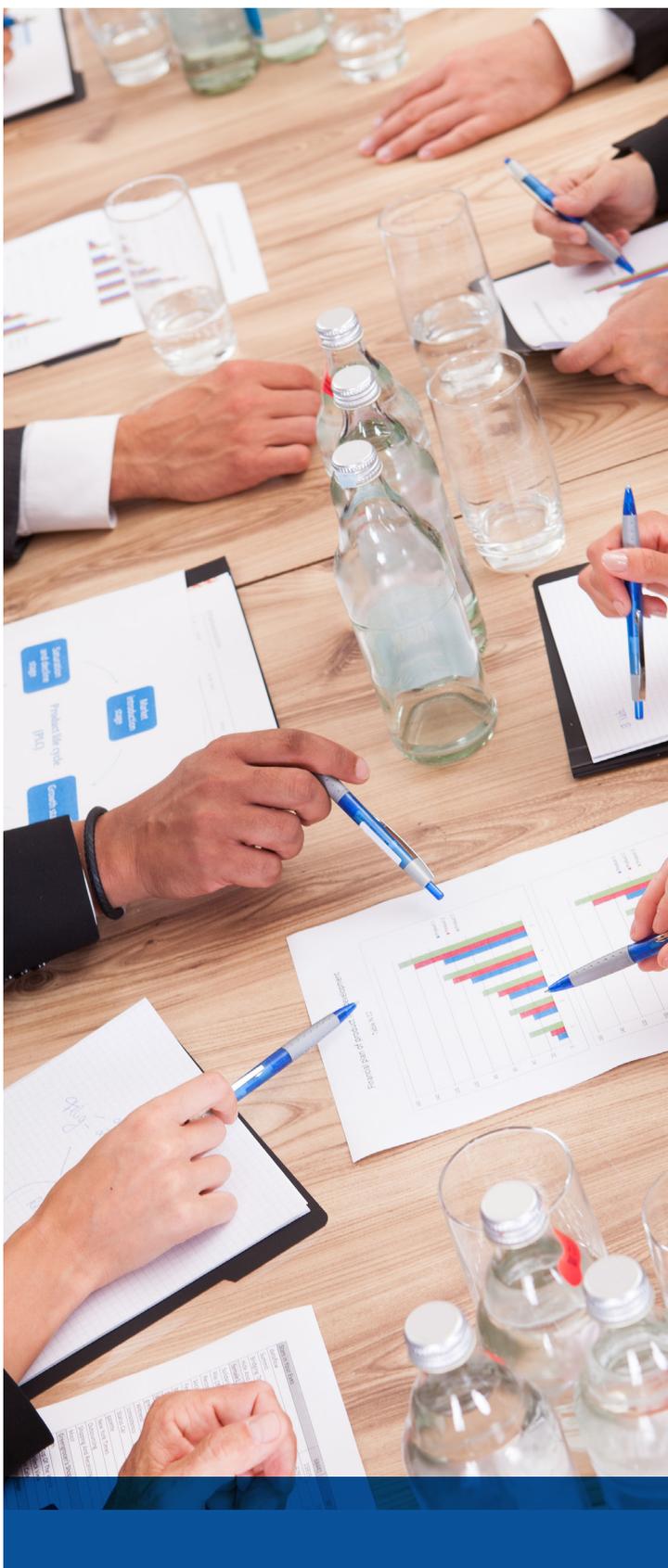


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EXECUTIVE SUMMARY

The healthcare and benefits industry can expect more change in 2019 as new innovations and players emerge in the market. Health insurance costs, however, remain on their upward trajectory.

Self-insurance continues to be a key strategy for many employers to better manage health plan costs. Compared to fully-insured plans, self-insurance reduces carrier profit margin, mandated state benefits costs, premium taxes, and ACA fees.

Pharmacy spending continues to be the fastest growing segment of health plans with many plans attributing 20 percent or more of their claim costs to pharmacy. Pharmacy will continue to be driven by new-to-market drugs, direct-to-consumer advertising, payer consolidation, and a continued lack of transparency into costs.

Improving the health of an employee population will always be important to an employer's bottom line, but which programs actually work? Some wellness programs have decreased in popularity over the last five years. On-site clinics can promise cost reduction but are not appropriate for every organization.

The leading human resources (HR) technology solutions are all incorporating artificial intelligence (AI) as they race to identify areas where it can be a differentiating part of their product solution. Currently, AI is improving the recruitment and onboarding of employees by utilizing algorithms and engagement data. Chatbots embedded in benefits administration solutions are reducing the number of mundane questions posed for HR about account balances or benefits policies. All of these advancements allow HR teams to focus more of their time and effort working on larger, more strategic initiatives.

Technological innovations shrink the world a little more each year, increasing employers' demands for globally mobile employees. These employees require benefits that are not only comparable in coverage to what domestic employees receive but also are appropriate for their location, creating special challenges for employers. Employers should

be aware of strategies that can minimize the number of insurers, reduce costs, mitigate risks, and improve the experience for their globally mobile employees.

Maintaining compliance with laws and regulations continues to be a leading priority for all employers, as failure to do so can lead to severe fines and penalties. USI's compliance team provides regular updates and hosts webinars on employment matters throughout the year.

Treasury rates are projected to increase in 2019, which is expected to drive an increase in the defined benefit plan termination funded ratios. Employers that are not making progress towards plan terminations often blame their situation on the absence of a clear exit strategy.

In this report, the Employee Benefits Practice Leaders at USI Insurance Services offer expert insights on trends, challenges, and solutions that employers should consider in 2019.

Highlights

- Self-insuring is an important first step to taking advantage of competitive stop loss and pharmacy markets as well as avoiding the Health Insurer Tax.
- Reference-based pricing will transform hospital transparency and billing.
- Artificial intelligence is rapidly improving to help HR departments become more efficient.
- Pharmacy claim trends continue to slow down but costs are still rising faster than other areas of expenditure.
- Declining interest in standard wellness programs has paved the way for more impactful wellness initiatives.

The Quantitative Case for Self-Insuring

A Strategy Worth Considering

Self-insurance has a very strong value proposition. The strategy gained status after a few pivotal changes in the health insurance marketplace: the Affordable Care Act (ACA), a lack of clarity around insurance company margins on fully-insured business, and increasingly competitive markets for stop loss, pharmacy benefit managers (PBMs), and claims administration.

