

LO 13-1

Discuss the strategic value of benefits programs, why these programs continue to grow, and considerations that need to be taken into account in providing benefits.

SHRM

K:B1

Statutory vs. Voluntary Benefits

SHRM

K:B19

Managing Employee Benefits

SHRM

K:B10

Family-Oriented Benefits

THE STRATEGIC VALUE OF BENEFITS PROGRAMS

The last of our chapters on compensation deals with benefits—indirect compensation that provides something of value to the employee. Some benefits are mandatory, due to federal and state statutes, and some are optional, based on the desires of the firm. In addition, we need to understand that if we *choose* to provide some benefits to our employees, there are mandatory laws that we have to follow as well. We will get into all of these shortly. First, though, we want to discuss the cost of benefits programs to the company.

How much would you think that companies spend on benefits packages—5% of direct wages? 10%? more? Benefits are expensive.¹ According to the US Bureau of Labor Statistics (BLS), benefits for all groups of workers average roughly 32% of total employee compensation cost.² Looking at it another way, benefit costs equaled about a 46.4% premium on top of direct wage costs in March 2014. This means that for every \$100 that goes into employee paychecks, another \$46.40 is spent on benefits. So, if you get a full-time job with average benefits and your salary is \$50,000, you would be getting around \$23,200 in benefits, or have a total compensation cost (to the firm) of around \$73,200.

If you became the HR manager for an organization and you were spending nearly one third of your total compensation dollars on employee benefits, would you want to manage those costs as closely as possible? It makes sense that you would. Luckily, we have some control over benefits costs, and as HR managers, we want to make sure that we get the best return possible—in loyalty, job satisfaction, and employee engagement—for our money.

The costs of benefits programs are staggering to most people. Of course, the BLS numbers are just an average cost to companies, but that means that for some employers, the costs are even higher than those noted already. Because benefits cost our companies so much, we need to plan our benefits programs to add value for our employees and their families as well as provide a strategic advantage to the company.³ How do benefits programs provide strategic value to the firm? As we noted in Chapter 1, our *human* resources are one of the few potential sources for competitive advantage in a modern organization. What keeps these employees happy and engaged and willing to create a competitive advantage for our firm? The totality of their compensation—including their benefits packages—is one major factor.⁴ While we are all aware that most employees take a job because of the advertised level of pay, many stay with a job because of the benefits package associated with it.⁵

CHAPTER OUTLINE

The Strategic Value of Benefits Programs

Why Are Benefits Continuing to Grow as a Portion of Overall Compensation?

Considerations in Providing Benefits Programs

Old Age, Survivors, and Disability Insurance (OASDI)

Social Security and Medicare

Other Statutory Benefits

Workers' Compensation

Unemployment Insurance

Family and Medical Leave Act of 1993 (FMLA)

The Patient Protection and Affordable Care Act of 2010 (ACA)

Statutory Requirements When Providing Certain Voluntary Benefits

Voluntary Benefits

Group Health Insurance

Retirement Benefits

Paid Time Off

Other Employee Insurance Coverage

Employee Services

Administration and Communication of Benefits

Flexible Benefit (Cafeteria) Plans

Communicate Value to Employees

Trends and Issues in HRM

Benefits for "Domestic Partners"

Personalization of Health Care

WORK APPLICATION 13-1

How important are benefits to you in selecting and staying on a job? How do benefits affect employment where you work or have worked?

Today, workers are demanding more benefits and an improved mix of choices and flexibility to better fit with their lifestyle and that of their family.⁶ This phenomenon has made it more difficult for the firm to keep track of and control benefits costs. Because people demand more and better benefits, companies add new benefits to what they have historically offered.⁷ This requires HR to spend more time monitoring the cost as well as the value provided by different types of benefits. But it also provides an incentive to our employees to continue working for us due to the fact that they feel as if they are being cared for by the company.⁸ We increase job satisfaction and engagement because when employees are taken care of, they work harder and take good care of our customers and the organization.⁹

Why Are Benefits Continuing to Grow as a Portion of Overall Compensation?

Growth in the cost of providing employee benefits has occurred for a number of reasons. Let's take a quick look at some of the biggest reasons for growth in benefits programs in the United States and worldwide.

TAX ADVANTAGES. One reason benefits are growing is that there are federal and sometimes state tax advantages for companies that provide them. If the company provides its employees with a benefit, the firm can write off all or part of the cost of providing the benefit. Sometimes the company can get benefits pretax for employees as well. As an example, most health insurance premiums are tax deductible for employers and are not taxable as income (pretax) for employees. So providing some benefits can reduce the tax burden on both the company and the individual. Take a look at the table on benefits taxation that is reproduced from IRS Publication 15B¹⁰ in Exhibit 13-1.

STATUTORY REQUIREMENTS. Federal—and, increasingly, state and local—laws require companies to provide certain benefits. A number of states have now made sick leave, other paid time off, retirement, health care, and other benefits mandatory for most or all private corporate employers in addition to the minimum wage increases we noted in Chapter 11.

EXHIBIT 13-1 SPECIAL RULES FOR VARIOUS TYPES OF FRINGE BENEFITS

Type of Fringe Benefit	Treatment Under Employment Taxes		
	Income Tax Withholding	Social Security and Medicare	Federal Unemployment (FUTA)
Accident and health benefits	Exempt, ^{a,b} except for long-term care benefits provided through a flexible spending or similar arrangement.	Exempt, except for certain payments to S corporation employees who are 2% shareholders.	Exempt
Achievement awards	Exempt ^a up to \$1,600 for qualified plan awards (\$400 for nonqualified awards).		
Adoption assistance	Exempt ^{a,c}	Taxable	Taxable
Athletic facilities	Exempt if substantially all use during the calendar year is by employees, their spouses, and their dependent children and the facility is operated by the employer on premises owned or leased by the employer.		
De minimis (minimal) benefits	Exempt	Exempt	Exempt
Dependent care assistance	Exempt ^c up to certain limits, \$5,000 (\$2,500 for married employee filing separate return).		

(Continued)

EXHIBIT 13-1 (CONTINUED)

Type of Fringe Benefit	Treatment Under Employment Taxes		
	Income Tax Withholding	Social Security and Medicare	Federal Unemployment (FUTA)
Educational assistance	Exempt up to \$5,250 of benefits each year. (See <i>Educational Assistance</i> , later in this section.)		
Employee discounts	Exempt ^c up to certain limits. (See <i>Employee Discounts</i> , later in this section.)		
Employee stock options	See <i>Employee Stock Options</i> , later in this section.		
Employer-provided cell phones	Exempt if provided primarily for noncompensatory business purposes.		
Group-term life insurance coverage	Exempt	Exempt ^{a,d,g} up to cost of \$50,000 of coverage. (Special rules apply to former employees.)	Exempt
Health savings accounts (HSAs)	Exempt for qualified individuals up to the HSA contribution limits. (See <i>Health Savings Accounts</i> , later in this section.)		
Lodging on your business premises	Exempt ^a if furnished on your business premises, for your convenience, and as a condition of employment.		
Meals	Exempt if furnished on your business premises for your convenience. Exempt if <i>de minimis</i> .		
Moving expense reimbursements	Exempt ^a if expenses would be deductible if the employee had paid them.		
No-additional-cost services	Exempt ^c	Exempt ^c	Exempt ^c
Retirement planning services	Exempt ^e	Exempt ^e	Exempt ^e
Transportation (commuting) benefits	Exempt ^a up to certain limits if for rides in a commuter highway vehicle and/or transit passes (\$255), qualified parking (\$255), or qualified bicycle commuting reimbursement ^f (\$20). (See <i>Transportation (Commuting) Benefits</i> , later in this section.) Exempt if <i>de minimis</i> .		
Tuition reduction	Exempt ^c if for undergraduate education (or graduate education if the employee performs teaching or research activities).		
Working condition benefits	Exempt	Exempt	Exempt

Source: IRS Publication 15B (2017) Fully or Partially Tax Exempt Benefits.

^a Exemption doesn't apply to S corporation employees who are 2% shareholders.

^b Exemption doesn't apply to certain highly compensated employees under a self-insured plan that favors those employees.

^c Exemption doesn't apply to certain highly compensated employees under a program that favors those employees.

^d Exemption doesn't apply to certain key employees under a plan that favors those employees.

^e Exemption doesn't apply to services for tax preparation, accounting, legal, or brokerage services.

^f If the employee receives a qualified bicycle commuting reimbursement in a qualified bicycle commuting month, the employee can't receive commuter highway vehicle, transit pass, or qualified parking benefits in that same month.

^g You must include in your employee's wages the cost of group-term life insurance beyond \$50,000 worth of coverage, reduced by the amount the employee paid toward the insurance. Report it as wages in boxes 1, 3, and 5 of the employee's Form W-2. Also, show it in box 12 with code "C." The amount is subject to social security and Medicare taxes, and you may, at your option, withhold federal income tax.

In 1935, Social Security laws were passed that required companies to provide employees with old-age, survivor, and disability benefits. Over the ensuing years, Congress has added other mandatory benefits such as unemployment, workers' compensation, family and medical leave, and the Affordable Care Act or ACA (we will discuss each of these shortly). Each time Congress or the states require employers to provide a new benefit, the cost to employers for providing benefits goes up.

INFLUENCE OF ORGANIZED LABOR We talked about the *National Labor Relations Act* in Chapter 9 and noted then that the act allows employees to “bargain collectively” with their employers. This is another reason that benefit costs have grown for companies over the years. A large part of collective bargaining is usually focused on employee benefits (for a variety of reasons), and once union members gain such benefits, employees in other competing companies use this as leverage to have the same benefits added to their workplace, even if the company is not unionized. Unions also use the tax-favored status of many benefits to make them more palatable to the company during negotiations, and organizations may prefer benefits concessions to wage concessions because of the tax advantages. So unions have had a significant effect on the cost and variety of benefits.

BUYING IN BULK. Virtually everyone now knows that if you buy things in larger quantities, you get them cheaper (think **Sam’s Club** or **Costco**). Buying benefits in bulk works the same way. If companies buy benefits in bulk for employees, it is cheaper than if the employee buys the same benefits individually.

As you can see, there are a variety of reasons why the costs of benefits have grown in the last 80 years. And once a benefit becomes part of the employee’s compensation package, it is very hard to delete that benefit in the future. We consider them an entitlement (Chapter 12)—we feel that the company owes us this benefit.¹¹ So the cost of providing benefits almost never goes down; it just keeps going up. However, some companies, especially companies with fewer than 50 employees, have decided to drop health care benefits for their employees as a result of the detailed requirements in the ACA. An **EBRI** study noted that “many small employers may have decided that the increasing costs and risks associated with offering health coverage were no longer justified.”¹²

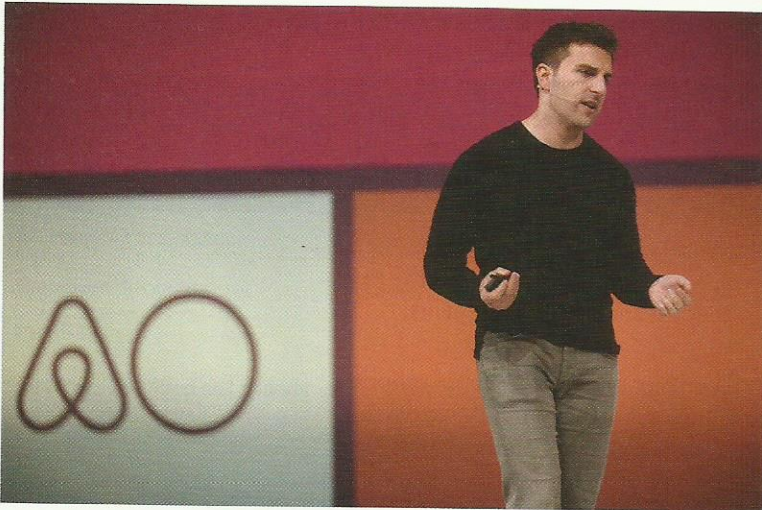
Considerations in Providing Benefits Programs

How do we create and then administer a benefits program for our workforce? We need to understand several things before creating the program so that we create a system that is both valuable to the employees and affordable for the organization. Remember that our goal is to have a program that increases employee motivation and engagement and helps create a competitive advantage.

As part of strategic value, to help attract and retain the best workers, some companies offer generous voluntary benefits. **Google** is well known for its generous benefits, including free gourmet food all day long, free gyms and massages, and generous parental leave, and dogs are welcome at work.¹³ **L.L. Bean** gives employees discounts of 33% to 40% on company-made items, and it increased its tuition reimbursement from \$2,750 to \$5,250 per year.¹⁴ **Starbucks** will reimburse tuition cost for online degrees from **Arizona State University**.¹⁵ But of course, any firm that decides to provide these generous benefits must be able to afford the high cost.

AMOUNTS. The first issue is how much money the company is willing to spend to provide an employee benefits program. Many companies will calculate this as a percentage of direct compensation. We may analyze the current situation and come to the conclusion that we are able to provide a 40% premium to direct compensation for the cost of benefits. We have to be very careful in our consideration of the amounts available for employee benefit programs. As with other types of compensation, if we tell our employees that we will provide a benefit that they value and then fail to follow through for any reason, it is just as damaging to motivation and engagement as any other type of management action that breaks the expectancy theory process discussed in Chapter 11. We need to make absolutely sure that we will have the funds available if we commit to providing the benefit.

MIX. Once we know how much money is available, we need to decide what types of benefits we will offer. Here again, the number of different types of benefits has exploded



Airbnb CEO Brian Chesky. Airbnb provides employees \$2,000 to travel as part of its benefits program.

over the past 40 years. In the 1960s and 1970s, most companies had limited benefit programs. They might have offered their employees a retirement benefit, health insurance, life and disability insurance, and possibly dental care, but nobody ever thought about providing “\$2,000 to travel” like Airbnb or “acupuncture or improv classes” like Twitter!¹⁶ Today, the number and type of benefits available in some company programs is limited only by the imagination of the employees of the firm.

