
# 2012-2013
# Health and Benefits
# Workgroup Report

LaWana Richmond, UC San Diego
Kori Soltz, UC Santa Barbara
Cindy Cordova, UC Los Angeles
JP Eres, UC Davis
Ellen Ford, Lawrence Berkeley National Lab
Kathy Jackson, UC San Francisco

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## Executive Summary

In response to UC management discussions about possible changes to health and welfare benefits offered to UC staff, the Council of UC Staff Assemblies (CUCSA) decided to take a proactive approach in order to be prepared to respond on behalf of staff when the discussions escalated to the decision-making level. In the meantime, systemwide Human Resources has moved forward with the process of sending out RFPs and reviewing responses to make changes to our benefits for 2014. In CUCSA meetings, we were assured this will be an iterative and ongoing process. So, while immediate changes to health and welfare benefits have begun, there are still long-term opportunities for staff engagement in the process of identifying solutions that will meet budgetary constraints with the best possible outcome for staff.

The Health and Welfare Benefits Workgroup report summarizes the current state of employee involvement in the determination of health and welfare benefits and explores the difficulty of educating employees regarding potential alternative options such as cafeteria plans and self-insurance. To facilitate such education and dialogue, this report includes a review of the post-employment benefits decision making process and the approach to staff engagement. We identified the following best practices for engaging staff when decisions with this level of impact are being made:

- Provide clear communication, perhaps through town halls and webinars, regarding changes to the 2014 health plans and what employees need to know in order to make informed decisions;
- Engage with staff to evaluate their satisfaction with the 2014 changes and explore possible changes for 2015 and beyond;
- Conduct surveys to determine what employees value in benefit plans; and
- When rolling out major changes that impact employees in such a fundamental manner, as a best practice, follow the model of engagement used with staff before the Post-Employment Benefit changes were implemented.

## Health Benefit Change Options

There are many types of health benefit plans that can be offered to employees. The workgroup decided to take a deep dive into two potential options: Cafeteria Plans and Self-Insurance.

**Cafeteria Plans**

There are two kinds of cafeteria plans: 1) a section 125 plan and 2) a cafeteria plan, also commonly referred to as flex accounts.

1. A section 125 cafeteria plan is designed to ease the administrative burden on the employer and to empower employees by offering them more choice and greater control over how their premium dollars are spent. Employees in this type of plan choose between receiving a predetermined amount of cash to be spent on benefits, rather than the employer and employee splitting the cost each month. Employers can benefit from this type of plan because there are fewer tax calculations. Employees can benefit from this type of plan because there can be greater flexibility in the allocation of health and welfare dollars.
2. A flexible spending arrangement (FSA) is a form of cafeteria plan benefit, funded by salary reduction, that reimburses employees for expenses incurred for certain qualified benefits. An FSA may be offered for a) dependent care assistance, b) adoption assistance, and c) medical care reimbursements; each is a separate plan. The benefits are subject to an annual maximum and are subject to an annual "use-or-lose" rule. The maximum amount of available to a participant must be less than 500 percent of the value of the coverage. An FSA cannot provide a cumulative benefit to the employee beyond the plan year.

For more information on Cafeteria Plans see **Appendix A**.

**Self-Insurance**

Self-funded health care is an insurance arrangement whereby an employer provides health or disability benefits to employees with its own funds. This is different from plans where the employer contracts an insurance company to cover the employees and dependents. In self-funded health care, the employer assumes the direct risk for payment of the claims for benefits. The terms of eligibility and coverage are set forth in a plan document which includes provisions similar to those found in a typical group health insurance policy.

In locations where there are medical centers, this can be a way to keep certain institutional costs down and provide employees with coverage at a low cost to both the employee and employer. For UC campuses that do not have a medical center, UC or the Third Party Administrator will have to contract with local providers. This can impact UC by having to pay higher costs to providers that are not affiliated with UC medical centers.

For more information on Self-Insurance Program see **Appendix B**.

