



SUMMER 2008

PRESIDENT'S COLUMN

Leslie Hallock

Dear MEBC Members:

Happy Summer! We expect most members have made plans to head for the hills or the shore to enjoy Maine's short summer, however, we hope you have also made plans to attend the coming MEBC meeting on July 24, 2008.

If you have not already received the summer program, Jim Racine of the Lincoln Financial Group and Lauren Corey of Macdonald Page & Co LLC will present "**403(b) Final Regs – What Must be Done Before December 31?**". December 31 is the deadline for the 403(b) plans to comply with final regulations issued by the Internal Revenue Service. These regulations effect plan documentation, plan operation and plan reporting. This program will inform employers of these important new requirements. We encourage all members who work with tax-exempt organizations or public schools to attend this meeting and we invite them to bring their clients along. Members and guests wishing to register for this important meeting should contact the Program Chair, Jennifer Breton of Lebel & Harriman at 773-5390.

In our last letter, we advised members that we would periodically post current eSeminars (webinars) on employee benefits topics to help members locate continuing education opportunities specific to their individual disciplines and professional areas. Given the broad range of interests of our members, as well as the large number of vendors now offering good eSeminars products, we determined that the best way to alert you to the many seminars available is to direct you to **www.benefitslink.com**. On the left side of the home page you can connect to Events [conferences, webcasts, Satellite Conferences and teleconferences]. The site is updated regularly and provides a comprehensive list of programs addressing a broad range of employee benefits topics. We hope it will be useful to you.

Our newsletter chair, Tony Ornatek of Actuarial Designs and Solutions, has coordinated this newsletter. We encourage members to help make the newsletters successful and interesting by providing educational articles from time to time. It is a great way to support the organization and gain recognition.

We hope to see you at the July meeting!

Leslie

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TO SELF FUND OR NOT TO SELF FUND, THAT IS THE QUESTION!

Peter Fendler

It seems most employers are either completely sold on, or completely opposed to the concept of self funding. In fact, it is neither a panacea nor a black hole. It is simply another tool to consider in your efforts to control health care costs.

First off, the term self funding is a misnomer. "Stop Loss" insurance accompanies most self funded plans. In general, the plan only self funds the front end of each covered person's claims up to the stop loss limit. Typically the limits run between \$25,000 and \$150,000 depending on the size of the employer. Whether or not it is a good fit for your plan depends on a number of variables that you should weigh before deciding to pursue self funding. Below is a discussion on some of the variables you should consider.

Cash Flow: Understanding cash flow is critical to managing a self funded plan. Upon leaving a fully insured plan, there are significant savings because you are paying lower premiums, and there is a lag before claims start being processed. In years where your claims are low, there can be significant savings over a fully insured plan, but if you do not reserve these savings and subsequently have a high claims, the result can be catastrophic. Finally, reverting back to a fully insured is difficult because the employer plan must continue to pay lag claims from the self funded plan while at the same time paying the fully insured premium.

Complexity: The multiple moving parts of a self funded plan create a steep learning curve for employers. Understanding stop loss contracts, managing claims data, tracking cash flow and interacting with the plan administrator are not variables associated with fully insured plans. The claims information you receive is generally much more detailed. If you have a wellness plan, this level of detail can be very helpful. In general, self funding is more "hands on."

Plan Design: Since these plans are not regulated by state mandates, the employer gets to be the author of the plan document. In practice, we find that most clients stick fairly close to convention, as the plan still has to serve to attract and retain employees; however, being able to play with the margins can provide some great outcomes. If you truly understand what is driving your claims, it is easier to design your plan to change behavior with a self funded plan than it is with a fully insured plan.

Administration: The administration of your plan has to be outsourced. There are a host of reasons you do not want to be adjudicating the claims of your employees and their dependants. HIPPA comes to mind. You can select either a Third Party Administrator (TPA) or a major insurance carrier under what is referred to as an Administrative Services Only (ASO) contract. Major factors in selecting an administrator include cost, technology, case management, physician networks and reporting. In general, TPAs are less expensive, but are less likely to be able to provide seamless networks for multi state employers. The other factors can vary significantly regardless of TPA or ASO platform. It is important to do your due diligence in selecting an administrator because replacing one for another is an involved process.

