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CAFETERIA BENEFIT PLANS: MORE VALUE FOR FEDERAL EMPLOYEES

HEARING

BEFORE THE

SUBCOMMITTEE ON THE CIVIL SERVICE, CENSUS AND AGENCY ORGANIZATION

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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CAFETERIA BENEFIT PLANS: MORE VALUE FOR FEDERAL EMPLOYEES

TUESDAY, MAY 21, 2002

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CIVIL SERVICE, CENSUS AND AGENCY ORGANIZATION,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 1 p.m., in room 2247, Rayburn House Office Building, Hon. Dave Weldon (chairman of the committee) presiding.

Present: Representatives Weldon, Davis, Morella, and Norton.

Staff present: Garry Ewing, staff director; Melissa Krzeswicki, professional staff member; Scott Sadler, clerk; Tania Shand, minority professional staff member; and Earley Green, minority assistant clerk.

Mr. WELDON. The hearing will now come to order.

Good afternoon. I want to welcome our witnesses and everyone in our audience to this important hearing.

The purpose of this hearing is to examine cafeteria plans. Cafeteria plans are an alternative to one-size-fits-all benefit packages that allow individual employees to tailor their benefits to meet their own needs. The Federal work force is 1.9 million people strong, not counting postal workers. Not surprisingly, a work force this large is extremely diverse. There are both full time and part time employees in the Federal work force.

Federal employees also range across a spectrum of jobs. The Government employs top scientists and highly skilled information technology workers, professionals and blue collar workers.

There is diversity in age and circumstances of life. Some Federal employees are straight out of college and working in their first full time job, some are very near retirement. Some are single, while others are single parents or married couples with children. These groups of employees do not have the same needs and interests.

The needs of employees also change through their careers. Young singles do not have the same needs as a middle aged couple with children. Employees with young children may have a strong interest in a child care benefit. An older employee may be more interested in a benefit that would help him or her care for elderly parents.

In short, we do not have a one-size-fits-all world. Increasingly, private employers as well as State and local governments have recognized this simple fact. And they have responded by offering flexible benefits to recruit, and importantly, retain, well qualified em-

ployees. Consequently, the Federal Government finds itself competing for talented workers with employers who offer cafeteria plans and other flexible benefit programs. Employees find such programs attractive because they empower the individual to maximize the value of the benefits an employer offers. Many employers have found cafeteria plans to be valuable recruiting tools.

To ensure that the Federal Government will be able to compete effectively for talent in today's market, it is the obligation of the subcommittee to carefully examine the potential offered by cafeteria plans and other flexible benefit arrangements. I look forward to benefiting from the views and insights of our distinguished witnesses as we examine this important issue.

[The prepared statement of Hon. Dave Weldon follows:]

OPENING STATEMENT

The Honorable Dave Weldon

Chairman

Subcommittee on Civil Service, Census, and Agency Organization

"Cafeteria Benefit Plans: More Value for Federal Employees "

May 21, 2002

Good Afternoon. I want to welcome our witnesses and everyone in our audience to this important hearing.

The purpose of this hearing is to examine cafeteria plans. Cafeteria plans are an alternative to one-size-fits-all benefit packages that allow individual employees to tailor benefits to their own needs.

The federal workforce is 1.9 million people strong, not counting postal workers. Not surprisingly, a workforce this large is also extremely diverse.

There are both full time and part-time employees in the federal workforce. Federal employees also range across a spectrum of jobs. The government employs top scientists, highly skilled information technology workers, professionals, and blue-collar workers.

There is diversity in age and lifestyle. Some federal employees are straight out of college and working in their first full-time job. Some are very near retirement. Some are single, while others are single parents or married couples with children. These groups of employees do not have the same needs and interests.

The needs of employees also change through their careers. Young singles do not have the same needs as a middle-aged couple with children. Employees with young children may have a strong interest in a child care benefit. An older employee may be more interested in a benefit that would help him or her care for elderly parents.

In short, we do not live in a "one-size-fits-all" world.

Increasingly, private employers, as well as state and local governments, have recognized this simple fact. And they have responded by offering flexible benefits to recruit and retain well-qualified employees. Consequently, the federal government finds itself competing for talented workers with employers who offer cafeteria plans and other flexible benefit programs.

Employees find such programs attractive because they empower the individual to maximize the value of the benefits an employer offers. Many employers have found cafeteria plans to be valuable recruiting tools. To ensure that the federal government will be able to compete effectively for talent in today's market, it is the obligation of this subcommittee to carefully examine the potential offered by cafeteria plans and other flexible benefit arrangement.

I look forward to benefiting from the views and insights of our distinguished witnesses as we examine this important issue.

[Recognize Mr. Davis for Opening Statement]

Mr. WELDON. I now recognize the distinguished ranking member for his opening statement, Mr. Davis.

Mr. DAVIS OF ILLINOIS. Thank you very much, Mr. Chairman.

First of all, let me thank you for holding this hearing. I also want to thank all of the witnesses for coming to participate.

Mr. Chairman, Federal employees can currently participate in a number of benefit options offered by the Federal Government. They include health insurance, group life insurance, long-term care insurance and retirement programs. Additionally, Federal employees can earn annual and sick leave on a prorated basis.

However, this does not preclude the Federal Government from improving its benefit options and structure for Federal employees, particularly at a time when we're trying to recruit and retain the best and the brightest for Federal service. To this end, the Clinton administration implemented one of three primary types of flexible benefit plan options for employees.

In 2000, the first type of flexible benefit plan, a premium conversion plan, was put into place to allow Federal employees to pay their Federal employee health benefit premiums on a pre-tax basis. Permitted under Section 125 of the Internal Revenue Code, premium conversion plans would allow employees to convert post-tax contributions to pre-tax contributions through salary reductions for payment of employee premiums.

The second type of flexible benefit plan is called a flexible spending account, FSAs. FSAs allow employees to purchase qualified benefits such as medical or dental expenses on a before tax basis. The 1998 Department of Labor survey of full-time employees in State and local government found that 47 percent, 6.7 million people, had access to an FSA. Federal employees should also have access to health care and dependent care FSAs.

The third and more controversial flexible spending plan is a cafeteria type benefit plan. Cafeteria plans offer employees a menu of benefit options. Employees would be allowed to design their own benefit package by selecting different types and/or levels of benefits that are funded with non-taxable employer dollars. Under this plan, each employee is allotted a predetermined number of dollars, credits or points with which he or she may purchase benefits from options made available by the employer.

A major and very valid concern here is that the Federal Government will attempt to control the cost of benefits by limiting increases in the number of dollars employees are given to purchase benefits. For example, employers generally use the increase in the consumer price index as the benchmark for annual increases in the amount of dollars they provide employees to purchase benefits.

With inflation averaging 2 to 3 percent in recent years, and annual health insurance premium increases averaging between 10 and 13 percent, the cost of these benefits would be shifted to the employee. This and other concerns that have been raised about cafeteria plans must be addressed. I hope we address them in this hearing.

Perhaps a cafeteria plan could be designed to address these concerns. But shifting the cost of benefits from the Federal Government to its already underpaid Federal employees is not an option.

I look forward to today's testimony, and again, I thank you for holding this hearing.

Mr. WELDON. I thank the gentleman.

Did the gentlelady from Maryland seek to make a statement?

Mrs. MORELLA. Thank you, Mr. Chairman. I just want to add a sentence to it. I think this hearing couldn't come at a more appropriate time and I thank you for having it. With the FEHBP premiums rising by almost 30 percent in the last 3 years, and 15 percent of the 1.8 million Federal employees not participating in the program, we need to look at making changes. And while I have serious reservations about the merits of cafeteria benefits plans, I want to thank the panelists for their testimony, for sharing their personal experience. We will keep an open mind.

Incidentally, if I might just add that I feel required to go to the White House because the Maryland Terrapins are going to be honored. So I will be back before the end of the hearing, probably.

Thank you, Mr. Chairman.

Mr. WELDON. I thank the gentlelady, and we do have a second panel. So if the President doesn't keep you too long, you should be able to be back here later.

We will now hear from our first panel of witnesses. Before us today we have Mr. David Wilson, president of FlexBen Corp., in Troy, MI. Mr. Wilson is an expert in designing and implementing flexible benefit programs.

We also have Ms. Marjorie Young, Commissioner of the Georgia Merit System. Ms. Young administers the State of Georgia's cafeteria plan.

Our third witness is Mr. Derrick Thomas, who is the national vice president of the second district of the American Federation of Government Employees.

And finally, we will hear from Ms. Leslie Schneider, who is a Senior Benefits Consultant for the Hay Group in Atlanta, Georgia. Ms. Schneider also has extensive experience as a consultant with both private and public employers in designing and implementing flexible benefit programs.

I want to thank all of you for joining us here today to share your thoughts on these important issues. Without objection, your written statements will be made part of the record.

After administering the oath, I will recognize each of you for 5 minutes. I would ask that you try to summarize your statement within that time period. There are lights in front of you that will indicate how much time you have left. The green light indicates that you have 4 minutes, you are still in your 4 minute statement. Then the yellow light turns on when you have a minute remaining, and the red light will turn on when your time has expired.

We on the committee also try to comply with the 5-minute rule that we are asking you to.

Now I would ask to administer the oath. The committee requires that all witnesses take the oath. So could you please rise.

[Witnesses sworn.]

Mr. WELDON. Will the court reporter please note thee witnesses have answered in the affirmative.

Again, thank you for being here. Mr. Wilson, we'll begin with you. You're recognized for 5 minutes.

STATEMENTS OF DAVID E. WILSON, CFCI, SENIOR CONSULTANT AND PRESIDENT, FLEXBEN CORP.; MARJORIE H. YOUNG, COMMISSIONER, GEORGIA MERIT SYSTEM; DERRICK THOMAS, NATIONAL VICE PRESIDENT, SECOND DISTRICT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO; AND LESLIE SCHNEIDER, SENIOR CONSULTANT, THE HAY GROUP

Mr. WILSON. Thank you. Let me begin by thanking you, Mr. Chairman, and the members before us today for the opportunity to discuss with you one of the most important and wise legislative actions passed by this House over the last four decade period.

Section 125 of the Internal Revenue Code, known as cafeteria or flexible benefit plans, and its expansion, is vital to the financial health of all Americans. As the wisdom within our constitution liberates and defines our opportunities as Americans, the wisdom and advent of Section 125 within the tax code liberates the genius of the marketplace.

It has and continues to redefine the employer-employee financial and reward relationship. It provides employees the opportunity to liberate their financial resources within the employer-employee reward system, enabling employees to tailor their benefits program to their individual and family financial and security needs.

Said simply, employees and their dependents love choice. The opportunity of intelligent employee benefit choice results in understanding, greater real value and greater employee appreciation. Understanding the broad adoption of employee benefit plan choice and Section 125 by the private sector, State, county and municipal employers over the last 20 year period, we are very pleased to see the Federal Government's embracement of Section 125 beginning with President Clinton's adoption of non-taxable employee premiums and now the implementation of health care and dependent care reimbursement accounts under the Bush administration.

We have encouraged the continued and prompt adoption of employee benefit choice by the Federal Government through the establishment of a broad based flexible benefit plan structure. This is both a competitive need and a requirement for the delivery of maximum award financial value to American workers who dedicate themselves to national service. It is the right and wise thing to do. Americans love choice. America's private sector and Government workers alike appreciate the opportunity to secure their financial well being and financial security.

What is a flexible benefit plan? I'd like to go through a couple of things that I presented in my testimony. One is that it is established under Section 125 of the Internal Revenue Code. This section of the Code establishes that employees shall not be taxed differently than employers in the purchase of employee benefits simply because employees have choice. A flexible benefit plan is a benefit delivery system, it is not the benefit. It is the milk truck, not the milk.

I'd like to address the concept of credit formula plans later, if we may.

Effectively managed, the flexible benefit plan liberates and focuses financial resources on the important financial security needs of the individual employee and his or her family, creating employee

appreciated financial value. By definition, it requires annual and ongoing education by the employer, providing the employee the opportunity to learn, create understanding and create increased value. It is dependent on the utilization of technology and advancements in technology that continue to create new value and knowledge management opportunities.

It liberates the genius of the marketplace to never-ending new opportunities to increase the value of the employer-employee relationship and its financial reward to employees. It establishes the core foundation within the marketplace for the continued evolution of employee-centric consumerism and the evolution of the employer-employee financial security/reward system.

I presented in my testimony a summation, if you will, of what the marketplace perceives to be a standard flexible benefit plan in the traditional sense, 1985 to 1993 kind of genre. I won't go into that, I'll leave that to questions that you may have.

I do present following that in the testimony a depiction of what a flexible benefit plan might look like today. Let me just draw on the time that I have remaining some comparisons between the old and the new. In the early years, we defined a flexible benefit plan as a benefit plan that had basically statutory benefits under Section 125 as the offerings and many offerings in the medical plan design area, for example, fewer options deeper into the menu.

Today if you look at best practice, you're going to see fewer medical plan options, try to drive attention to the employee making a good financial decision relative to health care, but using more of the dollars to get a stronger underpinning of the total financial security of the employee. This is the value. The employee gets to see the whole security value of the benefit program over time, and thus begins to make wise decisions that create more value for them.

I think my time is just about to expire.

[The prepared statement of Mr. Wilson follows:]

David E. Wilson, CFCI

Senior Consultant and President

FlexBen Corporation, Troy, Michigan

Testimony before the Subcommittee on Civil Service, Census, and Agency Organization

Committee on Government Reform

May 21, 2002

A statement introduced by: Mr. David E. Wilson, Senior Consultant, President of FlexBen Corporation, Troy, Michigan. FlexBen Corporation, founded in 1983 by Mr. Wilson, is an innovative employee benefit consulting firm recognized nationally for its expertise in the strategic design, management and administration of flexible benefit arrangements, providing employees value based and focused benefit choice. FlexBen Corporation serves over 1,200 clients, ranging from employers with as few as 10 employees to Fortune 100 employers. Mr. Wilson is a Board Member of the Employers Council on Flexible Compensation (ECFC).

Introduction

I wish to begin this statement by thanking the chairman of this committee and this subcommittee and each of the committee members, personally, before us today, for the opportunity to discuss with you one of the most important and wise legislative actions passed by this House over the last four decade period. Section 125 of the Internal Revenue Code (cafeteria or flexible benefit programs) and its expansion is vital to the financial health of all Americans. As the wisdom within our Constitution liberates and defines our opportunities as Americans – the wisdom and advent of §125 within the tax code liberates the genius of the market place. It has, and continues to redefine the employer-employee financial and reward relationship. It provides employees the opportunity to liberate their financial resource within the employer-employee reward system, enabling employees to tailor their benefits program to their individual and family financial and security needs. Said simply – employees and their dependents love choice.

The opportunity of intelligent employee benefit choice results in understanding, greater real value, and employee appreciation.

With the broad adoption of employee benefit plan choice and §125 by private sector, state, county, and municipal employers over the last 20 year period, we are very pleased to see the Federal Government's embracement of §125 beginning with President Clinton's adoption of non-taxable employee premiums and now the implementation of Health Care and Dependent Care Reimbursement Accounts under the Bush administration. We highly encourage the continued and prompt adoption of employee benefit choice by the Federal Government through the establishment of a broad-based flexible benefit plan structure. This is both a competitive need and a requirement for the delivery of maximum reward/financial value to American workers who dedicate themselves to national service. It is the right and wise thing to do; American's love choice. America's private sector and government workers alike

appreciate the opportunity to secure their financial well-being and financial security.

What does a flexible benefit plan do – What is it really?

- The section of the IRC establishing flexible benefit arrangements is §125.

- §125 establishes that employees shall not be taxed differently than employers in the purchase of employee benefits simply because employees have choice.

- A flexible benefit plan is a benefit delivery system – it is not the benefit. It is the milk truck, not the milk.

- Effectively managed, a flexible benefit plan liberates and focuses financial resources on the important financial security needs of the individual employee and his or her family; creating employee appreciated financial value.

- By definition, it requires annual and ongoing education by the employer, providing the employee the opportunity to learn, create understanding and create increased value.

- It is dependent on the utilization of technology and advancements in technology that continue to create new value and knowledge management opportunities.

- It liberates the genius of the market place to never ending new opportunities to increase the value of the employer-employee relationship and its financial reward to employees.

- It establishes the core foundation within the market place for the continued evolution of employee-centric consumerism and the evolution of the employer-employee financial security/reward system.

What does a traditional flexible benefit plan look like?

Benefit Menu

§125

Medical – four or more benefit options

Dental – two to three benefit options

Vision – two benefit options

Life insurance –

Employee coverage – five to six levels of coverage

Employee Supplemental AD&D – five to six levels of coverage

* Long-term disability – Two to three levels of coverage

Short-term disability – standard coverage, or possibly two options

Health Care Reimbursement Account – employee contribution only

Dependent Care Reimbursement Account – employee contribution only

Vacation – buy or sell up to five days

401(k)

After-tax

Dependent life insurance – four to five levels of coverage

* Long-term disability – One or more options may be purchased on an after-tax basis

Management Structure

• Annual enrollment, paper, new employees into standard plan

• Credit and pricetags

Current flexible benefit design

Benefit Menu

§125

Medical – One to three benefit options

Dental – One to two benefit options

Vision – One option, or Health Care Reimbursement Account funded benefit

Life insurance – Same

Long-term disability – Same

Short-term disability – Same

Health Care Reimbursement Account – Employee and Employer funded

Dependent Care Reimbursement Account – Employee and Employer funded

Vacation – Buy or sell up to five days.; Integrated Paid Time Off (PTO) – integration

of all absence programs managed as a single plan, including STD, LTD, vacation, holiday (floating), sick time, bereavement, etc.; Implementation of sabbatical and/or educational/retraining benefit.

401(k)

After-tax

Dependent life insurance – Same

Long-term disability – Same

Other Tax and Non-Tax Qualified Benefits Examples

Section 529 educational savings plans

Transportation and parking §132

Group Legal

Group Home and Auto

Group Universal or Universal Variable Life Insurance (in conjunction with group term life plan and retirement funding plans)

Long-term Care

Pet Insurance – Insured or discounted plans

Voluntary supplemental coverages – Cancer, hospitalization, disease-specific,

Medi-Gap

Management Structure

• Annual enrollment, and educational campaigns, paper, IVR and Web-based

• Ongoing enrollment and reporting for new hires, IVR and Web-based

• Credit and pricetags moving to simple salary reduction

• Integrated absentee management, STD, LTD, FMLA, PTO, Worker's Compensation, and Medical Plan management system integration

• The expansion of the reimbursement transaction for defined benefits delivery – founded on employer and employee understanding of existing reimbursement benefit offerings

• The continued expansion of Web applications, driving employee self-service and knowledge management initiatives

Conclusion

On behalf of myself, FlexBen Corporation, as a Board Member of the Employers Council on Flexible Compensation and a member of the employee benefit consulting and management community, we thank you again for this opportunity and stand ready to further testify and respond to your questions.

Mr. WELDON. Thank you, Mr. Wilson.

Ms. Young, you're recognized for 5 minutes.

Ms. YOUNG. Chairman Weldon and committee members, I appreciate the opportunity to address the subcommittee concerning the State of Georgia's benefit plans.

As Commissioner of the Georgia Merit System, I administer a cafeteria plan. This agency has been administering this plan since 1986. I also serve on the board of the Employer's Council on Flexible Compensation as many of my predecessors have in support of cafeteria plans.

Our benefits have been a fundamental part of our total reward or compensation initiative, enabling the State of Georgia to address major issues, such as turnover in our work force, employee requests for increased benefit choices, and taxpayer demand for more cost-effective government. As employee benefit costs have risen, the pre-tax element of the Internal Revenue Code Section 125 plan, coupled with the economies of scale realized through the large group plans, have mitigated cost increases for our participants, allowing for greater benefit selection at an affordable level that is attractive to current and potential employees.

While the Georgia Merit System offers the flexible benefit and deferred compensation plan, the Georgia Department of Community Health offers the State Health Benefit Plan. The two departments coordinate open enrollment period between April and mid-May for the plan year beginning July 1st. The Georgia Department of Community Health and the Georgia Merit System offer an array of benefits through the cafeteria plan design. I have enclosed exhibit A and the attachments displaying the details of our current options.

In addition to the health plan options offered by the Department of Community Health, the Georgia Merit System offers term life insurance up to a maximum of five times pay and offers spousal and dependent life care insurance; short term disability with two options of 7 day and 30 day waiting periods; long term disability; dental insurance; legal insurance; vision insurance; and long term care insurance, as well as health care spending accounts and child care spending accounts.

