

The Shifting Reality of Employee Benefits



2011
Corporate
Benefits
Brief



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Executive Summary

As we emerge from the most severe economic and financial downturn our country has seen in decades, and as we adjust to the many changes brought about by health care reform, most Americans are beginning to view the world through a completely different lens. The changes we have experienced have been noteworthy, pervasive and long-lasting.

In 2010, the health care reform legislation forced all employers to rethink their strategies for providing health benefits to employees. As health care reform implementation continues to unfold on both the federal and state levels, the dynamic political environment makes for a very uncertain future. All employers will have to pay careful attention to the regulatory guidance issued this year so they can shape effective strategies for the years to come.

For employers and employees, retirement can be as large an uncertainty as health care reform. As employers seek to help their employees become retirement-ready, it can no longer be presumed that the stock market will quickly roar back after taking a downturn, or that brand name financial institutions will always be around. The credit markets, once active and available to the masses, now seem accessible to only a select credit-worthy few. And the ever important job market, which flourished for so long, is struggling to get back on track. That means now, more than ever, employers have the responsibility to help employees achieve their retirement goals.

Welcome to the “new normal” — a world where caution is commonplace and nothing is taken for granted.



Shaping Employer Strategies in the Health Reform Era

In March 2010, after a year of intense debate, Congress passed monumental health care reform legislation. The legislation came in the form of two laws, the Patient Protection and Affordable Care Act and a related Reconciliation Act, which were signed into law on March 23, 2010, and March 30, 2010, respectively. References herein to PPACA are to the two laws collectively. PPACA's primary purpose is to expand health care coverage access to all Americans through individual and employer insurance coverage mandates, state insurance exchanges and other public health care programs, and reforms to the private health insurance market.

However, late in 2010 and in early 2011, several significant political and judicial events occurred that will likely affect PPACA's future. To begin, in the November 2010 general election, Republicans regained control of the U.S. House of Representatives, gained several new seats in the U.S. Senate and picked up many state governorships and legislative seats. Then, in December 2010, a federal court in Virginia ruled that PPACA's "individual mandate," which requires most Americans to purchase health insurance by 2014, is unconstitutional. In addition, in February 2011, a federal court in Florida went even further than the Virginia court in ruling that the entire PPACA is unconstitutional. Because other courts have held that the individual mandate and PPACA are constitutional, most commentators believe that the issue eventually is headed to the U.S. Supreme Court.

As many Republican candidates used PPACA's repeal as their main campaign platform, legislation to repeal the law may be introduced in the Republican-controlled House early in 2011. A total repeal is unlikely, however, since Democrats maintain a majority in the Senate, and President Obama maintains veto power. Also, several PPACA provisions that have already been implemented – such as the prohibition of pre-existing condition exclusions for individuals under age 19 and the expansion of dependent care coverage – are popular among both parties. Therefore, it is more likely that Republicans will launch a provision-by-provision attack on PPACA.

Among the methods available for the Republican-controlled House to aggressively challenge implementation of PPACA on a provisional basis is funding denials. Congress may deny funding to the agencies charged with implementation of PPACA and may also deny any appropriation bills that include PPACA funding. Again, because Senate Democrats maintain their majority and the president maintains veto power, such a denial is unlikely to succeed.

Congress could also challenge implementation of PPACA by conducting oversight hearings. Oversight hearings are generally used to evaluate and improve the efficiency, economy and effectiveness of newly enacted and long-standing laws, and to gather information to develop new legislative proposals or to amend existing law. Congress could also use the Congressional Review Act to challenge PPACA. Generally, the act allows Congress to review every new federal regulation issued by government agencies, and, by passage of a joint resolution, overrule a regulation. Using these methods, it is likely that on the federal level Republicans will influence significant revisions to PPACA mandates being implemented in 2012 and later.

Since the November 2010 election produced Republican gains in state legislatures and governorships throughout the country, implementation of PPACA could face challenges on the state level as well. State, not federal, governments are charged with the regulation of insurance, and will play an enormous role in shaping PPACA. In addition, state insurance commissioners generally are either appointed by state governors or are elected, meaning that the rise of Republican governors and members of state legislatures will particularly affect the state implementation of PPACA's insurance mandates. Thus, it is important to keep an eye not only on members of Congress, but also on major players at the state level.

Health Care

Looking forward, federal and state challenges in several forms will be mounted against PPACA in the coming months. Regardless of whether PPACA is repealed, modified or remains completely intact, cautious employers must be aware of the law's potential effect on employer-sponsored health care.