The ACA introduced the Health Insurer Tax, or HIT tax, a federal government revenue generator intended to fund parts of the law. The 2018 HIT tax, for example, was expected to generate about \$14.3 billion in government revenue,¹ directly translating to an increase of about two to three percent on fully-insured group health premiums. Over a five-year period, this add-on fee significantly increases costs associated with a fully-insured plan. One of the key advantages of self-insurance is the reduction of the state taxes and fees imposed on insurance premiums, which is a winning proposition for all group sizes, even those that were once considered too small to be self-insured.

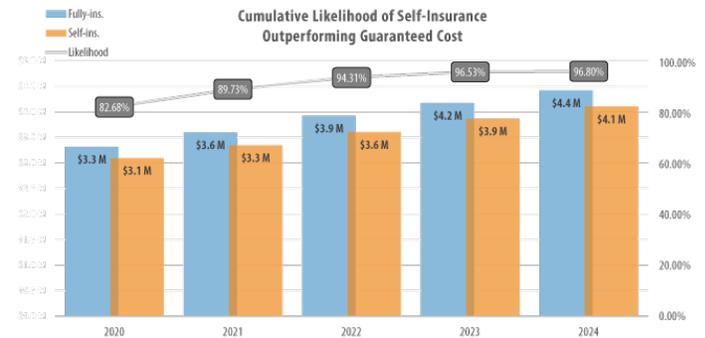
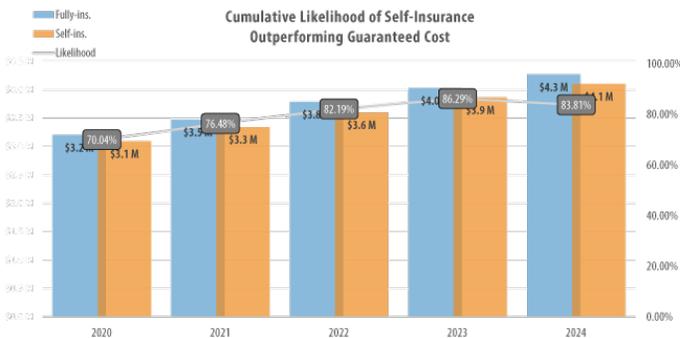
The following graphs show a typical fully-insured group with 300 employees and their families covered by employer-sponsored medical coverage. The first graph shows the cumulative likelihood over each of the next five years that self-insurance outperforms

guaranteed cost. The key assumption here is that the ACA HIT tax has not yet been included.

The second graph shows the same exact group, with the same claims, premium taxes, and carrier profit margin. The only change is the addition of a 2.8 percent HIT tax. The difference is clear: the chance in any given year of self-insurance “beating” full insurance increases by roughly 10 to 13 percent, and after five years the likelihood is over 95 percent.

This is like having the choice between two lottery tickets that pay the same jackpot and cost the same amount at the register, but one ticket has a 13 percent greater chance of winning. The value of that second ticket has increased tremendously, yet the cost has remained the same.

Another advantage of self-insurance is the opportunity to select different carriers or vendors for the plan components, who in turn compete for business, leading to competitive pricing as well as preferable terms and conditions for the employer. This is a common thread between the stop loss market and pharmacy benefit management (PBM) industry. For instance, due to the high cost of acquiring new business, stop loss insurers have increased the value proposition of staying with them for longer amounts of time. Carriers are offering better contract terms and rate caps that could benefit employers who run into a few years of bad luck with their claims costs.



¹ Giese, Glenn, et al. “New Analysis: How the ACA’s HIT Will Impact 2018 Premiums.” Oliver Wyman Health. October 10, 2017. Retrieved from https://health.oliverwyman.com/2017/08/analysis_HIT_impact.html.

PBM companies are getting more competitive because of the recent spotlight on drug costs. The extremely high costs of some specialty drugs and the negative press on PBM drug prices and profits have led to an uptick in the number of businesses committed to helping employers manage the cost of drugs and reduce PBM margins.

Increased competition in the stop loss and PBM markets means that an employer can benefit when stop loss insurers or PBMs want to acquire their business. USI experts have observed that PBMs are willing to go much further for clients when those services are out to market than if they are bundled in with a fully-insured plan.

Ultimately, becoming self-insured means taking on a limited amount of claims risk for the employer's plan. However with the right consultant designing the self-insured plan, employers will have opportunities for savings that do not exist with fully-insured plans.

Solutions for Consideration

- With the recommendation of your consulting team, consider moving to self-insurance; if self-insurance is too daunting, consider a risk-sharing alternative, such as level-funding or minimum premium funding.
- Ask about USI's Self-Insurance Exploration Analysis to help you make a quantitative case for taking on more claims risk.
- After moving to self-insurance, explore a prescription drug “carve-out,” or unbundle drug coverage from your medical coverage and send it out to market to optimize your spending in this area.
- Similarly, explore a stop loss “carve out” using USI's Stop Loss Consortium to obtain favorable terms and conditions.



ANALYTICS

Reference Based Pricing: A Strategy on the Rise

What is RBP?

Thrown to the wolves... that's how moving to a reference based pricing model might feel to employees who have been sheltered under the PPO healthcare model since the mid-1980s. Once considered a fringe approach, reference based pricing (RBP) strategies have been gaining traction and promise to be one of the most talked about cost containment solutions for employee benefits in 2019.

The approach is simple. Instead of relying on insurance carriers to negotiate a percentage-based discount on inflated hospital retail prices, RBP vendors estimate a hospital's expenses for each procedure and layer on additional profit margin.

Most RBP arrangements use Medicare reimbursement rates to establish procedure costs as they pay enough to cover hospital

expenses and also do a good job of adjusting fees by geography, making them a reliable baseline in most markets. An additional 20 to 50 percent is added to the Medicare rate to cover hospital profit margin and that becomes the price a plan is willing to pay for services.

