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Health care reform law poses many funding issues

By JERRY GEISEL

WASHINGTON—No federal law comes close to the 2010 health care reform law when it comes to its potential impact on employer-sponsored health care plans and the issues confronting them.

"The law has shifted health care benefits from a 'nice to have' to a 'have or else' posture that is unprecedented in our previously voluntary approach to employee benefits," said Andy Anderson, a partner with Morgan Lewis & Bockius L.L.P. in Chicago.

Two years after the passage of the Patient Protection and Affordable Care Act, employers already have felt the impact of the law.

Since Congress approved the bill and President Barack Obama signed the measure into law in March 2010, employers have had to make numerous changes to their health care plans.

Among other things, employers have had to amend their plans to cover employees' adult children up to age 26, eliminate annual dollar limits, provide full coverage for preventive services in many cases, and eliminate flexible spending account reimbursement for nonprescription drugs.

Employers with early retiree health care plans had to set up a claims reporting system to take advantage—before federal funding was exhausted—of a $5 billion program created by the health care reform law that partially reimburses plan sponsors for claims incurred by retirees at least age 55 but not eligible for Medicare and their dependents. That fund already has run dry.

Some issues are ongoing and involve continuing cost/benefit analysis. For example, the law exempts grandfathered health care plans from meeting certain reform law requirements, such as providing full coverage for preventive services.

But to qualify for grandfathered status, employers face limitations on how much they can shift funding cost increases to employees through increases in deductibles and copayments. That will involve economic calculations to determine if the savings achieved through maintaining grandfathered status for their health care plans outweighs financial savings from boosting cost-sharing requirements.

Yet another funding cost/benefit analysis triggered by the law involves a program Congress authorized in a 2003 law that gives hefty tax breaks and financial subsidies to employers that offer prescription drug benefit plans to Medicare-eligible retirees. The intent of the program was to encourage employers to maintain their prescription drug plans rather than flooding the newly established government Medicare Part D prescription drug plan with millions of additional retirees.

However, the health care reform law removes some of those tax breaks provided in the Medicare Retiree Drug Subsidy program, effective in 2013.

With the watering down of those tax breaks, employers will have to decide if it still makes sense to offer those plans or analyze if there are other, perhaps even more financially beneficial programs through which coverage may be provided.

"There may be better ways to do it," said Dan Levin, a principal with Buck Consultants L.L.C. in Chicago.

But the retiree prescription drug issue pales in comparison with the issues posed by the health care reform law provision of greatest significance to employers: the requirement, effective in 2014, that they offer "qualified" affordable health care plans or face financial penalties ranging from $2,000 to $3,000 per full-time employee.

"This will be a sea change for employers. We will go from a voluntary system to one in which there are mandatory obligations," Mr. Anderson said.

The law will present an array of financial issues that employers will have to consider. For example, under the law, employers are liable for financial penalties if they don't offer coverage to full-time employees.

Full-time is defined as working no less than 30 hours a week. That will present a problem for employers with large numbers of part-time employees who work more than 30 hours a week but are not eligible for health care coverage.

They could, of course, revamp eligibility requirements so that the part-time employees would be eligible for health care coverage. That approach, though, would significantly increase their health care plan costs.

Alternatively, they could do nothing. But that would be costly, too. If just one lower-paid part-time employee who works at least 30 hours a week were not offered coverage, and was eligible for a health care reform premium subsidy and used it to buy coverage in a state insurance exchange, the $2,000-per-employee penalty would be assessed on all the employer's full-time employees, including those with coverage.

Yet another approach—reducing

Continued on next page

SPECIAL ISSUE

ALTERNATIVE BENEFIT FINANCING

For years, group health care plan costs—no matter what actions employers take—have been going in only one direction: up. And at a rate far in excess of general inflation.

And the Patient Protection and Affordable Care Act, the sweeping 2010 health care reform law, didn't help matters much. Indeed, the law, if it stands Supreme Court scrutiny, will impose big financial penalties on employers if they don't offer coverage to full-time employees. It also requires them to upgrade their plans, such as eliminating annual and lifetime dollar limits, and soon will curb tax breaks for employers offering prescription drug coverage to Medicare-eligible retirees.

In this special issue of *Business Insurance*, we look at the challenges facing employers as they explore new and alternative ways to fund health care benefits to bring down the rate of cost increases to more acceptable levels.

Among other things, this issue examines the pros and cons of the ultimate health care funding strategy: not offering coverage at all. We also look at some of the newest and potentially promising ways of funding coverage, including utilizing private health insurance exchanges, as well as older but little-publicized approaches involving special tax-favored trusts.

Additionally, our fold-out data poster provides a trove of information on health care costs.

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HEALTH CARE LAW REVAMPS BENEFITS FUNDING

How the Patient Protection and Affordable Care Act affects the funding of health care benefits:

2010

- Creation of a $5 billion federal fund to partially reimburse employers and other early retiree health care plan sponsors for claims incurred by retirees and their dependents.

2011

- Elimination of health care plans' lifetime dollar limits.
- Extension of group health care plan coverage to employees' adult children up to age 26.
- Non-prescription drug costs no longer reimbursable through flexible spending accounts.

2013

- Maximum contribution to health care flexible spending accounts capped at $2,500 per enrollee. Future increases linked to annual rise in the consumer price index.
- Employer tax deduction for prescription drug coverage provided to Medicare-eligible retirees ended for amounts equal to federal subsidy to employers whose drug plans are at least equal to Medicare Part D.

2014

- Imposes an annual $2,000 penalty on employers with 50+ employees for each full-timer not offered coverage.
- $3,000 penalty on employers with 50+ employees for each full-time employee whose premium contribution exceeds 9.5% of income and receives subsidized coverage through state insurance exchanges.
- Maximum waiting period before new full-time employees can receive coverage limited to 90 days.
- Annual dollar limits on health care expenses eliminated.
- Federal premium subsidies provided to full-time employees with adjusted gross incomes of up to 400% of the federal level who are not eligible for affordable employer-provided health care coverage.

2018

- Forty percent excise tax imposed on health insurance premiums exceeding $10,200 for single coverage and $27,500 for family coverage. Cost thresholds slightly higher for plans covering retirees or employees in certain high-risk industries. In 2019, thresholds rise to match the increase in the consumer price index, plus one percentage point. In 2020 and succeeding years, thresholds match percentage rises in the index.

Funding: PPACA poses numerous funding issues

CONTINUED FROM PREVIOUS PAGE

the number of hours part-time employees work to below the 30-hour threshold—also presents issues.

One issue is whether such action could expose them to liability under the Employee Retirement Income Security Act. "Under ERISA, employers cannot take employment actions for the sole purpose of preventing an employee from becoming eligible under an ERISA-covered plan, such as a health care plan, said Tracey Giddings, a director with PricewaterhouseCoopers L.L.P. in Tampa.

"An ERISA issue could be created if the reduction in hours was taken for the sole purpose of avoiding the $2,000 penalty," Ms. Giddings said.

Starting in 2018, employers face yet another issue: exposure to a health care reform law excise tax. That 40% excise tax will be applied on health care plans whose costs exceed $10,200 for single coverage and $27,500 for family coverage. The tax will be paid by insurers—or third-party administrators in the case of self-funded plans—but experts expect insurers and TPAs to recoup excise tax payments by imposing additional charges on employers.

While 2018 is years away, employers already now have to decide what actions to consider taking to reduce the likelihood of being hit with the tax.

Yet moving too fast on changing plan design and funding approaches poses yet another issue. Sometime in June, the U.S. Supreme Court is expected to hand down a decision that potentially could make employer actions unnecessary.

Under one scenario, the high court, which is reviewing the constitutionality of the law's individual mandate, could decide that the mandate is unconstitutional and so intertwined with the entire Patient Protection and Affordable Care Act that the justices would strike down the broader law as a result.

"None of this may matter much until we hear from the Supreme Court," Mr. Anderson of Morgan Lewis & Bockius said.

Changing worker behavior key to cutting health costs

By LOUISE KERTESZ

Employers struggling to contain health care costs have found little success with methods based on cost-shifting. Experts say it appears benefit designs encouraging employee consumerism and accountability are helping to slow health care cost increases.

However, while the rise in health care costs has eased in recent years, health care cost increases still outpace the consumer price index and account for almost 18% of the nation's gross domestic product.

According to the 2012 Towers Watson/National Business Group on Health employer survey, health care costs increased 9% in 2007, 8% in each of the next four years, and are projected to rise by 7.4% this year, before plan and contribution changes.

Mercer L.L.C.'s 2011 employer survey places the 2011 increase at 6.1% and projects a lesser increase of 5.7% this year.

According to the Centers for Medicare and Medicaid Services, "Total health expenditures reached $2.6 trillion in 2010, which translates to $8,402 per person or 17.9% of the nation's gross domestic product, the same share as in 2009."

However, employers and consultants said programs encouraging employee consumerism and accountability and provider competition are holding down cost increases.

"Changes in the system have introduced more constraint on how fast health care costs increase," said Mike Thompson, principal in PricewaterhouseCoopers L.L.P.'s global human resources services in New York. But, he added, "It's an uphill battle."

"It would be worse if they (employers) didn't do the things they are doing," said Helen Darling, president and CEO of the National Business Group on Health in Washington.

Experts pointed to underlying drivers that continue to push up costs.

"The first is, as a nation, we're not getting any healthier," said Tracy Watts, a partner at Mercer in Washington. Obesity is "becoming more common," as is "the prevalence of childhood diabetes,"

Adding to that, she said, "While we're not getting any healthier, we are living longer, and that's tied to all the (expensive) innovations in health care."

"There's not much we can do about our aging population, but the impact on health care costs of the deterioration of lifestyles can be cumulative," said Mr. Thompson.

Economists have estimated that higher-priced technology has increased costs 1% to 2% per year, Mr. Thompson said. Overuse of that technology and of health care services in general "is directly related to coverage" and has been a major cost driver for years, said Ms. Darling, who formerly managed international compensation and benefits at Xerox Corp.

"Best practices are not being followed. So much care is provided that is not evidence-based," she said, citing an example from a study by Dr. Rita Redberg, editor of the Archives of Internal Medicine, that found Medicare pays for colonoscopies for patients over age 75, for whom those screenings are not recommended.

A lot of overuse comes from self-referral to the emergency room or to specialized services, such as to orthopedics, that may not be needed or advisable, Ms. Darling said. "Not having a good relationship with a primary care physician is a prime driver of health care costs," she said.

Ms. Darling referred to health care costs as "a crushing burden" in her chapter of the book "Engineering the System of Healthcare Delivery."

Asurion Insurance Services in Nashville, Tenn., which provides mobile device protection, found that a major health care cost driver was overuse of the emergency room by its employees who worked from home, said Milt Ezzard, director of benefits. The company piloted a telemedicine service for those employees, which reduced the ER visits and provided a 3-to-1 return on investment, he said. Asurion is now rolling out the telemedicine service to all employees, he said.