As an example, companies today may provide a transportation subsidy such as a vehicle allowance, a public transportation voucher, free parking near the office or a parking

voucher, alternative vehicle allowances (for buying “green” vehicles), allowances for bicycles and places for bike parking, a van or shuttle service to take employees to work and back home . . . and this is just benefits associated with transporting the worker to and from work. The company can provide on-site wellness centers and child care,¹⁷ child care vouchers, sick child care, paid child care leave, paid leave for pregnancy and childbirth, elder care, and/or pet care. So we can quickly see how large the pool of potential employee benefits can become. We have to decide which of the options is going to provide our workforce with the best benefits package for the money spent.

WORK APPLICATION 13-2

How important is benefits flexibility to you? How does benefits flexibility affect employment where you work or have worked?

LO 13-2

Identify and summarize the major components of OASDI and the Medicare program.

FLEXIBILITY. Finally, we need to consider how much flexibility we are willing to build into our benefits program because flexible options are very important to today’s employees. Flexible benefit programs allow employees to pick from a set of benefits in some way. The employee can, at least for a portion of their benefit package, choose one type of benefit over another in flexible benefit plans. Flexibility is important to motivation because it gives employees the benefits that are of value to them—expectancy theory.

We will get into the reasons behind these issues later in the chapter. Right now let’s get into a review of the mandatory and common voluntary benefits available today.

OLD AGE, SURVIVORS, AND DISABILITY INSURANCE (OASDI)

Statutory benefits are benefits that are required by law. A number of benefits are required by federal laws in the United States and in many other countries. There are also laws that apply if the company chooses certain optional, or nonmandatory, benefits in certain cases. Always remember that laws vary in every state and every country, so check to make sure you know all of the requirements based on where your organization is based. The first of our statutory benefits in the United States is Old Age, Survivors, and Disability Insurance.

Social Security and Medicare

By far the largest of the statutory US programs, in both size and cost to employers (and employees), are Social Security and Medicare. The combined cost of the Old Age, Survivors, and Disability Insurance (OASDI)—the formal name for what we generally call Social Security—and Medicare programs was more than \$1.5 trillion in 2016.¹⁸ To put that in perspective, the total federal revenue collected in 2016 was expected to be about \$3.27 trillion.¹⁹ This means that this one group of programs cost more than 46% of all money the federal government received in 2016.

Employers and employees are required to provide funds for Social Security benefits. The program was created with the passage of the Social Security Act of 1935. The act created a series of programs for the social welfare of the population of the United States, including OASDI, Medicare for elderly and disabled individuals, and several other

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Federal Insurance Programs

lesser-known programs. Since these programs are so complex, and this is an introductory overview of the field of HRM, the best that we can do in this text is to provide some general information on the programs.

How much money does the employee's Social Security benefit cost, and who pays for it? The employer and employee jointly pay into Social Security through withholdings from the employee's paycheck and a mandatory employer payment. Each of them pays 6.2% of the employee's total pay per pay period into OASDI and 1.45% of the employee's pay into the Medicare fund. The 6.2% contribution is only withheld on the first \$127,200 the employee earns during the year (in 2017),²⁰ and then it stops, but the 1.45% tax for Medicare is paid on all income, no matter how much is earned. So the combined amount sent to the federal government is 15.3% of the employee's income, half from the employer and half from the employee.

How does an employee become eligible for OASDI benefits? As a general rule, the individual must receive 40 "credits" in their lifetime in order to become eligible for Social Security *retirement*. They must earn \$1,300 in one quarter (in 2017) in order to receive 1 credit. The amount of earnings required to receive 1 credit rises each year as average earnings rise. The 40 credits do not have to be in consecutive quarters—the individual does not have to work for 10 years without a break in employment—and more than 1 credit can be earned in a quarter (if a person made \$2,600 in a quarter, they would earn 2 credits), but a person can only earn 4 credits per year.²¹ However, the 40-credit rule does not necessarily apply to *disability or survivor* benefits. While we would normally need 40 credits in order to be eligible for disability payments, if we were disabled before we could reasonably earn the 40 credits, we might become eligible earlier. For example, if disabled before age 24, you could qualify for disability benefits with as few as 6 credits earned in the 3 years prior to becoming disabled.²²

RETIREMENT. Once an employee becomes eligible through earning 40 credits and meeting the retirement age requirements, they can receive a monthly check, but is that monthly check supposed to help the employee maintain the lifestyle that they had before retirement? Social Security was only designed to pay about 30% of preretirement income. It was never designed to replace 100% of preretirement income. However, many employees plan on it as their only retirement.

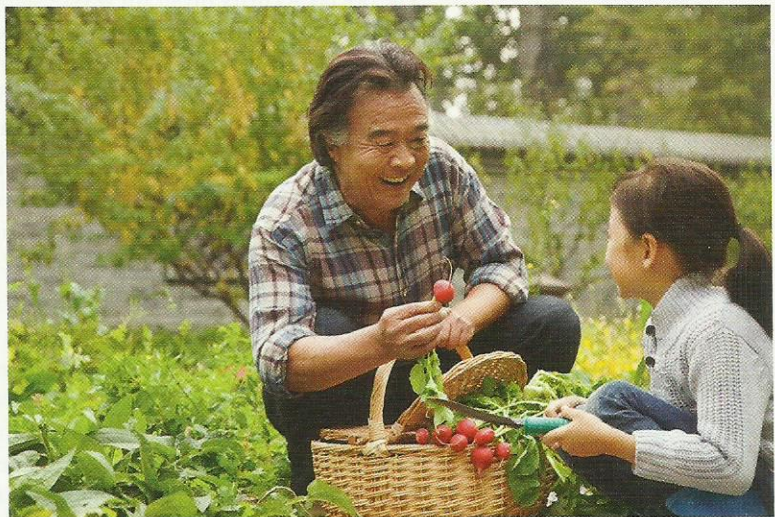
As HR managers, part of your job will be to make employees aware that they need to also *save* for retirement. Most people aren't saving at all or are not saving enough for retirement.²³ The savings rate in the United States compared to that in many other developed countries is low. In 1990 the US savings rate was around 7%, but by 2005 it had dropped to less than 1.5% and by 2017 had recovered to about 5.5%.²⁴ This compares with savings rates of 10% or more in Germany, Sweden, and Switzerland.

Regardless of your age, think *retirement*, right now.²⁵ There are sayings, such as pay yourself first and retirement should always be your top payment priority.²⁶ The common recommendation is to start when you get your first full-time job by putting 10% of your income into a retirement fund every month, no matter how low or high your income is, and always take advantage of matching benefits from your employer.²⁷ We'll talk more about retirement later in this chapter.

At what age are we eligible for Social Security retirement? If you were born in 1937 or earlier, you are eligible for retirement at age 65. If you were born in 1960 or later, your retirement age is 67. For those born between 1937 and 1960, it is based on a sliding scale.

WORK APPLICATION 13-3

Look at your last pay stub. How much was taken out for Social Security tax and Medicare tax? How much did your employer pay?



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The key to having money at retirement is to start saving at a young age to take advantage of compound interest.

EXHIBIT 13-2 FULL SOCIAL SECURITY RETIREMENT AGE

Age to Receive Full Social Security Benefits	
Year of Birth	Full Retirement Age
1937 or earlier	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943–1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

Source: US Social Security Administration, <https://www.ssa.gov/planners/retire/agereduction.html>, retrieved July 29, 2017.

Take a look at Exhibit 13-2. If you were born in 1956, you are eligible for full retirement benefits from Social Security at age 66 and 4 months.²⁸

One of the most important things to understand about social security is how many people lived to be age 65 when the Social Security law originally passed and how many it supports now. In 1935, approximately 6% of the population was age 65 or older, but in the year 2000, that number was about 12.4%, and in 2017, it was estimated at 14.9%.²⁹ The Social Security program was designed around a retiree population of 6%, but that has more than doubled, and it will continue to rise for many years to come. This is one of the issues with the way Social Security is set up today and one of the reasons that the program constantly has to be reevaluated. The changes in life span and changes in income that have occurred over the past 70 years have made the program unsustainable in its current form.

Another major issue with Social Security is the large number of baby boomers who are starting to retire, with fewer younger workers paying into the Social Security system. The Social Security Board of Governors estimates that the OASDI fund will have greater outflows than it takes in beginning in 2022 and will exhaust its funds in 2034 if legislative corrections are not undertaken.³⁰

What about early retirement? Can a person retire earlier than age 65–67? Yes, but their benefits will be *permanently* reduced. For example, if an employee was eligible for retirement at age 65, they could take early retirement and get an 80% benefit at age 62. That 20% reduction is forever, not just until they reach age 65. If an individual is not eligible for full retirement benefits until age 67 (they were born after 1960), the reduction is 30% at age 62—again for the life of the retirement benefit.

DISABILITY AND SURVIVOR BENEFITS. These components are really basically the same benefit. If an employee becomes disabled or dies and is otherwise eligible, the disability or survivor benefit will apply in most cases. The employee, or their survivors, will

get payments each month roughly equal to what the employee would have gotten in retirement based on their historical earnings. If the employee is disabled for at least 5 months and is expected to be disabled for at least 12 months, Social Security disability will be allowed. The disability must last at least 12 months or be expected to ultimately cause the covered person's death.

Survivor benefits can go to a widow/widower over age 60, any child or grandchild who is a dependent of the deceased and is under age 18, or any dependent parent over 62. If an individual has survivors in multiple categories, then the survivor benefit gets split among eligible survivors.³¹

MEDICARE. Finally, there is the Medicare component. Individuals become eligible for Medicare at the same time as their eligibility for Social Security retirement begins. There are currently four parts to Medicare:³²

- **Part A** is Hospital Insurance (HI). Hospitalization covers the inpatient care of a retiree in a hospital, skilled nursing facility, or hospice. Again, according to the Social Security Board of Governors: "The HI . . . trust fund ratio is already below 100 percent of annual costs, and is expected to stay about unchanged to 2021 before declining in a continuous fashion until reserve depletion in 2029."³³
- **Part B** covers non-hospital-related (outpatient) Medical Services Insurance (MSI).
- **Part C** Medicare recipients can also now choose this option, called Medicare Advantage plans, instead of Part A and Part B. Option C combines Part A (HI) and Part B (MSI) coverage in a plan similar to an HMO or PPO (we will talk about these in detail shortly). Private insurance companies approved by Medicare provide this coverage. Costs may be lower than in the original Medicare Part A and B plans, and the insured may get extra benefits.
- **Part D** is a prescription drug benefit. Part A and B are basically automatic upon the individual's retirement. The retiree has to elect to participate in Part C and/or D.

Medicare is not completely free to the retiree. The covered person has to pay copayments and deductibles of various types, the details of which are beyond the scope of this text. But understand that there are out-of-pocket costs involved with Medicare. There are also limitations on what is covered. So Medicare provides basic medical benefits, but it was not designed to be a full-coverage program.

OTHER STATUTORY BENEFITS

While social security and Medicare are massive programs that take up much of the federal budget in the US, there are a number of other required benefits. In addition, there are several statutory requirements if the company chooses to provide certain health and welfare or retirement benefits to their workforce. Let's review these requirements now.

Workers' Compensation

The next mandatory benefit is workers' compensation. **Workers' compensation** is an insurance program designed to provide medical treatment and temporary payments to employees who cannot work because of an employment-related injury or illness. "Employment-related" means that the illness or injury had to do with the worker's actions for the company, although the injury or illness didn't have to happen while the person was actually at work. For instance, if an employee were traveling through an airport as part of their job and picked up their suitcase, injuring their back, this would be an "employment-related" injury.

The workers' compensation program is paid for by employers—employees pay none of the cost of workers' compensation insurance. Workers' compensation payments to sick or injured employees are not permanent in most cases. The program was created to

WORK APPLICATION 13-4

Using Exhibit 13-2, at what age
can you expect to collect full
Social Security?

LO 13-3

Identify the statutory requirements other than OASDI, including those required if organizations choose to provide health care or retirement plans for their employees.

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Workers' Compensation

Workers' compensation

An insurance program designed to provide medical treatment and temporary payments to employees who cannot work because of an employment-related injury or illness

provide workers with *short-term* relief because of work-related injuries or illnesses. Social Security disability, on the other hand, generally provides long-term relief in the form of disability payments. Workers' compensation does, however, pay a survivor benefit in the case of death of the employee.

Workers' compensation is a type of "no-fault" insurance, which means that no matter which party—the employer or the employee—was at fault in an accident- or illness-related situation, the insurance will be paid out to the party harmed. Why is no-fault such an issue? The main reason is the problems that would arise if the employee had to sue in court. First, there would almost certainly be animosity between the employer and employee if the employer were to be sued. It would also take significant time to get the case settled and for the injured party (if the decision went in their favor) to receive compensation. The employer's maximum liability is also limited by workers' compensation. Without it, the employer could potentially be bankrupted by a single employment accident or incident, especially if an employee were killed. In all but situations of *gross negligence* or *intent to harm* (willful misconduct), neither party can take the other to court over compensation for such an injury or illness because of the no-fault nature of the insurance. So the ability to provide no-fault insurance in this circumstance is valuable to both parties.

Workers' compensation is mandatory in every state with the exception of Texas, where coverage is optional.³⁴ In the states where it is mandatory, employers must purchase workers' compensation insurance in order to operate their business. In Texas, companies can choose not to purchase insurance, but in fact most still do. Texas's nonsubscriber rate (those companies that do not purchase workers' compensation insurance) was about 22% in 2016.³⁵ Why would they buy this insurance if it is not mandatory? The simple answer is that it is cheaper than losing a court case concerning an employee injury. Here again, if there isn't an insurance policy in place, the employee can, and likely will, sue the company because they are unable to work. As most of you have seen in the newspaper, these types of court cases may provide very large awards to injured parties. It is likely that workers' compensation insurance is a very low-cost method to insure against a very large potential jury award. Of course, the company can get a blanket liability policy that would cover on-the-job injuries, but it might be much more expensive than workers' compensation insurance, and the company could still be bankrupted by a lawsuit if the liability policy limits were exceeded.

