WOODRUFF SAWYER

100 YEARS AND COUNTING

LOOKING AHEAD 2019

Considerations For The Employee Benefits Landscape

TABLE OF CONTENTS

4	Looking Ahead: Navigating Employee Benefits in 2019 and Beyond
6	US Healthcare Trends: Will the CVS/Aetna Merger Live Up to Its Promise?
10	Are Employers Footing the Bill for the Next Great Pill?
14	Addressing the Mental Health Crisis in the Workplace
19	How to Create a Wellness Strategy that Works
25	Can a 3(16) Retirement Plan Fiduciary Relieve Your 401(k) Administrative Headaches?
29	Developing a Centralized Global Employee Benefits Governance Model
34	Is a Captive the Right Choice for Your Employee Benefits Program?

Looking Ahead: Navigating Employee Benefits in 2019 and Beyond

by

Kathy Prosser

Senior Vice President, National Employee Benefits Practice Leader

503.416.7903 | *kprosser@woodruffsawyer.com* | *View Bio >>*

Navigating the broad and complex world of employee benefits keeps getting more interesting—or daunting—depending on your viewpoint. Keeping in tune with how the ever-changing market options can support your organization's people and risk strategy will continue to be a challenge throughout 2019.

In this issue of our *Employee Benefits Looking Ahead Guide*, we highlight key impact areas where we see employers looking for guidance. This can range from retirement plan prudence to international governance, as well as how captives can play a role in employee benefits —all centered around how to structure your programs. To improve health and address cost pressure, we are diving deeper into specialty pharmacy, mental health, and wellness strategies to help you understand and navigate market changes and opportunities.

Employer-sponsored benefit programs are the top provider of health insurance coverage for over 175 million Americans. The cost of healthcare in the US is $3.7 trillion, encompassing over 20% of our national economy. Insurance carriers, healthcare providers, and pharmaceutical companies are the traditional players, investing in outcome-based approaches to reduce overall costs and improve health (mental and physical). Outside of the traditional players, we will continue to see digital health, AI, and other new entrants bring solutions that not only advance our efforts in reducing cost and improving health, but also in creating a positive, more personal and holistic experience for the consumer—your employee. This consumer-focused theme is present across the entire employee benefits landscape and will continue to evolve at a steady pace.

In the meantime, employers are highly focused on offering competitive, compliant, cost-effective health and welfare plans to attract and retain employees. To maintain and evolve your employee benefits plans requires staying informed of changes. With this guide, Woodruff Sawyer provides you the insights you need to understand current and emerging options, and how the resulting impact can support your people and risk strategy.

US Healthcare Trends: Will the CVS/Aetna Merger Live Up to Its Promise?

by

Jeffrey Slay

Senior Vice President,
Employee Benefits Southern California Practice Leader

949.435.7390 | jslay@woodruffsawyer.com | View Bio >>

In November 2018, CVS, the nation's largest drugstore chain, serving over five million pharmacy customers *daily*, completed its $69 billion merger with Aetna, one of the nation's largest health insurance carriers. CVS Health President and CEO Larry Merlo stated that the merger's goal was to "transform the consumer health experience and build healthier communities through a new innovative healthcare model that is local, easier-to-use, less expensive, and puts consumers at the center of their care."

Will it live up to its promise? How will the merger ultimately impact patients, consumers, and employers?

Merger Impact: a Benefit to Providers and Patients

As an employer, it is important to understand the impact of this CVS healthcare model on your company and employees. The resulting model may lower premiums and offer a better solution for your employee population, especially if CVS retail stores are readily available in your area. And while the merger was not motivated to save incrementally on physician and hospital costs through leverage and negotiation, we can expect these costs to decrease due to the size of the organization.

Working to Improve Today's Healthcare Model

Today's healthcare model has disparate entities attempting to provide coordinated medical care without the benefit of common systems or shared data. For instance, a patient may see a primary care physician and specialists and then go to a neighborhood pharmacy for their prescriptions. These physician networks and pharmacy networks are not linked and may not be able to deliver consistent care nor monitor whether the patient ever fills their needed prescriptions.

Healthcare Delivery through MinuteClinics

CVS is attempting to transform healthcare delivery by linking the patient's information between physicians and pharmacists to deliver better outcomes. The physician will have visibility to the patient's prescription patterns and monitor if they are routinely filling and taking prescribed medications.

> *Today's healthcare model has disparate entities attempting to provide coordinated medical care without the benefit of common systems or shared data.*

Ideally, physicians will have visibility to patient pharmacy data. And these physicians will now be offered through CVS' 1,100-plus retail-based MinuteClinics located across 33 states, staffed with physicians and physician assistants. In addition, its virtual service, MinuteClinic Video Visits, serves patients remotely in 19 states through a partnership with Teladoc.

As MinuteClinic patients and CVS customers, people will benefit by having a "one-stop shop" for doctor appointments, prescriptions, over-the-counter medications, plus every day items like milk, toothpaste, and other necessities. While this increases convenience for the patient, it also allows CVS to collect data about the patient and consumer and aggregate it for better care.

An enhanced level of care is available to those with a chronic disease. With a "neighborhood approach," CVS professionals can perform patient outreach to offer coaching and assistance for managing their condition. Traditionally, insurance carriers have not had a close relationship nor an accurate phone number to provide patient coaching. CVS has access to current, detailed contact information for patients and consumers, and even has the ability to text patients.

What's the Catch?

CVS/Aetna can now collect and share patient data to improve outcomes, but data privacy is of increasing concern. The firewalls between consumer data and medical data are under review as CVS/Aetna attorneys grind through issues of ever-developing data privacy concerns.

Will MinuteClinics help solve the problems of a disparate healthcare system?

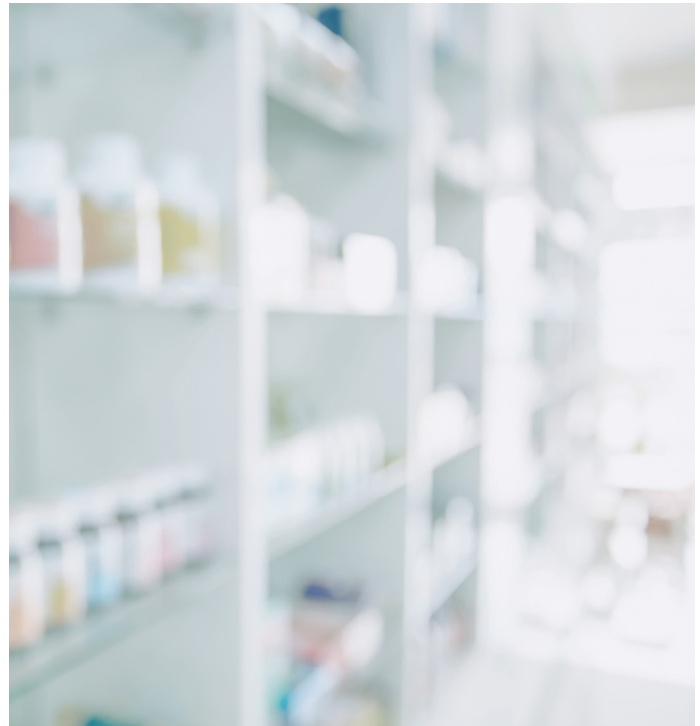
1,100+
CVS MINUTE CLINICS

33
STATES

- One-stop shop
- "Neighborhood" approach
- Aggregated patient data

For instance, Aetna, the insurance division, has partnered with Apple to create a unique app, Attain, which shares personal health information from CVS/Aetna with Apple Watch users to create activity goals. When the user meets those goals, they receive Apple rewards.

> *This merger raises privacy concerns about the merging and sharing of consumer and medical data.*



As a consumer, we need to understand and decide if we really want a for-profit corporate entity to merge our consumer data (juice, shampoo, pregnancy tests), our HIPAA-protected medical data (prescriptions and doctor exams) and our biometric data (activity levels, heart rate). This merger raises significant privacy concerns currently voiced by provider groups, patient advocates, economists, and antitrust experts, as outlined in a recent *Modern Healthcare* article[1].

What the Future Brings for Employers

Since the merger is still relatively new, it has yet to be seen if it will truly transform healthcare delivery as anticipated. But given the vast network of stores and access to Big Data, it does have the potential to disrupt the industry.

