PROPOSAL TO PROVIDE BENEFITS CONSULTING SERVICES

Mr. Mitch Bramstaedt
Vice President

Josh D. Timm, CEBS
Vice President

December 20, 2013

United Food and Commercial Workers Unions and Participating Employers Health and Welfare Fund

Segal Consulting

Segal Consulting

101North Wacker Drive, Suite 500 Chicago, IL 60606
T 312.984.8500 F 312.896.9364 www.segalco.com

December 20, 2013

Via E-mail: josephs@associated-admin.com

Mr. Joseph Sears, CEBS
Account Representative
Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451

Re: Proposal to Provide Benefits Consulting Services

Dear Mr. Sears:

Thank you for the opportunity to submit a proposal to provide benefit consulting services to the United Food and Commercial Workers Unions and Participating Employers Health and Welfare Fund (Fund). Our understanding is that the Fund wishes to retain a consulting firm with demonstrated successful experience with multiemployer health and welfare benefit programs. We have appreciated the opportunity to serve as your project-based consultant over the past few years, specifically working with the Fund Trustees and professionals on Mental Health Parity and Addiction Equity Act compliance and Summary of Benefits and Coverage (SBC). We realize there are numerous benefits consulting firms from which to choose and through this proposal, we will show that Segal Consulting (Segal) has the required experience and is qualified to provide the following services:

- Prepare annual reports analyzing the Funds benefit experience;
- Determine the Fund's current funding level and forecast future contribution levels;
- Calculate maintenance of benefit contribution and COBRA rates annually, in accordance with the collective bargaining agreements;
- Value plan design changes;
- Negotiate renewals with current and future healthcare providers;
- Assist with the development of benchmarks to monitor the Fund's performance;

- Determine the Medicare Part D creditable coverage status and draft the required annual notice to the Fund's participants;
- Review and coordinate compliance with the Fund's reporting obligations under the Affordable Care Act (ACA) and other applicable laws;
- Draft or review forms, participant notices, plan amendments and summaries of material modifications, as required;
- Advise and report on the financial impact of statutory and regulatory developments affecting the fund; and
- Attend four meetings of the Board of Trustees per year while being available for telephonic meetings as needed.

Segal proposes a team of consultants that has completed similar projects for the United Food and Commercial Workers Local 1500 Welfare Fund, Heartland Health and Wellness Fund, and the Rocky Mountain UFCW Unions and Employers Health Benefit Plan. We will reference these engagements and others throughout this proposal to demonstrate the proposed team's experience with other clients that generally represent multiemployer health funds with the following characteristics that appear to be relevant to the Fund and the work you seek:

- Large employer groups with greater than 7,000 employees;
- Diverse employee groups that include active employees, part-time associates, retirees and COBRA participants;
- UFCW participant base where Kroger is one of the employers;
- Clients for whom we have provided comprehensive benefit consulting services; and
- Multiemployer plans for which we have reviewed and analyzed benefit legislation specifically related to the ACA.

Segal has a deep understanding of the issues facing food industry multiemployer plans. Today, we are engaged by 53 food industry funds including 27 health and welfare funds. Segal is the consultant to approximately 588 multiemployer health plans.

Our approach is not set in stone. We do not simply offer an "off the shelf" program of services. Rather, we consider the unique culture and needs of each client to customize our work to fit those needs.

Experience has taught us that it is the quality of our work that gains our clients' trust. The Segal work ethic and culture is immersed in a drive for constant improvement. The information contained within is intended to fully meet the Fund's scope of services.

Requests for additional information regarding our proposal may be addressed to the following individuals:

Mr. Mitch Bramstaedt
Vice President
101 North Wacker Drive, Suite 500
Chicago, IL 60606-1724
Phone: 312.984.8652
Cell: 773.551.5134
mbramstaedt@segalco.com

Josh D. Timm, CEBS
Vice President
30 Waterside Drive, Suite 300
Farmington, CT 06032-3069
Phone: 860.678.3040
Cell: 860.384.3541
jtimm@segalco.com

We welcome the opportunity to meet with you to answer any questions you may have and to discuss our qualifications and experience in greater detail.

Sincerely yours,

Mitch Bramstaedt
Vice President

Josh Timm, CEBS
Vice President

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December 20, 2013

Executive Summary

Managing a health plan in today's dynamic environment requires a higher level of effort and expertise than ever before. The Fund can become a leader of multiemployer health funds by successfully implementing new ideas before they become mainstream. We look forward to the challenge of helping you build maintain and expand such a legacy. We will work with the Trustees and Fund Professionals in the following manner to meet these objectives.

Proactive

Trustees and Fund Professionals need ideas to react to and to consider. We present you with new industry trends, current compliance issues, and more importantly, proven solutions that address issues the Fund faces today and that will surface in the future.

Trustee Planning

Past experience has demonstrated the benefits of Trustees engaging in meetings and dialogue where healthcare strategic planning is a significant part of the agenda. Segal consultants typically use this time to facilitate Trustee discussion around health plan goals and objectives. We will use an approach that is illustrated in the table below and summarized in the following paragraphs.

Vendor Management	Plan Management Strategies	Individual Health Care Management & Wellness
• Competitive bidding • Contract negotiation • Vendor performance audits • Renewal negotiations	• Plan design • Plan cost modeling/actuarial services • Funding options and strategies • Reserve adequacy • Contribution strategies • Coverage rules and protocols	• Wellness and prevention programs • Disease management programs • Catastrophic claimant programs • Transparency tools

Vendor Management

Choosing the vendors that demonstrate the best fit with the Fund is the critical first step in creating a well-managed health plan. Once the correct mix of vendors is determined through procurement or selection processes, these organizations need to be monitored closely through frequent meetings, measurement of performance guarantees and performance standards, audits, and renewal negotiations.

Our approach to vendor management is described below.

➢ We aggressively negotiate vendor contracts and make sure clients receive a competitive price and top-ranked service. Our health analytical teams are comprised of actuaries, underwriters, and consultants, some of who were previously very senior underwriting managers or actuaries in insurance companies. We have found that this insurance company experience brings an extra level of scrutiny (and insight) into vendor contracts.

- We negotiate meaningful and measureable caps on the fees and premiums charged by vendors. We often devise long-term provisions that hold vendors accountable to realistic price increases. This process works well with multiemployer clients who must project budget costs many months in advance of the beginning of each program year due to the collective bargaining cycle.

- Segal can conduct audits to verify that vendors are performing. Our claims audit division has been assisting clients since 1973 through onsite and desktop audits of self-funded plans administered by carriers and third party administrators nationwide. Segal auditors are specifically trained to conduct health care claim audits. Because these individuals devote 100% of their time to this function, they have a level of experience and expertise that is unequaled in the industry.

Segal maintains an array of audit tools to assist in monitoring vendor service levels and validating their achievement, including:

- Periodic onsite claim audits to meet fiduciary responsibilities, reduce plan costs, enforce or implement performance guarantees, address benefit or plan concerns, and increase employee satisfaction.

- Desktop or electronic audits that lend themselves to reviews of Rx programs administered through a pharmacy benefit manager (PBM) or analysis of claims data to determine utilization trends and comparisons.

- Dependent eligibility verifications to identify, report, and disenroll ineligible dependents from one or more benefit plans.

- Develop standards for contract performance that reflect general practices among large employers. These norms will be tailored to the specific needs of the benefit programs.

Plan Management

The ultimate goals of plan design are threefold, and at times these goals may appear to be in conflict.

- The plan must encourage appropriate utilization by paying for necessary, quality care at a high level and by paying for discretionary care at lower levels.

- The governing plan design must be established in order to assist in meeting the overall cost and financing goals of the plan.

- The plan must be flexible so it meets the ever-changing needs of members and the current industry trends.

These competing goals can best be brought into alignment through strong data management and analysis. The Fund's data contains the information to determine how to encourage appropriate utilization at a cost that is affordable and, more importantly, sustainable.

Individual Health Care Management and Wellness

The Fund may have begun work in this area by engaging in wellness benefits and related programs, and exploring deeper impact programs, such as disease management. Subsequent steps will be to coordinate the program management properly, wellness benefits and related programs, as well as to monitor the programs' effectiveness.

Segal has the experience in coordinating vendor, plan design and individual health management to help Trustees achieve their short and long-term objectives with their wellness plan.

Health Care Reform

When President Obama signed health reform into law on March 23, 2010, he set the stage for a dramatic restructuring of the entire health care sector. As result, accurate, behind-the-scenes, detailed reporting will be essential in the coming months and years for multiemployer health benefit programs with a vested interest in this regulatory transformation.

Plan sponsors will be working through the implications of health reform for years, but the first step is to review the reforms for the coming plan year.

Segal's National and Regional Compliance teams have been following the reform process throughout, including publishing a periodic Health Care Reform Insights electronic update to keep our clients fully informed of the many changes in direction as this legislation has moved through Congress and into law. We are already working with many of our Taft-Hartley clients on active projects to review how these new short-term and long-term reforms affect their benefits programs. We propose to do the same for the Fund.

Services that Segal will provide to the Fund in this area include:

- Subject matter expertise;
- Responding to questions regarding federal health reform;
- Providing guidance and recommendations for compliance and implementation;
- Providing analysis of impacts to the Fund;
- Developing and/or reviewing presentation materials;
- Participating in conference calls and workgroup meetings; and
- Coordinating compliance with all Fund professionals.

Compliance Issues

With the recent passage and signing into law of the Patient Protection and Affordable Care Act ("PPACA") and the second Act, the Health Care and Education Reconciliation Act ("HCERA"), there are extensive changes that will impact all aspects of health care. We believe the first step for plan sponsors is to understand the implications of these new laws on their benefit programs, including how the new laws may change the benefits provided and the employees and

dependents covered by their programs. The changes contained in this complex new legislation have staggered effective dates over the next several years. This means that plan sponsors must understand not only what changes are effective immediately, but must also begin consideration now of changes that will not take place for several years.

Our approach during this time of rapid changes and issuance of agency regulations is to continue to keep an eye on reform progress while we help our clients identify and develop responses that make the most sense for their plans. We believe it is important to view the new laws as a series of changes that require not only an initial response, but ongoing review, reassessment and program changes as the new provisions become effective. Our objective will be to help the Fund focus on practical modifications to your programs to meet the immediate legal changes and to begin the process for future changes.

Questionnaire

1. What is the location of the office that would service the Fund? Please describe the staffing, facilities, and equipment available at that office, as well as the primary contact should your proposal be accepted.

Your Fund would be serviced from our Hartford and Chicago offices. These services would be provided by consultants, Mr. Josh Timm, and Mr. Mitch Bramstaedt.

Segal Consulting:

Mr. Mitch Bramstaedt
101 North Wacker Drive, Suite 500
Chicago, Illinois 60606
312.984.8500
312.896.9364 (fax)

Mr. Josh Timm
30 Waterside Drive, Suite 300
Farmington, CT 06032-3069
860.678.3000
860.371.3429 (fax)

Staffing

The multiemployer sector represents two-thirds of our total annual revenue. Of our Company's 944 employees, approximately 700 are involved in client-related services, and of those with client contact, about 350 spend more than 80% of their time consulting on multiemployer issues. 19 of our 22 offices that are located throughout the United States and Canada service multiemployer clients. Segal's system of Industry Group leaders ensures that each of the industries we serve has dedicated specialists constantly monitoring and anticipating their unique needs and challenges.

As a matter of policy and practice, we are committed to remaining independent of insurance companies, healthcare organizations (HMOs, PPOs, etc.), accounting firms and brokerage firms specifically to avoid any possible conflicts of interest. Our energy and creativity on ways to serve our clients better by providing the services that meet the highest standards of performance.

There are a number of individuals on our staff who have over 30 years' experience working with multiemployer plans. Among our actuaries, 108 are enrolled and 56 are FSAs. Many of the compliance consultants have law degrees (although Segal as a company does not practice law).

Segal's Hartford office has 24 employees and the Chicago office employs 136. Nationally, the breakdown is:

691	Consulting professionals, including: benefits consultants, actuaries, health benefits and pension analysts, administrative experts, claims auditors, communication consultants, investment solutions experts (through Segal Rogerscasey) and fiduciary liability experts (through Segal Select Insurance Services)
154	Other professional staff, including: human resources, information technology, public affairs, marketing staff, finance and legal
99	Clerical and support staff
944	Total among all offices

Mitch and Josh will be the day-to-day points of contact for the Fund. In addition, you will have direct access to all team members whenever necessary. The majority of your core team members are located in our Chicago office. However, at times we may draw on resources from other offices in order to bring the right expertise to a particular situation. Every member of your team is committed to be available in person, via phone or email as often as you deem necessary. As part of Segal's commitment to providing the greatest level of value to our clients, we endeavor to staff projects with people of different levels of skill and experience as appropriate for the tasks. We staff project teams so that our clients benefit the most from our matrix structure. We value direct client collaboration and consequently permit great accessibility to our national practice leaders to personally consult with clients and to review special situations that may arise.

Actuarial Software

Actuarial processing occurs on personal computers utilizing the most current Windows operating system on workstations connected to Windows servers located on the local area network (LAN) in the local office where actuarial work is performed. Each local office LAN is connected via a frame relay network to form The Segal Company's wide area network (WAN). Company standard software is used in every actuarial office, which facilitates inter-office client-load balancing to meet client deadlines. The Segal Company has designed and programmed its own software for all actuarial functions for many years.

The Actuarial Technology and Systems department is comprised of a group of dedicated systems developers responsible for providing and supporting the Segal Company's actuarial valuation system. The state-of-the-art actuarial valuation system has been designed internally to maintain control and flexibility to allow for modifications to best meet the unique needs of our clients.

Segal uses a DMZ to isolate Internet facing servers, in addition to appliance based CheckPoint firewalls at the network level. Windows firewall is utilized at the desktop level. Microsoft SQL Server is the company standard database for enterprise database applications. Database servers are located in the regional datacenters which are environmentally controlled and protected by card key systems which restrict access to IT and facilities personnel only. Database servers are configured in server clusters using Microsoft SQL Server 2005. Server operating system and SQL server software are patched in accordance with Microsoft security updates after operational testing is performed.

All servers are protected with McAfee antivirus software. Access control is based Microsoft Active Directory authentication and access to specific databases is role based.

All file servers are backed up nightly. Full backups are done weekly and incrementally changed files are backed up on a daily basis. Backup tapes are stored offsite, utilizing a nationally available data archive vendor throughout the country. Backup tapes are retained following the appropriate professional standards or government regulations.

We utilize industry standard technology solutions and best practices to maintain a secure environment for the storage and transmission of ePHI, SSNs and other confidential data and information. Electronic documents, messages, and data files can be transmitted securely through using several methods. All ePHI and SSNs sent via e-mail to outside parties must be encrypted prior to transmission. Alternatively, ePHI and SSNs can be transmitted using an alternative

secured email solution (Segal Secure File Transfer), a secured Website (which we can set up for mutual exclusive access), external alternative encryption solution (e.g., public key encryption from pgp) or overnight mail (with overnight tracking service required).

2. Please outline your firm's experience in providing consulting services to group health plans, particularly multiemployer group health plans, of a similar size to the Fund.

As the only major consulting firm whose core business is dedicated to collectively bargained multiemployer plans, Segal is uniquely qualified to help multiemployer health and welfare funds find the right solutions to the issues arising from today's challenging health care environment. We have pioneered many innovations in health benefit design, purchasing, cost management and communications. Our focus has always been on carefully crafted strategies that make business, philosophical and practical sense to trustees.

Our consulting team includes experienced actuaries, insurance experts, claims auditors, managed care experts, and client managers who are dedicated to helping multiemployer health funds address their unique health and welfare benefits challenges.

Following are three client examples that show that your proposed team has completed similar proposals for similar clients in the past:

Heartland Health and Wellness Fund

Background: Many members of the Fund's proposed service delivery team also work with the Heartland Health and Wellness Fund, formerly known as the UFCW Southwest Ohio. The health plan is managed by a Board of Trustees, which is comprised of union leaders and senior management from Kroger and CVS/Caremark. The health plan programs are self-funded, covering approximately 15,000 employee and retiree participants plus their dependents.

The Fund Office Staff provides customer services, claims adjudication, eligibility management and vendor management. Recently, the Fund hired a nurse to run the wellness program.

Segal Services: Segal assisted the Board of Trustees to address cost containment objectives through rigorous budgeting processes, collective bargaining consultation, and a recent PPO bid evaluation. A result of the PPO bid was the decision to remain with the current vendor, implementing more advantageous performance guarantees and multiple-year fee arrangements that will benefit the Plan and the covered participants on a long-term basis.

The Fund has an ongoing process for evaluating and growing its wellness program. Segal has assisted the Trustees in developing program objectives and associated programs. Quarterly, we prepare a wellness dashboard that evaluates the program's costs and achievements.

Segal prepares a quarterly report that evaluates the Fund's reserve position and claims experience. We value the Fund's retiree health valuation and IBNR liability annually for the auditor.

Rocky Mountain UFCW Unions and Employers Health Benefit Plan

Background: Many members of the Fund's proposed service delivery team also work with the Rocky Mountain UFCW Unions and Employers Health Benefit Plan. The health plan is managed

by a Board of Trustees, which is comprised of union leaders and senior management from Kroger, Safeway and Albertsons. The health plan programs are self-funded, covering approximately 13,500 active employee and retiree participants plus their dependents.

Zenith Administrators provides fund office support and CIGNA provides the healthcare plan and care.

Segal Services: Segal assisted the Board of Trustees in reducing plan costs. By changing the plan design, contributions were also increased. These changes were facilitated through a budgeting processes, collective bargaining consultation, and increased utilization of CIGNA programs.

UFCW Local 1500

Background: The health and welfare fund is managed by a Board of Trustees, which is comprised of union leaders and senior management from Stop & Shop, King Kullen, Pathmark and Fairway Markets. The health plan programs are both self-funded and fully insured covering approximately 18,000 employee participants and their dependents providing medical, prescription drug, dental, vision, life, AD&D, and disability benefits.

Segal Services: Segal assisted the Board of Trustees in addressing cost containment objectives through plan design options, collective bargaining consultation, and a recent PBM bid evaluation. The plan design process included reviewing the current status of the plan, benchmarking the plan compared to their peers and offering alternative plan options to consider. The result of the PBM bid was the decision to move to a new prescription benefit manager. The resulting savings was significant and the member disruption was minimal allowing the Fund to achieve savings without member impact.

Proposed Team

Consulting Strategy and Team		
Mitch Bramstaedt 312.984.8652 mbramstaedt@segalco.com	Vice President	Mr. Bramstaedt will lead this engagement and be responsible for day-to-day support. He will be responsible for assuring that the Fund's goals are met.
Josh Timm 860.678.3040 jtimm@segalco.com	Vice President	Mr. Timm, will support Mitch Bramstaedt in addressing day-to-day issues for the Fund.
Actuarial Support		
Chris Heppner, ASA, MAAA 312.984.8677 cheppner@segalco.com	Senior Vice President, Health Actuary, Health Practice Leader	Mr. Heppner will be responsible for preparing budgets, contribution rates and COBRA rates. He and his staff will provide actuarial support as required by the Fund.
John Priester 312.984.7921 jpriester@segalco.com	Senior Health Benefits Analyst	Mr. Priester will support Mr. Heppner in preparing budgets, contribution rates and COBRA rates.

Compliance		
Kathy Bakich, JD 202.833.6494 kbakich@segalco.com	Senior Vice President and National Health Compliance Practice Leader	Ms. Bakich will be responsible to address compliance issues, as needed.
Communications		
Joshua Meyer 212.251.5400 jmeyer@segalco.com	Senior Communication Consultant	Mr. Meyer will be available to coordinate communications needs.

3. Please provide three references from other multi-employer group health plans.

United Food and Commercial Workers Local 1500 Welfare Fund

Bruce W. Both
President
425 Merrick Avenue
Westbury, NY 11590
516.214.1305
bboth1500@aol.com

Heartland Health Fund

Lenny Wyatt
International Union Vice President
UFCW Union Local #75
7250 Poe Avenue, Suite 400
Dayton, Ohio 45414-2687
937.665.1901
lennie.wyatt@ufcw75.org

Henry Taylor
Director, Health Care Labor Strategy
The Kroger Co.
1014 Vine Street
Cincinnati, Ohio 45202-1100
513.762.1523
henry.taylor@kroger.com

Rocky Mountain United Food and Commercial Workers

Kim Cordova
President
UFCW Local Union #7
UFCW Building, Suite 400
7760 West 38th Avenue
Wheat Ridge, Colorado 80033
303.425.0897 x402
kcordova@ufcw7.com

Steve DiCroce
King Soopers, Inc.
65 Tejon Street
Denver, Colorado 80223
303.778.3269
steve.dicroce@kroger.com

Food Employees Labor Relations Association ("FELRA") and the United Food and Commercial Workers ("UFCW") Health and Welfare Fund

William Jensen, Fund Administrator
Associated Administrators, LLC
4301 Garden City Drive, Suite 201
Landover, MD 20785-2210
301.429.8960
billj@associated-admin.com

4. Please furnish a copy of a standard consulting services agreement. Please outline any limit of liability such agreement would contain.

We have included a copy of our Sample Retainer Agreement and Sample Business Associates Agreement in the *Appendix* of this proposal.

Segal does not require limitation of liability in our multiemployer retainer agreements

5. Please advise whether your firm will receive fees or other consideration, direct or indirect, from any party other than the Fund for, or in connection with, the provision of your services to the Fund, and if applicable, describe such fees.

Segal will not receive fees or other consideration, direct or indirect, from any party other than the Fund for, or in connection with, the provision of our services to the Fund.

As an independent consulting firm owned by our employees, we provide unbiased counsel and advice. We are not affiliated with any insurance company, third-party administrative agency, or provider network, nor are we driven by outside shareholders' profit expectations. The independent nature of our consulting organization, and our freedom from affiliations or external stakeholders, enables us to review and select service solutions without bias.

6. Do you contemplate subcontracting any portion of the work? If so, please describe.

Segal will not subcontract any work for the engagement proposed herein.

7. Please provide an estimated installation/startup timeline for the Fund.

Communication and collaboration on projects, strategic initiatives and day-to-day work will play a crucial role in the long-term success of the benefits program and partnership between the Fund and Segal. To support the growth of a successful partnership, Segal will work with the Fund's staff to understanding their objectives, challenges, and experiences. We will initially request historical data and reports. We will also ask to be included in vendor meetings in order to meet the group representative and to fully understand the current arrangements and programs.

