



SPRING VIEW

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Top EB Consultant Awards

Congratulations to Karen English and Teri Weber who won Risk & Insurance's award for Top Employee Benefit Consultants this year in the voluntary/disability category.

September is Life Insurance Awareness Month

Next month is life insurance awareness month, which is meant to raise awareness of the importance of life insurance coverage, especially when it comes to financial security.

Newsletter

August 2011

Healthcare Reform Watch List: HHS Releases New Guidance on Exchanges

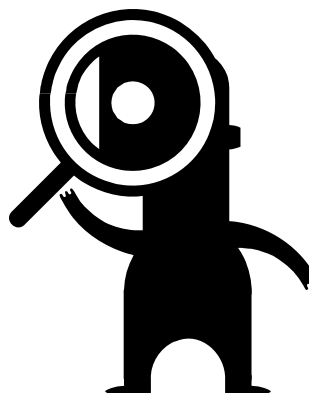
By Archana Kansagra

On July 11, 2011, The Department of Health and Human Services issued additional guidance on Health Insurance Exchanges. HHS proposed new rules offering states guidance and options on how to design and implement their Exchanges in two key areas:

- Setting standards for establishing Exchanges, setting up a Small Business Health Options Program (SHOP), performing the basic functions of an Exchange, and certifying health plans for participation in the Exchange
- Ensuring premium stability for plans and enrollees in the Exchange, especially in the early years as new people come in to Exchanges to shop for health insurance

There are three major structures of Exchanges; 1) Local or Regional Exchange, which operates in two or more states, 2) Exchange Governance and Operation, operated either by a governmental agency or a non-profit entity that is established by the state, 3) State-Federal Partnership, the federal government will give states the choice to receive assistance from the federal government to make Exchange development and operations more efficient.

Health plans offered through the Exchange must be certified as Qualified Health Plans (QHPs). To be certified, health plans must meet minimum standards; for example, the number and type of health plan choices, working with the state to establish network adequacy, health plan service area, and marketing standards, and also stabilizing the health premiums.



Exchanges will have a simplified enrollment system so members enroll in plans that fit their needs. There will be websites, toll-free call centers and staffed customer service centers to answer questions.

"Navigators" will reach out to employers and employees, consumers, and self-employed individuals to:

- Conduct public education activities to raise awareness about QHPs
- Distribute fair and impartial information about enrollment in QHPs, premium tax credits and cost-sharing reductions
- Assist consumers in selecting QHPs
- Provide referrals to an applicable consumer assistance program or ombudsman in the case of grievances, complaints, or questions regarding health plans or coverage
- Provide information in a manner that is culturally and linguistically appropriate

Beginning in 2014, Exchanges will operate a Small Business Health Options

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Program (SHOP). SHOP will offer small employers and their employees new choices similar to those offered by large employers.

Through the SHOP, employers can choose their desired level of coverage, (bronze, silver, gold or platinum plans), define their employee coverage contribution and then offer the employees choices of multiple insurers and plans. Individuals and small employers (with up to 100 employees) are eligible to participate in the Exchanges.

However, states have the option to limit use of the Exchange to businesses with up to 50 employees until 2016. Starting 2017, states lose the ability to restrict access to smaller businesses and groups with more than 100 employees must be allowed to participate.

It allows states to decide whether their Exchanges should be local, regional, or operated by a non-profit

organization, how to select plans to participate, and whether to partner with HHS to split up the work.

Also, starting in 2014, small employers purchasing coverage through SHOP may be eligible for a tax credit of up to 50 percent of their premium payments (35 percent through 2013) if they have 25 or fewer employees, pay employees an average annual wage of less than \$50,000 and subsidize at least 50 percent of the premium.

States are currently underway on establishing Exchanges. HHS reports 49 states, the District of Columbia and four territories have accepted federal grants to help plan and operate Exchanges. In order to be operational on Jan. 1, 2014, a state must receive HHS's approval of its Exchange plan by Jan. 1, 2013.