Just how expensive is workers' compensation insurance? It varies, but *as an average*, it generally costs between 1.2% and 2% of payroll for most companies.³⁶ It can go much higher than this, though, in some cases. Rates are primarily determined by three factors:

1. **Occupations.** Within a company, what are the risks of injury associated with each job? Some occupations are much more risky than others. For instance, it costs a lot more to insure firefighters, police officers, or construction workers than it does to cover office workers, sales clerks in a mall, or a librarian.
2. **Experience ratings.** An **experience rating** is a measure of how often claims are made against an insurance policy. A company's workers' compensation experience rating is basically calculated on the frequency and severity of injuries that occur within that company. There are companies that are in dangerous industries, but they have very few on-the-job injuries because they have very strong safety programs, while other companies in the same industry might have really high injury rates because they don't pay as much attention to safety. Experience ratings can significantly affect a company's workers' compensation costs.
3. **Level of benefits payable.** Injured workers will get compensated based on their particular state's workers' compensation rating manual. This manual provides the required payout rates for various types of injuries. For instance, an amputation of a finger other than the index finger or thumb might provide the employee with a small, one-time payment, but amputation of an arm below the elbow would likely provide more and continuing payments. Individual states can set the rates for injuries within the state's boundaries, and these rates affect the cost of workers' compensation insurance.

Experience rating A measure of how often claims are made against an insurance policy

If you read the previous paragraph closely, you will notice that the company has some control over their workers' compensation rates. The experience rating figures heavily into the company's cost of providing this insurance, so if we can lower our experience rating, we can lower our insurance cost as well. And the savings associated with a low experience rating aren't just one-time savings; our costs continue to be lower for as long as we maintain a safer-than-average work environment (we will discuss safety further in the next chapter). This is an area that HR managers need to understand so that they can lower company costs for workers' compensation insurance.

Who manages and monitors the workers' compensation programs? State governments have the primary authority for managing their state's program. However, the insurance doesn't come from the state itself. The insurance is almost always provided by a private insurance company that provides workers' compensation insurance in that state. Each state has an insurance commission that authorizes insurance firms to operate in that state, and if insurance companies choose to offer workers' compensation insurance in a particular state, they have to follow that state's guidelines. The company approaches a private insurer for workers' compensation insurance and purchases a policy from whichever state-licensed insurer they choose.

What if the company has a poor experience rating because of excessive accidents? In such a case, the insurers may choose not to provide insurance to the company because the risk to the insurance firm is too great. In this situation, the company that has been denied insurance can go to the state workers' compensation commission and ask to be covered in the workers' compensation pool. The pool is made up of insurers who provide workers' compensation policies in the state. Each insurer that is licensed to provide such insurance typically has to be part of the pool. The state commission will then assign the company requesting coverage to one of the insurers, and the insurer will have to write the policy for the company that was previously denied coverage.

The pool assignments are usually based on the percent share of each insurer's policies within the state. For instance, if one insurer writes workers' compensation policies that cover 13% of all employees in the state of Arkansas, that insurer would be asked to cover about 13% of the employees whose companies have to resort to the state pool for coverage. While this is a simplified example, it gives you an idea of how companies can get insured, even if no insurance company is willing to cover the risks associated with such an employer with a poor experience rating. Remember though that the cost associated with being in the state pool is significantly more in most cases than it is if the company can get insurance coverage without becoming part of the pool.

Because of their industry and their experience rating, there are cases where companies are spending significant amounts of money on worker's compensation. In some cases, as much as 25% of a company's total personnel costs can come from workers' compensation costs if they are in a high-risk business and their experience rating is also high. Obviously, it can be different from company to company. But again, we can actually lower our experience rating by providing safety training as discussed in Chapter 14.

Unemployment Insurance

The third statutory benefit is Unemployment Insurance. **Unemployment Insurance (UI)** provides workers who lose their jobs with continuing subsistence payments from their state for a specified period of time. It is a federally mandated program but is managed and administered separately by each of the states. UI originated under the Social Security Act of 1935 and is applied as a tax on the employers—"Only Alaska, New Jersey, and Pennsylvania levy UI taxes on workers."³⁷ The basic federal tax rate is set at 6.2% of wages earned (in 2011) for the first \$7,000 in individual wages, but this rate can be (and generally is) reduced by up to 5.4% if the employer pays state unemployment taxes on time and avoids tax delinquencies. A minimum of 5.4% of the first \$7,000 paid to each employee goes to the state unemployment fund, and 0.8% goes to the federal government.³⁸

In addition to the federal minimum of 6.2%, states can vary the tax rate and effective wage rate within their borders. Here again, as in workers' compensation, the tax rate is

WORK APPLICATION 13-5

How would you rate the risk of occupational injury or illness where you work or at an organization where you have worked? Is it high, moderate, or low? Why?

SHRM

K:B16

Unemployment Insurance

Unemployment Insurance

(UI) Insurance that provides workers who lose their jobs with continuing subsistence payments from their state for a specified period of time

also affected by the company's "experience rating." Employers who tend to terminate more employees who are eligible for UI benefits have a higher experience rating and, as a result, a higher UI tax rate. So, within the same state, some employers will pay much more in UI taxes than other employers will.

What is the logic behind UI? It is there to allow people to continue to have at least some purchasing power even when they are unemployed. If UI was not available, when the country experienced a recession, many individuals and families would stop spending as much as they possibly could. This could cause the recession to deepen even more and make it more difficult for the economy to recover, because consumer spending is the largest input into the national economy. If, however, unemployed individuals are provided with some funds, the overall economy is not harmed as much as it would otherwise be. In ordinary times, when unemployment rates are not very high, unemployment payments are capped at 26 weeks per recipient in most states. However, in times of high unemployment, this can be (and usually is) extended. In the 2007–2009 recession, some states with very high unemployment rates were allowed to extend unemployment benefits to as long as 99 weeks—nearly 2 years!³⁹

How does an individual become eligible for UI? What has to happen? They have to be terminated from employment—either through downsizing, layoff, or other processes—and in most cases must have worked in four of the last five quarters and met minimum income guidelines in each of those quarters. What makes them *ineligible*? A series of things can occur that make the individual ineligible:

- The individual quit voluntarily.
- They fail to look for work.
- They were terminated "for cause" (because they did something wrong).
- They refuse suitable work (work comparable to what they were doing prior to being terminated).
- They, as a member of a union, participate in a strike against the company (in most states).
- They become self-employed.
- They fail to disclose any monies earned in a period of unemployment.

What does the individual receive in the way of UI benefits? Generally the weekly benefit is about 60% of what the person was making when they were employed, but this also varies some by state, and there is a cap on the amount that will be paid out in unemployment benefits. So if the individual was highly paid, in some states they may only receive 25% (or even less) of their prior weekly pay because of the cap.

SHRM

B:9

Family and Medical Leave Act of 1993 (FMLA)

Family and Medical Leave Act of 1993 (FMLA)

The next mandatory benefit is Family and Medical Act leave, more commonly known as FMLA leave. FMLA requires that the employer provide unpaid leave for an "eligible employee" when they are faced with any of the following situations:⁴⁰

- Leave of 12 workweeks in a 12-month period for:
 - The birth of a child and to care for the newborn child within 1 year of birth
 - The placement with the employee of a child for adoption or foster care and to care for the newly placed child within 1 year of placement
 - To care for the employee's spouse, child, or parent who has a serious health condition
 - A serious health condition that makes the employee unable to perform the essential functions of their job
 - Any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty"

OR . . .

- *Leave of 26 workweeks during a single 12-month period* to care for a covered service member with a serious injury or illness if the eligible employee is the spouse, son, daughter, parent, or next of kin (military caregiver leave)

In addition, upon the employee's return from FMLA leave, they must be restored to their original job or one that is equivalent in pay, benefits, and other terms and conditions of employment.

Any private-sector employer is covered under the act if they have 50 or more employees who worked at least 20 weeks during the year, working within a 75-mile radius of a central location.

Eligible employees must

- work for a covered employer;
- have worked for the employer for a total of 12 months (not necessarily consecutive); or
- have worked at least 1,250 hours over the previous 12 months.

The act also exempts some eligible employees. "A salaried eligible employee who is among the highest paid 10% of the employees employed by the employer within 75 miles of the facility at which the employee is employed"⁴¹ is exempted from FMLA leave and can be denied restoration of their job if they utilize their "eligible employee" status to take such leave.

Reasons to deny restoration to a job include the following:⁴²

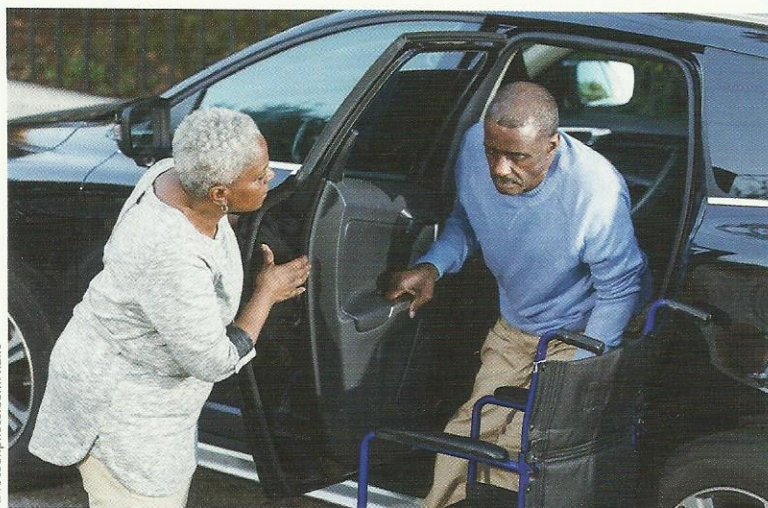
- Such denial is necessary to prevent substantial and grievous economic injury to the operations of the employer.
- The employer notifies the employee of the intent of the employer to deny restoration on such basis at the time the employer determines that such injury would occur.
- In any case in which the leave has commenced, the employee elects not to return to employment after receiving such notice.

One of the problems that employers run into with FMLA is the definition of "serious health condition." Under FMLA, a **serious health condition** means an illness, injury, impairment, or physical or mental condition that involves either inpatient care or continuing care for at least 3 consecutive days, but there is strong evidence that FMLA leave is heavily abused. All an employee needs in order to be able to claim FMLA leave is a document from a health care provider that says that they have such a serious health condition. When President Bill Clinton pushed the law through during his first term, the intent of the law was noble. However, the execution left something to be desired for businesses dealing with abuse of this benefit.

Why are there problems with the law? The employer has little leeway when an employee requests FMLA leave and has documentation of a serious health condition. The employer has to cover the costs of not having the employee at work (we talked about the costs of absenteeism in Chapter 1). The law also says that we have to give at least 90% (remember, we can exempt the top 10%) of our employees up to 12 weeks of FMLA leave per year and then have to give them their job back, or a comparable job. So if we have 50 employees who work within 75 miles of a central location, we would have to allow up to 45 of those employees to miss up to a quarter of the work year, every year. This puts a huge burden on both HR and operational managers, and it can easily affect morale of the other employees who have to take up the slack for the employee who is on FMLA leave. And remember when we discussed the issue of bad employees in Chapter 9, we noted that one bad employee can affect everyone's productivity. In fact, there is evidence that one person who games the company for unfair time off can bring performance of the entire organization down by 30% to 40%.⁴³

Serious health condition

An illness, injury, impairment, or physical or mental condition that involves either inpatient care or continuing care for at least 3 consecutive days



Many employees want to have time to spend with their family, which is made possible through FMLA leave.

FMLA leave be documented by a health care provider, at the employee's expense. The employer can also require a second or even third opinion on such reasons for FMLA leave (at the *employer's* expense), as well as requiring periodic certification of the continuing need for FMLA leave when the condition lasts for an extended period of time. Employers should typically get a second certification when it is suspected that an employee is abusing FMLA.

Companies can additionally require that employees substitute paid leave and completely use such leave up before taking unpaid FMLA leave as long as that is the employer's normal policy. And they can recover health care premiums that were paid to an employee on FMLA leave if the employee doesn't return to work.

Additional employer requirements include the requirement to post notice of FMLA benefits prominently in the workplace and to include this notice in either an employee handbook or other written guidance to employees when they are hired. Employers must also maintain health insurance coverage for the employee on FMLA leave if such health benefits are normally provided, again adding to the employer's costs.

All in all, even though FMLA requires only *unpaid* leave, the costs to the company are significant. It puts a significant strain on businesses, especially small businesses. The HR department usually bears a large part of the burden of monitoring and curbing abuses of FMLA leave, and HR managers must be aware of the rules and regulations in order to apply the law correctly.

The Patient Protection and Affordable Care Act of 2010 (ACA)

The last mandatory benefit is the Patient Protection and Affordable Care Act of 2010. This act mandated that all employers with more than 50 employees provide their *full-time employees* with health care coverage or face penalties for failing to do so.⁴⁴ Offering health insurance benefits helps to attract and retain employees, and it is a major concern for both employees and employers.⁴⁵ A MetLife study found that 60% of employees are concerned about having access to affordable health insurance and worry about how they will pay for the out-of-pocket medical costs. Employers are concerned about the rising cost of health care and how the ACA will affect their health care benefits as it is implemented⁴⁶ and the still unknown possible changes and effects of the ACA. The major provisions of the law are presented in Exhibit 13-3, by the year in which they became effective.