2010 Recap

Although PPACA was signed into law on March 23, 2010, its breadth and depth, and the need to allow time for government agencies to deliver guidance and for employers to comply, delayed the effective dates of most provisions to 2011 and beyond. However, some PPACA provisions did go into effect in 2010.

Two PPACA provisions went into effect immediately on March 23, 2010. These are the nursing mother provision, which requires employers to provide breaks and places for mothers to express breast milk, and the grandfathered health plan provision, which exempts certain plans in existence on March 23, 2010, from many PPACA requirements.

Two PPACA provisions went into effect 90 days after enactment, or June 23, 2010. These provisions relate to the temporary retiree reinsurance program and the national high-risk pool.

Several PPACA provisions went into effect six months after enactment, or Sept. 23, 2010. These include provisions relating to: dependent coverage, prohibited rescissions, restrictions on lifetime and annual limits, pre-existing condition restrictions, preventive care rules, nondiscrimination rules for fully insured plans, certain covered benefits, and new internal and external appeals procedures.

Lastly, several more PPACA provisions went into effect generally for 2010. These include provisions relating to: the small employer tax credit, Medicare prescription drug rules, rate review rules and the small employer grant for wellness programs (although the availability of the grant was delayed).


In addition to the provisions, many forms of guidance relating to PPACA were issued by various federal and state government agencies. The U.S. Departments of Labor (DOL), Treasury and Health and Human Services (HHS) issued notices, bulletins and regulations, and also developed websites with related PPACA information. Many state legislatures also passed laws to bring their state laws into compliance with PPACA, and state government agencies issued related guidance.

Needless to say, 2010 was a busy year for employers challenged with the task of becoming both familiar and compliant with the various provisions. Such challenges will continue in 2011 and beyond as further guidance is issued with respect to all of the PPACA provisions.

2011 and Beyond

Several PPACA provisions became effective on Jan. 1, 2011. These include provisions relating to medical loss ratio requirements, new rules for Medicare Advantage plans, restrictions on certain Flexible Spending Accounts (FSAs), Health Reimbursement Accounts (HRAs) and Health Savings Accounts (HSAs), and a new simple cafeteria plan safe harbor for certain small employers.

Several more PPACA provisions become effective on Jan. 1, 2012. These include provisions relating to employer W-2 and uniform benefit summary reporting requirements, the CLASS Act and the comparative effectiveness tax.



On Jan. 1, 2013, the next several provisions become effective. These include provisions relating to new annual limits on health FSAs, an increase in certain taxes for high-income taxpayers, taxation of retiree drug subsidies, and the new exchange notice requirement.

Beginning in 2014, many new major market reforms will be implemented. These include the prohibition of pre-existing condition exclusions, lifetime and annual limits, and waiting periods. These also include provisions relating to: the employer mandate (the “pay-or-play” mandate, which requires most employers to either provide qualified health coverage for employees or pay a penalty), the individual mandate, employer vouchers for state exchanges, automatic plan enrollment, the small business tax credit, benefit design and the “essential health benefits package,” state health insurance exchanges, wellness program initiatives and certain new reporting requirements.

Lastly, beginning in 2018, the tax on “Cadillac” plans will be imposed on insurers of employer-sponsored health plans with certain aggregate values.

The passage of PPACA means changes in the law for many years to come. Employers desiring to attract and retain talented employees must develop a strategic approach to understanding PPACA’s requirements and becoming compliant with them.

Employer Strategic Approach

Before discussing a strategic approach to PPACA for employers, it is important to understand the goal of health care reform, as well as the role that employer-provided health coverage plays in achieving that goal. The ultimate goal of health reform is the expansion of health care coverage. The mechanisms for reaching that goal are the individual and employer mandates to maintain coverage and the removal of current barriers to health care access.

Ironically, one barrier to access is affordability, yet health reform appears to negatively affect the cost of coverage. According to a Mercer study conducted in May 2010, early estimates of PPACA cost increases for employer-sponsored coverage range from moderate to severe, with 30 percent of employers surveyed still unsure what to expect.¹ (*Figure 1*)

Increases in health insurance costs adversely affect individuals and employers, but particularly employers. Nearly 69 percent (or 157 million) of non-elderly Americans are covered under an employer-sponsored health plan.² Employer-provided coverage is an integral part of health care reform, indicated by the many employer-related requirements of PPACA, including the employer mandate.