If CVS retail stores are prevalent in your area, you may be impacted by this merger and presented with CVS/Aetna insurance options for your employees. As an employer, you must now view your employees as patients *and* consumers, understanding not only where they will get the best care, but if they will receive the best consumer experience.

[1] CVS Health and Aetna close $70 billion merger, Modern Healthcare https://www.modernhealthcare.com/article/20181128/NEWS/181129943/cvs-health-and-aetna-close-70-billion-merger

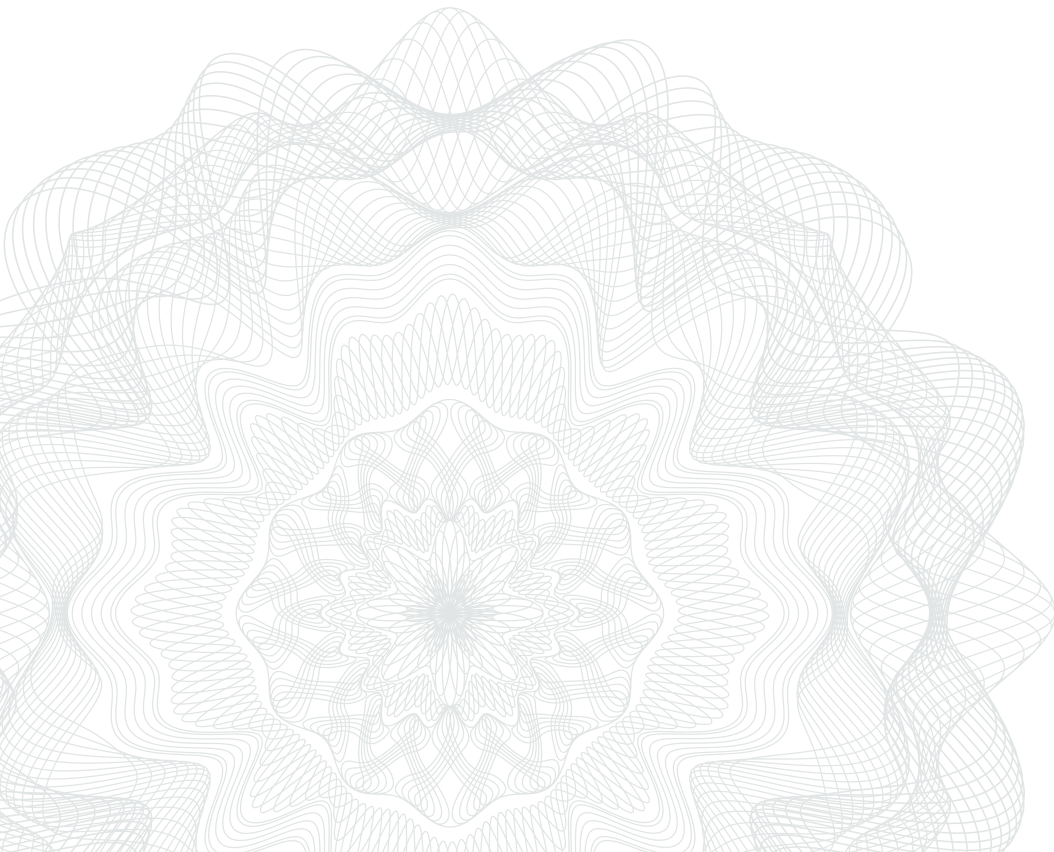
Are Employers Footing the Bill for the Next Great Pill?

by

Dave Erickson

Assistant Vice President, Data Analytics, Employee Benefits

949.435.7354 | *derickson@woodruffsawyer.com* | *View Bio >>*



We live in an exciting era of not only improving existing health care therapies but also curing diseases. These tremendous breakthroughs are great news for consumers and our society. Since businesses are the primary provider of health insurance for many Americans, does this mean they are footing the bill for the next great breakthrough?

Where is that next great breakthrough going to come from? As one of the fastest growing healthcare cost drivers, special pharmacy could be the answer. While specialty drugs are carefully monitored by pharmacy benefit managers (PBMs) who serve as third-party administrators, these costs can be part of the medical benefit which has little or no management by the health plan itself. Therefore, it is important for employers to understand and monitor all benefits associated with this rising cost.

In this article, we'll discuss the issues of specialty drugs, the trends in cost and coverage in this area, and what it means for employers.

Specialty Drug Manufacturing Has Become More Complex

Traditional pharmacy drugs were historically chemically produced using small chemical molecules. The pharmaceutical company would obtain a single patent for a formula that was easy to manufacture. In addition, generics were frequently available as a low-cost alternative. The cost of these drugs were typically managed through the prescription benefit plan, which made the costs easier to monitor.

Today's specialty drugs are much more complex. They are grown biologically and contain large protein molecules. There may be hundreds of patents involved and manufacturers may not be incentivized to invest in costly research and development. As a result, generics are not widely available. These specialty drugs are managed through both the medical and pharmacy benefit plans and may be difficult to monitor.

Controlling and Curing Disease Comes at High Cost

Specialty medications are now able to control and even cure diseases, offering life-saving alternatives to conditions that were previously un-curable. However, due to the complexity of developing and marketing specialty pharmacy items, they can be a high-ticket item. For instance:

- Hepatitis C can now be cured by the drug Harvoni, which has a $100,000 price tag.
- Migraines can now be prevented with several new market entrants that target a gene-related peptide (CGRP) and include Calcitonin, Aimovig, Ajovy, and Emgality.

These treatments offer a life-changing alternative for those who suffer from migraines, but come at an annual cost of nearly $8,400.

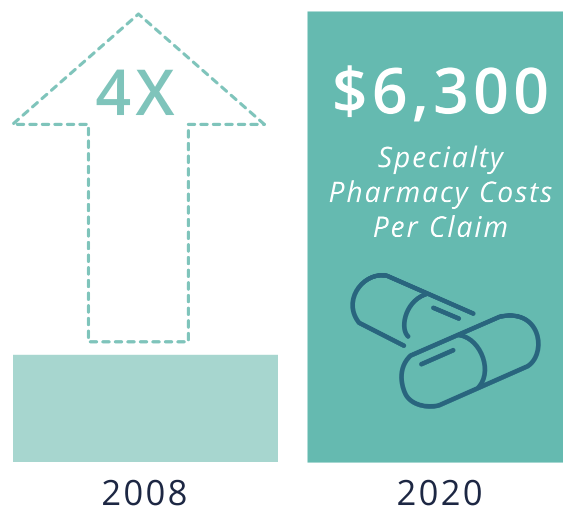
> *Today's more complex drugs are high-ticket items. For example, new migraine prevention drugs cost $8,400 annually.*

Trends to Watch

To be sure, the prescription drug market is robust and pharmaceutical manufacturers continue to have new products in their pipeline, with specialty drugs projected to reach close to 50% of total drug costs by 2020.

In fact, specialty pharmacy costs are expected to reach $6,300 per claim by 2020. This is almost four times the specialty cost per claim we experienced in 2008. The number-one driver of overall drug costs will be for autoimmune diseases that include anti-inflammatory and diabetes conditions. These diseases are expected to comprise between 30% to 35% of total pharmacy benefit costs.

Specialty RX costs will increase four-fold by 2020, driven largely by drugs for autoimmune diseases



One of the reasons behind the growth of specialty pharmacy is the practice of *direct-to-consumer (DTC) advertising* by pharmaceutical manufacturers. According to market research firm Kantar Media[1], only two countries are currently allowed to advertise directly to consumers: the US and New Zealand. It is estimated that in 2016, healthcare and drug companies spent $6.4 billion in ads in the US, a 62% increase since 2012.

The Impact on Employers and What to Do About It

As consumer demand increases for not only cures, but quality-of-life improvements, so will the costs associated with specialty drugs. And since employers are the number-one source of health insurance, they are footing the bill for

these advanced medications, so they will end up bearing the brunt of these increases.