We attribute a substantial portion of our success to a coordinated benefit package that addresses the individual financial needs and desires of employees. For example, the State of Georgia has a liberal leave policy for both annual and sick leave. Employees accrue 1.25 days of sick leave and between 1.25 and 1.75 days of annual leave, depending on years of service. Our short term disability coverage provides for a 7-day waiting period for those employees who have not accrued adequate leave to cover their disability period. Then we offer more affordable coverage with a 30 day waiting period for those who have more accrued leave.

Another example of benefit coordination relates to our long term disability plan. An employee is eligible through the Georgia Employee's Retirement System to receive a disability retirement after 13 years and 4 months of service. The disability retirement is coordinated with our long term disability plan to ensure affordable premiums for employees.

The benefits plans are designed to ensure that there is no overlap of coverage. Let me say that we compare our services to not only Fortune 500 companies but to other companies in Georgia, and find that our employees are very pleased in comparison with our plans.

I want to emphasize the importance of excellent communication during the implementation of the cafeteria plan. It's really important that employees understand the benefits and employers understand the risks. For example, an employer needs to evaluate the impact of pre-payment of benefits through the health insurance spending accounts.

I want to emphasize some things that I think would make cafeteria plans more helpful. It would be helpful to employers if a more accommodating structure could be legislatively enacted to make spending accounts a legitimate reimbursement account, to have them operate like the child care spending account. A second legislative improvement would be to do away with the forfeiture, the use it or lose it, features of the health care spending account, allowing unused coverage to roll forward.

A third legislative improvement would permit retirees to participate on a pre-tax basis in spending accounts and other benefits options. And finally, legislation is needed to permit long-term care premiums to be paid on a pre-tax basis. The cost of long-term care insurance is substantial and this would help considerably in mitigating those costs. We think it would make a great improvement in our total compensation and total rewards for recruiting and retaining employees.

[The prepared statement of Ms. Young follows:]

Marjorie H. Young, Commissioner

Georgia Merit System

Testimony Before the Subcommittee on Civil Service, Census, and Agency Organization of the Committee on Government Reform

Cafeteria Benefit Plans

May 21, 2002

I appreciate the opportunity to address the sub-committee concerning the State of Georgia's Benefit Plans. As Commissioner of the Georgia Merit System, I administer a cafeteria plan and this agency has been administering the plan on a continual basis since 1986. I serve on the Board of the Employer's Council on Flexible Compensation as many of my predecessors have in support of cafeteria plans. Our benefits have been a fundamental part of our total rewards initiative enabling the State to address major issues such as the transient workforce, employee requests for increased benefit choices, and taxpayer demand for more cost effective government. As employee benefit costs have risen, the pretax element of IRC Section 125 plans, coupled with the economies of scale realized through large group plans, have mitigated cost increases for our participants allowing for greater benefit selection at an affordable level that is attractive to current and potential employees.

While the Georgia Merit System offers the flexible benefit and deferred compensation plans, the Georgia Department of Community Health offers the State Health Benefit Plan. The two departments coordinate the open enrollment period from mid April to mid May for the plan year beginning July 1. The Georgia Department of Community Health and the Georgia Merit System offer an array of benefits through the cafeteria plan design. I have enclosed Exhibit "A" in the Attachments displaying in detail our current benefit options.

In addition to the health plan options (Indemnity, PPO, HMO's, and Consumer Choice) offered by the Department of Community Health, the Georgia Merit System offers:

- Term Life Insurance up to a maximum of five times pay and offer spousal and dependent life insurance.
- Short Term Disability with two options of seven day waiting period and 30 day waiting period.
- Long Term Disability.
- Dental insurance at indemnity, PPO Level and prepaid environment (i.e. HMO).
- Legal Insurance.
- Vision Insurance.
- Long Term Care with various product designs.

- Health Care Spending Account with maximum amount contributed at $5,040.
- Child Care Spending Account with maximum contributions at the statutory limit of $5,000.

We attribute a substantial portion of our success to a coordinated benefit package that addresses the individual financial needs and desires of the employee. For example, the State of Georgia has a liberal leave policy for both annual and sick leave. Employees accrue monthly 1.25 days of sick leave and between 1.25 and 1.75 days of annual leave depending on years of service. Our short term disability coverage provides for a 7 day waiting period for those employees who have not accrued adequate leave to cover their disability period. Then, we also offer more affordable coverage with a 30 day waiting period for those employees who have more accrued leave.

Another example of benefit coordination relates to our long term disability plan. An employee is eligible through the Georgia Employee's Retirement System to receive a disability retirement after 13 years and 4 months of service. The disability retirement is coordinated with our long term disability plan to insure affordable premiums for employees.

The benefits plans are designed to insure that there is no overlap of coverage which results in more affordable premiums. For example, the dental plan is coordinated with the State Health Benefit Plan to insure that procedures are not covered under both plans.

The State's benefit plans have been well received by the 120,000 plus participants in the cafeteria plan (602,655 covered lives in the Health plan) and those health participants that are not in the cafeteria plan. Our evaluations have indicated an 85% plus approval rating of the benefits offered and the related pretax savings generated by those plans. Additionally, we continually benchmark our plan against comparable employers in both the private and public sector to insure our competitiveness. Studies prepared in 2000 and 2001 comparing our benefit design with certain Fortune 500 companies, and companies in the Georgia competitive labor market, found that our benefit design was competitive but other private sector plans had a greater employer contribution for their benefits. We have found generally in the recruitment process that potential employees consider cafeteria plans a necessity when determining whether they would consider pursuing employment with that entity.

I would like to emphasize the importance of excellent communication during the implementation of a cafeteria plan. Employees who have never been exposed to these type plans must have a knowledge base to make informed decisions. Although I strongly recommend health care spending accounts, I would suggest that you research any risk exposure prior to implementation. For example, the employer needs to evaluate the impact of pre-payment (i.e., employee has not contributed) of benefits through health insurance spending accounts. Large employers can have very costly surprises with employees utilizing their benefits well in advance of their contribution and/or leaving employment. An employer might consider an actuarial evaluation of this risk given the turnover demographics of their employee population in order to anticipate this liability.

It would be helpful to employers if a more accommodating structure could be legislatively enacted to make spending accounts a legitimate reimbursement account, i.e., to have them operate like the child care spending account.

A second legislative improvement would be to do away with the forfeiture ("use it or lose it") features of the health care spending account allowing unused coverage to roll forward to the next plan year.

A third legislative improvement would permit retirees to participate on a pre-tax basis in spending accounts and other benefit options.

Finally, legislation is needed to permit long term care premiums to be paid on a pre-tax basis. The cost of long term care insurance is substantial and this would help considerably in mitigating those costs.

In summary, I believe the primary benefits of our cafeteria plan to be:

- The pretax status of cafeteria plans makes the benefits more affordable.
- We have a large participant base which allows for economies of scale in terms of administrative costs and results in the inherent spreading of risk over a large population. The products are a good value for participants.
- We get input from participants to assess participant needs. We obtain information from vendors on an ongoing basis to evaluate the products available in the market place. This helps to maximize the potential benefits to our population. We constantly analyze the demographics of our population to determine the best mix of products.
- The cafeteria plan allows participants to concentrate on the areas where they have the greatest needs to secure their financial future.

Chairman Weldon, it is our belief that cafeteria plans are an excellent way to expand cost effective benefit choices to our employees. In fact, we focus communication efforts on benefits, salary, and non-monetary rewards to present a total compensation package to attract and retain a competent workforce. I have appreciated the opportunity to appear before the sub-committee and wish you success in your endeavor. I would be happy to answer any questions you or the sub-committee may have. Thank you.

Attachment "A"

State of Georgia

Cafeteria Plan

Benefit Options	Summary of Benefits
Employee Life Insurance	Coverage Levels: 1X, 2X, 3X, 4X, or 5X Employee's Pay Maximum coverage: $500,000 Premium based on Employee's age and salary
Spouse Life Insurance	Coverage Levels: $6,000, $12,000, $30,000, $60,000, or $100,000 Premium based on Employee's age. Coverage not to exceed Employee's life coverage amount.
Child Life Insurance	Coverage Levels: $3,000, $6,000, $10,000, $15,000, or $20,000

	Flat rate structure Coverage not to exceed Employee's life coverage amount.
AD&D	Coverage Levels: 1X, 2X, 3X, 4X, or 5X Employee's Pay Maximum coverage: $500,000 Premium based on Employee's age and salary
Short Term Disability	Coverage Levels: 7 Day or 30 Day Elimination Periods Replaces up to 60% of Employee's salary, up to $800 per week.
Long Term Disability	Replaces up to 60% of Employee's salary up to $4,000 per month. Offers work and rehabilitation incentives.
Legal Insurance	Telephone Legal Services In-Office Legal Services (Both In-Network and Out-of-Network) Identity Theft Services Online Legal Services (Law Guide) Available in Single or Family
Dental Insurance	Regular Dental Option Preferred Provider Option (PPO) Prepaid Option Options cover from 50% to 100% of Preventive, Basic, Major and Orthodontia services Options available in Single or Family Coverage
Long Term Care	Coverage Levels: $75, $100, $125 per day. Optional buy-ups include: Reduced Paid Up and Inflation Protection Covers: Nursing Facility, Assisted Living, Adult Day Care and Home Care (Professional and Non-Professional Caregivers) Available to Employee (payroll deduction) Available to Spouse, Parents or Parents-In-Law through direct billing
Vision Plan	Covered Exams and Materials (Eyeglasses and Contacts) In-Network and Out-of-Network Services

	Available in Single or Family Coverage
Health Care Spending Accounts	Maximum Coverage: $5,040 Minimum Coverage: $120 Coverage for health care related expenses not paid or covered by any health, dental, or vision insurance plan.
Dependent Care Spending Accounts	Maximum Coverage: $4,992 Minimum Coverage: $120 Dependent children under age 13 Dependents of any age that are unable to care for themselves

Attachment "A" (Continued)

Health Insurance	Indemnity Option PPO Option Consumer Choice PPO Option HMO Options Consumer Choice HMO Options Options available in Single or Family Programs: • Behavioral Health Services Program • Prescription Drug Program • NurseCall24 Program

Attachment "B"

State Health Benefit Plan

(administered by Georgia Department of Community Health)

An active employee may select from 11 different medical coverage options during an open enrollment period. The employee must live or work in the approved HMO service area to be eligible for an HMO option. The following options are offered under the State Health Benefit Plan:

- PPO
- PPO Choice
- Indemnity Option
- BlueChoice Healthcare Plan HMO
- BlueChoice Healthcare Plan HMO Consumer Choice
- CIGNA HealthCare of Georgia HMO
- CIGNA HealthCare of Georgia HMO Consumer Choice
- Kaiser Permanente HMO
- Kaiser Permanente HMO Consumer Choice
- UnitedHealthcare of Georgia HMO
- United Healthcare of Georgia HMO Consumer Choice

If you are a retired employee, you may be able to select from up to 12 different medical coverage options during the retiree option change period. You may be able to choose from these options:

- PPO

- PPO Choice
- Indemnity Option
- BlueChoice Healthcare Plan HMO
- BlueChoice Healthcare Plan HMO Consumer Choice
- CIGNA HealthCare of Georgia HMO
- CIGNA HealthCare of Georgia HMO Consumer Choice
- Kaiser Permanente HMO
- Kaiser Permanente HMO Consumer Choice
- Kaiser Permanente Medicare+Choice (M+C) HMO
- UnitedHealthcare of Georgia HMO

Attachment "B" (Continued)

- UnitedHealthcare of Georgia HMO Consumer Choice
- "No coverage"

Preferred Provider Organization – PPO

A Preferred Provider Organization – PPO – is made up of a network of doctors and hospitals that have agreed to provide quality medical care and services at discounted rates. The PPO allows members and covered dependents to select health care services from inside or outside of the participating provider network.

The network is composed of primary care and specialist physicians, ancillary providers, and hospitals. Members must confirm a provider's network status prior to receiving services.

Members are *not* required to designate a Primary Care Physician (PCP) to arrange for medical care.

Participating network providers perform all precertifications through the Medical Certification Program (MCP) that are required, such as certifying hospital admissions.

The main benefit features of the PPO are:

- Office visits are covered after a co-payment of $20 and are not subject to the general deductible.
- Routine preventive lab work and other clinical tests in connection with a preventive care office visit are covered at 100% of the network rate (with no deductible) up to an annual maximum of $500 per person.
- The in-network/Georgia general deductible is $300 for individual coverage with a $900 maximum for family coverage.
- The in-network/out-of-state and out-of-network deductible is $400 for individual coverage with a $1200 maximum for family coverage.
- The lifetime maximum benefit is $2 million.

Attachment "B" (Continued)

- In-network/Georgia covered services are paid at 90% of the network rate after the general deductible (except as stated above for office visits and preventive services).
- Inpatient hospital services are covered at 90% of the network rate after the general deductible is satisfied.
- Note: The Georgia PPO service area includes the entire State of Georgia and the border communities of the Chattanooga, Tennessee area, including Bradley County; and Phenix City, Alabama.
- In-network/out-of-state coverage is 80% of the network rate if you receive care from an in-network provider located outside of Georgia.
- Annual out-of-pocket spending maximums for in-network/Georgia services are $1,000 (individual) to $2,000 (family) and for in-network/out-of-state services maximums are from $2,000 (individual) to $4,000 (family).
- Anyone eligible for State Health Benefit Plan coverage may select a PPO Option and take advantage of the national network of providers. You can benefit from the national network if...

- you or a dependent lives outside of Georgia
- you have a dependent going to school in another State
- you are traveling in another State
- you want to use an out-of-state provider

If you receive care from a Beech Street provider outside the "Georgia service area", you will receive the "in-network/out-of-state" (80%) level of benefit coverage, subject to separate deductibles and out-of-pocket spending limits.

Indemnity Option

The Indemnity option is an indemnity or traditional fee-for-service plan that allows provider choice and generally pays the same percentage of the plan's allowed amount to any covered provider after meeting an annual deductible. The plan also utilizes contracted health care providers who have agreed to discounted rates without balance billing for charges over the allowed amount. As long as an employee uses a participating provider, he may not be balanced billed. However, not all Georgia providers participate in these

Attachment "B" (Continued)

special arrangements and there are no participating providers outside of Georgia. Services from non-participating providers are subject to balance billing.

Out-of-state hospital charges for the Indemnity Option will be paid based on an allowable amount. After meeting your $100 per admission deductible, the Indemnity Option will pay 90% of eligible hospital charges. You will be responsible for the 10% co-insurance payment, plus any non-covered charges and any provider charges above the allowable amount. Indemnity Option members are subject to balance billing from out-of-state providers.

Indemnity Option and PPO Option Compared

The Indemnity Option out-of-pocket spending limits are $2,000 per person and $4,000 per family. This is $1,000 more per person and $2,000 more per family than in-network PPO limits. The PPO in-network/Georgia out-of-pocket limits are $1,000 per person or $2,000 per family. (Out-of-network and in-network/out-of-state maximums are $2,000 per person or

$4,000 per family.)

Reimbursements under the Indemnity option are based on allowed amounts and are subject to balance billing if you are using a non-participating provider. If you see a participating PPO provider you are protected from balance billing. (If you go out-of network in the PPO, you are subject to balance billing.) Deductibles for medical care and hospitalization must be met in both options before benefits are paid unless noted otherwise.

Indemnity option benefits are similar to PPO in-network benefits but with less coverage for preventive care. Also, Indemnity option premiums are higher.

Preventive care coverage is not available under PPO out-of-network benefits.

Covered wellness benefits associated with preventive care office visits have been enhanced and Indemnity option covered wellness benefits are now the same as covered wellness benefits under the PPO option, but with a lower annual maximum.

Attachment "B" (Continued)

Associated lab work and diagnostic tests for preventive care visits under the Indemnity option will be paid at 100% of the Indemnity option rate with no deductible, up to a maximum of $200 per plan year per person. The wellness benefit is $200 per person per plan year for the list of covered lab work and diagnostic tests, including such services as PSAs, EKGs, and pap smears. Under the PPO options, in-network coverage for the above is $500 per plan year per person.

Indemnity option coverage for screening mammograms is $125 per plan year. Indemnity option deductibles and co-insurance amounts are waived for screening mammograms. In the PPO options, in-network coverage for screening mammograms is included in the $500 annual wellness benefit.

The deductibles and maximums are outlined in the chart below:

	PPO OPTIONS		INDEMNITY OPTION
Deductibles*	In-Network/Georgia	In-Network/Out-of-State and Out-of-Network	
Per Person	$300.00	$400.00	$300.00
Per Family (maximum)	$900.00	$1,200.00	$900.00
Hospital Deductible			
Per Confinement	Not Subject to Separate Deductible	Not Subject to Separate Deductible	$100.00
Emergency Room Co-payment**			
Per Visit	$60.00	$60.00	$60.00
Out-of-Pocket Spending Limits – Medical*			
Per Person (annual)	$1,000.00	$2,000.00	$2,000.00
Per Family (annual max.)	$2,000.00	$4,000.00	$4,000.00
Out-of-pocket spending Limits – Generic and Preferred Brand Name Drugs			
Per Person (monthly)	$100.00		$100.00
Per Family (monthly max.)	$200.00		$200.00
Out-of-pocket spending Limits – Behavioral Health Services (BHS)			
Per Patient with BHS Authorization	$2,500.00	In-Network - $2,500.00	$2,500.00

*Covered services from a participating in-network/Georgia provider will apply only to the in-network/Georgia deductible and out-of-pocket spending amounts. When a member elects to use both in-network and out-of-network

Attachment "B" (Continued)

providers, payments made toward deductibles and out-of-pocket spending amounts will be applied separately to the respective amounts.

**The emergency room co-payment is waived if you are admitted to the hospital or it is reduced to $40 if you are referred by NurseCall24 before receiving emergency services.

Health Maintenance Organizations-HMOs

An HMO is a network of health care providers that offers services at discounted rates and provides its participants with medical service on a prepaid basis. If an employee chooses an HMO, he will receive medical care from doctors and hospitals that participate in the HMO. A primary care physician (PCP) coordinates the care and you must seek non-emergency care within the network to receive benefits. If the employee receives care outside the HMO's network, he is responsible for 100% of the medical expenses. Except in the case of a life-threatening emergency, charges for most treatment by non-HMO doctors and hospitals are not covered.

Consumer Choice Option

Consumer Choice is the result of a Georgia law called The Consumer Choice Option Law. The law states that if an HMO or PPO option member joins the Consumer Choice Option of the HMO or PPO, the member can request that an out-of-network provider deliver the member's care at in-network levels of benefit coverage.

Flexible Benefits Program

(administered by the Georgia Merit System)

Employee Life Insurance

Employee(s) through age 64 may choose life insurance coverage equal to one times pay ($250,000 cap), two, three, four, or five (5) times his/her Benefit Salary up to $500,000. If you are age 65 or older, you are eligible for a percentage of the amount that would apply if you were age 64 as indicated in the table below:

Attachment "B" (Continued)

Your Age	Percentage of the amount which would apply if you were age 64
65 but less than 70	65%
70 but less than 75	43%
75 but less than 80	29%
80 but less than 85	19%
85 but less than 90	13%
90 but less than 95	09%
95 but less than 100	05%

Spouse Life and Child Life Insurance

The employee may choose coverage amounts of $6,000, $12,000, $30,000, $60,000 and $100,000 for spouse and $3,000, $6,000, $10,000, $15,000 and $20,000 for each eligible child. If the employee is 65 or older, the Spouse Life coverage will be reduced by the same percentage and at the same time that the employee's life insurance reduces. (See the age reduction chart). Or the employee may choose not to have any spouse life and/or child life coverage. However, it's important to note that the coverage selection in either option cannot exceed 100% of the Employee Life coverage.

Physically and/or mentally handicapped children may be eligible for *continued* coverage beyond age 19 upon approval by the carrier. If coverage for a handicapped child is to be continued, the employee must file a request with the carrier within sixty days following the child's 19th birthday.

Accidental Death and Dismemberment (AD&D) Insurance

Employees through age 74 may choose accidental death and dismemberment insurance equal to one (1), two (2), three (3), four (4), or five (5) times their Benefit Salary, up to $500,000. Coverage is available for employees 75 or older at a reduced percentage of the amount which would apply at age 74. The reduction factor for ages 75-79 is 50%; for ages 80 or older is 75%.

Short-Term Disability Insurance

-

If an employee chooses short-term disability coverage, this plan will work with other benefits the employee is eligible to receive including social

Attachment "B" (Continued)

security, workers' compensation, other government benefit programs (e.g., retirement due to disability), other group disability plans, or special injury benefits, to replace 60% of the employee's salary, up to $800 per week.

The employee may choose one of two levels of short-term disability – the 30 day wait or the 7 day wait. The short-term disability plan works the same for both levels, except when approved benefits can begin.