The Exchange guidance issued by HHS is not final. HHS is accepting public comments on the proposed Exchange guidance for 75 days to learn from states and other stake-

holders how the rules can be improved. HHS expects to make changes to its proposed guidance based on the comments it receives. Spring will continue to monitor the status and development of exchanges and provide periodic updates in the future.

There are still many unknowns and moving parts involving Exchanges including the final role insurance brokers and agents play in them. Current MLR (minimum loss ratio) regulations include broker commissions/fees as part of the calculation.

Therefore, while broker commissions are being cut as part of the MLR calculation, they will still have a role in the exchanges and navigators. What exact role is still being flushed out and the final determination will have a profound effect on the success and overall viability of the Exchanges.

Source: Department of Health and Human Services

Funding Retiree Medical Liabilities

By Jay Fundling

Many employers face the decision of whether to fund their retiree medical benefits. Unlike pensions, which must be funded, retiree medical benefits can be funded when they are earned by the employee, or held as an unfunded liability of the employer and only funded when the benefits come due. While it is easy and common to not fund this liability, the proper funding approach can be a very cost effective.

Pre-funding is most desirable for established companies with a low cost

of funds, as well as for those industries, like utilities, that are inclined to pre-fund. Setting aside funds for retiree medical also helps to cover what is for many companies the largest unfunded liability on their bal-



ance sheet.

When funding retiree medical, or any liability, the sponsor wants to identify an investment that matches the needs of the obligation. As the retiree medical plan will need to pay medical benefits for decades in the future, it is best to have a long term asset that responds to the healthcare cost exposure of the plan.

Also, as retiree medical assets can be subject to Unrelated Business Income Tax (UBIT) it is desirable to invest in an asset that does not generate taxable income.

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One traditional option is Trust Owned Life Insurance, (TOLI). While TOLI is tax advantaged, it may not meet the payment needs of the medical program and has also been perceived negatively by the public. Another option is Trust Owned Health Insurance (TOHI), which pays benefits on a tax free basis to the trust when retirees have health claims.

In 1996, Spring consultants, working with our clients, developed a solution using TOHI policies written by a captive insurer. These policies provide

stop-loss coverage for the medical claims of members of the retiree medical plan.

Additionally, the policies invest in marketable securities, and as the assets grow, the benefits paid by the policies also grow. The trust then holds an asset in the form of an insurance policy that grows as the underlying assets grow, and pays tax free benefits related to the medical claims of the retirees.

This first member, with contributions of just over \$35M has saved an estimated \$10M in taxes that they would have paid if they had funded their

retiree medical benefit with similar taxable instruments. Since the program was established, three additional utilities have joined the program, building the program to over \$250M as of 2011.

Following the example of this program, other employers have funded their retiree medical liabilities with TOHI, some in captive policies, others with commercial insurance, enjoying the benefits of a tax advantaged instrument whose payments follow the pattern of the medical benefits provided.

Will the PPACA Affect Workers' Compensation?

By Donald Riggan

Since the second decade of the 20th century, employees injured on the job have been entitled to non-recourse benefits under the various states' workers' compensation statutes. Known as "the compensation bargain," employers must indemnify injured workers for medical costs and lost wages, in exchange for the relinquishment of their rights to sue their employers.

This fundamental function of workers compensation will not be affected by the Patient Protection and Affordable Care Act (PPACA), but there may be one or more indirect consequences for the workers' compensation system.

While we do not yet know the magnitude of the changes, the PPACA authorizes the Centers for Medicare and Medicaid Services (CMS) to modify Medicare reimbursement

levels. Such modifications may have an impact on those states that peg workers' compensation medical fee schedules to Medicare reimbursement rates. The degree to which this might affect workers' compensation costs depends on the



extent to which states adopt those rates for their workers' compensation fee schedules.

The Medicare Part D prescription

drug benefit contains a gap known as the "donut hole." Once someone's prescription costs exceed the coverage limit, they become responsible for the cost of prescription drugs up to a limit deemed to be catastrophic.