Employers’ top three goals for health care reform are containing costs, encouraging healthier lifestyles and improving the quality of care. But as they look down the road to when health reform is fully implemented, few employers think this legislation will achieve the goals that are most important to them. (*Figure 2*)

Regardless, employers sponsoring health plans should develop a game plan to implement PPACA procedures and practices to remain competitive in attracting and retaining employees and to come into compliance with the law.

Faced with cost containment and the pay-or-play mandate, employers must also rethink their benefits strategy. According to survey of 381 company executives performed by Ernst & Young in August and September of 2010, 31 percent of executives are most concerned about the cost of compliance with the law, while only 16 percent were most concerned about their overall readiness to comply with the law.³

Health Care

One-fourth of employers expect PPACA-related changes to push up 2011 cost by 3 percent or more

Employer estimates of cost increase due to covering children up to age 26 and eliminating benefit maximums.

- Increase by less than 1 percent
- Increase by 1-2 percent
- Increase by 3-4 percent
- Increase by 5 percent or more
- Don't know
- N/A - already in compliance

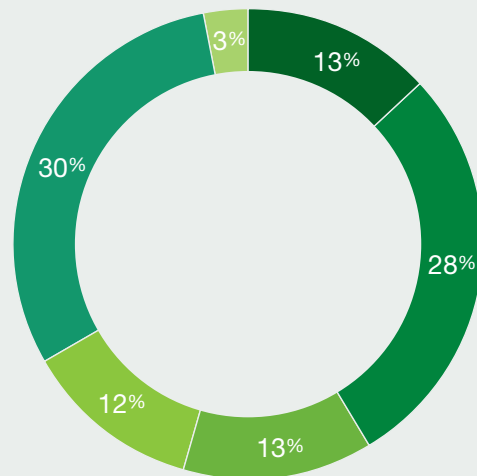


Figure 1

Source: Mercer. "2010 Survey on Health Reform: Sizing up the Challenge." 2010. www.mercer.com.

Importance and impact of health reform goals

- Goal is absolutely essential/high priority to organization
- Reforms are expected to have a positive impact on goal

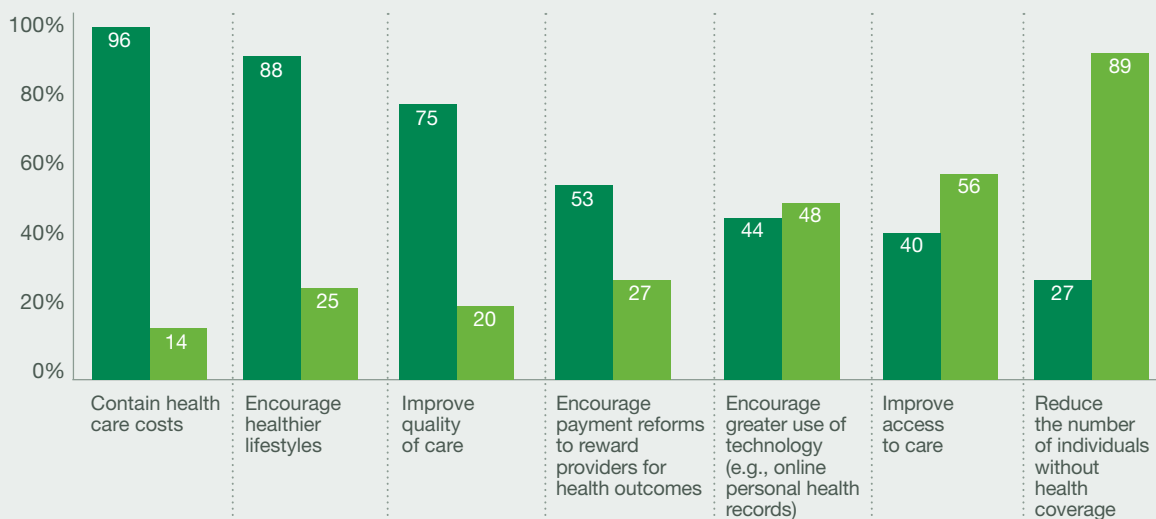



Figure 2

Source: Towers Watson. "Health Care Reform: Looming fears mask unprecedented employer opportunities to mitigate costs, risks and reset total rewards." May 2010. www.towerswatson.com.



It is no surprise, therefore, that some employers may decide that it is cheaper to pay a penalty than to offer health benefits. This conclusion, however, must be reviewed not only in terms of the cost of the pay-or-play mandate, but also in terms of the health and welfare of their employees and the employer's ability to hire and retain key personnel.