This also means it's up to employers to participate in containing these costs. Unfortunately, most plan designs don't account for specialty medication in their pharmacy or medical benefits. Here are some strategies and tips for addressing these rising costs:

- Find a PBM that understands how to contain these costs, while making specialty drugs accessible to your employees. This will be key for the future.
- Understand these potential cost increases, both in your pharmacy and medical benefits, so you can help formulate your budget appropriately.
- Set realistic expectations for deductibles and out-of-pocket maximums to pay for advanced medication benefits.

An additional upshot to getting ahead of this trend is that employees find specialty pharmacy a highly desirable benefit, so a greater understanding of the costs and coverage of these emerging pharmaceuticals can help you gain a competitive edge in a tight labor market.

---

[1] Direct-to-Consumer Drug Advertising: By the Numbers, *Experience L!fe* *https://experiencelife.com/article/direct-to-consumer-drug-advertising-by-the-numbers/*

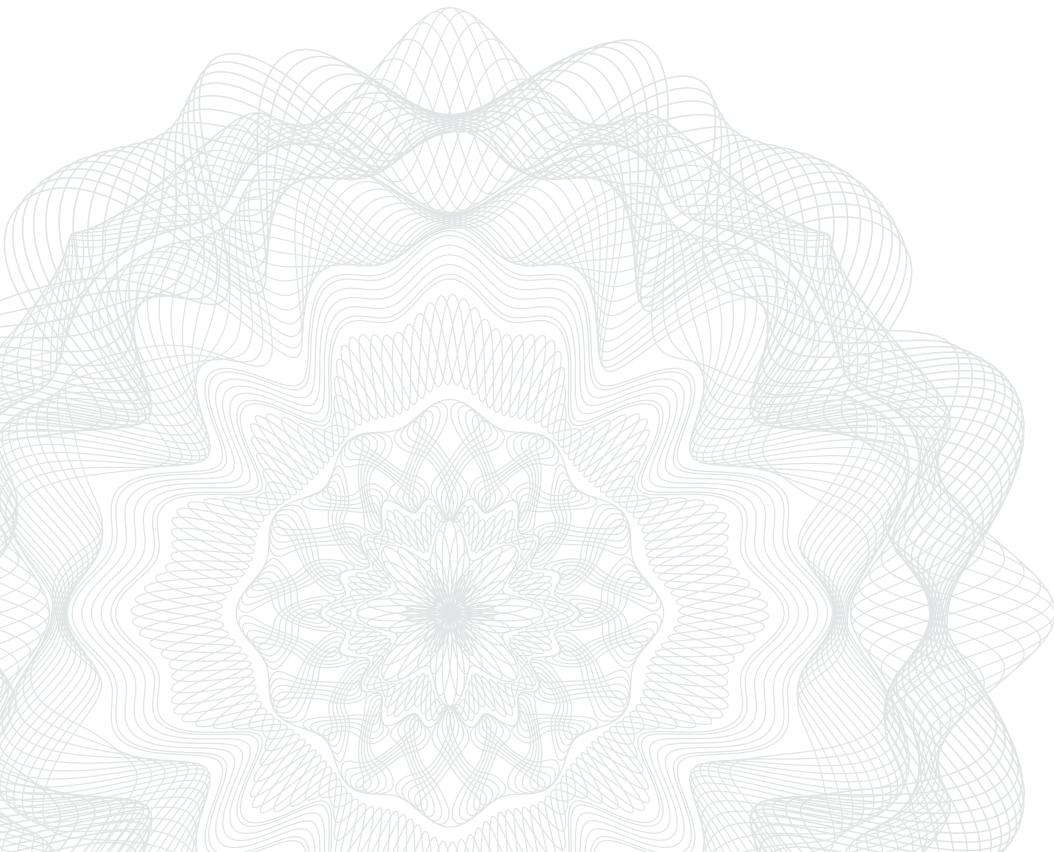
Addressing the Mental Health Crisis in the Workplace

by

Leslie Slay

Senior Vice President, Employee Benefits

626.788.4611 | *lslay@woodruffsawyer.com* | *View Bio >>*

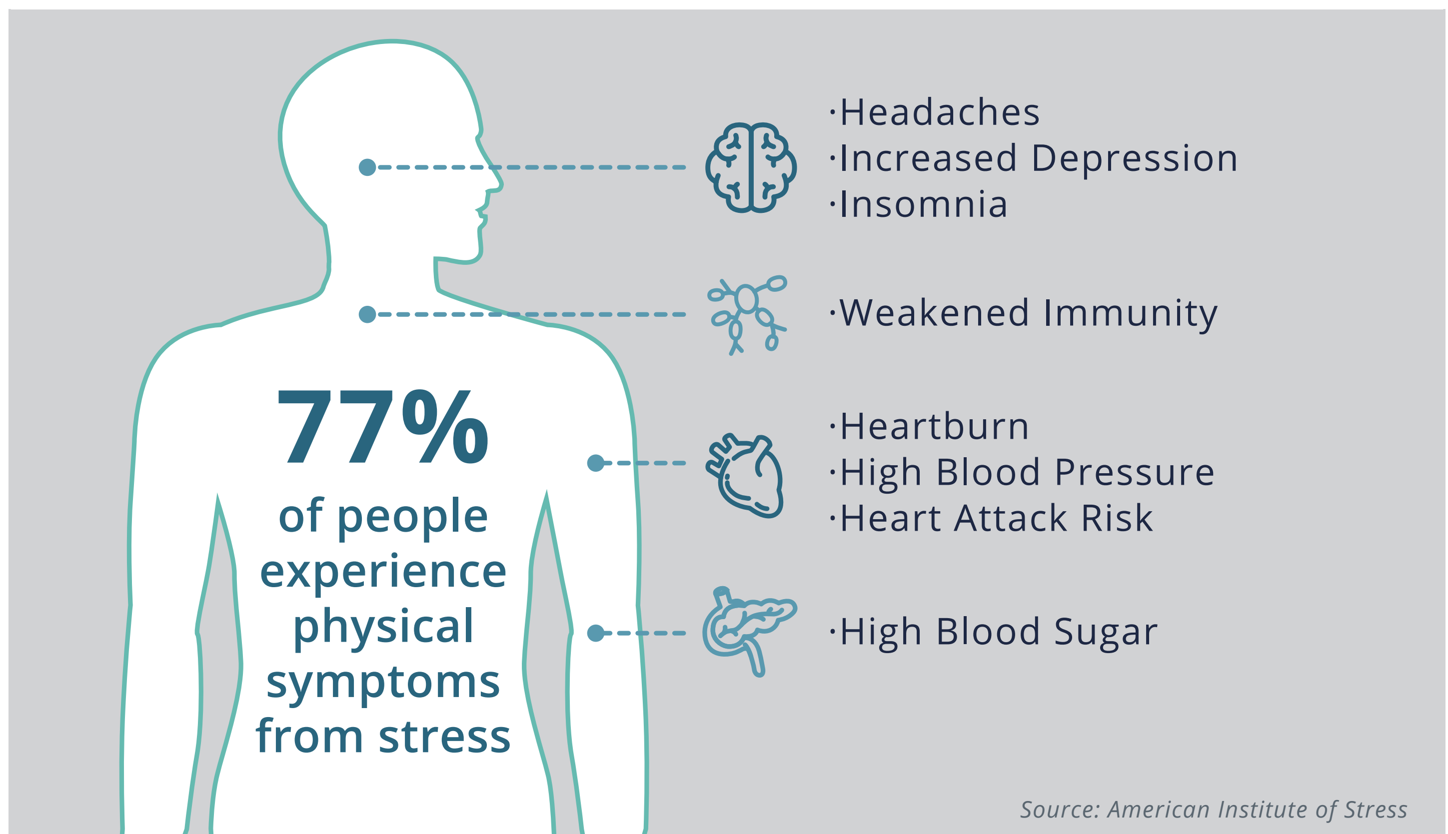


If you're an average American, you wake up between 6:00–6:30 AM after less than seven hours of sleep. You grab your first of three cups of coffee before heading to work. If you live in Buffalo, NY, you'll have a 20-minute commute by car. However, if you work on the East or West Coast, your commute time is at least 30 minutes or twice as long via public transportation. If you're a "mega commuter," you'll spend over 90 minutes one way by car. You'll work an average of 8 to 8 1/2 hours a day, in addition to a lunch break and any pre- or post-work networking meetings. After nearly 12 hours, you'll repeat your commute, stressing about your health, kids, relationship, and $5,700 credit card debt.

