difficult. But employers will want to know how many employees use the EAP, what the effects are on job performance and how employees feel about the program.

Advantages to Employers—EAPs may help employees deal with serious problems that could be interfering with their work performance, costing employers several billion dollars in productivity each year.

Program costs are minimal for employers who mainly use referral to outside agencies. For those employers hiring professional counselors or contracting with outside providers, costs will be somewhat higher, but the EAP will be more comprehensive.

Health Promotion Programs

Types—Programs that come under the heading of *health promotion* range from modest efforts (e.g., distribution of pamphlets on health

issues or provision of showers or changing facilities for employees who exercise) to elaborate, well-equipped gymnasiums and a full package of physical fitness activities.

One type of program, health risk screening, directly relates to health care by providing testing for high blood pressure, breast cancer, diabetes and high cholesterol levels. Screening is sometimes followed by education on how to reduce identified risks.

Other programs involve classes and seminars on how to stop smoking, lose weight, manage stress or learn about good nutrition.

Some companies have their own exercise facilities for employees (and sometimes for family members as well)—with swimming pools, jogging tracks, saunas, racquetball/handball courts and work-out rooms. If they do not have their own facilities, employers sometimes pay a share of an employee's health club membership.

Setting Up a Program—Careful planning helps to ensure high levels of employee participation. That planning includes:

(1) involving employees at all levels in the planning process;

(2) tailoring the program to the company and to its work force;

(3) communicating company commitment to the program and belief in its importance;

(4) providing a variety of options and developing incentives for employee participation;

(5) conducting periodic health assessments for employees to measure progress in achieving goals; and

(6) evaluating the program.

Employers have adopted a variety of incentives to encourage employee participation. Some employers pay a portion of the cost of having employees 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.

Advantages to Employers—Companies with health promotion programs generally report lower absenteeism rates, lower health care costs and more productive and satisfied employees. Some companies evaluate their programs by establishing control groups and then checking the fitness of those in the exercise program against the control group for such factors as weight control, smoking cessation,

elevated blood pressure and number of sick days used. In many cases, however, data have not been collected over a long period of time.

Some studies suggest that employees who are already fit and who exercise on a regular basis before joining a company program are the employees most likely to sign up and remain in fitness programs at work.

To make health promotion programs cost-effective, employers must encourage participation by employees. Drop-out rates can be high unless employers are innovative in the choice of programs and in the incentives offered to employees to take part in the program.

Health promotion programs can be valuable in providing early detection of health problems and the means for employees to reduce the risks from such problems. As employers modify and tailor programs to the needs and desires of their employees, the potential of the programs to improve productivity and reduce health care costs may increase.

Conclusion

The U.S. Chamber of Commerce estimates that employers spend as much as $2,000 a year on health costs for each employee. According to a 1985 study by the Office of Technology Assessment, a congressional agency, the nation's combined health care costs and lost productivity related to cigarette smoking each year total $2.17 per pack of cigarettes sold in the United States.

Many employers believe they have achieved significant health care cost savings through the initiation of employee assistance and health promotion programs. Moreover, they point to employee satisfaction with such programs.

To establish whether EAPs and health promotion programs can be credited with health care cost savings, employers and researchers will have to track a large number of employees over a long period of time. Regardless of these kinds of results, many employers believe that the existence of these programs demonstrates employers' concerns for their employees and the value they place on employees' well-being and good health.

Additional Information

Association for Fitness in Business
965 Hope Street
Stamford, CT 06907

Center for Corporate Health Promotion
11490 Commerce Park Drive
Reston, VA 22091

EAP Digest
2145 Crooks Road
Suite 103
Troy, MI 48084

National Health Network
3299 K Street, NW
Washington, DC 20007

Madonia, Joseph F. *Employee Assistance Programs: Their Impact on Health Insurance and Other Company Benefits*. Brookfield, WI: International Foundation of Employee Benefit Plans, 1985.

Meyers, Donald W. *Establishing and Building Employee Assistance Programs*. Westport, CT: Greenwood Press, 1984.

XXV. 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: (1) survivor income plans, which make regular (usually monthly) payments to survivors; and (2) group life insurance plans, which normally make lump-sum payments to a designated beneficiary or beneficiaries. 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 under Social Security. This chapter will focus on group life insurance plans.[1]

The concept of *individual* life insurance was developed centuries ago, but *group* life insurance is a relatively recent innovation. In 1911, the first known group life insurance contract was created at the Pantasote Leather Company in Passaic, New Jersey. The contract was called the *yearly renewable term employees' policy*. It included many features that are standard in today's group term life policies. By the end of 1912, there were twelve group contracts in existence providing total coverage of $13 million; by 1940, there were 8,800 contracts providing total coverage of $15 billion; and by 1945, there were 11,500 contracts providing total coverage of $22 billion.

In the years after World War II, the wage freeze spurred a boom in group life insurance. Employees, knowing they could not get wage increases, requested additional benefits. Employer-sponsored life insurance coverage was one of the most demanded benefits. As a result, in 1950, there were approximately 19,000 group contracts providing total coverage of $48 billion.

Growth of employer-sponsored life insurance has continued. At the end of 1985, approximately 642,000 master policy group contracts were providing $2.56 trillion of coverage to Americans—and most of this coverage was employer-sponsored. This $2.20 trillion *group* coverage accounted for 42.3 percent of *all* life insurance coverage in the United States in 1985.

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[1]For a discussion of survivor benefits under Social Security, survivor income plans and pension plans, see chapter XXVI.

The Insurance Contract

The contract between the insurance company and the employer is usually for group *term* life insurance. Many associations and multiple employer 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. 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 $0.10 per thousand dollars of coverage for employees in their early twenties, to $2.50 per thousand dollars of coverage for employees in their sixties. For large groups, the initial premium might also be taken from a standard rates table, but in the second and subsequent years of coverage, the premium may vary 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—While some group life insurance plans cover all of a company's employees, others cover limited groups, such as hourly-paid employees, salaried employees, members of a specific union, or employees at a certain plant location.

The Tax Reform Act of 1986 (TRA) revises the nondiscrimination rules applicable to group term life insurance plans to ensure that benefits under an employer-sponsored group life plan do not favor the highly compensated[3] and are distributed broadly among the rank-and-file employees. The nondiscrimination rules are generally effective for the later of (1) plan years beginning after December 31, 1987; or (2) the earlier of plan years beginning at least three months following the issuance of Treasury regulations or after December 31, 1988.

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[2]Other major types of group life insurance include *paid-up* and *ordinary life* insurance. Since term insurance is the most popular group coverage, the remainder of this chapter will focus primarily on group term insurance.

[3]See chapter IV for an explanation of highly compensated.

Under TRA, group term life insurance plans must meet three eligibility tests and a benefits test, or an alternative to the eligibility and benefits tests. The eligibility tests require that the employer satisfy three requirements. The first is that nonhighly compensated employees must constitute at least 50 percent of the group of employees eligible to participate in the plan. This requirement can be satisfied if the percentage of highly compensated employees who are eligible to participate is not greater than the percentage of nonhighly compensated employees who are eligible. This allowance is important to smaller firms where more than 50 percent of the workers are defined as highly compensated. In such cases, 100 percent of the nonhighly compensated would have to be eligible in order for the plan to pass the test.

The second requirement is that at least 90 percent of the employer's nonhighly compensated employees are eligible for a benefit that is at least 50 percent as valuable as the benefit made available to the highly compensated employee with the most valuable benefits.

The third requirement provides that a plan may not contain any provision relating to eligibility to participate that suggests discrimination in favor of highly compensated employees.

The benefits test requires that the average employer-provided benefit received by nonhighly compensated employees under all plans of the employer of the same type is at least 75 percent of the average benefit received by the highly compensated employees under all plans of the employer of the same type. The average employer-provided benefit is defined as the aggregate employer-provided benefits received by the highly or nonhighly compensated group divided by the number of employees in the respective group, whether or not they were covered by any of the plans.

An alternative to the eligibility and benefits tests allows an employer to meet the nondiscrimination rules if the plan benefits at least 80 percent of the employer's nonhighly compensated employees. Only individuals who receive coverage under a plan will be considered benefiting from the plan—eligibility to receive coverage is not sufficient.

There is a penalty if a plan fails to comply with the new nondiscrimination rules: All highly compensated employees in the plan will be taxed on the value of the discriminatory portion of the benefit. In the case of group term life insurance plans, the discriminatory excess is defined as the amount of employer contributions and elective deferrals required to have been made as after-tax employee contributions by the highly compensated employees if the nondiscrimination

tests were to have been satisfied. TRA language implies that this is determined by reducing the value of the benefits attributable to employer contributions (beginning with employees with the greatest benefits) until the plan is not discriminatory. The value subtracted is the discriminatory excess. Employers who fail to report in a timely manner that a plan is discriminatory are liable for an excise tax at the highest individual tax rate on the total value of benefits, unless reasonable cause for failure to report is demonstrated.

Amounts of Insurance—Employers provide varying levels of coverage. The amount of coverage can be based on one or more of a number of factors (e.g., occupation, tenure). The most common coverage is expressed as a flat-dollar amount or a percentage of salary. Some plans provide the same amount of coverage for all employees. Life insurance, however, is intended frequently to replace a portion of the deceased employee's earnings for a period of time. Thus, coverage may be stated as a multiple of annual earnings (e.g., one times pay, one and one-half times pay, two times pay or four times pay). This approach is one of the most popular and is becoming more popular among insurers, employers and employees. Often, supplemental plans are also used, to offer additional coverage.

Employee Cost—According to the Bureau of Labor Statistics, in most plans, employers pay the total premium for basic group life insurance. In other plans, employees pay part or all of the cost. When all or part of the cost is paid by the employee, the premium is usually a flat amount (e.g., 25 cents or 50 cents per thousand dollars of coverage per month) for each covered employee, regardless of age. The cost of *supplemental* plans is usually paid entirely by the employee; and, in supplemental plans, the monthly premium per thousand dollars of coverage increases with age.

Dependent Life Insurance—As part of the group life insurance plan, some employers offer insurance to employees' dependents. The cost of dependent coverage is usually paid by employees who elect such protection.

Dependent life insurance usually provides a fixed amount of coverage for the worker's spouse and a smaller fixed amount of coverage for other eligible dependents. Generally, the other eligible dependents are unmarried children between 14 days and 19 years old. Some contracts cover children from birth, however; and some set the upper age limit as high as 25 years old, if the dependent is a full-time student. Dependent coverage may continue indefinitely, if the dependent is physically or mentally disabled and unable to be self-supporting.

The level of dependent coverage is usually less—sometimes much less—than employee coverage. For example, a plan that provides two times pay for the employee might specify a flat $2,000 or $5,000 coverage amount for the employee's spouse and a flat $1,000 coverage amount for dependent children over the age of six months (and less for newborns).

Accidental Death and Dismemberment Insurance—Frequently, group life insurance plans include accidental death and dismemberment insurance. Thus, if death is the result of an accident, the plan may pay additional benefits. It may also pay benefits—usually stated fractions of the policy's face amount—for the accidental loss of a hand, foot or eyesight.

Beneficiary Provisions—Under a typical group plan, employees may designate and change their beneficiaries. At death, the stipulated benefit is paid directly to the named beneficiary. If a beneficiary is not named, proceeds generally go to the deceased employee's estate. (In the case of dependent insurance, unless someone is specifically named as beneficiary, the employee is considered to be the beneficiary.)

Benefits for Retired Persons and Older Workers—Most group life policies are designed to cover active employees. For active, older employees (age 65 is common) coverage can be reduced to reflect the increase in the cost of life insurance as a result of age. At retirement, coverage is often reduced to a smaller amount, or it may be canceled.

Conversion Privileges—When an employee's insurance expires because he or she terminates employment with the company, the employee may usually convert his or her group coverage to an individual permanent life insurance plan. Application must be made and a premium paid within one month after terminating from group coverage. (If the individual dies during the one-month period, the group protection is usually extended and benefits are paid.) The amount of converted coverage cannot exceed the amount of insurance previously provided under the group plan. Also, the premium will be the insurance company's standard rate for individual policies, based on the individual's age and risk classification.

Disability Benefits—Group plans generally continue to provide some life insurance protection for a covered employee who becomes totally and permanently disabled. Although there are several methods in use, the most popular is a *waiver-of-premium* provision. Under such a provision, coverage is continued at no cost to the disabled employee providing:

(1) the employee is under a specified age (usually 60)[4] at the onset of disability;

(2) the employee is covered under the plan at the onset of disability;

(3) disability continues until death;

(4) proof of total and continuous disability is provided annually.[5]

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 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

Group term life insurance is a tax-efficient benefit for the employer and the employee. The employer's premiums are tax-deductible as a business expense and the benefits paid to employees are exempt from federal income taxation. The proceeds, however, generally are subject to estate taxes.

If the employer provides the employee with coverage that exceeds $50,000, the employee must pay taxes on the employer-provided *cost* of the insurance coverage above $50,000. In cases where the plan discriminates in favor of key employees, the $50,000 coverage cost becomes taxable. (In the case of a discriminatory plan, some portion of the insurance will still be tax-free once the new nondiscrimination rules described previously take effect.) There are exceptions where the cost for group term life insurance in excess of $50,000 is tax-exempt. Where an employee contributes toward the cost of the insurance, his or her entire contribution is allocated to the coverage in excess of $50,000. Additionally, the $50,000 maximum does not apply if:

(1) the employee is totally and permanently disabled;

(2) the employee has legally specified that the policy proceeds go to a charitable organization.