Kick Off Meeting

It is standard practice for our benefit consultants to begin any significant benefits initiative with a "strategy session" in which priorities, goals, philosophy, history, culture, timing, and dos/don'ts are discussed thoroughly and mutually agreed upon. The outcome of this session is a summary of the principles for the project that will serve as a benchmark against which ideas will be tested or measured. Difficulties or challenges that arise during the process of fleshing out project details often can be resolved by "testing" them against the principles established at the beginning of the process. At the same time, we want to ensure that everything that is done in this initial phase is in concert with long-term objectives that will incorporate other dimensions of the Fund's ultimate goals of maintaining a predictable healthcare budget, protecting a meaningful benefit plan, and providing incentives to participants to partner with the Fund to manage healthcare costs effectively by making wise choices.

Immediately upon being chosen for this engagement, we will establish a meeting with the Fund Office staff and/or assigned committee to initiate the relationship and to clarify the scope of the consulting engagement. At the kick-off meeting, we will:

1. Confirm the goals and objectives of the consulting engagement;

2. Present a preliminary consulting plan based on our understanding of the engagement, and discuss the plan, project scope and timelines in detail;

3. Establish parameters for keeping the Fund updated, adjusting the consulting plan to fit the specific needs that have been identified; and

4. Identify data needed for the overall engagement.

8. Please provide a summary of any litigation involving your firm within the last five years. Please describe any governmental investigations involving your firm within the last five years.

With over 2,500 clients firm wide (including public sector and corporate), the Segal Group is occasionally named as a party in litigation involving the performance of its services. Past litigation did not affect Segal's ability to perform services for its clients nor did any litigation have a material effect on its financial position.

9. Please provide the name of your errors and omissions carrier and describe the applicable policy limits and sublimits.

The Segal Group maintains Errors and Omissions Insurance through Indian Harbor Insurance Company, an XL Insurance Company, in the amount of $12,500,000.

10. Please provide your annual retainer for 2014 and 2015, as well as hourly rates for any additional services not covered in your standard agreement or otherwise described above.

We have included our Sample Retainer Agreement in the *Appendix* of this proposal.

Standard Services

To provide the services listed in the RFP as "Standard Services," we propose an annual retainer of $64,000 for 2014 and 2015.

Our experience and expertise make us the preeminent multiemployer consulting firm. Further, we work hard to be efficient and use those efficiencies to offer the best fee for each client. When selecting a consulting firm, we hope that fees never keep us from being hired. If you find that our fee is not in the range of your budget, please reach out to us. It may be that we proposed more services than are necessary in an effort to address your longer-term needs, or that there is a misinterpretation regarding possible add-on costs. Whatever the case may be, we are happy to discuss pricing with you. We want to partner with you and establish a lasting relationship of value and trust.

Additional Services (upon request)

Our fees will be based on our standard hourly time charge rates, which are shown below. An estimate of fees can be provided for Trustee approval prior to beginning a project. In order to be most cost effective, work is performed at the lowest appropriate level and reviewed by more senior members of the team.

2014 Hourly Rates for Various Levels of Staff	
Job Title	**Hourly Rates***
Senior Vice President/Senior Benefits Consultant	$400 to $450
Vice President/Benefits Consultant	$325 to $410
Compliance Manager	$400 to $450
Compliance Analyst	$235 to $380
Health Actuary	$260 to $370
Health Analyst	$205 to $280
Associate Health Analyst	$125 to $235

*Typically, our hourly rates increase by 3% per year.

Generally, our fees for these services will be based on our regular time charge rates, which range from $125 to $510 per hour, but generally average $245 to $305 per hour for most services, depending on the nature of the work.

Additional expenses which may be incurred for special project work will be included in the fee estimate. Services provided by outside vendors (for example, design services for communication pieces) will, to the extent practicable, be billed directly to the Plan by the vendor.

Our fees are all inclusive and there are no additional administration, start-up, or implementation fees associated with the engagement. We do not bill separately for services performed by our clerical staff, duplicating, telephone calls, computer time, postage, etc. In situations where additional projects can have a project scope outlined in advance, we will devise an agreed-upon fee quote prior to beginning work. We will not assess an extra technology charge.

Summary of Proposed Services

Basic Annual Services

Segal is experienced in performing all of the services that are required by the Trustees as outlined below.

1. Prepare annual reports analyzing Fund claims experience, benefits paid, contributions, administrative expenses and other relevant items.
2. Prepare annual forecasts, reflecting the Fund's current funding level and forecasts of projected future contribution levels.
3. Calculate maintenance of benefit contribution rates annually. Review sufficiency of fixed rate contributions based on applicable bargaining agreements. Calculate COBRA premiums rates.
4. Perform actuarial costing and prepare recommendations with respect to plan design changes. It is anticipated that such cost estimates would be narrow in focus, as opposed to major plan changes.
5. Negotiate with insurance providers and health benefit vendors and assist in the selection of new Fund vendors or renewal of agreements with existing vendors.
6. Assist in developing benchmarks and monitoring Fund vendor performance.
7. Determine Medicare Part D creditable coverage status and draft the required annual notice to the Fund's participants.
8. Review and coordinate compliance with the Fund's reporting obligations under the Affordable Care Act and other applicable laws.
9. Assist in the drafting of forms, participant notices, plan amendments, and summaries of material modifications, as required.
10. Advise and report on financial impact of statutory and regulatory developments affecting the Fund.
11. Meetings:
    - Attend four meetings of the Board of Trustees per year.
    - Be available by telephone for Board meetings, if necessary.

Supplementary Services

We are prepared and qualified to provide a wide variety of other services to the Fund on a Supplementary Service fee basis. Following is an illustrative list of supplementary services that the Trustees may wish to consider but are not usually required on an annual basis and would not be part of our Basic Annual Services. It is our practice to provide a fee estimate to the Board of

Trustees for approval before commencing any supplementary work, based upon the scope of the project desired by the Trustees.

1. Prepare and circulate RFPs for vendors such as PPO, PBM, and other providers.
2. Prepare cost estimates of major plan changes, benefit redesign or cost restructuring studies.
3. Prepare proposals for benefit plan alterations.
4. Analyze compliance with legislation or new regulations that affect the Fund.
5. Assist in the review of plan documents or amendments.
6. Work required after the effective date of this contract because of legislation or regulations that affect the Fund.
7. Participation in litigation, lawsuits or arbitration involving the Fund.
8. Drafting of announcements or a completely revised Summary Plan Description (Booklets) or Plan Document.
9. Consultation and preparation of special reports and assistance in decisions with respect to mergers, spin-offs or acquisitions.
10. Redesign of basic Fund office administrative, recordkeeping and computer systems.
11. New procedures, calculations and determinations required due to changes in accounting and auditing standards issued by the Financial Accounting Standards Board or through state or federal legislation.
12. Services involving special claims audits.
13. Assisting fund counsel in the preparation of materials in support of special IRS or DOL ruling applications, reviews or appeals, including meetings with IRS or DOL staff.
14. Preparing an analysis of the impact of adding new employer groups.
15. Auditing the basic data and recordkeeping of the Fund.
16. Surveys of benefit practices within the geographical area or industry undertaken at the specific request of the Fund.
17. Non-routine work needed to analyze funding methods, funding vehicles, cost and financing of retiree health coverage, and cost management techniques and alternatives.
18. Other services requested but not specifically outlined in this document.

Appendix

Sample Retainer Agreement

This is a sample agreement for illustrative purposes only.

ANNUAL RETAINER – MULTIEMPLOYER HEALTH AND WELFARE FUND

DRAFT

[Insert date]

[Insert name of client]
[Insert address]
[Insert address]

Re: 2013 Consulting Services Agreement – Health and Welfare Trust Fund

Dear Trustees:

This Consulting Services Agreement ("Agreement") describes the consulting services that we will provide on a regular basis and the fees we will charge for these services. It also outlines how we will be compensated for additional work the Trustees may ask us to undertake.

In this Agreement, the services Segal will provide are presented in three separate sections: PART A General Consulting Services; PART B Health Benefit Analytical Services; and PART C Compliance Services. The Agreement describes the Basic Annual Services covered by the fee arrangement and outlines the kinds of additional services that are not routinely required for standard, on-going maintenance and operation of the Fund, but that may be provided as Supplemental or Specialized Consulting Services on a time charge basis or on the basis of a supplemental fee.

In this Agreement, our proposed compensation is presented in PART D Compensation for Services.

This Agreement is subject to the terms specified in PART E Miscellaneous.

It is difficult to predict whether the Fund will encounter complex or special problems, or the extent to which our assistance will be needed in areas beyond the scope of our Basic Annual Services. Supplemental and Specialized Consulting Services include any other service not specifically described or contemplated as a Basic Annual Service, as well as any new or special work required after the effective date of this Agreement and any work associated with changes in legislation or regulation. Because such Supplemental and Specialized Consulting Services require expenditures of time and expense not anticipated as a Basic Annual Service, we will advise you when possible of the work involved and provide a fee estimate, upon request. Supplemental and Specialized Consulting Services shall be subject to all of the terms and conditions set forth herein.

Segal is being engaged solely to provide the actuarial and consulting services described in this Agreement. We do not provide legal or accounting services, nor do we provide investment

consulting or management services, tax advice or act as a plan fiduciary. Any information, suggestions or materials that we provide regarding statutes, regulations or other legal matters do not constitute legal advice and are subject to the review and advice of Fund legal counsel. And, while we will work closely with the Fund staff and your other professionals and outside service providers, Segal is not responsible for services, information or materials provided to the Fund by individuals or organizations other than Segal, even if they relate to services that we are providing under this Agreement.

To enable Segal to perform the Basic Annual Services and any Supplemental or Specialized Consulting Services, the Fund and its administrator, trustees, employees and agents agree to promptly provide Segal with such direction, materials, information and access to its representatives as Segal reasonably requests and all data needed to perform these services. Segal may rely upon such data and other information provided to it by such parties as being accurate and complete. For example, Segal may rely upon any information supplied by the Fund and its agents and employees regarding the administration of the Fund, including without limitation information concerning the interpretation of the Fund's plan documents or matters involving the exercise of discretion by the Fund's trustees or administrator. Segal is not required to verify or audit any data or other information so provided, nor is it liable to the Fund or others if such information is inaccurate, misleading or false.

[Language to be used with new clients where appropriate: The Fund and Segal agree that Segal shall not have any responsibility whatsoever for the condition of the Fund prior to Segal's engagement or the consequences of that condition after Segal's engagement.]

[Language to be used where we are not retained to do financial projections or an FEBP: As Segal has not been retained to provide the Fund with periodic financial projections or a Financial Experience and Budget Projections report, Segal shall not have any responsibility for the emerging position of the Fund.]

PART A. General Consulting Services

1. Consultation

Basic Annual Services. We will be available for general consultation on Fund operations in such areas as plan design, funding, provider performance, administration, compliance and communications. We will report on the plan's overall progress and development and respond to routine questions and issues regarding the benefit program.

Supplemental Services. Examples include:

- Analysis of possible changes in funding methods; for example, an evaluation of whether the Fund should consider insurance versus self-insurance,
- Special studies on plan redesign and the resulting cost implications;
- Consultation on the design and implementation of a flexible benefit plan; and
- Consultation on cost containment and managed-care, including selection or development of provider networks.

Negotiations

Basic Annual Services. In the context of a routine renewal, we will negotiate with insurance companies, managed-care organizations, and other third party providers on their renewal rates and charges. This will include reviewing year end settlements. We will assist and respond to routine dispute resolution with a vendor over claims administration. To the extent that the dispute is not routine, it will be considered a Supplemental Service.

Supplemental Services. Examples include:

- Preparation and solicitation of competitive bids from insurance companies, managed-care organizations or other types of service providers and the related analyses.
- Initial contract negotiations with a new service provider or where there is a significantly revised relationship with an existing service provider.

3. **Meetings.**

Basic Annual Services. We will attend up to [Fill in the number] meetings per year, including meetings of the Board of Trustees, Trustees committee meetings and meetings with the professional advisors of the Fund, as part of our Basic Annual Services. If we are requested to attend more than [Fill in the number] meetings in a year, we will do so for an additional fee based on our time and travel and other expenses. We will bill for our time and travel and other expenses for meetings outside of the local area.

4. **Minutes.**

Basic Annual Services. We will review minutes prepared by the administrator or legal counsel based on our notes and understanding of the events at the meetings.

Or

[Alternate Language: We will prepare draft minutes based on our notes and understanding of the events at the meetings, for review by the Trustees, Fund Legal Counsel and any other professional advisors the Trustees designate.]

5. **Trends in Legislation, Benefits, and Plan Design.**

Basic Annual Services. By means of our publications and special advisory reports, we will continue to keep you apprised of new developments in the employee health benefits field and within the universe of multiemployer plans. Questions regarding the interpretation and application of laws, regulations, rulings and court decisions are legal matters, subject to Fund legal counsel's advice; however, we will assist Fund legal counsel upon request. Depending on the specific nature of the issues raised and the time required to respond, such assistance may be treated and billed as a Supplemental Service.

Supplemental Services. Examples include:

- Individualized analysis and specific guidance and recommendations on compliance and implementation issues, and
- Surveys of benefit practices within a geographical area or industry.
- Plan design, communications, actuarial valuations, financial modeling related to legislative and regulatory activities.

6. **Specialized Consulting and other Supplemental Services**

Examples of Specialized Consulting that we provide as a Supplemental Service include:

Mergers, Spin-offs and Plan Terminations — Consultation and preparation of special reports in connection with such developments.

Compliance — Any compliance and operational review of the plan.

Communications — Specialized participant communications, including strategic communications planning, concept development, writing, benefit statements, media selection (including Internet usage and Website development) and production oversight for graphic design, print and other media.

Administration and Technology Consulting Services – Technology consulting on the design and implementation of in-house systems and the evaluation of third party vendors, operational reviews and assistance with recruitment.

Fiduciary Liability Insurance, Fidelity Bonds and other Insurance Services – We will coordinate and provide the brokerage resources to market to insurers and service initial and renewal insurance coverages, including fidelity bond coverage and/or fiduciary liability insurance coverage for the Fund. These supplemental insurance coverage services will include the submission of completed applications to insurers, receiving and negotiating coverage terms and conditions, and reporting to the Fund the results of our marketing efforts inclusive of our recommendations, as appropriate. Our report, which is prepared by our licensed, professional staff, will include a policy explanation and other informational material to assist the Trustees in evaluating the cost and scope of coverage being offered. Normal maintenance, for example participating in a Trustee meeting via conference call, filing claims, answering coverage questions and amending coverage, as appropriate, will be provided. Informational material will be periodically supplied to keep Trustees informed. This is a supplemental service and our compensation will come from the commissions paid by the insurer to us, which commissions will be fully earned upon binding of coverage with an insurer. Our commissions will be disclosed annually in writing.

These supplemental insurance coverage services do not include specialized research, such as new or unique insurance coverages, policy reviews of insurance contracts for which we are not broker, and claims advocacy work, other than the initial filing of a claim notice, routine questions and the follow-up for the carrier's claim response or reservation of rights letter.

Legal Proceedings – For assistance or participation in actual or anticipated disputes, investigations, arbitrations, litigation or other dispute resolution proceedings (collectively, "Legal Proceedings"), we will be compensated on a time charge basis. Examples of this type of Supplemental Service include (but are not limited to) time spent (whether at the request of the Fund or pursuant to a subpoena), (i) assisting Fund legal counsel in the analysis and development of the Fund's legal position, (ii) preparing for or testifying at depositions or in connection with Legal Proceedings and (iii) responding to requests for documents and information in connection with disputes and investigations to which the Fund is a party. In addition, the Fund will pay all costs and fees, including attorney's fees that Segal incurs in connection with Segal's requested or compelled participation in Legal Proceedings on behalf of the Fund.

PART B. Health Benefit Analytical Services.

Regular Annual Reporting. We will prepare, each year, [a report] [reports] of regular and routine information about the Fund for the Trustees. These reports will include budget projections for upcoming years and will contain basic information on the Fund's financial position. These reports will review contributions, other income, expenses and the Fund's reserve position. We will provide information and data on claims experience and other benefit-related expenditures and will review insurance carrier and other provider renewal proposals. For insured benefits, we will also report on insurance carrier experience accountings and policy settlement analyses.

Supplemental Services. Examples include:

- Revised budget projections for evaluating major changes in the plan of benefits or eligibility rules;
- Detailed examination of claims experience for particular benefits
- Special studies of managed-care plans relating to reimbursement methodologies, network adequacy, cost management techniques or quality issues using our Q-Val service.
- Consultation regarding service provider profile and performance, predictive modeling, disease management, and integrated medical management
- Detailed comprehensive reserve analysis

Self-Insured Benefits.

Basic Annual Services. If the Fund provides some or all of its benefits through self-funding, we will calculate the appropriate costs, reserves and claims trend factors that should be taken into account for sound plan financing and policy determinations.

Supplemental Services. Example includes:

Calculations related to the initial establishment of new self-insured benefits.

3. **Data Request and Review.**

Basic Annual Services. The review of contribution and reserve requirements, experience/rate setting and other analyses described above will require extensive data. We will prepare a detailed data request outlining what is necessary to perform these services. We will also request the financial data required from the Fund's auditor and any other data or information required to complete our analysis, including where we do not prepare plan amendments, copies of the up-to-date plan and plan amendments.

Data will be requested in a computer format compatible with our computer system and Year 2000 compliant (that is, appears in four-digit year representation, for example 2006, instead of '06).

Upon receipt of these data, we will examine them to determine whether, based solely on a review of the data, there appears to be missing information or internal consistency. When the data reconciliation exceeds a reasonable and customary allotment of time, there will be additional fees based on hourly time charge rates. These fees may include work necessary to obtain additional information, to convert data not presented in the format requested and for the additional processing time required to reconcile data that contains errors, duplicate records or missing information.

4. **COBRA.**

Basic Annual Services. We will calculate the premiums for COBRA coverage charged to former participants and family members who elect to continue the Fund's benefits. We will provide technical expertise on general COBRA administration questions, but we will not administer COBRA.

Supplemental Services. Examples include:

- Preparation of revisions to COBRA Notices and forms, including updates.
- Preparation of COBRA manuals.
- Review of COBRA procedures and report regarding the operational issues with COBRA administration.

Annual Audits and Government Filings.

Basic Annual Services. We will supply the auditor and the Fund administrator with information that is reasonably available to us for the IRS Annual Return/Report (Form 5500). We will not prepare the 5500 as a basic service, but will review the portions of the form as prepared by the auditor that relate to the matters for which we provide consulting services. We have no responsibility for certifying or validating any numbers, costs or figures prepared by the Fund's auditor or administrator.

Supplemental Services. Examples include:

- Procedures, calculations and determinations required for compliance with accounting and auditing standards.
- Preparation of Form 5500.

Customized Audits

Supplemental Services. Examples include

- Claims Audits – Auditing the accuracy and quality of insurance companies and other third party providers in their payment of claims.
- Evaluating and advising on whether performance and contract guarantees have been met and negotiating when appropriate, adjustments in the charges or services.
- Other audits including eligibility audits, Prescription Drug Plan Audits, etc.

Retiree Health Consulting Services.

We will consult with respect to a plan's retiree health benefits with the following supplemental services. The Client, and not Segal, is responsible for filing the Medicare Part D Retiree Drug Subsidy application in a timely manner.

Supplemental Services. Examples include:

- [Include this language unless these services are already included in a fixed fee arrangement: Strategies for providing and financing retiree health coverage, including SOP 92-6 actuarial valuations,]
- Medicare Modernization Act consulting, Retiree Drug Subsidy actuarial analysis, attestation and administration; Medicare Advantage and Medicare Prescription Drug Plan bids and contracts. Segal acknowledges with respect to the Retiree Drug Subsidy that information it may provide to the plan will be used by the Plan sponsor for the purpose of obtaining federal funds.
- Medicare Part D creditable coverage testing and Notices of Creditable or Non-Creditable Coverage; filing Notices of Creditable Coverage with CMS.

PART C. Compliance Services

Application and Interpretations of the Plan

Basic Annual Services. We will consult on the cost, administrative and plan design aspects of the Health Plan and questions that arise during the normal course of operation and as a result of routine claims and appeals. As noted, however, interpretation of the plan is the responsibility of others to whom that role is entrusted under the plan and applicable law.

We do not advise on matters regarding medical or scientific judgement, such as questions on the efficacy of medical treatment or medical necessity. However, we will offer general

advice on where to find sources of qualified assistance on matters that require medical or other scientific expertise.

Supplemental Services. Examples include:

- Assistance in complying with regulations or other such guidance and with claims or appeals raising complex issues or requiring detailed record searches and review of historical plan provisions, and
- Assistance or participation in litigation, arbitration, investigations, administrative proceedings, or the analysis or documentation of claims.

Plan Changes.

Basic Annual Services. We will provide advice and assistance in evaluating and implementing routine plan changes authorized by the Trustees, including changes in plan cost, changes in premium rates, and changes in benefits.

Supplemental Services. Examples include:

- Plan amendments and formal Trustee resolutions may be required periodically to reflect plan interpretations, benefit changes made by the Trustees, new or newly effective tax laws, regulations, judicial precedents, or regulatory or administrative interpretations. Consulting, drafting or reviewing such amendments, restatements, resolutions or other plan documents are Supplemental Services.
- Any changes to the Plan or work performed in connection with a change in bargaining representation or the collective bargaining agreement.
- As noted, Segal does not provide legal services, and any draft plan amendment, Trustee resolution or similar documentation that we prepare will be prepared in draft form, subject to review and approval of Fund legal counsel and will not be considered final until it has received that review and approval.

Basic Communication with Participants

Basic Annual Services. We will consult with the Trustees, Fund administrator and Fund legal counsel in the preparation of notices to plan participants, including (i) identification of information that will be covered and (ii) review of information prepared by others.

Supplemental Services. Examples include:

- Drafting or coordination of production of a new or revised summary plan description,
- Preparation of notices and other explanatory material to participants for other than simple and routine matters.
- Preparation of notices required by regulation.

- Note that Segal does not provide legal services. Any legal notices or similar documentation that we prepare (or assist in preparing) shall be subject to the review and approval of Fund legal counsel and shall not be considered final until it has received that review and approval.

Fund Administration Support.

Basic Annual Services. We will consult with the Fund administrator as reasonably requested with regard to routine changes in forms and procedures and general recordkeeping questions. If such consultation exceeds a reasonable and customary allotment of time, Segal will bill for such additional time at its then current hourly time-charge rates. Compliance with the recordkeeping requirements of laws or regulations are matters subject to the advice of Fund legal counsel. We will be available to assist legal counsel and for consultation on non-legal issues.

Supplemental Services. Examples include:

- Preparation of, and Fund office training on substantially revised forms and new administrative procedures,
- Assistance with recruitment and other human resource matters,
- Assistance with qualified medical child support orders and other child and family support issues,
- Detailed review and analysis of Plan documentation and administration.