If the employee becomes disabled and cannot work, the employee is eligible to receive these benefits after having been disabled for seven (7) or thirty (30) calendar days of continuous disability. The 7 day wait, which is considered a "buy-up", allows approved benefits to begin after 7 days of continuous disability, unless the employee has a pre-existing condition prior to the effective date of the buy up. The employee may choose whether to use sick leave or receive these benefits. If he chooses to receive these benefits, the use of sick leave would stop at that time.

The short-term disability plan works with other benefit plans to replace 60% of the Benefit Salary in effect at the time of the employee's disability. Short-term disability benefits can continue until the employee recovers, returns to work full-time, or receive benefits for a maximum of 150 calendar days or a maximum of 173 calendar days, depending on the coverage level that was chosen, whichever is first. Then 150 or 173 calendar day maximum is reduced by any days of paid sick leave, donated leave or special injury leave that is used which would exceed the 7 calendar day or 30 calendar day elimination period.

Long-Term Disability Insurance

Long-term disability insurance can provide income protection for the employee and his family if the employee becomes disabled for a period longer than six (6) months. The plan works with other benefits the employee is eligible to receive to replace 60% of the Benefit Salary.

These benefits will begin after the employee is disabled from performing his occupation for 180 calendar days. These benefits will cease when the employee is no longer disabled or reaches age 65. However, if the employee becomes disabled after age 60, benefits may continue for a limited time past

Attachment "B" (Continued)

age 65. Additionally, benefits for mental and nervous disorders are limited to a two (2) year period.

Legal Insurance

The Ultimate Legal Plan is a benefit offered by the Flexible Benefit Plan with after-tax dollars. The Ultimate Legal Plan provides employees access to attorneys who will assist when personal legal representation or advice is needed.

The employee simply calls a network attorney when a legal matter arises. To schedule an

appointment with a network attorney, the employee provides the attorney with his social security number, the name of his employer, and a brief description of what the employee would like to speak with the attorney about. The network attorney will then submit the information and seek payment from the carrier for his/her hourly fees for covered legal matters. The employee is responsible for all out-of-pocket expenses such as postage, fax or long distance charges, filing fees, title work, etc. and possibly any additional hours that aren't covered by the plan. The network attorney will provide the employee with an itemized list of the out-of-pocket expenses for which the employee is responsible.

If the attorney is not in the network, the plan will reimburse the employee for the attorney's fees at the rate of $60 per hour up to the scheduled benefit maximum for the type of legal service being provided. The employee will be responsible for the rest of the bill. The employee may also request that the attorney be sent an application to become a network attorney in the event he/she is interested.

The plan will make reimbursement for covered services depending on the attorney the employee chooses. The chart and examples below show how benefits are paid for when using a network attorney versus a non-network attorney for the legal assistance in a consumer protection situation. This example assumes that the covered person is provided legal services for the enforcement of a lease.

Attachment "B" (Continued)

Final disposition terminates after filing civil suit and ending in a settlement without court appearance.	Network Attorney	Non-Network Attorney
	Charge (if any) NONE	Maximum Paid $120

Example A: If a network attorney spends 2 hours on the service, the plan will pay the attorney for two hours of his/her time. The network attorney cannot charge additional legal fees.

Example B: If a non-network attorney spends 2 hours on the service and charges $100 per hour; the plan will pay $120. The covered person will be responsible for the balance of $80 (charges of $200 less the plan payment of $120).

Dental Insurance

If the individual is a current employee who did not enroll in the Regular option or the PPO option when he was first eligible, the employee will be subject to the Late Entrant Limitation if he enrolls in one of these options during open enrollment period.

The Prepaid option does not have late entrant limitations. If the employee lives in the metropolitan Atlanta and in the Savannah areas, or if the Prepaid option is available in his area, the employee may choose this option without late entrant limitations.

Under the late entrant limitation, which applies only to the Regular and PPO options, benefits will be paid as follows:

- Benefits for the first twelve (12) months will be limited to Preventive (Type I) covered dental expenses only.
- Benefits for the second twelve (12) months will be limited to Preventive and Basic (Type I and Type II) covered dental expenses only.

Attachment "B" (Continued)

- At the end of two (2) years, the employee and his eligible dependents, assuming he has family coverage, will be eligible for Major (Type III) covered dental expenses.
- At the end of two (2) years, eligible dependents under age 19, assuming the employee has family coverage, will be eligible for Orthodontia (Type IV) benefits.

If the employee enrolls in the PPO and uses a PPO dentist, the dentist will charge only the difference between the benefits paid by the carrier and the scheduled fee amount. Also, Preventive (Type I) expenses are payable at 100% (UCR) and Basic (Type II) expenses are payable at 90% coinsurance. The following example illustrates how the PPO works:

	Dental Insurance Option	PPO Option	
		PPO Dentist	Non-PPO Dentist
Dentist's normal charge	$500	$500	$500
Discounted PPO fee	Does Not apply	$350	Does Not Apply
Covered Expense	$500	$350	$350
Plan pays (Basic Expense: Type II)	80%	90%	90%
	$400	$315	$315
Maximum amount dentist can bill you	$500	$350	$500
Your out-of-pocket expense	$100	$ 35	$185

If the employee enrolls in the Prepaid option, he must pre-select and use a participating dentist to receive benefits. There are no deductibles, waiting periods, late entrant limitations, pre-existing conditions or maximum benefit limitations. For many covered services, there is no charge or co-payment. For services that have a co-payment, the employee's payment is due at the time of service. Any services that are not specifically listed on the schedule of benefits are covered at a 25% reduction from the dentist's usual charge.

Preventive treatments include: exams, prophylaxis (cleaning), space maintainers, and X-rays.

Attachment "B" (Continued)

Basic treatments include: sealants for children under age 16 (limited to once for each permanent molar), fillings, root canals, extractions, scaling and root planning, and *repairs* to crowns, dentures, and bridges.

The Regular option and the PPO option plans will pay up to $1,000 per covered person each plan year. There is a separate orthodontia lifetime maximum of $1,500 per dependent child under age 19.

It should be noted that this option is also available to retirees.

Long-Term Care

Long-term care insurance is coverage designed to assist with the cost of long-term care. Long-term care is the type of care received when someone needs assistance with daily living, either at home or in a facility, due to a condition related to the natural course of aging, or a chronic illness, severe long lasting physical impairment or disease, an accident, or because of a cognitive impairment, such as Alzheimer's disease.

All employees who are eligible to participate in the State of Georgia Flexible Benefits Program are eligible to participate in the long-term care option through payroll deduction. Additionally, the plan is offered on a direct-billed basis to spouses (you must be legally married), parents, and parents-in-law of eligible employees.

The enrollment of the spouse and/or parents or parents-in-law is independent of the enrollment of the employee. As long as the employee is eligible to participate, the opportunity to enroll is also available to the spouse, parents, and parents-in-law.

The carrier's plan pays benefits based on the benefit level amount chosen as well as where

care is received. The percent of your monthly benefit based on where you receive care is as follows:

- Care provided in a long-term care facility or nursing home—monthly benefit based on 100% of your long-term care benefit level amount.
- Generally an institution or distinctly separate part of a hospital that provides skilled, intermediate and/or custodial care under state licensing and certification laws

Attachment "B" (Continued)

- Care in an assisted living facility—monthly benefit based on **60%** of your long-term care benefit level amount.
- is licensed by the appropriate agency to provide ongoing care of services to a minimum of 10 inpatients in one location.
- Professional Home Care Services—monthly benefit based on **60%** of the employee's long-term care benefit level amount.
- includes visits to the employee's home during which skilled nursing care, physical, respiratory, occupational, dietary or speech therapy or homemaker services are provided.
- Total Home Care Services—monthly benefit based on **60%** of your long-term care benefit level amount.
- includes professional home care services as well as care received from any care providers of your choosing—including relatives and friends who provide care in your home.

There are three benefit levels from which you may choose:

- $75 per day *with* a lifetime maximum benefit of $136,875; or
- $100 per day *with* a lifetime maximum benefit of $182,500; or
- $125 per day *with* a lifetime maximum benefit of $228,125.

For the benefit level selected, you may receive care in a(n):

- long-term care facility at a monthly benefit of 100% of the benefit level;

- assisted living facility at a monthly benefit of 60% of the benefit level; or
- home care services at a monthly benefit of 60% of the benefit level.

Premiums are based on the age of the insured at the time of enrollment and the amount of coverage (i.e., the benefit level) and additional features selected (i.e., inflation protection and/or reduced paid-up).

All active employees eligible to participate in the long-term care option may pay for this coverage through payroll deduction on a monthly basis. Spouses, parents, and/or parents-in law will be billed directly from the carrier. They will have the choice of paying quarterly, semi-annually, or annually. When an eligible family member enrolls in the plan, they must notify the carrier of their preferred payment method.

Attachment "B" (Continued)

The employee must lose the ability to perform at least three activities of daily living (ADLs) or suffer cognitive impairment after your effective date of coverage as defined in our contract. The employee will be considered to have lost the ability to perform an activity if he requires stand-by assistance in order to perform it safely and completely. Benefits are payable directly to the insured once the insured has been assessed as having a functional or cognitive impairment (as defined by the plan) and has satisfied the waiting period.

The activities of daily living are: bathing, dressing, transferring, toileting, continence, and eating.

The carrier's definition of a functional impairment is the inability to perform, without human assistance, three or more of the activities of daily living (ADLs) as follows:

- Bathing
- Dressing
- Transferring
- Toileting

- Continence
- Eating

A cognitive impairment is an organic brain disorder diagnosed by a physician, where the individual is unable to function without causing danger to himself/herself or others. Alzheimer's disease and senile dementia are examples of cognitive impairments.

The elimination period is ninety (90) consecutive days beginning on the date a physician has determined that the employee has lost three (3) of six (6) activities of daily living after the coverage effective date. You must satisfy this waiting period before benefits will be paid under this plan.

Vision Insurance

The Vision care program is a full service, freedom of choice program that offers both in-network and out-of-network benefits. In-network providers

Attachment "B" (Continued)

(or eye care professionals) are available statewide. It provides covered

benefits for routine eye exams, glasses, and contacts after the employee makes the co-payment at an in-network provider. It allows members to access refractive eye surgery at The Laser Center (TLC). The benefit is: cost for covered members will not exceed $1,800 per eye.

Network providers have an agreement with the carrier to provide many "covered in full" benefits, quality service and customer satisfaction. Through a network provider, some services are covered in full after the employee's co-payment. Additional services, such as coatings and progressives will be the responsibility of the employee but at a cost less than normal.

Service	In-Network Benefits	Out-of-Network Benefits
Routine Eye Exam *Every 12 months*	Covered after $10 copay	Reimburses up to $40
Lenses Standard *Every 12 months, if prescribed*	Covered after $20 materials copay	
Single vision, or		Reimburses up to $30
Lined Bifocal, or		Reimburses up to $45
Lined Trifocal, or		Reimburses up to $60
Lenticular		Reimburses up to $80
Frames *Every 24 months after a $20 materials copay**	Retail locations (Wal-Mart) • Up to $98 retail allowance toward any frame package • Frames below $98 provided at no additional cost Private Doctors Office • $45 wholesale allowance towards any frame. You pay the difference. • Group of select frames at no additional cost	Reimburses up to $45 of retail.
Contact Lenses *Every 12 months in place of eyeglasses*		
Medically Necessary	Covered after $20 materials copay	Reimburses up to $200

Attachment "B" (Continued)

Not Medically Necessary	Covered after $20 material copay for covered lenses selected from Spectera list. Effective 07-01-02 certain standard disposable contact lenses will be added to Spectera's covered list (Previously disposables were available only through the allowance). Now, up to four boxes of covered disposable contact lenses are included when using a network provider. All other contacts available through a $100 allowance that includes fitting, follow-up & materials. Please note to receive the full $100 credit, you must receive your exam, fitting evaluation and all contact materials at the same provider at the same time. (At Wal-Mart $65 of the$100 allowance is allocated to materials and $35 to professional fees)	Up to $100 max that includes fit, follow-up & materials
Refractive Eye Surgery The Laser Center (TLC) one location at: 1 Buckhead Loop Atlanta, GA 30326	Cost of prodecure not to exceed: $1,800 per eye – Lasik $1,500 per eye – PRK	No benefits

The Vision care plan includes the following exclusions:

Replacement of lost lenses and/or frames. Lost or stolen lenses or frames furnished under this program are not covered and are the responsibility of the enrollee.

Medical or surgical treatment of eye conditions. Under no circumstances will the carrier be responsible for payment for any medical or surgical services. If examination discloses that such treatment is required, notification of this exclusion will be communicated to the enrollee. Under no circumstances will the carrier be responsible for payment for any medical or surgical services.

Attachment "B" (Continued)

Services or materials for which the enrollee may be compensated under any worker's compensation law or other similar employer's liability law, or services which the eligible enrollee, without cost, obtains from any federal, state, county, city, or other governmental organization.

The carrier covers standard single vision and standard lined multi-focal lenses for glasses. Cosmetic lens options such as scratch coating, UV coating, progressive lenses, etc., are not covered but are provided to the carrier's members at savings.

Any amounts about the plan's schedule or allowances or benefits received before the appropriate benefits period (12 or 24 months from the last date of service).

Attachment "C"

State of Georgia

Percentage Summary of Chosen Benefits

Plan Year 2001

Description of Option	Percentage of Eligible Population
Employee Life	79%
Employee AD&D	72%
Dependent Life	45%
Employee Short Term Disability	38%
Employee Long Term Disability	44%
Dental	63%
Spending Accounts	11%

Legal	9%
Long Term Care	3%
Vision	40%
Health PPO	51%
Health Indemnity	5%
Health HMO's	26%

Mr. WELDON. Thank you very much.

Mr. Thomas, you are recognized now for 5 minutes.

Mr. THOMAS. Thank you, Mr. Chairman, and members of the committee. On behalf of the more than 6,000 Federal and District of Columbia employees AFGE represents, I thank you for the opportunity to testify before you today.

AFGE is strongly opposed to the establishment of cafeteria plans in FEHBP. We believe that the Federal Government, as an employer, has a duty to provide health insurance benefits to all its employees and a cafeteria plan approach would take us even farther away from the goal than we are today. FEHBP has several serious flaws that makes it more expensive than it should be. Its financing structure, along with its high cost, have made health insurance unaffordable for a large and growing number of Federal employees and their families. Introduction of cafeteria plans would only make this problem worse.

Cafeteria plans are deceptive. Under the slogan of freedom of choice, the plans force employees into either/or decisions between benefits that should be provided universally. Health insurance is not a choice that some people need and others do not. It is not a benefit that appeals to some but not others. Health insurance is a crucial component of economic security. As such, it should remain the employer's financial responsibility to provide, as part of a comprehensive compensation package.

Cafeteria plans have much the same impact on a group's insurance risk as vouchers or medical savings accounts. They provide a financial incentive for young, healthy workers to drop in and out of coverage. This in turn leads to an average risk that is higher than it would be under universal coverage of the group, and thus higher than necessary costs for the program as a whole.

Health insurance is most efficiently provided to large, diverse groups who pool their risk in order to pay less on average than any one would have to pay for him or herself. Cafeteria plans, along with MSAs or vouchers, defy this basic principle of group insurance. Cafeteria plans for Federal employees would transform the basic structure of the health insurance program from a defined benefit to a defined contribution. Defined contribution programs are best understood as vouchers. With a voucher structure for FEHBP, the Government could set its contribution each year without regard to changing health insurance premiums or other cost and without regard to the percentage of the premium the voucher would cover.

In any year that the voucher is increased by a smaller percentage than the increase in premium, the overall share of the Government's contribution would fall. When vouchers and cafeteria plans have been contemplated for FEHBP in recent years, legislative proposals have suggested annual adjustment equal to the CPI, which is used in the Government's budget to adjust baseline agency budgets. If such a plan had been in effect over the past 4 years, FEHBP's most popular plan, the Blue Cross/Blue Shield standard option, the cafeteria plan voucher would have only been increased by 9.5 percent, while premiums went up by 49 percent.

Although cafeteria plans may at first seem like a vehicle for facilitating health coverage for the more than 200,000 uninsured

Federal employees, by allowing them to tradeoff cash value of benefits now provided by the Government in favor of other benefits not fully subsidized, serious potential problems do exist. First, employees may not have the skills or expertise to design a benefit package that is best for them from among the options presented. If forced to choose, how does a young family rank its simultaneous need for child care, health care and time away from work and disability insurance? Which is expendable? Which can be foregone?

The employer's only motivation for establishing cafeteria plans is to save money on employee benefits. Because cafeteria plans carry their own additional administrative costs, just to keep employee benefit costs constant requires benefit cuts. Since the reason most commonly cited by the uninsured who are eligible for FEHBP participation is lack of affordability, lowering the Government's share and raising the employee's share is hardly the way to achieve universal coverage.

The combination of cafeteria plans and FSA holds numerous potential problems for employees. FSAs involve having workers voluntarily reduce their gross pay by specific amounts in an amount equal to the difference between what the employer pays for benefits and the costs of the benefit. The worker chooses the amount of the salary reduction at the start of the plan year.

Another financial disadvantage to workers of combined FSAs and cafeteria plans also comes from the fact that employee contributions to FSAs are salary reductions. Thus, benefits based upon salary are automatically lowered. Life insurance and disability insurance would be similarly affected, unless the Government specifically decides to rewrite the terms of its policies for Federal employees. Social Security benefits will be lower for workers who lower their salaries in a combined FSA cafeteria plan. The Government could, of course, compensate Federal employees for these differences, but that would deprive it of the primary motivation to establish these plans, saving money.

That concludes my statement. Thank you.

[The prepared statement of Mr. Thomas follows:]

STATEMENT BY

DERRICK THOMAS

NATIONAL VICE PRESIDENT, 2ND DISTRICT

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES,

AFL-CIO

BEFORE

THE SUBCOMMITTEE ON CIVIL SERVICE

HOUSE COMMITTEE ON GOVERNMENT REFORM

REGARDING

ESTABLISHING CAFETERIA PLANS WITHIN FEHBP

MAY 21, 2002

Mr. Chairman and Members of the Committee: My name is Derrick Thomas, and I am a National Vice President of the Second District of the American Federation of Government Employees, AFL-CIO (AFGE), which includes New York, New Jersey and the entire New England region. On behalf of the more than 600,000 federal and District of Columbia employees AFGE represents, I thank you for the opportunity to testify before you today on the question of whether the establishment of cafeteria plans would be good or bad for federal employees and their families.

AFGE is strongly opposed to the establishment of cafeteria plans. We believe that the federal government as an employer has a duty to provide health insurance benefits to all its employees, and a cafeteria plan approach would take us even farther away from that goal than we are today. The Federal Employees Health Benefits Program (FEHBP) has several serious flaws that make it more expensive than it should be. FEHBP's financing structure along with its high cost have made health insurance unaffordable for a large and growing number of federal employees and their families. Introduction of cafeteria plans would only exacerbate this problem.

In most cafeteria plans, the employer deposits a fixed dollar amount into a tax-free account that the employee then uses to help pay for health insurance or other benefits that the Internal Revenue Service (IRS) qualifies for tax-exempt status. The amount deposited into the account may be adjusted annually by the employer, or it may not. It may be adjusted by the rate of inflation, by an amount less than that, or not at all. The Heritage Foundation report that recommended cafeteria plans for the federal government admits that federal employees would be forced to provide their own "after tax funds to fashion a benefits package that suited his particular circumstance" if cafeteria plans were implemented.

The types of benefits that may be included under the cafeteria plan umbrella include the cash value of accrued annual leave and sick leave. That is, cafeteria plans not only facilitate, but actually give employees an incentive to trade off sick leave or vacation for health insurance, or vice versa. Most important, they put responsibility for paying for benefits onto the employee

instead of where they belong – on the employer.

Cafeteria plans work as follows: An employee decides to enroll in a particular health insurance plan. The employee's cost to enroll is the difference between the premium, deductibles, and copayments charged by the plan, and the amount of money deposited into the cafeteria account by the employer. The employee then allows the employer to reduce his/her wages or salary each month by an amount specified by the employee (calculated to cover the remainder of the premium and any anticipated out-of-pocket costs), and these funds are deposited into the cafeteria account. Each month, funds are transferred from the cafeteria account to the health plan to cover health-related charges. If there are any unused balances in the account at the end of the year, they revert to the employer.

Cafeteria plans are deceptive. Under the slogan of "freedom of choice" the plans force employees into either-or decisions between benefits that should be provided universally. Health insurance is not a choice that some people need and others do not. It is not a benefit that appeals to some but not others. Health insurance is a crucial component of economic security. As such, it should remain the employer's financial responsibility to provide as part of a comprehensive compensation package.