The lack of transparency in provider cost and quality is a major cost driver, said Sherri Bockhorst, principal at Buck Consultants L.L.C. in St. Louis. Employees are "isolated from the cost" of services like colonoscopies and MRIs, "where there's very little difference in quality but huge differences in cost."

Charlie Salter, vp of compensation and benefits at ConAgra Foods Inc. in Omaha, Neb., and a Buck Consultants client, said that in one city the cost of an MRI of the brain ranges in price from $1,340 to $4,820. In another location, providers charge from $500 to $3,700 for a colonoscopy.

"I have more cost and quality information on purchasing a toaster than a soft organ transplant," Mr. Salter said.

ConAgra and other large companies have begun to work with vendors such as Castlight Health Inc. and Health Care Blue Book, which provide cost information to employees, he said. Because ConAgra's consumer-directed plan, coupled with a health savings account, includes a high deductible, "our employees want to be careful with their money," he said.

Another major cost driver is expensive wellness programs that provide incentives for employee participation rather than for outcomes.

A Buck survey found that 60% of employers with wellness programs can't demonstrate their ROI, Ms. Bockhorst said. Health assessments and other components of wellness programs "of themselves don't change behaviors. We're seeing a shift to outcomes-based incentives," that is, providing a cash incentive only if an employee reaches a certain health level threshold, she said.

ConAgra has taken that approach. "We want people to recognize their risks and begin taking the steps to get within normal limits," Mr. Salter said. A salaried employee at ConAgra can earn up to $3,300 a year in incentives by making progress in reducing his or her health risks and maintaining good health status.

Mr. Ezzard said payers have "exhausted" cost-shifting as a strategy to hold down health care costs. "We shifted deductibles and copays, but we did not address the root cause: education on what's appropriate and efficient medical care and accountability for people making their decisions. Cost-shifting doesn't change behavior."

Health care costs may have reached "a new normal," Mr. Thompson said. Because of the structural changes in the health care system, "we have had a few good years. Increasingly people are wondering if we can sustain that."

REASONS BEHIND COST SURGE

Experts point to several factors that drive up health care costs, including:

- Obesity
- Childhood diabetes
- Longer life spans
- Higher-priced technology
- Overuse of screenings
- Self-referral to emergency rooms or specialized services
- Lack of transparency in provider cost and quality
- Expensive wellness programs that provide incentives for employee participation rather than for outcomes
- High-risk pregnancies
- Lack of education on what is appropriate and efficient medical care

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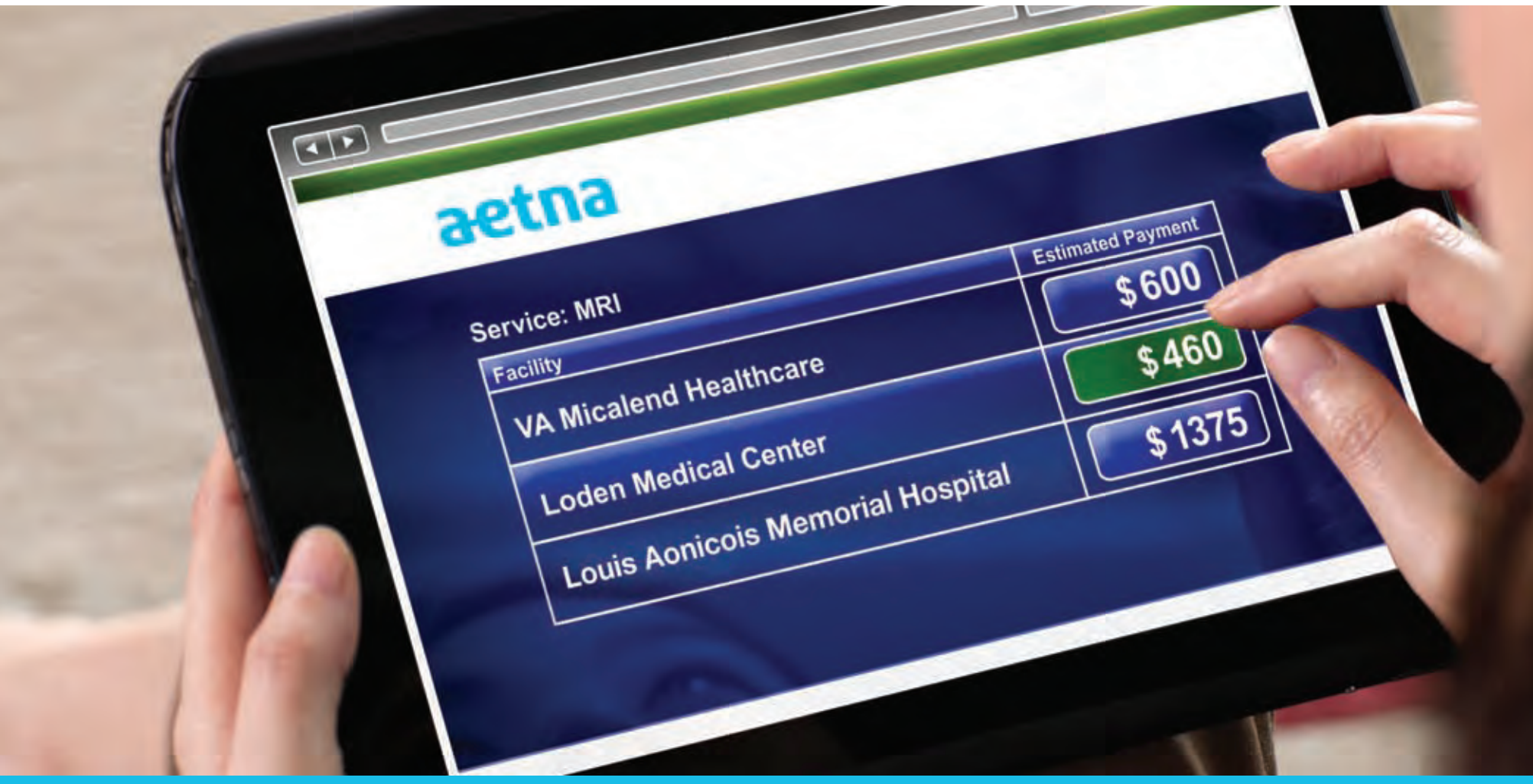

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BLOOMBERG

The Coca-Cola Co. in 2010 became the first company to win Labor Department approval to fund retiree health care benefits through its captive.

Regulators help shape landscape for benefits

Rules let employers try innovative solutions

By JERRY GEISEL

WASHINGTON—While federal lawmakers have played a crucial role in passing bills that affect the funding of health care and other employee benefits, the role of regulators also has been a vital one.

Perhaps the best example of their critical role in setting benefit funding rules involves the use of captive insurance companies to fund benefit risks.

Until 1979, the only guidance in that area was embedded in the Employee Retirement Income Security Act. When ERISA, which is primarily a pension law, was being put together, lawmakers first wanted to ban the use of captives to fund benefit risks because of the potential for self-dealing.

However, lobbying by then-Sears Roebuck & Co., which for years had been using its Allstate Insurance Co. unit to provide various benefit programs to Sears' employees, convinced lawmakers to modify the provision. Under the modification, employers could continue to use their insurance subsidiaries to fund employee benefit plan risks as long as no more than 5% of the subsidiary's business was third-party—a test Allstate could easily meet.

But other employers such as Deere & Co., with big insurance subsidiaries that had lots of but still not quite enough unrelated business to meet the 5% test, urged the Labor Department to ease the rule.

Their efforts were successful when the Labor Department in 1979 bumped up the 5% test to 50%. That change enabled Deere and other organizations whose captives did a lot of outside business to use their captives to fund corporate benefit risks.

But the liberalization of the outside business test was of no use to the overwhelming majority of employers whose captives had very little, if any, unrelated business.

It took more than two decades and many discussions with captive attorneys and consultants, but in 2000, the Labor Department offered an alternative to the 50% test.

Under that alternative, the 50% test could be disregarded as long as certain conditions were met including the use of an independent fiduciary, using top-rated fronting insurers, and enhancing the benefits of participants affected by the arrangement.

More than two dozen employers, including such household names as Alcoa Inc., H.J. Heinz Co. and Microsoft Corp., won Labor Department approval to fund benefit risks—typically, long-term disability and life insurance—under the alternative to the 50% test.

And one employer—soft beverages giant The Coca-Cola Co.—in 2010 became the first company to win Labor Department approval to fund retiree health care benefits through its captive. That complex arrangement, which also involves the use of a special trust, is under review by the Internal Revenue Service concerning certain tax aspects.

The Labor Department's captive benefit funding rules are just one of many examples of how regulatory actions have affected the funding of benefits.

"We have seen an accelerating expansion of a body of regulations that have impacted benefit plans," said Andy Anderson, a partner with the law firm Morgan Lewis & Bockius L.L.P. in Chicago.

Another example of the regulatory impact on benefit plans involves flexible spending accounts, a tax-favored method employers have tapped to make it easier to shift more health care costs to employees.

Under an FSA, employees make pretax contributions to pay for uncovered health care expenses, like costs that fall under a health care plan's deductible. That tax break reduces an employee's true cost in paying for a service.

But the rules involving the operation of FSAs have changed over the years. The most significant change was in 1984, when IRS regulators said account balances had to be forfeited at the end of a plan year.

Then in 1995, IRS regulators modified the rules again, allowing employers to redesign their FSAs so employees could carry over unused FSA balances to pay for expenses incurred during the first two and a half months of the succeeding plan year.

"It is a quid pro quo. If you want the tax advantages of FSAs, there is an arc of regulations to follow in offering and administering the plans," Mr. Anderson said.

Regulators also have modified rules affecting health reimbursement arrangements, which typically are coupled with high-deductible health plans. In 2002, the IRS gave its blessing to the arrangements, but attached certain conditions to its approval. Among other things, the arrangements must be funded solely by employers and used only for substantiated medical expenses.

If those conditions are met, the arrangements can be structured so that unused employer contributions can be rolled over to pay employees' expenses in succeeding years, the IRS said in a 2002 ruling.

And the 2010 health care reform law has given rise to numerous regulations affecting funding of health care benefits.

For example, regulators gave a temporary reprieve—through the end of 2013—that has enabled employers to offer mini-med plans. Such plans, without a special exemption, would flunk a basic health care reform law test than bans annual lifetime dollar limits.

And plenty of rules lie ahead. For example, the law imposes a special tax on insurers and—in the case of employers that self-fund their health care plans—on third-party claims administrators for plans whose costs exceed certain amounts.

Regulatory guidance is needed, though, in how the tax is to be calculated and allocated in situations where employers offer multiple plans with varying costs, said Tracey Giddings, a director with PricewaterhouseCoopers L.L.P. in Tampa.