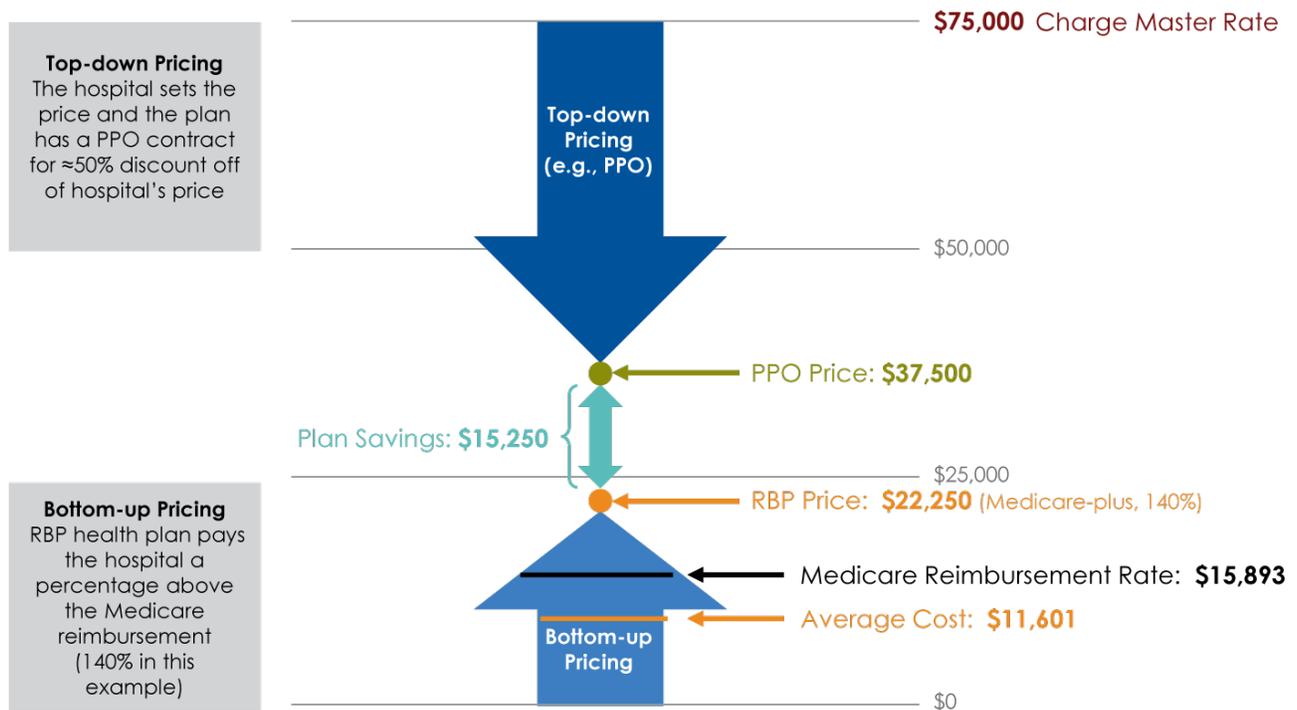
Implementing RBP typically generates 15 to 30 percent in total medical plan savings. So why isn't every organization doing it?

While the approach is uncomplicated, the implementation can be much more complex. There are numerous issues involving compliance, communications, stop loss placement, and member education that must be addressed. This evolving space also consists of several yet-to-be-decided court cases that may shape the future of both RBP and the hospital industry.

Due to the nature of employer-paid healthcare, the traditional balance of supply and demand is skewed in favor of the healthcare provider.

Ultimately, an RBP strategy is an attempt to provide price controls around an industry that has avoided them for decades.

PPO vs. RBP



So, why would a hospital accept half of the normal, insured payment for a procedure? Hospital systems accept these reduced payments because defending their prices would involve an uncomfortable level of transparency. For example, in 2016 Montana switched to an RBP plan for its state employees, and several hospitals initially refused to accept the reduced fee schedules. They changed their minds only after the state threatened to divulge that some Montana hospitals were priced up to three times higher than others – without any discernible difference in quality or location. When the holdouts folded, Montana went on to turn around a health plan that had been expected to go bankrupt the next year.² The North Carolina State Health Plan is following Montana’s lead and will be switching to RBP for the 2020 plan year.³ Other states are also considering the shift, keeping RBP in the news and helping to legitimize the model.

Most groups utilizing an RBP strategy today are doing so out of necessity; they cannot afford plan costs under a traditional network. As word spreads and the concept becomes familiar, more employers may consider RBP as a better investment of their healthcare dollars. While the savings are considerable, many plan sponsors may not be ready for the amount of education and employee guidance necessary to keep plan participants comfortable with an approach that greatly increases balance billing disputes and potential credit impairment.

An Evolving Industry

As reference based pricing gains market share, the traditional network approach will be forced to evolve. Increasing scrutiny of billed and allowed charges will help push hospital systems to become more transparent and competitive with their pricing.

In the meantime, employers willing to invest considerable time and resources into employee education and navigational support will be able to take advantage of the immediate savings RBP can generate. While RBP is not for every plan sponsor, it is important to become familiar with the approach and know why it does or does not make sense for employees. RBP promises to capture headlines for the foreseeable future and employers need to be ready to defend their stance.

Considerations for Employers Evaluating RBP

- Successful deployment of RBP takes significant planning, ideally one to two years.
- Employee communications are critical and should involve frequent reminders beginning six to 12 months prior to the RBP effective date.
- Employees need a knowledgeable advocate who can help navigate the healthcare industry, negotiate with providers, and resolve balance billing issues. Consider outsourcing these responsibilities to a nurse case manager service with RBP experience.
- USI can help you evaluate whether RBP might be a viable strategy for your organization. Our newly released proprietary decision support tool can help assess your readiness as an employer.

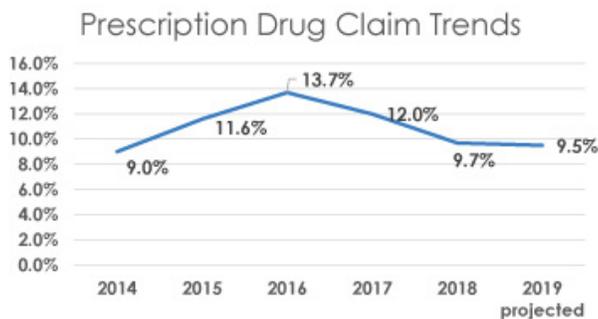
² Allen, Marshall. "In Montana, a Tough Negotiator Proved Employers Don't Have to Pay So Much for Health Care." October 2, 2018. Retrieved from <https://www.propublica.org/article/in-montana-a-tough-negotiator-proved-employers-do-not-have-to-pay-so-much-for-health-care>.