The Impact of Cafeteria Plans on FEHBP

Cafeteria plans have much the same impact on a group's insurance risk as vouchers or Medical Savings Accounts. They provide a financial incentive for young, healthy workers to drop in and out of coverage. This in turn leads to an average risk that is higher than it would be under universal coverage of the group, and thus higher than necessary costs for the program as a whole.

Health insurance is most efficiently provided to large, diverse groups who pool their risk in order to pay less on average than any one would have to pay for him or herself. Cafeteria plans, along with Medical Savings Accounts and voucher programs, defy this basic principle of group insurance. They are therefore a surefire recipe for making a bad system worse.

In its 1989 study of cafeteria and other "flexible" benefit plans, the Congressional Research Service (CRS) warned that such plans can set the stage for risk segmentation, "as employees juggle their benefit choices each year to maximize their own disposable incomes." In order to minimize the likelihood of risk segmentation, the CRS recommended that the health insurance plans offered in the context of a cafeteria plan have the following three characteristics:

1. Premiums for plans, and the differentials in premiums among the plans, should reflect actuarial differences in the value of benefits offered.
2. The benefit choices should be designed, "packaged" and marketed in a way that avoids having particular risk groups congregate in particular plans.
3. Waiting periods should be instituted as requirements before certain benefits become available.

Unfortunately, FEHBP already has a severe problem with risk segmentation, and none of the three conditions CRS has specified for a successful cafeteria plan prevails in FEHBP. Short of canceling every contract with every FEHBP plan, disenrolling each and every one of the 9 million current enrollees, and starting from scratch to redesign and re-enroll those same nine million, cafeteria plans will make FEHBP's risk segmentation problems worse, not better.

It is well known that in FEHBP, premiums reflect the risk characteristics of the participants enrolled, rather than the actuarial value of benefits provided in many if not most of its component plans. In each annual open season, FEHBP's plans advertise to a particular market niche, one emphasizing obstetrics and pediatrics, another emphasizing heart surgeons. They choose which radio stations and on which bus routes to advertise, tailoring their message to the segment of the FEHBP market their benefit package has been designed to attract. Since there is no standard benefits package, firms are free to pursue their individual marketing strategies through benefit design. While this is a profitable strategy for the plans, the risk segmentation it creates works to the detriment of enrollees and the FEHBP program as a whole.

Finally, FEHBP to its credit, does not allow waiting periods for coverage. While this does allow participants to "game" the system, it also ensures that no one covered under a FEHBP plan is denied service for a treatment or service regularly included in the plan.

Cafeteria plans for federal employees would transform the basic structure of the health insurance program from a defined benefit to a defined contribution. Although FEHBP's financing structure combines elements of both a defined benefit and a defined contribution, the defined contribution aspect of FEHBP is not its "defining" feature. Defined contribution programs are best understood as vouchers. With a voucher structure for FEHBP, the government would set its contribution each year. It would be free to set this contribution without regard to changes in health insurance premiums or other costs, and without regard to the percentage of any given FEHBP plan's premium the voucher would cover. Indeed, in any year that the voucher is increased by a smaller percentage than the percentage increase in premiums, the overall *share* of the government's contribution will fall.

The Financial Impact on Federal Employees

Although a voucher plan may have some appeal when it is first introduced, it will rapidly show its true colors in ensuing years. Upon introduction, the voucher may in fact be set to cover most of the cost of a modest plan, and be described to embody an incentive for participants to "shop carefully." It will also be described as fiscally prudent for the government, because with a voucher the government will be in complete control of how much it spends, i.e. whether, and by how much, it adjusts the voucher.

Under cafeteria/voucher plans, the government can act as though it is no longer at the mercy of the insurance and drug companies. It would no longer be forced to pay an average of 72 percent of whatever premium is charged. Instead, the government would become master of its own destiny, choosing when, whether, and by how much it will raise or lower the voucher amount.

Federal employees, however, will be stuck with having to pay the difference. When vouchers and cafeteria plans have been contemplated for FEHBP in recent years, legislative proposals have suggested annual adjustments equal to the Consumer Price Index (CPI), which is used in the government's budget to adjust baseline agency budgets. If such a plan had been in effect over the past four years, FEHBP's most popular plan, the Blue Cross/Blue Shield Standard Option, the cafeteria plan voucher would have only been increased by 9.5 percent, while premiums went up by 49 percent!

Cafeteria Plans could conceivably cover a large range of non-cash compensation currently provided to federal employees. In addition to health insurance, life insurance, dependent care expenses, annual and sick leave could be included. Legislative efforts are underway to allow private long-term care insurance to be included in tax-free accounts.

Cafeteria Plans are Inequitable

Cafeteria plans are inequitable in the sense that they provide a greater financial benefit to higher income employees than those with low incomes. Part of the reason for this is that the tax advantages to employees are more valuable to those with higher incomes. Since federal income taxes are progressive, the tax savings to higher income employees exceed the tax savings to low income employees. This disparate impact would be compounded for federal employees living in states with progressive income taxes.

Another source of inequity in cafeteria plans derives from the fact that some benefits that may be included in the plan have a financial value that is a function of income, and some have an equal dollar amount regardless of the salary of the worker for whom they are provided. Either way, the inequity in the benefit is compounded by the tax system. For example, the health insurance premium subsidy might be set, initially or continually, as a percentage of premiums. The only variation in the value of this benefit would occur because of the tax system.

Benefits such as disability insurance, long term care insurance, annual leave, or sick leave, are a function of salary. Cafeteria plans multiply the variation in value of these income-dependent benefits, increasing the differential in favor of high income employees even further because, again because of the variability in the value of the tax exemption.

Cafeteria Plans Would Not Solve the Problem of Uninsured Federal Employees

Estimates vary on the number of federal employees who are eligible to participate in FEHBP but who remain uninsured because they cannot afford the premiums. The Office of Personnel Management (OPM), which is understandably loathe to release information that is so damning to the program they administer, does hire a contractor every decade or so to survey federal employees about their decisions regarding FEHBP. The most recent survey does not attempt to gauge the number of uninsured federal employees, but it is possible to extrapolate from the most current survey data to estimate that the number ranges between 200,000 and 250,000.

Although cafeteria plans may at first seem like a vehicle for facilitating health coverage for this group by "allowing" them to trade off the cash value of benefits now provided by the government with no out-of-pocket expense to them in favor of other benefits that do require cost-sharing and out-of-pocket expense for the employee, serious potential problems do exist. First, employees may not have the skills or expertise to design a benefit package that is most advantageous for them from among the options presented. If forced to choose, how does a young family rank its simultaneous need for child care, health care, paid time away from work and disability insurance? Which is expendable? Which can be foregone?

The employer's only motivation for establishing cafeteria plans is to save money on employee benefits. Because cafeteria plans carry their own additional administrative costs, just to keep employee benefit costs constant requires benefit cuts. Since the reason most commonly cited by uninsured federal employees who are eligible for FEHBP participation is lack of affordability, lowering the government's subsidy and raising the employee's financial responsibility is hardly

a way to achieve universal coverage.

In addition to the segment of the federal workforce who remain uninsured is a substantial number who do not participate in FEHBP because they receive health insurance coverage from another source (e.g. as a part of military retirement, or from a spouse). This group would expect from a cafeteria plan the opportunity to utilize the government's health insurance voucher contribution for some other benefit. Since the government currently pays nothing at all for this group, this new expense would have to be considered in this context. Again, if in establishing cafeteria plans the government intends to hold its benefits costs constant, extending new benefits to this group would entail further reductions for those who currently participate in FEHBP.

The Relationship Between Cafeteria Plans and Flexible Spending Accounts

Cafeteria plans and Flexible Spending Accounts have some features in common which also must be considered financial disadvantages for employees. Structurally, a cafeteria plan involves establishment of individual accounts – like Flexible Spending Accounts -- for employees that allow them to select among cash and one or more qualified tax-exempt benefits. (The employer deposits into the account a subsidy sufficient to allow the employee to purchase some combination of benefits, and the employee is simultaneously permitted to deposit pre-tax salary into the account to supplement the employer's subsidy for these qualified benefits). While Flexible Spending Accounts can exist outside the context of a cafeteria plan, a cafeteria plan requires the establishment of Flexible Spending Accounts.

The combination of cafeteria plans and Flexible Spending Accounts holds numerous potential disadvantages for employees. Flexible Spending Accounts involve having employees voluntarily reduce their gross pay by a specific amount – an amount sufficient to pay the difference between what the employer pays for benefits and the cost of the benefit. The employee must choose the amount of salary reduction for each type of benefit at the start of the plan year. For the most part, the IRS does not allow changes in the amount of this reduction during the plan year except in cases where there is a change in family status (a marriage, birth, or death).

If an employee miscalculates and reduces his or her income by too much, the money remaining in a Flexible Spending Account/Cafeteria account goes to the employer. This is known as the "use it or lose it" rule. The employer can use this money in any way except returning it to the individual account holder. It can be kept by the employer or distributed among all plan participants in a manner chosen by the employer.

The financial disadvantages to employees of combined Flexible Spending Accounts and Cafeteria plans also come from the fact that employee contributions to Flexible Spending Accounts are salary reductions. Thus, benefits which are based upon salary are automatically lowered. Pensions, which are a function of salary, will be lower for employees who lower their salaries through Flexible Spending Accounts used to supplement Cafeteria plan contributions by the employer. Life insurance and disability insurance will be similarly affected, unless the government specifically decides to rewrite the terms of its policies for federal employees. Social Security benefits – and taxes -- will be lower for employees who lower their salaries in a combined Flexible Spending Account/Cafeteria plan. The government could, of course, compensate federal employees for the pension, insurance, and Social Security losses they would suffer as a result of participating in Cafeteria plans and Flexible Spending Accounts, but

that would deprive the government of its primary motivation to establish these plans – saving money.

Conclusion

AFGE opposes the establishment of Cafeteria Plans because they are disadvantageous for federal employees. They would transform what is now essentially a package of defined benefits into a defined contribution which places enormous financial risk onto employees. Cafeteria plans would not resolve the shameful failure of FEHBP that leaves more than 200,000 federal employees uninsured. Cafeteria plans are inequitable, effectively giving larger subsidies to higher income federal employees and smaller subsidies to lower income employees. Cafeteria plans, when combined with Flexible Spending Accounts, encourage employees to voluntarily lower their salaries in order to make their own financial contributions for various benefits more affordable, only to receive lower pensions, Social Security benefits, and insurance coverage as a result.

Finally, if designed either to save money for the government or in a way that hold the government's costs constant, cafeteria plans will entail a reduction in the economic value of the compensation package provided to federal employees. The administrative costs of Cafeteria and Flexible Spending Accounts, combined with the fact that expenses will be incurred for those who receive health insurance from a source other than FEHBP, would translate into a reduction from the amount the government currently provides for qualified benefits. For these reasons, AFGE strongly opposes the establishment of Cafeteria Plans.

Mr. WELDON. Thank you very much, Mr. Thomas.

Before recognizing Ms. Schneider, the Chair will announce that it is his intent to hear the testimony of Ms. Schneider, and then recess for the votes on the floor. There is a series of three or four votes, then we will reconvene for questioning of the panel after the votes are completed. Ms. Schneider, you are recognized for 5 minutes.

Ms. SCHNEIDER. Thank you for the opportunity to testify on cafeteria benefit plans.

Flexible benefit plans allow organizations to offer their work force a choice between non-taxable benefits, such as health benefits or disability coverage, and taxable benefits, such as additional cash in their pay. Typical reasons for implementing a flexible benefit plan include meeting the needs of a diverse work force, giving employees more decision power and a higher return on their benefit dollars, providing both employees and employers with tax advantages, raising employees' awareness of the cost and value of benefits, assisting employers in attracting and retaining quality employees, and allowing the employer to better predict their benefit costs.

There are three primary types of flex plans. The first is a premium conversion plan, which the Federal Government has already implemented. The second type of plan is flexible spending accounts, which let employees set aside money on a pre-tax basis in either health care or dependent day care account, to reimburse themselves for eligible expenses.

The third type of plan is a full flexible benefit plan. The most utilized types of full flex plans are structured in one of two ways. The first is a credit plan in which the employer provides a set of core benefits for all employees and then a set of optional benefits from which the employee may select to purchase either flex credit or salary reduction. Unused credits can be taken as cash.

The second type of plan is a trade plan that includes a standard set of benefits and allows the employee to either trade up or down. Trading down for less expensive benefits results in additional dollars that the employee can use to purchase more generous benefits, or take as cash.

Overall, 84 percent of employers surveyed in the Hay 2001 Benefits report offer premium conversation plans, 78 percent offer health care FSAs and 83 percent offer dependent day care FSAs. Twenty-two percent offer full flex plans, with 61 percent of these offering credit plans.

The typical design and implementation process includes first, defining the plan objectives. These typically include financial, employer relations, administration and employee communications objectives. Second, identifying challenges to implementing a new program, for example, systems constraints. Third, gathering information on existing plans, competitive employer plans and employee and management opinions regarding the benefit.

Fourth, based on the information gathered in the program objectives, developing a set of guiding principles for the plan design, which might include things like the existing HMO and PPO medical plans will be offered, there will be a choice of dental plans; flexible spending accounts will be included. The next step is to design the plan based on the guiding principles. The design includes

the types of coverage, level of choice that will be offered, employee contribution strategy and use of credits, and if credits are used, the credit structure and formula, whether employees will have complete freedom to choose the options they want or will be required to select benefits in certain categories, consequences of not enrolling and whether the plan design changes will be phased in over time.

Once the plan is designed, final steps include selecting vendors or developing internal capabilities for enrollment, administration and new plan options, modifying payroll and human resource systems for the new plan, developing administrative procedures and guidelines, developing and distributing employee communications, and administering the enrollment.

With the proper investment of time, resources and money, a well designed flex plan can be effectively used to meet the needs of a diverse work force, attract and retain highly qualified employees, and maximize the value of benefits to employees. The three critical components of flex plans are plan design, administration and communication. For a plan to be successful, it is essential that all of these components are carefully implemented.

Over the last 20 years, employers have faced many challenges with the design and implementation of flex plans. With the advancement of technology, the administration and communication have become more cost efficient and effective than ever before. Today there are many established best practices for employers to draw from as they consider these plans.

The unique organizational structure, complexity and sheer size of the Federal work force will create challenges that will have to be addressed as you proceed with your consideration of flexible benefits.

Thank you.

[The prepared statement of Ms. Schneider follows:]

Cafeteria Benefit Plans: More Value for Federal Employees?

Statement of

Leslie Schneider, Senior Consultant, The Hay Group

for the

Subcommittee on Civil Service, Census, and Agency Organization

of the Committee on Government Reform

Congress of the United States

May 21, 2002

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Introduction

Thank you for the opportunity to address the Subcommittee on Civil Service, Census, and Agency Organization of the Committee on Government Reform on "Cafeteria Benefit Plans: More Value for Federal Employees?" I am a Senior Consultant with the Hay Group, a global human resources consulting firm and the lead consultant for the FDIC flexible benefit plan. My background includes 18 years of consulting on all aspects of flexible benefit plans with both public and private sector employers such as Miami-Dade County and Georgia-Pacific Corporation.

I will focus on considerations in the design of a flexible benefit plan with particular emphasis on how private sector experience might be adapted to best meet the needs of Federal employees.

The primary points I will cover are:

- An overview of flexible benefit plans, including typical reasons for implementing a flex plan.

- Types of flexible benefit plans, highlighting the employer challenges and corresponding private sector utilization of each.
- Other common features of Section 125 plans.
- The typical design and implementation process.

The survey information in my testimony on private sector health plans is drawn from the 2001 Hay Benefits Report. The Hay Benefits Report is based on an annual survey of the benefits design of over 1,000 medium to large private sector employers in the United States. The survey results are often used by the Congressional Research Service and our other clients to determine the prevalence, cost and relative value of benefits plans.

An Overview of Flexible Benefit Plans

Flexible benefit plans, commonly called "flex" plans, were enabled by the Revenue Act of 1978, which added Section 125 to the Internal Revenue Code (IRC). Section 125 addressed the issue of constructive receipt in benefit plans and established that employees could not be taxed solely because they have a choice between cash and benefits. Flexible benefit plans allow organizations to offer their workforce a choice between non-taxable benefits, such as health benefits or disability coverage, and taxable benefits, such as additional cash in their pay.

Typical reasons for implementing a flexible benefit plan include:

1. **Meeting the needs of a diverse workforce** – Before flex, employers offered a one-size-fits-all package of benefits to all employees regardless of their needs. As workforce diversity continues to increase, fixed benefit programs cannot respond to the differing needs of a diverse employee population. By offering more choice, flexible benefit plans allow employers to meet the range of needs of an increasingly diverse workforce including the changing needs that individuals experience as they progress through their working lifetime.
2. **Giving employees more decision power and a higher return on their benefit dollars** – With flexible benefit plans, employees are able to select options that most closely match their individual needs rather than be forced into coverages they do not want or need. Decision making power helps employees become better benefits consumers and enables them to get a higher return on their benefits investment by customizing a benefits package that fits their changing needs.
3. **Providing both employees and employers with tax advantages** – Flexible benefit plans provide tax advantages to both the employee and employer. Pre-tax health care and dependent day care flexible spending accounts, and payment of employee premiums with pre-tax dollars reduce employees' taxable incomes. This also reduces Social Security, Federal and State income taxes for employees and Social Security and unemployment compensation taxes for employers.
4. **Raising employees' awareness of the cost and value of benefits** – When communicating flexible benefit plans, many employers specifically state the actual cost of each benefit coverage as well as the total cost of the benefit package in comparison to the employee's total compensation. Disclosing cost and value information increases the employee's awareness of the benefits offered as well as the significant percentage of total compensation that benefits represent.
5. **Assisting employers in attracting and retaining quality employees** – In the 2001 Hay Benefits Report, **87%** of employers surveyed offered some form of flex. Once an employee has experienced the choice, flexibility and tax savings of a flex plan, their expectations to continue participating in a flex plan are raised when they go job hunting. Not offering such a plan can be a negative to employees considering employment with a given organization.
6. **Allowing the employer to better predict their benefit costs** – Financial goals are a key component of the design of a flex plan. Depending on the objectives of the employer, plans are

designed to reduce cost, be cost-neutral or to increase costs for competitive reasons. Regardless of the financial goals, flexible benefit plans provide a mechanism through which employers can better predict their costs by allocating employer benefit dollars according to specific formulas built into the design of the program.

Types of Flexible Benefit Plans

There are three primary types of flexible benefit plans:

1. **Premium Conversion Plans** – the most basic Section 125 plans - allow employees to convert post-tax contributions to pre-tax contributions through salary reductions for payment of employee premiums.
2. **Flexible Spending Accounts** – the next level of flexible benefit plans - allow employees to set aside income on a pre-tax basis through salary reduction to pay for certain health care and dependent day care expenses.
3. **Full Flexible Benefit Plans** – the top end of flex plans - offer employees the widest range of choice and flexibility with a menu of benefits from which to choose.

The following provides more detail on each type of plan:

Premium Conversion Plans allow employees to convert post-tax contributions to pre-tax contributions through salary reductions for payment of qualified employee premiums. Premium conversion plans are advantageous to both employees and employers. Employees are able to reduce the amount of income subject to income and Social Security taxes. Employers also avoid Social Security and unemployment compensation payroll taxes on the premium contribution amounts.

Employer Challenges: This type of flex plan requires some increased administration due to enrollment requirements, compliance, payroll and tax changes. Although the employer must use resources to communicate how the plan and tax savings work to employees, this basic type of flex plan is the easiest to communicate to employees.

Private Sector Utilization: In the 2001 Hay Benefits Report, **84%** of employers surveyed offered premium conversion.

Flexible Spending Accounts, commonly called "FSAs" or "spending accounts," let employees set aside money on a pre-tax basis in either a health care or dependent day care account to reimburse themselves for eligible expenses. The two types of accounts must be kept separate. Money cannot be transferred between spending accounts - from the health care account to the dependent day care account, or vice versa.

For health care FSAs, typical eligible expenses include out-of-pocket medical, dental, or vision care expenses that are allowable tax deductible expenses under IRC Section 213. Examples of allowable expenses include medical and dental plan deductibles and copayments, glasses and contact lenses, weight loss programs and medically necessary care not covered by medical, dental, or vision plans.

For dependent day care FSAs, typical expenses include the cost of dependent day care needed for a child

under age 13 or a dependent who is physically or mentally incapable of caring for himself. The child or dependent must be living with the employee, so that the employee and spouse can work full-time or an employee can work full-time when the spouse is a full-time student or disabled. There are detailed caregiver eligibility requirements that must be met in order for the expense to be reimbursed.