PART D. Compensation for Services

1. Basic Annual Services

Our annual fee for providing these Basic Annual Services will be $[Fill in the amount] for the year commencing _____ and $[Fill in the amount] for the year commencing _____. The annual fee shall be payable [monthly] [quarterly] [in advance] [in arrears], plus reimbursement of travel expenses for meetings held in a location other than in [Fill in the name of the City where the client is located or where regular quarterly meetings are held].

Additional fees may be assessed for premium services such as requests for expedited services.

Should any commissions, other than for the placement of fiduciary liability or fidelity bond coverage, be received for the placement of insurance directly related to this engagement, they will be used as an offset against our fees, but only to the extent permitted by law.

[Name of Client] may provide incidental meals or refreshments to Segal staff in connection with Client meetings and other Client events.

Routine expenses such as photocopying, telephone calls, facsimiles, mailing costs, and secretarial and wordprocessing services are included in our fees. Unusual or unexpected expenses may be billed separately following consultation with and approval of the Trustees.

In the event we are required to spend significantly more time than anticipated because of circumstances beyond our control, we will inform you and bill separately for those services.

To assure continuity of services to the Fund, this Agreement will renew automatically at the end of its term, subject to fees negotiated by the parties. It is understood that adjustments to this Agreement upon renewal may be made in any post-Agreement annual period, on a mutually agreed upon basis, and may be reflected in resolutions or motions adopted by the Trustees or in separate correspondence, without formal amendment to this Agreement. This Agreement is subject to cancellation by either party upon 30 days advance written notice.

If this Agreement is terminated on a date other than an anniversary date, The Segal Company will be reimbursed for all time charges incurred from the beginning of the then current contract year to the date of termination, up to a maximum of the [balance of that year's annual fee] [balance of the time charge maximum for that contract year].

Segal is not responsible for work or work product developed prior to the date of Segal's retention as actuary and consultant even if such development is first brought to the attention of the Board of Trustees and Fund professionals as a result of Segal's provision of services to the Fund.

2. Supplemental and Specialized Consulting Services

Fees for Specialized Consulting Services and Supplemental Services generally will be charged on a time charge basis [plus the technology charge] or, in some instances, may be charged on a project basis. Supplemental and Specialized Consulting Service charges will be billed monthly in arrears unless agreed to otherwise.

[Include this language where the fee for SOP 92-6 is not included in a fixed fee arrangement: Our fee for the actuarial valuation of retiree health benefits for purposes of SOP 92-6 will be [based on hourly time charges [plus a 5% technology charge] with an annual cap of $_____.] [$[Fill in the amount] for the year commencing _____ and $[Fill in the amount] for the year commencing _____.]

PART E. Miscellaneous

This Agreement is binding on the parties to it as well as on the participants, beneficiaries, and fiduciaries of the Fund.

Any disputes relating directly or indirectly to this Agreement, or to Segal's services to the Fund, will be mediated under the auspices of the Judicial Arbitration and Mediation Service ("JAMS") as a condition precedent to the commencement of any legal proceeding regarding such dispute.

All persons bound by this Agreement waive any right to a trial by jury in any action, suit, or proceeding arising out of this agreement, or any other agreement or transaction between the parties.

This Agreement sets forth the entire agreement between the parties as to the subject matter hereof and merges all prior discussions between them. No party is bound by any conditions, definitions, warranties, understandings or representations with respect to such subject matter other than as expressly provided herein, or as set forth in a written amendment to this Agreement that is executed by all parties.

Very truly yours,

Segal Consulting

[Insert name of Segal Signatory]
[Title]

Agreed to on behalf of the Board of Trustees of the [Insert name of client] by:

_____	_____
Labor Trustee	Date
_____	_____
Management Trustee	Date

Sample Business Associate Agreement

CONFIDENTIALITY/BUSINESS ASSOCIATE AGREEMENT FOR MULTIEMPLOYER HEALTH PLAN SPONSOR

The Segal Group, Inc., the parent of The Segal Company, for itself and on behalf of its subsidiaries and affiliates[1] (collectively "SEGAL") understands that its client plans and plan sponsors desire to protect the confidentiality of plan participants' and beneficiaries' health information and keep such information secure. The confidentiality of individually identifiable health information ("IIHI") and the security of electronic protected health information (ePHI) have long been a priority for SEGAL. The privacy regulation ("Privacy Rule") and the security regulation ("Security Rule") promulgated by the United States Department of Health and Human Services under the authority of the Health Insurance Portability and Accountability Act[2] ("HIPAA") furnishes SEGAL with an opportunity to reaffirm that commitment. This Agreement, effective on ("the Effective Date"), by and between SEGAL and the client executing below _____ ("Client")[3], is the integration of the Parties' understandings as to the confidentiality of IIHI and the security of ePHI and supersedes all prior understandings and other contractual provisions in that regard (the "Agreement").

WHEREAS Client sponsors one or more "health plans" ("the Plans") which are "Covered Entities" under the Privacy Rule and the Security Rule. These rules require covered entities and certain of their service providers to enter into confidentiality agreements.

WHEREAS SEGAL may create on behalf of, or receive from, the Plans or the Plans' other service providers IIHI deemed protected health information under the Privacy Rule (the "Protected Health Information" or "PHI").

WHEREAS SEGAL, in the course of providing services to Client, may on behalf of the Client and/or Plans create, receive, maintain, or transmit electronic Protected Health Information. "Electronic Protected Health Information" is Protected Health Information as defined in 45 C.F.R. 160.103 that is transmitted by electronic media or maintained in electronic media. The term "electronic media" shall have the meaning set out in 45 C.F.R. 160.103.

WHEREAS the Parties wish to confirm the appropriateness of Client and/or Plans' sharing of IIHI, PHI and ePHI with SEGAL related to the services SEGAL provides and which are various functions deemed to be "treatment," "payment," or "health care operations" under the HIPAA Regulations set forth at 45 CFR Parts 160 and 164.

WHEREAS the Parties now desire to comply with HIPAA, the Privacy Rule, and Security Rule, as amended by the Health Information Technology for Economic and Clinical Health Act of the American Recovery and Reinvestment Act of 2009 ("HITECH") and any rules promulgated thereunder.

NOW, THEREFORE, in consideration of the premises and the mutual promises contained herein, Client and SEGAL hereby agree as follows:

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[1] The obligations and privileges of Segal herein extend to all companies in The Segal Group, Inc., a Delaware corporation except Segal Advisors, Inc., a New York corporation.

[2] Subtitle F, Public Law 104-191, Section 261, et seq.

[3] Segal and Client are referred to collectively herein as "the Parties."

1. **SEGAL Responsibilities with Respect to the Privacy of Protected Health Information.** To the extent that SEGAL is acting as a business associate under the HIPAA Privacy Rule, SEGAL hereby agrees, with regard to its use and/or disclosure of the PHI, to do the following:

   a. Subject to the provisions in Section 5 hereof, to use and/or disclose the PHI only: (i) in conjunction with the services it provides, or has contracted to provide, to Client ("the Services"), including but not limited to using data in bids and vendor selection processes; (ii) consistent with the manner which Client is permitted to use and disclose by 45 C.F.R. § 164.502 (as amended from time to time); (iii) for SEGAL's proper management and administration, or to fulfill any present or future legal responsibilities in accordance with 45 C.F.R. § 164.504(e)(4); (iv) to aggregate with the IIHI of other SEGAL engagements to furnish data analyses; (v) for use by SEGAL after being de-identified in accordance with the requirements of 45 C.F.R. § 164.514(b), (vi) as otherwise permitted or required by this Agreement; or (vii) as otherwise permitted or required by law;

   b. to report to Client, in writing, any material use and/or disclosure of the PHI that is not permitted or required by this Agreement of which SEGAL's Privacy Officials[1] become aware;

   c. to use commercially reasonable efforts to maintain the security of the PHI as required by the Privacy Rule and to prevent its use and/or disclosures contrary to this Agreement;

   d. to require all of SEGAL's non-affiliated subcontractors and agents utilized in providing the Services to agree, in writing, to adhere to equivalent restrictions and conditions on the use and/or disclosure of the PHI that apply to SEGAL pursuant to this Section;

   e. make available upon reasonable notice and during normal business hours, its internal practices, records, books, agreements, policies and procedures directly relating to the use and/or disclosure of the PHI to the United States Department of Health and Human Services for purposes of determining Client's compliance with the Privacy Rule subject to applicable privileges and confidentiality agreements;

   f. within thirty (30) days of receiving a written request from Client that Client has received a request by an individual for an accounting of the disclosures of the individual's PHI in accordance with 45 C.F.R. § 164.528, provide to Client a list of disclosures (if any) made: for public health purposes, regarding abuse, neglect or domestic violence; to a health oversight agency; in the course of a judicial or administrative proceeding; for law enforcement purposes; to coroners, medical examiners and funeral directors; to organ procurement organizations; for research; as required by law; to prevent a serious harm to health or safety; to military and veterans officials; or for workers' compensation purposes. In each case SEGAL shall provide at least the following information with respect to each such disclosure: (a) the date of the disclosure; (b) the name of the entity or person who received the Protected Health Information; (c) a brief description of the Protected Health Information disclosed; (d)

[1] As a Business Associate, Segal is not required to have a Privacy Official. However, we have created an Office of Privacy Officials for the purpose of implementing the Privacy Rule and for the convenience of our clients.

a brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure.

g. at such time as the Parties agree that SEGAL holds a portion of Client's members' Designated Record Set not in Client's possession, it will provide such information to Client to allow Client to fulfill access requests made in compliance with 45 C.F.R. § 164.524 or, at its option, respond directly to such requests; and

h. at such time as the Parties agree that SEGAL holds, and has edit control over portions of the Designated Record Set with respect to the Plans' covered persons, to process at Client's costs, in the manner required by 45 C.F.R. § 526, requests for amendment to the Protected Health Information relevant to those persons.

2. **SEGAL Responsibilities with Respect to the Security of ePHI**. To the extent SEGAL creates, receives, maintains, or transmits the ePHI in its capacity as a Business Associate to the Plan, SEGAL hereby agrees to do the following:

a. implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI;

b. require all of its non-affiliated subcontractors and agents utilized in providing the Services to agree, in writing, to implement reasonable and appropriate safeguards for the ePHI as those that apply to SEGAL pursuant to this Section 2; and

c. report to Client, in writing, any security incident of which it becomes aware. For purposes of this Agreement, "security incident" shall mean successful unauthorized access or disclosure or modification, destruction or interference with the ePHI by a third party.

3. **Breach Notification under HITECH**. SEGAL shall notify Client as soon as practicable, but no later than 30 days after discovery, of a Breach of Unsecured PHI, as defined in the regulations promulgated under HITECH, 45 C.F.R. Part 164, subpart D. Such notice shall include all available information required by 45 C.F.R. §164.410, including the identity of each individual whose Unsecured PHI has been or is reasonably believed by SEGAL to have been accessed, acquired, used or disclosed during the Breach; a brief description of what happened, including the date of the breach and the date of discovery if known; a description of the type of Unsecured PHI involved in the Breach; the steps individuals should take to protect themselves from any potential harm resulting from the Breach; a brief description of the steps SEGAL is taking to investigate, mitigate harm, and protect against further breaches; and contact information for follow-up questions.

4. **Responsibilities of Client**. With regard to the use and/or disclosure of PHI by SEGAL, Client hereby agrees:

a. that the uses and disclosures which SEGAL shall carry out pursuant to this Agreement are consistent with the form of notice of privacy practices (the "Notice") that Client provides to individuals pursuant to 45 C.F.R. § 164.520;

b. to notify SEGAL, in writing and in a timely manner, of any arrangements permitted or required of Client under 45 C.F.R. parts 160 and 164 that may impact in any manner the use and/or disclosure of PHI by SEGAL under this Agreement including, but not limited to, restrictions on use and/or disclosure of PHI as provided for in 45

C.F.R. § 164.522 agreed to by Client, but to hold SEGAL harmless from the financial impact of any such agreement by Client;

c. to obtain any consent or authorization that may be required under the Privacy Rule or state law prior to furnishing the PHI to SEGAL;

d. to ensure that any third party contacting SEGAL on Client's behalf has entered into a business associate agreement with Client as necessary;

e. if Client is a plan sponsor, to (i) limit its requests for PHI to summary health information and use such data for the purpose of obtaining premium bids or for modifying, amending or terminating the group health plan, or to enrollment information or (ii) to use the PHI for plan administration functions following the provisions to the plan of the certification and amendment of the plan documents each as described in 45 C.F.R. 164.504(f)(2); and

f. that SEGAL does not have direct responsibility to process requests by participants or beneficiaries under 45 C.F.R. §§ 164.522, 164.524, 164.526 or 164.528 but shall at its option, refer such requests to Client for its processing with SEGAL's assistance pursuant to Sections 1(f), (g) and (h).

5. **Term and Termination**. Unless otherwise terminated as provided in Sections 6, 7 or 8 this Agreement shall become effective on the Effective Date and shall have a term that shall run concurrently with that of any oral or written agreement by SEGAL to provide services to Client and will terminate without any further action of the Parties upon the termination of all such agreements. Upon the event of termination of this Agreement, SEGAL agrees, where feasible, to return or destroy the PHI, which SEGAL still maintains in any form. Prior to doing so, SEGAL further agrees, to the extent feasible, to request the destruction of the PHI that is in the possession of its subcontractors or agents. Client understands that SEGAL's need to maintain portions of the PHI in records of actuarial determinations and for other archival purposes related to memorializing advice provided can render return or destruction infeasible. If it is not feasible for SEGAL or any of its subcontractors to return or destroy portions of the PHI, SEGAL shall inform Client as to the specific reasons that make such return or destruction infeasible, extend the protections of this Agreement to such PHI, and limit any further use or disclosures to the purposes that make the return or destruction of those portions of the PHI infeasible.

6. **Statutory or Regulatory Changes with respect to Protected Health Information**. If Client notifies SEGAL that SEGAL's responsibilities set out herein should be altered as a result of any changes in HIPAA, the Privacy Rule, the Security Rule or HITECH ("Additional Responsibilities"), SEGAL shall make such changes to the Services provided that appropriate fees are agreed to by Client and SEGAL. If, in its reasonable discretion SEGAL determines that the proposed, Additional Responsibilities have a material adverse financial effect on SEGAL's interest in this Agreement, and SEGAL and Client cannot come to agreement on fees and implementation schedules for the Additional Responsibilities, then SEGAL or Client may terminate the Agreement upon thirty (30) days prior written notice to the other party. Neither party shall assert any claim against the other party for monetary damages or equitable relief or otherwise for SEGAL's failure to perform the Additional Responsibilities from the date of notice to SEGAL of the Additional Responsibilities or, if SEGAL or Client exercise a right to terminate the Agreement, through the termination date.

7. **Material Breach by SEGAL.** If Client determines that SEGAL has engaged in a pattern of activity that constitutes a material breach of SEGAL's obligations under this Agreement, Client shall, within twenty (20) days, notify SEGAL and SEGAL shall have thirty (30) days to cure the breach or end the violation. If SEGAL fails to take reasonable steps to affect such a cure within such a time period, Client may give such notice and opportunity to cure or invoke such dispute resolution as is otherwise permitted by any services agreement between Client and SEGAL. In the absence of such a procedure or in cases where such procedure has not successfully resolved the dispute relative to the pattern of activity alleged to constitute material breach, Client may terminate the relevant aspect of the services relationship, or, if not feasible to do so, may report the problem to the Secretary of Health and Human Services.

8. **Material Breach by Client**. If SEGAL determines that Client or the Plan has engaged in a pattern of activity that constitutes a material breach of Client's obligations under this Agreement, then SEGAL shall, within twenty (20) days, notify Client and Client shall have thirty (30) days to cure the breach or end the violation. If Client and/or the Plan fail to take reasonable steps to effect such a cure within such a time period, SEGAL may give such notice and opportunity to cure or invoke such dispute resolution as is otherwise required by any services agreement between Client and SEGAL or, in the absence of such a procedure, may terminate the relevant aspect of the services relationship or, if not feasible, may report the problem to the Secretary of Health and Human Services.

9. **Compliance with HITECH Act**. The Parties acknowledge that HITECH amended certain provisions of HIPAA in ways that now directly regulate, or will on future dates directly regulate, the Parties' obligations and activities under HIPAA, the Privacy Rule and the Security Rule. To the extent not referenced or incorporated herein, requirements applicable under HITECH are hereby incorporated by reference into this Agreement. The Parties agree to comply, as is necessary and appropriate, with each of the requirements imposed under HITECH, as of the applicable effective dates of each relevant HIPAA obligation.

10. **Third Party Beneficiaries**. Nothing in this Agreement shall be construed to create any third party beneficiary rights in any person, including any participant or beneficiary of the Plan.

11. **Counterparts**. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original. Facsimile copies thereof shall be deemed to be originals.

12. **Informal Resolution**. If any controversy, dispute, or claim arises between the Parties with respect to this Agreement, the Parties shall make good faith efforts to resolve such matters informally.

13. **Notices**. All notices to be given pursuant to the terms of this Agreement shall be in writing and shall be sent certified mail, return receipt requested, postage prepaid or by overnight air express mail service. If to Client, the notice shall be sent to the address set forth below Client's signature or such other address as Client notifies SEGAL of in writing. If to SEGAL, the notice shall be sent to the Privacy Official, c/o General Counsel, The Segal Company, 333 West 34th Street, New York, New York 10001, with a copy to The Segal Company, 333 West 34th Street, New York, New York 10001, ATTN President.

14. **Survival**. Section 5 shall survive the term of this Agreement.

15. **Effective Date**. The Effective Date shall be February 17, 2010, or if later, the date that SEGAL begins to perform the Services on behalf of the Client. However, to the extent that certain provisions under HITECH have effective dates that are different from February 17, 2010, those effective dates shall apply to the relevant provisions.

INTENDING TO BE LEGALLY BOUND, the Parties have duly executed this Agreement.

	The Segal Group, Inc.		**Client**
Signed	_____	Signed	_____
Print Name	_____	Print Name	_____
Title	_____	Title	_____
Date	_____	Date	_____
		Address	_____

SEGAL

MITCHELL W. BRAMSTAEDT

Vice President and Midwest Public Sector Market Leader, Chicago

Expertise

Mr. Bramstaedt joined The Segal Company in 1992 as a Health Consultant. As Midwest Public Sector Practice Leader, he assists clients with benefits strategy and design and specializes in developing managed care carve-out programs. Mr. Bramstaedt plays an active role in developing health care cost management programs. His past responsibilities have included supervising the managed care staff of the Chicago office.

Mr. Bramstaedt has been successful in reducing client health care costs by following a process of goal setting, data evaluation, plan design modeling, vendor selection, and vendor management. He has also worked with many clients to develop effective contribution options. As a past member of Segal's National Rx Consulting group, Mr. Bramstaedt was responsible for coordinating and keeping Segal's prescription drug consulting efforts current. He was instrumental in developing innovative methods for evaluating prescription drug programs analyses that have assisted many clients in comprehensively auditing their prescription benefit managers and reducing drug spending.

Professional Background

Prior to joining Segal, Mr. Bramstaedt was the Manager of Underwriting for a Chicago-area HMO. He also served for three years as an Employee Benefits Underwriter with a consulting firm specializing in association trusts and for four years as an Underwriter with a national insurance company. Mr. Bramstaedt is a past member of URAC's Consumer-Directed Advisory Committee. This committee assists URAC with the development of accreditation standards for Consumer-Directed Health Plans.

Education/Professional Designations

Mr. Bramstaedt received a BS degree from Bradley University (Peoria, IL) and an MBA from DePaul University.

Published Works/Speeches

Mr. Bramstaedt has been quoted several times as an expert on the topic of prescription drug programs, in periodicals that include *Crain's Chicago Business*, *Employee Benefits Review*, and *Business Insurance*. He has also been a guest presenter on health benefit design and prescription drug programs at many local, regional, and national conferences.

MITCHELL W. BRAMSTAEDT
mbramstaedt@segalco.com
312.984.8652
www.segalco.com

Expertise

Mr. Timm is a Vice President and Benefits Consultant in Segal's Hartford office with more than a decade of experience working with multiemployer health and retirement plans. He also works with several public sector health plans. Mr. Timm has deep expertise in health plan design, budgeting, and vendor management as well as plan design and compliance with the Affordable Care Act.

Mr. Timm serves as consultant to multiple Taft-Hartley plans covering members of the United Food and Commercial Workers (UFCW) throughout New England and the Mid-Atlantic, including the UFCW Local 919 Health and Pension Funds, UFCW Interstate Health & Welfare Fund, UFCW Local 1500 Health and Welfare Fund, UFCW Local 1459 Health & Welfare Fund, UFCW Local 371 Health and Welfare Fund and Warehouse Employees Local 730 Health & Welfare Trust Fund. Mr. Timm is also involved with the Pipe Trades and Ironworkers Health and Pension Funds. In addition, he provides support for numerous Taft-Hartley building trade health and welfare, pension and annuity clients throughout the Northeast.

Education/Professional Designations

Mr. Timm received a BS in Business Management from Western Oregon University. He also received a Certified Employee Benefits (CEBS) designation from the International Foundation of Employee Benefit Plans and The Wharton School of the University of Pennsylvania. Mr. Timm is a licensed insurance broker in all New England states.

Published Work/Speeches

Mr. Timm has been a participant at International Foundation of Employee Benefit Plans (IFEBP) and International Public Management Association for Human Resources (IPMA-HR) Conferences and often speaks about health care reform at regional UFCW Conferences.

JOSHUA TIMM
jtimm@segalco.com
860.678.3040
www.segalco.com

Expertise

Mr. Heppner is a Senior Vice President, Health Actuary and the Midwest Health Practice Leader in Segal's Chicago office with over 20 years of experience working with health plans. He provides retiree health expertise, as well as development of rating and contribution strategies, to corporate, public sector and multiemployer clients.

Mr. Heppner has been involved in a variety of projects that include flex plan pricing, PPO and prescription drug pricing, renewal negotiations, contribution strategy, plan design analysis, disability plans and valuations, Medicare Part D attestations, and reserve calculations. He also provides litigation support as a resident expert.

In a recent project, Mr. Heppner assisted clients in understanding their current cost components so that effective decisions could be made to manage those costs. He has developed interactive budget projection models to address client-specific interests, as well as engaged in successful negotiations with insurers to keep renewal increases consistently below trend. Mr. Heppner has also developed techniques to test and determine actuarial equivalents for unique plan designs.

In addition to his role as a Health Actuary for clients, Mr. Heppner develops and reviews health actuarial guidelines for the company and manages the Midwest Health Practice.

Professional Background

Prior to joining Segal, Mr. Heppner worked for a major medical insurance company conducting individual health insurance pricing and plan design analysis. He began his career at another international human resources and benefits consulting firm.

Education/Professional Designations

Mr. Heppner received a BS in Business Administration from the University of Illinois in 1991. He is an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries.