Employers that continue to offer benefits should review their overall benefits strategy to determine what appropriate short- and long-term cost containment strategies they should consider. Methods for containing an employer's health-care costs in the short term have tended to focus on three primary areas: eligibility, plan design and contribution strategy. Changes made in these areas generally produce more immediate cost savings. However, we are now seeing a growing emphasis on long-term strategies, such as wellness plan offerings, as employers set longer-term goals of having a healthier and more productive workforce.

Several cost-saving strategies, both short-term and long-term, are outlined below.

Eligibility

One method for containing health care costs is to review benefits eligibility requirements. For example, does the employer want to continue to offer coverage to retirees, spouses who have other employer-sponsored coverage and employees in all job classifications? (It is important to keep in mind state mandates, such as laws pertaining to spousal carve-outs, and federal mandates, such as nondiscrimination laws pertaining to highly compensated employees.)

Some employers may decide that they want to offer benefits for retirees only until 2014, when the majority of insurance reforms are implemented, providing access to individuals regardless of health status. Other employers may implement a spousal surcharge or not allow spousal coverage for individuals eligible for coverage under another employer's plan.

In light of the new requirements for covering dependent children to age 26, another eligibility management technique is an eligibility audit, which confirms the eligibility of a spouse or child and requires documentation, such as a marriage certificate, birth certificate or confirmation of no other coverage availability, for mid-year status changes. Employers that effectively manage dependent eligibility through a best practice verification process can directly impact their benefit costs by minimizing the number of ineligible dependents they cover.

Plan Design

The most immediate way for employers to achieve direct cost reductions is through careful health care plan design. Some employers have instituted cost-sharing measures under their current plan designs, such as increasing deductibles, co-pays and out-of-pocket maximums. However, more and more employers are instituting high-deductible health plans (HDHPs), particularly those that include a savings option (e.g., an HSA). HDHPs are intended to deter unnecessary utilization of services, lead consumers to consider costs and benefits in considering treatment, and encourage price shopping.

In the wake of rising health care costs, the percentage of covered workers enrolled in HDHPs rose from 8 percent to 13 percent in 2010.⁴ Though the HDHP may be the only plan option offered, it is more typical for an employer to offer a few plan design options, with a contribution strategy design that drives participation to the most cost-efficient plan via lower employee contributions. Employees may then opt to buy up to a richer plan design for a higher contribution amount. Some employers, at least temporarily, will choose mini-med options or executive carve-out plans, both of which will be unavailable in the future. Employers may find that a different plan design not only saves them money, but also better fits the particular needs of their employees. (Figure 3)

Health Care

Distribution of health plan enrollment for covered workers, by plan type, 1988-2010

- Conventional
- HMO
- PPO
- POS
- HDHP/SO

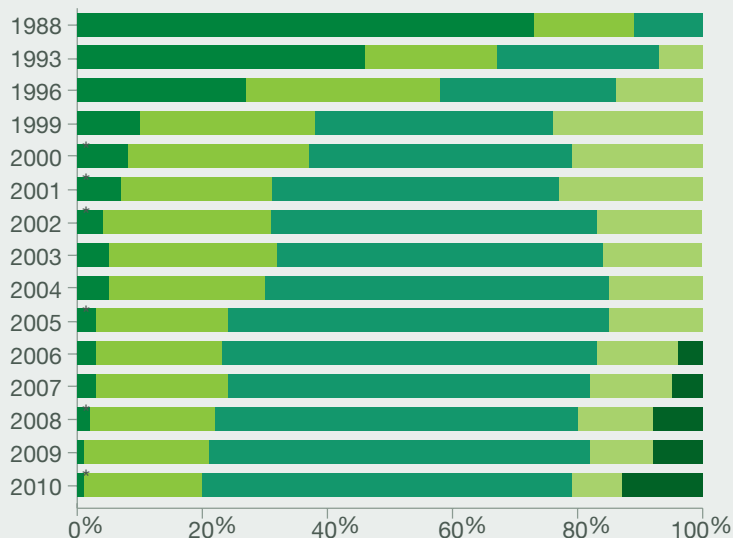


Figure 3

Note: Distribution is statistically different from the previous year shown. No statistical tests were conducted for years prior to 1999. No statistical tests are conducted between 2005 and 2006 due to the addition of HDHP/SO as a new plan type in 2006.

Information was not obtained for POS plans in 1988. A portion of the change in plan type enrollment for 2005 is likely attributable to incorporating more recent Census Bureau estimates of the number of state and local government workers and removing federal workers from the weights. See the “Survey Design and Methods” section from the 2005 Kaiser/HRET “Survey of Employer-Sponsored Health Benefits” for additional information.