There are six similarities between health care and dependent day care accounts:

1. Participation is totally voluntary. An employee decides whether or not to use the spending accounts before the start of each plan year - based on estimated expenses for the coming year.
2. The employee decides how much to set aside in each spending account. Again, this decision must be made before the start of the plan year and must be within the set minimum and maximum contributions. The money that is set aside will be available to reimburse the employee for eligible expenses incurred during that plan year.
3. The tax advantages of using the spending accounts are the same as those for pre-tax contributions. The employees don't pay Federal income or Social Security taxes on the pre-tax contributions withheld from their paychecks, and they are reimbursed for eligible expenses with tax-free dollars.
4. Typically FSA contributions are deducted from the employee's pay check throughout the year.
5. Employees are reimbursed upon proof of a paid expense. When employees have eligible expenses during the plan year, they pay the bill, then file a claim and proof of the expense with the spending account claim administrator who in turn reimburses the employees for the expense, provided the expense meets all eligibility requirements.
6. Employees generally have a set amount of time after the plan year ends to file claims for the previous year. Any money left in accounts at the end of the plan year's claim filing period is forfeited by the employee, according to IRS rules. This is known as the **"use-it-or-lose-it provision."**

One of the areas of difference between health care and dependent day care FSAs is the issue of **statutory limits**. For health care FSAs there **are no statutory dollar limits** on the amount an employee can contribute. However, amounts not claimed for medical expenses incurred during the plan year are forfeited.

For dependent day care FSAs **there is a statutory limit** on the amount an employee can contribute. The maximum is the *lowest* of the following:

1. The employee's earned income for the plan year,
2. The spouse's earned income for the plan year (if disabled or a full-time student, income is deemed to be $2,400 if the family has one dependent qualifying for dependent care and $4,800 if the family has 2 or more qualifying dependents), or
3. $5,000 (or $2,500 for married employees who file separate tax returns).

A second difference between health care and dependent day care accounts is the uniform reimbursement requirement. The **uniform reimbursement requirement applies to health care accounts**. This means that even though an employee agrees to contribute a certain amount to a health care FSA through salary reduction each pay period, the full year's elected reimbursement amount must be available at any time during the year. Thus, the employee can submit claims at a faster rate than contributions are being collected. If an employee who terminates service during the plan year has incurred more in health care expenses that are eligible for reimbursement from the FSA than they have contributed as of the termination date, the employer must absorb the loss (although any such losses would probably be more than offset by end-of-year forfeitures by FSA participants who did not use the full amounts they contributed.)

The uniform reimbursement requirement does not apply to dependent day care accounts. This means that, unlike health care FSAs, employees cannot claim reimbursement from dependent day care FSAs at a faster rate than they are making contributions.

Employer Challenges: This type of flex plan requires more administration and communication than the basic premium conversion plan. However, in the area of FSA administration, sophisticated systems have been developed to ease the payroll deduction and tax process on the front end, as well as the reimbursement process on the back end.

Likewise in the area of communications, the IRS provides supporting publications such as lists of eligible expenses for both types of accounts. In addition, over time employers have developed a range of best practice communication tools to help employers communicate FSAs to employees.

Private Sector Utilization: The 2001 Hay Benefits Report found that **78%** of employers surveyed offer Health Care Flexible Spending Accounts and **83%** offer Dependent Day Care Flexible Spending Accounts.

However, not all employees participate in FSAs when they are offered. For example**, 26%** of employers offering health care FSAs have an employee participation rate between **11 and 20 percent**. **Sixty-five percent** of employers offering dependent day care FSAs have an employee participation rate in these accounts **of 5% or less**.

Low participation in dependent day care FSAs is typically due to one or more of the following factors:

- The requirement to furnish the care provider's Tax ID or Social Security number,
- The age limit (under age 13) on children for whom qualifying expenses can be claimed,
- Avoidance of the "use-it-or-lose-it" provision,
- Advantages of the dependent care tax credit over the dependent day care FSA for lower income participants,
- Potential cash flow problems when the FSA is first opened when a participant would be making both the contributions to the FSA and paying child care expenses, and
- Not understanding the plan.

Typically, avoidance of the "use-it-or-lose-it" provision and failure to understand the plan contribute to low health care FSA participation.

Full Flexible Benefit Plans are commonly called "cafeteria" plans because they offer employees a menu of benefits from which to choose. Full flex plans are typically structured in one of three ways:

1. **A credit plan** in which the employer provides a set of core benefits for all employees and then a set of optional benefits from which the employee may select to purchase using "flex credits" or salary reduction. Unused credits can be taken as cash. The number of flex credits allocated to employees can be determined in a variety of ways. The employer can give a flat amount that is the same for every employee. If this approach is taken, the flat amount can be indexed to increase each year with the cost of living or other indices. Alternatively, the employer can allocate enough credits to each employee to cover a certain level of coverage. For example, the employer might allocate enough credits to cover 75% of the elected family coverage level (single or family) for a given medical and dental plan, 100% of life insurance equal to one times pay, and 100% of a basic disability coverage. Employees who choose higher levels of medical, dental, life or disability coverage will need to use additional salary reduction dollars to pay for their coverage. Employees

who choose lower levels of coverage can take their leftover credits in the form of taxable cash.

2. **A trade plan** that includes a standard set of benefits and allows the employee to either trade up or down. Trading down to less generous and less expensive benefits results in additional dollars that the employee can use to trade up to more generous benefits or take as cash.
3. **A modular plan** which offers two or more prepackaged plans from which the employee can select. No trades are permitted.

Full flex plans normally include benefits from one or more of three categories including health care, life insurance, and disability.

- Choices in health care plans involve determining optional deductible and coinsurance amounts, inclusion of services such as dental, vision or hearing, and managed care options such as Health Maintenance Organizations (HMOs), Point of Service (POS) plans or Preferred Provider Organizations (PPOs).
- With life insurance coverage, the employer must determine the minimal level of basic group coverage for employees, and what optional coverages will be available for employees and their dependents.
- Design issues for disability coverage include income replacement levels (including any minimum or maximum amounts), duration of coverage, and exclusion or waiting periods before benefits begin.

In addition, some flex plans include paid time off. In these plans, employees may sell back time off days or purchase additional time off days to supplement their core accrual schedule.

Benefits included in flex plans can be either taxable benefits or tax-exempt benefits. The following tax-exempt benefits are typically included:

- Health coverage (medical, dental, vision, prescription drug),
- Health and dependent day care FSAs,
- Employee life insurance up to $50,000,
- Accidental death and dismemberment benefits,
- Pre-tax disability,
- Paid time off, and
- Adoption expenses.

Taxable benefits that are typically included are:

- Cash,
- Employee life insurance greater than $50,000,
- Dependent life insurance, and
- After-tax disability.

Some employers will also include things like long term care, group and homeowners insurance as taxable benefit options.

When a flex plan includes taxable and non-taxable benefits, employees can elect cash or use after-tax contributions to purchase the taxable benefits. Thus, the flex plan can be designed, administered, and communicated as a comprehensive plan including both taxable and non-taxable benefits.

Employer Challenges: Due to their complex nature, full flexible benefit plans, compared to premium

conversion plans and FSAs, present more administration and communication challenges to employers. The addition of credits further raises the complexity. Some employers choose to offer trade plans because they can meet most of their plan objectives without the additional complexity of the credits.

Private Sector Utilization: In the 2001 Hay Benefits Report, **22%** of employers surveyed offered full flexible benefit plans, and **61%** of those employers offered a credit plan. It should also be noted that the prevalence of full flexible benefit plans increases with the size of the organization. Of those employers with 10,000 or more employees, **28%** offered a full flexible benefit plan.

Other Features of Section 125 Plans

Regardless of the level of flex that an employer offers, there are specific plan design features that are dictated or influenced by Section 125 and other sections of the IRS code.

Benefits Choices Remain in Place for a Year

Under Section 125 rules, employees select their benefits when they are first eligible and may only make benefit changes once a year during the annual open enrollment period for the coming plan year. Choices remain in effect for an entire plan year, unless the person has a qualifying status change, as described next.

1. ***Qualifying Status Changes***

   Under Section 125, employees may only make benefit changes during the year if they have a qualifying change in status and the new election is consistent with the status change. This allows a safety net of sorts so that employees can change their benefits accordingly in the event of a change in their status after their benefit elections are in place for the year. Status changes include things like getting married or divorced, adding a newly eligible family member, losing an eligible family member, or having a change in spouse's coverage or job situation. These and other qualifying status changes can be found in Treasury Regulation Section 1.125-4.

   Generally, benefit changes must be made within a time period specified by the employer - usually 30 or 60 days from the date of the qualifying status change, and coverage changes are prospective.

3. ***Nondiscrimination Testing***

   To preclude abuses such as special privileges to "key" employees, Congress passed non-discrimination testing requirements. Discrimination testing ensures all employees have equal access to the flexible benefits program.

4. ***Other Compliance***

   Flexible benefit plans must comply with statutory requirements for plan documents. Component plans that are subject to the Employee Retirement Income Security Act of 1974 (ERISA), for example medical plans, must comply with ERISA requirements for summary plan descriptions and annual reporting on Form 5500.

Design and Implementation Process

The typical design and implementation process that employers follow includes:

1. Defining the plan objectives – these typically include financial, employee relations, administration and employee communications objectives. An example of plan objectives could be that the program will be cost neutral, easy to use, responsive to workforce needs including family status and life stages and will be openly communicated.
2. Identifying challenges to implementing a new program, for example systems constraints.
3. Gathering information on existing plans, competitive employer plans and employee and management opinions regarding the benefits. The employee opinion research typically includes which benefits the employee population values and how they might trade benefits.
4. Based on the information gathered and the program objectives, developing a set of guiding principles for the plan design which might include things like the existing HMO and PPO medical plans will be offered, there will be a choice of dental plans, flexible spending accounts will be included, etc. Also, the guiding principles should include whether or not the plan will be uniform across all parts of the organization or if there will be variations allowed. If variations are allowed, guidelines regarding the types of variations, for example, in number of options offered or in credit level, will need to be developed. Nondiscrimination rules will need to be considered when determining the level of variation that will be allowed.
5. Designing the plan based on the guiding principles – the design includes:

- The types of coverages (medical, dental, disability, FSAs) that will be included in the plan.
- The level of choice that will be offered - how many medical, dental and life insurance and disability options employees will be able to choose. Employee satisfaction, administrative requirements and adverse selection considerations all play a part in this decision. (Adverse selection is the tendency of people with the greatest need for coverage to choose the plan with the highest coverage level).
- The employee contribution strategy and the use of credits. The flex plan's use of credits represents the most fundamental difference in the way an organization delivers benefits because:

    - providing credits to spend gives employees discretion over dollars the employer previously allocated for them.
    - "buying" benefits tends to encourage employees to take a more active role in selecting and using their benefits.
    - using credits with the option to buy or convert to cash gives employees more control and strengthens the link to total compensation.

    If credits are used, the credit structure and formula will be included in the design.

- Whether employees will have complete freedom to choose just the options they want, or will be required to select benefits in certain categories - for example, a life insurance option, a medical plan unless they have coverage elsewhere, etc.

- The consequences of not enrolling - a core set of benefits or no coverage at all.

1. Selecting vendors or developing internal capabilities for enrollment administration and new plan

options (such as flexible spending accounts).
2. Modifying payroll and human resource systems as necessary for the new plan.
3. Developing administrative procedures and guidelines.
4. Developing and distributing employee communications materials.
5. Administering the open enrollment.

It is important to note that often plan design changes are phased in over time. An employer might introduce premium conversion and Flexible Spending Accounts in the first year and follow with credits in the second or third year. This spreads out the costs associated with increased administration and communication, and eases the employee education process.

Concluding Remarks

With the proper investment of time, resources and money, a well-designed flex plan can be effectively used to meet the needs of a diverse workforce, attract and retain highly qualified employees and maximize the value of benefits to employees. The three critical components to a successful flex plan are plan design, administration and communication. For a plan to be successful, it is essential that all of these components are carefully implemented.

My testimony has summarized the prevalent private sector approach to flexible benefits. Over the last twenty years, employers have faced and overcome many challenges with the design and implementation of flex plans. With the advancement of technology, flexible benefits administration and communication have become far more cost efficient and effective than ever before. Today there are many established best practices for employers to draw from as they consider flexible benefit plans.

There are significant differences between the private and public sector. The unique organizational structure, complexity and sheer size of the federal workforce will create challenges that will have to be addressed in the plan design and implementation process if you proceed with your consideration of flexible benefits.

Mr. WELDON. I thank the gentlelady. The committee now stands in recess for 4 votes, for 30 minutes.

[Recess.]

Mr. WELDON. The hearing will now resume. I want to thank all the witnesses for waiting. Sorry for the extended delay. We had a series of five recorded votes on the Floor of the House.

The Chair now recognizes himself for 5 minutes of questioning. Let me begin with perhaps several of you, Mr. Wilson, Ms. Schneider in particular can respond to this. Ms. Young testified that the State of Georgia has found cafeteria plans a necessity when trying to attract employees. I found that extremely interesting. In your experiences, Mr. Wilson and Ms. Schneider, have cafeteria plans actually made employers more attractive in the labor marketplace, would you say?

Ms. SCHNEIDER. I think for most employees, if they've experienced a flexible benefit plan somewhere else that they have worked, when they're looking for employment, it is something that they look for because of the choice and because of the tax advantages that are involved. I don't have specific statistics that talk about or address the attraction and retention issue, but certainly know that in talking to employees and focus groups, that kind of thing, employees enjoy the plan and there are certain aspects that they miss greatly if they don't have the opportunity to participate in them in the future.

Mr. WILSON. Our experience clearly indicates that employees value choice to the point that they value it economically. There's no question that for our clients that they report back to us significant value appreciation, both in terms of surveys that we help them conduct, but realities in the hallway, that geez, this is great, why didn't we do this before?

Clearly from the perspective of an employee who has had a prior experience, and that employer does not have a flexible benefit plan, it is highly unlikely they will go to work for that employer that has a standard, traditional plan.

Mr. WELDON. So it's an impediment for employers that do not offer it to attract employees who have been previously working at a place where they had a flexible benefit?

Mr. WILSON. I think that's true.

Mr. WELDON. Was that one of the drivers, Ms. Young, that drove the State of Georgia to adopt cafeteria plans, just the ability to attract employees?

Ms. YOUNG. Yes, it was the ability to attract employees and our employees' awareness of things that were happening in the private sector. One of the things that we've been struggling with, and I know that's true not only with the State, but probably in private sector, at the local level and at the Federal level, we're struggling with retaining our work force and attracting the work force, especially our young people.

As we surveyed, we had some consultants come in and review our benefits program. They compared us to Fortune 500 companies, as well as employers across the State of Georgia. They strongly compliment our plan and have made recommendations even for future improvements. But it was through consultants' evaluation of the original plans that the original cafeteria plan was set up. Be-

cause employees were asking, frankly, they asked for a whole lot more than what we're doing, they're still asking, because we survey them.

So it's based on what the employees asked for that we're doing.

Mr. WELDON. So the driving force is to meet the needs and requirements of the employees in the competitive marketplace?

Ms. YOUNG. Yes.

Mr. WELDON. It was not a desire to save money on the part of the State legislature?

Ms. YOUNG. No.

Mr. WELDON. Mr. Thomas in his testimony raised an important point about health care benefits gobbling up other benefits with health care inflation being what it is. How do these flexible benefit plans deal with that typically? I guess in some of them the health benefit is outside the flexible benefit?

Ms. YOUNG. Yes.

Mr. WELDON. Is that how you handle it in Georgia?

Ms. YOUNG. Yes, as a matter of fact, we have two separate agencies managing the program. There's a Department of Community Health that administers the health benefits, and my agency administers the flexible benefits. The health benefits have no negative impact at all on the benefits to the employees, because employees basically choose their benefits, choose what they want and pay for what they want. It has no impact on the health plan.

Mr. WELDON. Are there examples in the private sector where there have been plans where the health benefit and the other benefits are all together and have been problems with health care inflation?

Ms. SCHNEIDER. Typically, when the health care benefits are included in the plan, the credit formula is designed to cover a certain percentage of those health care benefits. So it actually can be designed so that the employee contribution percentage, as you relate back to the health care, is no different than if it were an outside flexible benefit plan, except that it's pre-tax and they have the ability to trade.

So you might say in your credit formula that, as an employer, we're going to make sure that there are enough credits to cover 80 percent of the health care costs, would be an example in perhaps 80 percent.

Mr. WELDON. So by locking in that percentage, you have the protection on health care inflation issues?

Ms. SCHNEIDER. Yes. It's a design issue.

Mr. WILSON. Mr. Chairman, this is a point of education, I think. In my opening remarks, I tried to convey that a flexible benefit plan is a delivery system compared to a car. You can get into a car and use it for transportation, to go to work and pick up your family and use it productively. Or you can get in the car and smash it into a wall.

The concept of a flexible benefit plan intelligently managed is to provide productive choice to the employee population that they are going to value within the total reward system. Making decisions not to duplicate benefits unnecessarily, but to purchase the benefits that are of greatest value to them.

I think the point I would want to make here is that in the management of health care costs, there is no question that by creating more value within the flexible benefit plan, employees have made decisions not to necessarily buy the most expensive health care plans. They've decided to buy a plan that maybe is a little less expensive because they want more dental coverage. They find that the health care reimbursement count would be more important to fund because their child has orthodontia expenses in that year, and the dental plan doesn't cover that full cost.

So the point that I would want to try to relate to you here is that almost all of these are design issues. Not the car, whether the car is red or blue or what the interior is, can simply be addressed by design issues, the question about health care costs, actuarially going up because some employees don't take the health benefit plan. You design around those issues. That does not occur in the marketplace. We know what that is. We know how to actuarially expect what will happen given the design of the plan.

Ms. YOUNG. And Mr. Chairman, may I add that we began the cafeteria plan in 1986. It's only been in the last 3 years that the plan has been separate from the health plan. The same agency, the Georgia Merit System, administered both of them together until 3 years ago, when the State health plan was pulled out in order to create another department with a focus on community health.

Mr. WELDON. OK, so it was not separated because of the issues that Mr. Thomas brought up?

Ms. YOUNG. No. That had nothing to do with it.

Mr. WELDON. It was an unrelated issue?

Ms. YOUNG. Yes.

Mr. WELDON. OK. Ms. Schneider, as a Floridian, I was particularly interested in your experience in helping set up the Miami-Dade County program. Could you describe to me whether that covers only non-union employees or both, and a little bit about your experience there?

Ms. SCHNEIDER. Miami-Dade County of course has to deal with several unions. The unions, some union employees have a choice of whether or not to go into the flexible benefit plans and utilize the union health benefits or the county benefits. The plan itself is set up so that there is a flat credit amount that's given. Employees get additional credit, so they select lower level medical plans, and then they choose, with their credits, to purchase medical, dental actually is provided as a benefit plan that they don't need credits to purchase.

But vision, life insurance, above one times pay, and then outside the plan, and flexible spending accounts they have, and then outside the plan they have a group legal plan that's part of the total package.

Mr. WELDON. So it covers all employees, union and non-union?

Ms. SCHNEIDER. I'm not sure if all union employees are a part of it. I know that there are some union employees who have a choice of whether or not they want to be part of the plan.

Mr. WELDON. Was there opposition from the unions when the plan was initially set up?

Ms. SCHNEIDER. It has been part of the labor negotiations on a continuing basis. And the parties worked together to come up with

a plan that's suitable for all parties. It's been in existence for quite a while, though.

Mr. WELDON. OK. Mr. Thomas, you argue that when employees reduce their taxable salary by using flexible spending accounts they will also reduce the amount of their pensions, life insurance and disability insurance, which are all based on the employee's salary.

Since this was contrary, and this may have been in your written statement that I originally reviewed and not in your verbal statement, since this was contrary to my understanding, I asked OPM, which advised me that it was not the case, according to OPM, like premium conversion, FSAs will not reduce the gross salary on which these benefits are based. I have a letter from OPM stating that. And I ask unanimous consent, without objection, to introduce that into the record.

I was wondering if you wanted to clarify your position on that issue.

Mr. THOMAS. Social Security benefits would go down. As you know, a number of Federal employees are now covered by the Social Security benefit program. Those benefits would be affected by the reduction in their income, as opposed to those Federal employees who are covered under the Civil Service Retirement Plan, which I believe is what OPM is referring to.

Mr. WELDON. But the statement that you had made in your written statement that contributions into pensions would go down, that is not my understanding of it, correct? That is not true?

Mr. THOMAS. Yes.

Mr. WELDON. OK. I don't have any other questions. And the ranking member has not returned yet from the voting, so I want to thank all the witnesses here in this first panel. I again want to apologize for keeping you all waiting. Your testimony has been very, very informative.