CHRISTOPHER D. HEPPNER
cheppner@segalco.com
312.984.8677
www.segalco.com

Expertise

Mr. Priester is a Senior Health Benefits Analyst in Segal's Chicago office with over three years of experience in actuarial consulting. His responsibilities include conducting and managing the workflow of medical and prescription drug plan change analyses, claims data analysis, IBNR calculations, budget projections, fiscal year-end financial reviews and self-pay rate calculations. He is also responsible for annual renewal negotiations for stop-loss insurance, managed care organizations, dental carriers, and other health management related services.

Professional Background

Mr. Priester joined Segal in 2008 as an Actuarial Analyst in the firm's Retirement Practice. He became a Health Benefits Analyst in the firm's Health Practice in 2009.

Education/Professional Designations

Mr. Priester received a BS in Actuarial Science from the University of Illinois. He has a Certificate of Completion of the Group Insurance Course from the Health Insurance Association of America (HIAA) Insurance Education Program for Life, Accident and Health Insurance.

JOHN W. PRIESTER
jpriester@segalco.com
312.456.7921
www.segalco.com

KATHRYN BAKICH, JD
Senior Vice President, National Health Compliance Practice Leader, Washington, DC

Expertise

Ms. Bakich is a Senior Vice President in Segal's Washington, DC office with over 20 years of experience in health care compliance. She is the firm's National Health Compliance Practice Leader.

Ms. Bakich is one of the country's leading experts on employer sponsored health coverage. She specializes in providing research and analysis on federal laws and regulations affecting health coverage, including: ERISA, Medicare, HIPAA, COBRA, the Newborns' and Mothers' Health Protection Act, the Mental Health Parity Act, and the Women's Health and Cancer Rights Act.

Ms. Bakich is a recognized expert on the Patient Protection and Affordable Care Act passed in 2010. She speaks regularly about the law, helps plan sponsors understand its short and long term effects on their plans, and assists clients with preparing comments on the legislation for submission to regulatory Departments (Treasury, Labor, and Health & Human Services).

Ms. Bakich leads the Segal team responsible for publishing information about new health care laws and regulations, and trains internal staff on all legislation and related developments. She and her staff disseminate health compliance information, monitor federal and state laws and regulations, and prepare amendments for health plans and summary plan descriptions based on national models.

Professional Background

Prior to joining Segal, Ms. Bakich was an attorney in private practice representing multiemployer health plans and an appellate administrative law judge.

Education/Professional Designations

Ms. Bakich graduated in 1979 with a BA in Political Science, in 1982 with an MA in Public Policy, and in 1985 with a JD from the University of Missouri. She has been admitted to the Bar in the District of Columbia, United States Supreme Court, and multiple federal district and appellate courts.

Ms. Bakich is a member of the Working Committee of the National Coordinating Committee for Multiemployer Plans (NCCMP), the Health Technical Issues Taskforce of the American Benefits Council (ABC), the Employers Council on Flexible Compensation (ECFC) Flex Advisory Council, and the American Bar Association (ABA). Ms. Bakich is co-chair of the ABA Joint Committee on Employee Benefits Subcommittee on Welfare Plan Regulation. She was also appointed to the Government Liaison Committee of the International Foundation of Employee Benefit Plans (IFEBP). Ms. Bakich was named a Fellow of the American College of Employee Benefits Counsel in 2012.

Published Works/Speeches

Ms. Bakich has published multiple articles about employee health and welfare benefits, including a series of articles discussing HIPAA Administrative Simplification, EDI, and Privacy in the *Benefits Law Journal*. She is a co-author of the *Employers' Guide to HIPAA Privacy Requirements*, published by Thompson Publishing Group, and a chapter editor of *Employee Benefits Law*. Ms. Bakich speaks regularly on issues related to group health plans.

KATHRYN BAKICH
kbakich@segalco.com
202.833.6494
www.segalco.com

Expertise

Mr. Meyer is a Senior Consultant in Segal's National Communications Practice with over 20 years of strategic communications consulting experience. He serves as the Multiemployer Liaison for the National Communications Practice. He is located in the firm's New York office and provides counsel to clients on a wide range of benefits communications issues using a broad array of media.

Mr. Meyer works nationally with Segal's multiemployer clients in a number of industry groups, including Carpenters, Communications Workers, Electrical Workers, Entertainment Workers, Ironworkers, Laborers, Machinists, Painters, Plumbers and Pipefitters, Operating Engineers, Service Employees, Sheet Metal Workers, Teamsters Transit Workers and United Food and Commercial Workers. He is also the editor and project manager of *Health Report,* a quarterly publication for multiemployer client subscribers.

Professional Background

Prior to joining Segal, Mr. Meyer provided strategic communications, research, and planning consulting for local, regional, and national unions, benefit funds, and affiliated organizations. His experience also includes developing public image and branding campaigns; performing organizational analyses to develop long- and short-term strategic plans, organizational goals, resource allocation, and strategies for growth and membership mobilization; creating design, structure and content for Web sites; creating and analyzing polls; and developing e-advocacy strategies and campaigns. Mr. Meyer has researched and written position papers, policy briefs, speeches and Op-Ed pieces analyzing U.S. industries such as construction, transportation, health care and hospitality. He has also written about international health care and pension systems, economic development, labor law, immigration, and international trade.

Education/Professional Designations

Mr. Meyer received a BS in Industrial and Labor Relations from Cornell University and a Masters of Public Policy from Harvard University's John F. Kennedy School of Government.

Publications/Speeches

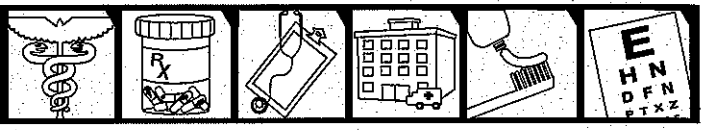
Mr. Meyer has been a presenter at the New York Fund Administrators Seminar and the Chicago Area Administrators Summit, and has been published in *Benefits Magazine*, a publication of the International Foundation of Employee Benefit Plans.

JOSHUA MEYER
jmeyer@segalco.com
212.251.5400
www.segalco.com

Sample Publications

2014 Segal Health Plan Cost Trend Survey

Segal Consulting



Slowest Rate of Increase in Health Plan Cost Trends in 14 Years Projected for 2014

Health benefit plan cost trend rates show the slowest growth in 14 years of trend forecasts, according to data compiled in the 2014 *Segal Health Plan Cost Trend Survey*, Segal Consulting's seventeenth annual survey of managed care organizations (MCOs), health insurers, pharmacy benefit managers (PBMs) and third-party administrators (TPAs).[1] (For a definition of trend, see the text box on page 2.) While this decline in the trend rate is positive news, it is important to note that medical health plan cost trends still outpace the consumer price index for all urban consumers (CPI-U) by a margin of at least three to one, which continues to serve as a drag on real wage growth.

As the Affordable Care Act[2] kicks into full gear in 2014 and as the economy continues to improve, it is unclear if health plan cost trends will continue to decline or return to the historic, inflationary underwriting cycle.

Trend Projections for 2014

Table 1 summarizes Segal's key findings on trend projections for 2014 and compares them to projections for 2013. Notes about the 2014 forecasted trends follow:

- All medical plan types are projected to experience trend rate declines in 2014.

[1] For information about the survey participants, see the text box on the last page of this report.

[2] The Affordable Care Act is the abbreviated name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-148, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152.

Table 1: Projected Medical, Prescription Drug, Dental and Vision Trends: 2013 and 2014

	2013 Projected		2014 Projected	
	(without Rx)	(with Rx)[1]	(without Rx)	(with Rx)[1]
Medical (Actives & Retirees <Age 65)				
Fee-for-Service (FFS)/Indemnity Plans	10.8%	10.0%	10.4%	9.7%
High-Deductible Health Plans (HDHPs)[2]	9.1%	8.6%	8.3%	7.9%
Open-Access Preferred Provider Organizations (PPOs)/Point-of-Service (POS) Plans[3]	8.8%	8.3%	7.9%	7.6%
PPOs/POS Plans (with PCP Gatekeepers)	9.3%	8.8%	8.4%	8.0%
Health Maintenance Organizations (HMOs)	8.2%	7.9%	7.2%	7.0%
Medical (Retirees Age 65+)				
Medicare Advantage (MA)[4] FFS Plans or PPOs	5.5%	5.4%	3.6%	4.3%
Medicare Advantage HMOs	5.8%	5.6%	3.3%	4.2%
Medicare Supplemental (Medigap)	5.3%	5.3%	4.9%	5.2%
Prescription Drug (Rx) Carve-Out[5]				
Actives & Retirees <Age 65	6.4%		6.3%	
Retirees Age 65+	5.3%		5.7%	
Dental				
Schedule of Allowance Plans[6]	4.0%		4.0%	
FFS/Indemnity Plans	4.0%		3.8%	
Dental Provider Organizations (DPOs)	3.5%		3.4%	
Dental Maintenance Organizations (DMOs)	4.1%		4.5%	
Vision				
Schedule of Allowance Plans	2.8%		2.9%	
Reasonable & Customary (R&C) Plans	3.7%		3.3%	

[1] Trend projections were derived by proportionally blending medical trends and freestanding prescription drug trends.

[2] HDHPs with an employee-directed, tax-advantaged health account — a health savings account (HSA) or a health reimbursement account (HRA) — are referred to as account-based health plans and are designed to encourage consumer engagement, resulting in more efficient use of health care services. HDHPs are defined as those plans where the deductible is at least the minimum health savings account (HSA) level required by the Internal Revenue Service ($1,250 single, $2,500 family in 2014).

[3] Open-access PPO/POS plans are those that do not require a primary care physician (PCP) gatekeeper referral for specialty services.

[4] MA plans, part of the Medicare program, can be private HMOs, FFS plans, PPOs or special-needs plans. The 2013 survey collected information about projected trends for MA PPO plans separately. The 2014 survey combines FFS plans with PPOs.

[5] Prescription drug carve-out data was captured for retail and mail-order delivery channels combined.

[6] A schedule of allowance plan is a plan with a list of covered services with a fixed-dollar amount that represents the total obligation of the plan with respect to payment for services, but does not necessarily represent the provider's entire fee for the service.

- Health maintenance organization (HMO) trend rate projections for 2014 are a full percentage point lower than HMO projections from just four years ago.
- Prescription drug benefit trends for retail and mail order combined are forecasted at 6.3 percent for active participants and early retirees. These projections are relatively consistent with last year's trend rate projections of 6.4 percent.
- Medicare-eligible retiree plans are also anticipating trend rate declines for Medicare Advantage (MA) preferred provider organizations (PPOs), MA HMOs and Medicare Supplemental plans. MA PPO trends are projected to decrease almost 2 percentage points below 2013 levels to their lowest point in 17 years. This predicted rate decrease for Medicare-eligible retiree plans is more than double the rate decline projected for PPOs for actives and pre-65 retirees.
- In 2014, Medicare-eligible retirees can expect lower trend rates for medical coverage compared to prescription drug coverage. For example, MA HMO trend rates are projected to be 3.3 percent while prescription drug trends (retail and mail order combined) are forecasted at 5.7 percent. These findings are a departure from last year's trends in which the forecasted medical and prescription drug trends rates were aligned. This is largely driven by the rise in specialty drug cost and significant price inflation on brand-name drugs without dramatic new gains in generic utilization. It is noteworthy that trend projections for MA plans are lower despite cutbacks in subsidies from the Centers for Medicare & Medicaid Services (CMS).
- Overall, dental plan trend rates are projected to remain relatively unchanged in 2014. Scheduled vision plan trend rates are projected at 2.9 percent and reasonable and customary plans are forecasted at 3.3 percent in 2014.

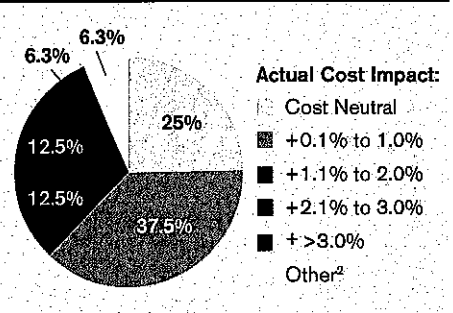
"HMO trend rate projections for 2014 are a full percentage point lower than HMO projections from just four years ago."

The survey also looked for regional variations in trend rates. Projected 2014 trend rates for PPO and POS plans combined show regional variations, with the lowest rate of 5.8 percent in the South and highest rate of 10.0 percent in the West.

"For the first time, Segal asked insurers to indicate 2014 expected medical PPO cost trends by group size. Results indicate that individual and small groups will trend approximately 1 percentage point higher than large group plans."

For the first time, Segal asked insurers to indicate 2014 expected medical PPO cost trends by group size. Results indicate that individual and small groups will trend approximately 1 percentage point higher than large group plans.

Graph 1: Projected Cost Impact on 2014 Plan Trend of Implementing Preventive Care Coverage for Plans That Lost Their Grandfathered Status by Percentage of Survey Respondents[1]



[1] This data reflects responses from 16 of the health insurers, MCOs and TPAs that participated in the survey. Total exceeds 100% due to rounding.

[2] The survey did not collect data on what the respondents meant by "other."

Impact of Losing "Grandfathered" Status

Segal asked the survey respondents about the expected impact of the Affordable Care Act on costs. Survey findings indicate nearly two-thirds of respondents project a cost increase of 1 percent or less due to loss of "grandfathered" status,[3] with one-quarter of the respondents predicting the loss of grandfathered status will be cost neutral, as shown in Graph 1 above. Only 6 percent of survey respondents anticipate that implementing preventive care coverage for plans that lost their

What Is Trend?

Trend is a forecast of per capita *claims cost increases* that takes into account various factors, such as price inflation, utilization, government-mandated benefits, and new treatments, therapies and technology. Although there is usually a high correlation between a trend rate and the actual cost increase assessed by a carrier, trend and the net annual change in plan costs are *not* the same. Changes in the costs to plan sponsors can be significantly different from projected claims cost trends, reflecting such diverse factors as group demographics, changes in plan design, administrative fees, reinsurance premiums and changes in participant contributions.

[3] Group health plans in existence as of March 23, 2010, when the Affordable Care Act was signed into law, and that remain largely unchanged from that date are grandfathered.

grandfathered status under the Affordable Care Act will result in a cost trend increase of more than 3 percent.

Trend Components

The survey also examined 2014 projected medical trends by service type. Table 2 presents that data. Similar to prior-year projections, price inflation remains the largest component of cost increases and continues high for hospital services and brand-name medications. For prescription drugs, price inflation is projected to jump more than 1 percentage point compared to 2013 forecasts. On the other hand, the projected specialty drug/biotech trend rate, while very high at 16.5 percent, is almost 1 full percentage point lower than the 2013 projection.

In 2014, the utilization component of trend for hospital services is projected to remain unchanged at 2.2 percent. Two noteworthy results supporting lower overall trend rates are the modest price inflation for physician services (3.7 percent) and the flat prescription drug utilization rate. However, the continued upswing in generic dispensing rates based on brands losing patent protection is likely to begin leveling off.

"Price inflation remains the largest component of cost increases."

Accuracy of 2012 Projections

To assess the accuracy of the reported projections, Segal compared the average 2012 trend *forecasts* by national and regional insurers, MCOs, PBMs and TPAs for group medical, prescription drug benefit and dental plans to the *actual* average trend rates experienced by the health plans covered by those organizations for the same 12-month period, as reported by survey respondents. Actual trends for 2012 (the most recent full year for which actual data is available), were the lowest reported in more than 12 years.

Consistent with previous survey findings, this year's findings support our observation that insurers and PBMs tend to make conservative projections and confirm that forecasted trends have been generally higher than actual experience. The following are the most notable findings about the accuracy of trend projections based on the data shown in Table 3:

- The survey found a significant spread of nearly three percentage points between actual and projected trends for high-deductible health plans (HDHP), open-access PPOs/point-of-service (POS) plans for actives and retirees,

"The projected specialty drug/biotech trend rate, while very high at 16.5 percent, is almost 1 full percentage point lower than the 2013 projection."

Table 2: Components of 2013 & 2014 Projected Trends for Hospital Services, Physician Services and Prescription Drugs

	Hospitals[1]		Physicians[1]		Rx	
	2013	2014	2013	2014	2013	2014
Total Trend[2]	8.7%	8.6%	6.8%	6.0%	6.3%	6.4%
Trend Component						
Price Inflation	6.4%	6.3%	3.9%	3.7%	8.4%	6.8%
Utilization	2.2%	2.2%	2.8%	2.3%	0.2%	0.7%

[1] Hospital and physician trends are for open-access PPOs.

[2] The components do not add up to the totals because there are other components of trend not illustrated, reflecting such factors as the impact of cost shifting, technology changes and drug mix. Not all survey respondents provided a breakdown of trend by component.

Table 3: Comparison of 2012 Projected Trends to 2012 Actual Trends

	Projected	Actual
Medical (Actives & Retirees <Age 65)	(without Rx)	
FFS/Indemnity Plans	11.7%	10.0%
HDHPs	10.4%	7.7%
Open-Access PPOs/ POS Plans	10.0%	7.3%
PPOs/POS Plans (with PCP Gatekeepers)	10.4%	8.4%
HMOs	9.6%	6.7%
Medical (Retirees Age 65+)	(without Rx)	
MA PPO[1]	N/A	0.4%
MA HMOs	6.6%	3.0%
Rx Carve-Out[2] (Actives & Retirees <Age 65)	7.2%	5.5%
Rx Carve-Out[2] (Retirees Age 65+)	6.5%	2.2%
Dental		
Scheduled Plans	4.1%	2.9%
FFS/Indemnity Plans	4.2%	2.8%
DPOs	3.8%	2.6%
DMOs	4.4%	3.4%
Vision		
Scheduled Plans	3.8%	2.3%
R&C Plans	3.9%	2.9%

[1] For 2012, the survey asked for Medicare Supplement (Medigap) trends and MA HMO trends for retiree medical post-65. It did not ask for MA PPO trend rate information.

[2] The 2012 survey captured prescription drug carve-out data for retail and mail-order delivery channels combined.

PPOs/POS plans with a physician gatekeeper *and* HMOs for the active and retiree under 65 population.

- For prescription drugs, the differential between actual and forecasted trend rates was more than double for retirees age 65 and older than for actives and retirees under 65: 4.3 percentage points compared to 1.7 percentage points.

Table 4 shows selected trends (actual trends for 2002–2012 and projected trends for 2013 and 2014).

It should be noted that the accuracy of projections is subject to both underwriters' conservatism in predicting future events and a natural lag in the underwriting cycle. In periods where costs are decelerating, forecasters will tend to overestimate trends. Similarly, when costs are accelerating, trend projections will generally be underestimated for a period. Consequently, accuracy of trend assumptions is best measured by comparing projected trend to actual trend over multiple years. Graphs 2 and 3 illustrate the significant but declining variances between trend forecasts versus actual trends experienced in 2008 and 2009.

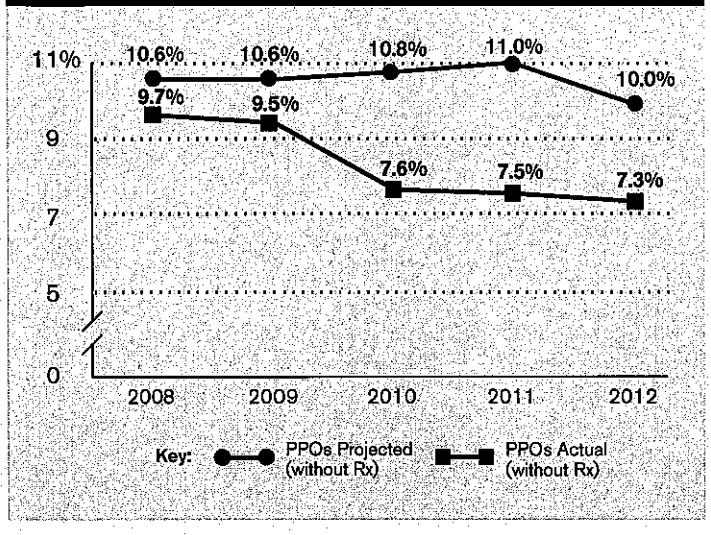
Table 4: Selected Medical, Rx Carve-Out and Dental Trends: 2002-2012 Actual and 2013 and 2014 Projected*

Year	PPOs (without Rx)	POS Plans (without Rx)	HMOs (without Rx)	MA HMOs (without Rx)	Rx	DPOs
2002 Actual	13.9%	12.2%	12.8%	12.9%	18.4%	6.4%
2003 Actual	12.0%	11.5%	11.5%	10.0%	14.3%	6.5%
2004 Actual	10.9%	11.6%	11.5%	11.4%	13.3%	6.2%
2005 Actual	10.4%	11.1%	10.6%	8.4%	10.5%	5.0%
2006 Actual	9.6%	10.0%	10.2%	7.2%	9.5%	5.1%
2007 Actual	8.9%	9.5%	9.8%	7.0%	7.9%	5.0%
2008 Actual	9.7%	9.4%	9.7%	7.7%	7.4%	5.5%
2009 Actual	9.5%	9.7%	10.2%	4.0%	7.9%	4.7%
2010 Actual	7.6%	8.3%	8.7%	3.6%	6.4%	3.0%
2011 Actual	7.5%	7.8%	8.0%	4.5%	5.0%	3.1%
2012 Actual	7.3%	8.4%	6.7%	3.0%	5.5%	2.6%
2013 Projected	8.8%	9.3%	8.2%	5.8%	6.4%	3.5%
2014 Projected	7.9%	8.4%	7.2%	3.3%	6.3%	3.4%

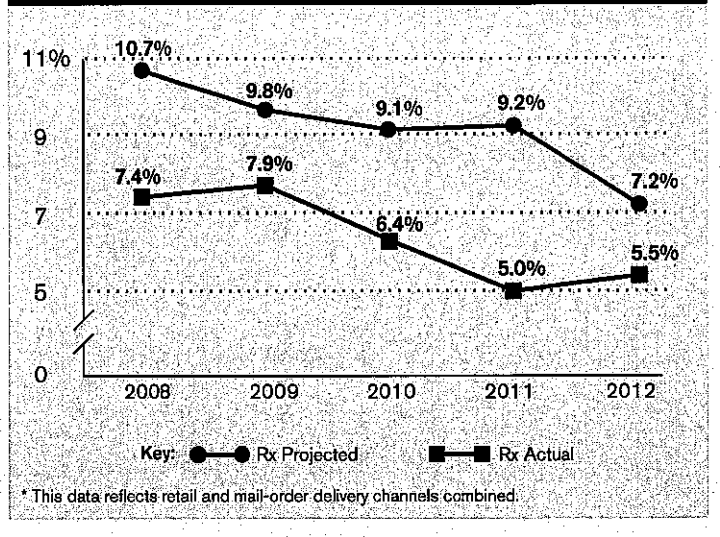
* All trends are illustrated for actives and retirees under age 65, except for the MA Plans. (A graph comparing 13 years of survey data — 2013 and 2014 projected trends to actual trends for 2002 through 2012 — is available on the following page of Segal's website: http://www.segalco.com/publications/surveysandstudies/2014TSsupp.pdf)

"The accuracy of projections is subject to both underwriters' conservatism in predicting future events and a natural lag in the underwriting cycle. In periods where costs are decelerating, forecasters will tend to overestimate trends."