LAWS, RULES AFFECTING BENEFITS FUNDING

Ever since the passage of the Employee Retirement Income Security Act, federal lawmakers and regulators have approved numerous bills and rules that have affected the funding of health care benefits. Those laws and rules include:

1974

- Federal lawmakers include a provision—responding to lobbying by then Sears Roebuck & Co.—in ERISA to allow employers to use their captive and other insurance company subsidiaries to fund parent benefit risks as long as no more than 5% of the captive's business is related to its parent.
- ERISA provision pre-empts state laws and rules that relate to employee benefit plans.

1978

- Congress mandates that employers provide the same health care coverage for pregnancy and childbirth as for other medical conditions. Prior to the passage of the Pregnancy Discrimination Act, it was not uncommon for employers to put dollar caps on pregnancy-related health care expenses.

1979

- Modifying the "5% test," the Labor Department says employers can fund benefit risks through their domestic captive insurance companies so long as at least 50% of the captive's business is third-party risk. Certain conditions are imposed, including that the captive be licensed in a U.S. state or territory.

1982

- Congress approves legislation making employers the primary payer of health care bills for employees ages 65-69.

1984

- The Internal Revenue Service issues "use it or lose it" rule that requires flexible spending account participants to forfeit unused account balances at the end of the plan year.

1986

- Congress approves legislation to require employers to extend group coverage to employees for up to 18 months after termination of employment, or up to 36 months to employees' dependents in situations involving death, divorce or marital separation. Employers can charge beneficiaries up to 102% of the group rate for coverage.

1990

- Congress allows transfer of some surplus pension plan assets to special retiree health care accounts.

1996

- Congress curbs employers' ability to deny coverage for new employees' pre-existing medical conditions.

2000

- In a filing involving Columbia Energy Group, the Labor Department gives employers an alternative to the 1979 captive benefit funding requirement that at least 50% of the captive's risk be third-party business in order for the captive to fund benefit risks of the parent. To comply with the alternative, captive parents, among other things, must sweeten plan participants' benefits, and coverages funded by the captive must be written by a highly rated commercial insurer.

2003

- Congress approves legislation to allow employers to offer high-deductible health insurance plans linked to health savings accounts. Employees and employers can make tax-favored contributions to HSAs, which employees can withdraw tax-free to pay for uncovered health care expenses that fall under the deductible, with unused amounts rolled over to pay for succeeding years' expenses.

2004

- The IRS rules that high-deductible health care plans to which HSAs must be linked can provide first-dollar coverage for preventive services.

2005

- The IRS modifies the 21-year-old "use it or lose it" rule to allow employees to carry over balances unused at the end of a plan year to pay for expenses incurred during the first two and a half months of the next plan year.

2006

- Congress approves legislation repealing requirement linking maximum HSA contribution to size of deductible in health care plan linked to the HSA.
- Congress approves measure allowing one-time transfers of FSA and health reimbursement arrangement balances to HSAs.

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Opinions

EDITORIAL

Creativity helps benefit funding

THERE IS BAD AND GOOD NEWS in this week's issue, which is devoted exclusively to the funding of group health care benefits.

First, the bad news: Health care cost increases continue to rise at a rate far surpassing general inflation. And there are no signs that cost increases will moderate to more acceptable levels.

The other bad news is the adverse impact the 2010 health care reform law will have on group plans. Among other things, the Patient Protection and Affordable Care Act imposes a tax on the most costly health care plans, cuts back on tax breaks Congress passed nearly a decade ago to encourage employers to offer prescription drug coverage to Medicare-eligible retirees, and drastically reduces the contributions employees can make to flexible spending accounts.

But there is much good news. This week's stories make clear how much energy and creativity employers and others are devoting to help bring costs under control while also expanding benefit choices.

For example, about 50 colleges and universities are participating in an innovative retiree health care benefits funding program. Through that program, the institutions provide fixed contributions to tax-favored trusts. When employees retire, they can draw upon the accumulated contributions to pay for retiree health care coverage.

That program strikes us as an attractive middle ground between the extremes of traditional plans, which become unaffordable over time, and no coverage, which leads to employees staying on the job longer than they or their employer would like.

We also are encouraged by the growth of private health insurance exchanges. Through these programs, employers can be free of the hassle and expense of offering and administering health care plans, while their employees and retirees may have a range of plan design choices that their employers could not provide.

In yet another innovative approach, a group of utility companies have found a way to tax-effectively fund retiree health care coverage through special trusts and stop-loss insurance.

These creative and innovative approaches clearly give us optimism that the private sector will find new and more effective ways to deal with the problem in the health care arena that has been the most resistant to change: rising costs.

LETTERS

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SCHILLERSTROM

COMMENTARY

Captives offer solutions for benefits

With benefits playing an important part of employee compensation at many organizations, and employers constantly looking for more cost-effective ways of providing those benefits, it's no surprise that companies increasingly are involving alternative financing vehicles in their benefits programs.

However the U.S. Supreme Court rules on the Patient Protection and Affordable Care Act, employee benefits—health care and otherwise—will continue to be a key concern of many employers as they look to control costs while remaining competitive with others vying for the same talent pool.

RODD ZOLKOS
SENIOR EDITOR

For owners of captive insurance companies, writing benefits business in the captive can offer various advantages including diversifying the captive's book of business, the possibility of reduced costs to the benefit program and, in some cases, opportunities for favorable tax treatment.

As an organization weighs placing benefits risks in a captive, an essential consideration is whether the benefits under consideration are subject to U.S. Employee Retirement Income Security Act regulations. For multinational companies looking to use a captive to finance international employees' benefits, ERISA isn't a factor, nor does it come into play if the captive parent uses the captive to finance various optional employee benefit programs.

For companies considering using the captive to fund ERISA benefits, such as reinsuring group life or long-term disability programs, the road is a trickier one, as the parent must obtain an exemption from the U.S. Department of Labor. But it's an effort some companies have found worthwhile.

Columbia Energy Group was the first to win such an exemption in 2000. When Archer Daniels Midland Co. won DOL approval in 2003 to use its captive to fund employee life insurance benefits, it became the second company to do so and, more significantly, helped "fast track" the approval process for other companies looking to write ERISA benefits in captives.

The Coca-Cola Co. also is among the companies going the captive benefits route. It received DOL approval in 2010 for a plan to use its captive to fund retiree medical benefits and is awaiting Internal Revenue Service approval of certain tax aspects of the arrangement.

Another potential benefit of placing employee benefits risks in a captive is that the arrangement can strengthen relationships between risk management and the organization's human resources department. Bringing those two departments together can be a challenge initially, but it is absolutely essential to make the programs work. If achieved, the alliance can pay dividends in providing a better understanding of the people risks inherent in the organization.

Captives bring their parents predictability, flexibility, the opportunity to apply creative solutions to risk financing problems and a better understanding of the organization's risks—potential advantages to all companies that look to their captives to finance benefits programs.

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CASE STUDY

Utilities band together to fund retiree benefits

VEBA-based plan offers tax benefits, investment income

By JERRY GEISEL

GREENVILLE, S.C.—Since the mid-1990s, a small group of utility companies has been participating in an innovative arrangement to tax-effectively prefund their retiree health care liabilities. Under the arrangement, to which the Internal Revenue Service gave its blessing through a 1995 private letter ruling, the utilities make tax-deductible contributions to their own voluntary employees' beneficiary associations.

In turn, the trusts buy stop-loss insurance that reimburses the trusts for claims incurred by salaried retirees above a specified attachment point.

The stop-loss policies are purchased from a cell of Greenville, S.C.-based Energy Insurance Services Inc., a subsidiary of Energy Insurance Mutual Ltd., a utility-owned insurer domiciled in Florida. All utilities participating in the VEBA retiree health care funding program are members of Energy Insurance Mutual.

Within the cell, 95% of the premiums paid by each VEBA for stop-loss coverage is held in a separate account and 5% is allocated to a general account that is available to fund claims should policy assets in any separate account be insufficient.

One appealing point of the arrangement is that under insurance tax law, the assets held in the stop-loss insurance accounts can earn tax-deferred investment income, while EIS stop-loss payments to the VEBA are not subject to tax.

"As long as our policies remain in force, there is no tax on the investment gain within policy assets and no tax on claims payments at the policyholder level just as is the case with life insurance," said EIS Chief Operating Officer Robert Schmid.

As the policy assets grow over time, due to favorable investment results or lower-than-expected claims, the band of stop-loss coverage—essentially the specific limit above each insured's retention—will increase.

"If we have a series of good years, you can expect that the band of coverage for claims will increase," said Mr. Schmid said.

Considerable investment income can be earned by the policies. That is because the policies are written to cover employees, among others, who are years away from retirement.

"Some of the employees included in the policies may have 20 or more years to work before they will file a retiree medical claim," Mr. Schmid said.

"It is a very cost-efficient way of funding retiree health care benefits," said Karin Landry, a managing partner at Spring Consulting Group L.L.C. in Boston. "As long as you can afford to put the assets in, it is one of the best funding vehicles out there," said Ms. Landry, who, as a consultant for then Watson Wyatt Worldwide, helped design the program.

The program had its origins in accounting rules issued in the early 1990s that require employers to calculate and disclose the future cost of retiree health care obligations.

To prevent an enormous hit to their financial statements, the utilities needed an efficient funding vehicle for their retiree health care obligations.

In some cases, VEBAs are that funding vehicle. But as part of a 1984 tax law, Congress curbed the appeal of VEBAs. Specifically, investment income earned by VEBAs to provide retiree health care to nonunion retirees is subject to a 34% unrelated business income tax.

"This is an efficient way to fund for future costs," Mr. Schmid said. Utilizing a VEBA and insurance brings the same tax advantages that would occur in a VEBA arrangement funding retiree health care coverage for union employees, he said.

Mr. Schmid declined to disclose the number of utilities that participate in the arrangement, but said the arrangement covers thousands of utility industry employees and retirees.

HOW IT WORKS

An innovative arrangement involving a small group of utility companies is used to tax-effectively prefund their retiree health care liabilities:

- The arrangement involves the use of special trusts set up by the utilities and stop-loss insurance the trusts purchase from a utility industry owned captive insurer.