The "pay or play" penalty noted in Exhibit 13-3 under 2015 applies to *full-time equivalent (FTE) employees*. Full-time equivalents include all workers putting in 30 or more hours per week *plus* the total number of hours worked by part-time employees per

Because of the burden that FMLA can create, employers want to make sure to the best of their ability that employees are not abusing FMLA. One thing that the employer can do to lower abuse is to enforce the requirement that employees give 30 days' advance notice of intent to use FMLA leave if they know that it will be needed. The law also says that if an employee cannot foresee the need 30 days ahead of time, they must provide notice to the company as soon as practicable. Usually this is within 1 day of learning of the need for FMLA leave, or if the need is emergent (for example, an employee is hurt in a car accident), they must notify the employer as soon as possible. Employers also have the right to require that the reason behind a request for

EXHIBIT 13-3 AFFORDABLE CARE ACT**2010**

- Children can stay on parents' health care insurance until age 26.
- Insurance companies are banned from rescinding coverage when the covered individual gets sick and from imposing lifetime caps on benefits.
- Children with preexisting conditions can't be excluded from health care coverage.

2011

- Employers have to disclose the value of employee health insurance on IRS form W-2.
- Flexible spending accounts (FSA—we will talk about these later in the chapter) no longer allow nonprescription medicines to be reimbursed.
- Medicaid begins providing preventive care services to beneficiaries with no out-of-pocket cost.

2013

- FSA contributions are limited to \$2,500 per year.
- High wage earners have an additional 0.9% Medicare tax on earnings in excess of the current limit. This additional tax starts at \$200,000 for individual earnings or \$250,000 for joint returns.
- Employers are required to notify employees of state health insurance exchanges.

2014

- Most individual taxpayers are required to have health coverage or pay a tax penalty at year end.
- Employer health plans may not impose more than 90-day waiting periods for new employee coverage.
- State health insurance exchanges must be open.
- State health insurance exchanges must be operational.
- Insurers will be banned from restricting coverage or providing differential premiums based on health of the covered individual.

2015

- Employers with 100 or more employees will be required to offer health benefits to employees or face penalties—this is called “pay or play.”
- Businesses with fewer than 50 full-time equivalent employees (FTEs) are not penalized for failing to carry employer health coverage.
- Businesses with 100 or more FTEs will be fined \$2,000 per full-time equivalent minus the first 30 FTEs.

2016

- Employers with more than 50 but fewer than 100 employees will be required to offer health benefits to employees or face penalties.
- Businesses with 50 or more FTEs will be fined \$2,000 per full-time equivalent minus the first 30 FTEs.

Source: Affordable Care Act of 2010.

month divided by 120. For example, take a look at the calculation below. If a company has 42 employees who work 40 or more hours per week, 22 employees who work fewer than 40 hours per week but more than 30, and 25 employees who work fewer than

30 hours per week and worked a total of 1,500 hours per month (an average of about 15 hours per person per week), the calculation of FTEs would be as follows:

40-hour employees (42)		30-hour+ employees (22)		1,500 hours (from employees working fewer than 30 hours per week)	
Traditional full-time employees		All employees working more than 30 hours are considered full-time		The number of part-time hours divided by 120: 1,500/120 = 12.5.	
42	+	22	+	12.5	= 76.5 FTE (round up to 77)

If this company chose not to provide health insurance, they would have to pay a fine of \$94,000: 77 FTEs – 30 FTEs = 47, $47 \times \$2,000 = \$94,000$.

Another provision of the law is that employees not covered by a health care plan at work are *required* to go to the state health exchange, where they can purchase individual coverage. Individuals who fail to gain coverage will also be fined. The penalty was a minimum of \$695 in 2017 and is indexed for inflation after that. The total amount of the penalty for a family will not exceed \$2,250. One caveat is necessary here. These penalties and amounts are as of the time that this text was written. There are ongoing attempts to change the structure of the ACA or even completely repeal the law. If this were to happen, HR managers would need to update themselves on the provisions of the law.

“Qualified” ACA plans (plans that meet the guidelines of the law) will have to pay at least 60% of allowed charges and meet some minimum benefit standards. The plan must also be “affordable,” which means it will not exceed 9.5% of the employee’s household income. If an employer offers a plan that is not “qualified and affordable,” they will be fined \$3,000 annually for each employee who goes to the health care exchange for coverage. So for an employer, offering *no* plan is cheaper than offering a plan that isn’t qualified and affordable—it costs \$2,000 per employee to have no coverage but \$3,000 to have nonqualifying coverage.

One of the most significant questions associated with the ACA is “Will employers just choose to pay the fine rather than provide health insurance, because the fine is less expensive?” The average cost for employer coverage of a full-time worker in 2016 was nearly \$6,000,⁴⁷ and cost for a family health plan was about \$17,000,⁴⁸ and that is just the direct cost of the insurance; it doesn’t include the costs of managing the program requirements created by the ACA. So a \$2,000 penalty may be the lesser of two evils for companies that are struggling with profitability.

Another concern associated with the ACA is that the company only has to provide insurance to full-time employees, even though part-time employees are part of the calculation of firm size under the law. This has caused a significant number of businesses to shift at least a portion of their workforce from full-time to part-time⁴⁹ and to cut existing part-timers’ hours.⁵⁰ There has also been a notable shift to more part time, contract, and other contingent employment, and companies expect that shift to intensify as they adjust to the new law.⁵¹ **Uber** has thousands of drivers, but they are contractors and don’t get any benefits. Everyone hired at **Sid Simone Solutions** is an independent contractor.⁵² Authors Robert Lussier and John Hendon are contractors for **SAGE Publishing**. Some companies are outsourcing work from employees to contractor companies, such as **Virgin American**. **Google** parent **Alphabet** has roughly equal numbers of outsourced workers and full-time employees.⁵³ Companies such as **FedEx** are also reclassifying their current employees as contractors to cut costs as they continue to do essentially the same work.⁵⁴

Statutory Requirements When Providing Certain Voluntary Benefits

Let’s take a look now at some legal requirements if we choose to provide certain benefits to our employees. These requirements don’t apply unless we make the choice to provide our employees with health insurance or company-sponsored retirement plans.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA). If employers choose to provide health insurance, we have to abide by the Consolidated Omnibus Budget Reconciliation Act (COBRA) law. **COBRA** is a law that requires employers to offer to maintain health insurance on individuals who leave their employment (for a period of time). The individual former employee has to pay for the insurance, but the employer is required to keep the former employee on their group insurance policy.

Why would a former employee want to remain on the company's health insurance policy? Primarily because buying an individual health insurance policy is much more expensive than buying insurance for a group of people. According to *Smart Money*,

Buying individual health insurance isn't as easy as having a clean bill of health and enough cash. . . . Should an insurer agree to provide coverage, it will almost certainly be costly and confusing. The average out-of-pocket costs for people insured individually is almost double what people covered by an employer pay.⁵⁵

So this option will save people money over buying health insurance on their own. Another reason is that in most cases, people don't leave one job and start another on the same day, so they will have a gap in their health coverage if they don't utilize COBRA coverage. COBRA allows coverage after termination of employment for at least 18 months and for as many as 36 months in some limited cases. This period is usually sufficient to allow an individual to leave one job, gain employment elsewhere, and switch to the new employer's health care plan without losing health coverage for themselves and their family.

COBRA applies to companies with 20 or more full-time equivalent employees. It is required to be offered to both terminated employees and those who voluntarily quit, in most cases. An interesting thing about this law is that it doesn't make failure to comply illegal. It instead denies a tax deduction that employers could otherwise take if they fail to comply with the COBRA regulations, and the law has been amended to charge an excise tax on employers who are not in compliance. So the employer's effective tax rate goes up significantly if they fail to comply with COBRA rules.

The employee, as noted earlier, has to pay the premium for health insurance continuation. The company can also charge the former employee a fee of up to 2% above the premium cost for administration costs. But even at 102% of the basic premium cost, COBRA coverage is almost always a good deal for the former employee, again because of the power of buying in bulk.

Why don't more former employees choose to continue their insurance under COBRA? In most cases it is because of the cost of paying the premium, especially if they will be out of work for a period of time. However, as HR managers, we need to remember that federal law requires that we offer COBRA to individuals who leave our employment.

The American Recovery and Reinvestment Act of 2009 (ARRA) added a new requirement to the COBRA rules: Companies were required to "front" a 65% subsidy of the COBRA cost of health continuation coverage for qualified employees who lost their jobs between September 2008 and December 2009. This means that the employer had to pay this cost and then file for a reimbursement of the cost on their quarterly payroll tax deposits. This was significantly different from providing COBRA coverage for individuals who lost their jobs outside of this period. ARRA also modified some other compensation and benefits requirements that continued past the end of the recession, including new shared health care IT networks, modifications to unemployment compensation, and some new limits on executive compensation in certain companies. You can read more about it at <https://www.irs.gov/newsroom/american-recovery-and-reinvestment-act-of-2009-news-releases-multimedia-and-legal-guidance>.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA). The Health Insurance Portability and Accountability Act (HIPAA) is another health insurance mandate from the federal government that applies if the company provides health

SHRM

K:B5

Regulation of Health Insurance Programs (COBRA, HIPAA, HMO Act of 1973)

SHRM

B:33

COBRA: Consolidated Omnibus Budget Reconciliation Act of 1985

COBRA A law that requires employers to offer to maintain health insurance on individuals who leave their employment (for a period of time)

SHRM

B:34

American Recovery and Reinvestment Act of 2009 (ARRA)

SHRM

B:37

Health Insurance Portability and Accountability Act (HIPAA) of 1996

insurance to its employees. Only part of the HIPAA law applies directly to all employers. What are the general provisions of HIPAA that all employers need to understand?

First, HIPAA requires that our health insurance is “*portable*.” This means that if we had group health insurance at our previous employer and *if* our new employer has health care coverage for their employees, the new employer is required to provide us with the opportunity to participate in their health insurance plan. Why wouldn’t the new company want us to participate in their plan? Well, if we had a preexisting condition that required a lot of health care expense, the new employer’s premiums might go up.

The second issue that is mandatory for all employers under HIPAA is the *privacy* and *security* requirements for medical information on employees. This is the *accountability* part of HIPAA. HIPAA protects “the privacy of individually identifiable health information” from being disclosed to unauthorized individuals.⁵⁶ It also provides that employers must take action to ensure the security of personal health information. The *privacy* rule requires that covered firms take “reasonable steps to limit the use or disclosure of, and requests for, protected health information.” The *security* rule requires covered firms to have “appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information” for individual employees.⁵⁷ So COBRA and HIPAA are mandatory if we as an employer offer health insurance to our employees.

In addition to its effects on COBRA and other forms of compensation, the American Recovery and Reinvestment Act of 2009 (ARRA) also created new HIPAA privacy and security requirements for companies with group health plans. Most privacy and security rules originally created by HIPAA were limited to the covered entities, including group health benefit plans. ARRA has extended HIPAA’s privacy and security rules to business associates and other vendors directly, and has enhanced HIPAA’s civil and criminal penalties.⁵⁸ New “notice requirements” for an inadvertent release of protected health information (PHI) are also included under ARRA.

SHRM

B:7

Employer Retirement Income Security Act of 1974 (ERISA)

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA). The first two government mandates that we discussed were contingent on company actions in companies that choose to provide *group health insurance* to their employees. However, the last one that we will discuss covers employers who provide a *group retirement plan and/or group health and welfare plans of basically any type*, including medical, dental, vision, life insurance and others. Employee Retirement Income Security Act (ERISA) guidance must be followed in any of these cases.⁵⁹ Let’s take a look at the main provisions of ERISA.

General provisions. Any organization that provides retirement or health and welfare plans must provide a document called a Summary Plan Description (SPD) telling beneficiaries about the plan and how it works—in plain language that the average employee can understand. The organization also has to provide similar information whenever the plan changes significantly and send an annual report to members, as well as meet some other requirements.

Eligibility. A major provision of ERISA is guidance on retirement (pension) plan eligibility. If the company provides employees with a retirement plan, the guidelines in ERISA say that the plan has to be available to all employees over 21 years of age who have worked in the company for 1 year. This brings up a common question about such laws. Can the company offer retirement options to employees who are not yet 21 or who haven’t worked there for a year? The answer is yes. The company can *relax* the requirements of ERISA, but it cannot be more restrictive than the law allows. This is the case in many similar laws and federal regulations.

SHRM

K:B3

Regulation of Retirement Plans

Vesting A maximum amount of time beyond which the employee will have unfettered access to their retirement funds, both employee contributions and employer contributions

Vesting. A second major provision of ERISA is the vesting rules. **Vesting** provides for a maximum amount of time beyond which the employee will have unfettered access to their retirement funds, both employee contributions and employer contributions. Most retirement plans today take in contributions from both the employer and the employee. Of course, the employee’s money is available to the employee at pretty much any time.

There are rules about how the employee can remove money from a “qualified retirement account” (an account that has federal and sometimes state tax advantages associated with it), including the requirement that they reinvest it into another qualified retirement fund within a certain time period, but the money they contribute can be removed from the account when they leave the employer or even before as long as they follow some IRS rules. ERISA identifies the maximum amount of time that the company can retain company contributions to the employee’s retirement account. The rules in ERISA say that the employer must vest the employee in all employer contributions based on one of two options:

- 100% of employer contributions at the end of 5 years of contributions to the plan; or
- 20% of employer contributions from the end of year 3 through the end of year 7.

So if an employer and employee have been contributing to the employee’s retirement fund for 5 years and the employer has provided \$1,000 per year to the account, the employee can take that \$5,000 employer contribution out of the retirement fund and move it to any other qualified retirement fund that they choose. Alternately, under the 20% per year option, the employee might only be allowed to have access to 20% of \$3,000 at the end of year 3, 40% of \$4,000 at the end of year 4, 60% of \$5,000 at the end of year 5, up until the end of year 7, when they would have access to all of the employer’s contributions to their retirement fund.

Can the company allow the employee to be vested earlier? Of course it can. In some cases, companies will immediately vest employees in their own retirement funds as a recruiting incentive. This can be a significant advantage over having to wait 5 years to have access to employer-provided funds. If the company doesn’t vest us in our retirement fund for 5 years, then if we leave the company for a better job after 4 years and 10 months, we forfeit all of the employer contributions to the fund (in this case about \$4,850).