³ North Carolina State Health Plan. "State Health Plan Launches New Provider Reimbursement Effort." October 5, 2018. Retrieved from <https://www.shpnc.org/blog/2018-10-05/state-health-plan-launches-new-provider-reimbursement-effort>.

PHARMACY

Pharmacy Challenges Persist; Will Employers Be Prepared?

Pharmacy claim trends are slowing down,⁴ but employers can expect pharmaceutical costs to continue making pharmacy one of the fastest growing health plan expenses to manage in 2019. The combination of new-to-market drugs, modest and occasionally excessive price inflation, direct-to-consumer advertising, payer consolidation, and limited government control will all contribute to rising pharmacy costs.



Retail prescription drug expenses made up approximately 12 percent of total U.S. healthcare spending in 2015, an increase of almost seven percent from the 1990s.⁵ Between 2006 and 2015, revenue from pharmaceutical and biotechnology sales increased from \$534 billion to \$775 billion, according to a recent report from the U.S. Government Accountability Office.⁶ About two-thirds of drug companies experienced an average 17.1 percent profit margin increase over that period.

Regular Price Inflation

In March 2018, Missouri Senator Claire McCaskill released a report, *Manufactured Crisis: How Devastating Drug Price Increases are Harming America's Seniors*, revealing the price of the 20 most-prescribed drugs for seniors increased at an average of 12% per year for the last five years. This is approximately ten times the cost of inflation during the period from 2012 to 2017.⁷

More of the same can be expected according to Scott Knoer, chief pharmacy officer at Cleveland Clinic, who said, "Drug companies

raise prices far exceeding inflation because they can. In the absence of regulation and without consumer awareness – since consumers don't generally see the price due to insurance – the sky is the limit."⁸

Payer Consolidation

In 2018, the CVS/Aetna⁸ and Cigna/Express Scripts⁹ mergers created concern about the future of PBM carve-out opportunities. Both newly formed companies stated the mergers will allow them to decrease healthcare costs, improve access to care, and deliver better outcomes.

New Drugs to Market

The following list is a small sample of more than 55 new drugs approved by the U.S. Food and Drug Administration (FDA) in 2018 that will contribute to increased employer costs in 2019.

Drug/Cost	Treatment	Approval Date
Emgality		
\$690 per month	Once-a-month injection for treatment of migraines	9/27/2018
Epidiolex		
\$1,482 per bottle	Marijuana-based pharmaceutical medication. FDA approved treatment of seizures associated with rare forms of epilepsy	6/25/2018
Vizimpro		
\$14,880 per month	Oral treatment for non-small cell lung cancer	9/27/2018
Talzenna		
\$17,496 per month	For the treatment of locally advanced or metastatic breast cancer patients with a germline BRCA mutation	10/16/2018
Copiktra		
\$15,171 per month	For treatment of relapsed or refractory chronic lymphocytic leukemia, small lymphocytic lymphoma, and follicular lymphoma	9/24/2018
Galafold		
\$31,185 per month	To treat adults with Fabry disease	8/10/2018

⁴ USI Insurance Services. "Fall 2018 Health Trend Survey." December 2018.

⁵ Kacik, Alex. "Drug prices rise as pharma profit soars." Modern Healthcare, December 28, 2017. Retrieved from <https://www.modernhealthcare.com/article/20171228/NEWS/171229930>.

⁶ U.S. Government Accountability Office. "Drug Industry: Profits, Research and Development Spending, and Merger and Acquisition Deals," November 17, 2017. Retrieved from <https://www.gao.gov/products/GAO-18-40>.

⁷ Ask a Patient. "Lawmakers continue to investigate pharmaceutical price increases." April 29, 2018. Retrieved from <https://www.askapatient.com/news/brand-name-price-spikes-seniors.asp>.

⁸ LaVito, Angelica. "CVS creates new health-care giant as \$69 billion merger with Aetna officially closes." CNBC. November 28, 2018. Retrieved from <https://www.cnbc.com/2018/11/28/cvs-creates-new-health-care-giant-as-69-billion-aetna-merger-closes.html>.

⁹ Livingston, Shelby. "Cigna and Express Scripts close on \$67 billion merger." Modern Healthcare. December 20, 2018. Retrieved from <https://www.modernhealthcare.com/article/20181220/NEWS/181229999>.

Direct-to-Consumer Advertising

Each year, drug companies spend more than \$5 billion on direct-to-consumer advertising.¹⁰ The only countries in the world that allow such advertising for prescription drugs are the U.S. and New Zealand; all others deem it irresponsible to advertise to the general public, who generally lack medical training to comprehend the complexities associated with the drugs. Institutions such as the American Medical Association (AMA) have called for a ban on advertising directly to consumers and have stated, “Direct-to-consumer advertising inflates demand for new and more expensive drugs, even when those drugs may not be appropriate.”¹¹

In 2018, the U.S. Senate passed prescription drug legislation¹² that would require direct-to-consumer advertising to disclose prices. This law may deter some consumers but is not likely to have great impact overall.

There are also efforts at both the federal and state government levels to attempt to drive greater pricing transparency. Additionally, the Trump administration and nine states are exploring the importation of prescription drugs to reduce costs.

Questions for Consideration

As pharmacy costs continue to rise faster than other areas of health plan expenditures, employers will seek better strategies to contain them. It is extremely important for employers to strive for as much transparency as possible with all stakeholders in the pharmacy plan.

Here are some questions to consider:

- Does the insurance company or TPA make money from the drugs our membership is using? If so, how much?
- Does the advisor make any hidden revenue from the pharmacy program? If so, how much?

- Is our organization receiving an appropriate number of rebates and/or a rebate credit?
- Is the PBM benefiting from how they design the formulary and does our organization have the ability to modify the formulary as desired?
- Does the PBM have a conflict of interest with respect to pharmacy rebates and the approval of specialty drugs?

Next Steps for Employers

The pharmacy program is one of the most complex and essential employee benefits offered by organizations. Employers will continue to struggle with managing their exposure to high cost specialty drugs. The pipeline of these drugs will be steady, and some employers will see rapid swings in cost as members begin new or existing regimens of specialty drugs.