Lack of sleep, unhealthy food habits, sedentary lifestyles, and financial issues can lead to excessive stress. According to a Kaiser Family Foundation study[1], only half of private employers offer benefits, yet employers are expected to pay for rising mental health costs. In this article, we ask and discuss the question: What power do employers have to correct America's growing mental health problem?

Stress and Anxiety are Everywhere!

According to the American Institute of Stress[2], 77% of people experience physical symptoms of stress. According to The Center for Discovery,



approximately 20% of teens experience depression before adulthood, yet less than 30% are treated, resulting in a teen suicide every 100 minutes.

Money and work are two of the top three stressors. As a result, stress and anxiety carry over into the workplace, with depression costing employers an estimated $23 billion in lost productivity, according to LiveScience[3]. Those who experience anxiety or depression take twice as many sick days and experience significantly impaired work performance due to poor sleep quality.

Doctors frequently prescribe medications for these conditions. One study[4] showed that in 2010, anxiety medications were prescribed for one in five Americans. Nine years later, the number is closer to one in four Americans. Self-medication is also an outlet, as alcoholism and drug use are at all-time highs. Ultimately, the cost of prescribed medications reflects in increased health plan costs, placing the financial burden of anxiety and stress on employers.

Stress and its treatments—medication or otherwise—increase health care spend and workers' compensation costs dramatically.

Can Employers Solve this Crisis?

Employers now understand that mental health issues significantly impact today's workforce. New options can help employees deal with the stress. Gone are the days of, "If you are not at your desk, you are not working." In response, employers are offering flexible schedules and remote working arrangements.

Employees are looking for flexibility and choice to ease the time constraints and burdens of a hectic lifestyle.

If mental health issues are taking a toll on employees or their families, it is critical that employers make mental health resources easily accessible. Improved online access to benefits and health plan information make it easy for an employee to reach out for help.

Some ways employers are helping their staff reduce stress:

- Offering flexible schedules and remote working arrangements
- Creating outlets at work, such as game areas or yoga classes
- Team-building to improve employee connections

In the workplace, employers are creating uplifting, reduced stress environments which can include gaming tables, uplifting décor, enhanced lighting, and quiet areas where employees can feel more at ease. Mindfulness training, yoga, and exercise club benefits can also alleviate stress. Team-building exercises and collaboration improve employee connections and create a support network to lean on in times of stress.

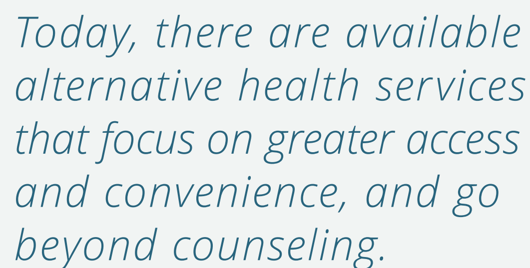
Addressing mental health issues in the workplace requires collaboration. Employers are not "parents" and expect consistent, adult behavior from their employees. However, they must also identify at-risk individuals who may need assistance but don't know how to ask for it.

At the same time, employees should take a proactive approach to their health and address their issues.

Alternative Mental Health Delivery Models Fill the Gaps

The increased use of depression- and anxiety-related medications today, as well as the increases in non-prescription drug use, suggest traditional employer-sponsored mental health programs may not be effective at treating the mental health crisis. Beyond medication, the resources available to truly address the employee's mental health-related issues have been limited and one-dimensional. Historically, most plans offered an Employee Assistance Program (EAP), which allowed employees to take advantage of three free sessions. Health plans have been reticent to increase outpatient mental health therapy or add life management visits. What is needed is to help people get to the root of their issues and give them the tools necessary that may help them get off of medication and get the longer-term attention they require.

Today's entrepreneurs are finding and filling these gaps that are prevalent in the traditional mental health delivery systems. Lyra Health helps people connect with the best mental health professionals and stay in treatment.



Stop Breathe Think is a mobile app that helps people check in on their emotional state and use guided meditations to reduce their stress level. And telemedicine programs now offer easy access to mental health professionals for quicker appointment times with qualified professionals.

Access is also an issue. Employees in crisis often don't want to take the time to find a provider. Many telemedicine programs now offer mental health services at the touch of a button. An employee can now Skype a professional 24/7.

Take Action: Acknowledge the Stress

As an employer, accepting that your employees are now under more stress than ever is the first step to helping them. Simple, low-cost changes can be made to your office environment to make it less stressful. Provide leadership training on the signs of stress and anxiety, and what managers can do to help employees in need. Finally, review your benefits program with a professional broker to identify mental health plans and models available to assist your employees. Doing so will ultimately become an advantage for your organization through lower costs and higher productivity.

---

[1] Percent of Private Sector Establishments That Offer Health Insurance to Employees, *KFF*
https://www.kff.org/other/state-indicator/percent-of-firms-offering-coverage

[2] What is Stress? *The American Institute of Stress*
https://www.stress.org/daily-life

[3] Depression Doubles Missed Work Days, *Live Science*
https://www.livescience.com/38403-depression-doubles-missed-work-days.html

[4] Anti-anxiety medication use soars in past decade, anxiety.org
https://www.anxiety.org/antianxiety-medication-use-soars-in-past-decade

How to Create a Wellness Strategy that Works

by

Kathy Prosser

Senior Vice President, National Employee Benefits Practice Leader

503.416.7903 | *kprosser@woodruffsawyer.com* | *View Bio >>*

and by

Sandi Leung

Vice President, Employee Benefits

415.402.6595 | *sleung@woodruffsawyer.com* | *View Bio >>*

The part can never be well unless the whole is well."

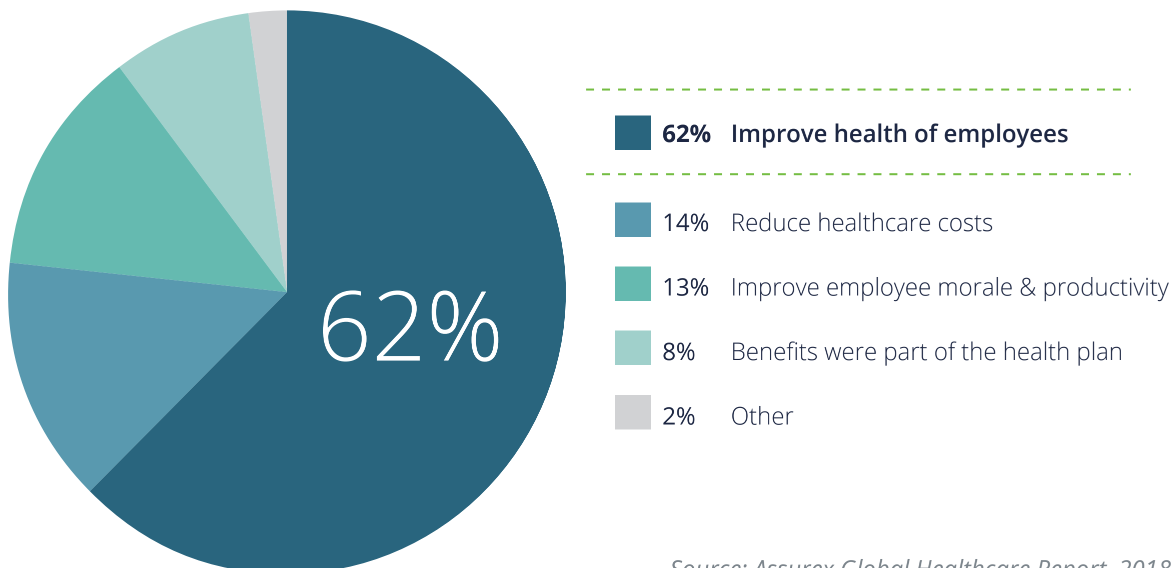
—PLATO

With the convergence of rising health care costs, a national focus on health improvement, a tight labor market, a boom in digital health solutions, and an expanding continuum of wellbeing program options, wellness in the workplace continues to be on employers' agendas. Executing on a wellness strategy that serves your employees and your overall corporate objectives can be one of the most challenging undertakings for employers, particularly if you don't define what "success" means. A clear strategy starts with a simple question: What are your corporate wellness objectives?