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[4]Although this is a common provision, there are legal opinions that this provision may violate the Age Discrimination in Employment Act.

[5]For more information, see Jerry S. Rosenbloom and G. Victor Hallman, *Employee Benefit Planning* (Englewood Cliffs: Prentice-Hall, Inc., 1981), p. 45.

Group Universal Life Programs

Recently, employers have begun offering group universal life insurance—a relatively new and fast-growing category that is paid for by the employee, but usually offers lower premiums than similar insurance purchased on an individual basis. In addition, coverage is usually provided up to a limit without evidence of insurability, such as medical examinations.

Group universal life programs, also referred to by the acronym "GULP," allow policyholders (i.e., employees) to vary the timing and amount of premiums, in addition to the amount of the death benefit and the extent to which it increases. Premiums, minus mortality charges and expenses, create policy cash values. Such plans also provide competitive interest rates and allow buyers to accumulate tax-deferred savings.

Group universal life programs, however, do not always offer spouse and child coverage. In addition, if a master group universal life contract is terminated or altered, terminated employees or retired employees may find the original costs and form of their insurance substantially revised. Finally, introduction of a GULP could entail a major communication effort on the part of the employer to inform the employees about the choices offered and answer questions about the insurance product and enrollment procedures.[6]

Employee contributions to group universal life premiums are made with after-tax dollars, often via payroll deductions. If the policy is surrendered early, there may be a penalty. Corporate benefits departments should be consulted before selections are made in order to better understand the policy's implications. Although GULP programs are group plans, the tax reform rules do not apply to most GULP plans because they are not subject to section 79 of the Internal Revenue Code, which governs group term life plans.

Conclusion

The death of a worker can be financially devastating to his or her family. Employer-sponsored life insurance benefits can ease the financial problems. The number of employer-sponsored life insurance plans continues to grow, attesting to their importance. To be effective and efficient in designing these programs, however, employers should

[6]For more information on group universal life insurance programs, see Ward E. Jones, "GULPs Are Not What They're Cracked Up to Be," *Benefits News Analysis* 9 (January 1987): 28.

consider all potential private and public sources of life insurance, survivor benefits and death benefits.

Additional Information

American Council of Life Insurance
1850 K Street, NW
Washington, DC 20006

Curry, Tim, and Mark Warsrawky. "Life Insurance Companies in a Changing Environment," *Federal Reserve Bulletin* 72 (July 1986): 449–460.

XXVI. Survivor Benefits

Introduction

Most employers offer survivor or death benefits to their employees. Traditionally, these benefits were provided through group term life insurance, which paid a lump sum to a designated beneficiary or beneficiaries.[1]

More recently, benefits to the survivors of deceased employees also have been paid through other sources, including: (1) Social Security; (2) employer-sponsored survivor income plans; and (3) employer-sponsored pension plans. This chapter offers an overview of these three survivor benefit sources.

Social Security Survivor Benefits

Social Security benefits for *widows* and *widowers* are payable at age 60 providing: (1) the deceased spouse had attained Social Security's *fully insured* status;[2] and (2) the couple had been married for nine months. Although a widow/widower generally loses the right to benefits on the deceased worker's record when she/he remarries, she/he does not if the marriage takes place after age 60. *Survivor* benefits may also be paid to a spouse under age 60 (including a divorced spouse) who is caring for an entitled *dependent* child under age 16.[3] The benefit rate for widows and widowers who began receiving benefits at age 65 is generally 100 percent of the deceased worker's primary insurance amount (PIA) plus any *delayed retirement credits*.[4] The

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[1]For more information on life insurance plans, see chapter XXV.

[2]Generally, to satisfy the fully insured requirement, a person must have earned at least one quarter of Social Security coverage for each year after 1950 (or, if later, the year when he or she reaches age 21) and before the year of death, disability or 62 birthday, whichever occurs first.

[3]Requirements to determine whether a child is dependent vary according to whether the worker is a natural parent, legally adopting parent, stepparent or grandparent. For more information, see Social Security Administration, *The Social Security Handbook 1984* (Washington, DC: U.S. Government Printing Office, 1984), pp. 46–48.

[4]Delayed retirement credit is based on when a worker attains age 62. For those reaching age 62 in 1987, the delayed retirement credit is 3.5 percent for each year a worker does not receive retirement benefits due to work between age 65 and 70. For those reaching age 62 in the year 2005 or later, the credit will increase to 8 percent annually.

benefit for a surviving spouse caring for the former worker's child is 75 percent of the worker's PIA.

If the widow or widower is disabled, benefits are payable at age 50. For a disabled widow(er) to receive benefits, certain conditions must be satisfied: (1) the disability must be so severe that it prevents engaging in any type of employment; and (2) the disability must have occurred prior to the seventh anniversary of the spouse's death. A disabled widow/widower may remarry after age 50 without affecting benefits. The current benefit rate for disabled widows and widowers who are age 50 to 60 is 71.5 percent of the deceased worker's primary insurance amount.

A divorced person, who was married to a fully insured worker for ten or more years, may also be entitled to survivor benefits.

Benefits for children and surviving spouses caring for entitled children, as well as a small *lump-sum health benefit*, are payable if the deceased worker had attained fully insured or *currently insured* status.[5] Unmarried children under age 18 (or under 19 if full-time high school students) are entitled to receive benefits. The child benefit rate is 75 percent of the deceased worker's primary insurance amount. (The combined spouse's and children's benefits, however, cannot exceed a family maximum.) Dependent parents age 62 or older may also be eligible to receive survivor benefits, providing specific conditions are satisfied.

Survivor Income Plans

Survivor income plans typically pay benefits to *specified dependents* rather than to *designated beneficiaries* (who may or may not be dependents) of deceased employees. These benefits are generally paid in equal monthly installments. They are related to survivors' needs and are intended to provide continuing income support. Survivor income plan advocates believe this need is greatest when the employee is young and has young children, instead of when the employee has reached peak earning years and probably has substantial life insurance protection.

When designing survivor income plans, employers should consider the: (1) income level necessary to maintain the survivors' living stan-

[5]To satisfy the currently insured requirement, a person must have earned 6 quarters of coverage in the 13-quarter period ending with the quarter when death occurs. A lump-sum death benefit of $255, which is intended to help the worker's family pay the costs associated with the worker's last illness and death, is paid under specified circumstances to a surviving spouse or children of the deceased worker, p. 60.

dard and (2) additional benefit sources that survivors may receive (i.e., other employer-provided death benefits and Social Security benefits). Some plans are designed to provide income for specified lengths of time; these plans enable survivors to make financial adjustments during a transition period. They may pay benefits for periods as short as two years or as long as twenty years.

Insurance companies are commonly used as providers of survivor income coverage. However, employers may also self-insure this coverage. Survivor income plans may be entirely paid for by the employer or they may be contributory. Employee contributions are generally made through payroll deductions.

Plan Provisions

(1) *Employee Eligibility*—Survivor income plans may cover employees immediately upon employment or after a specified waiting period.

(2) *Survivor Eligibility*—The definition of a qualified survivor varies among plans. Typically, qualified survivors include an employee's spouse and any unmarried dependent children under age 18 (or age 19 if they are still in high school). Less frequently, eligible survivors include parents or other relatives. In some instances, coverage depends on whether or not the survivors are *truly dependent* on the employee for support.

(3) *Benefits*—Survivor income plans are generally designed to supplement Social Security survivor benefits. Usually, survivor income plans base benefits on the employee's salary at the time of death. The spouse's benefit is typically 20 to 30 percent, and children's benefits are 10 to 20 percent, of an employee's salary before death. However, the family's combined benefit may be limited to an overall maximum (e.g., 40 percent).

The amount of a survivor's monthly benefit can also be: (a) a fixed-dollar amount (specified for all employees); or (b) an amount designated according to an employee's position.

(4) *Duration of Benefits*—Some plans are designed to pay benefits for time periods related to survivors' ages. Other plans pay benefits for survivors' lifetimes. Generally, children's benefits stop once they reach the plan's age limit or if they marry before reaching the age limit. Spouses' benefits may continue until age 60 when a widow(er) becomes eligible for Social Security survivor benefits. Other plans continue widow(er) benefits until the date when the deceased employee would have reached normal retirement age.

Spousal benefits may discontinue if the widow(er) remarries. However, some plans continue benefits for a specified period regardless of whether the widow(er) remarries. Other plans pay a *dowry* benefit (i.e., a lump-

sum benefit payable upon remarriage) to encourage reporting of the marriage.[6]

Taxation—The cost of survivor income benefit plans is tax deductible to the employer. Employer contributions to these plans are generally tax-free to employees. If the employer provides the employee with coverage that exceeds $50,000 in life insurance value, the employee may be required to pay taxes on the *cost* of the insurance coverage above $50,000. Life insurance proceeds are exempt from federal income tax. But if the beneficiary receives payment in installments over time, instead of a lump sum, then a portion of the installment payments, which represents the interest, is considered to be taxable income. Life insurance proceeds from an unfunded, self-insured plan are taxable if the lump-sum benefit exceeds $5,000.

Pension Plan Death Benefits

Most pension plans contain provisions for death benefits payable when a participant dies. The Internal Revenue Service requires that these benefits must be *incidental* to the plan's main purpose, which is to provide retirement benefits.

Although the Employee Retirement Income Security Act (ERISA) and the Retirement Equity Act of 1984 (REA) impose certain requirements, there is still a considerable amount of flexibility in designing pension plan death benefits. Plans may provide preretirement death benefits and postretirement death benefits.

The law requires that once a married participant in a pension plan becomes vested, he or she is covered by preretirement survivor annuity protection unless the participant and spouse elect otherwise. This protection will provide an annuity to a surviving spouse in the event the participant dies before the retirement annuity commences. This is true whether the participant stays with the employer up to retirement or terminates employment before that.

The minimum amount of the required preretirement survivor annuity is equal to the survivor portion of a joint and survivor annuity (discussed below). If the participant dies before reaching the earliest age at which annuity payments could begin, the annuity is determined by assuming that the participant terminated employment instead of dying and elected commencement of benefits at the earliest

[6]Jerry S. Rosenbloom and G. Victor Hallman. *Employee Benefit Planning* (Englewood Cliffs: Prentice-Hall, Inc., 1981), p. 60.

date allowed by the plan (usually age 55) and then died immediately thereafter. The plan could provide that no annuity payments be provided to the surviving spouse until the date the participant would have reached that earliest retirement age, had he or she lived. If the participant dies after the earliest retirement age, the survivor annuity is generally determined by assuming the participant elected commencement of a joint and survivor annuity at the time of death and died on the day after.

The law also requires that retirement benefits to married persons must be paid as a *qualified joint and survivor annuity, unless the participant and spouse elect to receive benefits in some other form* or unless the plan meets one of the following exceptions: under the Tax Reform Act of 1986 (TRA) a plan is exempt from the qualified joint and survivor annuity law if: (1) the plan was established before January 1, 1954, as a result of an agreement between employee representatives and the federal government during a period of government operation, under seizure powers, of a major part of the productive facilities of the industry; and (2) if participation in the plan is substantially limited to participants who ceased employment covered by the plan before January 1, 1976. Under a joint and survivor annuity, the retired worker receives a benefit during retirement years; benefits then continue to be paid after death in the same amount or in a lesser amount to the surviving spouse. If the spouse dies first, the lesser amount continues until the death of the retiree. The retired worker's benefit is usually reduced to reflect the cost of survivor protection and the ages of the retiree and spouse at the time of retirement. Some plans, however, pay an unreduced amount to the retired worker. If a married participant wants to reject the joint and survivor annuity, his or her spouse must agree to this rejection in writing before a notary public or plan representative.

ERISA also requires that all *employee* contributions be paid with interest to a beneficiary, if a participant dies before receiving benefits.

Other forms of death benefits under pension plans may include: (1) the lump-sum value of a participant's accrued benefit; (2) a life insurance contract with a face value equal to one hundred times the monthly pension benefit the decedent would have received at normal retirement; (3) monthly payments in the amount the decedent would have received as a pension; or (4) lump-sum death benefits designed to meet final illness and funeral expenses (usually these benefits range from $1,000 to $3,000).

Eligibility for survivor benefits may require a couple to have been married for a specified length of time. Or, it may require the bene-

ficiary to be a parent of a dependent child. When there is no surviving spouse, benefits may be paid to dependent children. Some plans pay benefits to other dependent relatives.

Taxation—A death benefit from a qualified pension plan paid as a lump-sum distribution may be eligible for capital gains treatment under the six-year phase-out rule of TRA beginning on January 1, 1987, or five-year forward averaging if received after the participant would have attained age 59 1/2. Under a transition rule, if the participant attained or would have attained age 50 by January 1, 1986, the lump-sum distribution may be eligible for five-year forward averaging or 10-year-forward averaging (at 1986 tax rates) with respect to a single lump-sum distribution without regard to attainment of age 59 1/2, and to retain the capital gains character of the pre-1974 portion of such a distribution. Under the transition rule, the pre-1974 capital gains portion would be taxed at a rate of 20 percent. The distribution must represent the full amount in the employee's account, and it must be received within the same taxable year. Lump-sum distributions may also be eligible for a $5,000 death benefit exclusion. This provision permits beneficiaries to exclude up to $5,000 in employer-provided death benefits from gross income for tax purposes.

Under certain circumstances, a lump-sum distribution to a surviving spouse may be eligible for rollover to an individual retirement account (IRA) or another qualified plan.