Employers have to be aware that a number of factors may cause retirement plans (as well as other benefits) to be nonqualified. Executive compensation in the form of a deferred contribution to the executive’s retirement accounts is one of the most common forms of nonqualified retirement funds. If the benefit doesn’t meet the requirements of IRS rules governing qualified retirement plans, the company must treat the contributions to the account as taxable.

Portability. The third major issue that ERISA addresses is portability of retirement accounts. The portability rule allows us to take our retirement fund and move it from our employer to another qualified fund. The employer cannot require that we keep the funds with them or under their control. Once the vesting requirements have been met, the employee has the ability to move funds from the employer’s control into another qualified retirement account.

Fiduciaries. The next provision of ERISA is the responsibility of individuals acting as fiduciaries for company retirement or health and welfare funds. A fiduciary is a person who has authority over how those funds are managed but also has financial responsibilities associated with that authority. ERISA notes that fiduciaries have the requirement to act under a concept called the “prudent man.” This includes requirements that the fiduciary will act to benefit the fund’s participants, minimize unnecessary expenses to the fund, and use “care, skill, prudence, and diligence” in managing the funds entrusted to them.

But what is prudence? Is it prudent to put the bulk of retirement investments into dot-com stocks, as many investment managers did prior to the year 2000? What about putting large portions of the fund into financial firm and real estate stocks, as many did up until 2007–2008? While in hindsight these were probably not good investments, they would have probably passed the “prudent man” standard, so prudence is a pretty minimal standard of diligence for the managers of retirement funds.

SHRM

K:B13

Nonqualified Plans for Highly Paid and Executive Employees

13-1

APPLYING THE CONCEPT

Statutory Benefit Laws

Place the letter of the relevant statutory benefit law on the line next to the statement below.

- | | |
|---|--|
| <ul style="list-style-type: none"> a. FMLA b. ACA c. COBRA d. HIPAA e. ERISA | <ul style="list-style-type: none"> ____ 1. I don't trust my company's financial future, so I like this law because it will allow me to move my funds out of my company fund to a new account with the stockbroker of my choice. ____ 2. I like this law because it will allow me to take time off from work to take care of my sick mother. ____ 3. I'm going to quit and look for a new job, so I like this law because I need to continue to have health insurance while I search for a new job. ____ 4. I currently have health insurance and medical problems, but when I change jobs, the new company can't refuse to give me insurance based on any medical problems I have when I join the firm. ____ 5. I'm out of school and almost 25, so I like this law that allows me to continue on my parents' insurance plan. |
|---|--|

WORK APPLICATION 13-6

Which, if any, statutory requirements governing certain voluntary benefits would be mandatory where you work or have worked?

PBGC. The last big provision of ERISA is the creation of the **Pension Benefit Guarantee Corporation (PBGC)**. The PBGC is a governmental corporation established within the Department of Labor whose purpose is to insure retirement funds from failure. Its main function is to act as an insurer for the benefits promised to employees whose employers go bankrupt or are for other reasons not able to provide the promised retirement benefits to their employees. It covers only “defined benefit” retirement plans (which we will cover shortly)—plans that have specified benefits that will be paid out to the individual employee on their retirement. The PBGC may not fund 100% of what was promised in the specific retirement plan, but it “guarantees ‘basic benefits’ earned before the plan’s termination date” or the employer’s date of bankruptcy.⁶⁰ There are also caps on coverage of pensions, which are determined by ERISA.

Who provides funds for the PBGC? In this case, even though PBGC is a federal government entity, the funds for the program come from employer payments into the program. If an employer chooses to provide “defined benefit” retirement accounts for their employees, they are required to pay into the PBGC. These funds are then used to provide benefits to workers whose employers are unable to pay the promised benefits. So PBGC acts as a guarantor of these retirement plans.

LO 13-4

Briefly describe the main categories of voluntary benefits available to organizations.

VOLUNTARY BENEFITS

In addition to mandatory benefits, almost all employers provide some group of voluntary benefits to their employees. These can range from a narrow group of commonly provided benefits such as retirement accounts, life insurance, and vacation time to a very broad group including company nap rooms, sick-child care services, and personal valets. How do companies determine what voluntary benefits they are going to provide? They look at their workforce and the funds available to the company and choose the package that will best allow them to minimize turnover while maintaining a satisfied and engaged workforce. Let’s discuss some of the more common voluntary benefits, including group health insurance, retirement, paid time off, and other forms of employee insurance.

PBGC A governmental corporation established within the Department of Labor whose purpose is to insure retirement funds from failure

Group Health Insurance

While the ACA requires certain employers with more than 50 full-time employees to provide health insurance to their full-time workforce, all other organizations generally have

the choice of whether or not to offer this benefit. As we have already noted, if a company chooses to provide health care to employees, they have to follow the COBRA, HIPAA, and ERISA rules. Companies also have to look at the rising cost of providing such care. In 1980, health care services accounted for less than 10% of gross domestic product (GDP), in 2000, that figure was 13.8%, and in 2015 (the latest government figures), these services accounted for 17.8% of GDP, or \$3.2 trillion.⁶¹

A survey by the **Bureau of Labor Statistics** reported that 67% of private-industry workers receive medical care benefits and that employers offering health insurance paid an average of 80% of the cost of premiums for single coverage and 68% of the cost for family coverage in 2017.⁶² Thus, companies that do provide health care have to be concerned with the costs. And remember that the ACA required many companies to start providing health insurance beginning in 2015, thereby increasing their overall costs of doing business. **Costco** offers its workers higher-than-average wages and better benefits. In 2013, 85% of its US employees, including part-time workers, received health care and other benefits (compared to less than 50% at **Walmart** and **Target**) prior to the implementation of the *Affordable Care Act*.⁶³ One of the ways that companies can control costs is to understand what coverage they are buying for what price. Let's look at the major types of group health insurance currently available to companies.

TRADITIONAL PLANS (ALSO CALLED FEE-FOR-SERVICE). Traditional health care plans typically cover a set percentage of fees for medical services—for either doctors or in-patient care. The most common percentage split between the insurance plan and the individual is 80/20. In other words, if the employee has to go to the hospital and is charged \$10,000 for services, the insurance would pay \$8,000 and the individual would be responsible for the other \$2,000. There are, of course, some variations on these plans, but this is basically how they work. One of the issues with traditional fee-for-service plans is that they typically do not cover preventive care, such as an annual physical exam. They do, however, cover most but not all of the costs to treat medical conditions covered by the policy.

One of the biggest advantages of traditional plans is that they allow employees to go to any doctor or provider they want without a referral to see specialists. Also, if the employee has traditional health insurance, they can live anywhere. With some *managed care* health insurance (we will talk about this next), employees are limited to living within a certain range of the network controlled by the insurance company. However, the big problem with such insurance is the high overall cost of medical care today. If a patient went to the hospital for a serious medical problem, such as cancer, it would be very easy to incur bills in excess of \$1 million. In such a case, the individual would be responsible for \$200,000 of the total charges, unless they had separate gap coverage or other major medical insurance. So traditional plans have somewhat fallen out of favor. Traditional plans do give the employee a lot of choice, but there are some serious issues with potential out-of-pocket costs.

HEALTH MAINTENANCE ORGANIZATIONS (HMO). HMOs are *managed care* programs. An HMO is a health care plan that provides both health maintenance services and medical care as part of the plan. This is health care that provides the patient with routine preventive care, but in the case of nonpreventive care, it requires that a review of specific circumstances concerning the individual and their health condition be completed before any significant medical testing, medical procedures, or hospital care is approved. Managed care plans generally require that the employee and their family use doctors and facilities that are in the managed care network. In some cases, the managed care plan will allow the insured person to go outside the network, but if this is done, the cost of care is usually significantly higher. This allows the managed care company to attempt to ensure that unnecessary tests and procedures are not done, thereby saving both the insured and the insurance company money.

SHRM

K:B4

Types of Health Care Plans

Traditional health care plans Plans that cover a set percentage of fees for medical services—for either doctors or in-patient care

HMO A health care plan that provides both health maintenance services and medical care as part of the plan

In the HMO form of managed care, the insured person will generally be required to use doctors and facilities in the network. The employee (and their family, if covered) will choose a primary care physician (PCP). The **primary care physician (PCP)** will be the first point of contact for all preventive care and in any routine medical situation, except emergencies. The PCP will see the patient and, if they feel the need for a specialist to be involved with the case, will refer the patient to that specialist. The specialists also usually have to be part of the network in order to accept referral patients from the HMO.

In the HMO form of managed care, the patient pays a copayment each time they visit their PCP and will generally also pay a copayment if they see a specialist after a referral. Once the copayment is paid, all other billable costs for the physician visit will generally be paid by the insurer. In addition, there will almost always be an annual deductible, an amount that the patient will be required to cover for any care beyond physician office visits (such as an outpatient procedure to have a child's tonsils removed) before the remainder of such costs will be paid by the insurer.

In an HMO plan, the PCP physicians are generally paid a flat fee per patient to take care of that patient for the year. This fee is provided to the physician to be the gatekeeper for any other medical services that the employee or their family may need during that year. The PCP will get the same amount of money no matter how many times a patient visits them during the year. Why is this significant? If the physician happens to be selected as the PCP by patients who don't use medical services at the average rate of the overall population, the HMO knows this (because they do a utilization analysis) and will cut payment to the physician next year because the PCP isn't using up as much time as the average physician.

The company should always do a similar utilization analysis on its employees. If the HMO can cut payments to the physicians that serve our company, we should share in the cost reduction. If the company fails to complete the utilization analysis itself, the HMO will be happy to keep all of the savings, but if the company is doing a utilization analysis, it can demand some share of the cash saved. This is another place where good HRM can save the company money.

HMOs have some very good characteristics and some bad ones. Preventive care is covered, and there are maximum out-of-pocket costs to the employee in any given year (at least for covered illnesses and injuries). However, the employee may be required to live in certain areas (because of the network of physicians and medical facilities) so that they can be safely covered without having to go long distances in an emergency. There may also be limits to the number and types of procedures that will be covered by the HMO; the employee does not have free choice in doctors, clinics, and hospitals for their care, and various copayments and deductibles are the employee's responsibility before the HMO covers the rest of the costs.

PREFERRED PROVIDER ORGANIZATIONS (PPO). Preferred provider organizations (PPOs) are a kind of hybrid between traditional fee-for-service plans and HMOs. They have some of the advantages and disadvantages as well as some of the requirements of both. PPOs have networks of physicians and medical facilities, just like HMOs. PPOs act like HMOs in that they prefer (but do not require) that you have a PCP within their medical network and that you go to that PCP before going elsewhere for medical care. They also provide preventive care services to their insured members, similar to HMOs, and have similar copayments and annual deductibles.

However, PPOs do not require that you have a referral from the PCP to see a specialist. In this way, they are more similar to a traditional health care plan. They will also allow you to see any provider of care either in or outside the network, although you may be required to pay a larger percentage of the cost of care if you choose to go beyond the network of physicians and facilities.

So if we compare PPOs with HMOs, we see that the advantages of PPOs include the ability to see any physician and use any medical facilities (as with a traditional plan), which in turn relieves the individual insured by the PPO of the necessity to live within

Primary care physician (PCP) The first point of contact for all preventive care and in any routine medical situation, except emergencies

Preferred provider organizations (PPOs) A kind of hybrid between traditional fee-for-service plans and HMOs

certain geographical boundaries. The member can live anywhere they want because they can use any medical facilities they choose. In addition, similar to HMOs, PPOs cover preventive care. However, unlike with HMOs, the cost of care can be significantly higher if the individual chooses to go outside the preferred providers that are identified as PPO participants. So PPOs prefer that we use physicians and facilities within their network, but we have a choice to go outside the network and pay at a higher rate if desired.

HEALTH OR MEDICAL SAVINGS ACCOUNTS (HSA/MSA) AND HEALTH REIMBURSEMENT ACCOUNTS (HRA). HSAs and MSAs are two very similar savings accounts for health care services. MSAs are medical savings accounts available to self-employed persons and small businesses with fewer than 50 employees. HSAs are available to employees of larger businesses who choose to provide these accounts. *An HSA or MSA allows the employer and employee to fund a medical savings account from which the employee can pay medical expenses each year with pretax dollars.* The money in this account is then used to pay for medical services for the employee (and their family, if desired) over the course of that year. One of the big advantages of HSAs and MSAs is that money remaining in the account at the end of the year can be rolled over to future years without paying a tax penalty as a general rule.⁶⁴

For example, assume that our employer provides an HSA and shares equally in funding our account at the maximum amount allowed for an individual for the year 2017—\$3,350. The employer puts in \$1,675, and we put in \$1,675 (deducted from our pay over the entire year). In February of that year, we go to our physician for our annual physical. The cost of the physical including tests is \$465. Our HSA provided us with a debit card for medical expenses at the beginning of the year, so we provide the debit card to our physician, and they bill \$465 to our card.

The remaining balance on our card will be \$2,885. Our physician reports that it appears that we have a small cancerous growth on our skin that needs to be removed in an outpatient surgery. We go to the outpatient surgery center, where they remove the cancer and charge us \$1,842, which we pay with our debit card, leaving a balance of \$1,043. The only other medical service that we have that year is a physician's office visit and antibiotics for a sinus infection. We are billed for the full cost of the office visit at \$80 and for the full cost of the antibiotics at \$34. This would leave a balance of \$929 in our HSA. At the end of the year, this \$929 will roll over to next year's HSA account and be added to the new contribution of \$3,350.

As you can see, in an HSA you pay the full cost of each of the medical services used in a plan year from the HSA account. There are no copayments; there are no deductibles. However, if you don't use the full value of the services, the remaining dollar amounts can be rolled over to future years, so you don't lose that money.

HSAs are also portable, so we can take our HSA balance with us if we change employers. One of the benefits to companies using an HSA or MSA is that it causes the employee to understand the full cost of providing health care for the year. If the full cost of health care is coming out of the employee's pocket through the use of the HSA debit card, it is thought that they might pay more attention to unnecessary medical expenses, including such things as going to the doctor's office when they have a cold or if they sprain a finger. The assumption is that if the employees pay more attention to the overall cost of health care, we can lower that cost.