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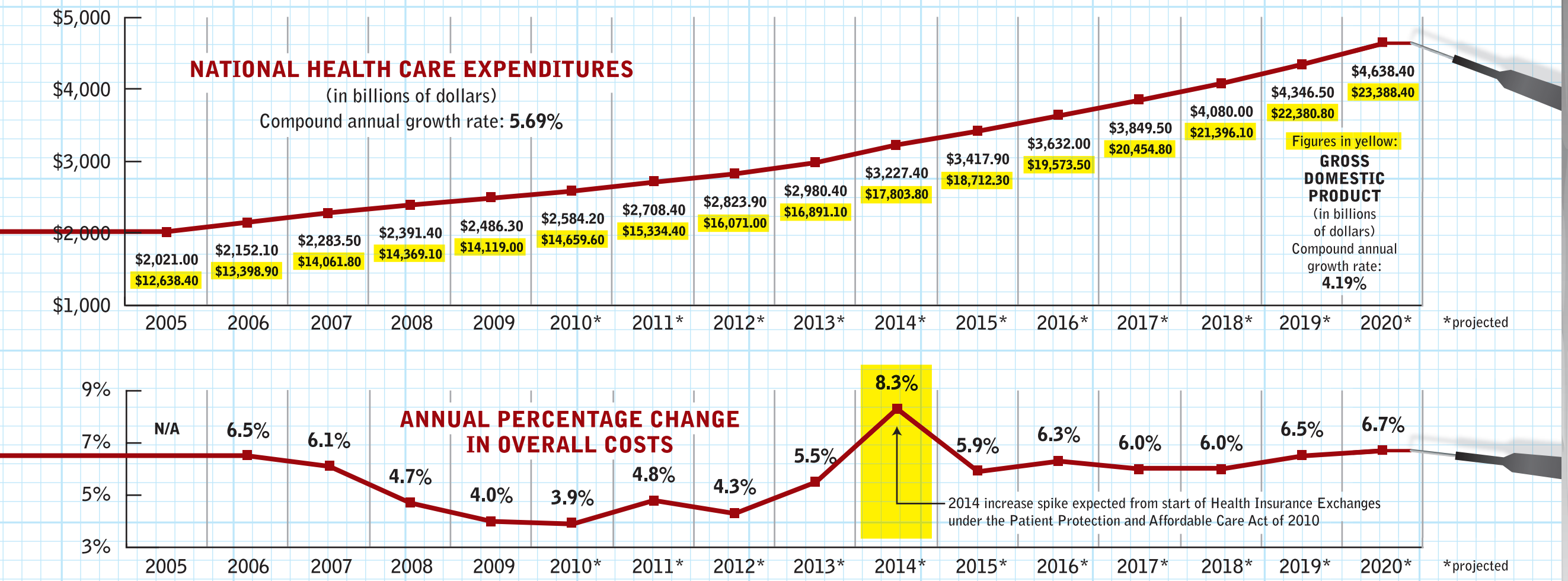
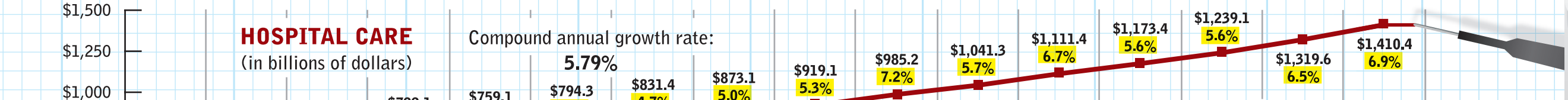
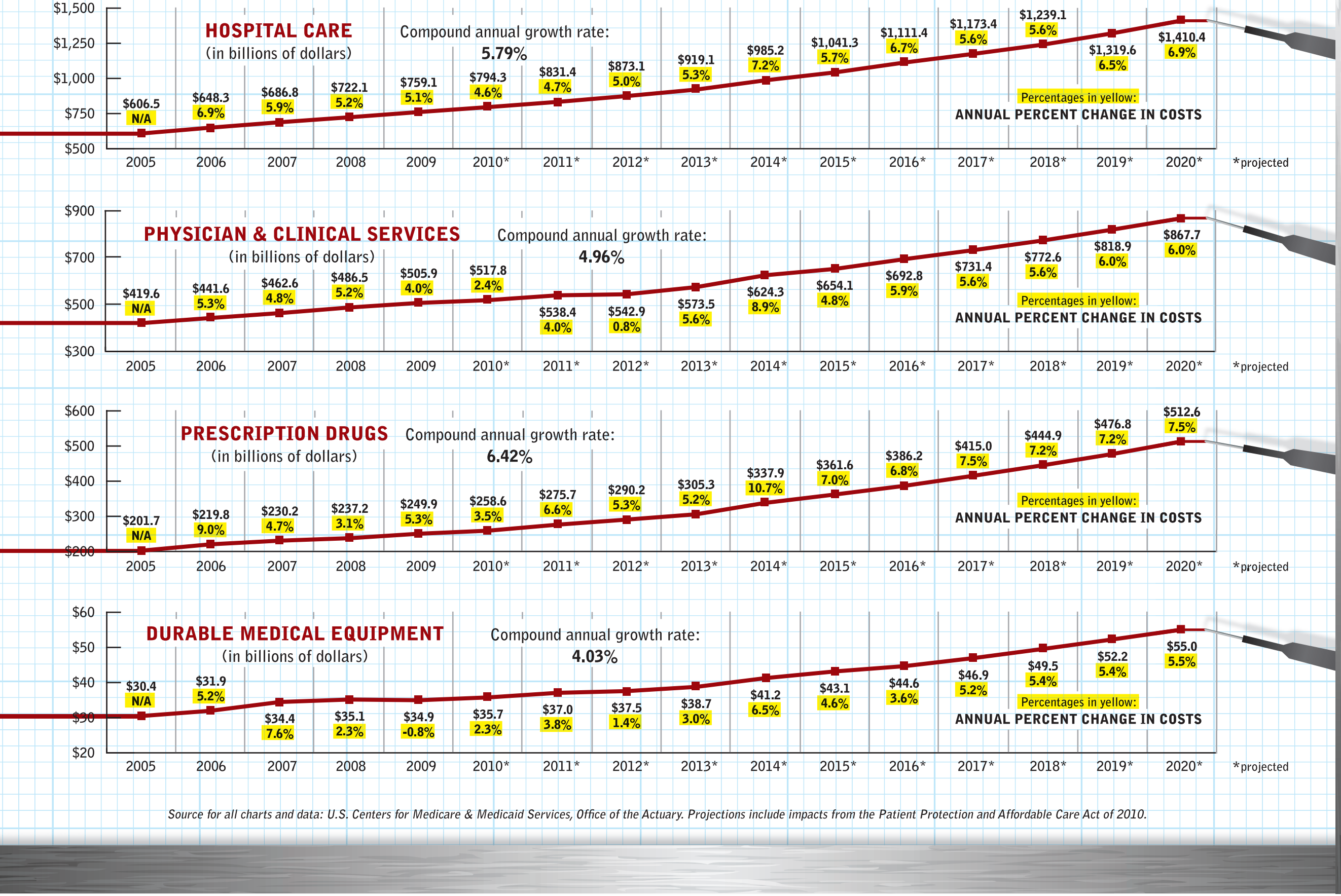
NATIONAL HEALTH CARE EXPENDITURES ARE PROJECTED TO HIT $4.63 TRILLION IN 2020



KEY COMPONENTS COVERED BY HEALTH CARE PLANS ANNUAL COSTS





Source for all charts and data: U.S. Centers for Medicare & Medicaid Services, Office of the Actuary. Projections include impacts from the Patient Protection and Affordable Care Act of 2010.

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CASE STUDY

Coca-Cola designs innovative captive plan

By JERRY GEISEL

An Internal Revenue Service ruling expected this year could provide a groundbreaking way for employers to fund retiree health care benefits through their captive insurers and special tax-exempt trusts.

Three years ago, The Coca-Cola Co. launched its drive to fund retiree health care obligations when it sought Labor Department approval of the trailblazing funding arrangement.

In its Labor Department filing, the world's largest nonalcoholic beverage company outlined the complex transaction.

Coca-Cola would use funds now held in a trust—known as a voluntary employees' beneficiary association, to purchase medical stop-loss policies from Prudential Insurance Co. of America to pay claims over the expected lifetime of about 4,000 retirees and dependents.

Coca-Cola established the VEBA in 2006, contributing $216 million in assets.

The medical stop-loss coverage would pay claims that fall between an attachment point and an upper limit.

In its application, Coca-Cola said the attachment point for all retirees would be $100. For those younger than 65, the upper limit would be $5,800; for retirees 65 and older, the upper limit would be $3,500.

In turn, Prudential would use the premium it receives from Coca-Cola to reinsure the risk with Red Re Inc., Coca-Cola's South Carolina captive insurer, and one of three Coca-Cola captives. Atlanta-based Coca-Cola now utilizes Red Re for a wide range of risks, including reinsuring fronting insurers used to provide international employee benefit coverage.

Coca-Cola executives say there are several advantages to the program. Among other things, the arrangement would ensure the "consolidation of cash in the captive and centralized control of the assets," said Laurie Solomon, Coca-Cola's director of risk management.

By retaining control of the cash, Red Re and ultimately Coca-Cola would be the beneficiary of favorable investment results, she said.

By contrast, in a traditional VEBA arrangement, once money is contributed to the trust, it and any investment gains must be used for the exclusive benefit of plan participants.

First, though, the arrangement had to pass muster with the Labor Department, which has jurisdiction over captive benefit funding plans.

In 2010, the Labor Department approved the arrangement, the first time it authorized such a transaction. In 2004, Whirlpool Corp. withdrew a somewhat similar plan after the Labor Department rejected its request to have the proposal considered under a special expedited review process.

Now, Coca-Cola is waiting for an IRS ruling addressing certain tax aspects of the arrangement. Ms. Solomon says she is optimistic that the IRS will issue its ruling this year.

While no one knows how the IRS will rule, experts say if the ruling is favorable, other employers will follow in Coca-Cola's footsteps.

"There are more than a handful of companies who are interested," according to to Mitchell Cole, a director in the Stamford, Conn., office of Towers Watson & Co., which is Coca-Cola's consultant on the project.

"I've always thought this type of arrangement made sense," said Karin Landry, a managing partner with Spring Consulting Group in Boston.

"You needed a pioneer," said Kathleen Waslov, a senior vp and senior resource consultant in Boston with Willis Group Holdings P.L.C., adding that many companies don't want to be the first to try an approach.

Still, the arrangement is not for everyone, experts say, noting that many companies would not want to commit so much cash.

In addition, "You need a partnership of risk management and HR," said George O'Donnell, a senior vp with Aon Hewitt in Somerset, N.J.

KEY POINTS

The Coca-Cola Co.'s trailblazing way to fund retiree health care benefits involves a fronting insurer, a special trust and one of its captives:

- Coca-Cola would use funds held in a VEBA to buy medical stop-loss coverage from Prudential to pay claims over the expected lifetime of about 4,000 retirees and dependents.
- The stop-loss coverage would pay claims falling between an attachment point and an upper limit.
- The attachment point for all retirees would be $100. For those younger than 65, the upper limit would be $5,800; for retirees 65 and older, the upper limit would be $3,500.
- In turn, Prudential would use the premium it receives from Coca-Cola to reinsure the risk with Coca-Cola's captive Red Re Inc.