Graph 2: Comparison of Projected to Actual Trends for PPOs for Actives and Retirees under Age 65: 2008–2012



Graph 3: Comparison of Projected to Actual Trends for Rx* Carve-Out Coverage for Actives and Retirees under Age 65: 2008-2012



* This data reflects retail and mail-order delivery channels combined.

Segal also asked the survey participants to indicate the top five major diagnostic categories (MDC) that had the highest actual cost trends in 2012. Table 5 shows the results, from highest to lowest, by rank in 2012 compared to rank in 2011.

In this year's survey, Segal asked the respondents to indicate the medical management strategies that are most effective in reducing medical plan cost trends based on their experience. Responses indicate that the most effective and widely used strategy is care management and specialty case management programs, such as those that focus on acute care, chronic care and oncology care. Another successful cost-containment option reported by survey respondents is the management of hospital admissions and readmissions using tools such as redirecting hospital outpatient services and overseeing inpatient admissions.

"Although it remains to be seen whether the deceleration in trends projected for 2014 has been influenced by short-term economic forces, the influence of the Affordable Care Act or some other factor not yet identified, there continue to be significant changes in the health care delivery system that could have long-term implications for health care costs."

Commentary & Outlook

Although it remains to be seen whether the deceleration in trends projected for 2014 has been influenced by short-term economic forces, the influence of the Affordable Care Act or some other factor not yet identified, there continue to be significant changes in the health care delivery system that could have long-term implications for health care costs. Some of these changes are noted below:

- Many plan designs now include greater levels of participant out-of-pocket costs.
- Provider reimbursement arrangements are beginning to shift from the fee-for-service model to alternative payment models, such as bundled payments, which are designed to encourage providers to coordinate care and reward efficiency.
- The Hospital Readmissions Reduction Program, which requires CMS to reduce payments to hospitals with excess readmissions, has helped to reduce overall hospital spending by including comprehensive strategies for discharge planning, medication management, and continuum of care.
- Participants are becoming more educated consumers through programs such as Choose Wisely, which lists five questions patients should discuss with physicians about medical tests and procedures that may be unnecessary (and, in some instances, can cause harm) and the Five-Star Quality Rating System created by CMS to help consumers compare how nursing homes' quality of care and services vary.
- Costs are becoming more transparent. A growing number of health insurers have invested heavily in new member-support decision tools that provide more information on health treatment costs. There are also publically available transparency tools, such as Hospital Compare (CMS-published data on what providers charge for common services, which shows significant variation across the country at over 4,000 Medicare-certified hospitals) and Fair Health, an independent not-for-profit

"The most effective and widely used strategy [for reducing medical plan cost trends] is care management and specialty case management programs, such as those that focus on acute care, chronic care and oncology care."

Table 5: Top Five Major Diagnostic Categories (MDC) with Highest PMPY Cost Trends in 2012 Compared to 2011

	Rank	
	2012	2011
Diseases and disorders of the digestive system	1	2
Diseases and disorders of the musculoskeletal system and connective tissue	2	1
Pregnancy, childbirth and the puerperium*	2	3
Diseases and disorders of the circulatory system	3	2
Diseases and disorders of the nervous system	3	Not in Top 5
Lymphatic, hematopoietic and other malignancies	4	3
Infectious and parasitic diseases, systemic or unspecified sites	4	Not in Top 5

*"Puerperium" is the period of adjustment after childbirth during which the mother's reproductive organs return to their non-pregnant state.

corporation with a web portal that allows consumers to access a medical cost transparency database for determining out-of-network reimbursement.

- Plan sponsors are encouraging participants to seek care for minor illnesses at lower-cost settings, such as telemedicine and walk-in clinics.
- There is growing use of Patient-Centered Medical Homes (PCMH), which focus an increased level of comprehensive health care resources on primary care and prevention for patients with chronic conditions. Also, as Accountable Care Organizations (ACOs)[4] and PCMHs expand, they will offer new options for plan sponsors.
- Reference-based pricing, in which the plan makes a defined contribution towards covering the cost of a particular service, to steer participants towards higher-quality hospitals or physicians for specific procedures or conditions (*e.g.*, the California Public Employees' Retirement System's use of maximum allowance for hip and knee replacement), is expanding.
- Network provider contracting is being improved to remove high-cost outlier providers who cannot prove their value.

While medical plan cost trend continues to decelerate, overall health plan costs are still on the rise. Faced with this reality, plan sponsors are becoming increasingly more progressive and creative in their efforts to manage costs while delivering high-quality, cost-effective health care. Plan sponsors must be ready to implement new requirements introduced by the Affordable Care Act[5] and to determine their impact on plan costs. Plan sponsors will need to play an active role to continue to get the most for their benefit dollars.

"While medical plan cost trend continues to decelerate, overall health plan costs are still on the rise."

■ ■ ■

For assistance with health care cost management strategies, contact your Segal consultant or the nearest Segal office. A list of Segal offices can be accessed from the second hyperlink in the blue box below.

[4] ACOs, which have mainly been developed for the Medicare population, are networks of providers and suppliers that agree to be jointly accountable for managing the health of participating populations across the care continuum.

[5] New guidance on the Affordable Care Act is released on a regular basis. As guidance is issued, it is summarized in Segal publications. All of Segal's publications on the Affordable Care Act can be accessed from the Health Care Reform Guide on the Segal website: http://www.segalco.com/publications-and-resources/health-care-reform/

The Survey Participants

The 2014 *Segal Health Plan Cost Trend Survey* was conducted in May and June of 2013. Survey participants were asked to provide the trend factors they will be applying to historical claims to predict expected claims for 2014. Segal received 99 responses to the survey. The following participants agreed to disclose their names: Aetna; Amalgamated Life; Amerihealth of New Jersey; Anthem Blue Cross and Blue Shield; Anthem Blue Cross of California; Arkansas Blue Cross and Blue Shield; Assurant Employee Benefits; Benecard; Blue Cross and Blue Shield of Illinois; BlueCross and BlueShield of Tennessee; Blue Cross Blue Shield of Michigan; Capital District Physician's Health Plan; Care Plus Dental Plans; Catamaran; CIGNA; ConnectiCare, Inc.; CVS Caremark; Delta Dental of Arizona, Delta Dental of Arkansas; Delta Dental Insurance Company (DDIC); Delta Dental of California; Delta Dental of Colorado; Delta Dental of Delaware; Delta Dental of the District of Columbia; Delta Dental of Idaho; Delta Dental of Illinois; Delta Dental of Indiana; Delta Dental of Kansas; Delta Dental of Massachusetts; Delta Dental of Michigan; Delta Dental of Minnesota; Delta Dental of Nebraska; Delta Dental of New Mexico; Delta Dental of New York; Delta Dental of North Carolina; Delta Dental of Ohio; Delta Dental of Pennsylvania; Delta Dental of Tennessee; Delta Dental of Virginia; Delta Dental of West Virginia; Delta Dental of Wisconsin; EmblemHealth; Envision Pharmaceutical Services; Excellus Health Plan, Inc.; Express Scripts, Inc.; Health Alliance Medical Plans; Health Net, Inc.; Horizon Blue Cross Blue Shield of New Jersey; Humana, Inc.; Independence Blue Cross; ING; Kaiser Foundation Health Plan; Lincoln Financial Group; Medical Mutual; Moda Health; MVP Health Care; Navitus Health Solutions; Nippon Life Insurance Company of America; OptumRx; Restat; The ODS Companies; Trustmark Life; Tufts Health Plan; UnitedHealthcare; United Concordia; and US Script.

Segal Consulting

To receive survey reports and other Segal Consulting publications as soon as they are available online, register your e-mail address via Segal's website: www.segalco.com/register/

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Health Care Reform

Timeline for Calendar-Year Group Health Plans

January 1, 2013

- **Women's preventive services** (for non-grandfathered plans, effective for plan year beg. on/after August 1, 2012)
- **Health FSA salary reduction** limited to $2,500 per year (effective for plan year beg. on/after Jan. 1, 2013, indexed annually)
- **Medicare Part A payroll tax: Employers** deduct and withhold employees' additional Medicare hospital taxes on annual wages that exceed $200,000 for individuals ($250,000 for married couples)
- Tax exclusion of **Medicare Part D retiree drug subsidy eliminated**
- **Medical Device Fee** starts (annual fee)
- **W-2 reporting** on the value of employer-sponsored coverage for 2012 (Jan. 2013)

February 2013

Employers prohibited from discriminating or retaliating against an employee who reports a violation of the Affordable Care Act or receives a premium assistance tax credit in a Health Insurance Exchange

July 2013

Comparative Effectiveness Research Fee/ PCORI: first year fee is $1 per covered life. For 2012 plan year, return/fees due by July 31, 2013. Fee sunsets after the 2018 plan year

October 1, 2013

- **Open enrollment for Health Insurance Exchanges begins for individuals and small employers**
- **Deadline for employers to send notice regarding Exchanges and premium assistance tax credits to current employees. Employers must begin sending the notice to new employees within 14 days of their start date**

Fall 2013

Summary of Benefits and Coverage (SBC) (first distributed with open enrollment beg. on/after Sept. 23, 2012) **Now must distribute with any enrollment opportunity (such as fall open enrollment) and upon request; provide 30 days before start of plan year if no open enrollment**

January 1, 2014

- **Health Insurance Exchange** coverage begins for individuals and small employers; premium assistance tax credits available to certain low-income individuals
- **Employer Shared Responsibility Penalty** begins to apply (Delayed)
- **Individual Mandate starts,** requiring individuals to obtain minimum essential coverage or pay a personal income tax penalty; 2014 penalty is the greater of $95/adult or 1% of taxable income
- **Medicaid expansion to 133% of Federal Poverty Level (at state option)**
- **Group health plan standards for all plans** (effective for plan year beg. on/after Jan. 1, 2014): ban on waiting periods that exceed 90 days, ban on annual dollar limits on essential health benefits, ban on pre-existing condition limitations (regardless of age), **wellness incentives can be raised from 20% to 30% (up to 50% for smoking cessation programs)**
- **Group health plan standards for non-grandfathered plans** (effective for plan year beg. on/after Jan. 1, 2014): cost-sharing limits, coverage relating to routine patient costs associated with approved clinical trials, provider nondiscrimination and protection of employees
- **Health Insurance Provider Fee** starts (annual fee)
- **W-2 reporting** on the value of employer-sponsored coverage for 2013 (Jan. 2014)

2013 2014

Effective Dates to be Determined in Regulations

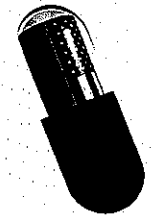
- **Quality reporting** (for non-grandfathered plans, awaiting guidance)
- **Nondiscrimination rules for insured plans** (for non-grandfathered plans, awaiting guidance)
- **Certify compliance with HIPAA EDI standards and operating rules** (awaiting guidance)

Later in 2014

- **Comparative Effectiveness Research Fee/PCORI** rises to $2 per covered life (return/fees due by July 31, 2014)
- **Temporary Reinsurance Program Fee** ($63/covered life for 2014) Fee sunsets after 2016
- **Use Early Retiree Reimbursement Program (ERRP)** reimbursement monies by end of 2014
- **Deadline for certain amendments to cafeteria plan documents (Dec. 31, 2014)**

July 15, 2013

Segal Consulting



Health Care Reform

Timeline for Calendar-Year Group Health Plans

January 2015

- **Individual Mandate Penalty** is the greater of $325/adult or 2% of taxable income
- **Employer Shared Responsibility Penalty** begins
- Employer Reporting to IRS on 2014 coverage offered to full-time employees, whether minimum essential coverage offered, number of months of coverage, etc. This includes **employer reporting to employees by Jan. 31, 2015** (Delayed)
- **W-2 reporting** on the value of employer-sponsored coverage for 2014 (Jan. 2015)

Later in 2015

- **Comparative Effectiveness Research Fee/ PCORI** continues (return/fees due by (July 31, 2015)
- Temporary Reinsurance Program Fee continues, with national per capita rate for 2015 set in 2014

2016

- **Individual Mandate Penalty** is the greater of $695/adult or 2.5% of taxable income
- **Employer Shared Responsibility Penalty** continues
- Employer Reporting to IRS on 2015 coverage (to employees by Jan. 31, 2016)
- **W-2 reporting** on the value of employer-sponsored coverage for 2015 (Jan. 2016)
- **Comparative Effectiveness Research Fee/PCORI** continues (return/fees due by July 31, 2016)
- Temporary Reinsurance Program Fee continues (final year), with national per capita rate for 2016 set in 2015

2017

- **Individual Mandate Penalty** is the greater of $695 (indexed)/adult or 2.5% of taxable income
- Exchanges may permit **large employers** to purchase Exchange coverage
- **Employer Shared Responsibility Penalty** continues
- Employer Reporting to IRS on 2016 coverage (to employees by Jan. 31, 2017)
- **W-2 reporting** on the value of employer-sponsored coverage for 2016 (Jan. 2017)
- **Comparative Effectiveness Research Fee/PCORI** continues (return/fees due by July 31, 2017)

2018

- **40% Excise Tax** on health plans that cost above $10,200 (single) and $27,500 (family), indexed to the CPI-U
- **Individual Mandate and Employer Shared Responsibility Penalties** continue
- Employer Reporting to IRS on 2017 coverage (to employees by Jan. 31, 2018)
- **W-2 reporting** on the value of employer-sponsored coverage for 2017 (Jan. 2018)
- **Comparative Effectiveness Research Fee/PCORI** (return/fees due by July 31, 2018) Fees for 2018 plan year due by July 31, 2019

2015 | 2016 and beyond

Effective Dates to be Determined in Regulations

- Auto-enrollment of new hires (not expected to become effective until after 2014)
- Reporting related to transparency in coverage (for non-grandfathered plans, not sooner than 2015)

July 15, 2013

Segal Consulting

Bulletin

Benefits, Compensation and HR Consulting

November 2013

For 2014, Increases in Some IRS Dollar Limits and Social Security Figures

This *Bulletin* reports indexed Internal Revenue Service (IRS) and Social Security figures for 2014 that are of interest to retirement plan sponsors. It also includes the 2014 Pension Benefit Guaranty Corporation (PBGC) premium increases and single-employer guarantee limit.

IRS RETIREMENT PLAN LIMITS

The 2014 IRS dollar limits for qualified plans and other tax-favored retirement plans are determined using the Consumer Price Index (CPI) data released on October 30, 2013. Because of rounding rules, the CPI increase of 1.2 percent over the 12 months that ended September 30, 2013, will cause only some of the IRS dollar limits to increase in 2014. The press release is on the following page of the IRS website: http://www.irs.gov/uac/Newsroom/In-2014,-Various-Tax-Benefits-Increase-Due-to-Inflation-Adjustments. The table below compares the 2014 limits to the 2013 limits.

SOCIAL SECURITY BENEFITS

In 2014, Social Security benefits will increase by 1.5 percent. A fact sheet on this cost-of-living adjustment and other 2014 Social Security changes is on the Social Security Administration (SSA) website: http://www.ssa.gov/pressoffice/factsheets/colafacts2014.pdf. The table on the next page compares the 2014 figures to the 2013 figures.

PBGC PREMIUMS AND GUARANTEE LIMIT

On November 6, 2013, the PBGC released the 2014 premium increases. The flat-rate, per-participant PBGC premiums for 2014 will be $12 for multiemployer plans (unchanged from 2013) and $49 for single-employer plans

IRS RETIREMENT PLAN LIMITS

	2013	2014
Maximum Annual §415 Payout at Age 62 from a Defined Benefit Plan[1]	$205,000	**$210,000**
Maximum Annual Addition to an Individual's Defined Contribution Account under §415(c)	51,000	**52,000**
Maximum Elective §401(k) and §403(b) Deferrals	17,500	**Unchanged**
Deferral Limit for §457(b) Plans	17,500	**Unchanged**
§401(k) and §403(b) Catch-Up Limit for Individuals Age 50 and Older	5,500	**Unchanged**
Maximum Amount of Annual Compensation that Can Be Taken into Account for Determining Benefits or Contributions under a Qualified Plan	255,000	**260,000**
§414(q) Test to Identify Highly Compensated Employees	115,000	**Unchanged**
Cost-of-Living Adjustment (COLA) factor for the 100%-of-Pay Limit under §415[2]	1.70%[3]	**1.55%**[4]

[1] There are late-retirement adjustments for benefits starting after age 65.

[2] This limit does *not* apply to multiemployer plans.

[3] The 2013 factor was for participants who separated from service before 1/1/13.

[4] The 2014 factor is for participants who separate from service before 1/1/14.

SOCIAL SECURITY BENEFIT TESTS AND LIMITS

	2013	2014
Wage Base: a) for Social Security Tax b) for Medicare	$113,700 No Limit	**$117,000** **No Limit**
COLA Increase	1.7%	**1.5%**
Social Security National Average Wage Index[1]	$42,979.61 (for 2011)	**$44,321.67** **(for 2012)**
Primary Insurance Amount (PIA) Formula:[2] a) First Bend Point b) Second Bend Point	 $791 $4,768	 **$816** **$4,917**
Maximum Social Security Benefit at Social Security Normal Retirement Age (SSNRA)[3]	$2,533/ Month	**$2,642/** **Month**
Earnings Test — Early Retirement (Age 62) (Amount that Can Be Earned before Benefits Are Cut)[4]	$15,120/ Year	**$15,480/** **Year**

[1] This amount is not tied to the CPI, but rather to earnings as reported to the SSA. The 2012 average and background can be found on the following page of SSA's website: http://www.ssa.gov/oact/cola/AWI.html.

[2] PIA formula "bend points" are updated each year to reflect changes in the National Average Wage Index. The 2014 bend points can be found on the following page of the SSA's website: http://www.ssa.gov/oact/cola/piaformula.html.

[3] The maximum Social Security benefit at SSNRA is not tied to the CPI. It is based on the PIA formula (reflecting updated bend points) where a worker's earnings are at the maximum taxable amount for his or her career. For workers born in 1943-1954, the SSNRA is age 66. For information on how SSNRA varies by birth year, see the following page of SSA's website: http://www.ssa.gov/OACT/ProgData/nra.html.

[4] In the year of attaining SSNRA, the early retirement earnings test is higher. In 2014, it will be $41,400/year ($3,450/month), up from $40,080/year ($3,340/month) in 2013. After attaining SSNRA, individuals can receive their full benefits regardless of how much they earn.

(up from $42 in 2013). The variable-rate premium for single-employer plans, which is indexed, will increase to $14 per $1,000 of unfunded vested benefits for 2014 (up from $9 in 2013). The per-participant cap on the variable-rate premium will increase to $412 in 2014 (up from $400 in 2013). The 2014 premium rates are noted on the following page of the PBGC website: http://www.pbgc.gov/prac/prem/premium-rates.html.

The PBGC's multiemployer benefit guarantee is not indexed.* On November 6, 2013, the PBGC also released its monthly maximum guarantee for participants in single-employer pension plans that terminate during 2014, which will increase to $4,943.18 per month ($59,318.16 annually) at age 65 from $4,789.77 per month ($57,477.24 annually) in 2013. The press release is on the following page of the PBGC website: http://www.pbgc.gov/news/press/releases/pr13-13.html.

* There is no dollar limit on the monthly benefit payable under the multiemployer program, only a limit on the benefit rate used to calculate the monthly benefit. PBGC guarantees 100% of the first $11 of the benefit accrual rate and 75% of the next $33 for a maximum guaranteed benefit accrual rate of $35.75. Thus, for a participant with 30 years of service, the maximum annual benefit is $12,870. For additional information, see the following page of the PBGC website: http://www.pbgc.gov/prac/multiemployer/multiemployer-benefit-guarantees.html.

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If you would like additional information about any of these items, please contact your Segal consultant or the Segal office nearest you.

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Survey

Benefits, Compensation and HR Consulting SPRING 2013

Survey of Calendar-Year Plans' 2013 Zone Status

A solid majority of calendar-year multiemployer pension plans — 61 percent — are in the green zone[1] in 2013, according to Segal Consulting's *Survey of Calendar-Year Plans' 2013 Zone Status*. Although this percentage represents a slight decline from 2012 (62 percent) and 2011 (66 percent), it is significantly higher than it was in 2010 (54 percent) and dramatically higher than in 2009 (39 percent).

One reason for the improvement since 2010 is the ongoing strengthening of the investment markets. Segal Rogerscasey (the SEC-registered investment solutions member of The Segal Group) reports that the average Taft-Hartley pension fund annualized market return for the nearly four years from April 1, 2009 (the bottom of the market) to December 31, 2012, was 13.4 percent, significantly exceeding multiemployer plan investment return assumptions, which, of course, from an actuarial perspective is a relatively short time frame. Further, trustees' specific rehabilitation efforts based on the provisions of the Pension Protection Act of 2006 (PPA'06) gave multiemployer pension plan trustees the ability to make changes necessary to strengthen struggling plans.

Despite the small decline in the percentage of calendar-year plans in the green zone, an overwhelming majority of plans in the survey (97 percent) do not anticipate a solvency problem over the next seven years. This is significant because insolvency — the inability to pay benefits — within seven years is one of the criteria for determining red-zone status. Many red-zone plans have minimized the likelihood of a future insolvency by taking advantage of the ability to adjust benefits.

While there is reason for some optimism, the survey shows that multiemployer plans are still facing funding challenges. Ongoing recognition of earlier losses triggered by the 2008/early 2009 market downturn and exacerbated by the concurrent recession continues to have a negative impact on the funded status of many plans.[2]

"A solid majority of calendar-year multiemployer pension plans – 61 percent – are in the green zone. ...This percentage...is significantly higher than...in 2010...and dramatically higher than in 2009."

Zone Status

Details about the change in calendar-year plans' zone status follow:

➤ ***For 2013, 61 percent of calendar-year plans are in the green zone.*** As noted at the beginning of this report, this represents a decline from 2012 and 2011 and is higher than 2010 and 2009. This is still short of 83 percent, the percentage of plans in the green zone as of January 1, 2008, prior to the market downturn that began in late 2008.

➤ ***The percentage of calendar-year plans in the yellow zone is the same for 2013 as for 2012: 11 percent.*** This is similar to the 2008 survey, when 10 percent were in the yellow zone.