## Post-Employment Benefits Process Review

**History and Timeline of the Post-Employment Benefit (PEB) Process:**

The Post-Employment Benefits (PEB) process came into being in 2010 around proposed major changes to the benefits of UC faculty, staff and retirees. As such, its impact reached across almost all areas of the UC system. Therefore, broad and extensive staff, faculty and retiree engagement prior to any changes being made was imperative. UC President Mark Yudof kicked off the process with a town hall taking place at UCOP (and webcast to all UC locations) which was moderated by then Staff Advisor to the Regents, Juliann Martinez. President Yudof announced that changes were forthcoming and took questions from the audience about those proposed changes. Subsequent to that town hall, a system-wide PEB Task Force was formed, which included representation from each campus as well as representation from the faculty, staff and retiree populations across the UC system.

Then CUCSA Chair, Lin King, was a member of the system-wide PEB Task Force and, as such, represented the staff voice on that committee. The PEB Task Force looked at what the changes would mean to all constituencies and made recommendations based on their conclusions.

Following that system-wide town hall, there was an intensive 18-month process that included traveling "road shows" or town halls at each of the campuses for garnering feedback. This allowed staff, faculty and retirees a chance to come and ask questions, make comments and suggestions, and, in general, be heard about what the changes to the UC retirement plan would mean to them.

There were also committees at each campus that worked on the bottom line numbers on what these changes would mean and who, in turn, educated other groups on their campuses. In one example, the UCSF Academic Senate formed a committee to look at what the changes would mean to the faculty and this committee then shared those numbers with the staff groups at UCSF. This allowed a larger population to understand what the proposed changes would mean, both to current employees as well as those being hired as of July 1, 2013 under the new guidelines.

The PEB consultative process worked well, as all UC constituencies had a chance to be included and heard. This enabled the PEB process to go through with the least amount of resistance. Even though people were not fully happy about the changes, they had a much better understanding of why these changes needed to happen and what the consequences would have been if they did not take place.

The best practices that worked well in the PEB process are as follows:

- Announcing proposed changes to staff and other constituencies well in advance of the timeline of these changes taking place;
- Having a true cross-section of representation from all affected groups on the system-wide decision-making body;
- Allowing all constituencies a period of time for comments and suggestions; and

- When suggestions were reasonable, UCOP and President Yudof did their best to implement them.

In summary, this consultative process works well for large changes across the organization and we would hope that UCOP would continue to use them when rolling out any program with substantive changes for staff, faculty and/or retirees.

## Determining What Employees Value in Health and Welfare Benefits

A critical consideration in determining or changing health and welfare benefits for employees should understand what employees at UC value. In our research, we looked at several sources to help reveal this information. We explored the evaluation efforts that preceded the changes made to the UC post-employment benefits program in 2010. We looked at market research to try to determine what employees value in the market outside of the UC system. We also looked at past campus surveys and system wide employee satisfaction survey data for information about what UC employees value.

When looking at presentations and notes from the PEB process to extract information relevant to employment benefits. There were some questions and observations raised in that forum that we believe could also be translated to employee health and welfare benefits. An overarching theme was that employees wanted maximum benefit for minimum price. It was suggested that some employees might be willing to pay more for greater benefits. (Notes from Faculty Staff Forum 4/23/2010).

90% of U.S. employees who receive health benefits through their employers say that these benefits are as important as their salary (Mercer Workplace Survey, October 2010). Employees want simple, personalized health plans that support wellness. Workers desire programs and communication that are easy to use and understand, that are motivating and meaningful to them, but that also provide personalized information and ideas. The following are the list of what our Internet research revealed are of most importance to employees in their benefits plans (in no particular order): lower deductibles, lower cost health plans, Health Reimbursement Accounts (HRAs), a personalized plan that recommends specific actions they can take to improve their health, cost-saving tips, wellness website, personalized health tips and reminders, cash incentives to encourage them to take part in wellness, smoking cessation help, and domestic partner coverage (same sex and opposite sex).

We wanted to determine what questions had been asked and what questions were missing that needed to be asked in the future to determine what staff value. In UCOP Medical Plan Satisfaction Survey Overview Reports the following areas were addressed in health care surveys: overall rating of health plans, claims processing, customer service, number of doctor or clinic visits, ease in obtaining care, tests, or treatments, satisfaction with choosing a personal doctor, ease in getting an appointment with a specialist, getting urgent care, getting routine care/after-hours advice, overall rating of personal doctor, overall rating of specialist, importance of having a personal doctor, doctor's communication skills, shared decision making with our physician, coordination of care, illness prevention discussions with your physician, smoking cessation assistance, if people received a flu shot, and health plan website satisfaction. We determined that few questions have been asked by UC about what it is that employees value in their benefit plans outside of health and retirement.