The PPACA eliminates this gap, but this may increase the demand for prescription drugs which could cause drug prices to rise. Mitigating factors include the degree to which a Medicare beneficiary's medications mirror those drugs prescribed to injured workers, yet the potential price increase of some drugs could adversely affect the entire market.

The issue of "coordination of benefits" might arise during the PPACA's rulemaking process. Federal standards regarding coordination, subrogation, and reimbursement may be re-introduced (they were in an earlier version of the PPACA, but removed in the reconciliation process).

If the rules include workers' compensation medical benefits, then the current state-level rules governing

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workers' compensation will be altered or replaced.

Section 10109 of the PPACA requires the Secretary of Health and Human Services to solicit input from various constituencies to develop national reporting standards for healthcare services.

The stated goal of this effort is to "improve the operation of the healthcare system and reduce ad-

ministrative costs." At some point the Secretary must (by dint of the Act) determine whether reporting workers' compensation health services should be part of these standards.

If the Secretary decides to do so, state record keeping and reporting practices would have to be augmented to comply with the law. This, along with the possible reintroduction of the "coordination of benefits" provision, could serve to convince lawmakers that federal oversight of the workers' compensa-

tion system may be administratively preferable to the current state-based system.

In conclusion, we have no idea whether these or any other facet of the PPACA will materially affect workers' compensation in the foreseeable future. Early last year Congress specifically decided to *exclude* workers' compensation as a target for reform, citing the fact that reforming the nation's healthcare insurance and delivery systems were enough of a challenge.

11th U.S. Circuit Court of Appeals Rules "Individual Mandate" Unconstitutional

By Vince Branchesi

The Affordable Care Act has been at the center of controversy since its enactment in 2010, more specifically the clause described as the "individual mandate". The law would require individuals to obtain health insurance coverage by 2014, failure to do so would result in individual fines, mirroring the platform currently in place in Massachusetts.

The individual mandate has prompted 26 states to challenge it in federal court, attempting to repeal the act, deeming the law unconstitutional and not an authorized act of Congress under the Constitution's Commerce clause.

On August 12, 2011 the 11th U.S. Circuit Court of Appeals in Atlanta ruled 2-1, siding with a federal district court in Florida, which ruled the individual mandate was unconstitu-

tional. The three-judge panel released a majority opinion stating: "The individual mandate exceeds Congress's enumerated commerce power and is unconstitutional.

This economic mandate represents a wholly novel and potentially unbounded assertion of congressional authority: the ability to compel Americans to purchase an expensive health insurance product they have elected not to buy, and to make them re-purchase that insurance product every month for their entire lives."

Two other U.S. Circuit Court of Appeals have heard arguments thus far. The 6th U.S. Circuit Court of Appeals in Cincinnati upheld the mandate in a ruling in June 2011 with the 4th U.S. Circuit Court of Appeals in Richmond expecting to rule by the end of September 2011.

The ruling by the 11th Circuit is the second by a federal appeals court, which is in direct opposition to the 6th Circuit,

which upheld the individual mandate as constitutional. The opposing views of federal courts have set the stage for the U.S. Supreme Court to ultimately rule on whether the mandate is unconstitutional.

Legal experts have predicted that the U.S. Supreme Court will hear this case in the upcoming term. As the legislation continues to evolve, Spring will monitor the landscape and provide you with updates.



Spring Sightings

Employee Benefits in Single-Parent Captives

Donald Riggan authored this article about the basics of funding employee benefits in a captive.

Captive Insurance Company Reports
August 2011

Tipping the Balance

This article by Donald Riggan, discusses how global regulatory changes may affect the captive industry.

Captive Review
June 2011

Integrated Claims Approach Pays Off

Karen English is quoted in this article covering her DMEC session about disability savings and better productivity resulting from claims integration.

Business Insurance
August 15, 2011



HDHP Critical Illness Coverage

By Teri Weber

Spring's independent research on the voluntary marketplace notes that employees find greater value in benefits with a *pay out*, even if they have the means to successfully self insure for that same type of risk over time.