It is important that employers receive professional advice from people they can trust. USI's pharmacy consultants have experience navigating the many challenges employers will face. Our team can assist with every facet of pharmacy consulting such as:

- PBM contract review
- PBM market comparison
- Plan design modeling
- Formulary and rebate considerations
- Pharmacy benchmarking
- Pharmacy audit
- Pharmacogenetics
- Prior authorization effectiveness.

¹⁰ Lazarus, David, “Direct-to-consumer drug ads: A bad idea that’s about to get worse,” Los Angeles Times. February 15, 2017. Retrieved from <https://www.latimes.com/business/la-fi-lazarus-drugadvertising-20170215-story.html>.

¹¹ Kelly, Susan, “U.S. doctor group calls for ban on drug advertising to consumers,” Reuters. November 17, 2015. Retrieved from <https://www.reuters.com/article/us-pharmaceuticals-advertising/u-s-doctor-group-calls-for-ban-on-drug-advertising-to-consumers-idUSKCN0762WT20151117>.

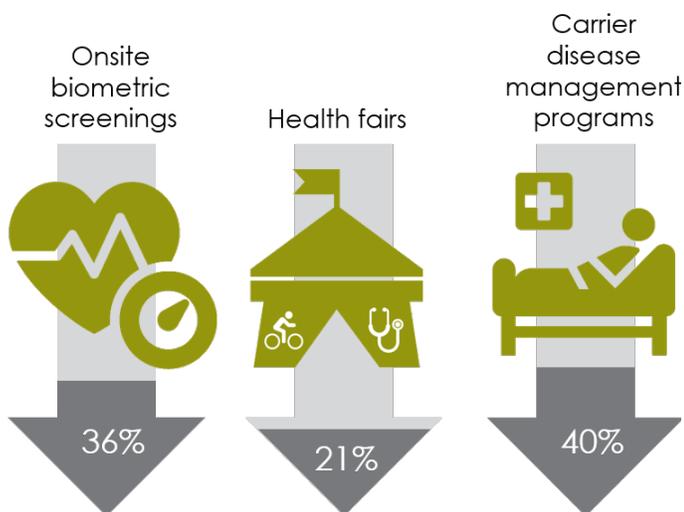
¹² Grassley Press. “Grassley: A Important Step Forward for Transparency in Drug Pricing.” August 27, 2018. Retrieved from <https://www.grassley.senate.gov/news/news-releases/grassley-important-step-forward-transparency-drug-pricing>.

POPULATION HEALTH MANAGEMENT

Promoting a Healthy Workforce Will Always Be Important

Corporate health as an industry is only about 30 years old. When it comes to corporate wellness initiatives, we are still beginning to figure out what works and what doesn't. The goal for most corporate wellness programs is to positively impact healthcare claims and improve the health status of employees. When an employer cannot see data that portrays a positive impact on these metrics, the programs often stagnate or even terminate.

In the 2018 Society of Human Resource Management (SHRM) Employee Benefits Report¹³ on wellness programs, SHRM reported decreases in on-site biometric screenings, health fairs, and carrier disease management programs since 2014.



While these types of programs may have assisted companies in beginning their wellness journeys, it's difficult to measure impacts on healthcare costs or health status. For example, on-site biometric

screenings were previously a mainstay of the wellness industry but, for many employers, screenings have failed to slow the ever increasing and costly prevalence of chronic conditions like high blood pressure, high cholesterol, and diabetes.

In 2013, USI leaders recognized the lack of impact these programs had on claims and launched its proprietary CORE Health Strategy physician engagement initiative. The initial focus of USI's CORE Health Strategy is incentivizing employees to engage with their primary care physician each year and identify existing or potential health issues before they become catastrophic claims. Many employers have found USI's CORE Health Strategy very effective at improving the health of employees and reducing their benefits spend.

Comprehensive management of on-site clinic vendors

According to the National Association of Worksite Health Centers (NAWHC), 16% of employers with 500-4,999 employees had an on-site clinic but another 8% expect to add one in 2019.¹⁴ While on-site clinics often improve access to care in rural areas, they are also an opportunity to increase adherence to disease management programs. USI envisions that corporate adoption of on-site clinics for mid-market clients will expand over the next three to four years.

However, employers need to be extremely judicious when evaluating whether or not to offer these services on-site. While they may be a highly effective population health management solution for the right organization, many employers have little experience or clinical expertise to manage the vendors. Unfortunately, many benefits consultants don't know how to manage the programs either, allowing the vendors to do what they want, quickly making the costs prohibitive.

¹³ Society for Human Resource Management. 2018 Employee Benefits. Retrieved from <https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/Documents/2018%20Employee%20Benefits%20Report.pdf>

¹⁴ National Association of Worksite Health Centers. "What is an Onsite Clinic?" Retrieved from <https://www.nawhc.org/about-nawhc/what-onsite-clinic>

For example, USI acquired a client with an existing on-site clinic and discovered that the clinic's claims were escalating well above the projected budget. USI reviewed the claims data and found that the clinic was overcharging on lab fees. USI presented their findings to the clinic vendor who refunded the client \$120,000 for the erroneous fees.

How We Can Help

USI's Population Health Management initiatives are primarily focused on delivering solutions that can demonstrate a meaningful impact on claims and the health status of a population. If you are not satisfied with results of your Population Health Management initiatives, it may be time to consider a new strategy. USI's knowledgeable team can help you define your company's goals and implement a long-term strategic plan to mitigate future claims costs, as well as evaluate your data to identify those initiatives that support plan objectives.



HUMAN RESOURCES TECHNOLOGY

Artificial Intelligence: Are Employers Ready?

New Technologies are Coming

All the hype around artificial intelligence (AI) can make anyone both nervous and excited. The fact that self-driving cars are a reality and not a dream makes one wonder how these types of technology will impact professional life. Nearly every top HR technology solution provider is building AI functionality. Everyone wants solutions that will automate as much as possible in a smart and effective way, but how will AI truly affect your HR department?