One of the biggest differences between HRAs and HSAs is the portability of the account.⁶⁵ HRAs do not go with an employee who leaves the company. Another difference is that the HRA is not funded with real dollars until the employee provides a claim against the HRA. So HRAs provide more control to the employer than does an HSA. The employer can choose what deductibles to require and can manage the account in other ways such as through managing the pharmacy benefits and maximum out-of-pocket costs. The HRA also does not carry over from year to year unless the employer decides that they want it to, and it is not treated as a retirement account. Finally, there is no *requirement* that an HRA is tied to an high-deductible health plan,⁶⁶ which we will discuss next.

HSA or MSA A plan allowing the employer and employee to fund a medical savings account from which the employee can pay medical expenses each year with pretax dollars

WORK APPLICATION 13-8

Select a company that offers health insurance and identify the type of insurance it offers.

High-deductible health plan (HDHP). One of the problems that we can quickly see within HSA is that our medical services in a particular year could cost us much more than \$3,350, especially if we had to have a surgery. However, federal rules on HSAs and MSAs require that employees who have these accounts also participate in something called an HDHP. A **high-deductible health plan (HDHP)** is a “major medical” insurance plan that protects against catastrophic health care costs and in most cases is paid for by the employer. A very common HDHP would pay for medical costs in any given year that total more than \$10,000. So if an individual exceeded the \$3,350 in their HSA, they would be responsible for out-of-pocket costs of a maximum of \$6,650, at which time the HDHP would take over and pay the remaining costs of the individual’s health care for the year.

At first glance, this looks like a large out-of-pocket expense for the individual employee. However, in other forms of health care, the employee generally has copayments, deductibles, and prescription copayments that come out of their own pocket during the course of the year. Annual deductibles can frequently be as high as \$2,000 to \$4,000, while each PCP visit can cost between \$20 and \$40, each specialist’s office visit costs \$40 to \$50, and prescription copayments typically cost from \$25 to \$40 or more. So if an individual had large-scale medical costs in any given year, they would most likely have at least as much in out-of-pocket costs as they would under the HSA plan.

One of the big advantages of HSAs and MSAs is that the individual can go to any physician or medical facility. There is no HMO network and no preferred providers. If the employee wants to go to the top specialist in their field and is willing to pay the extra cost of the office visit for such a specialist, they have the ability to go. In this way, HSAs and MSAs are much more like traditional fee-for-service plans than HMOs and PPOs. However, they are much more like HMOs and PPOs in the fact that there are maximum out-of-pocket costs per year before the HDHP takes over and pays all other medical expenses.

Because HSAs and MSAs cause the individual employee to see the total cost of their health care and might cause these employees to use such care at a lower level because it is a direct cost to the employee, about 50% of employers now offer these accounts to employees in an attempt to control ever-rising health care costs.⁶⁷ The HSA can cause people to realize that medical care costs a lot more than their copayments. If the employee only pays \$20 to go to the doctor, they will go whenever they feel the slightest problem coming on, but if they have to pay the entire \$125 for the cost of the office visit, they may think much harder before they spend that money to go to the doctor to remove a splinter. Because of the fact that it makes employees aware of the entire cost of health care, it is expected that HSAs and MSA accounts will continue to become a more significant proportion of the health care plans provided by employers over at least the next several years.

UTILIZATION ANALYSIS. We briefly mentioned utilization analyses earlier. Let’s take another look at them now. A **utilization analysis** is a review of the cost of a program and comparison of program costs with the rate of the program’s usage by the members of the company. In other words, is the company getting a valuable benefit out of the program, or could the same money be spent in a different way to get better returns on money spent?

High-deductible health plan (HDHP) A “major medical” insurance plan that protects against catastrophic health care costs and in most cases is paid for by the employer

Utilization analysis A review of the cost of a program and comparison of program costs with the rate of the program’s usage by the members of the company

If, for instance, our average employee is healthier than the national average employee, we might use fewer medical services over time than other companies of similar size in the same industry. But our premiums for health insurance will (at least initially) be based on the “average” employee in our industry. If we investigate and find that our employees do, in fact, use fewer medical services each year than the average, we can ask the insurer to lower our insurance rates to match our utilization rates. Health insurance is one of the easiest things for us to do a utilization analysis on because we are provided information on the services that our employees use by the insurance company. If we have a strong case, we need to go to the insurance company and request that they lower our rates to match our utilization of services.

13-2

APPLYING THE CONCEPT

Group Health Insurance

Place the letter of each type of health insurance option offered on the line next to the statement describing it.

- | | |
|--|--|
| <ul style="list-style-type: none"> a. Traditional b. HMO c. PPO d. HSA e. MSA | <ul style="list-style-type: none"> ____ 6. I don't like the new insurance plan because I can only go to doctors and hospitals that are approved by the plan. I have to stop seeing my doctor and start with a new one that I'm assigned to. ____ 7. I have expensive health problems, and my insurance plan requires me to pay 20% of my health care costs, making it very expensive for me. ____ 8. I like my insurance plan because I'm healthy and pay the full cost, but I don't use it all every year and it has accumulated in case I need it someday. ____ 9. I have the same insurance deal that you have (#8), but my company only has 25 employees. ____ 10. I do have copays and deductibles, but at least I can go to any doctor or hospital I want too at an extra cost. |
|--|--|

Retirement Benefits

According to the Bureau of Labor Statistics, employer-provided retirement plans are available to 77% of all full-time workers and 38% of part-time workers in private industry.⁶⁸ They are not mandatory, but if we provide them, we have to comply with ERISA. Employees say that retirement benefits are very important for feelings of loyalty—retention.⁶⁹ As with health insurance, companies provide retirement benefits to motivate employees. However, as discussed in Chapter 12, employees may view them as simply an entitlement.⁷⁰ Retirement benefits are categorized into two types. Let's discuss both followed by five options for defined contribution plans.

DEFINED BENEFIT VERSUS DEFINED CONTRIBUTION PLANS. A **defined benefit plan** provides the retiree with a specific amount and type of benefits that will be available when the individual retires. The retiree knows exactly what they are going to receive in benefits when they retire. For instance, a simple defined benefit plan might provide that employees who work in the company for 25 years will get 60% of the average of their two highest years of pay. In addition, they will receive 1% more for every additional year that they work. So if the same employee worked for 35 years, they would receive 70% of the average of their two highest years of pay. If such an employee made \$64,238 in their highest-paid year and \$63,724 in their second-highest-paid year, their two highest years' average pay would equal \$63,981. If this individual retired with 25 years of service, they would receive \$38,388.60 per year in retirement. If they instead retired after 35 years of service, they would receive \$44,786.70 per year in retirement. Because it is a defined benefit retirement plan, the employee knows exactly what their retirement will be.

Defined contribution plan. Unlike with a defined benefit plan, under a defined contribution plan, the employee does not know what their retirement benefit will be. **Defined contribution plans** identify only the amount of funds that will go into a retirement account, not what the employee will receive upon retirement. The employee only knows what their contribution to the retirement fund consists of. What will the employee who contributes to a defined contribution plan receive upon retirement? The answer to this question will depend on the success of the investment of their retirement funds over the years between the contribution of the funds and the employee's ultimate retirement. If the retirement funds are invested successfully, growing significantly over time, the individual's retirement account will be able to pay much higher benefits than if the funds are not invested successfully and don't grow very much.

Defined benefit plan A plan providing the retiree with a specific amount and type of benefits that will be available when the individual retires

Defined contribution plan A plan providing only the amount of funds that will go into a retirement account, not what the employee will receive upon retirement

Shift from defined benefit to defined contribution plans. Defined benefit plans used to be the most common type of retirement plan, but they have been overtaken by defined contribution plans—some would say for legitimate business reasons. Kroger Co. had to raise \$1 billion in 2017 to add to its underfunded defined benefit retirement plan while moving some participants in the plan to other (defined contribution) plans moving into the future.⁷¹ Providing a defined contribution retirement plan to employees shifts the investment risk from the company to the individual employee. Under a defined benefit plan, the employer puts money into retirement accounts and expects that money to grow at a certain rate over time. But if the funds do not grow at the expected rate, the employer is left with a shortage in the retirement accounts and must add money to those accounts in order to be able to pay the promised benefit to retired workers. This also happened in the US auto industry as large numbers of retiring employees combined with lower sales and a period of no profits and layoffs, which left fewer employees to cover the cost of those retirees. So the cost of adding funds to the defined benefit plans for their retirees contributed to a cost advantage for foreign automakers, and (when the 2007–08 recession occurred) to the US government bailout of General Motors and Chrysler.

SHRM

K:B2

Types of Retirement Plans

In the case of a defined contribution plan, the risk of slow growth of the investment shifts to the employee. The company has no obligation to pay a specific amount to the employee, so if the fund doesn't grow at the expected rate, the employer is not required to add money to that fund. However, the employee may not be able to draw as much in benefits as they had anticipated if the account hasn't earned interest or grown at the rate that was expected over time.

There are a number of different defined contribution plans that meet federal and state guidelines for favorable tax treatment (these are called qualified plans) and therefore have added value to both employers and employees. Let's take a look at some of the most common types of defined contribution plans now.

401(K) AND 403(B) PLANS. The most well-known retirement plan in US companies today is the 401(k). 401(k) accounts are available to nearly all employees of corporations as well as most self-employed persons. A 401(k) *retirement plan* is a savings investment account for individual employees of corporations. A 403(b) *retirement plan* is a very similar plan to the 401(k) with the exception that it is used for nonprofit entities.

Both the employee and the employer are allowed to contribute funds each year to the employee's 401(k) or 403(b) account, with the *employee* allowed to contribute up to a maximum of \$18,000 (for an employee under 50 years of age in 2017).⁷² Contributions to these accounts are made on a "pretax basis." This means that when funds are put into the account, they do not count as taxable income for the individual. Once the individual retires and begins to remove funds from the account, they pay income taxes on the distributions at their current tax rate, which tends to be lower at retirement. The earliest point at which the contributor can withdraw money without incurring a penalty from a 401(k) or 403(b) account is at age 59½.

Matching contributions. Many employers that offer a 401(k) or 403(b) provide a matching contribution up to a set maximum. Matching dollar for dollar is a 100% return on your investment. For example, an employer might allow a 100% match of employee contributions up to a \$2,000 maximum. So if the employee put \$2,000 of their salary into the retirement account over the course of the year, this plus the employer's matching funds would add \$4,000 a year to the individual's retirement account. Among the 250 largest companies, ConocoPhillips offers the largest potential match at 9%; companies at a 6% match include Citigroup, Bristol-Myers Squibb, and Verizon.⁷³ Some companies in certain industries say they need to spend more to retain the best employees and motivate staff. Microsoft and Host Hotels are among a growing number of companies boosting contributions to 401(k) plans because some workers aren't saving enough, a move many firms have long resisted because of the costs.⁷⁴

On a personal note, never refuse free money. “If your employer offers a 401(k) plan, embrace it. . . . Whatever the match is, put as much into the plan as you need to get it.”⁷⁵ You would be amazed at how many people refuse the retirement match. Taking the full match as early as you can is one of the most important tips in this book.

Would you like to be a millionaire? If you start putting away \$2,000 a year (with or without a match) in your early 20s, such as in a low-fee stock index fund,⁷⁶ with competent professional help, you can be a millionaire by the time you retire at age 67. Besides, if you start your retirement account with your first job, you will never miss the money. So pay yourself first by putting away 10% to 15% of your gross income into retirement every payday,⁷⁷ and even more if you are older, no matter how low your income is.⁷⁸ It’s also a lot less stressful and can bring happiness knowing you have financial security.⁷⁹

IRAs AND ROTH IRAs. An IRA is an Individual Retirement Account. Under US law, any person who pays taxes can have and contribute to an IRA, and the contributions are tax free (subject to a maximum annual income limit). In other words, they reduce your taxable income by the full amount of the contribution in the year in which they are contributed to the account. Both IRAs and Roth IRAs can supplement the amount that an individual is contributing to a company-sponsored 401(k) account, because we are allowed to contribute to both. An individual can contribute a maximum of 100% of their income up to \$5,500 per year (in 2017) into a standard, or Roth, IRA.⁸⁰

The Roth IRA is basically the same type of account as a regular IRA with the exception that the Roth IRA “front-loads,” or requires that we pay the taxes immediately for funds put into the retirement account. If we put \$4,000 into a Roth IRA in 2017 and were in the 25% federal tax bracket, we would pay \$1,000 in tax for 2017, but when we withdrew these funds upon retirement, they would be tax free. With the standard IRA, you pay no tax on the funds when you contribute them, but you pay taxes at your current tax rate when those funds are withdrawn.

What is the advantage to paying the taxes up front on a Roth IRA? If you expect to be in a much higher tax bracket later in life, it makes sense to pay the taxes at your lower (current) tax rate instead of paying a higher tax rate later. Assume that you are currently in the 15% tax bracket, but your income triples over the next 40 years and you expect that (based on current tax rates) you will be in a 38% tax bracket later. You can pay \$750 on a \$5,000 Roth IRA contribution today but might have to pay \$1,900 on that same \$5,000 contribution (plus any interest earned) when you withdraw it in 40 years. So if you expect your tax bracket to go up over time, a Roth IRA may be advantageous.

SIMPLIFIED EMPLOYEE PENSION (SEP) PLANS. The last common retirement plan that we will discuss here is the SEP. SEPs are primarily used for self-employed individuals and members of small companies. According to the **US Department of Labor**, “Under a SEP, an employer contributes directly to traditional individual retirement accounts (SEP-IRAs) for all employees (including the employer). A SEP . . . allows for a contribution of up to 25% of each employee’s pay” up to a maximum of \$52,000 (in 2014) into the person’s IRA each year.⁸¹ Because the owner is not an employee with pay, the self-employed person can tax defer a set percentage of the company profits. A SEP can also be used by a person who has a job that has retirement benefits and who is also self-employed to defer taxes and save more for retirement.