Perspectives

Few employers are using captives to reinsure medical risks. Here, Mitch Cole, a director at Towers Watson & Co., and Nicole Serfontein, a senior consultant with the firm, offer some advice on using captives for active and retiree medical exposures.

Using captives for medical risks

Mr. Cole

Ms. Serfontein

Mr. Jack Smith
Vp-Compensation and Benefits
XYZ Corp.

Dear Jack:

In our recent meeting, you asked why so few companies use their captive insurance companies to reinsure either active medical or retiree medical risks. You asked us to elaborate on our answer in a letter that you can share with your leadership group.

To recap, we said that, indeed, some companies have used their captives for U.S. active medical, retiree medical and stop-loss medical, as well as for non-U.S. medical.

We agree, however, that not many companies have pursued this option, especially relative to other captive use. There are three primary reasons for this:

- Vexing U.S. regulations
- Need to clarify captive use for retiree medical
- Perception that using captives for multinational pooling is too complex

But we also think there are some good reasons to use a captive for non-U.S. medical. To start, let's consider the reasons companies have been reluctant to use captives in this way.

1. VEXING U.S. REGULATIONS

There is probably no greater area of concern for U.S. human resource and finance leadership in many companies than health care regulations and the cost of claims. Yet doing something about them has proven a challenge even for very creative HR and finance departments. For two reasons, captives are almost never part of the solution except for medical stop-loss insurance:

- Regulatory and cost hurdles of moving from self-insured to insured status

Jack, I'm sure you recall that to use a captive for U.S. benefits, a sponsor would be required to obtain a Department of Labor Prohibited Transaction Exemption. This requires the use of a fronting insurance company, effectively requiring self-insured programs to move to insured status. In addition to regulatory hurdles, this approach can prove costly.

Because the medical program would be fully insured, the fronting company would be required to include state-mandated benefits, and possibly rates, for its insurance. For most employers, this would present an insurmountable hurdle for two reasons: First, most companies with self-insured medical programs are large enough to pay their own claims and, second, self-insurance gives them more design discretion compared with insured products. It is unlikely that state-mandated coverage would be a good fit for these self-insured employers. Yes, they could reinsure the risks into their captive, but the risks insured would very likely be different than what they would have been under the self-insured program.

Second, these self-insured employers are used to paying the net cost of only their own claims and avoiding state premium taxes and insurer margin charges. With a captive arrangement, more money would flow between the company and the captive, resulting in more out-of-pocket cost in fees, premium taxes and the like.

As if this were not enough, there are very few tax savings in using a captive for medical. Nearly all medical claims are paid in the same year in which they are incurred, except those incurred in the last month or so of the year. The incurred but not-yet-paid claims are generally paid in the first two months of the next year. So aside from perhaps an accelerated deduction for medical inflation from one year to the next, there's not much financial benefit to the employer in the way of accelerated tax deductions or deductible reserves.

- Regulatory uncertainty

A sea change in what insurance companies may provide in the future colors employers' thinking on captive use. Health care reform, if it survives, may encourage certain types of employers to drop sponsorship of a medical plan for employees. While an employer exiting sponsorship may be prepared to subsidize a portion of some employees' personal premium costs, it is unlikely that such an employer would want to reassume the burden of actually providing the coverage. In short, in the current U.S. regulatory environment, a self-insured company may not view captive use as a worthwhile option until the status of health care reform stabilizes.

Nevertheless, companies that shift employees to private insurance or health insurance exchanges might use a captive to finance their own cost burden, much like stop-loss insurance. In this scenario, the employer would have to consider ways to do this most cost-effectively—especially if a number of subsidiaries are involved.

Notably, captives are increasingly used for medical stop-loss insurance in and outside the U.S. There are generally four reasons: cost, capacity, coverage and control. On capacity, the captive provides direct access to reinsurers, which may in turn provide sharper pricing. For control, a self-insured can use a stop-loss program among its subsidiaries to reflect their own risk and cost tolerance, which almost always is less than the family of companies. For coverage, as multinational corporations expand into markets with insufficient public health benefit programs or where local insurers don't offer sufficient coverage, the captive can be used to close gaps for coverage that insurers are unwilling to carry.

2. NEEDING TO CLARIFY CAPTIVE USE FOR RETIREE MEDICAL

Most employers with a retiree medical obligation generally do not fund it except as part of collective bargaining. There are three reasons companies most frequently cite not to fund. Firstly, using that money in operations can earn more than placing it in a fund. Secondly, funding may send an unintended signal to employees that the benefit is guaranteed. And thirdly, the company could withdraw the benefit in the future, especially under health care reform.

Your company has identified a cadre of retirees for whom the benefit would almost never be revoked. By funding the benefit today, you could monetize all of the deferred tax deductions now on your balance sheet, thereby converting nonperforming assets into performing assets. And, by using your captive, any investment earnings in excess of what is needed to pay claims would be profit for use by the captive.

We also understand that your company will give the balance of its post-65 retirees an annual subsidy to buy insurance from an exchange. You will still have to accrue a liability for this future cost, but it will be lower than your current liability for retiree medical. A captive could be a very important vehicle for funding the future liability.

But this may not be the right answer for every company. This isn't an easy captive arrangement to implement, and only one company has done it so far. Yet, as you said, it's worth considering if the gain is worth the effort.

3. UNDERSTANDING WHY A CAPTIVE FOR MULTINATIONAL POOLING ISN'T COMPLEX

Very often, employers believe that using a captive to reinsure multinational benefits that include medical is too complex to undertake. And for employers with very limited resources, that may be the situation. However, we know of employers that successfully use their captive to reinsure multinational benefits for their global operations, despite a perpetually stretched HR staff.

So why can some employers manage it—even with limited resources—and others cannot? We think it comes down to the interested employer (1) recogniz-

Continued on next page

Exhibit A

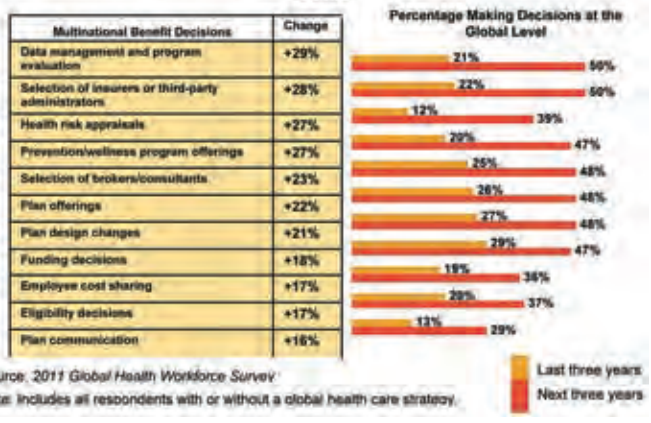
A key reason for seeking greater control is medical trend, which is now in double digits in many countries

	2006	2009	2011
Asia Pacific			
China	15.2%	10.1%	9.4%
India	22.0%	12.0%	12.3%
Singapore	5.5%	7.4%	8.4%
Europe			
France	5.6%	6.5%	8.4%
Netherlands	5.0%	5.0%	5.5%
UK	6.0%	9.3%	9.5%
Latin America			
Brazil	9.2%	10.4%	11.0%
Chile	5.8%	13.9%	18.5%
Middle East and Africa			
South Africa	7.4%	12.5%	9.3%
UAE	15.0%	10.3%	10.1%
North America			
Canada	12.3%	12.5%	13.3%

Source: *2011 Global Health Workforce Survey*

Exhibit B

Centralization of multinational benefit decisions is an expected organizational response for Needed Control



Source: *2011 Global Health Workforce Survey*
Note: Includes all respondents with or without a global health care strategy

CONTINUED FROM PREVIOUS PAGE

ing that for many employers the pooling program is just a way to finance claims and that the insurer will be paid back over time; (2) understanding that the nature and cost of non-U.S. benefits is increasingly important to global governance and oversight; and (3) capturing claim data, especially on medical, is a key priority to identify cost drivers and develop interventions that manage cost and improve employee productivity.

We think the ability to capture claim data could be the most important. With health care inflation continuing to climb—and reaching double digits in many countries (see chart, page 16)—data has become increasingly important as companies look for ways to slow their annual cost increases and manage the health risks of their employee population. Many companies with operations outside the U.S. have a difficult time getting timely and wholly reliable data from their insurers and cannot be proactive in designing interventions to better manage both costs and employee health.

A captive is not a silver bullet for data collection, but it can help facilitate the process. Because the captive's sponsoring company is the ultimate risk taker, it has a greater say in the type and extent of data to be collected and analyzed. Most data is delivered quarterly to captives, making it far more valuable than 12-month-old data for identifying and responding to employee population health trends and risks. This ability to access and analyze data across the company is increasingly important as companies move to more centralized decision-making about benefit programs and program governance (see chart, page 16). A captive can facilitate that process.

Once the direction of U.S. health care reform becomes clearer, we'll gain a clearer understanding of whether using a captive for U.S. health benefit obligations—both active and retiree—makes sense for your company.

Until then, using your captive for non-U.S. health benefits is a good option, largely because of the current data it can provide allowing you to understand your claims and providing a platform for HR and finance to join forces to manage what is a growing problem for many multinationals.

Jack, let's talk again once your leadership has had a chance to give you their views on their desired way forward or we have a known outcome on health care reform.

Sincerely,
Mitch and Nicole

Mitch Cole is a director of Towers Watson & Co. in its Stamford, Conn., office. He can be reached at 203-326-5431 and mitchell.cole@towerswatson.com.

Nicole Serfontein is a senior consultant in the Towers Watson Arlington, Va., office. She can be reached at 703-258-8286 and nicole.serfontein@towerswatson.com

Dropping health care coverage not viable for many employers

By JERRY GEISEL

WASHINGTON—At first glance, the health care reform law would seem to open the door for employers to terminate their health care plans.

Employers choosing to go that route simply could bump up salaries of employees to help offset the premiums they would pay to buy coverage in state health insurance exchanges that the reform law authorizes and are supposed to be set up by Jan. 1, 2014.

Employees buying coverage through the exchanges could not be denied policies due to pre-existing medical conditions. In addition, health insurers authorized to provide coverage through the exchanges would be limited in how much they vary rates based on age.

In the case of lower-income employees—those making up to 400% of the federal poverty level, about $92,000 for a family of four—federal premium subsidies would be available that would reduce the premiums.

In turn, employers would be free of the hassle and expense of offering coverage, dealing with insurers and third-party claims administrators and could reduce the size of their benefit departments.

But in many cases, the theory is sharply different from the reality, benefit experts say. And, in fact, survey after survey has found that only a small percentage—less than 10%—of employers say they are actively considering terminating their health care plans when key provisions of the reform law kick in starting in 2014, assuming the Supreme Court upholds the constitutionality of key provisions of the law.