Cost: As with fully insured plans, if you have low claims you will have low cost. The difference is transparency. With self funding, you can easily account for all the costs associated with your plan and if claims are low, the savings are realized immediately. The Kaiser Family Foundation study shows the rate of inflation associated with self funded plans to be lowest when compared to fully insured HMO, POS, PPO or indemnity plans, which suggests that they are a good mechanism for containing cost.

Again, self-funding is simply another choice to consider. Whether it is appropriate for your company is something you study with an open mind. It can be complicated, so do your homework and make an informed decision. Good luck.

PETER FENDLER is President and Co-owner of Norton Financial Services, a group benefits brokerage with offices in Maine and New Hampshire. A founding board member of Maine Healthcare Purchasing Collaborative, Peter has served on Anthem, Aetna and Harvard Pilgrim Health Plans' broker advisory councils and was state legislative Chair for the Maine Association of Insurance and Financial Advisors.

COST CONTROL?

Peter Fendler

The 300-pound gorilla in the benefits arena is health insurance. It not only dictates most employers' benefits decisions, it represents one of the largest line items in corporate budgets. Employers are now in a similar place with health insurance as they were 15 years ago with workers' compensation insurance – the breaking point. It took getting to that point before employers started to take action by developing and enforcing policies and procedures to reduced work place accidents.

We are now at the breaking point with health insurance because of the impending claims of the baby boom generation. The irony is that because of medical technology, we are wearing out, but not dying. So, there are simply going to be too many aging Americans, demanding too many medical services, to think that cost is going anywhere but up. Regardless of who is working on it, the government, private insurers or the medical community, this freight train is a reality that cannot be stopped.

So what are employers to do? They cannot just toss in the towel. The employment market demands they provide benefits to attract and retain staff. We are advising our clients to develop short, intermediate and long-term strategies. To date, most companies have been relying on a combination of a competitive market and reductions in benefits to help keep health insurance costs down. This is an effective short-term strategy that will continue to play a role, but because employees have a threshold for out-of-pocket expenses, and because the baby boom freight train is coming, a new paradigm is unfolding. Employers now have to become more involved.

Successful companies will get away from relying solely on a short-term strategy and will develop intermediate and long-term strategies that will foster cultural changes within the company, among your employees and their families. The intermediate strategy is fostering a spirit of partnership with your employees in attacking a common enemy, the cost of health care. One tool in this approach is "consumer driven health care." The increasing popularity of HRAs and HSAs is evidence that more employers are taking action. The intermediate strategy has to get the end-user to understand the cost associated with health care.

Finally, employers must implement long-term strategies. Affecting long-term strategies requires two steps that employers have not previously wanted to take. The first of these is to better understand the claims of their employees. Most employers have not wanted to delve into claims detail. Even if they had, insurance carriers frequently resisted or were unable to provide useful reports. However, because claims are the single largest variable in determining premium, simply accepting whatever comes at you is not a strategy. To begin to develop long-term strategies, you need to be able and willing to analyze your claims data in a way that allows you to identify problem areas. We are seeing more employers not only willing to do this analysis; they are demanding HIPAA compliant access to the data. And, established brokers have invested in the software to help their clients extract and analyze the data they need.

The other requirement in a long-term strategy is a commitment to invest in a wellness policy. The key word here is "investment." Many look at the cost of a wellness program as an expense. But remember, this is part of a long-term strategy, which is to say that the ROI will not be overnight. That said, there are ample case studies that prove that the return on investment is significant. There are many approaches to wellness, but the end goal is to foster behavioral changes and to develop awareness that the lifestyle choices people make affects a larger community than themselves. Wellness is a broad topic that I cannot do justice in this article, but I encourage you to investigate. A good place to start is www.welcoa.org

We cannot change the inevitable surge of the boomers, but being complacent is not the answer. Having a strategy is the key. The combination of proactive claims analysis and a wellness program provides employers with the information and process necessary to bring about real and sustainable change in behavior. What is your plan?

PETER FENDLER is President and Co-owner of Norton Financial Services, a group benefits brokerage with offices in Maine and New Hampshire. A founding board member of Maine Healthcare Purchasing Collaborative, Peter has served on Anthem, Aetna and Harvard Pilgrim Health Plans' broker advisory councils and was state legislative Chair for the Maine Association of Insurance and Financial Advisors.