Conclusion

The death of a young worker can be devastating to the surviving family. Statistics of elderly widows in poverty demonstrate that the death of an elderly worker or pensioner can also be devastating to the surviving family. Awareness of these problems has resulted in an increasing interest in survivor benefit plans. In designing survivor benefit plans, however, one must consider the different public and private programs that currently provide survivor protection. Careful benefit planning can produce effective protection while reducing costly benefit overlaps.

Additional Information

Martorana, George. *Your Pension and Your Spouse-The Joint and Survivor Dilemma*. Brookfield, WI: International Foundation of Employee Benefit Plans, 1985.

U.S. Department of Health and Human Services. *Your Social Security Rights and Responsibilities, Retirement and Survivors Benefits*. Baltimore, MD: Social Security Administration, 1986.

XXVII. Disability Income Plans

Introduction

Unexpected illness or injury can result in a person's inability to work. This may create serious financial problems for individuals and families. The costs of necessary medical treatment can exacerbate such 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.

A report released by the U.S. Bureau of the Census in 1986,[1] found that 20.6 percent of people age 15 and over—including 14.1 percent between ages 16 and 64 and 58.5 percent of those 65 and over—had difficulty performing one or more basic physical activities. The survey also found that the proportion of women with disabilities was 23.2 percent, compared with 17.7 percent for men. The difference occurs largely because women outnumber men in the elderly age groups. Of people age 16 to 64, the report said that about 18.2 million, or 12 percent, have a disability that affects their work and 8 million were prevented from working by the disability.

When disability occurred in the past, many employers offered *informal* pay-continuation arrangements—especially for salaried employees. Today, *formal* disability income programs have gained wide acceptance. About 63 percent of business and industry employees are covered by some form of private disability income plan. Virtually all workers are covered by mandatory public disability plans (e.g., Social Security and workers' compensation).

Disability can be categorized as: (1) short-term or long-term and (2) partial or total. Most plans require disabled employees to be under a physician's care. Benefits must be provided for pregnancy-related disability on the same basis as for any other disability.

Public Programs

Social Security—The Social Security program provides long-term disability benefits for workers who satisfy the following conditions:

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[1]U.S. Bureau of the Census, *Disability, Functional Limitation, and Health Insurance Coverage: 1984/85*, Washington, DC: U.S. Government Printing Office, 1986.

(1) the worker must have achieved *fully insured* and *disability insured* status;[2] (2) he or she must be totally and permanently disabled as defined by law; and (3) he or she must have suffered from the disability for at least five consecutive months.

The Social Security disability benefit is equal to the primary *Old-Age* benefit. However, when combined with workers' compensation, it may not exceed 80 percent of *average current earnings* before disability.[3] (Employees covered by the Railroad Retirement Act are entitled to disability income benefits under that act rather than under Social Security.)

Workers' Compensation—Workers' compensation provides benefits to workers disabled by occupational injury or illness. These benefits are provided under state law; every state requires workers' compensation coverage. In most states, this coverage is provided through private insurance or through an employer self-insurance arrangement. Twenty states offer coverage through state funds, however, and six of these *require* employers to use the state funds. Employers pay for workers' compensation through risk-related premiums. The amount and duration of workers' compensation benefits depend upon state laws and the extent of the disability.

Nonoccupational Temporary Disability Insurance—Most of these plans are voluntary. However, California, Hawaii, New Jersey, New York, Rhode Island and Puerto Rico require employers to provide disability income protection for nonoccupational temporary disabilities. Under these compulsory laws, benefits are payable after a short disability period (e.g., one week). Depending on the state, temporary disability coverage is provided through state funds, private insurers or both. Eligibility criteria and benefit formulas vary from state to state. However, a maximum protection period of twenty-six weeks is generally imposed.

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[2]To satisfy the fully insured requirement, a person usually must have earned at least one quarter of coverage for each year after 1950 (or, if later, the year when he or she reaches age 21) and before the year of death, disability or 62nd birthday, whichever occurs first.

To satisfy the disability insured requirement, a person must have earned at least 20 quarters of coverage, during the 40-quarter period, ending with the quarter in which the disability begins. If a person becomes disabled before reaching age 31, more liberal rules apply.

[3]For purposes of Social Security disability, average current earnings are generally defined as a person's highest-year earnings in the six-year period consisting of the calendar year when disability begins and the five years preceding that year.

Private Programs

Individual employers, jointly managed (Taft-Hartley) trust funds, insurance companies and associations may offer private disability income plans. Before a private plan is adopted, a number of plan design and administration 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 (i.e., indirectly by stockholders and customers), and what portion should be paid by employees?

Employers are legally required to contribute to the public disability plans discussed in the previous section. To avoid costly duplication, private plan sponsors must 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).

There are two primary types of private disability income plans: (1) short-term disability plans (benefit payments usually are provided for 26 weeks or less); and (2) long-term disability plans (benefit payments usually are provided after short-term benefits have ended). Long-term benefits generally are paid until age 65 or the normal retirement age. 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 eligibility for these benefits by active employees. The benefits may be paid longer than to age 65 for older employees who become disabled, based on age-related cost considerations. Employers must either provide equal benefits to employees of all ages, or, as is usually the case, provide benefits that are equal in cost to employees of all ages. Since 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, both relative to younger employees.

Short-Term Disability Plans—A short-term disability is usually defined as *an employee's temporary inability to perform normal occupational duties*. Under most short-term disability plans, such as 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. 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.

Short-term disability protection may thus include sickness and accident insurance benefit programs as well as paid sick leave. Under these programs, sick leave usually provides 100 percent of the worker's normal earnings; sickness and accident insurance usually replaces 50 to 67 percent of pay during limited disability periods. Sick leave plans frequently specify a number of covered days each year that are permitted for paid sick leave.

Sickness and accident insurance plans may be used instead of, or in conjunction with, sick leave plans. When used in conjunction with sick leave plans, sickness and accident plans provide benefits after sick leave benefits are exhausted. The level of sickness and accident benefits for short-term disability may be expressed as a specified weekly dollar amount or as a percentage of straight-time pay. The level and the 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: (1) a group insurance contract with a private insurance carrier; (2) an employer self-insurance arrangement; (3) an employer-established employee benefit trust fund; (4) a Taft-Hartley multiemployer welfare fund; or (5) general corporate assets (e.g., for a sick leave plan). Short-term disability plans may be administered by the: (1) employer; (2) insurance carrier; or (3) board of trustees of a Taft-Hartley plan.

The duration of short-term disability benefits typically ranges from 13 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.

Long-Term Disability Plans—Many employers offer long-term disability benefits. In most long-term plans, disability for the first two years is defined in the same way as disability under short-term plans (i.e., an employee's inability to perform normal occupational duties). 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.

Long-term disability plans generally provide benefits when short-term disability benefits expire. Similar to short-term benefits, integration of long-term disability benefits with benefits from a variety of sources is usually used to produce reasonable replacement rates and to control costs.

Private sources of long-term disability benefits include disability provisions under: (1) long-term disability plans; (2) group life insurance; (3) employer-sponsored pension plans; and (4) other insurance arrangements (e.g., individual insurance protection). Generally, these plans pay benefits amounting to between one-half and two-thirds of a person's predisability gross weekly income. Some plans, however, provide as much as 70 to 80 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 salary). The cost of long-term disability benefits may be financed by: (1) employer contributions; (2) employee contributions; or (3) employer/employee cost sharing.

Although long-term disability plans may limit benefits to a specified period (e.g., 5 or 10 years), most provide benefits for the length of a disability, up to a specified age (e.g., age 65, when Social Security and employer-provided retirement benefits begin). 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 take on rehabilitative employment.

Conclusion

The possibility of disability threatens everyone. When a family's primary supporter becomes disabled, the financial impact can be devastating. Employees and employers are placing greater emphasis on disability income plans. Although nothing can eliminate the suffering caused by disabling injuries or illnesses, private and public disability plans can provide some economic security for disabled persons and their families.

Additional Information

The Disability Advisory Council
P.O. Box 17064
Baltimore, MD 21203

Berkowitz, Monroe, and Anne M. Hill. *Disability and the Labor Market*. Ithaca, NY: ILR Press, New York State School of Industrial and Labor Relations, Cornell University, 1986.

DeVol, Karen R. *Income Replacement for Short-term Disability*. Cambridge, MA: Workers Compensation Research Institute, 1985.

XXVIII. Educational Assistance Benefits

Introduction

During the last forty years, the popularity of higher education has grown. One reason has been the demand for more skilled workers to meet the challenges of high technology industries. Another factor was the passage of the World War II GI bill, which entitled World War II veterans to a higher education — previously an impossibility for low-income veterans. In the late 1950s and in the 1960s, higher education also became more accessible to minorities and low-income individuals, due to government grant, job and loan programs, mainly established under the Higher Education Act of 1965.

Higher education is now more expensive than ever. Many individuals who cannot afford to finance their education in full look to federal loan and grant programs for financial assistance. Some of these programs, however, apply only to students who are enrolled at least half-time. Many part-time students, therefore, may not receive government assistance. For these individuals, employer-provided educational assistance is an important benefit in supplementing their educational pursuits.

Employer-Provided Assistance

Employer-provided educational assistance benefits facilitate career advancement for employees at all income levels, particularly for lower-compensated employees, many of whom are women and minorities. These programs are widely used by employers. The availability of tuition assistance has increased from 40 percent of employers in 1977 to 69 percent in 1985, according to U.S. Chamber of Commerce estimates.[1] Among larger firms with at least 10,000 employees, 95 percent provide tuition assistance, while 85 percent of employers with 1,000 to 10,000 employees offer some type of tuition program.[2]

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[1]U.S. Chamber of Commerce, Survey Research Section, Economic Policy Division, *Employee Benefits 1985* (Washington, DC: 1986).

[2]Gerard Gold and Ivan Charner, Employer-paid Tuition Aid: Hidden Treasure," *Education Record* 64, no. 2 (1983): 45.

According to recent U.S. Chamber of Commerce estimates, the cost of employer-provided tuition assistance accounts for 0.3 percent of total employee wages and salaries. These programs are, thus, not excessive in cost to the employer, attract motivated employees and may reduce employee turnover by promoting job satisfaction and internal career-ladder programs. Educational assistance programs can, therefore, play an important role in a worker's career development, often being a contributing factor in an employee's salary growth.

Employee participation rates in educational assistance programs, however, are low. According to the National Institute for Work and Learning, a nonprofit organization that researches and implements education and work programs, during the 1970s, only 3 to 5 percent of employees eligible for the tuition assistance benefit took advantage of the program annually. This percent may be increasing, but no firm data are available. The American Society for Training and Development estimates broadly that between 2 and 7 million working adults annually use tuition assistance. Low worker participation can be attributed to a number of factors: scheduling problems, low worker interest and insufficient management encouragement and incentives. Companies that actively promote educational benefits, however, experience higher participation rates of between 10 and 12 percent.[3]

According to a 1984 corporate survey, most tuition assistance plans paid for degree and career-related courses as well as job-related courses. Ninety-nine percent of the plans covered expenses directly related to the employee's job. Seventy-nine percent of employers reimbursed employees for career-related courses, whereas 66 percent covered courses that were degree-related only. Only 14 percent reimbursed expenses for courses that were neither job-related nor degree-related. About one-fourth of the employers surveyed paid 100 percent tuition reimbursement with no maximum.

Types of Educational Assistance

Employers can provide the following types of educational assistance to employees:

Tuition Aid—Tuition aid, or assistance, is usually provided by the employer on a reimbursement or prepayment basis to employees who pursue educational programs on their own time. Reimbursement is

[3]Gerard Gold, *Employment-Based Tuition Assistance: Decisions and Checklists for Employers, Educators, and Unions* (Washington, DC: National Institute for Work and Learning, 1985), p. 7.

generally made to the employee upon course completion. Some plans provide temporary loans for employees who cannot advance fund their educational expenses. Most prepayment plans have recapture provisions to protect the employer if a course is not completed or the employee resigns. Some employers reimburse according to the grade obtained by the employee. For instance, a grade A would be reimbursed at 100 percent of the tuition cost, B at 90 percent, C at 80 percent, D at 70 percent, and there would be no reimbursement for failed courses.

In a 1983 survey of the Fortune 500 companies conducted by the Conference of Small Private Colleges, 26.4 percent of firms responding required that the employee pay part of the tuition. Eighty-six percent of firms responding reimbursed the employee only after "satisfactory completion" of a course.

Training Funds—Training funds are established for entry-level training or apprenticeships, often through combined efforts of small employers and trade unions. The funds are administered by a firm's board of trustees.

Educational Leave—Many corporations offer leave to allow the employee time to complete final papers or courses needed for a degree. The leave can be with or without pay.

Scholarships and Educational Loans—Scholarships, which are nontaxable to the employee who is a degree candidate, and educational loans, which are repaid to the employer, are two other types of employer-provided programs that assist employees with educational expenses.

Federal Educational Assistance Programs

The U.S. Department of Education (DE) offers six major student financial aid programs: Pell Grants, Supplemental Educational Opportunity Grants, College Work-Study, Perkins Loans (formerly known as National Direct Student Loans), Guaranteed Student Loans and PLUS Loans/Supplemental Loans for Students (SLS).

Pell Grants—Pell Grants help undergraduates finance their college education. This is the largest federal student aid program. Awards may be as high as $2,100 per year per student. If a student is enrolled in two different schools, he or she may not receive Pell grants for duplicative costs. For these grants, the U.S. Department of Education (ED) guarantees that each participating school (i.e., one that meets ED requirements) will receive enough money to pay the Pell grants

for each qualifying student. A student must show financial need to qualify.