10%

Several surveys have found that only a small percentage—less than 10%—of employers say they are actively considering terminating their health care plans when key provisions of the reform law kick in starting in 2014.

"The vast majority of companies we have spoken to have concluded that the risk is too great," said Steve Raetzman, a partner with Mercer L.L.C. in Washington.

As to potential savings resulting from terminating their health care plans, those savings "evaporate" when employers calculate the costs associated with plan termination, Mr. Raetzman said.

Employers that do not offer coverage must pay the government an annual non-tax-deductible $2,000 penalty for each full-time employee that is not offered coverage.

Then there is the cost to employers of bumping up employees' salaries to offset premiums they would pay for coverage in the exchanges.

If employers intend to keep employees whole—that is, employees would not pay any more for coverage after their employers terminate coverage compared with before—potential savings would quickly evaporate.

That is because under current tax law, the premiums employers pay are excluded from employees' taxable income. By contrast, if employers terminate their plans and increase employees' salaries to enable employees to buy coverage in the exchanges, that additional cash employers would be giving their workers would be considered taxable income.

See **TERMINATE** on next page

Terminate: Not viable

CONTINUED FROM PREVIOUS PAGE

Take the case of a group health care plan in which family coverage costs $12,000, with employees paying $3,000. Assume the same coverage also costs $12,000 in an exchange. Depending on the employee's tax bracket, an employer would have to give the employee considerably more than $9,000 to keep him or her whole—plus the employer would be paying the $2,000 penalty for not offering coverage.

"When you bump up salaries, you can see how quickly the savings evaporate," Mr. Raetzman said.

"The economics in many cases are not in favor of plan termination," said Ed Fensholt, a senior vp and director of compliance services for Lockton Benefit Group in Kansas City, Mo.

Then, there are the unknowns associated with plan termination. For example, it is impossible to predict—at least not yet—the premium rates insurers will charge for exchange coverage and how those rates will compare with the premiums employers now pay or, in the case of self-funded employers, their claims' costs.

Mr. Raetzman predicts that premiums in many cases will be higher in exchanges than for comparable coverage offered by employers.

That is because those buying coverage through exchanges will be more likely to have health insurance problems.

"It is almost certain that there will be adverse selection, and that will drive up premiums compared to employers' plans," he said.

Even though the health care reform law imposes penalties on individuals who are not enrolled in a qualified health care plan, those penalties, at least initially, are modest and pale in comparison with premiums individuals would have to pay for coverage.

As a result, the cost of keeping employees whole by boosting their salaries to purchase exchange-based coverage for employers terminating coverage could be more expensive than anticipated, experts say.

Yet another disincentive to terminating coverage could be the state of the economy. If the economy over the next couple of years strengthens significantly, far more employers will have to aggressively compete for employees.

"Today, the economy is down. But at some point, it will cycle back," said Dan Levin, a principal with Buck Consultants L.L.C. in Chicago.

At that point, companies that don't offer coverage could find themselves at a competitive disadvantage in recruiting and retaining employees compared with those that do, he said. "You can't judge the economy by how it is now."

Alternatives for drug benefits

Federal tax change prompts employers to review retiree cover

By LOUISE KERTESZ

Employers are turning to alternative financing strategies as they face the loss of a federal tax deduction in 2013 for a subsidy they receive for providing drug coverage to Medicare-eligible retirees. While most companies are implementing an employer group waiver plan, many anticipate ending direct sponsorship of the drug benefit by giving a defined contribution to retirees to purchase coverage in the individual market, observers say.

Under an EGWP, a Medicare Part D plan is offered to retirees through a pharmacy benefit manager or insurer that contracts directly with the Centers for Medicare & Medicaid Services. An employer wraps a supplemental plan around the Part D plan to close the gap in coverage known as the doughnut hole.

The 2003 law that created the Medicare Part D prescription drug program gave employers powerful tax incentives to retain the prescription drug plans they offered to Medicare-eligible retirees.

Employers received tax-free payments from the government based on a percentage of prescription drug expenses. In addition, employers could continue to take a full tax deduction for prescription drug expenses.

SURVEY SAYS

More employers considering employer group waiver plans

- The 2012 Towers Watson/National Business Group on Health annual employer survey showed that 57% of employers plan to or are considering implementing an EGWP over the next three years.
- A November 2011 survey by Aon Hewitt showed that 62% of plan sponsors who have already decided to change their Medicare Part D retiree strategy are implementing an EGWP.

The 2010 health care reform law continued the tax-free status of the subsidy to employers but, starting in 2013, their tax deduction for prescription drug expenses must be reduced by any subsidy amounts received.

For example, assume an employer paid $100 in prescription drug expenses for a Medicare-eligible retiree and received a $30 government subsidy. In that example, under the health care reform law change, the employer could only take a $70 deduction for the expense.

As a result, "Most large employers have decided to implement an EGWP," said Sherri Bockhorst, principal for health and productivity at Buck Consultants L.L.C. in St. Louis.

Furthermore, a final CMS regulation released in April further enhanced the value of EGWPs by eliminating the need to wrap a supplemental/wrap plan to take advantage of additional pharmaceutical manufacturer discounts in the doughnut hole. The new regulation effectively simplifies the administration by allowing EGWPs to achieve the same results without the need to split the benefit between a Part D plan which did not cover brand drugs in the doughnut hole and wrap plan that filled in that gap. This will result in substantial additional savings for EGWPs in general.

Implementing an EGWP could result in pretax costs 20% lower than what employers pay for retiree drug coverage under the Retiree Drug Subsidy program, said Martin Hill, director and actuary at PricewaterhouseCoopers L.L.P.'s human resource services in New York.

The 2012 Towers Watson/National Business Group on Health annual employer survey showed that 57% of employers plan to or are considering implementing an EGWP over the next three years. A November 2011 survey by Aon Hewitt showed that 62% of plan sponsors who have already decided to change their Medicare Part D retiree strategy are implementing an EGWP.

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"Early adopters typically gravitated toward the EGWP," said John Grosso, health care actuary and leader of Aon Hewitt's retiree health care subpractice in Norwalk, Conn. "It requires less analysis, and fewer approvals are required than for sending people to the open market" to buy cover.

ConAgra Foods Inc., which will implement an EGWP on Jan. 1, 2013, for most of its retirees, "decided to work with a PBM far earlier than otherwise," said Bart Karlson, Omaha, Neb.-based ConAgra's senior director of benefits. One advantage is ConAgra could account for the additional liability of the RDS change on its 2011 financial statement, he said.

With the EGWP, ConAgra is able "to keep pretty much the same benefits" for retirees, and benefits were improved for some groups as plans were consolidated, he said.

The second most-popular strategy, called the Connector model, is for an employer to give a retiree a defined contribution to purchase Part D coverage through a private administrative entity or insurer, sources said. The Aon Hewitt survey showed that 19% of employers plan to use the defined contribution approach.

The Towers Watson survey said that 53% of companies have considered or will consider dropping their employer-managed drug coverage for Medicare-eligible employees and relying on Part D plans. Mark Olson, senior consulting actuary at Towers Watson & Co. in Boston, said that some of those companies will provide a defined subsidy to purchase a Part D plan, while others may not.

"We think that most employers over time will have defined contribution subsidy funding," although they may begin with an EGWP, Mr. Grosso said. "There are pretty strong arguments to be made for a company to send retirees to the individual market," he said, including "the robustness of the individual market and Part D enhancements," such as the phase-out of the doughnut hole.

ConAgra is using the Connector model for about 6,000 of its retirees, some of whom worked for companies ConAgra acquired. Through My Medicare Advocate, sponsored by ACS, the parent of Buck Consultants bought by Xerox in 2010, retirees will be able to choose among several Medicare Advantage plans, Mr. Karlson said.

Private exchanges link buyers, sellers

By RUSS BANHAM

Private health insurance exchanges pack pros and cons for employers and employees that require both sides to make some choices.

So far, the advantages seem to outweigh the disadvantages when it comes to private health insurance exchanges, according to several consulting firms and health insurers that have established private exchanges or are in the process of doing so.

"Anytime you change the status quo, you create unease; but in the case of exchanges, you're essentially shifting certain burdens from employers to the exchange, which for some companies, especially smaller ones, is a very good thing," said Shawn Nowicki, director of health policy at HealthPass New York, a 12-year-old private commercial health insurance exchange.

HealthPass, which covers some 30,000 lives linked to 3,700 businesses, is open to New York state-based firms with two to 50 workers as well as sole proprietors.

"An exchange is a marketplace where you bring buyers and sellers together and create competition and efficiency," said Ken Sperling, national health care exchange strategy leader at Aon Hewitt in the Norwalk, Conn.

"Since the employee is given the choice of myriad health insurance options that are very competitive, he or she can make a decision that best meets their particular needs, which we view as offering superior value over a traditional employer-sponsored plan," he said.

Others share this view.

"An employer-provided plan may provide an employee with two or three different plan designs, none of which may meet the needs of the individual," said Sherri Bockhorst, principal, health and productivity, at Buck Consultants L.L.C. in St. Louis. "Additionally, those plans are often times offered through a single vendor, further restricting the choices for the employee."

Buck Consultants has established a private exchange for retirees aimed mainly at companies that are ending or have ended company-provided retiree benefits, and is working on developing an exchange for active employees.

Private health insurance exchanges obtain their revenue through commissions or fees, Ms. Bockhorst said.

Generally, employers provide a specified dollar amount toward the coverage, and the individual selects from packages offered by the exchange.

"Employees have more control—only they make the decision about whether to pay more for a richer plan or pay less for a less-rich plan," Mr. Sperling said. "And they have a user experience that feels more like a shopping experience akin to an Amazon.com or Zappos."

UPS AND DOWNS

Pros and cons for employers and employees in regard to private health insurance exchanges

Pros

- Certain burdens shift from employers to the exchange
- Competition and efficiency are created
- Employers gain ability to make a decision that best meets their particular needs
- Employees have more control
- Less administrative burden for employers

Cons

- Too many options
- Individual health insurance may affect cost

The key downside for the employee is having so many options that selecting one is a bit like tossing darts.

"It's the tyranny of choice," Mr. Nowicki said. "That's why the exchanges are being careful with regard to how much choice they offer. There are different purchasing models—beginning with a clearinghouse approach where the employer takes all comers and any carrier can offer a plan, to more of a selective contractor approach where the employer agrees to work with all carriers, but then whittles down the choices in the end."

Another potential downside is how individual health insurance may affect cost.

"If you push an individual product to employees that might not be in the best of health, you will definitely see some winners and some losers," Ms. Bockhorst said. "Clearly, the benefit of group insurance is lost for less healthy employees and their dependents."

Ken Dallafior, senior vp of group sales and corporate marketing, at Detroit-based Blue Cross Blue Shield of Michigan, sees an advantage for employers.