➤ ***The percentage of calendar-year plans in the red zone increased by one percentage point between 2012 and 2013.*** For 2013, 28 percent of calendar-year plans are in the red zone, up from 27 percent in 2012. This is in sharp contrast to 2008, when only 7 percent of the surveyed plans were in the red zone.

In last year's survey of calendar-year plans, 13 percent of the plans that were certified as green were projected to migrate into the yellow or red zone. Data from this year's survey indicates that 2.2 percent (five plans) did change status from green to red or

About the Survey

The survey data is based on actual certifications for more than 220 calendar-year multiemployer plans (all of which are Segal clients) that represent a wide range of industries from across the country with combined assets of more than $85 billion. The certifications took into account any changes in plan design, employment outlook, negotiated contribution rates and investment performance through the end of 2012.

[1] The text box on the last page provides background on the zones.

[2] Plans that elected funding relief in 2010 under the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PRA 2010) extended the impact of 2008-2009 investment losses up to the following 10 years. More than one-half of the plans in this survey continue to extend the impact of these losses. For plans that did not elect relief under PRA 2010, the impact of investment losses was more immediate. For more information on the pension funding relief provisions of PRA 2010, see Segal's July 2010 *Bulletin*, "Temporary Pension Funding Relief for Multiemployer Plans": http://www.segalco.com/publications/bulletins/july2010relief.pdf

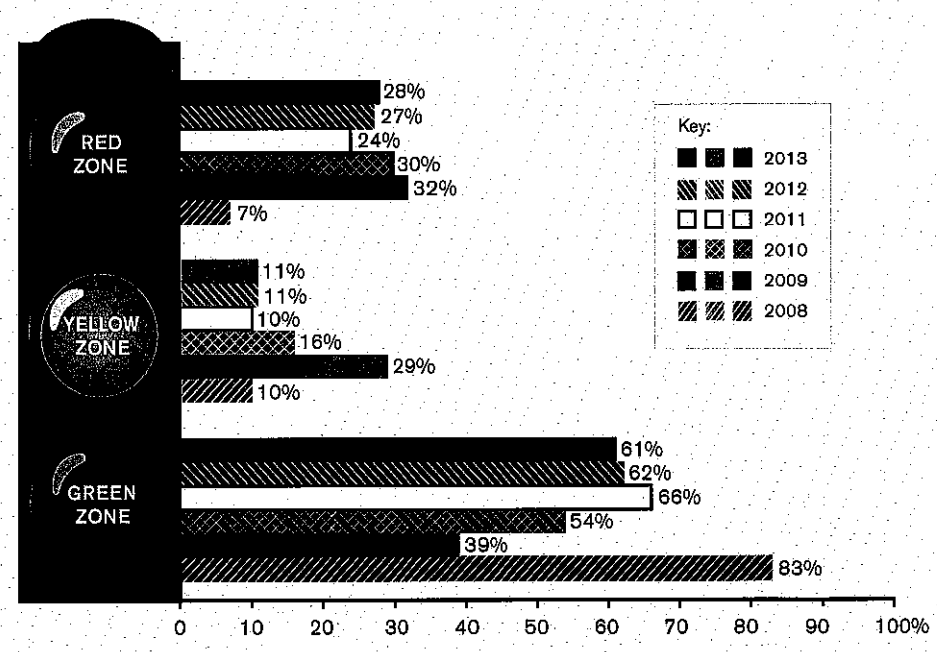
yellow since the last survey; 1.3 percent (three plans) changed status from yellow to red; and 1.8 percent (four plans) improved their status from yellow or red to green.

Graph 1 shows how the zone-status breakdown of calendar-year plans changed from 2008 to 2013.

The survey results show a few industry differences in the calendar-year plans' zone status. Notably, for 2013, the construction industry has the greatest percentage of plans in the green zone (70 percent), with the entertainment industry close behind (62 percent). The service industry has a slightly greater percentage of green-zone plans for 2013 than for 2012. The retail trade and food industry has the greatest percentage of red-zone plans for 2013 (55 percent) with transportation close behind (52 percent). See Graph 2.

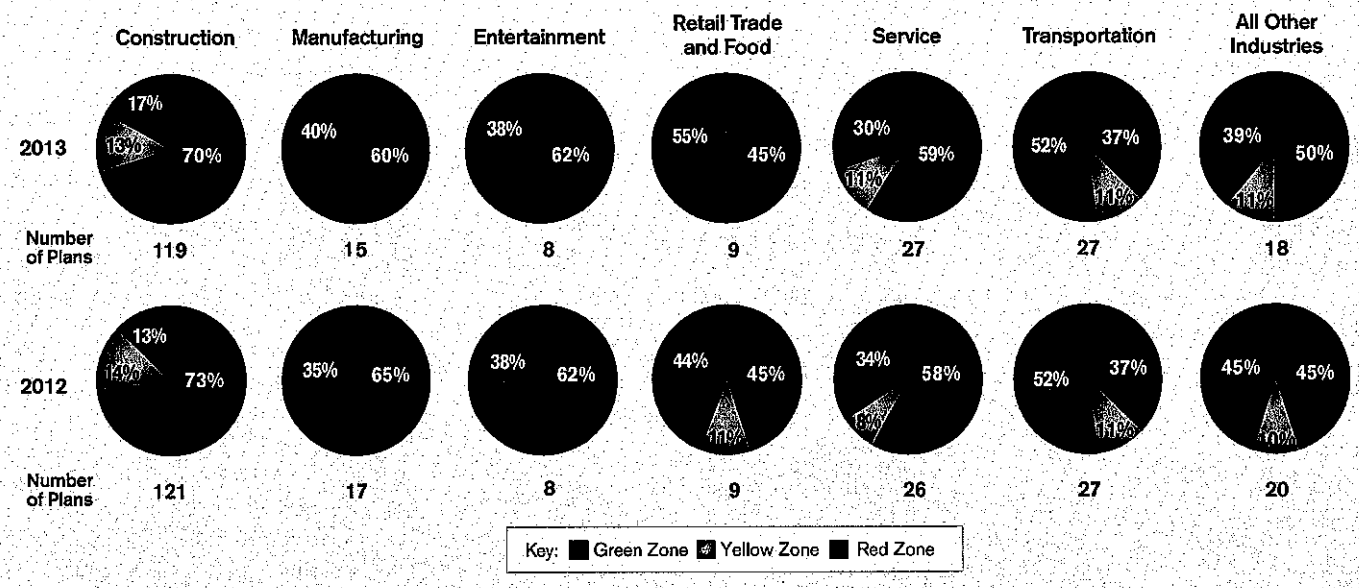
"The survey results show a few industry differences in... zone status."

Graph 1: Breakdown of Calendar-Year Plans' 2013, 2012, 2011, 2010, 2009 and 2008 Zone Status by Percentage of Plans in Each Zone*



* For each year, the zone-status breakdown is based on calendar-year plans' certifications, which were due by the end of March and reflect investment performance through the end of the prior year. For example, the 2013 survey data is based on certifications that were due by the end of March 2013, reflecting investment performance through December 31, 2012. Reports of results from all of Segal's zone-status surveys can be accessed from the following page of Segal's website:
http://www.segalco.com/publications-and-resources/multiemployer-publications/surveys-studies/

Graph 2: Industry Breakdown of Calendar-Year Plans' 2013 and 2012 Zone Status by Percentage of Plans in Each Zone



Note: An online supplement to this survey report, which includes graphs showing the zone-status breakdown of plans by plan assets and number of participants, is available on the following page of Segal's website: http://www.segalco.com/publications/surveysandstudies/spring2013zonesupp1.pdf

PPA'06 Funded Percentage

The average PPA'06 funded percentage[3] for the plans in the survey is 85 percent, almost the same as the 2012 survey figure of 86 percent. The average PPA'06 funded percentage for 2013 is still lower than the average for the 2008 survey (97 percent). The PPA'06 funded percentage is based on the "actuarial asset value" for each plan, which does not reflect all of the market gains and losses each year.

"The average PPA'06 funded percentage for the plans in the survey is 85 percent."

About 22 percent of the plans in the survey have a PPA'06 funded percentage of 100 percent or more. (In 2012, 21 percent of the plans in the survey had a PPA'06 funded percentage of 100 percent or more.) The bars in Graph 3 show a breakdown of plans in the survey by their 2013 PPA'06 funded percentage. The small pie charts indicate the zone status for the plans in each funded percentage range. Together, both sets of data illustrate that there is not always a direct correlation between the PPA'06 funded percentage and zone status. It is important to remember that no single measurement is sufficient for an actuary to determine a plan's zone status under PPA'06.

"It is important to remember that no single measurement is sufficient for an actuary to determine a plan's zone status under PPA'06."

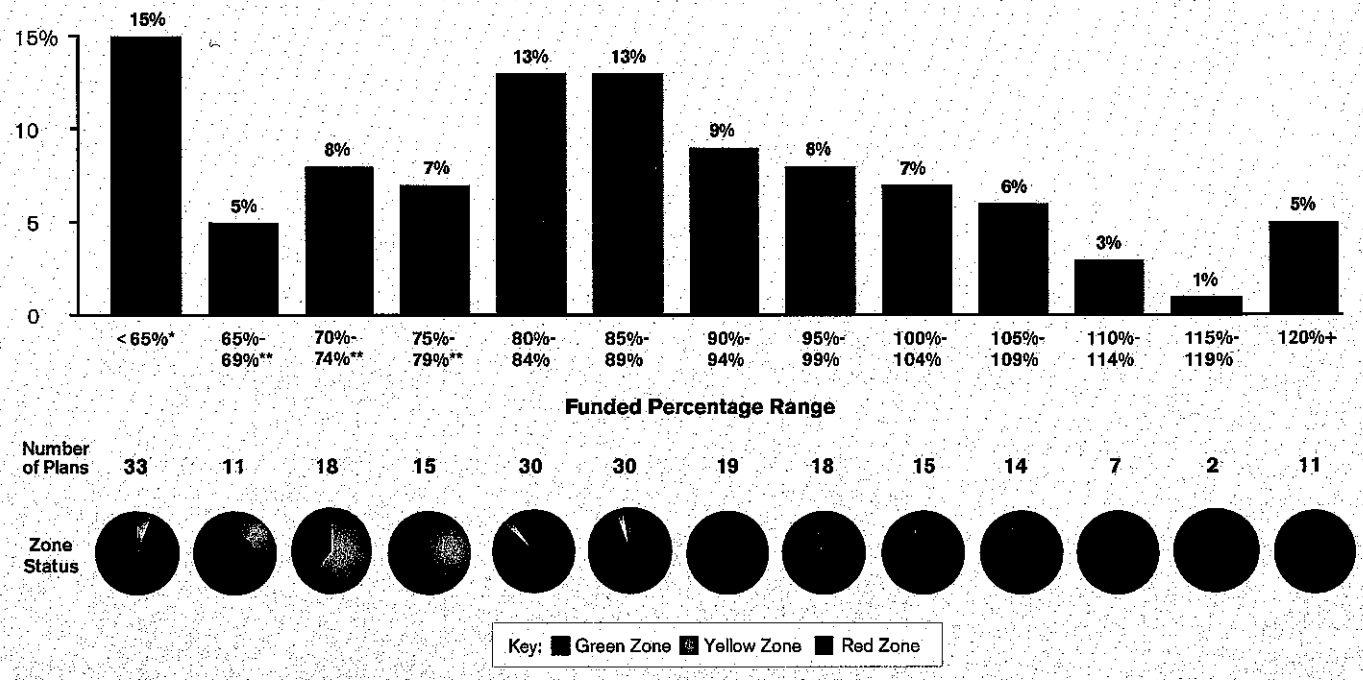
Commentary and Outlook

The outlook for improved funding status remains challenging, given that many employers and unions in the industries represented in this survey cannot predict when they may return to pre-recession employment levels. Although continued market performance volatility underscores the need for ongoing vigilance, positive market returns since the downturn are a bright spot. For example, 2012 was a relatively good investment year in which performance improved dramatically in the third and fourth quarters and the average market-value rate of return for the calendar year was almost 11 percent for all plans in the survey. Another bright spot: 91 percent of the red- or yellow-zone plans that are now in their rehabilitation or improvement period reported meeting scheduled progress defined in their RP or FIP.[4]

[3] The PPA'06 funded percentage is based on a ratio of assets to the actuarial present value of accrued benefits, measured using the plan actuary's funding assumptions and the plan's actuarial asset valuation method.

[4] RPs and FIPs are defined in "The Zones" text box on the next page.

Graph 3: Percentage, Number and 2013 Zone Status of Calendar-Year Plans by PPA'06 Funded Percentage Range



*This funded percentage threshold is important because it is one of the criteria for determining red-zone status.

**A funded percentage less than 80 percent is one of the criteria for determining yellow-zone status.

The Zones

Under the funding provisions of PPA'06, trustees must review projections of the financial status of multiemployer plans at least annually in order to identify emerging funding challenges so they can be addressed effectively. The plan's actuary must prepare a certification no later than 90 days after the beginning of the plan year. For example, if the plan year began on January 1, 2013, the certification was required by March 29, 2013 (rather than March 31, since March 31 fell on a Sunday).

If the actuary's projections reveal an emerging funding problem, a plan will be classified as being in either "endangered status" (nicknamed the yellow zone) or "critical status" (nicknamed the red zone). In either case, the trustees and bargaining parties generally will be required to take specific actions to improve the plan's financial status.*

Plans with a certified funding status that is neither endangered nor critical are considered to be in the "green zone."

Although PPA'06 does not require that these plans take any particular action, trustees of green-zone plans need to continue to pay attention to all of the funding indicators that were important prior to PPA'06, in addition to the new PPA'06 measurements, in order to monitor and manage their plans' financial condition effectively.

The "zone" certification rules created by PPA'06 are scheduled to expire ("sunset") for plan years beginning after December 31, 2014. However, if a pension plan is operating under a Funding Improvement Plan (FIP) or a Rehabilitation Plan (RP) for its last plan year beginning in 2014, the plan shall continue to operate under that FIP or RP during the period the FIP or RP remains in effect. All provisions of the Internal Revenue Code and the Employee Retirement Income Security Act relating to the operation of the FIP or RP also will remain in effect during that period.**

* The criteria for an emerging funding problem are summarized in an online supplement to this survey report, which is available on the following web page: http://www.segalco.com/publications/surveysandstudies/spring2013zonesupp2.pdf

** For more information about FIPs and RPs, see Segal's August 2006 *Bulletin*, "Pension Protection Act of 2006's Key Multiemployer Plan Provisions": http://www.segalco.com/publications/bulletins/aug06PPAmulti.pdf

The results of the *Survey of Calendar-Year Plans' 2013 Zone Status* highlight how important it is for trustees to understand their plans' vulnerability to risks, such as investment risk (*i.e.*, the volatility of returns), employment risk (*i.e.*, an employment level that falls short of expectations) and longevity risk (*i.e.*, increased life expectancy), so that appropriate preemptive or corrective actions can be considered.[5] To assess a plan's vulnerability to risks, it can be helpful for trustees to consult their advisors for answers to questions like the following:

- For plans in the green zone, to what degree can investment strategies mitigate the near-term probability of falling out of that zone without materially harming the longer-term financial health of the plan?
- For yellow-zone or red-zone plans, how much of an effect will changes in investment strategies, or contribution rate increase, make?

For trustees that need to continue to consider actions to improve the funding status of their plans, options might include benefit changes, trustees recommending changes in contribution rates to the bargaining parties and changes to the investment policy.

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Consultants and actuaries from Segal Consulting, together with investment consultants from Segal Rogerscasey, can be of assistance in developing the appropriate strategies for maintaining and enhancing benefit security. Segal has developed Forecast, a dynamic asset-liability modeling tool that allows trustees to analyze future scenarios using real-time modeling.

For additional information, contact your Segal consultant or one of the following experts:

- *Phillip A. Romello*
  202.833.6441
  promello@segalco.com
- *Susan Lee*
  212.251.5184
  slee@segalco.com

[5] See Segal's February 2009 *NewsLetter*, "Multiemployer Defined Benefit Plans in a Time of Crisis: Keeping a Long-Term Perspective": http://www.segalco.com/publications/newsletters/feb2009.pdf

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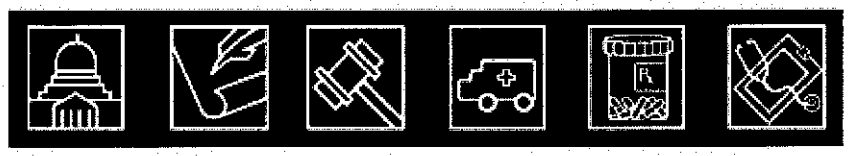

CAPITAL CHECKUP

October 31, 2013

2014 Medicare Premiums, Deductibles and Coinsurance

The Centers for Medicare & Medicaid Services (CMS) has announced the Medicare Part A and Part B premiums, deductibles and coinsurance paid by beneficiaries.[1] These amounts take effect on January 1, 2014.

The standard monthly Part B premium and the Part B deductible will be unchanged from 2013. The Part B dollar amounts are shown in the first two rows of the table below.

The Part A numbers will increase by less than 3 percent. See the last rows in the table below.

The table also shows the base Part D beneficiary premium that CMS announced in July, which will increase slightly to $32.42 per month.[2] Next year will mark the fourth straight year that the average Medicare Part D monthly premium will remain relatively steady.

Cost-Sharing Requirement	2013	2014
Standard Monthly Part B Premium*	$104.90	**$104.90**
Medicare Part B Deductible	$147.00	**$147.00**
Base Part D Beneficiary Premium**	$31.17	**$32.42**
First-Day Part A Hospital Deductible***	$1,184.00	**$1,216.00**
Daily Part A Coinsurance for the 61st through 90th Day of a Hospital Stay****	$296.00	**$304.00**

Daily Part A Coinsurance for Hospital Stays Longer than 90 Days	$592.00	**$608.00**
Daily Part A Coinsurance for the 21st through 100th day in a Skilled Nursing Facility	$148.00	**$152.00**

* Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment and other items. The monthly Part B premium varies for high-income enrollees, as noted in the chart below.

** The actual premium paid by a Medicare beneficiary for a Part D Prescription Drug Plan will vary due, in part, to the type of plan he or she selects. Factors could include the amount of the deductible, the level of coverage through the coverage gap ("donut hole") and the range of covered drugs in the plan's formulary. For more information about the "donut hole," see the chart in Segal Consulting's April 11, 2013 *Capital Checkup*, "2014 Medicare Part D Amounts Will Be Lower than 2013 Amounts," which is available as both a web page and a printer-friendly PDF.

*** Part A pays for inpatient hospital, skilled nursing facility, hospice and certain home health care services.

**** There is no cost-sharing requirement for the 2nd through 60th day of a hospital stay.

Higher Part B and Part D Premiums for the Affluent

Since 2007, as required in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, high-income Medicare-eligible individuals who enroll in the Part B program have been required to pay a monthly Part B premium that is higher than the standard premium. It varies depending upon enrollees' modified adjusted gross income and income tax filing status. All of the income adjusted Part B premium rates will be the same in 2014 as in 2013. The third column of the table below shows the income-related monthly Part B premiums.

There is also an income-related monthly adjustment for enrollees in Part D prescription drug plans, which started in 2011. The Affordable Care Act[3] requires Part D enrollees whose incomes exceed the thresholds established for Part B to pay their regular Part D premium to their plan (that amount will vary based on the plan they choose) and also pay an income-related adjustment to Medicare. The last column of the following table shows the 2014 income-related monthly adjustment amounts, which were announced in July, and represent increases of around 4 percent.[4]

Income Ranges by Tax Filing Status		**Monthly Adjustment Amount**	
Individual Return*	**Joint Return**	**Part B Premium**	**Part D Premium**
$85,001 to $107,000*	$170,001 to $214,000	$42.00	$12.10
$107,001 to $160,000*	$214,001 to $320,000	$104.90	$31.10
$160,001 to $214,000	$320,001 to $428,000	$167.80	$50.20
$214,000+	$428,001+	$230.80	$69.30

* Married beneficiaries with income in 2014 of more than $85,000 and less than or equal to $129,000 who file a separate return from their spouse *and* lived with their spouse at some time during the taxable year must pay the following monthly premium adjustment in 2014: $167.80. (The Part D monthly adjustment for these couples will be $50.20.) Married beneficiaries with income in 2014 of more than $129,000 who file a separate return from their spouse *and* lived with their spouse at some time during the taxable year must pay the following monthly premium adjustment in 2014: $230.80. (The Part D monthly adjustment for these couples will be $69.30.)

Implications for Plan Sponsors

Plan sponsors that pay the Medicare Part B premium or deductible should carefully review their plan documents and communications to assure that they are accurately stating the amount that the plan intends to pay. For example, plans that simply promise to pay the "Part B deductible" or the "Part B premium" may want to set that payment at a fixed amount or maximum, so that it does not increase automatically. In addition, if the plan has participants who are subject to income-based higher rates, then it is important that the plan language is specific about how much of the Part B premium the plan pays. If the plan language is vague regarding the amount that the plan will pay, costs could inadvertently increase when premiums begin to rise again, and could rise substantially in any year if the plan has participants subject to income-based indexing.

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As with all issues involving the interpretation or application of laws, health plan sponsors should rely on their legal counsel for authoritative advice on the integration of Medicare with their health benefit plans. Segal can be retained to work with plan sponsors on their retiree health coverage.

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1 The CMS announcements of the 2014 numbers were published in the October 30, 2013 issue of the *Federal Register*: (Part B) and (Part A). (Return to the *Capital Checkup*.)

2 The base premium was announced by the Office of the Actuary. (Return to the *Capital Checkup*.)

3 The Affordable Care Act is the abbreviated name for the new health care reform law, the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-48, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-52. (Return to the *Capital Checkup*.)

4 The announcement is available on the CMS website. (Return to the *Capital Checkup*.)

Capital Checkup is Segal Consulting's periodic electronic newsletter summarizing activity in Washington with respect to health care and related subjects. *Capital Checkup* is for informational purposes only and should not be construed as legal advice. It is not intended to provide guidance on current laws or pending legislation. On all issues involving the interpretation or application of laws and regulations, plan sponsors should rely on their attorneys for legal advice.

Back

Segal Consulting

NewsLetter

Benefits, Compensation and HR Consulting SEPTEMBER 2013

How to Talk to Participants About the Affordable Care Act

All group health plan participants have already received some mandated communications about the Affordable Care Act,[1] such as a Summary of Benefits and Coverage (SBC),[2] but there is a need for additional information before October, when the Health Insurance Marketplaces (also known as Exchanges) will "open" for enrollment. It is nearly impossible to read a newspaper, watch the news or listen to talk radio without hearing about the Affordable Care Act and the Marketplaces. Moreover, health insurance companies are starting to advertise their "products" and some are even opening up storefront shops and mall kiosks to sell their coverage to the public.