Supplemental Educational Opportunity Grants (SEOGs)—An SEOG is also a financial award for college undergraduates of up to $4,000 a year. Unlike the Pell grants, however, a SEOG allocates a set amount of money each year to an institution. There is, thus, no guarantee that each qualified applicant will receive an award. Like Pell Grants, awards are also based on financial need.

College Work-Study (CWS)—A CWS is a program for both undergraduate and graduate college students. It is a combined contribution program of the employer, college, institution or off-campus agency and the government that pays students to work on- or off-campus. A CWS job must always be for a public or private nonprofit organization. The government may contribute up to 80 percent toward the work-study grant of a student, and the on- or off-campus employer contributes the remainder.

Perkins Loans—Perkins loans are low-interest loans available to undergraduate and graduate college students through a school's financial aid office. Repayment begins six months after the student graduates, leaves school or drops below half-time student status. Half-time status is based on whatever the college or institution determines to be half-time. Depending on a student's need, the availability of Perkins Loan funds at the school and the amount of other aid received, a student may borrow up to:

(1) $4,500 if enrolled in a vocational program, or if completed less than two years of a program leading to a bachelor's degree;

(2) $9,000 if an undergraduate student has already completed two years of study toward a bachelor's degree and has achieved third-year status (this total includes any amount borrowed under the Perkins Loan program for first two years of study);

(3) $18,000 for graduate or professional study (this total includes any amount borrowed under the Perkins Loan program for undergraduate study).

A Perkins loan is generally repaid monthly over a total repayment period of ten years—with a few exceptions. An individual may defer payment if he or she continues to study at half-time status, becomes temporarily/totally disabled, enters the U.S. armed forces, is an officer in the U.S. Public Health Service Commissioned Corps or if he or she serves in the Peace Corps, Action programs or a comparable program in a tax-exempt organization. A deferment of up to two years is allowed for service in certain internship programs, and deferment

may be obtained under extraordinary circumstances (e.g., illness or unemployment).

Guaranteed Student Loans (GSLs)—GSLs are also low-interest loans financed through a bank, a credit union, savings and loan association and other eligible lenders that are available to undergraduate and graduate students who show financial need. A first or second year undergraduate student may borrow up to $2,625 a year; an undergraduate student who has completed two years of study may borrow up to $4,000 a year; and a graduate student up to $7,500. An undergraduate may incur a total debt of $17,250 and a graduate student, $54,750, including undergraduate loans. A student cannot borrow more than the cost of the education at the attending school minus any other financial aid and the expected family contribution. Loan repayments begin anywhere from six to twelve months after graduation; the lender must allow at least five years for repayment of the loan and may allow up to 10 years. Deferments are allowed under similar circumstances that apply to the Perkins Loans. GSLs allow additional deferments, such as graduate fellowship programs or return to full-time study. A student may defer loan repayment for one year if he or she is unemployed and actively seeking employment.

PLUS/SLS Loans—PLUS loans, are available to parents of dependent students; Supplemental Loans for Students (SLS) are for student borrowers. PLUS/SLS loans are similar to GSLs, but they are available at higher interest rates. Unlike GSL borrowers, PLUS/SLS borrowers do not have to show need for their loan. Parents may borrow up to $4,000 per year to a maximum of $20,000 for each child who is enrolled at least half-time as a dependent student. Under SLS, self-dependent undergraduate and graduate students may borrow up to $4,000 per year to a total of $20,000 when combined with a GSL loan.

GSLs and PLUS/SLS programs are administered by a state or private nonprofit agency referred to as a "guarantee agency." Each state has its own guarantee agency, which usually charges an origination fee and an insurance premium at the time the loan is disbursed. The origination fee is 5 percent and the insurance fee is 3 percent of the outstanding principal balance of the loan. Interest repayments for an SLS loan begin within 60 days unless the applicant has qualified for a deferment and the lender agrees to allow the interest to accrue until the deferment ends. There are no deferments for a parent borrower.

For more information on grant, job and loan programs and state guarantee agency information, contact the U.S. Department of Education, Office of Student Financial Assistance, Washington, DC 20202.

State Student Incentive Grant Program

The State Student Incentive Grant Program is a combination state and federal tuition assistance program. The government allocates funds to each state guarantee agency based on the enrollment of students in postsecondary education in each state. The state agency must contribute at least 50 percent of the total grant awards made available to students.

Other Federal Assistance Programs

The Veterans Administration (VA) offers two types of educational assistance programs today. For veterans of the Korean and Vietnam Wars with service between February 1, 1955 and December 31, 1976, assistance is available under the GI bill. Veterans have ten years from the last day of active duty to use the benefit. Veterans who served after 1976 will receive assistance under a contributory plan. Under such a plan the serviceperson contributes $25 to $100 monthly from his or her military pay to a fund for education or training. For every $1 that the serviceperson pays into the fund, the government pays $2. A veteran is eligible to receive this benefit without showing financial need and regardless of whether his or her enrollment status will be part-time or full-time.

For more information on these programs, contact the Veterans Administration, Washington, DC 20420.

Taxation

The Educational Assistance Act, which became effective after December 31, 1978, established section 127 of the Internal Revenue Code. Until December 31, 1983, when the law expired, all amounts incurred by the employer for an employee's educational assistance were excludable from the employee's gross income. In late 1984, Congress extended benefits through December 31, 1985. Under the law (P.L. 98-611), Congress placed a $5,000 limit on the tax-free status of employer-provided educational assistance and extended the tax exclusion retroactively for the year 1984, with no penalties for employers who did not withhold taxes from employees' salaries in that year. Under the Tax Reform Act of 1986, the tax exclusion was retroactively extended through December 31, 1987, and the prior $5,000 limit on tax-free employer-provided educational assistance was increased to $5,250 (effective January 1, 1986). One advantage of employer-provided educational assistance over individually financed education,

where a deduction is taken, is that education reimbursed by the employer does not have to be job-related to qualify for tax-preferential treatment.

Employer-Provided Assistance—As mentioned above, up to $5,250 of employer-provided educational assistance is excluded from an employee's income, if it is provided under a plan that does not discriminate in favor of highly compensated employees. The education need not meet the IRS definition of job-related, but may not involve sports, games or hobbies, unless it involves the business of the employer or is required for a degree program. The $5,250 cap does not apply to education meeting the IRS definition of job-related.

Any excess over $5,250 is taxable income to the employee. When an employee works multiple jobs, the annual $5,250 limit applies to the total amount of educational assistance from all employers. Employers offering this benefit must file an information return with the U.S. Department of Treasury that shows the: (1) number of employees in the firm; (2) number of employees eligible to participate in such a program; (3) number of employees participating in general; (4) total cost of the program during the year; and (5) name, address and taxpayer identification number of the employer, and the type of business in which the employer is engaged.

These reporting requirements are intended to provide an accurate picture of the rates and costs of employer-provided tuition assistance plans.

Individual—To claim an individual income tax deduction for educational expenses, one must be currently employed or engaged in a trade or a business. Amounts spent for education qualify as a deductible employee business expense if the education maintains or improves skills required for the employee's job but without qualifying the employee for another job with the worker's current company. Deductible expenses include tuition, books, supplies, laboratory fees, correspondence courses, tutorial instruction and research undertaken as part of the education. The costs of travel, meals and lodging are deductible expenses as long as they are not personal in nature. Transportation expenses are also deductible if directly related to educational expenses. An individual cannot claim an individual income tax credit for educational expenses paid by his or her employer. Under the Tax Reform Act of 1986, beginning in 1987, educational expenses are included as one of the miscellaneous items, which may not be deducted unless in aggregate they exceed 2 percent of adjusted gross income.

Federal Loans and Grants—The portion of a federal grant that is used to pay for tuition fees, and required equipment is not taxable

to the recipient. The Deficit Reduction Act of 1984 (DEFRA) required the Internal Revenue Service (IRS) to treat defaulted loans as part of the individual's taxable income if all measures fail on behalf of the bank or guarantee agency to collect the debt owed. The IRS is required to notify the individual, however, before such action is taken.

Conclusion

Like most other employee benefits, educational assistance is often a combined effort of employers, the federal government and individuals. Employers provide educational assistance that can enrich the skills and careers of their employees. The federal government provides grants, loans and work-study for undergraduate students, and loans and work study for graduate students seeking a degree or certificate. Employees, with or without federal or employer assistance, also enrich their job skills and careers by pursuing education on their own. This individual effort, in turn, is subsidized by the tax code, if the education meets the conditions set out under the Internal Revenue Code.

Additional Information

American Society for Training and Development
600 Maryland Avenue, SW, Suite 305
Washington, DC

Federal Student Aid Programs
Department J-8
Pueblo, CO 81009-0015

National Institute for Work and Learning
1200 18th Street, NW, Suite 316
Washington, DC

Barton, Paul. *Worklife Transitions: The Adult Learning Connection*. New York: McGraw-Hill, 1984.

Gold, Gerard G. *Employment-Based Tuition Assistance: Decisions and Checklists for Employers, Educators and Unions*. Washington, DC: National Institute for Work and Learning, 1985.

XXIX. Legal Services Plans

Introduction

According to an American Bar Association (ABA) survey, 80 percent of the public is uncertain about how to obtain legal advice. Unlike lower-income workers, middle-income workers are not generally eligible for legal aid or for the services of public defenders. Unlike higher-income workers, middle-income workers tend to postpone hiring attorneys until their needs become acute. Thus, wills go unwritten, legal documents go unchecked and many people take the risk of inadequately representing themselves in court. Legal services plans provide affordable legal representation and consultation, especially to middle-income workers.[1]

The ABA defines legal services plans as "programs in which legal services are rendered to large numbers of the public who are associated with groups, rather than individuals without such group associations." The legal services plan is not a new concept. Studies indicate that the development of such plans, however, was hindered by ABA objections. The ABA originally opposed these plans on ethical grounds; they were concerned that legal services plans constituted a form of client solicitation. Additionally, employees were reluctant to accept these plans; initially, legal service plan benefits were generally counted as gross income to the employee. Employers, however, were allowed to take a tax deduction for their contributions to employee legal services plans.

The legislative and judicial branches have since issued several decisions, and changes in legislation removed many of the initial deterrents to legal services plans until the Tax Reform Act of 1986 (TRA) eliminated the tax-favored status of legal services benefits. For example, four Supreme Court decisions between 1963 and 1971 recognized the constitutional right to associate to obtain legal advice, and the Court ruled that bar associations could not interfere with the establishment of legal services plans. Furthermore, the 1976 Tax Reform Act provided that employees do not have to include employer-

[1]Legal services plans are also known as *prepaid legal services plans* and *group legal services plans*.

provided legal plan benefits in their gross income. Under TRA, however, these tax benefits are scheduled to expire at the end of 1987.

Legal services plans offer the potential for reduced legal rates and broader protection against unexpected, costly lawsuits. They offer a form of preventive service that can cut legal costs. Under these plans, legal costs can be predicted, and they are based on group rates. A prepayment feature permits legal services costs to be spread over a period of time.

Plan Design

Legal services plans are financed with periodic payments, rather than on a fee basis. Advance payments are made to a lawyer or insurance company by the plan sponsor. In the latter case, the plan sponsor pays a group premium that covers all employees; or, contributions may be deposited into a legal services trust fund, which makes payments only when legal work is actually performed. The scope of services and benefits covered under prepaid legal services plans ranges from limited to comprehensive.

Limited Service Plans—These plans cover basic services, such as telephone or office consultation, and advice about simple legal problems. Uncovered services are paid for by the participant at rates agreed upon by the plan sponsor and the attorneys. Some limited service plans have made arrangements with networks of attorneys; in this case, the attorneys who form the network agree to charge reduced fees for referrals.

Comprehensive Service Plans—These plans cover consultation *and* other services. Services that are typically covered include: (1) providing unlimited legal advice; (2) drafting legal documents; (3) drafting wills; (4) filing for divorce; (5) handling lawsuits; (6) transferring real estate; and (7) representing a participant in court. Most comprehensive plans do not cover legal services associated with an employee's trade, business or investment property. (See section below on taxation.)

The remainder of this chapter will focus on comprehensive service plans.

Payment of Benefits

Comprehensive service plans provide benefits under three basic arrangements: (1) open-panel plans; (2) closed-panel plans; and (3) combination plans.

(1) *Open-Panel Plans*—These plans allow participants to use any licensed attorney. Payment for services is usually made according to an established fee schedule; fees vary depending upon the type of services 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. Participants are able to choose their own attorneys. The attorney selected, however, is not obligated to accept the case, especially if his or her workload is heavy or if the case is outside his or her area of expertise. Administrative costs are generally higher in open-panel plans, because the administrator must keep records of all services provided by the various attorneys. Since the sponsoring employers have no control over the attorneys' fees, sponsors often restrict coverage to selected services, require deductibles (i.e., a specified amount that the plan participant must pay before any costs are paid by the plan) and/or impose maximum coverage limits.

(2) *Closed-Panel Plans*—Closed-panel plans primarily are intended to cover job-related or occupational legal problems. There are two types of closed-panel plans: (a) staff plans; or (b) participating attorney plans.

(a) *Staff Plans*—These plans provide benefits through a full-time salaried staff of lawyers who are hired specifically to handle the group's needs. This arrangement generally only works well when most of the plan's participants live in one location that has easy access to the lawyers who are providing the legal services.