PARTIALLY SELF-INSURING YOUR GROUP MEDICAL PLAN

Alan Parks

The ever-rising cost of medical premiums has become a huge burden to employers. They have tried everything from small plan design changes to cost shifting premiums onto employees to keep renewal increases to a somewhat reasonable level. One direction many employers have not taken is to scrap altogether the HMO/low deductible PPO options they currently offer and leap into consumer-directed health care. In this author's humble opinion, it is the only way to significantly reduce health insurance costs, not only for the next 12 month cycle, but also for the mid- and long- term.

The prospect of moving employees to a \$3,000 deductible HSA-compatible plan, for instance, with no copays for office visits or prescriptions, is daunting. How to fund that high deductible is the key component – many times, the premium savings of moving to an HSA-compatible plan is enough to allow the employer to cover a large portion of the deductible for the employee, while creating a 1st dollar benefit plan that reduces the out-of-pocket costs for both parties.

Using an HRA (Section 105 health reimbursement arrangement), which is nothing more than a “promise to pay” by the employer, the employer finds savings on two fronts – the reduced premium costs of a high-deductible plan, and the utilization of those promised payments for services. The premium argument is easy; the utilization of HRA funds is harder to quantify. National statistics, however, show a utilization rate of 20-30% of “promised” funding, and more local statistics mirror those numbers.

Lets take an example – Employer A, with 20 employees, saves 33%, or \$32,000, of premium moving from a \$500 HMO with an out-of-pocket limit of \$2000 to a \$3000 deductible HSA compatible plan. The employer utilizes an HRA and promises to pay the first \$1500 of all employee deductibles. If every employee uses every dollar of the HRA funds in that plan year, the employer realizes no net premium increase. His employees using less than \$1,500 of medical services have no out-of-pocket costs that year; for those employees who use more than \$1,500 of services, say \$3,000, their net out-of-pocket costs could actually be less than if they had the HMO. Overall, with a utilization rate of even 50% of HRA funds, the employer saves \$16,000 instead of paying a renewal increase of 6%-13% or more, and sets himself up for a much smaller rate increase next year because of lower experience.

In effect, self-funding a larger portion of health insurance within the framework of a fully-funded health insurance plan can be an effective cost-saving measure for employers.

ALAN PARKS founded Integrated Benefit Solutions LLC, an employee benefits brokerage and consulting firm, in December 2006, after working in the insurance industry for 15 years. Mr. Parks is dedicated to integrating the best of group, voluntary, and individual insurance policies into comprehensive packages that meet the needs of diverse businesses and their owners.

Alan focuses on consumer-directed health plans as a way of controlling employer benefit costs. He advocates for self-insured and partially self-insured group medical plans for businesses. Alan is also a life and health insurance consultant, working with organizations like the Manufacturers Association of Maine and CompuPay's payroll services in Maine and New Hampshire.

OPEN LETTER TO A CLIENT ADDRESSING THE PROS AND CONS OF FREEZING THE COMPANY'S PENSION PLAN

Tony Ormatek

Dear Mr. Employer:

Last week you asked me to share my thoughts about freezing the current population in your pension plan while funding benefits for future employees in your 401(k) Plan. Actually you had asked for some "pros and cons". I'd rather share my concerns and suggestions, and let you be the judge as to which are pros and which are cons. Some will be obvious, but others, I think, will depend on what perspective you take when looking at the situation.

To some participants, continuing to accrue benefits in the pension plan is comforting and welcomed. It shows a commitment by management to fulfill the pension "promise" made over the years; even though the company has no obligation to continue the benefit. And yes, most of these people will be at or relatively near retirement... say, over the age of 45 or 50. Also, the last few years of benefit accrual for these people is something they can reasonably estimate, and it is already translated into their estimated monthly income for life.

To other participants, continuing to accrue benefits will not be welcomed because they would rather have a contribution made to their 401(k) plan account; which they value more than the pension benefit. You guessed it, primarily the under 45's. But maybe they are right? Would a contribution to their 401(k) account benefit them more than the DB accrual? If they are not going to stay around much longer that answer is probably yes; depending on the relative difference in the accruing benefit and amount of 401(k) contribution.