What makes a SEP retirement plan valuable to small business is the lower paperwork burden compared to a 401(k) or 403(b) retirement account. The contributions follow the same basic tax rules as a 401(k): Contributions are not taxed when made, but the individual pays taxes on the money when it is withdrawn during retirement. For self-employed proprietorships without any employees getting SEP retirement benefits, the only records needed are the individual tax return 1040 with a Schedule C for self-employed income showing the SEP deduction from profits going into the SEP and the SEP account records verifying that the money was actually put into the SEP.

13-3

APPLYING THE CONCEPT

Retirement Plans

Recommend the appropriate retirement plan based on the person's situation.

- a. 401(k)
 - b. 403(b)
 - c. IRA
 - d. Roth IRA
 - e. SEP
- ____ 11. I work for a church, but we do have a retirement account.
- ____ 12. My company doesn't offer any retirement benefits for part-time employees, so how should I save for retirement?
- ____ 13. I work for a major corporation, and it offers the standard retirement plan with a 5% match.
- ____ 14. I already have a retirement plan at work and put in the maximum tax-deferred contribution. What other options do I have to save even more for my retirement?
- ____ 15. I started my own business and want to save for retirement. What retirement plan should I use?

WORK APPLICATION 13-9

Select a company that offers retirement benefits and state the type of plan it offers. If it is a defined benefit, describe the plan. If it is a defined contribution, identify the option selected and, if the employer offers any matching contributions, what they are.

Paid Time Off

Paid time off (PTO) benefits include a group of options such as vacation time/annual leave, severance pay, personal time off, sick days, and holidays. Some companies provide an all-encompassing PTO plan, sometimes called a "PTO Bank," that allows the employee to use their paid time off in any way they wish, whether for sick days or vacation, holidays, or any other purpose. Others apportion the available days for vacation, sick time, holidays, and others.⁸² These benefits contribute approximately 7% of the average employer's total cost of wages and benefits, or a little over 10% of direct wages.⁸³ Another way to look at this is that the *average cost of paid time off is \$1 for every \$10 in direct wages*. None of the listed PTO benefits is mandatory at the federal level in the United States at this point, yet most employers provide at least some holidays off and some vacation and/or sick time. In addition, you need to be aware that some states have already passed, or are currently attempting to pass, mandatory sick leave and even, in some cases, annual leave and other PTO laws. Paid time off is commonly viewed as an entitlement (Chapter 12). Let's do a quick review of the most common types of PTO.

SHRM

K:B15

Time Off and Other Benefits

VACATION OR ANNUAL LEAVE. Although federal law does not currently require any paid vacation time, the majority of US firms provide paid vacations to their employees, according to the US Bureau of Labor Statistics. In fact, about 97% of employers provide paid vacation in some form—either as a stand-alone benefit or as part of a PTO plan—to their full-time workforce.⁸⁴ The average time provided was about 8 days after 1 year of service in 2017, while workers with 10 years of service averaged 14 days.⁸⁵ Why do companies provide this time off? The simple answer is that it refreshes the employee so that they can come back to work and be more productive. Many studies show that when we leave a stressful situation for a period of time, we lower our stress level, which in turn raises our ability to be productive.⁸⁶ Good employers know this and, as a result, provide time off to allow their employees to relax.

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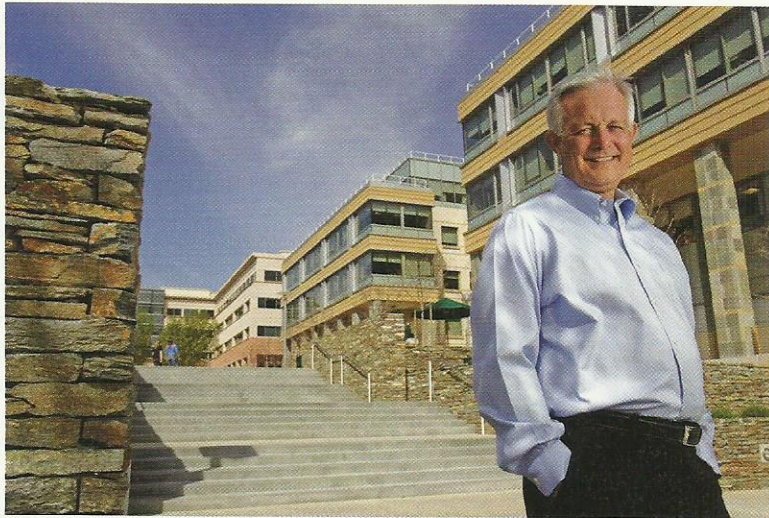
K:B21

Paid Leave Plans

SICK LEAVE. The next most popular PTO is sick leave. Approximately 92% of employers in the United States provide sick leave of some type to their employees, whether in an all-encompassing PTO plan or specifically designated as "sick days."⁸⁷ Paid sick leave can offer employees relief from loss of income associated with having to miss work due to an illness. However, there is significant evidence that sick leave is abused by employees, especially in the case of a "use it or lose it" sick leave policy. With the entitlement mentality, some employees take every sick day off even though they are not sick. This is

one of the reasons why more companies have moved to the PTO Bank concept instead of designating a specific number of days as sick leave.

HOLIDAY PAY. Nearly all employers provide for at least some paid holidays with their workforce. In 2017, the US government identified 10 federal holidays, and many companies also observe some local, state, and religious holidays as well. Here again, companies can be subject to problems or even charges of discrimination if there is cultural or religious diversity in the firm. Because of these issues, some companies provide “floating” holidays so that the employee can pick which days they will observe as holidays during the work year. Between one third and one half of companies in the United States currently provide floating holidays. In addition, some firms allow employees to swap holidays to observe a holiday of their choice that would normally be unpaid, for instance swapping Christmas Day for Yom Kippur or the first day of Eid al-Fitr.



Bryan Chan/Los Angeles Times via Getty Images

Former **Amgen** CEO Kevin Sharer at the Amgen campus. Amgen has been rated one of the top companies for paid time off, with more than five weeks of paid time off per year.

PAID PERSONAL LEAVE. Finally, many companies today provide time off for a wide variety of personal needs. Many firms allow employees to use such leave to visit their child at school or accompany them on a field trip. Other options might include funeral leave, family leave that would not be covered under the FMLA, time off on their birthday, and “mental health” days among others. A growing number of companies have even gone as far as providing unlimited PTO, where workers decide how much time off they will take in any given year. Personal leave is an effort on the part of the organization to maintain or improve job satisfaction and organizational commitment on the part of their employees.

WORK APPLICATION 13-10

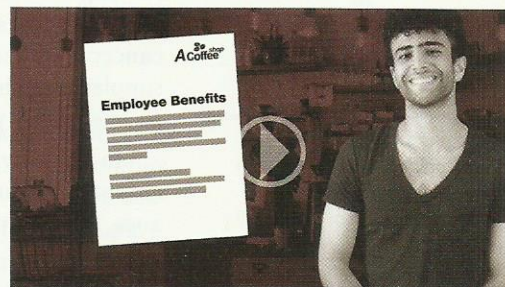
Identify the paid time off benefits offered where you work or have worked.

Other Employee Insurance Coverage

The next major category of voluntary benefits is insurance. There are a number of different types of insurance that are provided as common voluntary benefits to our employees. The largest of these is life insurance, but disability policies (both short- and long-term), supplemental unemployment policies, income continuation (also called supplemental health) policies, travel accident insurance, individual cancer and genetic disease policies, and other insurance options are also available and are part of some companies' voluntary benefit programs. Let's review some of the major employee insurance options.

LIFE INSURANCE. Many firms will provide group term life (GTL) insurance policies to provide for survivors of an employee who dies while employed by the company. In 2017, about 80% of employers provided this service to their full-time employees.⁸⁸ GTL provides for a survivor payment to occur only if the employee dies during the term that is covered by the insurance policy. It is also a valuable benefit to the employer because it is eligible for an employer tax deduction for up to \$50,000 in coverage if it complies with IRS regulations.⁸⁹ A fairly standard benefit here would be 1 to 2 times the individual's annual compensation. So if an employee dies, on or off the job for most causes of death, the beneficiary would get 1 to 2 years' salary. Many companies will allow the employee to add to this coverage at the group rates, which is generally a very good deal for the employee. Generally, once the employee leaves the company, the term insurance policy will be discontinued.

In addition to GTL, employers can provide permanent, or whole, life insurance. Unlike term life policies, this life insurance benefit has no termination or end date.



HRM in Action Employee Benefit

SHRM

K:B12
Life Insurance

SHRM

K:B7

Disability Insurance

It continues for the life of the individual as long as premiums continue to be paid. Whole life policies can also be used for retirement. However, they are not commonly offered.

DISABILITY INSURANCE. The other large-scale insurance benefit in many companies is disability insurance. This insurance can be either short- or long-term in nature, and some companies offer both options.

Short-term disability is insurance against being unable to perform the essential functions expected of the employee at work for up to 6 months due to illness or injury—*not necessarily a work-related illness or injury*. This is valuable because most long-term disability policies do not provide replacement income until the employee completes a 180-day “elimination period” (a period during which they are unable to work). Short-term coverage closes this 6-month gap. Because 71% of Americans say that it would be difficult to pay their bills if their paycheck were delayed for more than a week, waiting 6 months would likely create a massive hardship for the disabled worker.⁹⁰ Remember, too, that Social Security Disability doesn’t apply unless the employee is going to be disabled *for at least 5 months*, so short-term disability can bridge this gap in income.

Long-term disability policies cover employees who are unable to work for more than 6 months due to illness or injury—again, *not necessarily a work-related illness or injury*. Long-term disability is designed to replace a portion of the disabled employee’s income (typically 50%–60%) for extended periods of time, or even permanently.⁹¹ This is a supplemental benefit to Social Security Disability payments because, remember, Social Security payments are not designed to replace 100% of an employee’s preretirement (or predisability) income. Long-term benefits most often begin once the employee has exhausted their short-term disability benefits. Benefits from *group* long-term policies will generally continue until the employee reaches their eligible retirement age under Social Security or until they are able to return to work.⁹²

OTHER COMMON INSURANCE BENEFITS. In addition to standard life and disability insurance, there are a number of other insurance benefits provided by at least some employers. These can be loosely grouped into two categories: *life and health* and *other insurance*. Among the *life and health* benefits, we might see (percentage of firms offering coverage is in parentheses) vision (87%) and dental (96%) insurance; long-term care (27%); cancer insurance (12%); critical illness insurance (31%); accident insurance (48%); and supplemental insurance policies such as AFLAC, which pay for routine expenses (like car payments) not generally covered by health or disability insurance.⁹³

In the *other insurance* category, we may provide many types of additional insurance to employees. Some common examples are employer-sponsored automobile (6%) insurance, homeowners and renters insurance (7%), and pet insurance (9%).⁹⁴

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K:B8

Educational Benefits

Employee Services

In addition to other voluntary benefits, companies may provide a wide variety of employee services as benefits for their workforce. *Educational (or tuition) assistance* is one common benefit in this group. In 2017, roughly 55% of all companies provided some form of educational assistance to their employees.⁹⁵ Unfortunately, with the rising cost of benefits, this benefit has been cut back at many firms.

Other common employee services include on-site child care or child care vouchers; elder care assistance; executive coaching; company-provided gyms and fitness facilities or vouchers for memberships outside the business; organization-sponsored sports teams; services to mitigate commuting costs including work shuttles, company-provided or paid parking, “green” vehicle allowances, or public or private transportation vouchers; cafeterias or meal vouchers; plus too many others to name.

Employee services are provided in order to minimize disruptions to the employee’s work life. If the employee isn’t worried about their children (because the company has a day care facility on site), they can concentrate on work. If they don’t have to deal

WORK APPLICATION 13-11

Select a company that offers voluntary benefits. Besides paid time off, retirement, and health and employee insurance, what other benefits does it offer?

EXHIBIT 13-4 EMPLOYEE BENEFITS

Statutory Benefits	Voluntary Benefits
• Social Security and Medicare • Workers' compensation • Unemployment Insurance • Family and Medical Leave Act (FMLA) • The Patient Protection and Affordable Care Act (ACA) • Statutory requirements when providing certain voluntary benefits • Consolidated Omnibus Budget Reconciliation Act (COBRA) • Health Insurance Portability and Accountability Act (HIPAA) • Employee Retirement Income Security Act (ERISA)	• Paid time off • Group health insurance • Retirement benefits • Employee insurance coverage • Employee services • Educational (or tuition) assistance • On-site child care or child care vouchers • Elder care assistance • Company-provided fitness facilities or vouchers for memberships • Organization-sponsored sports teams • Services to mitigate commuting costs including work shuttles, company-provided or paid parking, "green" vehicle allowances, public or private transportation vouchers • Free or low-cost meals

with figuring out where they can park downtown, they are less stressed when they start their day. If they need 15 minutes' rest, they can take a nap, and if they want to work out to relieve some stress, they can go to the company gym. Companies don't provide these services because they like to throw money away. They provide employee services to lower stress and allow employees to concentrate on the job. Any service that takes the employee away from being able to focus on work is a legitimate target for an employee service benefit, and more and more companies are paying attention to such services.

Before we go on to discuss how to administer and communicate benefits, let's review the list of benefits discussed so far in Exhibit 13-4. Note that there are an unlimited number of voluntary benefits, but only the major ones discussed are listed here.

ADMINISTRATION AND COMMUNICATION OF BENEFITS

Because of their significant cost to the company, HR managers must pay close attention to the administration of benefit programs in order to get the most return for the money spent. In almost all cases today, benefit programs are not "one size fits all"—they are flexible because that is what employees want.⁹⁶ And because they are flexible for the employees, they take more management time. Let's briefly discuss the management of flexible benefits programs now, followed by how to communicate value to employees.