Looking Beyond ROI

We frequently see employers go into wellness believing it will create a return on investment (ROI). This is where wellness can get a bad rap. While there are evidence-based programs that do potentially create an ROI when deployed properly, our experience suggests that wellness programs are becoming table stakes in a competitive benefits package, and that you should reframe your investment and desired outcome, which may not be solely for an ROI.

Employers say their #1 reason for having a wellness program is to improve employee health



Source: Assurex Global Healthcare Report, 2018

As evidenced in the *2018 Assurex Global Healthcare Report*, conducted by Milliman, not all employers are looking for an immediate ROI. Over 2,400 US employers participated in the study, indicating their number-one reason for a wellness program was "to improve health of employees." The report noted:

> *We are seeing the majority of employer groups offer wellness programs to benefit their employees. As these programs have become a cost of doing business, the expectation of a monetary profit in return is diminishing. With this in mind, when offering a wellness program, it is important to determine realistic goals for each program —both qualitative and quantitative—and establish meaningful outcome metrics to routinely measure and monitor.*

So, the first step is to define your corporate goals—this is essential to developing a coherent wellness strategy, and consider looking beyond ROI dollars. The next step is to ensure all programs are aligned across the organization.

Alignment is Essential

Successful wellness programs are strategically aligned across the organization, and this takes money, time, and effort. An illustration of alignment is when top management, HR, and employees partner to create cross-organizational programs. These programs are communicated throughout the year, across multiple channels. There is not only investment in these programs, but also in the incentives to join the programs, including wearables, gift cards, contribution discounts, and HSA/HRA contributions. Organizations with alignment have increased employee engagement, lowered healthcare costs, increased productivity, and enhanced culture.

This is where the Wellness Program Spectrum, as depicted below, comes in. As discussed in our recent blog post, the Wellness Program Spectrum categorizes wellness programs into three key types, each with its specific focus and goals. You should have an understanding of this spectrum so you can assess your organization's readiness in implementing a wellness program; the spectrum will help you determine what type of program is the right fit for your organization.

From here, you can begin to develop a roadmap for creating and implementing a wellness program.

Organizations with alignment have increased employee engagement, lowered healthcare costs, increased productivity, and enhanced culture.

Keep the Doctor Away: Introducing the Wellness Spectrum

Three-Part Roadmap to Creating a Wellness Program

Creating a wellness program can be a significant undertaking, and of course, you'll want to create a program (or advance an existing one) that is sustainable for the future. Here, we've broken down some key steps to get you started.

There are three distinct parts that comprise a wellness program roadmap: strategic review, program design/implementation, and measurement. While we give a broad overview here, note that each part of the roadmap can range from simple to highly complex, depending on your organization and program design.

Part One: Strategic Review

In this stage, you clarify your wellness program goals and commit the resources for making it happen. A strategic review includes:

- Validating your company's employee health objectives
- Understanding how the program will fit into your corporate culture
- Reviewing previous wellness program "lessons learned"
- Understanding your employee population's needs (age, lifestyle, health conditions) and data available
- Validating if employees will use potential programs
- Dedicating leadership resources
- Establishing a program budget

Part Two: Program Design and Implementation

After you have surveyed the corporate landscape and committed resources, it's time to select a program design within the Wellness Spectrum. Your program will reflect your strategic plan and be supported by committed resources, including a detailed implementation plan to address all underlying requirements. Examples in each area of the spectrum include:

- **Activity-Based:** Create engagement with programs designed to improve health and fitness levels that may include flu shots, exercise wearables, gym discounts, or cash

incentives. Offerings may include free insurance carrier programs, healthy meals and snacks, or activity monitors (e.g., Fitbits) for employees. The goal is to raise awareness in the employee population and get your program off the ground.

- **Health Optimization:** If your company has invested in activity-based programs and created awareness, it's time to take it to the next level. These include targeted programs to help employees with chronic conditions improve their lives and reduce overall costs to you, the employer. Programs that focus on diabetes management, high blood pressure, and weight management, many times with the use of Health Coaching, will help employees better manage their health.
- **Cultural Wellbeing:** At this level, health promotion is not just a program, it is embedded within the corporate culture. Leadership exemplifies health and leads by participating in programs. A focus on work-life balance is at the forefront and may include flexible work schedules, childcare, home food delivery, and other programs that improve quality of life for employees and their families. This is the highest level of employee engagement and provides both tangible and intangible benefits to the employer.

Part Three: Measurement

Employers have long been dissatisfied with wellness program results, primarily because they could not adequately measure their investment in time, money, or effort. Incorporating measurement and routine evaluation is vital to the success of the program.

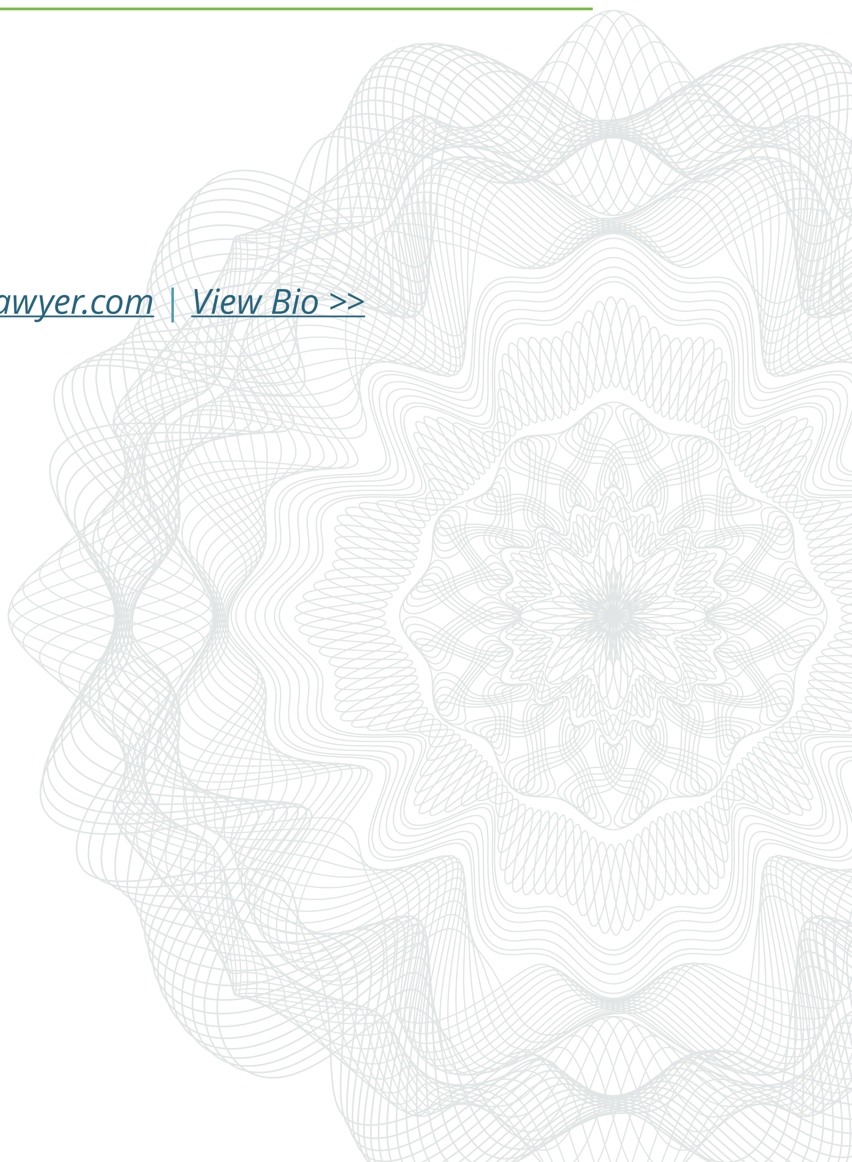
- **Financial Results:** Reviewing program cost investments against reductions in claims experience, prescription costs, and premiums can be validated and measured, given a large enough population. Some employers are also measuring productivity and performance.
- **Health Impact:** Data from biometric and health risk assessments, condition management programs, and adherence to medications are ways employers can measure health impact.
- **Participation:** Wellness engagement can be measured by health promotion and condition management program enrollment and results, 401(k) enrollment, and contribution results, as well as HSA contributions as a measure of consumer engagement.
- **Employee Satisfaction:** An engaged employee population is critical, especially during times of low unemployment. Routine surveys that monitor satisfaction levels are a common measurement tool and can determine if your program is on target.
- **Culture:** "Best Places to Work" and other awards, NPS and Glassdoor ratings, and recruitment and retention metrics are ways some employers are measuring culture.