We suggest that several things need to be considered when determining what employees value in benefits plans. When considering changes to employee health and welfare benefits, the following observations by the previous PEB task force should be noted: 1) cutting benefits erodes UC competitiveness and 2) staff will need salary increases if benefits are reduced.

Additionally, a thorough evaluation of the long-term impact (20 years) to UC's operating budget should be made before any changes are made. Many of the same questions that have been asked in the UCOP Medical Plan Satisfaction Survey Overview Reports regarding health should be asked in determining what employees want in the future. Employees should be asked how valuable the following services are to them: health, dental, vision, disability, life insurance, accidental death and dismemberment, business travel accident insurance, legal plan, auto renter and home insurance, behavioral health insurance, and health and dependent care flexible spending accounts. We suggest that in depth questions are included for employees to answer in each of these areas including how much of a co-pay is too much, how important is it to have the ability to choose your own doctor, how important is proximity of care, and which of the services listed above do employees rank as most critical.

As the appendices show, even changes in insurance types require careful communications and thoughtful feedback avenues.

## Conclusion

Although UC is in the midst of continued fiscal challenges, it is important to remember that health and welfare benefits are one of the key factors attracting talent to the UC system for employment when salaries are on the average 10% below market rate. In order to continue to attract and retain staff committed to excellence, it imperative that the health and welfare benefits package remains highly competitive and valued. Gathering this information from staff through surveys and having avenues for staff engagement are methods that have proven effective, most recently with the post-employment benefits process.

The members of this work group remain optimistic that staff will have the opportunity to provide information about their health and welfare interests and preferences for consideration in determining the future of health and welfare benefits offered by the University of California System.

# Appendix A: Cafeteria Plan Information

There are two kinds of cafeteria plans: 1) a section 125 plan and 2) flexible spending accounts. (IRS FAQs for government entities regarding Cafeteria Plans, 2013; IRS Fringe Benefits Cafeteria Plan Overview, 2013)

**I. Section 125 Cafeteria Plans**

a. A section 125 cafeteria plan is designed to ease the administrative burden on the employer and to empower employees by offering them more choice and greater control over how their premium dollars are spent. Employees in this type of plan choose between receiving a predetermined amount of cash to be spent on benefits, rather than the employer and employee splitting the cost each month. Employers can benefit from this type of plan because there are fewer tax calculations. Employees can benefit from this type of plan because there can be greater flexibility in the allocation of health and welfare dollars. An example of this type of plan can be found in the City and County of San Francisco.

   Employer contributions to a cafeteria plan are usually made pursuant to salary reduction agreements between the employer and the employee in which the employee agrees to contribute a portion of his or her salary on a pre-tax basis to pay for the qualified benefits. Salary reduction contributions are not actually or constructively received by the participant. Therefore, those contributions are not considered wages for federal income tax purposes.

   The plan may make benefits available to employees, their spouses and dependents. It may also include coverage of former employees, but cannot exist primarily for them. Cafeteria plans can offer health insurance to employees, their spouses and their dependents.

b. Tax Considerations: Generally, qualified benefits under a cafeteria plan are not subject to Federal Insurance Contributions Act (FICA or Social Security), Federal Unemployment Tax Act (FUTA), Workers' Compensation, and some state taxes. However, group-term life insurance that exceeds $50,000 of coverage is subject to social security and Medicare taxes, but not FUTA tax or income tax withholdings, even when provided as a qualified benefit in a cafeteria plan. Adoption assistance benefits provided in a cafeteria plan are subject to social security, Medicare, and FUTA taxes, but not income tax withholdings. If an employee elects to receive cash instead of any qualified benefit, it is treated as wages subject to all employment taxes (IRS FAQs for government entities regarding Cafeteria Plans, 2013).

c. Pay Deferral: Generally, a cafeteria plan does not include a benefit that defers pay. However, a cafeteria plan can include a qualified 401(k) plan as a benefit. Also, certain life insurance plans maintained by educational institutions can be offered as a benefit even though they defer pay.

d. Qualified and Unqualified Benefits

A qualified benefit is a benefit that does not defer compensation and is excludable from an employee's gross income under a specific provision of the Code, without being subject to the principles of constructive receipt.