Source: Kaiser/HRET. “Survey of Employer-Sponsored Health Benefits, 1999-2010”; KPMG LLC. “Survey of Employer-sponsored Health Benefits, 1993, 1996”; The Health Insurance Association of America. 1998.

Employer Contribution Strategy

An employer should review their employee benefit contribution levels in light of increasing costs and determine whether changes are required. Though some employers are holding fast to their contribution percentage so that the employer and the employees together absorb increases in costs on a pro rata basis, many are increasing employee contributions through a variety of avenues. Some are changing their plan’s tier structure to align contribution rates with the number of individuals covered. Others are simply increasing the contribution percentage for coverage tiers that include dependent children or are adopting salary-based contributions.

Carrier Review

Employers should prudently review their current carrier contract, compare different carriers and search for a carrier that offers affordable and innovative solutions for the employer’s particular needs. Employers should consider making vendor evaluations more rigorous and performing them more frequently, and should also look for aggressive performance guarantees. Testing the market ensures that the plan is obtaining competitive pricing for all components, including prescription drug coverage, wellness programs and stop-loss insurance (for self-insured plans).



Prescription Drug Costs

Prescription drug costs comprise a significant portion of overall health care expenses under most plans. Employers may choose to manage costs by increasing the number of prescriptions that are filled by generic equivalents rather than name-brand drugs. Some employers may provide favorably priced mail-order options or require special dispensation for use of brand name drugs. Employers should also evaluate the utilization and cost containment programs available from their pharmacy benefit manager. Many of these programs provide a guaranteed return on investment. In addition, regular audits performed on prescription drug claims can assure employers that they are receiving the appropriate contracted discounts and pricing from their vendors. Lastly, educating employees on appropriate utilization, generics versus name brand drugs, and alternatives (such as 90-day at retail and mail order options) is key to containing these costs.

Large Case Management

Large case management helps control costs associated with the care of participants who have long-term or catastrophic illnesses or injuries. This may become easier for employers in the future with the general push toward Accountable Care Organizations under health reform, which will help coordinate care to improve the continuity and quality of care a participant receives while presumably also lowering costs. One example of a case management technique to lower costs is to provide support to a cancer patient through the use of homecare workers, thus reducing hospital admissions and related costs.

Disease Management

Chronic care and disease management programs have been around for some time and have the capability to maintain and improve the health of the workforce and reduce medical cost trend. Employers should routinely evaluate any existing programs in place to make sure they have all of the critical components of a successful program. These components include: population identification processes, evidence-based practice guidelines, collaborative practice models, patient self-management education, process and outcomes measurements, and a routine reporting/feedback loop.

In this same arena, some employers are also exploring “value-based” benefit designs that actually reduce cost sharing (e.g., reduced copayments, deductibles, etc.) to reward desired behaviors, such as meeting minimum standards of care for certain chronic diseases. Alternatively, these programs could allow for increased cost sharing for less efficient use of care.

Wellness

According to MetLife’s “8th Annual Study of Employee Benefit Trends,” 69 percent of employers agree that health and wellness programs can be effective at reducing medical costs. In addition, 47 percent of employers that offer wellness programs and 57 percent of employees who participate say they are effective in improving productivity.⁵ A growing number of employers are implementing wellness programs not only to reduce medical health care costs, but also to improve their employees’ morale, increase employee loyalty and improve absenteeism and presenteeism rates.

The role of education concerning wellness cannot be overstated. Employees need information about healthy living and how to improve habits and behaviors that affect their health. Health risk appraisals, biometric screenings and health fairs make it convenient for participants to become more aware of health issues and get individual assistance. Many conditions can be prevented or managed with minimal medical intervention if employees understand what they need to do. PPACA enables employers to provide an even greater incentive to employees to participate in wellness programs by increasing the allowable wellness incentive from 20 percent to 30 percent, (and possibly up to 50 percent if HHS so desires). These financial incentives may be one tool that enables employers to increase participation in wellness programs.

Health Care

Funding

As employers consider various cost containment strategies, they should learn the merits of different funding options. Fully insured products are the simplest product with a more hands-off approach, though they do not have any real reporting and clients do not generally know how their plan is performing from a claims perspective.

Partially self-funded plans require an employer to remain actively engaged in the monthly plan performance. This allows the employer to better understand claims patterns and trends, and develop mitigation strategies sooner rather than later. Though not always the case, a self-funded plan can be more cost effective than a fully insured plan, and it can allow the employer more control over the administration, funding and plan design.