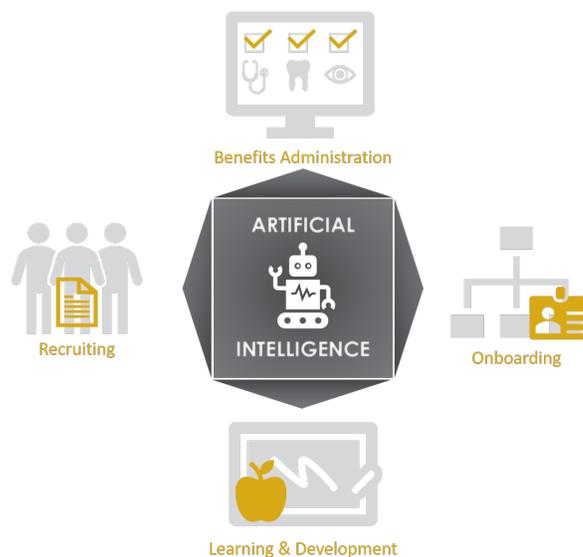
One of the first areas to be transformed by AI is recruiting, which is traditionally a heavily human-based process and costly if done incorrectly. Algorithms based on AI sort through resumes in seconds, bringing to the top a list of candidates most likely to be successful in an organization. Studies have shown success rates for this type of functionality has increased by over 30 percent,¹⁵ while eliminating bias inherent in the recruiting process.

AI solutions are also being used for personalized onboarding of new employees and as training and development tools for employees and managers. By using sentiment and engagement data to help coach people to be better managers, employers are able to retain talent, saving time and expense.

The most common AI in benefits administration is the automation of simple tasks such as inquiries with chatbots or a virtual assistant. Employees ask the bot a question like, “What is my HSA balance?” and the system directs the employee to that information. AI chatbots understand native language; the question can be written normally, and AI will identify key words to put it together and provide the right answer. Chatbots can explain benefit plans at a high level, taking the burden off HR staff and helping employees to be more self-sufficient.

Increasing Efficiency and Effectiveness of HR Teams

New HR technology with artificial intelligence can impact almost every stage of the employee life cycle in a very positive way. As a



result of AI, Human Resource teams will have more productive discussions with their C-suite based on real and personalized information (not another company’s data) to enable more effective decision making.

Solutions for Consideration

- Determine if the existing technology has any AI features that can be added or activated.
- Verify how the AI receives data and analyzes it. AI processes should be transparent; AI will learn based on actions within the solution so if “bad” decisions are being made, the AI tool could learn “bad” behaviors. In that case, it is important to understand how appropriate adjustments can be made to be sure human bias is not recorded and learned by the machine.
- USI can assist your organization with human capital management or the benefits administration evaluation process. Our dedicated team has vast experience with search and selection based on your organization’s specific needs.

¹⁵ Bersin, Josh. “AI in HR: A Real Killer App.” *Forbes*, June 18, 2018. Retrieved from <https://www.forbes.com/sites/joshbersin/2018/06/18/ai-in-hr-a-real-killer-app/#3674230248f1>.

INTERNATIONAL EMPLOYEE BENEFITS

Effective Benefit Strategies for Globally Mobile Employees

With technology, telecommunication, and transportation innovations, companies are increasingly conducting business globally around the clock. This makes the need for talent to connect virtually from any country crucial.

Globally mobile employees include those on assignment in foreign countries (expatriates and third country nationals or “TCN”) and employees who travel outside their country of employment on company business.

Global mobility creates special risks for employees and unique benefit challenges for employers. Some of those challenges include: offering access to adequate health insurance protection regardless of employee citizenship and work location; travel assistance and support services abroad; emergency evacuation; and returning an expatriate to their home country.

Cost and Financial Liability

To meet the global mobility challenge, employers often purchase various insurance policies to cover medical care, emergency evacuation and repatriation, and travel assistance support. Often, these policies are purchased across departments including relocation, benefits, HR, and finance/risk management, resulting in multiple policies with different insurers.

Lack of coordination between departments purchasing insurance policies is disadvantageous to employers and may cause:

- Gaps and/or redundancies in coverage and service providers
- Unnecessary costs
- Administrative inefficiencies
- Unsatisfactory employee experience

Policy Type is Important

While policies are in many ways alike, it's the unique differences that create concerns. Take a look at medical benefits, for example. Depending upon the policy type, the medical benefits may be payable only for accident or work-related incidents, but not illness or disease. Further, the amount of medical coverage may be insufficient depending on the countries to which employees travel.

A traditional business travel plan is a casualty policy providing benefits only in the event of an accident (e.g. AD&D, accidental medical). A medical policy for expatriates is a health policy which provides medical benefits for accident and illness, including routine care, exams, and prescriptions.

Evacuation service providers are a common area of redundancy as each insurer has its own provider. It is not uncommon to see three or four different policies, each with a different emergency evacuation service provider, which can be confusing to the employee during a real emergency.

Inter-departmental Coordination is Crucial



Legal Obligations

Recent court cases have heightened employer awareness of and the need to demonstrate “duty of care” for their employees.

“The employment relationship, in general, includes an obligation of duty of care of employers for the health, safety, and security of their employees. This obligation extends to employees and to their dependents who are abroad as international business travelers or as short- or long-term assignees.”

Dr. Lisbeth Claus

From Duty of Care of employers for protecting international assignees, their dependents and international business travelers

Workforce Attraction and Retention

Attracting, retaining, and maximizing the productivity of globally mobile employees is essential to companies that conduct business across different countries, time zones, and cultures.

An increasingly important component of a global employee’s compensation is a benefit plan that provides (at a minimum) adequate insurance protection, assistance services, and exceptional service and care.

Strategies for Consideration

To effectively provide benefit insurance solutions for globally mobile employees, employers must avoid operating in silos. Cross-department communications and cooperation is essential to:

- Identify and understand the global risk employees may face,
- Develop a common benefit strategy, and
- Harmonize the purchase of insurance policies.

An effective communication strategy will reinforce the value of the benefit program and optimize employee experience.

Effective Strategies for Employers with Globally Mobile Employees



Effective communication strategy, including cross-department cooperation



Inventory and compare all policies



Use qualified insurers offering competitive prices; quality over quantity

As a collective team, companies should inventory, outline, and compare the various insurance policies that provide benefits for globally mobile employees. The comparative analysis should focus on:

- Coverage and benefits
- Geographical scope
- Eligibility
- Insurers and policy types, including terms and conditions
- Premium costs
- Evacuation and repatriation service providers

Selected coverage, benefits, and services should be competitively bid with qualified insurers with a view to:

- Minimize the number of insurers (including a single provider for emergency services and travel assistance services)
- Reduce costs
- Mitigate risks
- Improve employee experience

Experienced international employee benefits consultants at USI assist multinational employers by providing insights into local issues and employer requirements when offering benefits in foreign countries.