"If you're in an industry that is highly competitive in terms of recruiting and maintaining talent, you have better control of the process and the plans that are offered to employees, which can affect your talent objectives," he said. Blue Cross Blue Shield of Michigan is one of three insurers that established Bloom Health Corp., a nationwide private exchange based in Minneapolis.

Another benefit for employers is administrative: Since the premium billing and enrollment burdens happen within the private exchange, there is less administrative burden for employers.

"The exchange sends a consolidated bill, minus the employee contributions, and then divvies up the employer contribution among the different carriers," Mr. Nowicki said. "In essence, you're taking the administrative burden off 'Joe's Pizzeria' and transferring it to the health care exchange."

Mr. Sperling agreed that employers benefit by being able to "jettison low-value activities such as vendor management and plan design, to focus on things that really matter like employee health and productivity."

For retirees using Medicare Advantage plans, there is "a competitive marketplace that makes the employer's subsidy and their own contributions go much further, in terms of the coverage they buy and the value they can obtain," he said. "You have an entity—the exchange—that will help them navigate through the choice-making process."

Aon Hewitt last year announced that it would establish a health care exchange for corporate clients based on its existing retiree exchange model, a rollout an Aon spokesman said is expected in 2013.

As for insurers, "they're not winning or losing big pockets of employees," Ms. Bockhorst said. "Some are already well-positioned in the individual market, while others have always focused on the group side and don't have individual products filed or marketing plans and distribution channels in place."

Perspectives

As health care undergoes unprecedented change due to health reform and other market factors, the relative roles of employers, individuals and government related to health care financing need to be reexamined. Michael Thompson of PricewaterhouseCoopers L.L.P. offers insights on four key principles for employers as they reconsider their role in health care financing going forward.

New economics of benefits demand rethink of financing

By Michael Thompson

For years, health economists have spoken of the three-legged stool for financing the American health system: employers, individuals and the government "safety net."

Employers traditionally have covered a significant percentage of the costs for most workers and their families, with workers picking up a minority share in premiums and costs at the point of service. Government has picked up the lion's share of the cost of coverage for the elderly and the poor, with individuals supplementing that coverage commensurate with their needs and ability to pay.

Mr. Thompson

Medical benefits continue to be the most valued employee benefit offered by an employer.

In addition, a significant minority of people have remained uninsured and ineligible for safety net programs, resulting in these individuals paying their own health bills directly or becoming an indirect burden on the balance of the stakeholders through uncompensated care.

But in spite of the current three-legged stool, costly health bills have been reported to be the leading source of personal bankruptcy in the United States.

Market dynamics and health care reform are fueling changes in these economics. While the players (or payers) remain the same, recent and anticipated changes in the marketplace and the regulatory environment require rethinking how each should or will contribute to the pie and, in particular, what the optimal role of the employer is as related to health benefits.

In fact, the expected availability of guaranteed issue coverage in the state exchanges has given rise to discussion about whether employers will continue to provide coverage to workers and their families. Medical benefits continue to be the most valued employee benefit offered by an employer, and while there has never been more of an ability for employers to consider getting out, there has never been more of an incentive to stay in. Following are health care financing principles for consideration in that regard.

■ Continue and expand access to employee health benefits. For the vast majority of employers, "the math" continues to reinforce the value of continuing to provide health benefits to compete effectively for employees. When one considers the economics of substituting taxable cash income for tax-favored health benefits, the loss of "opt-out" savings and the added burden of nondeductible excise taxes if just one full-time employee is not offered coverage, one quickly realizes that the savings of discontinuing coverage are illusory. Even for employers with low-wage workers who otherwise would be eligible for subsidies in the state exchanges, there continues to be value to providing access to coverage even if not deemed affordable to avoid the larger of the free-rider penalties. In this way, the employer will only be subject to excise taxes on those employees who opt out and can get subsidized coverage from the exchange rather than excise taxes being levied on all of their full-time employees.

■ Rethink subsidy levels for dependents. The coverage of spouses and dependents as an employee benefit is a vestige of an environment where single-earner families prevailed and few had access to either safety-net coverage or affordable guaranteed issue coverage in the open market. While some employers view subsidizing medical benefits as a core element of their health and productivity strategies, the arguments for similar subsidies for spouses and dependents are less clear. Health reform requirements such as coverage of children to age 26 reinforce the need to influence consumer economics so that employer subsidies are focused where business interests are most aligned. As guaranteed issue coverage is available in the open market, employers will re-evaluate their subsidies for other family members. As more employers do so, the impetus to ensure that a disproportionate share of spouses/dependents is not attracted to a given employer's plan will be critical to sustain and manage costs over time.

■ Accelerate transition to value-based plans with higher cost sharing. The growth and impact of consumer-directed health plans over the past decade has reinforced the effectiveness of meaningful cost sharing at the point of service in changing consumer behavior. While there is evidence that the magnitude of that cost sharing needs to be sensitive to the nature of the services (e.g. not being a barrier to compliance with medications for chronic conditions) and the population affected (e.g. lower-income workers), there is growing evidence that consumerism has led to lower medical costs, lower cost increases, and more focus on prevention and consumer engagement. Largely untapped is the opportunity to incent and channel toward higher-value delivery solutions. Further, the transition to value-based plans with higher cost sharing will be a key consideration for employers interested in mitigating the 40% excise tax imposed on high-cost plans in 2018.

■ Condition financing on shared accountability for health. Health and wellness initiatives have become mainstream for most employers, as employers try to influence employees to take better care of themselves to be healthier and, indirectly, more productive. While initially focused on education and employee support, employers are increasingly raising the bar on employee expectations by introducing greater alignment around incentives and accountability. To this end, employers can "condition" all or a portion of their financing of health benefits on employees doing their part to improve their engagement in program support and, most importantly, managing their health. While incentives alone may not lead to the intrinsic and sustainable change in attitudes and behaviors that is possible through broadly executed culture change, making some elements of the health benefits financing (either through contributions or benefits) conditional can reinforce the need for shared accountability to manage health. Even where behaviors do not follow, it can help to allocate costs on a basis more equitable based on elements they can control. Health reform further reinforces, guides and expands an organization's ability to better align health care financing with personal health behaviors.

■ Evaluate new defined contribution solutions through private exchanges. Health reform has even more potential to transform the way health care benefits are financed for many. While the state health insurance exchanges scheduled to open in 2014 are initially limited to individuals and small businesses, there is the potential for states to allow larger employers to participate as early as 2017. Further, market activity already is emerging to develop private exchanges which may provide the opportunity for larger employers to transition from a defined benefit approach to a defined contribution approach to providing benefits. The emergence of public and private health exchanges and the expected availability of guaranteed issue coverage in the open market without any pre-existing condition exclusions remove some of the key barriers to moving health coverage to a basis more comparable to the defined contribution movement on the retirement side of benefits. If defined contribution health care can be structured to preserve the tax-effective nature of the benefit, many employers may find this solution to be more aligned with their overall total rewards strategy while mitigating their need to tie such benefits to the escalating costs of health care.

The movement toward many of these health care financing principles has been growing over the past decade and now is likely to accelerate due to the changes in the market and regulatory environment. In the end, there will be a new equilibrium where employers facilitate access to coverage for a broader number of employees with more selective subsidies for dependents, greater incentives to promote consumer engagement, improved health management and higher value delivery.

Over the longer term, the role of some employers may diminish as consumers are given more choice among plans available in the private and state exchanges and potentially from one or more employers. The government will continue to serve as a safety net for those without access to affordable coverage and as a facilitator in establishing the overall framework that will support public- and private-sector transformation of the health system.

If managed well, this can help to optimize health care financing across the three-legged stool for better outcomes for employers, consumers and society as a whole.

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CASE STUDY

College program provides retiree health care model

By JERRY GEISEL

A pioneering program launched in 2005 has enabled about 50 colleges and universities to offer retiree health care coverage that avoids the extremes of coverage that becomes unaffordable over time and provides no coverage at all.

The New Windsor, N.Y.-based Emeriti Retirement Health Solutions program broke new ground in the retiree health care plan funding arena when it was launched in 2005. And it continues as a model for meeting the needs of academic institutions and their employees.

"It has the appeal of being both predictable in cost and being a reliable source of coverage from employees' perspective," said Michael Thompson, a principal with PricewaterhouseCoopers L.L.P. in New York and an Emeriti adviser.

Under the program, each school makes contributions to tax-exempt trusts known as voluntary employees' beneficiary associations. Each school decides its contribution based on the level of financial support it wants to provide. The minimum contribution is 0.5% of payroll of the group of employees eligible to receive an employer contribution.

Employees also contribute after-tax dollars to separate VEBAs. Employees direct VEBA contributions into a set of mutual funds, including a money market fund and life cycle funds, offered by financial services firm TIAA-CREF of New York.

The contributions and the investment income earn tax-free interest. When employees retire and are eligible for Medicare, they can withdraw funds tax-free to pay premiums for one of several health care plans offered by Aetna Inc. In Minnesota, coverage is offered by HealthPartners, a nonprofit health maintenance organization.

Retirees also can take out funds to pay for other uncovered health care expenses, such as claims subject to a deductible as well as Medicare Part B and Part D premiums. Employees who meet their academic institution's retirement eligibility requirements but retire before they are Medicare-eligible can withdraw funds tax-free to pay health care-related expenses.

Executives at academic institutions say the program is a good middle approach between two extremes. At one end are traditional defined benefit-type retiree health care plans whose costs are difficult to project and have become very expensive. At the other end is no coverage at all, which can result in employees staying at their jobs past age 65, limiting openings available to new academic talent.

With a traditional plan, "You have a huge accrual of liabilities. This is a reasonable way of providing coverage without amassing the liabilities," said Don Mortenson, senior vp-business and planning at Seattle Pacific University in Seattle. Seattle Pacific contributes an amount equal to just over 1% of employees' gross salary for employees ages 35 to 60.

"We thought this was a good benefit to provide," said Robin Aspinall, treasurer and vp of business and administration and treasurer at Claremont McKenna College in Claremont, Calif. The coverage aids in recruitment and provides an incentive—not a deterrent—to retirement, Ms. Aspinall said. Claremont contributes 0.5% of salary for employees, starting at age 40.

"We know exactly our costs are, while this makes it easier for people to retire when they need to. This fills a noticeable gap in our benefits program," said G. Richard Wynn, treasurer and vp of finance and administration at Haverford College in Haverford, Pa. Haverford contributes about $1,000 a year for eligible employees.

While employer sponsorship of retiree health care plans has slumped over the past two decades, the Emeriti program bucks that trend. Of current participants, about 40% didn't previously offer retiree health care coverage, said Barbara Perry, Emeriti's vp for marketing and membership in New Windsor, N.Y.

The program also is available to a wide variety of other nonprofit institutions: elementary and secondary schools, teaching hospitals, medical research organizations, libraries and museums, certain educational associations and certain charitable foundations, such as those that direct a substantial part of their philanthropic efforts toward colleges and universities.