Changing Perspectives: More than ROI

Clear, measurable wellness objectives that align with corporate culture/goals are the starting point for successful wellness programs. To accomplish this, establish strategic objectives that address everything from employee engagement to financial investment. Secondly, understand where your organization lies within the wellness program spectrum. It will help you identify if you need an initial educational or an activity-based program, remedial action, or are ready to advance to a deeper wellbeing commitment. Follow a defined roadmap as we've discussed here, which includes employing measurements to monitor the success of your program.

Remember, corporate wellness requires a change in perspective, from merely expecting financial returns to improving the quality of life for employees and helping to ensure the long-term health of your organization.

Can a 3(16) Retirement Plan Fiduciary Relieve Your 401(k) Administrative Headaches?



by

Kristina Keck

Vice President, Retirement Plans

415.878.2310 | *kkeck@woodruffsawyer.com* | *View Bio >>*

Unless your HR and finance teams are experts in retirement plan administration, they may be saddled with the confusion, administrative headaches, regulatory nightmares, and increased workload that are part of the 401(k) plan sponsorship landscape. Loan processing, required notice delivery, and plan contribution changes are duties that your teams are tasked with, but do they have the experience and bandwidth to stay on top of the excessive administrative duties associated with being a plan sponsor?

Even a small oversight can result in your plan participants receiving the wrong information or, worse yet, unintended or overlooked changes.

Enter the 3(16) Fiduciary Administrator, an emerging trend in the retirement plan marketplace that performs administrative functions in a fiduciary capacity, relieving employers of retirement plan management nightmares. Let's talk about who they are and how they can benefit employers.

3(16) fiduciary administrators help you stay on top of the many administrative duties associated with your 401(k) plan.

What is a 3(16) Fiduciary Administrator?

The term "3(16)" refers to a section within the ERISA Act of 1974 that specifically designates who will serve as plan administrator. Traditionally, many third-party administrators (TPAs) prepared the annual 5500 form, but left it to the actual plan administrator to sign. A 3(16) Fiduciary takes the next step and signs it themselves, therefore taking on the fiduciary responsibility for the plan.

In addition to signing the 5500 form, administrative tasks that a 3(16) Fiduciary performs may include:

- Non-discrimination testing
- Oversight of loans and ordinary distributions
- Qualification of Domestic Relations Order (QDRO)
- Hardship withdrawals
- Required notice mailing and distribution
- Interpreting plan document provisions
- Impartially evaluating, replacing, or sourcing service providers
- Monitoring and notification of plan irregularities

Hiring a 3(16) Fiduciary Administrator adds a significant extension to your HR and finance team in terms of plan administration. At the same time, these professionals can help mitigate plan risks through their industry expertise and fiduciary capacity.

Penalties, Mistakes, Audit: Plan sponsors are responsible. Are you ready to take on that liability?

Is Outsourcing Right for You?

You probably don't need an outsourced administrator if your plan is not subject to an audit, entails little day-to-day administration, and does not require excessive work for your team. If you are overloaded with tasks or are facing an audit, a fiduciary may provide much-needed oversight.

Does a 3(16) Fiduciary completely remove the fiduciary liability for your plan? If you select a true, full 3(16) administrator with a service agreement that supports this, they can accept all plan liability. However, plan sponsors must remember that there is one fiduciary liability that cannot be removed: The simple act of hiring an outside fiduciary is in itself a fiduciary function. Plan sponsors are on the hook to make appropriate service provider choices and if they fail, they may be held liable.

Still, surveys show that employers and retirement plan advisors alike increasingly see outsourcing as a prudent and safe option that can benefit anyone who deals with the day-to-day minutia of administering their plan. A recent article featured in *401(k) Specialist Magazine* reports:

- ***84% of retirement advisors are considering offering 3(16) fiduciary services.***
- ***Over half (56%) of retirement advisors' clients are receptive to outsourcing.***
- ***The number-one reason for electing a 3(16) Fiduciary is that it "mitigates retirement plan risks.***

Given today's competitive market and need to focus on customers, not administrative tasks, outsourcing is a viable alternative for today's employers by improving compliance and protecting them against making errors in the course of plan administration—errors that can result in hefty government penalties.

Things to Consider

According to Vanguard, the average individual's 401(k) balance now exceeds $100,000. As an employer and plan sponsor, it is imperative that you have proper fiduciary oversight of those funds and their administration. At the same time, it is important that your HR and finance teams remain productive and focused on their areas of expertise. You can start by asking these questions:

- How much time does your team spend on 401(k) administrative functions?
- Are they processing loans, required notices, and requests on a timely basis, or is there a backlog?
- If you use a TPA, are they providing as-promised services, or would a 3(16) Fiduciary offer a cost-effective alternative?

Transitioning 401(k) administration to a fiduciary is fairly simple, but you should perform due diligence in choosing the right administrator. If it is time to consider a fiduciary to relieve your administrative headaches and mitigate your risks, turn to trusted financial advisors who can help you select a reputable firm.

Developing a Centralized Global Employee Benefits Governance Model

by

Jake Leary

Account Executive, International Benefits

415.399.6471 | jleary@woodruffsawyer.com | View Bio >>

As companies expand globally, their employee benefits programs become more complex, more costly, and more prone to risk. They are challenged to offer competitive benefits packages that attract and retain top talent, but must be consistent and cost-effective in the management of those benefits programs. This is where a centralized employee benefits governance approach becomes critical to effective global program management.

What is Employee Benefits Governance?

Ideally, each company should have a standardized approach that includes rules and processes for managing their employee benefits programs, and this is at the heart of governance. On a global scale, governance is more than compliance with international laws; the company's international benefits must also align with their corporate benefits philosophy and strategy. A consistent and centralized strategy sets the governance framework for ensuring that the company is actively working across all of its regions to remain compliant, contain costs, mitigate risk, streamline administration, and be transparent and accountable across all business units.

With the technology available today, there's no better time to do this. Previously, governance mirrored the business lifecycle, starting as a centralized function, then becoming decentralized to multinational units, and boomeranging back to a centralized function at headquarters. Advances in electronic communication tools now allow multi-country teams to better collaborate. HR teams can potentially access information worldwide, including benefits data, financials, and key metrics. Benefits management platforms also allow brokers to more easily manage plans and keep abreast of issues.

Technology now allows global companies to more easily centralize employee benefits governance.

Advantages of Centralized Employee Benefits Governance

Improved cost control is a key advantage that makes centralized governance a worthwhile consideration, given that international employers incur benefits expenses estimated to be an additional 23% on top of employee salaries, and nearly 32% atop salaries for US-based companies.

As shown in the table below, in comparison with a decentralized one, there are many elements of the centralized approach to consider.

Better Results with a Centralized Approach

Advantages of Centralized Benefits Governance	Potential Consequences of Decentralized Benefits Management Structure
Risk Mitigation	Increased risk exposure
Omnipresent Record Keeping	No access to local data
Global Benefits Philosophy	Local coverage anomalies/deviation; not aligned locally and across borders to corporate strategy
Proactive Project Management, Planning, and Tracking	Reactionary, resulting in insufficient time for market review if rate action is unexpectedly high
Uniform Renewal Process	Inconsistent presentation of key metrics
Uniform Approval Process	Local HR makes important decisions without corporate input and approval
Big Picture/Committee Decision Making	Making decisions based solely on local broker recommendations or limited benchmark data
Sharing of Best Practices	Isolated islands of excellence or inefficiency
Escalation Support and Rectification	Suboptimal service from providers and neglected employee concerns
Legislative Monitoring and Compliance	Potential statutory noncompliance, with resulting consequences (e.g., fines and/or imprisonment)
Benchmarking Supervision	No second opinion/narrow outlook
Leverage Efficiencies/Economies of Scale	Strict underwriting, no dividend potential, too many stakeholders/providers
Cost Containment	No leveraging of economies of scale, inconsistent claims management and coverage review

STAY INFORMED ON INTERNATIONAL BENEFITS

Changing international benefits legislation can have a major impact on your benefits governance. To keep informed, check out Woodruff Sawyer's *International Benefits Update*. Read the latest issue and subscribe to receive the quarterly publication.