(b) *Participating Attorney Plans*—Where plan participants are geographically dispersed, the plan sponsor may prefer to contract with a number of law firms; this can assure that employees in all locations have access to legal services. Here, the law firms agree to provide certain types of legal services for a set fee per participant. In return for the fee, the attorneys provide services with little restrictions on time.

The administrative costs under closed-panel plans are generally lower than those under open-panel plans. Since a smaller number of attorneys is involved, there are fewer records to manage and payment 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, because under these plans, unions 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. Due to the salary arrangement between the attorney and the plan, however, it may be difficult for attorneys to

reject cases—even when attorneys do not feel they are qualified for the case or when they would rather not take the case.

(3) *Combination Plans*—Some plans offer combinations of the open- and closed-panel plan characteristics. Under a partially closed-panel plan, employees can choose from a small number of lawyers and law firms selected by the plan sponsor. Alternatively, under a partially open-panel plan, employees can choose an attorney from a specified geographic area, or from a group of lawyers who subscribe to the plan's terms and conditions.

Services

There are four broad service categories under typical comprehensive service plans: (1) consultation; (2) general nonadversarial; (3) domestic relations; and (4) trial and criminal.

Consultation—Most legal problems are consultative in nature. They deal with 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 alone.

General Nonadversarial—These services are generally performed in an attorney's office. They include reviews of documents, wills, adoption papers, guardianship and conservatorship (i.e., pertaining to protector, guardianship and custodial) matters. They also include name changes, personal bankruptcy, real estate transfers, estate closings, as well as Social Security, unemployment and other benefit claims.

Domestic Relations—Legal separations and divorces are the most expensive overall services covered by prepaid legal plans. Most plans that cover these services also cover the costs of modifying divorce and separation agreements (e.g., changes in the terms of child custody agreements, visitation agreements, child support or separate maintenance arrangements). Due to the cost and emotional nature of domestic relations legal problems, many plans do not cover these legal services.

Trial and Criminal—This benefit classification includes adversarial legal matters such as contested adoptions and guardianship, civil suits and contested domestic relations matters. Also included in this category are minor criminal matters such as suspension or revocation of drivers' licenses, juvenile court proceedings and misdemeanors. These services usually require the highest plan cost per claim. How-

ever, utilization of these services is fairly infrequent. Many plan sponsors do not cover these services.

Exclusions and Limitations

Legal services plans may be subject to potential abuses such as excessive attorney fees and unnecessary services; thus, they frequently build in cost controls. The following are typical services that may be excluded in order to control plan costs:

(1) actions against employers and unions (these actions *must* be excluded in Taft-Hartley plans);

(2) services rendered for legal problems existing before the plan's effective date;

(3) contingent fees that are charged by lawyers only if they win the case;

(4) court expenses such as fines, court costs, filing fees, subpoenas, assessments, penalties and expert witness fees.

Other methods of controlling costs include:

(1) closed lists of eligible procedures—under closed-list arrangements, some legal services are automatically excluded from the schedule of benefits;

(2) maximum ceilings on hours or costs of services rendered;

(3) limits on the frequency of a particular service over a specified time period;

(4) yearly deductibles and/or copayments (i.e., the participant pays some portion of the cost and the plan pays the remaining portion for each legal service);

(5) maximum limits on the hourly fees of attorneys—usually this is set below the prevailing rate.

Taxation

In a qualified plan, the employee does not include any share of the employer's contributions toward legal services benefits in his gross income. Under current law, this provision is effective only through December 31, 1987. Until then, the Internal Revenue Code contains certain requirements that legal services plans must meet in order to qualify for favorable tax treatment. For example:

(1) An application for qualification must be filed with the Internal Revenue Service (IRS).

(2) The employer must establish a separate written plan for the exclusive benefit of employees (and their spouses or dependents), and it must provide only legal services.

(3) The plan must provide personal legal services. It cannot provide legal services related to an employee's trade or investment property.

(4) The plan cannot discriminate in favor of shareholders, officers and highly paid employees. In determining whether the plan is discriminatory, certain employees may be excluded from consideration. The excluded employees are those covered by an agreement, which the Secretary of Labor finds 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 that are made on behalf of shareholders and owners who have more than a 5 percent interest.

(5) The employer must transmit his plan contributions to designated recipients (e.g., insurance companies, tax-exempt trusts or authorized service providers).

Employee Retirement Income Security Act

All legal services plans maintained by an employer or an employee association are classified under the Employee Retirement Income Security Act (ERISA) as employee welfare benefit plans and are subject to certain requirements. For example, summary plan descriptions must be provided to plan participants and reports must be provided to certain government agencies.[2] Furthermore, 1984 legislation established certain annual reporting requirements of plan information that employers must submit to the IRS.

Conclusion

Legal services plans were almost unheard of a decade ago. Today about 12 million Americans participate in these plans, which are often used in conjunction with flexible compensation plans.[3] Although current law has extended exclusion of these benefits from gross income only through 1987, supporters of legal services plans are hopeful that the increased popularity of the plans will cause the tax-favored status to become permanent.

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[2]For more information on ERISA, see chapter III.
[3]For more information on flexible compensation plans, see chapter XXXI.

Additional Information

American Prepaid Legal Services Institute
1155 East 60th Street
Chicago, IL 60637

National Resource Center for Consumers of Legal Services
3254 Jones Court, NW
Washington, DC 20037

Billings, Roger D. *Prepaid Legal Services*. Rochester, NY: Lawyers Cooperative Publishing Co., 1981.

National Resources Center for Consumers of Legal Services. *Group Legal Service Plans: Organization, Operation and Management*. Washington, DC: National Resources Center for Consumers of Legal Services, 1981.

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XXX. Child Care Programs and Options

Introduction

Private-sector provisions for child care in the United States originated during the Civil War and were reestablished in World War I, when nurseries were set up to enable women to work in hospitals and war-related industries. During World War II, approximately 4,000 federally funded child care programs were established under the Lanham Act of 1942. This legislation allowed mothers the opportunity to help in the war effort. Most of these child care centers, however, were terminated at the end of the war.

Interest in employer-sponsored child care centers was displayed in the mid-1960s and early 1970s when several U.S. corporations established on-site day care centers. Most of the corporate day care centers, however, closed due to management problems and insufficient use by employees. Today there is renewed interest in child care on the part of government and private employers. As a result of the changing needs in the work place, and as women participate in the work force at a greater rate then ever before, child care is emerging as a valuable employee benefit offered by a relatively small, but growing, number of employers.

Women with children are now in the paid labor force more than ever before. According to the Department of Labor (DOL), more than one-half of married mothers (51 percent) with children under age three were in the work force in March 1986.[1] DOL estimates that by 1990, 66 percent of new entrants in the labor force will be women. Current estimates show that 80 percent of women in the work force are of child-bearing age, and that 93 percent will become pregnant at some time during their careers.[2]

More and more families are relying on women's earned incomes, either as part of a two-earner couple or as a single head of household. DOL estimated that in 1986, the husband was the sole earner in only 20.4 percent of married-couple families, down from 33.3 percent in

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[1] U.S., Department of Labor, Bureau of Labor Statistics, "Half of Mothers With Children Under Three Now in Labor Force," USDL 86-345 (August 20, 1986).
[2] U.S., Congress, House, *Families and Child Care: Improving the Options*, Committee Print, 98th Cong., 2nd Sess., 1984, p.v.

1970.[3] At the same time, the number of husband and wife two-earner couples has grown from 34 percent of all married-couple families in 1970 to 54.5 percent in 1986. Due to the growing number of families in which both spouses work, employers providing child care benefits may have an advantage in attracting young professionals.

The increasing rates of separation, divorce and single parenthood have resulted in a growing number of single-headed households. According to data compiled by the House Select Committee on Children, Youth, and Families, the population of children under age ten living in single-parent households is expected to rise 48 percent—from 6 million to 8.9 million—between 1980 and 1990. The growing number of children living in female-headed households, where earnings tend to be substantially less than in male-headed households, could increase the number of children living in poverty. For these women to work, some form of dependent care is a necessity.

Child Care and the Employer

Child care is usually provided through one of these options: (1) in-home care—where someone other than the parent comes into the child's home for care; (2) family care—where a child is taken to the home of another adult; or (3) child care centers—where the child attends a facility for care or a play group with other children. Child care provided in the parents' home or in another adult's home is the most prevalent type of child care arrangement. Most of this care is unlicensed. Care for disabled or ill children is severely inadequate.

Employer-assisted child care may be provided through a number of options. Programs range from company-owned and operated day care centers to indirect services, such as information and referral services, financial assistance programs and contributions to local child care programs.

Employer-sponsored child care is not a common employee benefit, but it is growing. It is most often provided in the service industries (e.g., hospitals, banks and insurance companies). The Work and Family Information Center of the Conference Board (a nonprofit, New York-based research organization), reports that in October 1985 approximately 2,500 of 6 million employers in the U.S. offered some

[3]Figures from 1970 are from U.S., Department of Labor, Bureau of Labor Statistics, *Labor Force Statistics Derived from the Current Population Survey: A Databook Volume 1*, Bulletin 2096 (Washington, DC: U.S. Government Printing Office, September 1982), p. 722.

type of child care service—up from 600 in 1982. The following lists employer-supported child care by type of service.

Types of Assistance	Number of Companies
On-site or near-site child care centers	
Corporate	150
Hospitals	400
Public agencies	30
Family day care support	50
After-school child care	75
Sick child care initiatives	20
Information and referral	500
Financial Assistance	
Vouchers	25
Discounts	300
Comprehensive cafeteria plans	150
Flexible spending accounts/salary reduction	800
Total	2,500

In addition, the Conference Board estimates that as many as 1,000 employers make corporate contributions to community child care programs and another 1,000 employers offer parent education seminars.

There are several possible reasons why more employers do not offer child care services. Some employers may be unaware of the growing need for and the available options in child care. There are potential liabilities and administrative burdens involved in offering *on-site* child care. Employers might be reluctant to offer child care services because it is estimated that in the average work force of a large company, less than 10 percent of employees will be able to use a child care program at any given time.[4] Moreover, among those employees who have the need for child care services, demand for employer-sponsored programs is small. One reason for this under-utilization may be that employers commonly require that *licensed* care be purchased under the plan. Day care, other than group child care centers, as noted before, is generally unlicensed. Parents seem to dislike, all else being equal, institutional care. At the same time, employers un-

[4]Peter L. Hutchings, "Managing Salary Reduction Dependent Care Benefits," *Benefits News Analysis* 6 (October 1984): 24.

derstandably fear liability for substandard care that might occur under unlicensed providers.

The advantages of child care benefits to the employer, however, may include a decreased rate of employee turnover and absenteeism. The Conference Board indicates that these benefits could also heighten morale in the work place, create good public relations, and hence, attract better employees. Ultimately, the quality of products and services is affected by the quality of the work force. According to a 1984 survey of 415 businesses, in which 178 employers responded, 90 percent reported that child care had a positive effect on employee morale; 79 percent of employers felt that child care programs had a positive effect on their ability to attract employees; 65 percent reported a positive effect on job turnover; and 53 percent reported a positive effect on absenteeism.[5]

Employer-Supported Child Care Centers—Employer-sponsored centers can be administered by the company or an outside service. Centers are not always located at the work site, and admission may be limited to include only employees' children.

Many firms support community child care programs. When the employer chooses to finance community day care centers rather than create an on-site child care service for employees, 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 to the center. In this way, the employer avoids the administrative and legal responsibilities but still offers support services.

Information and Referral Services—Information and referral services can help parents obtain information on child care and, in many cases, refer them to the most appropriate form of child care in their community. Most companies contract with an existing referral agency in the community; others have an in-house hotline capacity. A growing number of employers sponsor educational seminars on parenting issues. These forms of assistance help the employer estimate the potential demand for child care services before investing in other forms of child care support.

Flexible Personnel Policies—Flexible personnel policies often reduce the need for extensive child care. Some examples of the options available to employees are flextime (flexible work schedules), job sharing, part-time work, work at home and flexible leave policies. From 1968

[5]Sandra Burud, Pamela R. Aschbacker and Jacquelyn McCroskey, *Employer-Supported Child Care: Investing in Human Resources* (Boston, MA: Auburn House, 1984).

to 1985, the number of women in part-time jobs rose faster (increasing by 87 percent) than those in full-time jobs (increasing by 64 percent). In 1985, 10.5 million employed women, one quarter of all employed women 20 years and over, were employed part time.[6]

Flexible Benefit or "Cafeteria" Plans—Flexible benefit plans, or "cafeteria plans," are another way for employers to offer child care assistance. Flexible benefit plans allow employees to choose among a variety of benefit options paid for by employer contributions or employee pretax contributions. Employers can include child care (and care for elderly parents and handicapped dependents) in a cafeteria plan if they offer a qualified Dependent Care Assistance Plan (DCAP). When child care is offered in a cafeteria plan, employees may, for example, elect child care benefits in lieu of dental care. By allowing choice among different benefits, cafeteria plans allow employees flexibility to meet household needs and avoid duplicate benefit coverage.

Flexible Spending Accounts—Flexible spending accounts, also known as reimbursement accounts, are a way of funding child care and other benefits within a cafeteria plan. These accounts, in turn, may be funded by salary reduction, employer dollars or both. Under a salary reduction arrangement, the employee contributes a portion of pretax (gross) salary to his or her flexible spending acount to help fund the benefit, in this case, child care. The employee pays no federal income tax on the contribution, but some states impose a tax on the contribution.