i. Qualified benefits include:
   - Accident and health benefits (but not Archer medical savings accounts or long-term care insurance)
   - Adoption assistance
   - Dependent care assistance
   - Group-term life insurance coverage
   - Health savings accounts, including distributions to pay long-term care services
   - The written plan must specifically describe all benefits and establish rules for eligibility and elections

ii. Benefits not allowed:
   - Archer MSAs. See Accident and Health Benefits in section 2
   - Athletic facilities
   - De minimis (minimal) benefits
   - Educational assistance
   - Employee discounts
   - Employer-provided cell phones
   - Lodging on your business premises
   - Meals
   - Moving expense reimbursements
   - No-additional-cost services
   - Transportation (commuting) benefits
   - Tuition reduction
   - Working condition benefits
   - It also cannot include scholarships or fellowships (discussed in Publication 970, Tax Benefits for Education)

## II. Flexible Spending Accounts

A flexible spending arrangement (FSA) is a form of cafeteria plan benefit, funded by salary reduction, that reimburses employees for expenses incurred for certain qualified benefits. An FSA may be offered for a) dependent care assistance, b) adoption assistance, and c) medical care reimbursements; each is a separate plan. The benefits are subject to an annual maximum and are subject to an annual "use-or-lose" rule. The maximum amount of reimbursement reasonably available to a participant for such coverage must be less than 500 percent of the value of the coverage. In the case of an insured plan, the maximum amount reasonably available must be determined on the basis of the underlying coverage. An FSA cannot provide a cumulative benefit to the employee beyond the plan year. (IRS FAQs for government entities regarding Cafeteria Plans, 2013)

Employees can only be reimbursed for allowable, documented expenses incurred during the plan year after the expenses have been substantiated.

There are two ways in which one may benefit from an FSA. The first is by taking advantage of the tax savings. By reducing gross income, one pays less in taxes, takes home more pay and has greater freedom to choose how money is used or invested; the tax savings results in a higher net income. The second benefit is the "cash flow" increase built into the medical FSA. This means that no matter how much money one has actually contributed to the plan at any given point, participants can still be reimbursed up to the entire annual election. Thus, a major medical expense at the beginning of the claim period can be reimbursed even though few, if any, deposits have been made into the account at that time.

Unless the employer's plan document states otherwise, any funds remaining after all eligible reimbursements have been made is forfeited to the cafeteria plan; these funds are commonly used to offset plan losses and administrative expenses. In order to prevent the loss of funds, it is important to plan carefully so that the annual election matches actual expenses as closely as possible. Of course, it is impossible to project with 100% accuracy, so participants may come up short or have a little money left at the end of the claim period. However, it is important to realize that loss of funds does not necessarily indicate a loss out-of-pocket. In most cases, even when participants claim less than their election, they still save money by participating in the plan.

a. Tax Considerations

An employee can generally exclude from gross income up to $5,000 of benefits received under a dependent care assistance program each year. The limit is reduced to $2,500 for married employees filing separate returns. The exclusion cannot be more than the earned income of either the employee or the employee's spouse. The total dependent care benefits the employer paid to the employee or incurred on the employee's behalf (including amounts from a section 125 plan) should be reported in Box 10 of Form W-2. Any amount over $5,000 should be included in boxes 1, 3, and 5, as "wages," "social security wages" and "Medicare wages."

b. Medical FSA

For a medical FSA, the maximum annual election is set by your company and can be found in the Summary Plan Description (SPD). For medical accounts, any out-of-pocket expenses related to services covered by insurance, including co-pays, deductibles, prescription drugs, and out-patient elective surgery; dental, orthodontic and ophthalmologist's fees and expenses including prescribed treatments and maintenance; chiropractic, psychiatric, and psychologist's fees and expenses; disability-related expenses. In general, any treatment for a diagnosed medical condition is reimbursable; cosmetic or preventative expenses are not. For example, teeth-whitening and multi-vitamins are not eligible, but prescription sunglasses are. Insurance premiums are not eligible for reimbursement (IRS FAQs for government entities regarding Cafeteria Plans, 2013).

c. Dependent Care FSA

For a dependent care FSA, the maximum annual election is set by the IRS. The Plan Year is the 12-month period specified in the SPD that determines the beginning and ending dates of plan contributions (salary reductions). Amounts paid to a daycare provider either in or out of the home are eligible, as long as the provider is not a dependent or relative under the age of 19. Pre-school tuition is reimbursable, but tuition and expenses from grade K-12 schooling are not.