EMPLOYEE BENEFITS COMPLIANCE

2019 Employer-sponsored Healthcare Compliance Update

New and Changing Rules Continue to Impact Employers

While the recent government shutdown and a stalled Congress may seem like the time to shy away from employee benefit compliance obligations, think again. There are many upcoming deadlines and requirements along with new guidance that remain relevant, even in this time of uncertainty. While the government may be closed, it doesn't mean employers can forget their legal requirements.

Deadline for 2018 Forms 1095-C Extended



The IRS extended the Form 1095-C deadline to provide calendar year 2018 forms to employees until March 4, 2019 (as opposed to January 31, 2019).¹⁶ This extension does not apply to the IRS filing (combined Form 1094-C with all Forms

1095-C), which remains due by April 1, 2019 if filing electronically or February 28, 2019 if filing by paper.

2016 Letter 226J

Letter 226J¹⁷ is issued by the IRS to certain applicable large employers for calendar year 2016, reflecting potential penalty assessments under Internal Revenue Code (IRC) 4980H (the “employer mandate”). Based on an initial review, like the 2015 letters, many of the assessments received by employers are due to errors in reporting and not usually reflective of an actual liability.

Incentive-based Wellness Programs

On January 1, 2019, Americans with Disabilities Act (ADA) and Genetic Information Nondiscrimination Act (GINA) guidelines on permissible incentive thresholds were vacated. While the Equal Employment Opportunity Commission (EEOC) indicated new proposed guidance may be available in June 2019, the recent shutdown may further lengthen the release. Unfortunately, this leaves employers with some uncertainty.

The EEOC rules apply when a wellness program uses incentives to encourage employees (or their spouses) to complete health risk assessments or certain medical exams (e.g., a physical or biometric screening). Before they were retracted, the rules permitted incentives of no more than 30% of the total cost of self-only coverage in the lowest cost plan option offered by the employer. A lawsuit brought by the AARP successfully argued the agency failed to sufficiently explain its decision to use 30% as the permissible threshold for voluntariness.

Absent further guidance, employers with incentive-based wellness programs that require medical exams or disability-related inquiries should determine a path forward. Conservatively, employers may opt to remove any rewards tied to completion of these activities. Alternatively, many employers have decided to follow the “pre-2019” ADA and GINA guidelines on incentives. These guidelines are more restrictive than the existing HIPAA and Affordable Care Act (ACA) rules and many experts believe there is limited risk that the EEOC will challenge these arrangements while developing new guidance. Whichever approach an employer decides to take should be reviewed with counsel.

Prescription Drug Transparency

As the cost of pharmaceuticals has spiked in the United States, so has the public's interest in this area. The Trump administration issued proposed regulations¹⁸ that would provide additional transparency in the Medicare market by, among other things, requiring the inclusion of pricing information for many prescription drugs advertised on television.



Additionally, new legislation¹⁹ enacted on October 10, 2018 prohibits “gag clauses” in pharmacy contracts. These clauses are used to contractually bar pharmacists from disclosing the cash price of a prescription (which may be more cost effective) when coverage is provided through an insurance plan and/or pharmacy benefit manager (PBM).

¹⁶ Internal Revenue Service. “Notice 2018-94: Extension of Due Date for Furnishing Statements of Good-faith Transition Relief Under I.R.C. Sections 6721 and 6722 for Reporting Required By I.R.C. Sections 6055 and 6056 for 2018.” Retrieved from <https://www.irs.gov/pub/irs-drop/n-18-94.pdf>.

¹⁷ Internal Revenue Service. “Understanding Your Letter 226-J.” June 2018. Retrieved from <https://www.irs.gov/individuals/understanding-your-letter-226-j>.

¹⁸ Centers for Medicare & Medicaid Services. “Proposed Regulation: Medicare and Medicaid Programs; Regulation To Require Drug Pricing Transparency.” Federal Register. October 18, 2018. Retrieved from <https://www.federalregister.gov/documents/2018/10/18/2018-22698/medicare-and-medicaid-programs-regulation-to-require-drug-pricing-transparency>.

¹⁹ Sen. Stabenow, Debbie (D-MI). Public Law No. 115-262, “Know the Lowest Price Act of 2018.” United States Congress. October 10, 2018. Retrieved from <https://www.congress.gov/bills/115/congress/115th-congress/senate-bill/2553?q=%7B%22search%22%3A%5B%22s2553%22%5D%7D&s=1&r=1>.

Association Health Plans (AHPs)

In June 2018, the Department of Labor (DOL) released final regulations²⁰ paving a new way for unrelated employers to establish a single health benefit plan for their employees. While the regulations were a focal point of the Administration's policy, the development and rollout of new AHPs has been very slow due to concerns about the cost-effectiveness in the current environment, state laws that restrict creation of AHPs and carriers unwilling to enter this market. Additionally, many states have filed a lawsuit against the DOL challenging these final rules.

Health Reimbursement Arrangements (HRAs)

Recently, the IRS issued guidance²¹ on HRAs, a significant departure from policy under the previous administration. The new guidance, if finalized, will permit integration of HRAs with individual health insurance coverage for the plan year beginning on or after January 1, 2020.

The Importance of Being Compliant

Compliance issues for health and welfare benefits remain an area of change and an enforcement priority. These issues are important, as penalties for non-compliance can be significant and open employers to potential litigation. Recently, the DOL sued a handful of employers and group health plans over HIPAA/ACA violations and breaches of fiduciary duty pertaining to wellness programs and plan document deficiencies. In one instance, the DOL alleged the employer's outcome-based wellness program did not provide reasonable alternatives to participants who did not meet certain outcomes (e.g., body mass index, blood pressure, cholesterol level, glucose level, and use or nonuse of tobacco products). The employer and DOL settled for nearly \$60,000.

Solutions for Consideration

Employers should continue to comply with existing compliance obligations and educate themselves on new laws and regulations that impact their business. In addition, the following actions are recommended:

- Keep an eye out for Letter 226J applicable for calendar year 2016. USI has many resources to assist in evaluating these letters.
- Review existing wellness programs to identify potential risks once existing EEOC rules on permissible incentives are vacated, and review programs to ensure reasonable alternatives and appropriate notices are provided.
- Await revised guidance from the EEOC addressing permissible incentive limits for wellness programs.
- If sponsoring a self-funded health plan, take steps to ensure any "gag-clauses" included in PBM or other insurance contracts are removed.