The Chair notes that some Members may have additional questions they may wish to submit in writing. So without objection, the hearing record will remain open for 2 weeks for Members to submit written questions to these witnesses and place their responses in the record.

The first panel is now excused. Again, thank you very much. The committee appreciates your time.

On our second panel, we have the Honorable Dennis Jacobs. Judge Jacobs sits on the U.S. Court of Appeals, Second Circuit, in New York City.

Judge Jacobs, as before, you are required to take the oath.

[Witness sworn.]

Mr. WELDON. Thank you. You may have a seat. Will the court reporter please note the witness has answered in the affirmative.

Judge Jacobs, you're the only witness in this panel and I seem to be the only one here, so I will be somewhat flexible on the 5-minute rule as it's right now only my time and your time that we're dealing with. But if you could, please summarize your written statement to the best of your ability. You are recognized now for an opening statement.

STATEMENT OF DENNIS JACOBS, CIRCUIT JUDGE, U.S. COURT OF APPEALS FOR THE SECOND CIRCUIT

Judge JACOBS. Thank you very much, Mr. Chairman.

I'm Dennis Jacobs, Circuit Judge of the Court of Appeals for the Second Circuit. I sit in New York. I appear today on behalf of the Judicial Conference of the United States, which is the policymaking body of the Federal Judiciary. I have this distinction because I chair the Conference Committee on Judicial Resources, which has jurisdiction over personnel matters.

It's a privilege to speak to the interests of 32,000 people, and I am acutely aware from what I've learned at the earlier panel that the matters that this subcommittee are considering will affect an enormous number of people in ways that are far-reaching, and that could reach forward into a generation and affect people's lives in very real and important ways.

I have been anxious and pleased to receive your invitation to testify, because we have implemented a cafeteria benefits plan. We've had excellent experience with it. And I thought that I would tell you briefly why we did it and what our experience has been with what it is we have done.

We implemented the plan in response to a need. In the 1990's, in the early to middle 1990's, there was something of a crisis because health care premiums were going up and benefits were going down. There was a tremendous anxiety existing among employees in the Federal Judiciary.

And in response to that, the director of the Administrative Office, L. Ralph Mecham, initiated recommendations that were adopted by the Judicial Conference to seek out the advice of one of the Nation's foremost advisors on benefits, the Towers Perrin Group. They issued a report in March 1998. I remember the report very well because I was, at the time, one of the newest members of the Committee on Judicial Resources. It was enough to stir genuine anxiety.

The Federal Judiciary, like I believe other branches of Government, was at a point where we could expect large numbers of baby boomers to be retiring, and we would have to replace them. And we wanted to replace them with people of comparable talent, skill and dedication. We knew that we had identifiable competitors for those services, not just in the private sector but also within State government and State courts.

The Towers Perrin report indicated that we were quite deficient and perhaps even flatly uncompetitive with the agencies and institutions that would be hiring the people that we needed.

We have spent the intervening years filling the gaps that the Towers Perrin study has identified. It occurred to me coming down here that it might be useful to file for the reference of the committee the executive summary of that, which I have read and which has been a very useful document, to outline the nature of those deficits and the recommendations.

Mr. WELDON. Without objection, we will take a copy of that and submit it into the record.

[The information referred to follows:]

Administrative Office of the
United States Courts

BENEFIT IMPROVEMENT INITIATIVE

Executive Summary

Final Report
Volume 1

March 1998

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Executive Summary

Background

The Administrative Office of the United States Courts (the AO) is charged with the administrative business of the United States Courts (except the Supreme Court) under the direction of the Judicial Conference of the United States. The Federal Employees Health Benefit Program (FEHBP) provides health coverage for approximately 30,000 judicial officers and judiciary employees who are located throughout the United States and its territories. In 1997, total benefits were provided at a cost to the Judiciary of approximately $335 million. The Office of Personnel Management (OPM) regulates the FEHBP on a government-wide basis, but within the Judiciary, the AO handles such matters as distribution of health benefits information and enrollment of members.

The Blue Cross Blue Shield Service Benefit Plan is one of the seven nationwide managed fee-for-service plans offered under the FEHBP. As described to us by the AO, Blue Cross and Blue Shield Service Benefit Plan enrollees were adversely affected by a little-noticed change to the plan which took effect on January 1, 1996. Under this change, enrollees were reimbursed based on local Medicare participating fee schedule amounts (rather than the former "usual, customary and reasonable" amounts) for charges by non-participating providers (health care providers who had not signed on to the Blue Cross and Blue Shield Service Benefit Plan's network). As a result of the change, the AO determined that some enrollees who expected the Blue Cross and Blue Shield Service Benefit Plan to pay up to 80% of their medical costs, found that their health insurer was paying only 10% of these costs.

As a result, many judicial officers and judiciary employees expressed to the Director of the Administrative Office concern about OPM's administration of the FEHBP, which is controlled by OPM with little agency involvement. In particular, these judicial officers and judiciary employees have stated that they receive insufficient information about health benefits and the options available to them during the annual "open season" (which lasts for a period of four weeks every year). In addition, there has been a general desire to evaluate the entire federal benefits package available to judicial officers and judiciary employees and compare it to packages offered in other private and public sector organizations.

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Executive Summary

Purpose of the Study

On August 1, 1996, the Judicial Conference's Judicial Resources Committee approved a proposal by the Director of the Administrative Office that funds be identified in the fiscal year 1997 financial plan to retain a benefits consultant to:

- Determine if judicial officers and judiciary employees have adequate access to quality health care benefits;
- Determine if the judicial officers and judiciary employees have sufficient information to make informed health care purchasing decisions;
- Determine the adequacy of the employee benefits package offered to judicial officers and judiciary employees, and in particular, identify gaps in coverage compared with "similarly situated groups";
- Provide OPM with information outlining the needs of the judicial officers and judiciary employees.

Towers Perrin's Role

The AO hired Towers Perrin on August 22, 1997, to assist them with their Benefits Improvement Initiative project. Towers Perrin staff members worked closely with AO staff during the course of this project. We requested various data items throughout the project, and AO staff provided the necessary information.

Various consultants and staff from Towers Perrin were utilized throughout this project. Consultants from our Health and Welfare, Retirement, Survey, and Communication practices were involved.

We met often with the AO staff, and the resulting end product of our work (the Report Card, the survey instrument, the recommendations for change, etc.) reflect and incorporate the AO's input. The recommendations reflect the AO's desire to improve the benefits, and the delivery of those benefits, to the Judiciary workforce.

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Executive Summary

Key Findings

1. Need a Benefits Philosophy

Most organizations develop a benefits philosophy and design programs based on that philosophy. It is our understanding that the Judiciary does not currently have a benefits philosophy because Judiciary management is not responsible for the design of the benefits program. If the Judiciary implements a supplemental benefits program, development of a benefits philosophy is recommended.

2. Benefit Gaps in Federal Program

Based on the benefits assessment which compared the federal benefits package to other "similarly situated groups" as defined by the AO, the benefit gaps are:

Federal Benefits Package

Below Average	Not Available
■ Dental ■ Vision ■ Long-term Disability ■ Prescription Drugs ■ Mental Health ■ Life Insurance	■ Flexible Spending Accounts ■ Pre-Tax Employee Contributions ■ Long-term Care

BENVAL® is the name of a software package used by Towers Perrin which develops a numerical assessment of the "value" of a benefit program, compared with selected comparator organizations. The AO selected 20 large and nationally-known organizations that represent a cross-section of mainstream U.S. industries (including 5 universities, 3 quasi-federal organizations, and 12 other large national employers) from Towers Perrin's database of organizations.

Based on the BENVAL® analysis, the federal program plans rating below average include medical (reflecting the Blue Cross Blue Shield Standard Option), dental, life insurance and disability insurance.

The **medical plan** rated below average primarily due to:

- Poorer than average mental health and substance abuse benefits
- Poorer than average prescription drug benefits
- Higher than average annual medical deductible

The **dental benefits** rated considerably below average because of the very limited coverage available in the Blue Cross Blue Shield standard option.

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Executive Summary

The life insurance benefits rated considerably below average because of the high employee contribution that is required for basic and optional coverage.

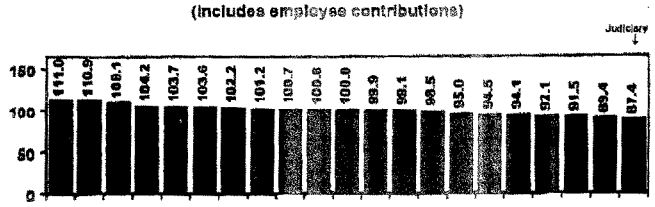
Technically, there are no short-term disability (STD) or long-term disability (LTD) plans in the federal benefit package. The federal sick leave plan is relatively generous, and could be adequate for most short-term disabilities. The Federal Employees Retirement System (FERS) retirement program contains a provision for a benefit similar to an LTD plan; however, the basic benefit is below average. The Article III judges retirement plan provides for 100% continuation of pay upon disability, with immediate eligibility if the judge has 10 or more years of Article III service. If the judge has fewer than 10 years of Article III service, the judge receives one-half the salary of the judicial office. The JRS provides for 100% continuation of pay upon disability, after 5 years of service.

The lack of availability of pre-tax options is a significant gap in the federal program, compared with other organizations in our analysis. The option to pay employee contributions for medical and life insurance with pre-tax money, as well as the availability of flexible spending accounts (health care and dependent care) is almost universal in the large employer private sector, and is also very common with state benefit packages.

The BENVAL[c] analysis showed that the federal benefit program (reflecting FERS as the retirement plan) rated considerably higher than the comparator organizations regarding retirement benefits (including retirement income, retiree medical and retiree life insurance). The federal retirement programs have an 18% greater value than the average of the comparators. The retirement programs rate higher then average largely due to two plan features: generous early retirement provisions (under FERS) and the automatic cost-of-living-adjustment (COLA). However, none of the comparator organizations required employee contributions for defined benefit retirement plans and all the comparator organizations allow employee contributions of over 10% of pay to their defined contribution plans.

The following is a sample BENVAL[c] graph comparing the value of the Judiciary's medical and dental programs with the comparator organizations (average = 100). Volume 5 of our report contains further analysis on the benefit programs.

Active Health Care
(includes employee contributions)



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Consolidated findings based on the employee benefits survey, judicial officers' interviews, and the similarly-situated groups analysis is presented below:

Medical

Medical benefits provided through the states vary considerably, but are generally competitive with the benefits provided by the FEHBP. The states do, however, offer the following features not included in the FEHBP: prescription drug cards and centers of excellence programs (i.e. transplants are performed at facilities designated as "centers of excellence" by the plan). Also, states generally charge employees a lower employee contribution for employee-only coverage than the FEHBP (an average of approximately 10% of the cost of employee-only coverage is charged to employees in the states, compared with about 25% under FEHBP).

Federal Deposit Insurance Corporation (FDIC) employees pay considerably less than Judiciary employees for the same FEHBP coverages because the FDIC has chosen to subsidize a portion of the cost using non-appropriated funds. The Federal Reserve Board (Federal Reserve) and the Office of the Comptroller of Currency (OCC) employees have the same health plan options and pay the same employee contribution rates as Judiciary employees.

Dental and Vision

The overwhelming majority of employees gave a low rating to their *dental* benefits. Approximately 2 out of 3 survey respondents were dissatisfied with the current dental coverage available, and felt that the dental coverage offered through FEHBP was poor or below average.

Standardized dental and vision programs are commonly offered by the states. FEHBP does not offer such optional benefits (limited dental coverage is provided under some medical options of FEHBP).

The FDIC, the Federal Reserve, and the OCC each offer stand-alone dental benefits and LTD benefits to employees. The FDIC and the OCC also offer a stand-alone vision benefit to employees.

Life Insurance

Forty-four (44) states provide at least a basic life insurance benefit at no cost to the employee. Under the Federal Employees Group Life Insurance (FEGLI) program, the cost of the basic insurance is shared by the employee and the government (as the employer). The employee share is two-thirds of the cost of basic insurance and is withheld from salary. The FDIC, the Federal Reserve and the OCC sponsor life insurance programs for their employees, in addition to the FEGLI plan. If the employee elects only the agency plan, the FDIC contributes the entire cost of the basic plan; the Federal Reserve and the OCC pay one-third of the cost.

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Disability

As with the federal benefit program, disability insurance is not commonly available through the states, although some states do offer disability coverage. Nineteen states reported that STD insurance is provided and twenty-two states indicated that LTD insurance is provided. Some states also indicated that disability insurance is available as an optional benefit at the employee's expense. Of the three agencies included in this study, the FDIC offers a stand-alone STD benefit.

Long-Term Care

A portion of the employee benefits survey dealt with possible new programs that would be of interest. The responses showed that 70% of judicial officers and 65% of judiciary employees rated long-term care insurance as being very important.

Eleven states offer long-term care (LTC) insurance to employees. One state does pay LTC premium for some of its employees; the other ten states offer LTC on an employee-pay-all basis.

Pre-Tax Payment and Flexible Spending Accounts

The availability of pre-tax payment of employee contributions and flexible spending accounts is prevalent among the states but is not an option for employees of the Judiciary. Forty-seven (47) states offered employees the tax-advantaged option of making health contributions on a pre-tax basis; Thirty-one (31) states allowed employees to direct part of their paycheck into a flexible spending account. The FDIC, Federal Reserve, and OCC also have pre-tax options and flexible spending accounts.

Retirement

State retirement plans have similar features to FERS: defined benefit plans requiring an employee contribution and provision for an automatic COLA; however, the state benefits are somewhat greater than FERS (generally 1.5%-2.0% of pay for each year of service), and generally cost more in employee contributions (5-6% of pay).

The FDIC and Federal Reserve have supplemented the federal retirement program with additional programs:

- The FDIC offers a second defined contribution savings plan into which employees can contribute (on a pre-tax basis) up to 10% of pay, and receive up to a 5% employer matching contribution. FDIC employees also participate in FERS, and are eligible to participate in the Thrift Savings Plan (TSP).

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- The Federal Reserve sponsors a stand-alone retirement program different from FERS.

Title 12 of the United States Code governs financial institutions, which include the FDIC, the Federal Reserve and the OCC. Title 12 provides special statutory authority for these organizations to establish and adjust schedules of compensation and benefits. Given the flexibility of the special provisions of Title 12, these financial institutions have made enhancements to the federal benefit package as shown below:

Comparison Between the Judiciary and 3 Other Agencies				
	Judiciary	FDIC	Fed. Reserve	OCC
Medical	✓	✓	✓	✓
Dental	✓*	✓	✓	✓
Vision		✓		✓
Life Insurance	✓	✓	✓	✓
AD&D	✓	✓	✓	✓
LTD	✓**	✓	✓	✓
STD		✓		
LTC			✓	
Reimbursement Accounts		✓	✓	✓
Personal Accident Ins.			✓	✓
Business Travel Accident		✓	✓	✓
Retirement	✓	✓	✓	✓

* limited coverage through some health plans
** some LTD coverage is offered through the FERS retirement plan

Retirement Plans Available to Judicial Officers

Shortfalls in Judicial Officer's Retirement Plans
■ Lack of vesting schedule in Article III judges plan ■ No early retirement provisions in Article III judges plan or the Judges Retirement System (JRS) ■ Judicial officers are required to pay for survivor pension benefits while they are active employees

The continuation of 100% of pay into retirement is a very generous program compared with almost any organization.

However, there are three missing features that are common provisions of most pension plans: (1) The Article III judges plan has no concept of vesting, and participants must be at least age 65 and satisfy the rule of 80 (age plus service is at

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least 60 years, e.g., age 70 and 10 years of service) to receive a benefit. In the private sector, a vesting schedule of not more than 7 years is a requirement for a qualified retirement plan. The JRS plan does allow for a deferred benefit to age 65 after the completion of 8 years of service; (2) Neither the Article III judges plan nor the JRS provides for early retirement; almost all private sector retirement plans allow for early retirement with a reduced benefit; and (3) Both the Article III judges plan and the JRS require a pre-retirement contribution for post-retirement survivor coverage. This is not a common feature of retirement plans.

3. Lack of Meaningful Choice

Employees expressed considerable doubt as to whether the FEHBP provides *meaningful choice* because there are too many options within the FEHBP. The key to any successful benefits program is having meaningful choice. But as the number of choices grows, the ability to carefully examine and weigh the alternatives becomes an increasingly complex and difficult task.

Data from the employee benefits survey suggest that the number of choices available to a federal employee has become staggering. One in five respondents feel he/she has too many options; a few expressed the need for more fee-for-service options and less HMOs; and, others expressed concern about the fact that each year the options change and there is no stability. Many respondents do not have a clear idea of how to seek the detailed information of most immediate relevance to them or, it arrives too late and they must make a decision without the necessary information. One in three respondents wrote in additional comments to emphasize the need for better information to help with their health care decisions. While data from this survey support the concept of choice and flexibility, it also shows the need for "tools" to help federal employees make good choices.

4. Poor Employee Communication

Employees believe the *written communication material* they receive explaining their benefits is difficult to understand and is not timely. Since employees receive benefits information from numerous sources, they want the AO to be the primary provider of clear, concise benefits communication. When it comes to getting information about benefits, fewer than half (43% overall) feel they know who to contact or where to go within the AO.

Written comments to the survey emphasized the need for better information "in plain English". In addition, respondents expressed a desire for an on-site advocate who is knowledgeable about current benefits. Communications must be improved to convey the true value of the existing benefit program. It appears that a major deficiency in the program lies in the lack of clear, easily understandable information.

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The AO needs to improve the delivery of its communication materials to the entire agency population. A key method of delivery is to train Benefits Coordinators adequately so that they will be able to perform their required duties to support the delivery and comprehension of benefits information.

5. Changing Workforce Demographics

The Judiciary is a different workforce today than it was five or fifteen years ago. The needs and preferences of the group could potentially be changing as well. Our demographic analysis shows that 15.7% of the Article III/Senior Judges, 11.5% of Magistrates & Bankruptcy Judges and 16.1% of judiciary employees will retire within the next 1-5 years.

The Administrative Office (AO) should make efforts to periodically assess the overall satisfaction of this changing population regarding the employee benefits provided, as well as other employment issues. This will allow the AO to remain closer to employee preferences. Ideally, the AO would have the flexibility to create a benefits program to meet their employees' needs.

Total Federal Civilian Employment (in thousands)

Year	1982	1984	1986	1988	1990	1994	1995	1996
Ees	2,824.8	2,934.3	3,022.2	3,112.8	3,128.3	2,971.8	2,920.3	2,847.0
% Change	—	3.9	3.0	3.0	0.5	-5.0	-1.7	-2.5

Judicial Branch Employment (in thousands)

Year	1982	1984	1986	1988	1990	1994	1995	1996
Ees	16.0	17.2	19.0	21.5	23.6	28.0	29.0	29.6
% Change	—	7.5	10.5	13.2	9.8	18.6	3.6	2.1

Source: The Fact Book, 1997 Edition; Federal Civilian Workforce Statistics, published by OPM

Although the percent change in the total federal civilian workforce has declined in recent years, the percent change in the judicial branch workforce has increased over the same time period. The Judiciary has doubled in size (number of employees) since 1982 whereas the entire federal government has remained relatively stable. The issues of providing benefits for an employee group with this growth rate can be different from the issues of providing benefits in a stable workforce.

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A consistent message throughout the judicial officer interviews was that the demographics of the Article III judgeships are changing significantly, and that new appointees are entering the Judiciary at younger ages than in the past. It was suggested that the Judiciary should create flexible benefits to help meet the needs of the judicial officers. Again, the lack of a vesting schedule in the pension plan was mentioned.

Our demographic analysis supports the fact that judicial officers appear to be entering the Judiciary at younger ages than in the past. This has significant implications regarding retirement benefits, and the suitability of no vesting. Based on employee opinion and apparent AO desire, increased benefit flexibility is needed to provide meaningful benefits to a diverse and changing workforce.

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Recommendations

The graphic below illustrates the current versus the desired state of benefits at the Judiciary which condenses our findings and recommendations based on the information drawn from the employee benefits survey and benefit assessments.

Current State		Desired State
■ No benefits philosophy		■ Develop benefits philosophy that addresses the goals of the AO
■ Gaps in current benefits coverage		■ Offer supplemental benefits to fill gaps in coverage
■ No control in design and administration of benefits program	→ vs.	■ Engage in discussions with OPM to influence the core benefits provided and to ensure that the needs of judicial officers and judiciary employees are met
■ Benefits do not meet the needs of the Judiciary's diverse population		■ Attain flexibility to make changes and enhancements to the benefits package offered to judicial officers and judiciary employees
■ Judicial officers' retirement plans do not reflect that the average age of hire for judicial officers has decreased in recent years		■ Review relevance of provisions in judicial officers' retirement plans and address the changing demographics
■ Lack of clear, easily understood benefits information		■ Develop improved benefit communication that is delivered to employees on a timely basis
■ Little training of benefit coordinators leading to inconsistent delivery of benefits information		■ Develop comprehensive training and development plan to assure more consistent and accurate delivery of benefits information

Strategies to achieve the desired state include the following considerations:

- Consider the pursuit of amendments to Title 28 of the United States Code that would provide the Judiciary with the benefit flexibility similar to that provided to financial institutions under Title 12. Short of this, consider the pursuit of legislative change to create the ability for the Judiciary to offer pre-tax benefit options and flexible health care and dependent care spending accounts.