To elaborate on one of the areas in the table, legal and compliance issues are growing at a frenetic pace worldwide. Mandatory retirement and health programs, compulsory paid parental leave policies, BREXIT, and data protection laws are just a few types of legislation with which a global company must comply. A centralized employee benefits governance model allows for a singular focus on this rapidly changing landscape.

Under a decentralized model, some outlying countries are neglected because there are few systems to support them. Under a centralized approach, these countries can be properly benchmarked, receive annual bids, and get proper attention through consistent policies and programs.

Best Practices for a Centralized Approach

Implementing a centralized employee benefits governance framework doesn't happen overnight. With foresight and a clear strategy, these best practices can ensure your organization receives the greatest benefit:

1. **Align your global benefits philosophy with your total rewards strategy and communicate it.** Companies that are successful in global benefits governance are ones that communicate their benefits philosophy, core values, and commitment to their employees. Best practices for doing this include outlining key benefits objectives (e.g., attract and retain talent, enhance employee engagement, promote health and well-being, drive performance), communicating as part of Total Rewards offerings to meet those objectives (e.g., compensation, benefits, work-life balance, career development, recognition), and deciding how you want to position your benefits against the market (e.g., all industries, specific industry, select peer companies).

2. **Determine your governance framework.** The optimal components of the framework include appropriate program design and administration, data management, communications, compliance, cost management, and mergers and acquisitions. As a best practice, include employee benefits functions that are best served through a centralized approach (see next bullet).

3. **Identify benefits programs included in your framework.** Key programs to include in a governance model are savings programs (pension and retirement), risk (death, injury, illness), health benefits (medical, dental, vision, wellness), paid and unpaid leaves, severances, allowances, and prerequisites (memberships, awards, car, etc.). Under a centralized approach, these benefit programs can be consistently administered and monitored.

4. **Assign roles and responsibilities.** Daily administrative tasks should be decentralized to local HR and brokers. However, important decisions regarding plan design, program, or financial changes should remain centralized at the corporate level. Global broker(s) can assist with annual meetings and quarterly reviews, along with claims and service issues.

The Challenges… and How to Get Started

Even with its many advantages, global benefits strategies and governance are often neglected. Only 31% of companies have had a defined global benefits strategy in place for more than three years. What are the challenges of instituting a global strategy? Communicating and enforcing your centralized approach will still require buy-in at the local level. While technology allows for easy access to data, the daily tasks of collecting data on a global scale can be laborious, as is monitoring compliance. Finally, local brokers may not have the background or skills to communicate with and provide analysis for corporate decision-makers.

So how can you get started? As stated above, the first step is committing to a program that aligns with your corporate values. Next, understand where your current employee benefits governance gaps are so you can address the high-priority areas. Move forward and engage in the best practices outlined above.

If you don't have the expertise or resources within your organization, secure an external partner such as a broker with specialized resources and expertise in international benefits. They can help you close existing gaps and map a global strategy for long-term, consistent employee benefits governance. They can also represent you on the ground locally to execute on your governance framework.

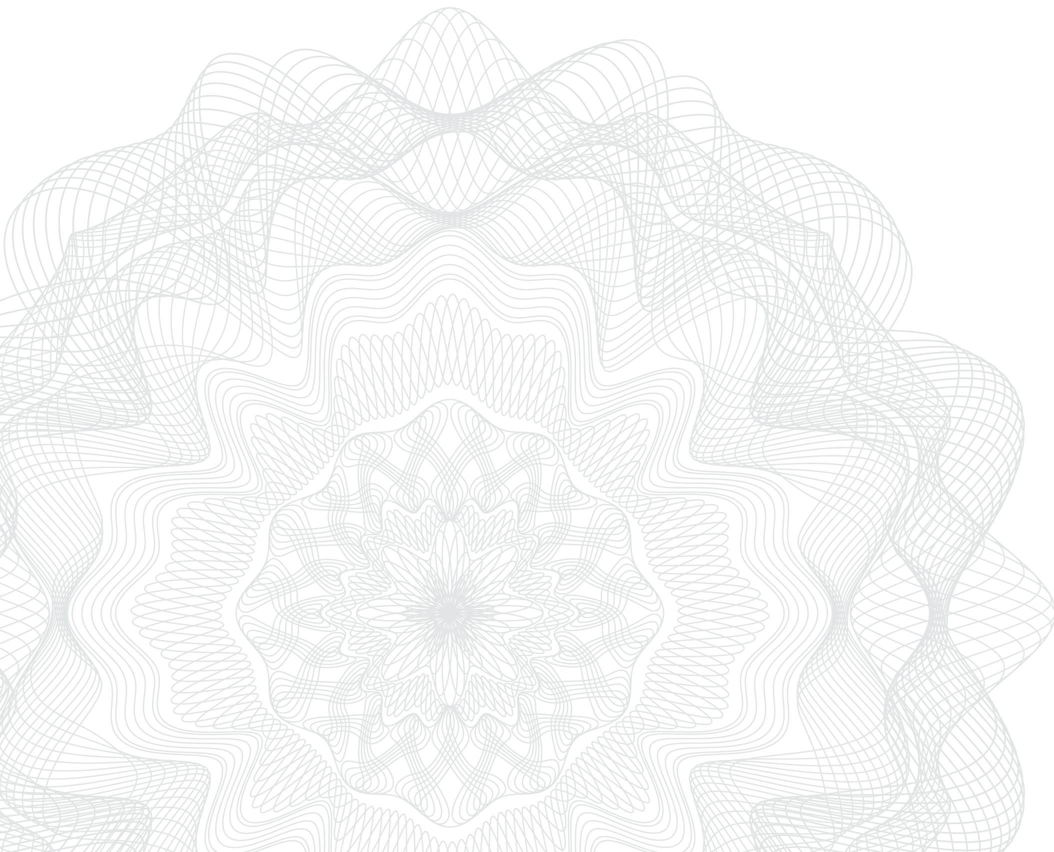
Is a Captive the Right Choice for Your Employee Benefits Program?

by

Ryan Meissner

Vice President, Data Analytics, Employee Benefits

949.435.7363 | *rmeissner@woodruffsawyer.com* | *View Bio >>*



Employee benefit plans represent a significant investment in your company's talent. As costs continue to rise in the health insurance market, it becomes increasingly important to evaluate your benefits program financing options. Captives are one solution that gives employers more control over their benefits costs. In this article, we'll go over the basics of a captive and how to determine whether it's the right fit for your organization.

What is a Captive?

You may have heard of employers leaving the traditional insurance marketplace and turning to a "captive" to insure their benefits plan. Officially, a captive is defined as an "insurance company that is wholly owned and controlled by the insureds." In practice, a captive is a group of employers pooling their resources to better manage employee benefits risk and lower overall plan costs.

Three Layers of Risk

In a captive, employer groups have three "layers" of risk: retained risk, shared risk, and catastrophic risk—this third layer is shifted to outside parties.

In the first layer, the employer group will insure a set amount for each member of the policy. For example, the employer may retain risk for the first $60,000 of its claims. In other words, the employer is paying the first $60,000 in claims incurred by its population.

In the second layer, the employer shares the risk with other organizations. In using the same example, they may share responsibility for claims from $60,000 up to $500,000. A stop-loss premium is often shared across all groups to further reduce risk in this layer.