A flexible spending account must meet special Internal Revenue Service (IRS) requirements if plan benefits are to be nontaxable to the employee. If the account is funded through a salary reduction arrangement, the employee must decide how much money to put into the account before the beginning of the year. According to IRS regulations, the employee would be required to "use or lose" these funds. This means that if any money remains in the account at year's end, the remaining dollars would be forfeited by the employee.

Federal Programs

Federal support for dependent care is provided through a variety of programs. The dependent care income tax credit is the largest segment of federal support. An estimated $3.1 billion in dependent care credits were claimed in 1985. Approximately $800 million are

[6]Thomas J. Nardone, "Part-Time Workers: Who Are They?" *Monthly Labor Review* 2 (February 1986): 13–19.

spent annually on child care programs through the Human Services Block Grant (HSBG)—formerly referred to as Title XX of the Social Security Act—which supports low-income families. States determine the specific allocation of funds received under the HSBG act. Among the variety of services provided under the HSBG, child care is the only service that does not have an alternative funding source. Limited federal funds for extremely low-income families are provided through programs such as Head Start, the Child Care Food Program, Job Training Partnership Act and Aid to Families with Dependent Children (AFDC).

In February 1984, the U.S. Senate opened a nonprofit child care facility for its employees. Start-up funds were appropriated by the Senate, and tuitions are based on a sliding scale depending on parental income. In late 1987, the U.S. House of Representatives is also going to open a child care facility for its employees.

Taxation

Employer-Provided Child Care—Child care programs became nontaxable in January 1982 as a result of the 1981 Economic Recovery Tax Act (ERTA). Child care benefits under a qualified Dependent Care Assistance Program under section 129 of the Internal Revenue Code may be excluded from the employee's taxable income if the program meets certain eligibility requirements. The program provided by the employer must be available to all employees and cannot discriminate in favor of employees who are officers, owners or highly compensated. The 1986 Tax Reform Act (TRA) establishes a new nondiscrimination test generally effective for plan years after December 31, 1987.[7]

The maximum amount an employee (single or married) may exclude from income annually is $5,000—$2,500 for a married individual filing separately. Amounts above these levels are included in the participant's taxable income. Excludible amounts are limited to the types of expenses eligible for the federal income tax credit (described below). Dependent care benefits provided by the employer are not eligible for the individual tax credit.

Individual Income Tax Credit—A federal income tax credit is available for qualified child care expenses not covered by or paid for by

[7]Under TRA, employer-provided child care programs must satisfy a new "benefits" test, which is designed to prevent highly compensated employees from receiving a disproportionate share of benefits provided under the plan. It is one of the same tests other statutory health and welfare benefit plans must satisfy. See chapter XVII for a complete description.

an employer-sponsored plan. A credit is allowed for children under age 15 when both spouses work full-time or when one spouse works part-time or is a student.[8] The amount of qualified expenses eligible for the credit is subject to both a dollar limit and an earned income limit.

Qualified expenses are limited to $2,400 for one child and $4,800 for two or more children, but generally cannot exceed the earned income of the individual, if single, or, for married couples, the earned income of the spouse with the lower earnings. A credit equal to 30 percent of eligible expenses is available to individuals with adjusted gross incomes of $10,000 or less, with the credit reduced by one percentage point for each $2,000 of income between $10,000 and $28,000. For individuals with adjusted gross incomes above $28,000, the credit is limited to 20 percent of qualified expenses.

The federal tax credit has become the largest source of child care support. Reports indicate, however, that the credit has not been benefiting those with very low incomes. Estimates show that in 1981, only 7 percent of the 4.6 million families claiming the dependent care tax credit had income below $10,000.[9] The credit may become more popular in 1987 and future years. The reduced marginal tax rates under TRA will make the value of the tax exclusion for employer-sponsored child care benefits less valuable than the tax credit for many more low- and lower-middle-income employees.

Parental Leave

The shift from the traditional married-couple family, with the husband as sole wage-earner, to the two-career family[10] has probably been a major influence in the increased interest of employers and employees in parental leave.

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[8]A credit is also allowed for other "qualifying individuals," which include a dependent of the individual who is physically or mentally incapable of taking care of himself or herself, or a spouse of the individual if the spouse is physically or mentally incapable of taking care of himself or herself. Expenses must be employment-related; they must be incurred to enable the taxpayer to work and must be for the care of qualifying individuals. Expenses may include household services to the extent that such services are performed for the qualifying child or dependent.

[9]U.S., Congress, House, Select Committee on Children, Youth and Families, *Families and Child Care*, p. 83.

[10]For a discussion of demographic changes affecting the work place, see Thomas Espenshade and Tracy Ann Goodis, "Demographic Trends Shaping the American Family and Work Force," in *America in Transition: Benefits for the Future* (Washington, DC: Employee Benefit Research Institute, 1987).

Maternity Leave—Under the Pregnancy Discrimination Act of 1978, employer short-term disability plans must treat disability due to pregnancy and childbirth in the same way as any other disability. Employers must, therefore, offer short-term disability benefits for maternity leave if they provide a short-term disability plan to their employees.

Federal law, however, does not require employers to provide disability plans. If the employer does not offer such a plan, then the employer is not required to provide maternity leave. In addition, small employers with fifteen employees or less do not have to extend short-term disability benefits for maternity-related disabilities unless state or local laws provide otherwise. Only five states and one U.S. territory have mandated short-term disability policies: California, Hawaii, New Jersey, New York, Rhode Island and the territory of Puerto Rico. Maternity leave, therefore, is up to the discretion of the employer if the employer does not operate in a state that requires short-term disability and does not offer short-term disability as a benefit.

Company policies on maternity and parental leaves have only recently been documented. One of the most extensive is a 1984 survey of the nation's 1,500 largest companies by Catalyst, a New York based research organization.[11] Catalyst reports that in 1984, 95 percent of respondents in their survey had a short-term disability policy. Most disability leaves were paid, with full or partial salary plus benefits, and the average length of leave taken by women was five to eight weeks. The Bureau of National Affairs also has surveyed parental leave policies as part of a larger report on policies on leave from work,[12] but the survey does not distinguish between disability leave and other unpaid leaves.

Unpaid Leave—Unpaid leave can be granted alone or in conjunction with disability benefits and paid leave (such as annual or sick leave). More than one-half of the responding companies in the Catalyst survey offered unpaid leave,[13] which the parent often took after the disability period (women) or after the birth of the child (men). The length of unpaid leave offered varied, but 65 percent of respondents reported three months or less.

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[11]Catalyst, *Report on a National Study of Parental Leaves*, (New York, NY: 1986).

[12]Bureau of National Affairs, *Policies on Leave From Work*, PPF Survey No. 136 (Washington, DC: BNA Inc., 1983), pp. 21–25.

[13]Catalyst included only companies that guaranteed job reinstatement after leave on the assumption that "the conditions of reinstatement heavily influence the employee's decision on whether or not to take unpaid leave and, if so, for how long."

Paternity Leave—Child care has become an important concern for men as well as for women. It is estimated that 60 percent of men in the work force have working spouses.[14] Fewer firms provide child care leave for male employees than for female employees, but the number appears to be rising. According to the Catalyst survey, 37 percent of the firms questioned allowed men to take leave from work for child care with a job guarantee upon return to work. The practice is not usually called paternity or parental leave, but is classified under the company's general personal leave or leave of absence policy.

Adoption Leave—Fewer employers offer adoption leave than maternity and paternity leave. But Catalyst reports that there has been a significant increase since 1980—from 10 percent of responding companies in that year to 27.5 percent in 1984. Adoption leaves were generally unpaid, but about one-third of the companies Catalyst surveyed reimbursed employees for adoption expenses. The amount of reimbursement varied, but in general ranged between $1,200 and $2,000. A report by National Adoption Exchange[15] found that most company adoption plans set a ceiling, with median reimbursement at about $1,500, and reimbursed for specific itemized expenses, such as agency fees, court costs and legal fees.

Future Outlook

The number of employers offering child care services is limited. Benefits could be greatly expanded in the future, but the extent of their role remains uncertain. On the one hand, because of the changes in the composition of the U.S. work force and the need for employers to attract and retain employees, employer-assisted child care is emerging as a valuable employee benefit. Indeed, in the next decade it may become a commonly offered benefit. On the other hand, the government is carefully scrutinizing the favorable tax treatment of child care expenditures.

As the child care industry grows and more information becomes available, marketing of these services may become more sophisticated and pervasive. Employers currently uninterested in establishing child care programs may become more interested as the work force continues to change and child care needs become more prom-

[14]Dana E. Friedman, "Improving Child Care Services: What Can Be Done?" testimony presented before the House Select Committee on Children, Youth, and Families, August 2, 1984, p. 3.

[15]National Adoption Exchange, *Adoption Benefits Plans: Corporate Response to a Changing Society* (Philadelphia, PA: National Adoption Exchange, n.d.).

inent. The role of government will also need to be more clearly defined to meet the changing work force. Legislation was introduced in the 99th Congress that would have required employers to provide a minimum period of leave without pay for the birth or adoption of a child. It was reintroduced in the 100th Congress.

Conclusion

The demand for child care services is growing as a result of a combination of factors, including the increase in the child population, in two-wage earner families and in single-headed households. Although some employers are providing child care benefits, individuals still pay most day care expenses in this country. The federal government is presently exploring new roles in child care. As the needs of employees change and as employers try to satisfy these needs, both the private sector and the federal government may choose to take an expanded role in the provision of child care benefits.

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XXXI. Flexible Compensation Plans

Introduction

In recent years, family relationships, lifestyles, trends toward early retirement and increased longevity have raised questions about the efficacy of conventional benefit plans. We have seen an influx of young workers and female workers whose lifestyles and values are different from the male breadwinners of 20 years ago. Changes in social and economic circumstances have affected the needs and preferences of workers.

Most employee benefit programs are designed to satisfy the *traditional* family's needs. Workers' benefit needs are largely determined by their ages, marital and family status, and compensation levels. Traditional programs do not reflect the circumstances of single workers with no dependents, two-earner couples and single-parent workers; additionally, they seldom consider the changes in workers' needs over time.

Some employers have implemented *flexible compensation plans*[1] to respond to the differing needs of their workers and to help manage employee benefit costs. Compensation is flexible when employees are entitled to choose among benefit options paid for by employer contributions. Compensation is also flexible when employees can purchase nontaxable benefits through *salary reduction* arrangements. Such arrangements allow employees to elect to have a portion of their compensation (otherwise payable in cash) contributed to a qualified profit sharing, stock bonus or pre-ERISA money-purchase pension plan. The employee contribution is treated not as current income, but most commonly as a pretax reduction in salary, which is then paid into the plan by the employer on behalf of the employee.

Employee choice is not a new idea in benefit design; many traditional plans offer options to employees. For example:

(1) Employees may choose among different levels of protection under group life insurance, survivor income and medical care programs.

[1]Flexible compensation plans are also known as cafeteria, supermarket and smorgasbord plans.

(2) Employees may choose between cash and deferred profit sharing.

(3) Employees may choose between participating or not participating in a thrift (i.e., savings) plan, and among a number of contribution levels and/or investment options in such plans.

According to the U.S. Bureau of Labor Statistics (BLS) survey "Employee Benefits in Medium and Large Firms, 1986," although flexible compensation plans and reimbursement accounts (see p. 275) have attracted recent attention, their incidence is limited. Among the 21.3 million, private, full-time employees surveyed, 8 percent of white-collar workers and 2 percent of blue-collar workers could participate in one or both of these benefit plans. Five percent of all employees covered by the survey were eligible for reimbursement accounts, and 2 percent of all employees were eligible for flexible compensation plans. A flexible compensation plan was defined in the survey as a plan giving employees a choice among two or more types of benefits. Therefore, plans that permitted a selection in only one benefit (e.g., a choice among several health insurance options or plans) were not classified as flexible compensation plans.

Types of Plans

In a typical flexible compensation plan, the employer provides a minimum level (i.e., a core) of certain basic benefits. The basic benefits generally include health insurance, life insurance, disability insurance, pensions and vacation. A second level of coverage may also be provided in the form of benefit credits. Employees use these credits to purchase: (1) additional coverage in the basic benefit areas; or (2) benefits in other areas such as child care, dental care and legal services.

Although the approach just described is common, there are many variations. For example, employers may provide a core of benefits, but they may permit employees to choose *among several levels of core coverage*. Again, benefit credits may be offered as a second tier of coverage and may be used for obtaining additional protection or services. Under another arrangement, employees choose from *several predetermined benefit packages*. All benefit packages try to represent equal value, but each is designed to meet the needs of different lifestyles.

Through salary reduction arrangements, flexible plans may also permit employees to pay for additional benefits with their own *pretax* dollars. Also, some plans permit employees to purchase additional

benefits with *after-tax* dollars. Within the structure of a particular flexible compensation plan, therefore, an employee can use core benefits, benefit credits and personal contributions to help design his or her own benefit package.

Tradeable Benefits

A 1984 amendment to the Internal Revenue Code limited the benefits that may be provided under a cafeteria plan[2] to the following menu:

(1) medical care, including dental care, eye care, hearing care, etc;

(2) group term life insurance (on employee's life or dependent's life);

(3) disability benefits;

(4) group legal services;

(5) cash or deferred plans under section 401(k);

(6) vacation days (if unused days may not be cashed out or rolled over into a subsequent plan year).