USI will keep organizations informed and ready through Compliance Updates and Webinars as developments occur.



²⁰ Employee Benefits Security Administration. "Definition of "Employer" Under Section 3(5) of ERISA-Association Health Plans." Federal Register. August 20, 2018, Retrieved from <https://www.federalregister.gov/documents/2018/06/21/2018-12992/definition-of-employer-under-section-35-of-erisa---association-health-plans>.

²¹ White House Fact Sheet. "President Donald J. Trump's Administration Proposes Regulation That Would Increase Employer and Worker Health Insurance Options." October 23, 2018. Retrieved from <https://www.dol.gov/sites/dolgov/files/OPA/factsheets/wh-hra-factsheet.pdf>. See also The Federal Register. Vol. 83, No. 209. October 29, 2018. Available from <https://www.gpo.gov/fdsys/pkg/FR-2018-10-29/pdf/2018-23183.pdf>.

RETIREMENT & INVESTMENT

Defined Benefit “Glide Path to Termination” Strategies: Will De-risking Ever Come to an End?

Eliminating Risk and Terminating Plans in 2019

Ultimately a pension plan’s risk is not eliminated until full settlement of all plan liabilities.

The goal for most plan sponsors with hard-frozen defined benefit plans is to eliminate all risk with a plan termination. The significant increase in interest rates seen during 2018 has helped many sponsors move closer to that goal. However, the vast majority still have significant progress to make in paying down their unfunded termination liabilities. While the average funded ratio for frozen plans is now over 100 percent²² on an ongoing funding basis, on a plan termination basis the average funded ratio is closer to 80 percent.²³

We expect to see an increase in Treasury rates in 2019, which could help move plan termination funded ratios higher, but are very unlikely to significantly decrease the funding gap. Offsetting these increases in Treasury rates is an ongoing decline in the overall set of discount rates as the 25-year yield curve rolls forward, each year dropping an older, higher rate and adding a newer, lower rate. It may be that increasing rates has no positive effect on pension liability values.

As a result, the need for strategic de-risking actions by plan sponsors will continue into 2019 and beyond. Which actions make the most sense will depend on where a sponsor is on the glide path to, and their expected timing for, termination. Proactive collaboration with the sponsor’s actuary and investment advisor is essential in developing and executing an effective de-risking action plan. A common theme among plan sponsors who are not making progress toward their plan termination goal is lack of a clear exit strategy.

Prioritizing Goals

Creating and implementing an effective exit strategy requires a company to identify its objectives in three key areas. These objectives sometimes conflict, so the plan sponsor should outline parameters to resolve which goals take priority. The key areas are:

- Goals for managing the company’s balance sheet impact,
- Goals for the total cash contribution costs for the life of the plan, and
- Goals for managing investment risk.

The rise in interest rates during 2018 and the expected increases in 2019 should help reduce the unrecognized losses many companies are carrying on their balance sheets. Of course, that rise may also reduce asset values, an offsetting impact that decreases the liability gains. Some of the de-risking actions available to a plan sponsor such as lump sum windows, targeted annuity purchases, or a move towards liability-driven investing (LDI) can have a material impact on pension plan expense, directly or indirectly.

The first key objective companies need to identify is what level of expense recognition is acceptable for every year leading up to and including the year of the plan termination.

Goals for an Effective Exit Strategy



²² Based on target liability and asset values shown on the latest available 5500 filings of 2,662 hard frozen defined benefit plans with more than 100 total participants.

²³ Plan termination funded ratio estimated from target liability assuming a 3.75% settlement rate and a liability duration of 12 years.

The second key component relates to the company's plan for funding. Unfunded plan termination liabilities (after any reduction in settlement costs) will eventually be paid for either by investment earnings or cash contributions. Setting goals for how much should be paid for by the company and how much needs to come from investment earnings is a critical element in the exit strategy. The level of investment return is linked to the investment risk the plan sponsor must accept to earn that return.

The final objective of setting the company's goals related to investment risk is closely tied to their contribution goals. These two objectives need to be harmonized so they are consistent with one another and are based on realistic current market conditions. Coordination between the actuary and the investment advisor is critical since balancing the company's goals for contribution levels and investment risk often requires iterative analysis to arrive at the optimal solution.

Developing a Clear Exit Strategy

Setting these three goals and the related parameters to resolve any conflicts between them provides the foundation for creating a clear exit strategy. It is important that these established objectives provide enough detail to be actionable across different scenarios.

For example, a goal of \$0 impact on the annual pension plan expense is likely to be overly restrictive and may preclude de-risking actions that would help accomplish other goals. Assuming that this goal was overly conservative in conveying the company's intentions, a better-designed goal would be one that describes a preference for zero-dollar impact, allows for a 0- to 10-percent increase in the expense, rules out any impact of over 15 percent, and provides for consideration of impacts between 10 to 15 percent. The company's objectives for the total cost and investment risk should be constructed in a similar way.

The end result is a set of actionable goals that create a road map for getting to a plan termination. A valuable by-product of this road map is an estimate of the time frame for getting the plan terminated. At one end of the spectrum, a company with no limits on cash contributions that wants no risk should terminate their plan immediately. At the other end of the spectrum, a company that wants to make no contributions and is willing to accept the risks necessary to become fully-funded through investment earnings alone, will need to calculate the point in time that can reasonably be expected to happen. Having the road map and knowing how long it will take to get there provides the information needed to evaluate progress along the way.



Solutions for Consideration

Once the road map is set all you need to know is your starting point. For this, we recommend that you work with your actuary and investment advisor to get an accurate estimate of your plan's termination shortfall and the near-term outlook for your investment portfolio.

If a 2019 plan termination is affordable, then you should contact USI Consulting Group (USICG) for a quote on plan termination and annuity placement services. If your goals dictate a longer-time horizon, then use your road map and work with your actuary and investment advisor to implement the contribution plan and asset allocation that meet your objectives and get you to the finish line with the lowest cost in the shortest time frame.

USICG's actuaries, annuity desk, and investment advisors can assist along this journey and help you meet your objectives.

How can we help?

For more information regarding these topics, please contact your USI Consultant, or visit us at www.usi.com

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