I often get the question about new employees in the 401(k) plan working side by side with grandfathered employees in the DB plan. The issue of doing the same job but getting rewarded differently. My usual answer is that it really does not make a difference as long as you are clear about communicating the cut-off rule. For one of those unknown psychological reasons, people seem to accept the fact that they were hired after the benefit opportunity ceased... and that's okay. Another reason that this does not become an issue is that the new employees would probably rather have a DC plan anyway. If there would be envy, I suspect that it would be on behalf of the younger grandfathered employees, who are the "401(k) generation".

To take this last issue further, you could offer your employees choice as to which plan they would prefer to participate. The problem here is for the company. Plan choice always selects against the company financially. And although you would have a number of people (probably younger, with lower service) jump over to the 401(k) option, the increase in cost due to keeping the older people would increase your cost in the short run. Choice is not all bad. It does 1.) make up for any otherwise presumed unfairness to younger people, and 2.) create a smaller overall group of grandfathered people.

From a compliance perspective, freezing the population will at some point down the road likely create a non-discrimination problem. Just how far in the future is difficult to say, but it is not an irreparable issue. Plus, by that time it would be prudent to revisit your decision, the participant group and the compliance climate to see what, if anything would need to be changed at that time. This is simply reasonable plan management.

The non-discrimination issue arises from the fact that you are likely to see more attrition in you Non-Highly Compensated Employees (NHCEs) than your Highly Compensated Employees (HCEs), thus the relationships of benefit coverage, and average benefit amounts among the groups favors the HCEs over time. At some point in the future the balance of coverage begins to weigh towards the HCEs rather than the NHCEs. This creates a discriminatory situation and remedies need to be taken to resolve it.

Finally, from a cost standpoint freezing your population makes prudent sense. Based on preliminary 2008 valuation numbers and projections, it looks like your costs for the frozen group will continue to increase until your plan reaches it's 100% Funded Target Attainment Percentage under the new Pension Protection Act of 2006. That looks to be around 2010, assuming you continue to contribute the minimum required contribution. Assuming you replace the pension with a smaller 401(k) contribution, the weighted average of cost as a percentage of total payroll should go down over time to something that is closer to industry standards, albeit providing less of a benefit to the new generation.

Lesser benefit? Yes, but it is relative. We have discussed the career income replacement ratios for your overall retirement program, and concluded that your total retirement benefit structure, when including Social Security benefits, is a substantial benefit. (Yes, for our purposes here we can assume that Social Security will still be around a while.) So is reducing a "substantial" benefit to simply a "very good" or competitive benefit a "con"? Or is it a prudent management decision that needs to be made, perhaps even strengthening your total benefits offering to new employees?

OPEN LETTER TO A CLIENT ADDRESSING THE PROS AND CONS OF FREEZING THE COMPANY'S PENSION PLAN - continued

Tony Ornatek

If you can target your overall pension cost to an ultimate range of 4.5% to 6.5%, you should be able to provide your employees with a strong, meaningful (even adequate?) benefit. The way you distribute the dollars to your employees is just as important as the absolute amount you provide. This, of course, ignores the other softer, emotional issues of benefit form (lump sum or life income), benefit type (contribution now or salary continuation later), etc. I can assure you that there is absolutely no consensus as to these issues, and I don't expect us to see any consensus until the majority of Baby Boomers reach that magic age of retirement. That is still 12 to 15 years away.

As an objective consultant I can't help but believe that a defined, guaranteed income for life is a superior benefit for any employee. At the same time, however, there are so many issues (real and perceived) from the employees' as well as the employers' perspective that make this model very difficult to exist in today's culture and business environment.

I hope this is what you were looking for. Please call to discuss if you have questions.

Sincerely,

TONY ORNATEK is Vice President and Principal at Actuarial Designs and Solutions, Inc. Mr. Ornatek is an Enrolled Actuary with over 37 years of experience in the pension and insurance industry. Prior to his affiliation with ADS, he operated his own consulting practice called TEAK Associates specializing in all aspects of retirement plan and executive deferred compensation consulting services for non-profit healthcare organizations. He has spent over 12 years working in the Retirement Security Product Division of UNUM Life Insurance Company. In addition to holding a Bachelors degree in Actuarial Science from the University of Illinois, Tony is a Member of the American Academy of Actuaries, the American Society of Pension Actuaries and the Conference of Consulting Actuaries.

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