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- Identify non-appropriated funds within the Judiciary that could be used to subsidize the cost of any supplemental benefits offered to judicial officers and judiciary employees.

A well-designed strategy — regardless of how flawlessly it is implemented — is affected by other issues and challenges that may exist within an organization. Some issues and challenges, which if neglected may become barriers to implementation, are shown in the chart that follows:

Possible Barriers to Achieving Desired State
■ Limited financial and staffing resources
■ Capability of present payroll/personnel system to implement and/or maintain a supplemental benefits program
■ Timing of approval to offer supplemental benefits from Judicial Resources Committee and Judicial Conference, authority of Congress (if necessary)
■ Procurement timing

We recommend that the Administrative Office concentrate on the key areas of improvement shown below. Towers Perrin developed these recommendations in conjunction with AO staff. Any suggested changes may require approval from Congress.

1. Offer supplemental benefits

Given the judicial officers and judiciary employees perceived shortfalls of the current federal plans, and the Judiciary's desire to improve benefits, the AO should pursue offering benefit programs to supplement the federal benefits. These supplemental benefits would be implemented and administered by the AO.

The suggested schedule for supplemental benefit implementation is:

By January 1, 1999: Long Term Care
By January 1, 2000: Dental, Vision and Long Term Disability

In the benefits survey, judicial officers and judiciary employees specified these programs as being the most important programs currently not available. Although the above benefit programs are not particularly complex benefits, offering them would likely require the AO to develop a benefit administration infrastructure that is not currently in place.

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These programs can be offered on an employee-pay-all basis. However, if the Judiciary were able to subsidize a portion of the benefit cost, the employees' perceived value of these benefits would likely be enhanced.
The Judiciary should confirm their ability to offer these supplemental programs. Also, an administrative assessment should be performed to determine the AO's actual staffing, systems and other administrative needs.

As a long-term approach, the Judiciary should also consider changes to the Article III judges' retirement plan and the JRS that would add some features common in other retirement programs, and which would be compatible with the judicial officers' emerging demographics (i.e., earlier ages at appointment):

- Consider eliminating the age 65/rule of 80 requirements from the Article III judges plan, and introduce a vesting schedule.
- Consider introducing an early retirement feature to the Article III judges plan and the JRS.
- Consider revising the financing arrangement for the JSAS portion of the Article III judges retirement plan and the JRS such that contributions are not required while in active service.

2. Meet with OPM and offer suggestions for change

We were asked to provide the AO with suggestions the AO could offer to OPM in order to improve the FEHBP, in light of the findings of this project. Our suggestions are shown below.

- Discuss methods of collecting Judiciary-specific data that is currently not available.
- Review upcoming benefits that may soon be available to federal employees in order to avoid redundancy under the supplemental benefits plan.
- Reduce the number of plans offered under FEHBP.
- Introduce more benefit provision standardization between plans.
- Offer a separate "out-of-area" plan to employees in underserved areas.
- Increase the attention paid to plan performance, for new and continuing health plans. Terminate under-performing plans.
- Introduce plan cost as a criteria reviewed when considering the continued offering of health plans.

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- Change the health plan pricing methodology to allow for three- or four-tier rates.
- Change the health plan pricing methodology to reflect health plan efficiency in the pricing of the plans to participants. Eliminate the inefficient health plans.
- Improve the mental health and substance abuse benefits coverage under FEHBP managed fee-for-service plans.
- Improve the prescription drug benefits coverage under FEHBP managed fee-for-service plans.
- Separate the retiree experience from the active employee experience in the development of health plan rates.

3. Improve employee communications and training for Benefit Coordinators

Benefits communication materials

Benefits communication materials must be presented in a timely, straightforward, easy-to-understand and easily accessible format. The language should be simple and complemented with graphics, charts and quotes to emphasize key points within the text. Materials should be prepared and designed with the intent to distribute them in a variety of media and formats.

Benefits information must be delivered consistently to all employee groups regardless of the delivery method. Delivery methods also need to consider two-way communication to allow employees to easily provide input, ask questions and receive answers to their inquiries.

Benefits materials need to educate employees about the importance of benefits, encourage the employee's responsibility in making informed benefit choices and emphasize the role benefits play in the total compensation of the employee.

Benefits Coordinators training and development

Training must be presented in an interactive, timely and straightforward manner. Training materials should be easy-to-understand, easily accessible and should adhere to the commonly understood rules of effective communication (as described in the *Communication Materials Audit* section of Volume 3 of our report). The language should be simple and complemented with graphics, charts and quotes to emphasize key points within the text.

Materials should be prepared and designed with the intent to distribute them in a variety of media and multiple formats. Resources should be readily available and

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easy for Benefits Coordinators to access. Networking and information-sharing among Benefits Coordinators should be facilitated and encouraged.

Benefits information must be delivered consistently to all Benefits Coordinators, regardless of the delivery method. Benefits Coordinators, in turn, must assure information is delivered accurately and consistently to various employee populations. Delivery methods also need to consider two-way communication to emphasize the role of Benefits Coordinators, allow Benefits Coordinators to easily share information with each other and receive answers from the AO staff to their benefits inquiries.

Benefits materials need to educate Benefits Coordinators about the importance of benefits, emphasizing their responsibility helping judiciary employees make informed benefits choices. Benefits Coordinators also need a thorough understanding of the role benefits play in judiciary employees' total compensation.

More details about the approach used to reach these recommendations can be found in Volume 3 of this report. This information is supported and should be viewed in conjunction with that volume.

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Judge JACOBS. Thank you very much.

Partially in response to the Towers Perrin program, in March 1998 the director of the administrative office was given authority to establish a program of supplemental benefits. We have done that. I think with your indulgence, I'll just review the five programs that we have established very briefly.

One is a health care reimbursement account. The employee decides before the end of the calendar year how much money to set aside on a pre-tax basis to pay certain medical expenses. These sums are used for co-payments, deductibles, vision, dental care, everything that's not covered, virtually everything that is not covered, by the Federal employee health benefits. About 7,500 employees enrolled in that in the year 2002. It's a very high number, and it reflects the high level of interest that Towers Perrin had detected when they conducted their study.

We also instituted a dependent care reimbursement account. It works, there are bells and whistles that differ, but basically it is also a program by which employees deposit money and uses that money to pay for benefits that are not otherwise available, such as child care, care for sick dependents, elderly people, and so forth.

About 9,000 employees of the Federal Judiciary are participating in these reimbursement accounts. That's about 27 percent of those who are eligible. This is a very high percentage. We are advised by experts in the area that the usual for the area would be 10 or 15 percent out in the national work force. It reflects a very high interest in it and also reflects, I think, an intense educational effort to publish the details and the information about these programs to warn people of some pitfalls that lie in them, that is, for example, a use-it-or-lose-it feature that was referred to by one of the speakers on the earlier panel, and to make people sufficiently comfortable with it.

Our experience is that complicated as it is, it's extremely valuable. And every year, appreciable additional percentages of people participate. The data of that is in my report, and I'm not going to tarry over the actual numbers. But the success of that program has been in part a result of a very determined educational effort.

The program is a great benefit to everyone concerned. One of the subjects that people most cite as a benefit, an advantage that they have from the health care account, is being able to pay for orthodontia. For young children, it is an astonishingly expensive item. It is not at all uncommon for people to pay for it on an installment basis, because it is such a huge expenditure. These funds are available. The health care reimbursement account has now reached a $10,000 limit, a very large and very substantial benefit.

To go on to the next program, which is the premium payment program, it essentially reduces by about 38 percent the cost of the Federal employee health benefit, because it allows a deduction from the pay check every month which is placed directly in an account that pays the premium. I should add that does not affect annuities or other arrangements. It does, as you have pointed out, Mr. Chair, it does affect Social Security payments, but in a completely insignificant way.

Next to last, the Federal Judiciary long term care program allows people to pay premiums to buy 5 years of coverage for long

term care, not only for themselves, the employee can buy such coverage regardless of pre-existing conditions, without a medical examination, but also allows purchase of a long-term care program for relatives, parents, grandparents and others. The nature of the custodial arrangements that are insured are legion. It can be a nursing home, it can also be home care, it can be community care and so on.

Finally, we instituted a commuter benefit program, which allows employees to set aside pre-tax dollars to pay for mass transit and parking expenses.

Programs like these are common, as the subcommittee has learned from the prior panel, common in State government and the private sector. We implemented these measures within the existing statutory framework, but to do more, we require legislation. And we would propose to add these benefits on a cost sharing basis. We would like to establish a full cafeteria-style program, funded in part by a modest contribution from the Judiciary as employer. We are thinking in terms of $500, at least as an example, but we would have to do a good deal of actuarial work in order to come up with the exact amount that would be useful.

The programs that we envision could be offered would be dental insurance, foremost, because a very large proportion of the expenses accrued under the health care reimbursement account is for dental care. This clearly is a felt need. Vision insurance, leave conversion, expanded commuter subsidies, also very important, short-term and long-term care disability.

Mr. WELDON. I've let you go on for 10 minutes now. Could you try to wrap it up?

Judge JACOBS. The astonishing thing I have learned on my years on the committee has been that it's really very difficult to figure out what other people need in the way of benefits. This cafeteria system is a way of assuring that people can make their own choices based on their own needs, based on their own family circumstances. And if I were to go on, I would basically be repeating much of what you said, Mr. Chairman, when this meeting started. That's a good note, I think, to end on.

[The prepared statement of Judge Jacobs follows:]

Statement of Circuit Judge Dennis Jacobs

to the U.S. House Government Reform Committee

Subcommittee on Civil Service, Census & Agency

Organization

Mr. Chairman and Members of the Subcommittee, I am Dennis Jacobs, Circuit Judge of the United States Court of Appeals for the Second Circuit. I appear today on behalf of the Judicial Conference of the United States, which is the policy-making body for the federal judiciary. I chair the Conference Committee on Judicial Resources which has jurisdiction over personnel matters. I have the distinction and responsibility today of representing their views and concerns. The judiciary greatly appreciates the Subcommittee=s interest in the judiciary=s innovative benefit programs.

I am no expert on employment benefits, so I will not undertake to describe the technical aspects of cafeteria plans under 26 U.S.C. ' 125. With your indulgence, I am here to testify about why the judiciary implemented an expanded flexible benefit ' 125 plan; the success we have enjoyed with the present plan; and how beneficial it would be to expand the choices available under the plan and to institute an employer contribution.

The innovative benefit plan now available in the Third Branch is the product of a systematic benefits initiative undertaken in response to anxieties expressed by employees and judges in the 1990s about the Federal Health Insurance Program, which was narrowing coverage and raising premiums. The Judicial Conference approved a request from the Director of the Administrative Office, Leonidas Ralph Mecham, to conduct a comprehensive study that would survey benefits available to judicial employees and compare those benefits to the benefits available in the private sector, state government, and some federal agencies.

To do this study, the Administrative Office retained the services of Towers Perrin, an international benefits consulting firm, which completed its work in March 1998. The study identified several critical gaps in federal benefits: no long-term care insurance; no dental or vision benefits; and no pre-tax benefits such as flexible spending accounts for health care and dependent care.

The deficiencies identified in the Towers Perrin study were alarming. The judiciary was facing the prospect of replacing a significant portion of its whole workforce as its baby boomer employees retired over the coming years; the new generation of employees would be recruited in a highly competitive environment for skilled workers, in an era when people change jobs frequently. As the judiciary recognized, we could not compete in that environment with substandard benefits.

In March 1998, the Judicial Conference voted to seek legislation conferring upon the

Director of the Administrative Office authority to establish a program of supplemental benefits. Later the Judicial Resources Committee endorsed a plan for an employee-pay-all long-term care insurance program, as well as certain other employee-pay-all benefits identified by Towers Perrin.

* * *

Today--as a result of that effort and under the current statutory authority--the judiciary offers its current and prospective employees a package of employee-funded supplemental benefits: (i) a health care reimbursement account; (ii) a reimbursement account for dependent care; (iii) a plan for pre-tax payment of health insurance premiums; (iv) a long-term care program; and (v) a commuter reimbursement.

I will very briefly review each of these benefits.

(i) The Health Care Reimbursement Account permits the employee to set aside money on a pre-tax basis to pay non-covered medical expenses for themselves and dependents (co-payments, deductibles, vision and dental care). Employees have access to the dollars they set aside at the beginning of the year and fund the account through payroll deductions throughout the year. The average set-aside per participant is $1,650. About 7,500 employees were enrolled in 2002. Interestingly, about half of all the money set aside in this plan has been used for dental expenses.

(ii) The Dependent Care Reimbursement Account permits the employee to set aside pre-tax dollars at the start of each year to pay for dependent care expenses, as outlined in IRS Code ' 129. Allowable expenses include child care, as well as elder care and care of disabled dependents. Unlike the health care reimbursement account, employees must first fund their dependent care reimbursement account before expenses can be reimbursed. Families with such expenses bear a considerable financial burden; dependent care expense can easily exceed a family=s monthly mortgage. The IRS limit of $5,000 barely covers half a year of such expenses. Still, employees electing maximum participation saved about $1,500 a year, providing some relief from these costs.

These two reimbursement accounts are administered by a third-party administrator at a contract cost of $3.10 per employee per month. This modest cost includes enrollment processing, payroll tape transfers and interfaces, an interactive voice response system, dedicated benefit counselors, claims handling, and the preparation and distribution of program communications. The third-party administrator offers us state-of-the-art systems and expertise that the judiciary could not create in-house without years of development and training, and considerable infrastructure expense.

Almost 9,000 employees participated in the reimbursement account feature of the flexible spending programB-more than a quarter of employees eligible. Our administrator advises that participation in the judiciary is well above the industry average of 10% to 15%. Attachment 1 of my statement outlines participation of the last three years, reflecting a

steady increase in the number of participants and in the dollar amounts set aside by them.

These reimbursement accounts entail some risk sharing. Employees set aside the money at the beginning of the year on a use-it-or-lose-it basis. The judiciary (as employer) is at some risk because employees can make claims for incurred health care expenses against the full dollar amount designated at the beginning of the year, before the account is fully funded by payroll deductions. Still, claims have never exceeded the moneys collected, and employee forfeitures have been few: seven out of eight participants forfeit nothing; and forfeitures are approximately one percent of total elections. Forfeitures are still deemed employee money and are held in a separate account to offset the program=s administrative costs and to finance other benefit programs in the future.

We believe this program has been successful because we have tailored it to what employees asked for in surveys conducted by our consultant in the 1998 study. The AO carefully educated employees over a long period of time so that they can appreciate the financial advantage of the program, budget their medical costs, and avoid forfeitures. Frequent reminders warn against the risk of forfeiture. The third party administrator provides on-line enrollment and interactive worksheets to help employees figure out how much money to set aside. Special training programs are conducted for benefit coordinators in the courts. And a benefit mailbox was established so that employees can email their questions and get answers the same working day.

This successful program is a great benefit to everyone concerned regardless of their individual and specific needs. For example, it is easier to hire the people we want if they can finance child care; the high cost of orthodontia for families with children is at least somewhat alleviated by this program; and other families have been able to purchase hearing aids and other medical goods and services not covered by their health plans. Among a host of other advantages, this program encourages our employees to plan for their health care needs and to be more careful consumers of health services. We have had not one complaint.

(iii) The premium payment plan allows employees to pay their health care premiums with pre-tax dollars. Employees are automatically enrolled (subject to an opt out election) if they participate in the Federal Employee Health Benefit program. Participating employees thereby save approximately 38 percent of the cost of health care premiums, an average annual savings of $526. This is money that is now available to pay medical expenses that are not otherwise covered (such as vision and dental care) or that helps employees absorb steady increases in premiums without being compelled to elect a different health plan that might not be as suitable to their needs. The judiciary instituted this plan in January 2000; I understand that the Office of Personnel Management established a similar plan in October of that year.

(iv) The Federal Judiciary Long-term Care Program, underwritten by CNA in 1999, offers coverage for nursing homes, assisted living facilities, and a variety of home-care and community-based custodial options that fit the needs and budgets of our employees. CNA, based in Chicago, has been offering long-term care insurance for 30 years, and was

competitively selected for its experience, strength and flexibility in this market. Depending on the terms selected by the employee, this plan pays long-term care expense for the employee, the employee=s spouse, and certain other close relatives. For employees themselves, this plan is available during open season on a guaranteed issue basis without regard to pre-existing conditions. The plan provides an option for inflation-protected benefits. Among other things, it assures that after three years of participation and even if no further premiums are ever paid, the employee continues to have at least 30 days of coverage.

(v) Finally, under the Commuter Benefit Program, introduced in 2001, employees set aside pre-tax dollars in special accounts to pay mass-transit and parking expenses. The maximum set-aside is $100 per month for mass transit and $185 for parking. This benefit is used in conjunction with commuter subsidy programs that are optional with individual courts (and which are also available to federal employees in other branches).

* * *

Benefit programs like these are common in state government and the private sector. We implemented them within the existing statutory framework, without seeking additional funds. We would like to do more; but that will require legislation. The programs I have been talking about are entirely funded by the employees themselves.

We believe that we would need an amendment to Title 28 of the U.S. Code to allow us to add more benefits to the flexible benefit plan in a cost-sharing arrangement with employees. The cost-sharing feature of our request would not entail additional funds, at least initially, and could be provided from current appropriations. We believe that such a program would provide a substantive return on investment by reducing turnover expenses, which include recruitment costs, hiring bonuses for certain categories of employee, training costs, lost productivity, severance costs, and all of the other losses and frictions associated with turnover.

If such authority is provided, we would establish a full scale cafeteria-style benefits program that would be funded in part by a modest per-employee contribution by the judiciary. A $500 employer contribution would (for example) amount to $15.5 million for the present workforce size. Individual employees could elect to supplement the employer contribution by post-tax or pre-tax payments (depending on IRS rules), or the exchange of earned leave. The combined employee and employer contributions could then be used to purchase benefits from a menu of choices. Among the new benefits we could offer are:

$Dental insurance;

$Vision insurance;

$Leave conversion;

$Expanded commuter subsidies;

$Short term and long term disability; and

$Prescription drug insurance and mental health insurance that would plug gaps in the FEHB programs.

The incremental administrative cost for improving our current benefits program is estimated to be less than 1/10th of one percent of the total payroll.

A modest employer contribution would allow greater flexibility, and would give each employee leverage to design a benefits package that fits the particular needs of the employee and the employee=s family. We anticipate that this flexibility would improve recruitment and retention rates and increase employee morale, and would yield dividends (well in excess of the outlay) to ensure that the judicial branch can recruit and retain employees who are skilled, talented and dedicated.

We are aware of other legislative initiatives to make changes in ' 125 regulations that would allow retirees to participate in the premium payment plan, pay for long-term care premiums with pre-tax dollars, and permit participants to roll over funds in the cafeteria plan rather than forfeit unused dollars. We in the judiciary fully support and endorse these proposed changes.

Benefits, which amount to one-third of total compensation, are a key element in the recruitment and retention of the employees we need. Congress has granted other agencies, such as the IRS, special compensation authority to help in recruitment and retention. As the baby boomer generation retires over the coming years, the judiciary will be hiring from a generation that has broader employment options and different career expectations. Recognizing (as we do) the choices and opportunities that a new generation has in organizing their lives, families and careers, we want to assure that our benefits package is attractive to everyone: to one-earner families, and two-earner families, to single parents, to empty-nesters, to urbanites and long-distance commuters, to people with elderly parents and grandparents, to people who are healthy and want to stay that way, and to people who are trying to cope with the costs of their own health problems or illnesses in the family.

A cafeteria-style benefits package that allows people to identify their own needs and custom-design their own benefits is the best way to attract and keep the employees we need. It is also the only way I can think of to assure a satisfactory benefits program to each employee of the judiciary.

Mr. WELDON. Great. Thank you very much. I appreciate your testimony. It's been very, very informative.

I take it, based on your testimony, that you have experienced an improved ability to retain and attract employees as a consequence of offering this? Has it been an overall useful recruiting and retention tool?