While we know this is true of the average population, the *why* is a bit harder to pinpoint. It may be partially related to how most of us are programmed to avoid risk and self insuring for a potential future risk forces us to consider the risk, quantify it and plan for it.

Regardless of the reason, as the employee benefit market evolves into a more consumer driven model, the best positioned employees will plan in advance for optional expenses and build cash over time to support paying

a high deductible when and if required. Although high deductible plans require employees to be able to self insure their risks to a certain level, it will be difficult at best for some employees to proactively set aside funds when an estimated 4 in

10 employees are living paycheck to paycheck¹.

At Spring we feel it is important to ensure that your employee benefit plans, both core and voluntary, support your employee population. We often talk to our clients about the critical links between health and wealth.



If your organization has moved or is moving to a more consumer driven model with high deductible health plans or other similar products, it may be time to examine if employees need greater support in planning for the push toward consumerism. Every employer is unique but some

strategies that have worked for other firms include:

- Considering voluntary products that allow for a *pay out* including, but not limited to, critical illness or accident programs, which may provide comfort to employees
- Establishing a benefits counselor role at open enrollment to discuss the detailed plan design features and talk to the employee about *self insuring* their risk
- Setting incentives to fund side accounts (i.e. health savings accounts, etc.), which will lower the out of pocket deductible expense

As you begin to receive your 2012 renewals and design the strategy to take forward, consider the support employees will need to appropriately respond to changes in your benefit offering.

In addition, consider offering additional coverage lines through a voluntary product offering, which will allow them to provide additional coverage at their own expense.

¹ *CareerBuilder.com*

Events

HR Policy Washington Update

Spring will be sponsoring this event. See our logo on the conference provided water bottles and meet with Karin Landry at this event in Washington, D.C, on September 7-8.

2011 LIMRA Conference

Here Karen English speak about disability, WC and leave management at the 2011 LIMRA conference in Chicago on September 8.

IHR/Employee Wellness Webcast

Karen English will be speaking about wellness and employee health during the IHR virtual conference September 14-16.

NEEBC Seminar: Building a Culture of Health

Teri Weber will be speaking at this seminar about wellness and productivity in the workplace. The seminar takes place on September 20 in Marlborough, MA.

Captive Live USA

Spring will be sponsoring this event September 26-27 in Chicago. You can also hear industry experts Karin Landry and Donald Riffin speak about employee benefits and trade credit risk. Please visit us at booth 201.

NEEBC Webinar: Update on the New 'Americans with Disabilities Act Amendments Act' (ADAAA) Regulations

Teri Weber will share her expertise on ADAAA during a webinar hosted by NEEBC on September 27.

National WC and Disability Forum

Karen English will be speaking on absence management at this event, November 9-11 in Las Vegas.



Is Inclement Weather Skewing Your Absence Rates?

2011 has brought inclement weather effects to the forefront with most areas of the country experiencing some type of catastrophic situation.

Be it excessive snow in the northeast, intense heat in the south, or torrential rains in the west, employers of all types are wrestling with absence policy and how days off due to these circumstances should be communicated, tracked and monitored.



In the fourth quarter of 2011, Spring will release a brief survey to its customers to understand how:

- Policies treat weather related absences
- Employee pay is being adapted
- Employer financial results are being impacted

If you have particular questions you would like included in our survey, please contact Karen English at Karen.english@springgroup.com or 617-589-0930 x105.

Spring is a leading professional services firm and the best in the world at developing integrated and innovative solutions with a focus on employee benefits, risk management and wealth strategies. We partner with clients to identify and resolve the challenges they face by protecting their health, creating wealth and ensuring their interests. We are industry experts with a solid foundation of international experience. A recognized thought-leader; people who get-it today, see-it tomorrow and who can make-it happen for you. Please contact us at (617) 589-0930 or visit us on the web at www.springgroup.com.