Self-funding is not for everyone, but when combined with greater cost controls, reduced operating costs, increased employee accountability and involvement, and reporting to see key performance indicators, it is certainly a strategy to consider.

Communications

Effective benefits communications can improve the overall effectiveness of most benefits programs. They can also lead to employees' greater appreciation, participation and usage of benefits, as well as to increased levels of job satisfaction.⁶ Benefits communication leaders are using multiple channels of delivery to better address the various communication needs of their employee population. These channels include individual and group meetings, e-mail, outbound calls, social media and communication via mobile devices. Some employers are also using methods such as total compensation statements, benefits fairs and employee surveys.

Employees rank benefits among their top contributors to job satisfaction.⁷ Because of this, employers that continue to provide a strong benefits package, even in difficult times, will likely see that investment pay off in higher rates of employee job satisfaction and retention. In addition to the cost containment strategies noted above, employers will need a strategy to stay abreast of new employer requirements and regulatory changes.

With so much on an employer's plate, the need for expert advice and guidance in all of these areas has never been greater. Organizations should engage strong independent advisors who are familiar with and understand all of their benefits and insurance needs, and who bring them the highest level of knowledge, expertise and solutions.

Retirement

Managing a Retirement Plan in the “New Normal”

After two stressful years of a struggling economy and erratic markets, most retirement plan sponsors found themselves settling in to the “new normal” in 2010. This new baseline includes a retirement plan world that has become further rooted in a few key areas: insecurity about the markets; heightened awareness and concern about fees and fiduciary issues; political, legislative and regulatory uncertainty; and a lack of participant retirement readiness.

It is a world that has, for most workers, made it challenging to stay on track with retirement goals. Many workers have a less than optimistic view of their financial future. In fact, according to a 2010 Deloitte survey, 60 percent of employees worry about the future of their employment security.⁸ The once anticipated American dream of working hard and then retiring comfortably is no longer guaranteed, particularly since almost two-thirds of workers surveyed by the Employee Benefit Research Institute report that the total value of their household savings and investments, excluding the value of their primary home, is less than \$50,000.⁹

It is therefore imperative that plan sponsors take an active role in helping employees prepare for a comfortable and secure retirement through the company’s retirement plan.

Market Trends


Although plan participation rates have remained fairly steady since 2007 – sitting right around 82 percent – plan participants seem to have a general reluctance regarding their retirement plan.¹⁰ In fact, a survey performed in 2010 by Deloitte on 401(k)s found that a majority (53 percent) of plan participants are holding a “wait and see” approach before increasing contribution rates and resuming the level of activity seen in prior years.¹¹

Demonstrating the participants’ cautious approach, plan sponsors reported that the most common actions taken by participants over the past 12 months were:

1. Increased loan activity (49 percent)
2. Decreased deferral rates (41 percent)
3. Increased withdrawals — hardship, in-service (40 percent)
4. No changes (23 percent)
5. Rebalancing portfolios to be less aggressive (21 percent)

Plan sponsors, on the other hand, appear to be more trusting of the recovery as they begin to shift from cost-cutting back toward ongoing plan management, including plan contributions. For example, according to the Deloitte 401(k) survey, there was an increase of plan sponsors offering employer matching contributions from 2009 (59 percent) to 2010 (66 percent). Also, among those plan sponsors that previously suspended matching contributions, 55 percent reported that they plan to reinstate matching contributions within the next 24 months.

In addition, it appears that employers are feeling more responsible for the retirement stability of their employees. Deloitte’s survey showed that more than three-quarters (77 percent) of employers believe they have a



responsibility toward helping employees prepare for retirement, and 15 percent feel “very” responsible to prepare employees for retirement.

Perhaps because of the improving economy or perhaps because of this perceived responsibility, from 2009 to 2010, employers seemed to trend toward increasing contributions and management of their retirement plans. Further, showing a substantial rebound from 2009, 39 percent of plan sponsors surveyed by Deloitte responded that the average participant account balance exceeds \$75,000 (only 25 percent reported the same in 2009).

So while retirement plan participants remain somewhat cautious about the state of the economy, plan balances are slowly rebounding from the lows of 2008 and 2009, and employers are slowly warming to playing an increased role in helping their employees achieve financial security for retirement.

Legislative Update

As plan sponsors work to come to terms with the new normal, they have another major factor to consider besides the economy — the regulatory and legislative environment surrounding retirement plans. The environment has been extremely active over the past 12 months, a trend that is anticipated to continue. For the most part, employers are confused about what the recent changes mean and how they will affect them. The need for accurate guidance continues to increase, and employers are seeking advisors knowledgeable about the current regulatory environment.