Benefits that may not be included under a cafeteria plan include van pooling, educational benefits, deferred compensation plans (other than 401(k) plans), employee parking, employee discounts and other fringe benefits, whether or not taxable.

Reimbursement Accounts

Reimbursement accounts (also known as *flexible spending accounts*) became quite popular in 1983 and early 1984, and the IRS issued proposed regulations on cafeteria plans in May 1984.

One early type of reimbursement account was set up by employers solely as an incentive for health care cost containment. Here, the employer agreed to reimburse uninsured medical claims incurred over a year's period up to a fixed amount (e.g., $500). At year's end, if the employee had not exhausted his or her "account," the balance could be taken by the employee in cash or placed in a deferred compensation plan.

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[2]Characterization as a cafeteria plan under Internal Revenue Code section 125 protects the participant from being taxed, under the *constructive receipt* doctrine, on the value of taxable benefits (e.g., cash) the participant could have selected, even though he or she does not select such benefits.

A second arrangement was called a "benefit bank," which was funded by employees through salary reduction, by employer contributions or both. Here, employees typically could make claims for reimbursement of medical, legal or dependent care expenses from the same unallocated credit pool. At year's end, unused credits could be taken in cash, rolled into the next year's credit pool or placed in a qualified deferred compensation plan.

The most aggressive type of spending account was the zero-balance reimbursement account (ZEBRA), which offered all the advantages of the other versions, but required funding only through salary reduction, and only after the covered expense was incurred.

Primarily in response to the rapid growth of reimbursement accounts, the IRS proposed the adoption of the following rules, which would be applicable to all cafeteria plan elections.

(1) *Advance Elections*—Employees must elect to allocate flexible credits to specific benefits before the coverage period begins. Generally these choices cannot be revoked after the start of the plan year.[3]

(2) *Coverage Periods*—To assure that the regulations are satisfied, the coverage period for each benefit should be a full year and all coverage periods should coincide with the cafeteria plan year.

(3) *No Credit Carry-Over*—Here the IRS strictly construed section 125 of the Code to prohibit the carry-over of unused benefit credits, or unused vacation days, to a subsequent plan year.

(4) *Forfeitures*—Flexible credits allocated to a spending account, but not used during the coverage period, must be forfeited.

(5) *Separate Accounts*—Credits allocated to one account, such as the medical spending account, cannot be used to reimburse other types of claims, such as dependent care or legal services.

Funding

Flexible compensation plans and reimbursement accounts may be funded by employer contributions, employee contributions or both. As mentioned, some plans utilize salary reduction, which enables employees to use pretax dollars to pay for additional benefits. Through this approach, employees and employers share the costs of providing for employees' health, welfare and retirement protection.

[3]The proposed regulations allow a prospective change of elections in connection with certain family status changes.

Establishing a Flexible Compensation Plan

A common method for establishing a flexible compensation plan is to reduce the employer's existing benefit package to a core of basic benefits. All or part of the cost difference between the original package and the core benefits is converted into benefit credits. Each employee then receives a share of the credits and may use them to pay for a second tier of coverage or convert them to cash. Alternatively, the employer may retain present benefit coverage as the core and grant a supplemental allowance to provide for benefit credits. This method is more costly than the first, but it is viable when employers are willing to allocate additional resources to employee benefits.

Benefit Taxation

IRS once took the position that employees would be taxed on the value of all taxable benefits available under a flexible compensation plan, whether or not the employee in fact elected the taxable benefits. The Revenue Act of 1978, however, changed this. Section 125 of the IRC now states:

> ...no amount shall be included in the gross income of a participant in a cafeteria plan solely because, under the plan, the participant may choose among the benefits of the plan.

Employers can now offer flexible compensation plans, which include cash *and* statutory nontaxable benefits. Similar to other tax-qualified plans, with regard to participation, contributions and benefits, flexible compensation plans cannot discriminate in favor of shareholders, officers and highly paid employees.[4] When an employee selects a *taxable* benefit, its cost is included in his or her taxable income in the year the benefit is received.

The Tax Reform Act of 1986 (TRA) changes certain aspects of flexible compensation plans, generally effective for the later of (1) plan years beginning after December 31, 1987, or (2) the earlier of plan years beginning at least three months following the issuance of Treasury regulations or after December 31, 1988.

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[4]A numerical discrimination test, added by the Deficit Reduction Act of 1984, may be particularly troublesome to small plans. Under this test, the value of nontaxable benefits selected by certain officers and shareholders cannot exceed 25 percent of the value of benefits selected by all employees under the plan. Also, TRA changed the definition of highly compensated employees (see chapter IV).

Under TRA, each type of benefit available under a cafeteria plan is subject to its own applicable nondiscrimination rules and to any applicable concentration test (such a test compares the benefit amounts of the highly compensated employees with the benefit amounts of the remaining employees). If a cafeteria plan is discriminatory, highly compensated employees are taxed on *all* benefits received. Also, salary reduction under cafeteria plans is excluded from Social Security (FICA) and unemployment (FUTA) taxes, unless it flows to a 401(k) plan.

Advantages of Flexible Compensation

Flexible compensation plans offer employees and employers a number of advantages:

(1) Employees may receive more benefit value, because employers provide a benefit program that is tailored to each employee's needs. Employees can change benefits as their lives change (e.g., when they marry or divorce, as their salaries increase or as their children mature and leave home).

(2) Employees become more aware and appreciative of their benefits. This may improve employee morale and productivity.

(3) Employees may become more involved in controlling benefit costs. Additionally, when employees want a new benefit, they are asked to trade off another benefit, rather than look to their employer to provide more.

(4) Flexible compensation plans can be used to convert workers' earnings into tax-free employee benefits, thereby producing a more valuable compensation dollar.

Flexible compensation plans also present potential disadvantages to employees and employers. Most of these can be minimized, however, by careful planning:

(1) Some employees may not understand their choices well enough to choose the most needed benefits; thus, families could suffer from losses in areas where they did not select adequate coverage. This problem can be addressed, in part, by a mandatory core program that assures basic protection and also by an effective communications program.

(2) Effective employee benefit communication is always important, but it is critical in a flexible compensation plan. To assure that employees fully understand their plan and options, as well as their savings and consumption needs, the following techniques can be used:

(a) an advance survey to determine whether employees are receptive to flexible compensation—the survey can also be used to identify the benefits employees most need and want;

(b) a letter to employees' homes announcing the adoption of a flexible compensation plan;

(c) articles in company newsletters;

(d) a booklet describing the plan's primary features;

(e) meetings where benefit professionals explain the plan using slide or video presentations, workbooks and enrollment materials—a question and answer period may be helpful;

(f) a telephone hotline, when benefit elections are made, to answer employee questions;

(g) after benefit elections are made, a personalized statement delineating each employee's individual elections;

(h) an election-screening process, whereby suspect choices may be reviewed with the employee.

(3) Flexible compensation requires substantial advance planning. Employers must make a number of basic decisions. The most basic one is "How much do I want to spend and how can I maximize employee satisfaction or minimize employee dissatisfaction while limiting costs to that figure?" For example: (a) How will the present benefit package be converted into a new flexible plan? (b) Will a core of benefits be provided? (c) What benefits will be optional? (d) What value will be placed on each option? (e) Will the employer provide supplemental money to expand current benefit coverage? (f) How can adverse selection (i.e., those with the highest risks select the greatest protection) be anticipated and minimized? (g) How often will employees be permitted to change elections?

(4) Flexible plans may result in increased utilization and adverse selection. Increased utilization and adverse selection can cause problems with group insurance underwriting requirements and may result in higher benefit costs. Plan features can be added to minimize adverse selection; for example, limits can be placed on coverage levels and the frequency of election periods.

(5) Greater benefit flexibility is likely to result in greater administrative complexity and costs. To some extent, administrative costs can be controlled by restricting employee options and the frequency of benefit election periods. These restrictions, however, limit the amount of flexibility under the plan. A number of packaged computer systems for handling enrollment, benefit payment and record keeping, however, are now available. Where appropriate, these systems can reduce the time and costs of implementing flexible compensation plans.

Conclusion

Flexible compensation programs are attracting the interests of employees and employers. Although the BLS survey data show that the extent of flexible compensation plans is now limited, prospects for the future seem favorable. For example, the benefits consulting firm A.S. Hansen (now part of William M. Mercer-Meidinger-Hansen) found in their 1986 survey of 824 employers in 7 major U.S. demographic centers that 24 percent of the employers surveyed offered flexible benefits in 1986, and 35 percent of the survey respondents without such programs were seriously considering them.[5] The opinion of experts in the field is that tax reform legitimizes these programs, and therefore more companies are expected to offer them.

Additional Information

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[5]A.S. Hansen, Inc. *Instant Survey National Results*. Deerfield, IL: A.S. Hansen, Inc., Fall Planning Conference, 1986.

XXXII. Guidance on Evaluating an Employee Benefit Package

Introduction

Employee benefits make up a sizable portion of total compensation, and it is important not to overlook their worth. If an employee accepts a higher paying job and pays more expenses out-of-pocket to duplicate benefits at a prior job, the employee may not gain anything at all. Only by understanding which benefits are provided and how each benefit works can an employee utilize the full value of a benefit package. Just because a particular benefit fails to meet an employee's needs, that does not mean the entire package is without value. It is important to focus on the whole benefit package and not only on its individual parts.

What to Expect

Employers offer a wide variety of benefits. Some are legally required, and some are offered voluntarily. Legally required benefits include Social Security, Medicare, unemployment insurance, and workers' compensation.

Additional benefits offered voluntarily by employers will vary. U.S. Department of Labor statistics show that among full-time workers in medium and large firms in 1986, 9 in 10 participated in medical plans, group term life insurance, short-term disability insurance, and pension plans. Seven in 10 participated in dental plans and were eligible for educational assistance; 4 in 10 used long-term disability benefits; 3 in 10 used vision care coverage; and 3 in 10 participated in 401(k) plans. Fewer than 1 in 10 were eligible to participate in cafeteria plans, group legal services or dependent care.

The levels of benefits vary by industry and within industries. Hewitt Associates estimates that employer-provided, voluntary retirement, insurance and retiree benefits received by employees of the *Fortune* 500 Industrials ranged from 10.7 percent of pay to 34.4 percent of

TABLE 1
1985 Benefit Index ™ Values[a] as Percentage of Pay

	Total Worker Retirement			Total Worker Insurance Benefits			Total Retiree Disability & Health[b]			Grand Total		
	Low	Avg.	High	Low	Avg.	High	Low	Avg.	High	Low	Avg.	High
Petroleum & Refining	4.7%	12.2%	14.6%	4.5%	9.2%	12.8%	0.4%	1.3%	2.6%	14.3%	22.7%	26.3%
Electronics (appliances)	0.7	8.4	14.1	8.1	10.7	12.3	0	1.4	3.3	10.7	20.5	28.3
Office equipment (includes computers)	0.7	5.0	8.6	9.1	11.2	13.7	0	1.0	2.8	12.6	17.2	22.9
Industrial and farm equipment	5.9	9.5	12.9	8.1	11.2	13.4	0	1.5	3.3	17.0	22.2	28.9
Pharmaceuticals	5.4	8.9	11.8	9.5	10.8	12.2	0.5	1.6	2.5	16.3	21.3	25.3
Chemicals	7.9	11.6	18.4	5.3	10.6	12.5	0.5	1.6	2.6	14.8	23.8	32.0
Paper, fiber, and wood products	6.4	10.0	12.1	9.9	10.9	12.4	0.2	1.2	1.9	18.3	22.1	25.0
Food	4.8	10.2	16.8	9.0	11.1	14.0	0	1.4	2.7	13.9	22.7	32.1
Utilities	8.6	11.0	14.7	8.1	10.7	12.6	0.6	2.0	3.0	20.8	23.7	29.0
Life insurance	10.8	12.0	13.3	8.8	10.2	11.6	1.7	2.3	2.7	23.3	24.5	26.5
Banks	7.6	14.3	18.7	7.3	9.0	10.6	0.8	1.5	2.4	18.0	24.8	30.0
Retailing	3.0	5.9	9.5	5.8	8.0	10.2	0	0.9	2.0	10.9	14.8	19.0
Fortune 500 Industrials	0.7	10.0	21.4	5.3	10.8	14.0	0	1.5	3.3	10.7	22.3	34.4

Source: Hewitt Associates.

[a] "Benefit Index Values" are estimated values of employer-provided, voluntary benefits to each participant considered as a percent of pay. The estimates assume that all firms have the same, typical work force profile (age and sex distribution, etc.). The value of benefits to each participant in the assumed work force is then estimated actuarially by considering the present value of pension accruals and the probability and size of insurance claims. Administrative costs are not considered. The individual participant benefit values are then added together to provide aggregate estimates.

Since assumed work force profile and method of estimating benefit value are the same for all firms, differences between firms or industries reflect only differences in benefit design, and not differences in administrative costs, insurance providers, age or size of work force, funding level of pension plans, etc.

Current retirees are not considered in these estimates; they reflect only the value of benefits to currently active participants.

[b] These figures represent the discounted present value of future retiree benefits to currently active participants in the assumed work force.

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pay in 1985.[1] The average value of these benefits was 22.3 percent of pay (table 1).