Most multiemployer health fund participants may not feel the need to pay any attention to this barrage of messages because they have medical and prescription drug coverage through their plan. However, as the amount and frequency of information about the Marketplaces increase, they may have questions about their current benefits and, based on what they are hearing from these other sources, may be led to think that they need to purchase coverage through a Marketplace when, in reality, the coverage provided by the fund is better and, in most cases, fully meets their individual obligation under the Affordable Care Act.

This *NewsLetter* explains why now is the time for trustees and administrators of multiemployer health plans to communicate with plan participants and their families about the Affordable Care Act in general and the Marketplaces in particular.

Clear Up the Confusion

According to a Kaiser Family Foundation (KFF) survey, there is considerable confusion about the Affordable Care Act.[3] For example, the survey found that:

- More than four in 10 Americans (42 percent) are unaware that the Affordable Care Act is still the law.
- Twelve percent believe the law has been repealed by Congress.
- Seven percent believe it has been overturned by the Supreme Court.
- About half of Americans feel that they do not have enough information about the Affordable Care Act to understand how it will affect their own families.

The survey found that Americans are getting their information about health care reform from multiple sources: friends and family (40 percent), newspapers, radio or other online news (36 percent) and cable news (30 percent). Participants will also be hearing from others, as noted in the text box below.

IN THIS ISSUE:

Who Else is Talking to the Fund's Participants?

Under the Affordable Care Act, employers are required to send out certain communications to their employees, including one notice entitled "New Health Insurance Marketplace Coverage Options and Your Health Coverage." This notice is intended to inform employees of the existence of the Marketplaces and to provide information about how they will work. Employers must send the notice to current employees by October 1, 2013. New hires must receive the notice at the time of hire, starting October 1, 2013. The notice must inform employees of coverage options under the Marketplaces.

Employers may turn to the fund office for guidance in completing this notice. Even if the fund office is not directly involved with these notices, it is important that fund staff know what the participants will be receiving before the notices are sent. That is because the fund office will likely be the first place that participants call with questions about the notices since they are used to hearing about their benefits exclusively from the fund.

[1] The Affordable Care Act is the abbreviated name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-148, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152.

[2] Current and forthcoming required Affordable Care Act communications are discussed in the August 2013 issue of Segal Consulting's *Health Care Reform Insights*: http://www.segalco.com/publications/HCRI/aug2013ME.pdf

[3] That April 2013 poll is available on the following page of the KFF website: http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-april-2013/

Major news about the Affordable Care Act can cause confusion for participants especially when the news has almost no practical impact on them. An example is the delay of the law's employer shared responsibility payment, announced in July 2013, which was widely covered in the media and may have given an erroneous impression that the Affordable Care Act in general is on hold. Clearly, fund offices, which have built credibility with participants over the years as a reliable source of benefits-related information, can play a role in getting the facts straight. Trustees of multiemployer plans that choose *not* to educate participants about the Marketplaces will allow others to control the message and permit misinformation to work its way into the conversation.

Develop a Game Plan

Trustees of multiemployer plans should develop a communications strategy that covers everything from the basics about the law and the Marketplaces to how the plan coverage compares with Marketplace offerings. This section presents an overview of this approach.

Tell Participants How the Affordable Care Act Affects Them

Trustees who have been communicating about the Affordable Care Act may only need to provide a recap. Others may want to explain what the law means in more detail. While the law is complicated, communications should focus on the aspects that have the greatest impact on participants (*e.g.*, expanded coverage of preventive services).

"Trustees of multiemployer plans should develop a communications strategy that covers everything from the basics about the law and the Marketplaces to how the plan coverage compares with Marketplace offerings."

What is a Marketplace?

To help people meet the individual mandate, private health insurance companies will start selling insurance through the Health Insurance Marketplaces on October 1, 2013.

Some states will create and run their own Marketplace; some will partner with the federal government to run their Marketplace; and others will opt out and allow the U.S. Department of Health and Human Services (HHS) to run the Marketplace for their residents. Up-to-date information about the Marketplaces is available from www.healthcare.gov.

U.S. citizens and legal residents can purchase coverage through a Marketplace. However, those with access to adequate and affordable health insurance through their employment, their spouse or another government program are not eligible for the premium tax credits and cost-sharing subsidies provided through the federal government.

"For many multiemployer plans, participants will continue to receive their medical and prescription drug benefits from the plan and, consequently, will not need to worry about the Marketplaces at all. This is a key message to convey. Trustees should not be silent just because nothing is changing."

Explain the Marketplaces

The concept of public Marketplaces may be difficult, but how trustees and administrators communicate about the Marketplaces need not be complicated. First, it is important to describe the relationship between the Marketplaces and compliance with the law's individual mandate requirement.[4]

An explanation of what the Marketplaces are (as discussed in text box above) should include the rules for possibly getting coverage through a Marketplace, as well as those for getting a subsidy from the government for purchasing coverage through the Marketplace. Participants can be directed to the federal and state websites and other resources about the Marketplaces.

Describe What the Fund Is Doing

The next step is to explain how the Marketplaces will or will not affect the coverage participants receive through their health plan. For many multiemployer plans, participants will continue to receive their medical and prescription drug benefits from the plan and, consequently, will not need to worry about the Marketplaces at all. **This is a key message to convey.** Trustees should not be silent just because nothing is changing.

An important message for trustees of plans that are continuing to provide medical and prescription drug benefits to participants is that their benefits are more than adequate and affordable under the Affordable Care

[4] The "individual mandate" will take effect in 2014. It means that everyone needs to have health insurance coverage or face a fine. They can have health insurance coverage from their (or their spouse's) employment, through a policy they buy on their own, or through a government-sponsored program like Medicare or Medicaid. (People who have lower incomes will be eligible for assistance.)

Act — and that is the case for most multiemployer plans. Most multiemployer plans offer coverage that is more comprehensive and less expensive than the Marketplace options.

In situations where some workers (*e.g.*, certain part-time workers) will be getting their medical and prescription drug coverage through a public Marketplace, it is critical that participants receive a clear explanation of any change, when it will take effect, the enrollment process, the role that the fund, the union and the contributing employers will play in this process and where the participants can go for more help. And, so long as the coverage meets the requirements under the Affordable Care Act, plan participants would not be eligible for a subsidy in the public Marketplace.

Retirees present a special challenge for trustees, because they will also receive confusing communications about the Marketplaces. While Medicare-eligible retirees may see few changes as a result of the Marketplaces, pre-Medicare retirees may have new choices available to them for health coverage. These choices need to be described to those with existing fund coverage so that they understand their options for receiving their health coverage.

If participants or their family members will be shopping for coverage on the Marketplaces, trustees may want to develop a "buying guide" to help those individuals evaluate their options. The guide can explain the factors that participants should take into account when deciding on coverage (*e.g.*, network size, premium amounts, and benefits and coverage levels).

"Retirees present a special challenge for trustees, because they will also receive confusing communications about the Marketplaces."

"Another way to show the value of fund coverage is to compare the fund's medical and prescription drug benefits with the plans that will be offered through the Marketplace — as well as a comparison of the monthly premiums for each."

It will also be very important to explain whether or not participants are eligible for tax subsidies should they purchase coverage through the Marketplaces.

Remind Participants about the Value of Fund Benefits

Regardless of whether the trustees intend to make changes to the plan, this is an opportunity to remind participants of the full package of benefits that they receive from the fund besides medical and prescription drug coverage (*e.g.*, dental, vision, disability, life and accident insurance coverage).

Not only are these other benefits important to the participants, the fund's comprehensive benefits package is something that sets it apart from the plans that will be offered through the Marketplace. The Marketplace plans will generally be limited to medical and prescription drug coverage.

Another way to show the value of fund coverage is to compare the fund's medical and prescription drug benefits with the plans that will be offered through the Marketplace — as well as a comparison of the monthly premiums for each. Here, communications can explain the platinum, gold, silver and bronze Marketplace plans. While it is not necessary to go into a lot of detail about what these categories mean, the communications can show which category would apply to their benefits plan. The majority of multiemployer benefit funds provide comprehensive benefit packages with little or no participant contributions to monthly premiums (beyond what employers contribute on their behalf), so their collectively bargained and multiemployer benefits package will generally be more all-inclusive and cost-effective than the Marketplace options. As the state Marketplaces come "online" later this year, it will be important for trustees to explain these comparisons to their participants.

"By communicating strategically and regularly, trustees and administrators can explain the information in bite-sized, easy-to-digest pieces."

Reach the Fund's Audience

Although it can be tempting to try to explain everything at once, communications professionals know from experience that people are better able to absorb complex information that they receive gradually. By communicating strategically and regularly, trustees and administrators can explain the information in bite-sized, easy-to-digest pieces. They can start with high-level explanations and then drill down into the finer points. This kind of phased approach to communicating will allow the trustees and administrators to set expectations and let participants know what is coming and when.

Participants and their families are most likely to be receptive to information that speaks *directly* to them. A conversational tone and real-life

examples are both invaluable ways to ensure that the trustees' messages are truly "heard."

Segal also recommends that trustees and administrators take advantage of the different media that are available. Not everyone absorbs information the same way. Some like to read; some want to watch a video; others may appreciate a face-to-face explanation; and some may want to access the information online. It is important to know the participants and how they want to receive their information.

It is also important to take more than one approach: have meetings; send out an e-mail, text message or Tweet; put the information on the plan's website; create a video; mail the information to participants' homes; and use the fund, employer (when possible) and union staff to reinforce the message. This type of coordinated approach will help reach fund participants in the ways that they will best absorb it — but with a single, consistent message.

"Even though the communications requirements that the Affordable Care Act is imposing on fund offices may take a lot of work and time, it is important to think of them as opportunities to enhance communication with participants and to consider and implement new ways of communicating."

Conclusion

Even though the communications requirements that the Affordable Care Act is imposing on fund offices may take a lot of work and time, it is important to think of them as opportunities to enhance communication with participants and to consider and implement new ways of communicating. The trustees can reinforce the value of benefits, promote a wellness program or upcoming event like a health fair, or educate participants about the right time to go to the emergency room or about the importance of using in-network providers. It is an opportunity for the trustees and the fund office staff to educate, motivate and engage participants.

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For more information about or assistance with participant communications about the Affordable Care Act, contact your Segal benefits consultant or Joshua Meyer at 212.251.5400 or jmeyer@segalco.com

Does the Fund Have Benefits Enrollment Coming Up?

The Marketplaces will hold the first open enrollment beginning on October 1, 2013 (and thereafter annually from October 15 through December 7). Some multiemployer plans also hold annual enrollment, which is the perfect time to tell participants about their benefits in 2014, as well as to describe any plan changes that the fund is making (some as a result of the Affordable Care Act). It is also the opportunity to tell participants what they need to know and do to make the most of their coverage in 2014.

With all of the information about Marketplaces, participants will have questions about how the Marketplaces are going to fit in with their fund-provided benefits. Even if the fund started communicating over the summer, it will be important to re-explain the Marketplaces and what they mean for participants again in the fund's enrollment materials.

If some or all participants will be getting their medical and prescription drug benefits from the Marketplaces, the fund will have to explain the Marketplace enrollment process as well as the enrollment process for the participants' other fund-provided benefits.

Segal Consulting

To receive *NewsLetters* and other Segal Consulting publications of interest to sponsors of multiemployer plans as soon as they are available online, register your e-mail address via Segal's website: www.segalco.com

For a list of Segal's 22 offices, visit www.segalco.com/about-us/contact-us-locations/

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Stat! Health Reform News

Welcome to **Stat! Health Reform News**. On this page, Segal provides highlights of recent health care reform developments.

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July 3, 2013

Employer Penalty Under the Affordable Care Act Will Not Take Effect Until 2015

On July 2, 2013, the Treasury Department announced that it is delaying until 2015 the employer shared responsibility payments that were to have started in 2014. In a statement on the Treasury Department's website, the Assistant Secretary for Tax Policy stated that formal guidance on this transition relief will be released within the next week.* In addition to delaying the effective date of the employer penalty, Treasury is also delaying by one year detailed reporting requirements for employers and insurers that would have applied to coverage provided during 2014. Treasury still expects to publish proposed rules on those reporting requirements this summer, so that Treasury has plenty of time to consider stakeholder feedback before issuing final reporting standards.

This transition relief does not apply to any other provisions of the Affordable Care Act, including the employer Notice about the health insurance Exchanges (now called Marketplaces by the federal government) or the individual mandate. The relief did not address the existing transition rule for contributing employers to multiemployer plans under the employer penalty proposed regulations.

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As with all issues involving the interpretation or application of laws, regulations and judicial decisions, plan sponsors should rely on their attorneys for authoritative advice on the Affordable Care Act. Segal Consulting can be retained to work with plan sponsors and their attorneys on all compliance issues related to health care reform.

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* The statement is available on this web page: http://www.treasury.gov/connect/blog/Pages/Continuing-to-Implement-the-ACA-in-a-Careful-Thoughtful-Manner-.aspx

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COMPLIANCE ALERT

June 4, 2013

DOL Seeks Input on Required Disclosure of Estimated Annuity Value of Account Balances

On June 27, 2013, in response to requests for more time in which to respond to the request for comments discussed in this *Compliance Alert*, the DOL announced in a press release an extension of the comment deadline from July 8, 2013 to August 7, 2013.

The Department of Labor (DOL) has issued an Advance Notice of Proposed Rulemaking (Notice) asking for comments on possible rules that would require defined contribution (DC) plans — commonly annuity plans, but including profit-sharing plans and §401(k) plans — to provide benefit statement estimates of the monthly annuity that each participant's account balance could buy.[1] Comments are due on or before July 8, 2013.

Background

DC plans covered by the Employee Retirement Income Security Act (ERISA) are required to provide participants with benefit statements, quarterly for participant directed plans and annually for others. The content of these statements is prescribed by regulations that do not require information about the estimated monthly annuity amount that the account balance could purchase. In the past, the DOL has encouraged DC plans to include this estimated amount on a voluntary basis. However, for various reasons (including participant confusion, possible litigation risks and administrative cost), few plans have done so. The Notice is the first step in developing rules that would require disclosure of estimated annuity amounts, including safe harbors to address plan concerns.

The Notice is a product of a joint initiative between the DOL and the Department of the Treasury (Treasury) that has a goal of encouraging plan sponsors to offer, and participants to elect, benefit payment options that provide lifetime income. In 2010, the agencies put out a request for information (RFI) on how to encourage lifetime income streams which included several questions related to showing DC plan account balances as estimated lifetime income streams The content of this Notice is in large part the DOL's response to the opinions, suggestions, concerns and other information it received in answer to those questions.[2]

The Suggested Proposal

The DOL's suggested proposal would require DC plans to include in the quarterly and annual benefit statements the estimated monthly annuity that a participant's current and projected account balance would buy. The estimated monthly annuity amount would be determined using specified conversion methods and either specified "safe harbor" assumptions provided in the regulations or other "reasonable" assumptions selected by the plan.

Under the suggested proposal, the method for calculating each of the estimates is as very generally described below:

- ***Current Account Estimate*** The suggested conversion method for determining the current monthly annuity amount would assume that the participant had reached the plan's normal retirement age (NRA) at the time of the statement and, using the participant's current account balance, would calculate the immediate monthly annuity amount based on the assumptions used by the plan (either safe harbor or reasonable).
- ***Projected Account Estimate***: The suggested conversion method for determining the projected annuity amount also would assume that the participant had reached NRA at the time of the statement and also would calculate the immediate monthly annuity amount based on the assumptions used by the plan, but instead of using the participant's current account balance, would use an estimated NRA account balance projected using plan assumptions (safe harbor or reasonable) as to continuing contributions, earnings and inflation.

If a participant was married at the time of the statement, the monthly annuity amounts would be presented as a "joint and survivor" amount as well as a "single life" amount. If a participant had reached NRA at the time of the statement, no projected estimate would be required.

The safe-harbor assumptions suggested in the Notice for conversion purposes are an interest rate equal to the 10-year constant maturity Treasury securities rate and the mortality table used for lump-sum payments under Internal Revenue Code §417(e)(3). The assumptions suggested for projection purposes are continuing contributions increased by 3 percent per year, investment returns of 7 percent per year (nominal); and a discount rate of 3 percent per year (for expressing projected amounts in current dollars).

As part of the Notice, the DOL has developed an interactive, online calculator that can be used to show the annuities that would be provided under the safe-harbor assumptions suggested in the Notice.[3]

Considerations for Plan Sponsors

The DOL clearly recognizes that there are many issues involved in requiring plans to provide these estimates and, as a result, the Notice asks for comments on virtually every aspect of the proposal, including the following:

- The impact of a particular "reasonable assumption" standard on stochastic modeling,
- Whether a lower projection interest rate assumption (*e.g.*, 5 percent for nominal) would encourage better retirement planning, and
- Whether there are cheaper or more effective means of providing this information to participants.

While the idea of requiring ERISA-covered DC plans to disclose an estimated monthly annuity amount is still taking shape, various indicators point to definite agency interest in providing this information. These indicators include the often expressed and well-founded concerns on the part of both DOL and Treasury about the retirement readiness of American workers, and about the challenges of relying on DC plans for lifetime income. DC plan sponsors, therefore, will want to take this opportunity to consider how a disclosure requirement like this might affect them and consider whether they should submit a comment by the July 8, 2013 deadline. Segal consultants are available to help clients in thinking through these issues.

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As with all issues involving the interpretation or application of laws and regulations, plan sponsors should rely on their attorneys for authoritative advice on the DOL's proposed required disclosures. Segal can be retained to work with plan sponsors and their attorneys on comments to the DOL.

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1 The DOL's Notice was published in the May 8, 2013 *Federal Register*. (Return to the *Compliance Alert*.)

2 Information about the RFI, copies of the more than 700 comments received and transcripts of related hearings are available on the DOL's website. (Return to the *Compliance Alert*.)

3 The calculator is available on the DOL website. (Return to the *Compliance Alert*.)

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SEGAL Bulletin

Benefits, Compensation and HR Consulting

April 2013

GAO Report to Congress on Multiemployer Pension Plans Recommends Timely Action on Structural Reforms

On April 8, 2013, the Government Accountability Office (GAO) released to the public a report it prepared for Congress on multiemployer pension plans, *Private Pensions: Timely Action Needed to Address Impending Multiemployer Plan Insolvencies*.[1] The report notes:

> Despite unfavorable economic conditions, most multiemployer plans are currently in adequate financial condition and may remain so for many years. However, a number of plans, including some very large plans, are facing very severe financial difficulties. Many of these plans reported that no realistic combination of contribution increases or allowable benefit reductions — options available under current law to address their financial condition — will enable them to emerge from critical status. As a result, without Congressional action, the plans face the likelihood of eventual insolvency.

Consequently, the GAO recommends that Congress "consider comprehensive and balanced structural reforms to reinforce and stabilize the multiemployer system" taking into account "the relative burdens" of each reform option to key stakeholders. The report notes:

> The scope and severity of the challenges outlined by stakeholders suggest that a broad, comprehensive response is needed and Congress faces difficult choices in responding to these challenges. ... Nevertheless, this situation can also be viewed as an opportunity both to protect the benefits of hundreds of thousands of older Americans and stabilize a pension system that has worked fairly well for decades.

[1] The 66-page report (GAO-13-240), which was delivered on March 28, 2013 to the House of Representatives' Committee on Education and the Workforce, is available on the following page of the GAO website: http://www.gao.gov/assets/660/653383.pdf

Referring to Pension Benefit Guaranty Corporation (PBGC) reports on multiemployer plans published earlier this year,[2] the GAO observes that the PBGC generally agreed with its findings and analysis.

THE GAO'S OBJECTIVES

The GAO sought to examine (1) actions taken by multiemployer plans in the weakest financial condition to improve their long-term financial position; (2) the extent to which multiemployer plans have relied on PBGC assistance since 2009 and the prospective financial condition of the PBGC's multiemployer plan insurance program; and (3) options for enhancing the program's future financial stability.

The GAO analyzed government and industry data, including Segal's surveys, which it supplemented by interviews with 13 multiemployer plans[3] and relevant research, including proposals by the National Coordinating Committee on Multiemployer Plans (NCCMP).[4] In addition, the GAO interviewed stakeholders,[5] government officials, academics, actuaries (including actuaries from Segal) and attorneys who have pension expertise.

THE GAO'S FINDINGS

Actions to Improve Plans' Financial Position

The GAO concluded:

> The most severely distressed multiemployer plans have taken significant steps to address their funding

[2] That report (http://www.pbgc.gov/documents/pbgc-report-multiemployer-pension-plans.pdf) was discussed in The Segal Company's February 2013 *Bulletin*: http://www.segalco.com/publications/bulletins/feb13PBGC.pdf

[3] Of these plans, eight were in critical status, according to criteria established by the Pension Protection Act of 2006; two were in endangered or seriously endangered status; and three plans were in neither critical nor endangered status.

[4] The NCCMP recommendations (http://www.nccmp.org/forEmails/SolutionsNotBailouts.pdf) were summarized in Segal's March 2013 *Bulletin* (http://www.segalco.com/publications/bulletins/march13NCCMP.pdf) and were discussed in more detail in Segal's April 2013 *In Depth* (http://www.segalco.com/publications/indepths/april2013NCCMP.pdf).

[5] Stakeholders included trustees, plan administrators, contributing employers, employer trade associations and participating unions.

problems and, while most plans expected improved financial health, some did not. ...[T]he large majority of the most severely underfunded plans…either have increased or will increase employer contributions or reduce participant benefits. In some cases, these measures will have significant effects on employers and participants.

PBGC's Financial Assistance to Multiemployer Plans and Its Implications

The GAO observes that the PBGC's financial assistance to multiemployer plans has increased significantly since 2009, primarily because of plan insolvencies, which threaten the multiemployer insurance fund's ability to pay pension guarantees for retirees.[6] The GAO reports:

> PBGC officials said that financial assistance to plans that are insolvent or are likely to become insolvent in the next 10 years would likely exhaust the insurance fund within the next 10 to 15 years.

The GAO also noted that about 25 percent of plans in critical status face eventual insolvency.

Options to Address the Impending Funding and PBGC Crises

The GAO refers to and analyzes the following policy options proposed by experts and/or stakeholders:

- ***Permit reduction of accrued benefits.***[7] Although this dramatic step would only be allowed for plans likely to become insolvent, the GAO points out that it "would not occur without considerable sacrifice and may not be sufficient to help some plans avoid insolvency." The GAO observes that reducing accrued benefits could impose significant hardships on some retirees and notes that some experts suggested that federal financial assistance may be needed "to mitigate the impact on participants."

- ***Provide financial assistance to keep plans and the insurance fund solvent.*** Plan insolvencies could be diminished by PBGC financial assistance to more PBGC-blessed plan partitions, though this increases the likelihood that outside federal funding will be needed to keep the PBGC program itself from becoming insolvent; such assistance would be difficult in light of the already strained federal budget.