In addition to this confusion, there is also fear. Fear of the unknown, fear of changes to the way things have always been done, but most of all, fear of being out of compliance. Seemingly every day there are reports of settlements or penalties for plan sponsors operating non-compliant retirement plans. This is where the advisor relationship is so vital and has the opportunity to be a source of relief and comfort for a plan sponsor.

Of the regulatory guidance issued in 2010, one area has drawn much attention: fees. Fees were already gaining the attention of regulators before the economic downturn, but the current situation has provided the optimal environment to finalize fee-related regulations.

The first major piece of regulatory guidance was provided through “interim final” regulations under ERISA Section 408(b)(2).¹² Under existing law, all payments from a retirement plan to a “party in interest” are prohibited, unless those payments are specifically allowed under Section 408(b)(2). A party in interest includes nearly every service provider, including a record keeper, third-party administrator, consultant, auditor, advisor or attorney.

Section 408(b)(2) is important because it allows transactions to be performed that are “necessary for the establishment or operation of the plan” as long as the arrangement is reasonable and reasonable compensation is paid. In other words, employers are allowed to hire third parties to perform administration on their retirement plans, and pay for that expense by using plan assets, as long as the payment was reasonable. Previously, this was the only language contained within the law, leaving many unanswered questions, primarily, what is considered reasonable? The new interim final regulations expanded and established requirements for what constitutes a reasonable contract or arrangement through a disclosure.

As a result, the regulations require service providers that reasonably expect to receive \$1,000 or more in indirect or direct compensation for providing services to the plan to provide a detailed disclosure to the plan sponsor. The disclosure will have several requirements, but generally the level of detail provided must be enough for a fiduciary to determine whether plan costs are reasonable.

Retirement

That means an employer sponsoring a retirement plan will now be receiving disclosures from every service provider that receives payment out of the retirement plan assets. The sponsor can then use this information in an effort to satisfy their fiduciary obligations and determine on an ongoing basis if the plan is engaged in reasonable arrangements and paying reasonable compensation for these arrangements. The regulation was issued July 16, 2010, and will apply to retirement plan years that begin on or after Jan. 1, 2012.¹³

The regulation was issued July 16, 2010, and will apply to retirement plan years that begin on or after July 16, 2011, which means that calendar year plans would have to adhere to the rule as of January 2012.

The second major piece of regulatory guidance was provided through another interim final regulation addressing the need to improve transparency of fees and expenses to workers participating in participant-directed plans. These plans provide for the allocation of investment responsibilities, and, according to the DOL, current law does not adequately ensure that all workers are given the information they need or ensure that information, when provided, is furnished in a format useful to them, particularly information on investment choices, including associated fees and expenses.¹⁴

The final regulation requires plan fiduciaries to:


- Give workers quarterly statements of plan fees and expenses deducted from their accounts
- Provide workers with core information about investments available under their plan, including the cost of these investments
- Use standard methodologies when calculating and disclosing expense and return information to achieve uniformity across the spectrum of investments that exist in plans in an effort to satisfy the DOL's goal of transparency
- Present the information in a format that makes it easier for workers to comparison shop among the plan's investment options
- Provide workers access to supplemental investment information in addition to the basic information required under the final rule

Of relief to plan administrators, the rule provides protection from liability for the completeness and accuracy of information provided to participants if the plan administrator reasonably and in good faith relies upon information provided by a service provider. The regulation has been in effect since Dec. 14, 2010, and will apply to retirement plan years that begin on or after Nov. 1, 2011, which means that calendar year plans would have to adhere to the rule as of January 2012.

Analyzing Fees

Given the new regulatory requirements and the increased focus on fees, a disciplined process of understanding and benchmarking fees is critical for plan sponsors to be successful in helping employees become retirement-ready. At the very least, plan sponsors should understand:

- The total amount of plan fees
- Who is receiving plan fees (provider, investment manager, advisor, etc.)
- What services are being provided for plan fees
- How the total plan fees compare to the marketplace



The new plan-level disclosures require all investment companies, providers, advisors and brokers to fully disclose all fees, so having an understanding of the total plan fees and the breakdown of those fees should be much easier than in years past. However, understanding all of the related services a plan sponsor is receiving and performing a marketplace comparison may be more difficult.