While none has yet joined, there has been "keen interest" in the program from several nonacademic organizations, Ms. Perry said.

WIDELY AVAILABLE

Emeriti Retirement Health Solutions is available to a wide variety of nonprofit institutions:

- Colleges and universities
- Elementary and secondary schools
- Teaching hospitals
- Medical research organizations
- Libraries and museums
- Certain educational associations
- Certain charitable foundations, such as those that direct a substantial part of their philanthropic efforts toward colleges and universities

> 'It has the appeal of being both predictable in cost and being a reliable source of coverage from employees' perspective.'
>
> Michael Thompson, PricewaterhouseCoopers L.L.P.

inBrief

Hawker Beechcraft could add to PBGC woes

The Pension Benefit Guaranty Corp. would be hit with a loss of more than $500 million if financially troubled aircraft manufacturer Hawker Beechcraft Inc. terminates its underfunded pension plans. The three plans are 56% funded, with $1.4 billion in liabilities and $769 million in assets, according to the PBGC. The agency said if the plans are terminated, it would be liable for $533 million of the funding shortfall. Wichita, Kan.-based Hawker Beechcraft has not said it intends to terminate the plans. But in a bankruptcy factsheet posted on its website, the company said that as part of the Chapter 11 process—and in order to obtain financing to exit the bankruptcy—it may be required to fold its pension plans.

Ryan Specialty, CRC dispute settled

CRC Insurance Services Inc., Crump Insurance Services Inc. and R-T Specialty L.L.C. , a unit of Ryan Specialty Group Inc., jointly announced they have resolved their dispute over the issue of CRC employees joining Ryan Specialty. As a result of the settlement announced last week, the pending lawsuits between the entities and the employees will be dismissed, the firms said in a statement.

AIG profit up 147% in first quarter

American International Group Inc.'s 2012 first-quarter profit rose to $3.21 billion, an increase of 147.3% compared with the same quarter last year. Its Chartis Inc. property/casualty insurance unit reported net written premiums of $8.82 billion for the quarter, a 3.7% drop from the same period a year earlier. Chartis posted pretax income of $910 million for the quarter, up from a $374 million loss during the 2011 period. Meanwhile, the U.S. Treasury Department said it planned a third sale of AIG stock that it acquired in its 2008 bailout of the insurer.

P/C rates up 3%: MarketScout

The composite rate for commercial property/casualty and professional lines coverage increased an average of 3% in April 2012 compared with the same month a year ago, Dallas-based MarketScout said. The electronic insurance exchange found that workers compensation and commercial property experienced the greatest rate increases at 4% each, while business owners policy and general liability rates each rose 3%. Increases were uniform by industry, with the manufacturing, contracting, service, transportation and energy sectors all seeing rates rise by 3%.

Health insurers to return $1.3B to policyholders

Health care plan insurers will return approximately $1.3 billion in excess profits and administrative charges to employers and individual policyholders as required by provisions of the health care reform law, according to an analysis released last week by the Henry J. Kaiser Family Foundation. Fully insured employers with more than 100 full-time employees are expected to receive a total of $541 million in rebates this year, while smaller employers will receive $377 million, according to the Kaiser Foundation report. The rest, $426 million, will be refunded to consumers who purchased health care plan coverage privately.

Pension plan funding sees downward turn in April

Pension plan funding among some of the largest U.S.-based companies regressed in April, marking the first downward turn since the end of 2011, according to Mercer L.L.C. Pension plans sponsored by S&P 1500 companies incurred a $73 billion rise in their aggregate deficit over totals from a month ago, to $409 billion from $336 billion in March.

Noted

Mark Ugoretz, the first and only permanent head of the **ERISA Industry Committee**, will retire next month after nearly 29 years with the employee benefits lobbying organization....**Endurance Specialty Holdings Ltd.** announced that President William M. Jewett had stepped down as president and would resign from the company board on May 10.

POLICYHOLDER SUES BROKER OVER WEED DEAL

Owners of a large, commercial building are suing their insurance broker for allegedly failing to inform their insurer that they rented their Montana property to an operation growing medical marijuana.

The lawsuit seeks to recover $75,000 in damages allegedly caused to the building and its heating and electrical systems when federal agents raided it in 2011 along with other Montana medical pot-growing operations.

The complaint, filed in federal district court in Helena, Mont., reportedly alleges that in 2010 the building's owners told their broker, Insurance Unlimited Inc. in Helena, that they rented the greenhouse to the marijuana growers.

But the brokers failed to inform insurer Farmers Alliance Mutual Insurance Co. of that fact, the lawsuit contends.

The broker allegedly told the building owners it had informed the insurer and that the building was properly covered. But when the owners filed a claim for the damage caused during the raid, the underwriter declined it.

Had the owners been properly notified that their coverage request had been declined, they could have purchased insurance elsewhere, the civil complaint reportedly alleges.

CONTRIBUTING: Roberto Ceniceros, Matt Dunning, Mike Tsikoudakis

End Page

A South African man has accused Elton John of stealing his idea for the song 'Nikita.'

AP PHOTO

Man says Elton's 'Nikita' is his song

A South African photojournalist has accused Elton John of stealing his idea for a Cold War-themed ballad and repurposing it for his 1985 hit song "Nikita," according to a report.

In a lawsuit filed April 26 in U.S. District Court for the Northern District of Illinois in Chicago, photographer Guy Hobbs claims to have written the lyrics to a song entitled "Natasha" about a Russian waitress with whom he had a romantic relationship aboard a cruise ship in 1982, at the height of the Cold War, according to the report.

Mr. Hobbs claims he registered a copyright for the song, and in 1984 submitted it to several music publishers, including the Elton John-linked Big Pig Music Ltd., the report said.

According to the report, Mr. Hobbs became aware of similarities between his song and Elton John's "Nikita" in 2001, and had since made several unsuccessful attempts to settle with the pop artist and his longtime songwriting collaborator, Bernie Taupin.

FRAUDSTER GOES TO EXTREME LENGTHS IN FAKE BIKE WRECK

Individuals who make fake insurance claims seldom lack creativity, and an Idaho Falls, Idaho, man proves it again after trashing his motorcycle for the insurance payout.

Jason Preston pleaded guilty to two charges of insurance fraud and damage to insured property and received 20 days in county jail, 100 hours of community service, 4 years of probation, and was ordered to pay a $750 fine, according to news reports.

The district court reportedly suspended Mr. Preston's prison sentence of one to four years.

Mr. Preston in July reported that his motorcycle was damaged after he swerved and crashed to avoid hitting an animal on the road, according to media reports.

But investigators figured Mr. Preston's story didn't add up.

According to reports, Mr. Preston loaded the motorcycle in the back of his pickup truck, which was driven by his girlfriend, and, after reaching speeds of up to 50 miles per hour, pushed the bike off the truck and onto the road.

Enter creativity: To make the crash appear to have been an accident, Mr. Preston tied himself to the back of the truck and had his girlfriend drag him down the road, reportedly to make his clothing appear to have been damaged in a motorcycle crash.

Mr. Preston's girlfriend left the scene and he called 911 to report the "accident." Subsequently, he filed a false statement to his insurer, according to media reports.

Mr. Preston's girlfriend reportedly cooperated as a witness and was not prosecuted.

KEEP CALM, CARRY ON AND CLAIM WHIPLASH

In the latest cash-for-crash crime wave sweeping Britain, organized crooks seeking insurance payouts are ramming cars into buses filled with "stooges," according to news reports from across the pond.

Detectives are investigating one scam involving 36 fake passengers, or stooges, claiming whiplash injuries after an Audi TT crashed into the side of a bus.

The incident isn't isolated.

Five similar crashes in northwest England—all believed linked to an organized crime ring—accounted for £1 million ($1.6 million) in illegal claims, causing police to launch a lengthy investigation.

Such cases have put Britain in the spotlight for being Europe's whiplash capital, with a 70% increase in personal injury claims due to auto accidents over the past six years.

Britain reportedly has fewer crashes than other European countries, but more whiplash claims, reportedly causing one observer to quip that his countrymen either have weaker necks or there is more fraud occurring in the nation.

To help address the problem, Justice Secretary Kenneth Clarke held a "whiplash summit," and introduced new measures including one requiring injury claimants to undergo thorough exams by specially trained doctors.

In addition, attorneys will be banned from offering "no-win-no-fee deals." Reports say whiplash claims won by no-win-no-fee lawyers add about £90 ($146) in costs to the average British insurance policy.

Business Insurance

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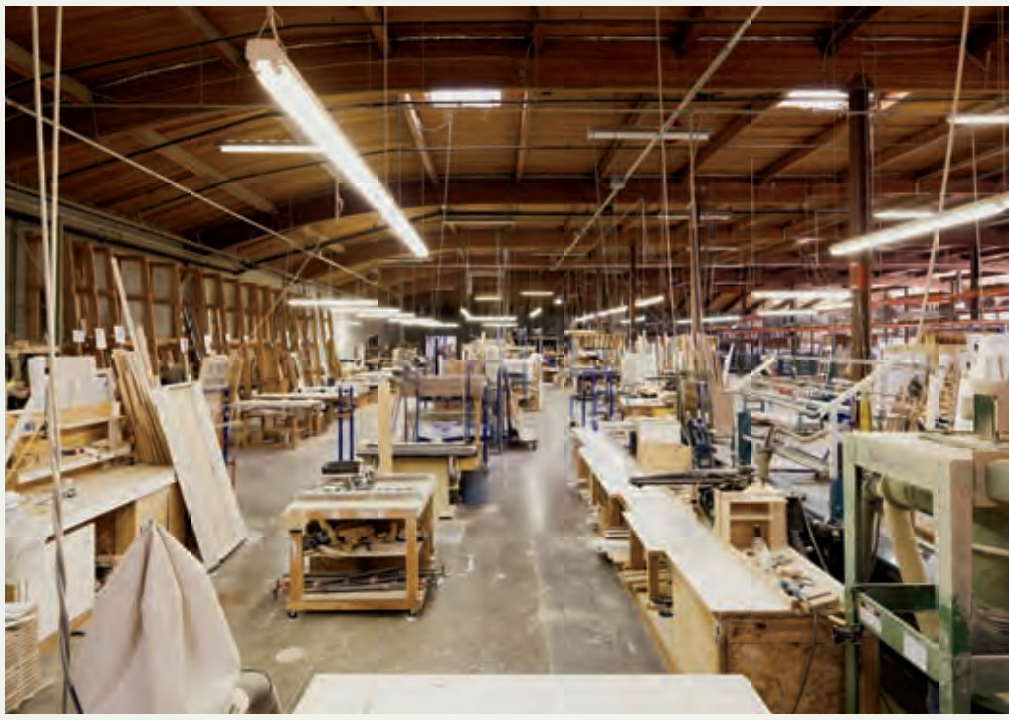

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