Judge JACOBS. We think it has been. Although as members in the earlier panel indicated, it is not so easy to quantify this. Recruiting and hiring in the Federal Judiciary takes place in about 110 courts, spread all over the country. To know whether people are having trouble or not having trouble, we would have to, as it were, survey 100 chief judges.

But if there are problems, we hear about it. We think that the primary benefit of this is in retention. We compete with State courts for many of the same people doing many of the same things. It is a very hard thing for us to lose people that we have trained at great cost and expense to State courts that do offer these cafeteria programs. So we are quite confident that we are seeing an improved measure of retention.

Mr. WELDON. Mr. Thomas in his testimony earlier in the first panel made a statement that one of his concerns was that some employees would have difficulty understanding or negotiating these plans with all the choices in them. Have you had any experience in that arena, where employees have had problems with it?

Judge JACOBS. We have had no problems. I believe, however, that Mr. Thomas is identifying a real concern. I think the concern can be dealt with with very carefully drawn brochures. And most of all, we in the Federal Judiciary use an interactive link, so that someone who has a question about their benefits can contact the benefits officer in their court. The benefits officer in their court can ask a very specific question and it will be answered in Washington the same day.

So we think it's very important, I agree that many of these arrangements are complicated. And they involve, and they require, a certain level of explanation by the Government. I think it's a responsibility, when you're offering these things, to explain them. But we have developed brochures for it, and we have had no trouble, because we have made a substantial effort.

Mr. WELDON. Would you be willing to work with the committee in developing legislation to authorize the Judiciary to offer a full-fledged cafeteria plan?

Judge JACOBS. The Judiciary and the staff, the administrative office and I would dearly love the opportunity to do that.

Mr. WELDON. Well, I thank you for your testimony and I again thank all the witnesses. And with no other Members here for questioning, the hearing is coming to a conclusion. The Chair notes that some Members, as stated before, may have additional questions, particularly for the second panel. We will keep the record open for 2 weeks to allow sufficient time for the submission of written questions and responses from our witnesses.

I also ask unanimous consent to enter into the record the written statement submitted by the National Treasury Employees Union and the Senior Executive Association.

[The information referred to follows:]

May 28, 2002

M E M O R A N D U M

TO: Chapter Presidents and Legislative Coordinators

RE: Testimony on Cafeteria Benefits for Federal Employees

Summary: Attached is testimony that NTEU submitted for a recent hearing exploring the possibility of providing federal employees with a cafeteria benefits arrangement.

Last week, the House Civil Service Subcommittee held a hearing to explore the possibility of providing benefits to federal employees through a cafeteria benefits arrangement. This is also sometimes called a flexible benefits arrangement.

As you will see from the attached testimony, NTEU made clear that while we are always interested in improving the federal benefit package, we will oppose efforts to require federal employees to choose between competing benefits -- something that is often required in cafeteria benefits plans.

Under a cafeteria, or flexible benefits plan, employees are usually given a pool of money to spend on an array of benefits such as health insurance, life insurance, additional annual leave or other benefits the employer may choose to include. Employers that provide cafeteria benefits to their employees often use the increase in the Consumer Price Index (CPI) as the standard for increasing the annual pool of money they provide their employees. The CPI has averaged two to three percent in recent years while annual health insurance premium increases have averaged between 10 and 13 percent. Given these facts, I pointed out to the Committee, it would not be long before federal workers would be forced to give up other benefits just to maintain their health insurance coverage. For this reason, NTEU is not in favor of cafeteria or flexible benefits for the federal workforce.

I also used this opportunity to point out to the Committee NTEU's continued interest in making Flexible Spending Accounts (FSAs) available to federal workers. Under a FSA, an employee can set aside money on a tax-free basis for certain out-of-pocket health and dependent care costs. FSAs are often made available to employees following introduction of Premium Conversion Plans. As you know, NTEU successfully convinced the last Administration

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to make Premium Conversion plans, which permit employees to pay their health insurance premiums with pre-tax dollars, available to federal employees in 2000.

NTEU continues to work with the current Administration to make FSAs available to the federal workforce as soon as possible. When there is further information to report on these accounts, I will let you know.

Colleen M. Kelley
National President

Attachment

Testimony Of

Colleen M. Kelley

National President

National Treasury Employees Union

on

MORE VALUE FOR FEDERAL EMPLOYEES: CAFETERIA BENEFIT PLANS

May 21, 2002

1:00 PM

Civil Service Subcommittee
Committee on Government Reform
2147 Rayburn Building

901 E Street, N.W. • Suite 600 • Washington, D.C. 20004-2037 • (202) 783-4444

Chairman Weldon, Ranking Member Davis, Members of the Subcommittee, my name is Colleen Kelley and I am the National President of the National Treasury Employees Union (NTEU). NTEU represents more than 155,000 federal employees across 25 agencies and departments of the federal government.

I very much appreciate your scheduling this hearing today to examine issues surrounding the Federal Employees Health Benefits Program (FEHBP). It is my understanding that you are also interested in exploring whether or not a cafeteria benefits plan might be a viable way of delivering benefits to federal employees.

NTEU's members are increasingly concerned about the exorbitant rate increases in FEHBP plans in recent years. As NTEU's President, I have been received a growing list of complaints from our members. As you know, not only have premiums skyrocketed, but many participating FEHB plans have simultaneously increased their required copayments and deductibles, limited covered services and dropped participating physicians from their programs. In addition, health maintenance organizations in many parts of the country have announced that

they will no longer participate in the FEHBP. Federal employees are being required to pay considerably more for coverage with health choices that continue to shrink.

As the Chairman knows very well, the federal government is in the midst of a human capital crisis. Attracting and keeping employees with the best skills is a challenge for all employers; it has become a particularly significant challenge for the federal government. What used to be considered one of the premiere programs in the federal employee benefit package - the FEHBP - is today often regarded as a disincentive by those considering employment with the federal government. The FEHBP has become prohibitively expensive for lower paid employees and unattractive to prospective employees.

Last October, the Office of Personnel Management announced average 13% rate increases for FEHBP plans in 2002. This increase followed average FEHBP premium hikes of 10.5% in 2001, 9.3% in 2000, and 9.5% in 1999. Employees choosing the most popular FEHBP plan, Blue Cross-Blue Shield Standard Option Family coverage for 2002, were faced with 17% premium increases. Moreover, since 1998, premiums for Blue Cross Standard Option Family coverage have increased by 43%.

To provide a better perspective on what these increases have meant to the average federal employee, from 1998 to 2001, federal

salaries increased an average of 13%. I think its easy to see why federal employees find the FEHBP increasingly unaffordable.

The federal government as an employer currently pays an average of 72% of the health insurance premium for its employees, with employees paying the other 28%. There is a sharp contrast between private sector employer contributions toward employee health benefits and the portion the federal government pays for its own employees. According to the 2001 Kaiser Family Foundation's Employer Health Benefits Survey, the average employee participating in employer-sponsored health insurance pays 15% of the premium for single coverage and 27% of the premium when choosing family coverage.

A December, 2000 Bureau of Labor Statistics analysis of employee benefits in state and local governments found similar trends. Most state and local government employers pay at least 80% of the health insurance premium for their employees; some pay as much as 90% of employee health insurance premiums.

Bipartisan legislation, introduced by Congressman Hoyer, is pending before your Committee that can help address this critical issue. H.R.1307 would increase the employer share of FEHBP premiums from the current average of 72% to the most common industry standard, 80%. NTEU, as well as 84 of your colleagues in the House of Representatives have endorsed this legislation.

When I last appeared before your Subcommittee in October, 2001, I urged you to convene hearings on this important bill. Unfortunately, your Subcommittee has yet to consider this legislation.

Recently, Congresswoman Morella introduced H.R.4580, which among other things, would increase the federal government's contribution toward employee health benefits from 72% to 76%. Both of these bills are important steps toward making the federal government an employer of choice. Absent competitive pay and benefits, the federal government will never effectively compete for the talent it needs. H.R.1307 and H.R.4580 represent modest steps in addressing our human capital crisis.

NTEU has pressed for improvements in the federal benefit package over the years that we believe are key to recruiting and retaining the best employees. For example, NTEU worked closely with the last Administration to put in place a mechanism to permit federal employees to pay their FEHBP premiums with before-tax wages. Called a Premium Conversion Plan, it is a benefit employers are permitted to offer their employees under Section 125 of the Internal Revenue Code. Although private sector employers had widely offered this benefit to their employees since 1978, the federal government did not make it available to its own employees until the year 2000.

Most medium and large employers, as well the majority of state and local governments, provide Premium Conversion Plans to their employees. Furthermore, employees of the U.S. Postal Service, the Federal Judiciary, the Comptroller of the Currency, Federal Deposit Insurance Corporation, Office of Thrift Supervision and the Federal Reserve System have participated in Premium Conversion for many years. The extension of this benefit to the entire federal sector not only enhances the ability of the federal government to more effectively compete in the labor market, it will help those federal employees who, until now, were unable to afford FEHBP coverage, better able to purchase coverage. As a result of this one provision, the average federal employee has experienced a $450 increase in annual take home pay. I also want to applaud the Congress for subsequently making Premium Conversion Plans available to legislative branch employees.

The same section of the tax code that authorizes the establishment of Premium Conversion Plans, Section 125, permits employers to make Flexible Spending Accounts (FSAs) available to their employees. NTEU also strongly supports extending Flexible Spending Accounts to the full federal sector. Like Premium Conversion Plans, FSAs have been available to employees of medium and large employers, state and local governments as well as to employees of the U.S. Postal Service and the other federal agencies listed above. As far back as 1994, the Department of

Labor reported that 69% of full time state and local government employees were eligible to participate in FSAs.

An employee eligible for a Flexible Spending Account would set aside a specific amount of money at the beginning of each year to pay certain health care costs such as deductibles and copayments as well as some medical costs not covered by insurance plans, as well as dependent care benefits, if the employee chooses. These set-asides are accomplished through payroll deductions each pay period. As the employee incurs expenses that meet IRS rules, the employee files a claim with the employer and is reimbursed with his or her own pre-tax FSA contributions for these medical and dependent care expenses.

NTEU has met with OPM Director James in an effort to make FSAs available to the entire federal workforce. It is our understanding from conversations with Director James that OPM is committed to broadening the availability of FSAs as soon as possible. We are also encouraged that the Bush Administration's FY 2003 budget recommends permitting FSA participants to carry up to $500 in unused benefits in an FSA forward into the next calendar year. This would be a positive step in encouraging more employees to take advantage of this benefit. Under current law, amounts that an employee sets aside for medical and dependent care expenses, but does not use, are forfeited to the federal government at the end of the calendar year.

Some employers also choose to offer their employees what is called a cafeteria benefits plan. This is sometimes also referred to as a Flexible Benefits Plan, not to be confused with Flexible Spending Accounts which permit employees to shelter their own money on a pre-tax basis to help with out of pocket medical and child care expenses.

NTEU does not support extending cafeteria benefits, or Flexible Benefits Plans to the federal workforce for a number of reasons which I will outline for the Subcommittee.

Under a cafeteria benefits plan, employees are usually given a pool of money to spend on an array of benefits that the employer has chosen to include in the package. Benefits typically included in such a mix are health insurance, life insurance, additional annual leave, or other benefits the employer may choose to include.

Cafeteria benefits, or Flexible Benefits Plans, are often used by employers as a method of controlling the costs of benefits they provide to their employees. This is accomplished by limiting increases in the annual pool of money employees are given to purchase these benefits. Employers often use the increase in the Consumer Price Index (CPI) as the benchmark for annual increases in the pot of money they provide employees for the purchase of benefits. With simple inflation averaging 2 to 3

percent in recent years and annual health insurance premium increases averaging between 10 and 13 percent, it would not take long before employees would be required to forgo other benefits just to continue to maintain the health insurance coverage they choose.

Indeed, a 1989 Employee Benefit Research Institute (EBRI) report entitled, "Flexible Benefits for Federal Employees" details exactly the reason NTEU opposes the introduction of cafeteria, or flexible benefits for federal employees.

The report states, "Flexible benefits can help employers control costs in several ways. First, they can relieve some of the pressure on employers to offer and help fund new benefits. Second, employers can use flexible plans to break the automatic link between their contribution and the cost of inflation-prone benefits such as health insurance." The report continues, "...this practice limits employer exposure by shifting inflation costs to the employees."

Earlier in this testimony, I detailed the reasons NTEU believes the federal government needs to move in the direction of increasing the share of FEHB premiums it pays for its employees. NTEU is not opposed to providing federal employees with benefit choices, however, we will not support proposals that in reality will have the effect of limiting employee choice by shifting

health care inflation costs away from the government as the employer and onto its employees.

Rather than enhancing the federal government's ability to compete in the labor market, it would be difficult not to view the introduction of cafeteria benefits as a major step backwards and a further disincentive to federal employment. I hope that this Committee, too, will firmly reject this notion.

Health insurance is usually the core benefit available in a cafeteria, or Flexible Benefits Plan. The EBRI report referenced above points out that, "As currently structured, the Federal Employees Health Benefits Program (FEHBP) is unsuited to that (Flexible Benefits Plan) role." NTEU agrees with that assessment.

As the Chairman knows, both current and retired federal employees participate in the FEHBP. Under the present law, only current employees are eligible to participate in plans available under Section 125 of the tax code, such as Flexible Benefits Plans. Thus, introduction of such a plan for the active workforce would necessitate separating health insurance programs for current and retired federal employees. In our view, the introduction of a Flexible Benefits Plan would only serve to further destabilize the FEHBP program.

In conclusion, Mr. Chairman, NTEU believes there are many steps this Committee could take to address the crisis in the FEHBP. Introducing cafeteria benefits, or Flexible Benefits Plans into the federal benefit package is not one of them. I look forward to working with you on these issues in the coming months and urge you again to hold hearings on H.R.1307 and H.R.4580 during this session of Congress.

Mr. WELDON. With that, the meeting is now adjourned.

[Whereupon, at 2:47 p.m., the subcommittee was adjourned, to reconvene at the call of the Chair.]

[Additional information submitted for the hearing record follows:]

Statement of Carol A. Bonosaro, President, Senior Executives Association
Submitted to the House Civil Service, Census and Agency Organization Subcommittee
Committee on Government Reform
Tuesday, May 21, 2002

The Senior Executives Association (SEA) represents the interests of career federal executives in the government, including those in the Senior Executive Service (SES) and in equivalent positions, such as Senior Level and Senior Technical employees and Boards of Contract Appeals Judges. Thank you for the opportunity to submit a statement for today's hearing on Cafeteria Plans and the Federal Employee Health Benefits Program (FEHBP).

While, overall, the FEHBP could be viewed as a model program, its coverage is lacking in some areas, notably dental benefits. Most important, the federal government does not offer enough flexibility in the use of "benefits dollars" to meet the needs of the diverse group of federal employees who, depending on the point in their career or family situation, have diverse benefits needs. Some employees, for example, do not need the health insurance coverage that is offered through the government. These employees could better use the government's contribution to FEHBP (if they had access to those benefits dollars) for other types of insurance they might need, such as short-term disability insurance or extra life insurance. Other employees need the flexibility to apply benefits dollars toward child or elder care. Still, many others would like the opportunity to purchase a dental plan that covers orthodontia. The one-size-fits-all approach of the current benefits scheme does not work for these employees.

That need for added flexibility is why SEA would support a legislative proposal that would make available "Section 125" benefits for federal employees. Private-sector employees have long enjoyed the flexibility offered by cafeteria-style benefits plans that allow them to pay for childcare expenses, disability insurance, and other needs with pre-tax dollars. A first step toward added flexibility was enactment of the premium conversion law that allows current civilian employees to pay for their contribution to the FEHBP premium in pre-tax dollars. Extending the full range of Section 125 benefits to federal employees is the logical next step.

SEA supports this extension with one caveat: while flexibility is important, that flexibility should not come at the expense of federal employees. Therefore, SEA would not support any change in the FEHBP or in the benefits scheme that would come out of federal employees' pockets or that would be used as a present or future justification to reduce federal employees' benefits.

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Marjorie H. Young
COMMISSIONER

State Merit System of Personnel Administration • Suite 504, West Tower • 2 Martin Luther King, Jr. Drive, S.E. • Atlanta, Georgia 30334-5100
(404) 656-2705 • (404) 656-5979 FAX • www.gms.state.ga.us

June 27, 2002

Dave Weldon, M.D., Chairman
Subcommittee on Civil Service,
Census, and Agency Organization
House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Dr. Weldon:

Attached are answers to questions that were submitted following the subcommittee hearing on May 21, 2002.

Please let me know if I can be of further assistance.

Sincerely,

Marjorie H. Young
Commissioner

MHY:gl

Attachments

I. **How do you link the pool of money one receives so that purchasing benefits are not weakened i.e. are they linked to the CPI, medical inflation, regular inflation?**

These types of concerns are addressed through the procurement process, which establishes the rate structure for our benefits. All benefit products are procured through a competitive process. A Request for Proposal is normally issued to procure benefits for a three-year period, which provides for a one-year contract with two options to renew the contract for additional one-year periods. The vendor proposes the rate structure for the three-year period. The renewal period is sometimes extended in extenuating circumstances to a fourth year – however, if the rate quoted for the fourth year is out of line with industry rates or if at any time service delivery does not meet expectations, the contract is not renewed or extended and is re-bid.

II. **Let's say that the tax code was changed to allow employees to rollover unused balances in their Flexible Spending Accounts (FSAs). Is it possible that the health expense portion of a Flexible Spending Account (FSA) could be used as a proxy for the savings account part of a Medical Savings Account (MSA) if the employer also offered a high deductible health insurance plan:**

Because there are major differences between FSAs and MSAs, the appropriateness of a rollover of FSA dollars into MSAs is questionable without extensive changes to the tax code. Those differences include:

- Currently, MSAs are only available to employees of small employers (50 or fewer employees) or self-employed individuals and only if the account owner has qualifying high deductible insurance. (There is proposed legislation that may change this).
- Individuals covered under a health plan (not including supplemental plans such as cancer, dental, vision, etc.) that is not a high deductible plan are ineligible to participate in an MSA. Therefore, most employees participating in a typical health FSA would not be eligible for an MSA.
- MSA funds may be withdrawn for nonqualified (subject to taxes and possibly penalties), while FSA funds may only be used for qualified medical expenses and subject to third-party substantiation of expenses.
- Employers, employees or both may make FSA contributions. MSA contributions may be made by employers or employees, but not both.
- FSA contributions occur only during the plan year. MSA contributions can be made until the due date of the taxpayer's tax return.
- Currently, MSAs cannot be offered under a Cafeteria Plan.

III. **Based upon your experience, what are the key elements of a successful program for communicating about cafeteria plans with employees? Are there best practices you would recommend?**

The key elements of the State of Georgia Flexible Benefits communications are:

- The provision of timely, clear and concise materials to State of Georgia employees.
- The opportunity for employees to ask questions and get clarification on available benefit options.
- The provision of adequate training to all Benefit Coordinators.

The State of Georgia Best Practices:

The State of Georgia recognizes the importance of communication regarding the cafeteria plan benefits. This information must be easily attained and understood by all eligible employees. Best practices have been developed through the exchange of information with other state programs and input via a Flexible Benefits Advisory Committee, which is comprised of Personnel Directors and/or Benefit Coordinators from various state entities. Communication practices for the Georgia flexible benefit plan are outlined below.

1) It is crucial for employees to understand the concept of a cafeteria plan – that it provides a way for employees to pay for benefits while saving on taxes. Explaining and giving examples of the concept of pre-tax premiums provides the employee with a concrete value of the cafeteria plan, particularly for the Flexible Spending Accounts.

2) To avoid employees becoming overwhelmed by the number of benefits offered, the number of options in each benefit are reasonably limited. We try to assure that each benefit option is communicated in a way that is easily understood by employees and department representatives.

3) We are committed to providing employees adequate information and assistance to make informed choices. This information is provided through various means:

   - Enrollment Booklet outlining all available benefits is provided to each employee.
   - Video(s) are provided to each entity as requested to make available to employees and department personnel.
   - Train-the-Trainer sessions are conducted prior to the Open Enrollment period to train benefit coordinators. Sessions for the veteran coordinator cover changes from the previous year. Sessions for new coordinators are more extensive and cover all aspects of all the benefits.
   - Electronic Open Enrollment offers employees the opportunity of completing their selections, as well as medical underwriting forms, via the web.
   - The Agency Web Site is used extensively to provide information regarding the State of Georgia Flexible Benefits Program to employees. The enrollment booklet, video and session presentations are available for viewing or to download. Information on each benefit and vendor, including web site links, phone numbers, claim forms, contact information are also posted on the web site.
   - Georgia Merit System staff is available to both employees and department personnel to assist with problems, questions and concerns.
   - The Georgia Merit System contracts with the vendors to provide customer service support to program participants.