**Examples:**

**Current UC FSA Accounts:**

UC offers two flexible spending accounts (FSAs) to help employees save on taxes: the Dependent Care FSA (DepCare FSA) and the Health FSA. The plans allow employees to pay on a pretax, salary reduction basis for eligible dependent care expenses or health care expenses not covered by medical, dental, or vision plans. CONEXIS currently administers the FSA plans.

Employees specify an amount to be taken from their paycheck each month which is then deposited into a Health FSA and/or a Dependent Care FSA. When eligible expenses are incurred, the employee submits a claim form and appropriate documentation of these expenses to CONEXIS. CONEXIS then reimburses the employee from the funds in the appropriate account. Claims must be submitted by March 15 of the following year to receive reimbursement.

Because the FSA contributions are deducted from paychecks before taxes are withheld, taxable income is reduced, and employees save money on taxes. Individual savings are dependent on the employee's particular tax situation.

**DepCare FSA Contributions:**

Employees determine how much they want taken from their monthly paycheck(s), from a minimum of $180 per plan year up to the lesser of $5,000 per plan year ($2,500 if married and filing a separate income tax return).

If the employee's spouse is incapable of self-care or is a full-time student, employees may claim up to $2,400 for one dependent or $4,800 for two or more dependents.

If a spouse is also eligible to participate in a dependent care FSA, the combined contributions should not exceed the maximums stated above. Any money not used will be forfeited, so it is critical for employees to calculate contributions carefully.

**Health FSA Contributions:**

Employees can contribute up to $2,500 per plan year. If both the employee and spouse are UC employees, each contribute up to $2,500. Employees must contribute a minimum of $180 per year to participate. Any money not used will be forfeited; so employees must calculate contributions carefully.

## Appendix B: Self-Insurance Information

Self-funded health care is an insurance arrangement whereby an employer provides health or disability benefits to employees with its own funds. This is different from plans where the employer contracts an insurance company to cover the employees and dependents. In self-funded health care, the employer assumes the direct risk for payment of the claims for benefits. The terms of eligibility and coverage are set forth in a plan document which includes provisions similar to those found in a typical group health insurance policy. Unless exempted, such plans create rights and obligations under the Employee Retirement Income Security Act of 1974 ("ERISA").

The company usually hires a 3rd party administrator (TPA) to handle claims, build provider networks, etc., which could be an added expense for UC.

In locations where there are medical centers, this can be a way to keep certain institutional costs down and provide employees with coverage at a low cost to both the employee and employer. This plan may limit the ability of the patient to go to non-UC medical centers, so options will need to be provided within the plan for when specialists or certain treatments from outside providers are necessary.

For UC campuses that do not have a medical center, UC or the TPA will have to contract with local providers. This can impact UC by having to pay higher costs to providers that are not affiliated with UC medical centers because insurance coverage is required for every employee within a certain number of miles from their residence, not their work location (usually within 20-30 miles).

If the UC medical centers will still provide services to the public community as well, it is critical to ensure there are enough staff and providers to meet the needs and demands of patients.

**Stop-Loss Coverage**

Many employers seek to mitigate the financial risk of self-funding claims under the plan by purchasing stop-loss insurance from an insurance carrier. Stop-loss coverage is a form of reinsurance for self-insured employers that limits the amount the employers will have to pay for each person's health care (individual limit) or for the total expenses of the employer (group limit). One important aspect of self-funded group health plans lies in the requirement that the employer remain liable for funding plan claims regardless of the purchase of stop-loss insurance. What this means, in turn, is a fund or a company's own bank account creates a pool of its employees and is managed and distributed to claim payouts. In other words, only the employer has a contractual relationship with plan participants and beneficiaries. The stop-loss policy exists solely between the employer and the stop-loss carrier and creates no direct liability to the individuals covered under the plan. This feature provides the critical distinction between fully insured plans (subject to state law insurance regulations) and self-funded health plans, which, under the provisions of Section 514 of ERISA, are exempt from certain state insurance regulations.