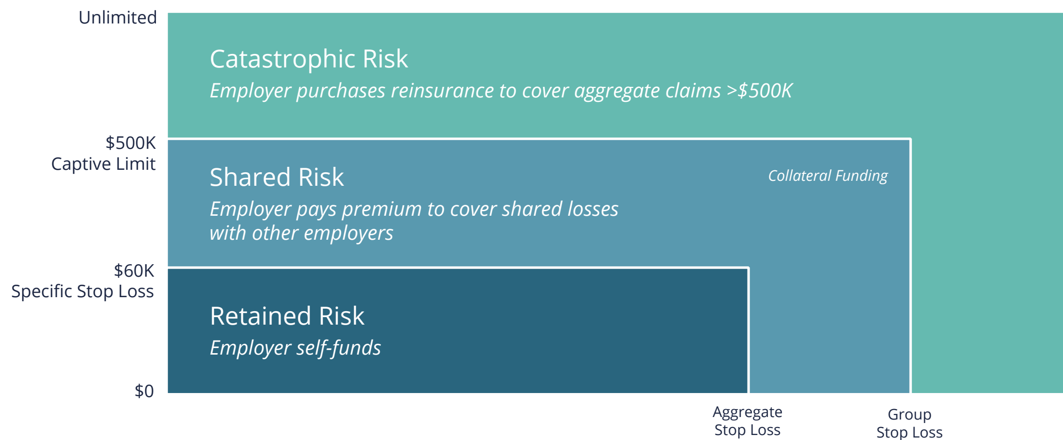
The third and final layer covers catastrophic risks. In our example, this is above $500,000 or 125% of expected aggregate claims. In this layer, the employer essentially shifts the risk by purchasing reinsurance through the captive and sharing the premium, thereby stabilizing the risk.

The Benefits and Pitfalls: Things to Consider

As an employer and plan sponsor, there are potential benefits (and pitfalls) to participating in a captive that should be carefully evaluated:

Tailored Coverage – Captives allow employers to tailor their coverage to meet the needs of their employee population, risk profile, and budget. These programs may also allow employers to access wholesale reinsurance markets that allow for greater flexibility and autonomy.

Captives create three "layers" of risk, with catastrophic risk shifted to outside parties*



*Numbers in each risk layer are shown for illustrative purposes.

Stabilized Costs – The primary goal of an employee benefits captive is to reduce medical costs and stabilize trends over time for captive participants. Many companies do achieve actual reductions in major medical costs. Employers can also reduce fixed costs and get more control over variable costs associated with the plan. A captive can take advantage of the underwriting principle of large numbers, allowing plan sponsors to take control of pricing for the long term.

Dividends for Plan Sponsors – While managing risk and lowering costs are a driving motivation, the opportunity to provide dividends to plan sponsors is also attractive. The remaining funds in the aggregated risk account of all groups are typically paid out as dividends in proportion to the premiums they paid.

Sharing in Claim Losses – Betting on your co-captive participants' health can be one of the biggest downsides of participating in a captive. If one of the other organizations has a large loss, all captive participants must share the loss. In fact, not all organizations are accepted by captive managers. If an organization has a history of bad and large claims, it may be difficult to find a captive that is willing to take a risk on that organization.

Financial, Legal, and Compliance Considerations – For instance, choosing between a single parent, 831(b), or a non-831-(b), will require careful evaluation. What are the tax advantages and cash flow opportunities for your organization? The type of captive chosen will depend upon how your organization measures risk against taxable liability.

In addition to weighing the advantages and pitfalls, understanding and working closely with the captive underwriters and insurance

marketplace are keys to optimizing your employee benefit plan's performance under a captive arrangement.

Captives versus Self-Funding

Large employer groups typically choose to bypass both insurance carrier and captive options by self-insuring their benefit plans, thereby enabling them to manage their own risk. The balance between self-funded plans and captive plans is being played out in today's marketplace:

- Over 98% of employer groups with more than 1,000 employees choose to self-insure their medical plan.
- Middle market employers (e.g., 100–750 employees) prefer the costs savings that a self-funded plan offers, but typically cannot afford the cost volatility and fluctuation. A captive can help alleviate these concerns and offer cost savings.
- Year over year, specific large-claim volatility will remain a significant risk for middle market employers. Therefore, the alternative risk-sharing structure within a captive may offset and reduce risk of claims volatility.

How Should You Get Started?

Having a broker by your side who is experienced with captives is a good start. At Woodruff Sawyer, we've helped many employers properly evaluate their options, including whether a captive is the right fit, and manage their benefit costs for the long term.

Should you self-insure or go with a captive? The answer may depend on your size as an employer.

We recommend a thorough evaluation of your existing plan, including costs, employee demographics, and claim trends. This is the first step in considering your captive benefit options. As I've described, your organization's risk tolerance is also key, because in a captive plan you are responsible for paying claims at certain levels. Finally, you should seek to understand the available captives within your marketplace, taking all of the above factors into account as you evaluate whether a captive is right for your organization.

About Woodruff Sawyer

As one of the nation's largest insurance brokerage and consulting firms, Woodruff Sawyer protects the people and assets of more than 4,000 companies. We provide expert counsel and fierce advocacy to protect clients against their most critical risks in property and casualty, management liability, cyber liability, employee benefits, and personal wealth management. An active partner of Assurex Global and International Benefits Network, we provide expertise and customized solutions where clients need it, with headquarters in San Francisco, offices throughout the US, and global reach on six continents.

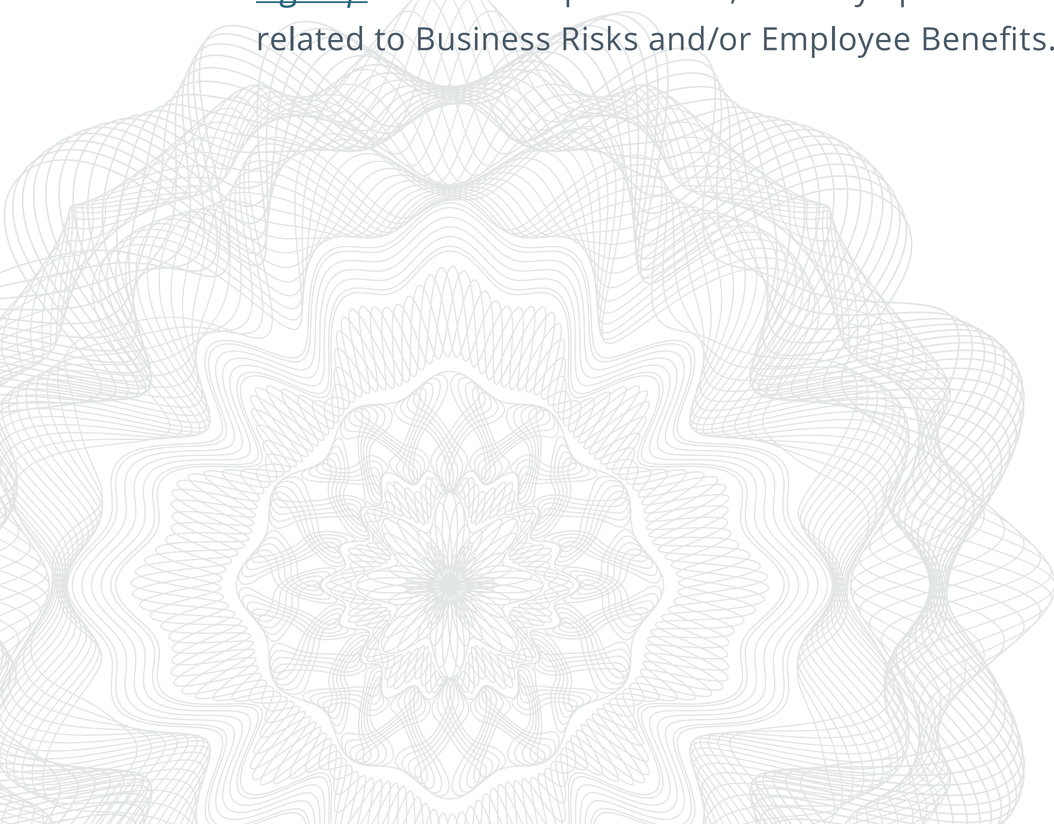
For More Information

Call 844.972.6326, or visit *woodruffsawyer.com*.

See why clients choose to work with Woodruff Sawyer

Subscribe To Our Newsletter

Sign up to receive expert advice, industry updates and event invitations related to Business Risks and/or Employee Benefits.



WOODRUFF
SAWYER

WOODRUFF-SAWYER & CO.

AN ASSUREX GLOBAL & IBN PARTNER

woodruffsawyer.com