- ***Allow flexible plan designs.*** The GAO notes that trustees could be allowed to adjust future benefits based on such factors as the plan's funded status, investment returns or demographics. Design options include those described in the NCCMP Commission report as "target benefit" and "variable annuity" plans.

- ***Change withdrawal liability[8] policy.*** Changes might include increasing the amount of assets plans can recover in bankruptcy or encouraging employers to either remain in or join multiemployer plans.

- ***Promote mergers and alliances.***[9] The PBGC, which already approves mergers to ensure that the resulting, merged plan will be stronger than the individual plans being merged, could play a more active role to promote mergers and alliances, including possibly providing financial assistance. The GAO notes that the cost the PBGC would incur "to facilitate such arrangements may be more than offset by preventing the plan from becoming insolvent."

OUTLOOK

The new GAO report, which closely follows the PBGC and NCCMP reports released earlier this year, may help fuel Congressional interest in reforming the laws affecting multiemployer plans. Congressman John Kline (R-MN) Chairman of the House of Representatives' Committee on Education and the Workforce, who requested the GAO report, said it is a "stark reminder" of the significant challenges facing the multiemployer pension system and "the need for structural reform to improve its long-term stability."

■ ■ ■

Segal can be retained to work with trustees who want to contact Congress with suggestions for strengthening the PBGC's multiemployer program and for new legislation to help plans improve their funded position.

[6] The number of plans on the PBGC's "contingency list" of multiemployer plans that are likely to become insolvent and make a claim to its multiemployer insurance program has increased. This has almost tripled liabilities, from $1.8 billion in 2008 to $7 billion in 2012.

[7] This would require a change in the anti-cutback rule of the Employee Retirement Income Security Act (ERISA).

[8] For information about withdrawal liability, see Segal's June 2010 *In Depth*: http://www.segalco.com/publications/indepths/june2010withdrawalliability.pdf

[9] Alliances allow plans to combine administrative and investment management services, but retain separate liabilities and funding accounts.

SEGAL

Health Care Reform Insights

Benefits, Compensation and HR Consulting | March 2013

How Health Reimbursement Arrangements Will Work Under the Affordable Care Act in 2014 and Beyond

In light of the Affordable Care Act[1] prohibition against health plans with an annual dollar limit on essential benefits, which takes effect in the plan year beginning on or after January 1, 2014, there have been concerns about whether Health Reimbursement Arrangements (HRAs) will be permissible in 2014 and subsequent years. The Department of Health and Human Services (HHS) waived the annual dollar-limit rules through December 31, 2013 for HRAs in existence prior to 2014.

The three federal agencies implementing the Affordable Care Act — HHS, the Department of Labor and the Treasury Department (collectively, the "Departments") — recently released a set of answers to frequently asked questions (FAQs) addressing the future of HRAs.[2] The answers discuss guidance that the Departments intend to issue on how the Affordable Care Act's ban on annual limits on the dollar value of essential health benefits will affect HRAs. **This issue of *Health Care Reform Insights* summarizes this news, which confirms that for an HRA to be a permissible type of coverage under the Affordable Care Act, an employee must be enrolled in other primary group coverage that complies with the annual dollar-limit rules.**

HRAs are a Popular Plan Option

HRAs are a popular group health plan design feature that provides participants with a spending account to reimburse them for qualified medical expenses. HRA contributions must be made exclusively by the employer or other plan sponsor — no employee contributions are permitted. Distributions from the HRA are tax-free. Balances remaining in the HRA at the end of a coverage period may be carried forward if the plan documents permit them to do so.[3]

The flexibility of the existing HRA rules makes HRAs attractive and allows them to take on a wide variety of characteristics. Now, plan sponsors must look at their individual HRAs to determine whether they meet the criteria set forth in the answers to the FAQs on HRAs.

Integrated vs. Stand-Alone HRAs

Whether an HRA will be considered permissible under the Affordable Care Act's annual dollar-limit rules will depend on whether the HRA is an "integrated" HRA or a "stand-alone" HRA. The introduction to the latest answers to FAQs confirm what the Departments stated in the 2010 interim final rule on annual and lifetime dollar limits:[4] HRAs do not violate the annual dollar-limit rules if they are "integrated" with other coverage as part of a group health plan where that other group health plan coverage complies with the rules.

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[1] The Affordable Care Act is the abbreviated name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-148, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152.

[2] The answers to these FAQs, which were posted on January 24, 2013, are on the DOL website: http://www.dol.gov/ebsa/faqs/faq-aca11.html

[3] The Segal Company has created tables that compare characteristics of HRAs and other health accounts: "Deciding Whether to Use an HRA or HSA: Comparative Chart for Sponsors of Multiemployer Health Plans" (http://www.segalco.com/publications/presentations/HRAandHSAchart.pdf) and "Comparison of Key Elements of FSAs, HRAs and HSAs" (http://www.segalco.com/publications/presentations/FSA_HRA_HSA_chart.pdf), which is of interest to sponsors of public sector plans.

[4] That interim final rule was discussed in Segal's July 2010 *Bulletin*, "Latest Agency Regulations Address the Affordable Care Act's Rules for Group Health Plans": http://www.segalco.com/publications/bulletins/july2010ACAregs.pdf

Based on the answer to FAQ #3, it is clear that for an HRA to be considered an integrated HRA, the employee must also be enrolled in the primary group health plan coverage. Moreover, if the HRA is available to employees who are not covered by the primary group coverage, it is not an integrated HRA.[5]

This means that stand-alone HRAs, which are not integrated in the way described above, will violate the annual dollar-limit rules and will not be a permissible type of coverage in 2014 and beyond.[6]

HRAs and Individual Market Coverage

An HRA is not an integrated HRA if it is paired with individual market coverage (rather than coverage under a group policy) or with an employer plan that provides coverage through individual market policies, under FAQ #2. This means that employers and other plan sponsors will not be able to offer a stand-alone HRA for employees to purchase individual market coverage (whether sold inside or outside a health insurance Exchange).

Spending Down HRA Balances

The guidance also addresses the ability to spend down unused amounts credited before January 1, 2014. All amounts credited prior to January 1, 2013 may be used after December 31, 2013 to reimburse medical expenses under the terms of the HRA (FAQ #4). Amounts credited during 2013 under the terms of an HRA in effect on January 1, 2013 may also be used after December 31, 2013. (Special rules apply if the HRA terms do not set the amount to be credited during 2013.)

Retiree-Only HRAs

HRAs — even stand-alone HRAs — that qualify as separate retiree-only plans can continue in 2014 and beyond. This is because retiree-only plans are not subject to the ban on annual dollar limits. There is no guidance on what constitutes a "retiree-only plan" other than the statutory rule that there must be fewer than two current employees in the plan. Plan sponsors that consider an HRA to be a "retiree-only plan" and therefore not subject to the annual dollar limit should review that decision with counsel.

Plan sponsors of such HRAs should watch for future guidance on how those HRA funds may be used, as there are likely to be tax rules that would prohibit the use of these funds to purchase subsidized coverage through a health insurance Exchange, because the HRA would be a group health plan.

Action Steps for Plan Sponsors

Plan sponsors that offer HRAs must carefully examine each HRA option to assure that it is permissible in 2014. Some of the issues that must be reviewed are whether plan documents clearly show the integration with other coverage, and whether the distributions permitted from the HRA align with the FAQ requirements.

Continued on next page

[5] The FAQ uses the word "employer," but states that the guidance applies equally to HRAs sponsored by employee organizations or jointly by employers and employee organizations.

[6] Stand-alone HRAs currently have a blanket waiver from the annual dollar-limit rules, but those waivers will last only through the plan year that ends immediately before the plan year that begins on or after January 1, 2014.

In some cases, stand-alone HRAs that are not integrated with primary coverage will need to be changed. In other cases, an integration might be able to be established that allows the HRA to continue. These issues should be reviewed in 2013, to assure that plan designs are compliant for 2014.

Plan sponsors should rely on their attorneys for authoritative advice on the interpretation and application of the Affordable Care Act. Segal can be retained to work with plan sponsors and their attorneys on compliance issues. In addition, Segal can help plan sponsors to evaluate their current plan design and draft employee communications. Segal will keep clients informed as additional regulations are issued.

SEGAL www.segalco.com

To receive issues of *Health Care Reform Insights* and other Segal Company publications as soon as they are available online, register your e-mail address via Segal's website: www.segalco.com/register/

All Segal information about health care reform is accessible from the following web page: www.segalco.com/publications-and-resources/health-care-reform/

For a list of Segal's 22 offices, visit www.segalco.com/about-us/contact-us-locations/

SEGAL Bulletin

Benefits, Compensation and HR Consulting

March 2013

New NCCMP Report Recommends Strategies for Strengthening Multiemployer Pension Plans

On February 19, 2013, the National Coordinating Committee for Multiemployer Plans (NCCMP) issued *Solutions not Bailouts: A Comprehensive Plan from Business and Labor to Safeguard Multiemployer Retirement Security, Protect Taxpayers and Spur Economic Growth.*[1] The report, which is the product of more than one year of deliberations by the NCCMP's Retirement Security Review Commission (the Commission), includes a series of recommendations intended to improve the retirement security of plan participants, enhance the ability of plans to retain contributing employers and help prevent the need for future taxpayer assistance.

THE COMMISSION AND ITS OBJECTIVES

The genesis of the Commission was to provide Congress with input regarding the approaching sunset of certain multiemployer provisions of the Pension Protection Act of 2006 (PPA'06) and to address some other basic precepts under the Employee Retirement Income Security Act (ERISA) in order to allow multiemployer plans to continue their mission for the foreseeable future. More than 40 organizations from both business and labor were represented, spanning every major industry that relies on multiemployer plans as a primary vehicle for providing retirement income security to employees.

The Commission identified two primary objectives:

- Provide regular and reliable lifetime retirement income to participants, and
- Reduce or eliminate financial risks to contributing employers.

The Commission studied the challenges facing the multiemployer pension system in the U.S. In addition, it examined the operations and the statutory/regulatory environments that govern similarly structured plans in Europe and Canada. The Commission sought input from a range of experts: economists, public policy experts, investment advisors, actuaries (including The Segal Company), lawyers and foreign plan professionals.

The Commission's recommendations, which address the challenges facing multiemployer defined benefit retirement plans that the Pension Benefit Guaranty Corporation (PBGC) and other agencies have identified,[2] fall into three main categories:

- ***Preservation*** This category encompasses proposals to strengthen the current multiemployer system, including technical adjustments to troublesome aspects of PPA'06.
- ***Remediation*** Recommendations in this category would address the minority of multiemployer plans that are deeply troubled.
- ***Innovation*** This category includes proposals intended to foster new and innovative plan designs that will better enable bargaining parties to adopt more "flexible" future plan designs that reduce risks for contributing employers than current designs compared to current defined benefit structures.

The next section of this *Bulletin* summarizes selected recommendations in these three categories.

[1] The 35-page report is available on the following page of the NCCMP website: http://www.nccmp.org/forEmails/SolutionsNotBailouts.pdf

[2] In late January, the PBGC sent to Congress three reports that signaled problems with the PBGC's multiemployer program. For a summary of the key points in the reports, see Segal's February 2013 *Bulletin*, "Recently Released PBGC Reports Focus on Multiemployer Plans": http://www.segalco.com/publications/bulletins/feb13PBGC.pdf

SELECTED RECOMMENDATIONS

Recommendations for Preservation

The Commission recommends a continuation of the PPA'06 "zone" rules beyond the scheduled sunset date, as well as 13 technical corrections and enhancements to that law and others, including the following:

- Extend to plans in endangered status (in the "yellow zone") some of the rules for plans in critical status (in the "red zone") — regarding benefit improvements, contribution decreases and waiver of excise taxes on funding deficiencies.
- Allow yellow-zone plans that have a Funding Improvement Plan requiring no action for emergence from endangered status to avoid being considered endangered (*i.e.*, to be considered in the "green zone").
- Permit plans that are projected to enter critical status in any of the next five plan years to choose to enter critical status in the current year.

Other Commission recommendations to strengthen the system concern mergers and alliances[3] and allowing plans to "harmonize" normal retirement age with Social Security.

Recommendations for Remediation

These recommendations, which are intended to be optional, would help the relatively few plans facing insolvency in situations where the trustees are able and willing to avoid the plan's demise through additional benefit reductions. The Commission notes:

> In order to return such plans to solvency, it is necessary to modify the rules regarding the suspension of accrued benefits for all categories of participants, including pensioners, provided that certain protections for vulnerable populations are included.

The Commission proposes establishing criteria that must be met before accrued benefits can be suspended.

Recommendations for Innovation

The Commission believes that "defined benefit plans must continue their vital role in providing retirement security to millions of multiemployer plan participants."

It also recognizes that because of employer concerns about withdrawal liability,[4] laws need to become more flexible to allow "plan designs that either do not create any withdrawal liability, or greatly reduce the potential for it to develop."

The Commission supports the development of the two optional alternative plan designs noted below:

- ***Variable Annuity Plans*** These plans are a form of defined benefit plan that are already being explored under existing law. The benefit varies according to the plan's investment experience.
- ***Target Benefit Plans*** This new plan design would offer "the retirement income security and economic efficiency of defined benefit plans with the predictable employer costs of defined contribution plans" by requiring conservative funding targets and permitting certain benefit reductions when adverse experience requires trustees to rebalance benefits and resources.

OBSERVATIONS AND OUTLOOK

It is important to note that the Commission's recommendations are not a plea for financial assistance. Rather, they are a road map of additional tools that can be used to address the current system's deficiencies and that would result in fewer failed plans. In fact, they could retain billions of dollars in liabilities within the private sector that might otherwise become the responsibility of the PBGC.

The Commission's recommendations should be useful for Congress as it considers the sunset of certain PPA'06 provisions and other potential changes to laws affecting multiemployer plans. The recommendations for alternative plan designs can be used to start conversations that could spur new legislation. The report may help encourage Congress to pass new legislation or extend key provisions of PPA'06 so that troubled multiemployer plans can gain strength and strong multiemployer plans can thrive.

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Segal can be retained to work with trustees who want to contact Congress with suggestions for new legislation to help plans improve their funded position. We can help trustees evaluate the impact on their plans of legislation based on recommendations in the NCCMP report.

[3] An alliance would allow a large plan to form a partnership with a smaller plan without taking on responsibility for the smaller plan's unfunded liability. The plans would share a common benefit structure and administration. This would provide an opportunity to reduce the operating costs for the smaller plan.

[4] For information about withdrawal liability, see Segal's June 2010 *In Depth*: http://www.segalco.com/publications/indepths/june2010withdrawalliability.pdf

Segal Select Insurance

THE FIDUCIARY SHIELD
Insurance News for Plan Sponsors

Benefits, Compensation and HR Consulting

JANUARY 2013

Challenges and Opportunities: The 2013 Market for Insurance to Protect Multiemployer Plan Fiduciaries

2013 is expected to be another challenging year for trustees of multiemployer plans that are purchasing or renewing insurance coverage. Nevertheless, there is also some good news to report. This issue of *The Fiduciary Shield* presents a brief overview of the 2013 market for each of the following types of insurance that provide protection for multiemployer plan fiduciaries:

- Fiduciary liability insurance,[1]
- Fidelity bonds,[2]
- Cyber liability insurance,[3] and
- Employment practices liability insurance.[4]

Fiduciary Liability Insurance

During 2012 we began to see a trend of increasing litigation against multiemployer plans. This increased activity typically translates into insurance company losses that have historically been passed through to policy holders as premium increases. While Segal Select has been able to mitigate this trend through effective negotiations with the carriers, its impact will no doubt continue to place pressure on pricing in 2013. While price negotiations are an important part of our role — one that we will continue to stress — there is another, equally important part of the insurance policy equation: scope and type of coverage available.

[1] Generally, fiduciary liability insurance provides protection for trustees and employees of benefit plans with respect to claims alleging a breach of fiduciary responsibility or an administrative error or omission. In addition to providing coverage for defense costs associated with such claims, the limits of liability purchased, less any paid defense costs, are also available to cover settlements or judgments.

[2] The Employee Retirement Income Security Act (ERISA) requires that every person who handles plan assets be covered by a fidelity bond. For a more detailed discussion of fidelity bonds, see the June 2009 issue of *Fidelity Bond Update*: http://www.segalco.com/publications-and-resources/multiemployer-publications/fidelity-bond-update/?id=1276

[3] Cyber liability insurance is designed to provide protection against improper disclosure of participants' private information. For an overview of cyber liability insurance, and more details on the scope of coverage is provides, see the April 2012 issue of *The Fiduciary Shield*: http://www.segalco.com/publications/NFLIP/april2012.pdf

[4] Employment practices liability insurance is designed to provide protection for a self-administered benefit plan, its trustees and employees with respect to alleged violations of federal or state harassment laws. Like all insurance policies, the exact terms and conditions are subject to the policy language.

The Segal Company's National Fiduciary Liability Insurance Practice (NFLIP) has been incorporated as the insurance brokerage subsidiary of The Segal Group, Inc., and is now known as Segal Select Insurance Services, Inc.

Segal Select Insurance Services — also referred to as "Segal Select" for simplicity — specializes in various types of insurance coverage for Taft-Hartley plans. The group has a national reputation for bringing creative and innovative solutions to help manage risk, working with carriers to enhance and improve coverage terms, negotiating to hold down premium prices and assisting with claims management. Segal Select is licensed in all 50 states.

To this end, some carriers will introduce fiduciary liability coverage enhancements for 2013.[5] Examples include the following:

- ***Expanded Fiduciary and Non-Fiduciary Coverage*** Fiduciary liability policies essentially cover actual or alleged breaches of a fiduciary's duties, responsibilities or obligations under ERISA, as well as certain administrative errors or omissions. Some carriers are now introducing new policy language that expands the scope of coverage available to trustees for specific fiduciary and non-fiduciary issues. Examples include surcharge liability under ERISA Section 502(a)(3) and certain settlor[6] decisions that are considered to be outside the scope of ERISA.
- ***Additional Fines and Penalties Coverage*** One insurance carrier has introduced a new excess-type policy to provide coverage for the payment of additional fines and penalties.
- ***New Coverage for Investigation-Monitoring Expenses*** Legal fees associated with a regulatory audit or investigation can be substantial and, historically, in most instances are not covered by a fiduciary liability policy. At least one carrier is exploring some level of legal fees, or "monitoring expense" coverage for these events.

These enhancements demonstrate Segal Select's commitment to working with carriers to fine-tune coverage and to introduce new coverage where there are gaps.

[5] In our December 2012 webinar, which can be accessed from http://www.segalco.com/publications-and-resources/archived-presentations-webinars/?id=859), we anticipated some of these changes. Now, they are happening.

[6] For information on settlor functions in the context of a multiemployer plan, see The Segal Company's December 2002 *Bulletin*, "DOL Guidance on Using Multiemployer Plan Assets to Pay Expenses": http://www.segalco.com/publications/bulletins/dec02FAB2002-2.pdf

Fidelity Bonds

Segal Select expects two significant developments to affect fidelity bond coverage in 2013. One will limit the coverage and another will expand it:

- ***The Coverage Limitation*** A recent court decision[7] had the effect of broadening an insurance company's intended scope of coverage under a fidelity bond's computer-fraud endorsement to include expenses the insured incurred as a result of reporting a breach of participants' personal information. In the insurance industry's opinion, such expenses, which are covered by cyber liability insurance, are not within the scope of either the fidelity bond or its computer-fraud endorsement. It is insurers' intention for fidelity bonds to cover only the direct loss (*e.g.*, fraudulent transfer of funds resulting from computer fraud) — not related expenses. The insurance industry is addressing this difference between their intention and the judicial decision by preparing new policy language for fidelity bonds that will limit coverage to the direct losses. The new policy language will return the computer fraud coverage back to the industry's intended coverage parameters (*i.e.*, computer fraud coverage offered under these bonds *will not* cover cyber liability exposures). Once that happens, multiemployer plans that want coverage for notification expenses associated with a cyber breach of personal information event will either have to purchase cyber liability insurance or seek some other coverage alternative.
- ***The Coverage Expansion*** Another major change is the agreement by one insurance carrier to offer its ERISA-compliant fidelity bond on a discovery, rather than a loss-sustained, format.[8] The discovery format offers a much broader level of coverage and, potentially, simplifies the claims-adjustment process.

Cyber Liability Insurance

Cyber liability insurance provides two kinds of coverage. The first is for scheduled expenses associated with a breach-of-personal-information event. (This is the "expanded" coverage found by the fidelity bond court decision discussed above.) The other is liability protection (*i.e.*, defense, settlement and judgments) in situations where a plan is sued, for example, by participants as a result of the breach incident. To some extent, this liability protection may overlap with a fund's existing fiduciary liability insurance. Segal Select has been working with insurance carriers to see if these policies can be better coordinated.

[7] *Retail Ventures, Inc. v. National Union Fire Insurance Company of Pittsburg, PA.* Nos. 10-4576/4608 (6th Cir. Aug. 23, 2012)

[8] The discovery format looks solely at the limits, terms and conditions in place with the current carrier. The loss-sustained format allows the current carrier, in certain instances, to look back to the limits, terms and conditions that had been in force at the time of the actual fraud or dishonesty.

Employment Practices Liability Insurance

A pattern of significantly increased premiums for employment practices liability insurance that began during the second half of 2012 is expected to continue in 2013. The primary reason for this is that litigation has been growing exponentially in this area and insurance companies have had to pay out more claims than expected. Some multiemployer plans, especially those located in California, have seen increases of 40 percent or more. Nonetheless, because of the real exposure that employers have to employment practice lawsuits, Segal Select recommends that all multiemployer plans employing fund office staff weigh the pros and cons of purchasing this coverage.

Conclusion

While pricing will remain important, for many clients the main focus in 2013 will be coverage options. Some carriers will offer improvements to existing coverage and new types of coverage during 2013. This is good news for trustees. At the same time, it is important to note that these enhancements can add complexity to the decision-making process and may come with premium increases. For trustees and their advisors, this may translate into the need to devote more time and attention to the renewal process, with a specific focus on the cost and benefit of improved scope of coverage opportunities.

■ ■ ■

Segal Select Insurance Services can help trustees of multiemployer plans understand each type of coverage mentioned in this issue of The Fiduciary Shield, *solicit and evaluate quotations, negotiate pricing and contract terms, present quote results, and make recommendations. To discuss any of these services, contact Brian L. Smith, Chief Operating Officer, at 212.251.5333 or bsmith@segalsi.com.*

Trustees of multiemployer plans should always rely on fund counsel for authoritative advice on all issues involving the interpretation or application of laws and regulations. *The Fiduciary Shield* does not provide legal advice or a binding interpretation of coverage.