Part-time employees and those working for small employers often get fewer benefits. Generally, benefits legally required for full-time workers are also required for part-time workers. The voluntary benefits that employers offer vary considerably more. In general, the more hours worked and the longer the years of service, the greater the likelihood of earning benefits voluntarily provided by employers. Working 30 hours a week or more tends to increase employee benefit coverage for major benefits like medical insurance, life insurance and paid leave. Those working less than half time (i.e., under 17½ hours per week under the new tax reform nondiscrimination rules) are not generally provided with these voluntary benefits because of benefit costs.

How to Get Started

Evaluating an employee benefit package requires detailed knowledge of the benefits offered and a clear understanding of personal and family situations. A good way to start is by reading the preceding chapters for basic explanations of various benefits. Also, any private-sector employer must automatically provide a summary description of most types of benefit plans. More detail is usually available from the plan administrator upon request.

General factors to consider when evaluating a benefit package include family composition, career plans, age and the tax treatment of the benefits. An employee with a family should check which benefits cover dependents, since employers are not required to offer dependent coverage. Benefits specifically for dependent care can also be important to look for when considering the value of a benefit package.

Benefit coverage sometimes overlaps in families where more than one person is in the work force. To make the most efficient use of benefits, employees should be aware of when and how they are covered under another family member's benefit plan. Knowing how a plan's coverage works is especially relevant when an employee participates in a flexible benefit plan and can choose from a variety of benefits.[2] For example, if covered under a spouse's medical plan, an employee may want to choose a less-generous medical benefit under

[1] See Employee Benefit Research Institute, "Employer Outlays for Benefits Rise," *Employee Benefit Notes* (May 1986).

[2] For more information on flexible benefit plans, see chapter XXXI.

his or her own plan and take cash or another benefit instead. Balancing employee benefits in this way maximizes the value of an employee benefit package.

The value of a benefit package varies with career plans and age. For employees who plan to change jobs frequently—often younger employees—shorter vesting requirements for their pension plans and waiting periods for other benefits are important. Older workers may prefer defined benefit retirement plans, which allow a more rapid accrual of benefits, and health plans that will continue coverage during retirement. In addition, older workers are more likely than younger workers to make large contributions to a pension or savings plan to finance their approaching retirement.

The value of a benefit can be enhanced by its tax treatment. Some benefits are taxed as ordinary income, whereas others are tax-deferred or tax-exempt.[3]

To keep up with changes in individual circumstances, an employee benefit package should be evaluated periodically. Most employers allow certain changes in plan choice at specified intervals or events. More frequent evaluations of a benefit package are necessary if an employee has had a change in position, employer, family status or retirement planning.

Pension Plans

An employer-sponsored pension is probably the largest single benefit an employee may get in terms of the percentage of a worker's total compensation that goes into the plan. Almost all workers will qualify for Social Security benefits, but Social Security only provides a minimum floor of protection—a foundation on which to build. Most people want more than a minimum income when they retire. They want to continue in the lifestyle they were accustomed to during their working years. An employer-sponsored pension plan can make the difference between a "bare-bones" retirement lifestyle and a comfortable one.

The first step in evaluating a pension plan is to understand how it works. Employees should obtain a copy of the Summary Plan Description available from the employer or plan administrator. It will explain what must be done to be eligible to participate in the plan, when a benefit becomes irrevocable (vested), what the benefit will be, and at what ages employees may claim benefits. Employees also

[3]See specific chapters for tax treatment of various benefits.

need to know what adjustments in their pension benefits or contributions will occur because of their Social Security coverage.[4]

Most pension plans also offer other benefits in the event the worker dies or becomes disabled. Employees should inquire which of these may be available.

Broadly speaking, there are two general types of pension plans: defined contribution plans and defined benefit plans.[5] It is important to understand the differences. In a defined contribution plan, the worker bears the risk and the reward of his or her investment decisions; poor investments can result in less than adequate retirement income. Defined benefit plans, on the other hand, leave the risk and reward of investment decisions with the employer, not with the individual.

Defined contributions are often more popular with employees, because these plans have an individual account that the worker can see accumulate each year. But defined contribution plans, as valuable as they are, may not necessarily be the best pension plan, depending on a worker's age, previous work and future years of service before retirement. Many employers offer both types of plans.

The tax status of the pension plan is also quite valuable. Qualified plans—those complying with IRS regulations—allow employer contributions and some types of employee contributions to accumulate tax free until the benefit is paid to the worker. The Tax Reform Act of 1986 adds a penalty to lump-sum withdrawals made before age 59 1/2, with some exceptions, to encourage workers to save adequate benefits for retirement rather than spend them along the way. Early retirement at age 55 is one such exception. Favorable tax treatment of a pension benefit can have a major effect on the final benefit received in retirement, so employees should keep abreast of any tax changes and make appropriate adjustments to finance their retirement.

Health Plans

With today's high health care costs, an employer-sponsored health plan is probably the employee benefit most valued by workers and their families. Without some form of health care coverage, a hospital stay or prolonged illness could financially devastate a family.

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[4]For more information on integrating pension plans with Social Security, see chapter VII.

[5]The differences between defined benefit and defined contribution plans are discussed in chapter VI.

To evaluate a health plan, it is important to understand how it works. A description of the employer's health plan usually provides information on what an employee must do to qualify as a plan participant, which expenses are covered, how the plan is financed and how participation in other health plans could limit an employee's participation or range of benefit choice.

Generally, there are two types of health plans offered by an employer: prepaid plans, such as health maintenance organizations; and fee-for-service plans.[6] Increasingly, employer plans are adopting "managed care" approaches for their fee-for-service plans, in an effort to help workers seek low-cost, high-quality health care. Managed care approaches include design features whereby medical services personnel help the patient review health care options and select from a variety of medical care choices and providers.

When choosing health care coverage, employees should take their particular needs and preferences into consideration. Those with families making frequent medical and dental visits may prefer a prepaid plan, where costs are limited regardless of the number of visits or services needed. Some employees and their dependents may have or develop medical conditions requiring specific services, and they may want to keep or choose their own doctors. Employees have always been able to choose their own physicians under fee-for-service plans, and this is now becoming an option under some prepaid plans as well.

After thoroughly analyzing individual needs and requirements, employees should take a close look at their existing coverage. When evaluating a health plan, employees should consider these key items: the range of benefits, the accessibility of the care, the cost of premiums, the amounts of deductibles and copayments, and the limits on out-of-pocket expenses for catastrophic illness. Different procedures may be covered at the doctor's office than at the hospital, and the amounts of deductibles and copayments may vary, depending on the type of service or the provider. Also important are the attitude and accountability of the medical staff, the facilities, the review procedures to monitor physicians' performances and adhere to standards for quality of care, and the time spent waiting for appointments. Employees should also understand what procedures need to be followed in an emergency.

Employers with health insurance plans must offer continued access to group health coverage, at the recipient's expense (limited to 102

[6]The various health care plans are explained in detail in chapters XVII, XIX and XX.

percent of the premium), to workers and their dependents, who might otherwise lose coverage because of changes in employment or family status. Also, a firm's filing for chapter 11 bankruptcy qualifies retirees and their dependents for continued access to their group health coverage at their own expense—limited to 102 percent of the premium. Companies with fewer than 20 employees are exempt from these continued access requirements.

Understanding a health plan could mean the difference between adequate and inadequate medical care. Employees should know their options and regularly evaluate how their plan is meeting their individual and family needs.

Disability

Sudden injury or illness can leave an employee unable to work and cause serious financial troubles for individuals and families. Disability income plans are intended to prevent this. Some areas to consider are the types of disability provided, the extent and length of coverage and the cost of various levels of benefits.

Disability plans are categorized as short-term disability and long-term disability.[7] In short-term disability plans, benefit payments are usually provided for twenty-six weeks or less. Workers may receive paid sick leave, which usually provides 100 percent of a worker's normal earnings, or sickness and accident insurance, which usually provides 50 to 67 percent of normal earnings. In long-term disability plans, benefit payments are usually provided after short-term benefits have ended. They usually provide one-half to two-thirds of an employee's predisability gross earnings, although some plans may replace as much as 70 to 80 percent of predisability pay.

Employees should learn the specific definition of disability under their plans and be aware of the conditions under which the definition may change. One question to ask is whether the disability insurance covers the employee in his or her own occupation, regardless of whether the employee can get paid work in another occupation. To qualify for disability under Social Security, which provides only long-term disability benefits, an employee must be unable to do virtually *any* paid work. Employees should also be aware of when successive periods of disability are considered separate disabilities or the same disability, since this could substantially affect how long benefits are provided.

[7]For more information on disability, see chapter XXVII.

Employers recognize all sources of disability income when calculating a benefit, and there are usually provisions regarding the integration of an employer's voluntary disability benefits with those required by law. Employers are legally required to contribute to workers' compensation and to Social Security. Some states also require employer payments to nonoccupational temporary disability insurance.

The level of benefits an employer pays is often related to each employee's salary, so a disability benefit may increase in value as an employee gains experience or improves position. Some plans also make cost-of-living adjustments.

The length of time that benefits continue also varies. It may increase with service. There is no upper age limit on eligibility for disability benefits for active employees. The level and/or duration of disability benefits may be reduced for older employees, based on age-related cost considerations provided that older workers do not receive less in benefits than that which is provided to younger employees.

Another important consideration is whether payments for partial disability are available. This covers employees who continue to work at their own occupation, but at a reduced capacity. Some plans require the employee to be totally disabled for a certain period of time to become eligible for partial disability benefits. Other plans require a certain percentage of income loss to have occurred before a worker can qualify. Employees generally experience about a 25 percent decline in income before qualifying for partial disability.

Employees should also understand what portion of the disability premium is paid by the employer and what portion by the employee. One way to reduce employee costs is to choose a longer waiting period before disability payments commence. Social Security has a waiting period of five full months from the date of onset before the individual can begin to receive disability benefits. Private plans generally have a waiting period before long-term benefits are paid.

Understanding the disability benefits can be one of the most important things to do in evaluating a whole benefit package.

Group Term Life Insurance

Employers often provide group term life insurance benefits for their employees. Life insurance benefits can make a big difference in the financial stability of an employee's survivors.

When evaluating a group life insurance plan, employees should consider the eligibility requirements, the levels and extent of cover-

age, the cost of premiums and what portion, if any, employees must pay.

Group term life insurance is generally intended to replace a portion of the deceased employee's earnings for a period of time. It is pure insurance protection, paying a benefit to the beneficiaries only at the employee's death.

Eligibility to participate in a life insurance plan is generally granted after an employee has worked a designated length of time—usually no more than a few months. Coverage may also be available for dependents. They are often entitled to a lower level of coverage, usually at an additional cost, and their coverage may last only for a specified amount of time, usually based on their age.

When employees participate in their employer's life insurance plan, they must designate primary beneficiaries. Contingent beneficiaries are often overlooked and should also be designated. Employees should find out how often the beneficiaries can be changed and keep the beneficiary designations up to date.

The amount of life insurance coverage received is often a multiple of an employee's annual earnings, so it varies for each employee. Additional benefits for accidental death and dismemberment insurance may be also included in a life insurance plan. Also, some plans continue life insurance protection in the event an employee becomes totally and permanently disabled and in the event of retirement (usually at a substantially reduced level). Employees need to find out under what circumstances such coverage continues—and at what cost to them.

Employees should also determine how much life insurance they need. The cost of monthly premiums varies, and the cost may be split between the employer and employee. In plans where employees pay all or part of the cost, the premium is often a flat amount for each covered employee, regardless of age. Also, supplemental insurance plans are sometimes available. Employees usually pay for this additional coverage. Workers should be aware of how often and under what conditions supplemental insurance can be purchased.

Also important to check is whether the group insurance can be converted to an individual insurance policy if an employee leaves the company or retires. Workers should also be aware of the conditions under which their employer can cancel the group policy, and what their options are if the insurance carrier cancels their employer's policy.

Dental and Vision Care Plans

Proper dental care and vision care are important to the prevention and treatment of potentially serious health problems, and growing numbers of employers are providing benefits for this care.

When evaluating dental and vision care plans, employees should consider eligibility requirements, services covered, the availability of dependent coverage and the existence of copayments and deductibles.

According to *Small Business Report*,[8] dental care is the fastest growing employee benefit, with approximately one-third of the population covered by dental plans in 1986. Industry experts project that over 60 percent will have some form of coverage by 1990. Dental coverage is increasing among companies of all sizes. *Small Business Report* says that two-thirds of large businesses, 40 percent of midsize companies and 35 percent of smaller firms offer dental plans. In comparison, vision care plans have experienced slower growth.

Eligibility to participate in these plans is usually granted immediately or after a short waiting period.

Employees should consider whether specific procedures they anticipate needing will be covered by their dental and vision care plans. Coverage for certain services may be limited to the employee only or may be less for dependents. Coverage may also be limited to a certain number of services. For example, in a vision care plan, a participant may only be covered for the cost of a designated number of glasses or contact lenses. In a dental care plan, the amount of coverage may vary by the type of treatment. Treatment and preventive services may also get different amounts of coverage. Employees should be aware of the amounts of deductibles and copayments and of how often deductibles must be satisfied (e.g., once annually).

Conclusion

Today's workers often take their benefit packages for granted, but unmet needs, rising costs, and retirement planning have forced employees to take a closer look at what they have and to take more responsibility for providing what they need. The importance of various benefits depends on individual needs and preferences. When evaluating the value of their benefits, however, employees should look

[8]See "Dental Coverage, Fastest Growing Employee Benefit," *Small Business Report* (October 1986): 44–47.

at their total benefit package, not merely the separate parts. To get the most from their employee benefits, workers must take the time to understand their options.

Additional Information

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