Flexible Benefit (Cafeteria) Plans

Flexibility focus should be on work performed, not set hours worked.⁹⁷ In a survey, 87% of respondents said that flexibility in the offered benefits package would be extremely or very important in deciding whether to take a new job or not.⁹⁸ Because the mix of workers is so broad, we need to allow at least some flexibility in our benefits system so that it can be partially tailored to the needs of the worker. We need to be careful, though. If an unlimited amount of flexibility is allowed in the benefits program, some bad consequences can occur. We will discuss this issue shortly when we cover *full-choice* plans.

What is a flexible benefits plan, commonly known as a *cafeteria* plan? Cafeteria plans are called that because they are similar to a cafeteria restaurant or college dining hall. You get to pick what you want—at least as far as what is available. You may decide that you want more paid time off and less insurance or that you want medical coverage for you and your family, or you may choose to put more money into retirement accounts. Flexible

LO 13-5

Discuss the organization's options when providing flexible benefit plans and why benefit plans need to be communicated to employees.

13-1

SELF-ASSESSMENT

Selecting Employee Benefits

Assume you are graduating with your college degree and getting your first or a new full-time job. The organization gives you the list below and asks you to rank order the list of employee benefits from 1 (the most important to you) to 11 (the least important to you).

- _____ Paid time off (vacations, sick and personal days, holidays)
- _____ Health insurance (traditional, HMO, PPO, HSA/MSA)
- _____ Retirement benefits (401 [k] or 403 [b], IRA or Roth IRA, SEP)
- _____ Employee insurance coverage (life, disability, others)
- _____ Educational (or tuition) assistance (getting your MBA or other degree or some type of certification or license like the PHR and SPHR, CPA, or FICF)
- _____ Child care (on-site or vouchers)
- _____ Elder care (on-site or vouchers)
- _____ Fitness (organization-provided fitness facilities or vouchers for memberships)
- _____ Organization-sponsored sports teams (softball, basketball, bowling, golf, etc.)
- _____ Commuting (work shuttles, company-provided or paid parking, "green" vehicle allowances, public or private transportation vouchers)
- _____ Meals (free or low-cost meals on site or meal vouchers)

There is no scoring as this is a personal choice. Think about your selection today. Will your priority ranking change in 5, 10, 15, or 20 years?

practices by Ryan LLC resulted in a decrease in voluntary turnover from 18.53% to 10.33%.⁹⁹ Most cafeteria plans fall into one of three categories—each with its own advantages and disadvantages.

MODULAR PLANS. Modular plans are pretty much what they sound like. The employee has several basic modules from which they can choose to provide a set of benefits that match their life and family circumstances. Each module has a different mix of insurance, employee services, and retirement options. The employee chooses a module that most closely meets their needs. There may be a module for young single employees that maximizes work flexibility with more time off for personal activities but has minimal or no benefits in areas such as family health plans, child care, or dental. Another module designed for families with children might have much more emphasis on family health, retirement planning, and more life insurance in case the employee were to die and leave the family without income. And still a third module might be designed for workers whose children are grown.

Modular plans are much easier for HR to manage than other types of flexible benefit plans, because there are a limited number of modules to keep track of. Because they are easier to manage, they are cheaper. We also have the advantage of having more people using the same set of benefits, so utilization analyses are a bit easier in this case. However, since there is no flexibility within each module (you get the exact set of benefits specified within the module), the employee may not be able to get the coverage and options that they want or need.

CORE-PLUS PLANS. In a *core-plus plan*, we have a base set of benefits, called the *core*, that are provided to everyone, and then employees are allowed to choose other options to meet personal needs and desires. The core benefits are there to provide basic protection for all of the company's employees in areas such as health and life insurance and maybe a minimum amount of retirement funding. The remaining benefits are available for the employee to pick and choose other options that match their personal needs.

If the employee has a family and wants to provide them with coverage, they can choose family health coverage. If they are getting older and didn't save for retirement earlier in their work life, they can put more funds into their retirement account. The limiting factor is that each employee is provided with a benefits account, and once that account is empty, they can't pick any additional benefits for their personal plan.

The biggest advantage of core-plus plans to the employee is, of course, the ability to partially tailor the plan to their individual circumstances while providing a minimum level of health and wellness benefits. The plan is also cheaper than a full-choice plan to administer. HRM personnel can still analyze the benefit options and complete utilization analyses on core-plus plans, but it is more difficult than in modular plans.

FULL-CHOICE PLANS. The full-choice plans provide complete flexibility to the organizational member. Each employee can choose exactly the set of benefits that they desire, within specified monetary limitations. If a member chooses to have no health care coverage, they can use the money saved for whatever other available benefit that they want. This is truly a cafeteria plan in that employees can choose any offered benefit they want without a modular or core set of benefits.

Probably the biggest advantage in a full-choice plan is that it is easy for the employee to understand. However, there are some significant problems with full-choice plans for both the individual and the organization. One of the problems, "moral hazard," may occur because the employee doesn't fully identify the consequences of their selection. Moral hazard problems can occur when the individual makes bad choices and will be forced to live with those choices in the future. For instance, we may have an employee that decides that they don't need a retirement account because they are going to "work until I die anyway." A few years down the line, this same person may be getting tired of working or may even be unable to continue to work in the same field because of illness or injuries and want to retire but will be unable to because of the choices made in previous years.

A second disadvantage to full-choice plans comes from the problem of "adverse selection." For example, most company plans allow changes to the employee's benefits during an open enrollment period at the end of the year. Suppose an employee knows that they have a physical problem that will likely result in the need for surgery in the coming year, and they therefore choose to increase their health care insurance to pay for more of the cost of the upcoming surgery. The next year, with the surgery over and knowing that they have children who are going to need braces, they choose to increase their dental coverage and lower their health care insurance coverage. Through this manipulation of the benefits system, the overall cost to the organization for providing these benefits can go up significantly over time. So this problem of adverse selection is an issue of selecting only the benefits that we think will immediately benefit us and then dropping those benefits once we feel that we don't need them. This can cause the utilization rates for the organization to significantly increase over time, which in turn causes an increase in the cost to the organization of providing those benefits.

The third big issue with full-choice plans is the cost associated with administration of the plans. It is not too difficult to manage the paperwork of a modular plan—HRM just figures out the number of employees choosing each module and then calculates the total usage for each benefit based on the modules. In full-choice plans, every employee can change their plan (in its entirety) every year. This is much more difficult to manage and creates a much larger paperwork burden for HRM.

The bottom line is that flexible plans are really gaining ground because our workforce is much more diverse than it used to be. Benefits need to match the needs of our workers, but we have to remember that the more flexible the plan, the more expensive it is.

Communicate Value to Employees

In addition to administration of benefit programs, HR is spending significantly more time than in past years to educate their employees and communicate the value of company benefits to all workers.¹⁰⁰ Many of us may work for a company that provides a summary of

WORK APPLICATION 13-12

Select a company that offers a flexible benefit plan. Identify its type and describe the major benefit options within that category of flexibility.

13-4

APPLYING THE CONCEPT

Flexible Benefit Plans

Place the letter of the type of flexible plan on the line next to statement that describes it.

- a. modular
- b. core-plus
- c. full-choice

- ____ 16. I don't think our benefit plan is fair because I use my spouse's health insurance plan and I just lose the benefit. To be fair, I should be able to use the money for other benefits I want.
- ____ 17. I sure wish we got more of our compensation in benefits, but at least with my benefit package, I can choose any benefit I want to every year.
- ____ 18. My benefit plan has five packages, and I get to pick any one of them that I want every year. But it's difficult to select one.
- ____ 19. I definitely want to get health care and retirement benefits, and it's nice to have the option of selecting a few other benefits with a set dollar value.
- ____ 20. The hard part about my benefit plan is that there are so many options to choose from that I have a hard time selecting the ones I may really need.

benefits and the value of each of them on some routine basis, usually at the end of the year. The basic reason for doing so is that most of us don't understand the true cost and value of the benefits that our organizations provide. And if we don't understand the cost and the return of our benefits programs, we don't *perceive* the value that we get from having the organization provide us with these benefits.

All we really need in order to communicate the value of benefit programs is a basic, ongoing communication process. We provide information through multiple communication channels and should provide it more often than just once per year during open enrollment. There are a number of methods that have achieved acceptability in HR departments around the world and can reach at least part of our workforce.

We may want to use more than one method because of the multigenerational nature of today's workforce. For older baby boomers, *standard mailings* to the employees' homes may be a good method, but for generation X and Y employees, *searchable knowledge bases* and *email reminders* may work better, while finally with net-gen employees, *social media* may take the lead. We have to consider the makeup of our workforce and use methods that will be appropriate in reaching each of the groups within it. Finally, if we aren't sure of the best way to communicate with our employees, we should ask them. On a global basis, the channels of communication may be very different. For example, in underdeveloped countries, many employees will not have a home computer to receive the communications in an email or through a social network. Value communication is one of the most important jobs within HR in the 21st-century workplace. We have to try to help all employees understand their benefit packages, which in turn makes the package more valuable to the individual employee. If they understand the total value of their benefits, we end up with a more loyal and more satisfied workforce. The effort is absolutely worth it.

WORK APPLICATION 13-13

Does any company you know of offer domestic partner benefits? Do you believe these benefits should or should not be offered by a specific organization you work or have worked for? Why or why not?

LO 13-6

Discuss the issue of domestic partner benefits and review the issues in personalization of health care.

Domestic partners Individuals who are not legally married but who are in a one-to-one living arrangement similar to marriage

TRENDS AND ISSUES IN HRM

The first trend that we will discuss is the question of providing benefits for "domestic partners" who are not spouses of our employees.

Benefits for "Domestic Partners"

One of the more significant recent issues in benefits management has been the question of providing benefits for domestic partners. Sometimes called "significant others," **domestic partners** are individuals who are not legally married but who are in a one-to-one living

arrangement similar to marriage, whether that arrangement is same-sex or opposite-sex. About 25% of companies offered some benefits to domestic partners in 2017,¹⁰¹ but should we treat such domestic partners the same as spouses for the purpose of providing company benefits?

Our purpose here is not to discuss the validity of domestic partner arrangements and whether or not they are morally right or wrong. That is up to the individuals, the organization, and the state and country in which they operate. Our analysis has to look at the costs as well as any organizational advantage that might be gained by providing domestic partner coverage. Organizations may choose to provide domestic partner benefits in order to support a more diverse workforce, to recruit the best talent possible, or just to provide equity to all of their employees.

Benefits that are affected by the employee's marital status include Social Security survivor benefits, workers' compensation survivor payments, access to FMLA, and coverage under COBRA and ERISA. Each of these laws has at least some language that provides for benefits only to legal spouses of employees, not to domestic partners. In some cases, federal law requires the employer to tax any benefits provided to an employee's unmarried domestic partner, because the tax code says that to receive favorable tax treatment for benefits, such as a health savings account, the coverage has to go to the employee and their immediate family members, not to domestic partners. Employers have to be aware of the language of the laws so that they don't unintentionally violate such laws. One significant recent change has been the recognition of same-sex marriage at the federal level in the United States, which is different in the eyes of the law from domestic partnerships. The Treasury Department and the IRS have ruled that legally married same-sex couples must be treated the same as other married couples for federal tax purposes.

In addition, companies have to be aware that providing domestic partner benefits may cost them significant amounts of money. Allowing domestic partners to be covered under company insurance and other benefit policies will almost always add to the cost of the benefits program. We must weigh the value of the loyalty and satisfaction gained by such actions against the direct monetary cost of this type of coverage. Companies are taking a hard look at the cost of domestic partner benefits and, in some cases at least, deciding that the cost is too high to cover the added value to their employee base.

Personalization of Health Care

In 2014, Jeff Bauer, a "health futurist," said, "The health care system in the United States will change more in the next five to seven years than it has in the last 50."¹⁰² And by all accounts, the personalization of health care continues at a rapid pace. Individuals continue to gain more control over their own health and their health care planning. From apps to health services shopping and finally to managing ongoing health care costs, individuals will continue to gain power as they become closer to the health care provider by using technology.

Smartphone apps continue to evolve as a mechanism for managing personal health care. We now have apps for checking symptoms (**WebMD** and **MayoClinic**); apps for checking and tracking heart rate, blood pressure, and other vital information (**Cardiio** and **HealthKit**); apps to interface directly with medical service providers without going into a doctor's office (**eDocAmerica**); and many others that help us manage our health—and the number and types of these tools continues to grow at a rapid rate.¹⁰³

Shopping for the best plans for you as an individual will also continue to get easier as the state, federal, and even some private insurance exchanges become more readily available online. The ACA requires that the prices for insurance on these exchanges be public information, so it is pretty easy to compare coverage, which is a significant change from in the past when it was very difficult to compare policies.

Managing cost will also become easier as more of us move to HSA/MSA/HRA and HDHPs, where we directly control medical expenditures. The monies in an HSA/MSA/HRA are controlled by the insured individual¹⁰⁴—again a change from what has been the case in

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Domestic Partner Benefits

HMO/PPO organizations. The insured person decides when, where, and how to spend their HSA/MSA/HRA funds, which gives them direct control over their health care dollars.

This trend toward individualization of health care will only continue to expand in the future. There doesn't appear to be any evidence that we are going to go back to the days when your health care decisions were made completely by other people. So company employees will need to become more knowledgeable about their health care options, which means HR will have to educate them.



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... CHAPTER SUMMARY

13-1 Discuss the strategic value of benefits programs, why these programs continue to grow, and considerations that need to be taken into account in providing benefits.

Human resources are one of the few potential sources for competitive advantage in a modern organization. The totality of their compensation—including their benefits packages—is one major factor in keeping employees happy and engaged

and willing to create a competitive advantage for our company. Today's workers demand more benefits and a better mix to fit their lifestyles. Because people demand it, companies add new benefits. This allows companies to increase job satisfaction and engagement, because when we take care of our employees, they work harder and take better care of our customers and organization, which in turn allows us to create a competitive advantage based on our people.