It could be argued that looking solely at fees, without regard to the services a plan sponsor is receiving, is not that prudent. Looking at fees in the context of what one is receiving for those fees could be considered the more prudent approach. The U.S. Court of Appeals for the Seventh Circuit supports this view, as held in *Hecker v. Deere*.¹⁵ In *Hecker*, the Seventh Circuit recognized that the “reasonableness” of costs borne by a plan is dependent, to a substantial degree if not entirely, on the services being offered to the plan.

Further, a plan sponsor must be able to compare related retirement plan fees to the marketplace. In fact, ERISA Section 404(a)(1)(a) requires that sponsors know that their plan fees are “reasonable.” Since ERISA does not provide a clear definition of “fees,” benchmarking fees in relation to the marketplace can be the only prudent approach.

To help analyze a plan’s fees, a plan sponsor should consider working with an advisor who knows the landscape. A quality advisor can help you understand which providers, record keepers and investment companies have or have not complied with the new disclosure requirements, guide you thoroughly through the process, and clearly lay out all fees and services associated with your retirement plan.

Retirement Readiness

All of the major decisions a plan sponsor must make (such as plan design features, locating the right provider, selecting quality investments, etc.) boil down to one fundamental question: Will your employees have enough money to comfortably retire?

According to the 2010 Deloitte Annual 401(k) Survey, only 15 percent of surveyed employers believe most employees are or will be prepared for retirement, leaving an astounding 85 percent that believe some or very few will be prepared for retirement.¹⁶

Participant retirement readiness should be the ultimate goal of any company’s retirement plan. So how does one determine if participants are going to be ready for retirement? What are the key indicators that will determine if they are on track?

The two most critical indicators of a participant’s readiness to retire are: (1) employee participation rates and (2) employee deferral rates. Participation rates and deferral rates are the two most critical places to start when measuring the success of your retirement plan.

With respect to employee participation rates, if an employee is not participating in the retirement plan, then the employee is obviously unable to adequately save through the retirement plan. Employers should therefore take steps to increase employee participation in their retirement plans.

With respect to employee deferral rates, a plan sponsor should ensure that employees are contributing as much they can afford. It has been shown that a participant’s deferral rate affects their final account balance more than any other metric, including investment strategy.¹⁷

Retirement

	PARTICIPATION RATES	DEFERRAL RATES
2008 ¹⁸	82.7%	5.5%
2009 ¹⁹	82.2%	5.2%

Employers should take several steps to help employees achieve retirement readiness. First, employers can establish auto-enrollment in their retirement plans for employees who are eligible for participation. These so-called “autopilot” plans allow sponsors to:

- Automatically enroll employees into the plan (unless they opt out of the plan)
- Routinely increase participants’ deferral amounts over time
- Default participants into certain investment vehicles such as target date funds or managed accounts

Advantages of autopilot plans are that they:

- Offer participants a pre-defined path that is designed to maximize retirement readiness, which mitigates fiduciary risk
- Reduce direct recordkeeping costs and administrative overhead; no customized offering for each participant
- Streamline plan operations and simplify decision-making for the employer because it is mostly automated
- Reduce the amount of time that a sponsor needs to periodically redesign the plan and educate participants

Second, employers can offer matching contributions to its retirement plan participants. Matching contributions continue to be the most popular way for plan sponsors to help employees prepare for retirement. In fact, plan sponsors are more likely to provide matching contributions for employees (66 percent, up 7 percent over 2009 data) than they are to offer profit sharing (4 percent) or both matching contributions and profit sharing (20 percent).²⁰

Lastly, employers should continually measure important plan metrics, such as participation rates, deferral rates and replacement ratio, and compare them to an industry benchmark. The results will be the best indicator of a plan’s current condition.

If you need help understanding the new regulations, analyzing fees or otherwise helping your employees become retirement ready, your NFP advisor can assist you by using NFP’s proprietary Plan Diagnostic. After determining your plan’s diagnostic results, your advisor will create a Plan for Success that outlines specific steps you can take to improve your plan.

Advisor Engagement

The new normal has brought with it a shift of focus for plan sponsors. Historically, plan sponsors spent a good deal of time determining if they were with the right provider and managing the investment process. While those activities are important, sponsors are now almost five times more concerned with finding the right advisor than changing their provider.²¹ (Figure 4) In fact, when it comes to working with an advisor:²²

- More plans than ever are currently working with an advisor (25 percent increase since 2008).
- Demand to change current advisor rose to its highest level yet in 2010 (12.7 percent).
- Over 10 percent of plans without an advisor are likely to add one.

Opportunity indices for 2010 (all markets)

- Actively searching/thinking of changing record keepers
- Planning to revise/add funds
- Considering changing advisors
- Considering adding an independent advisor

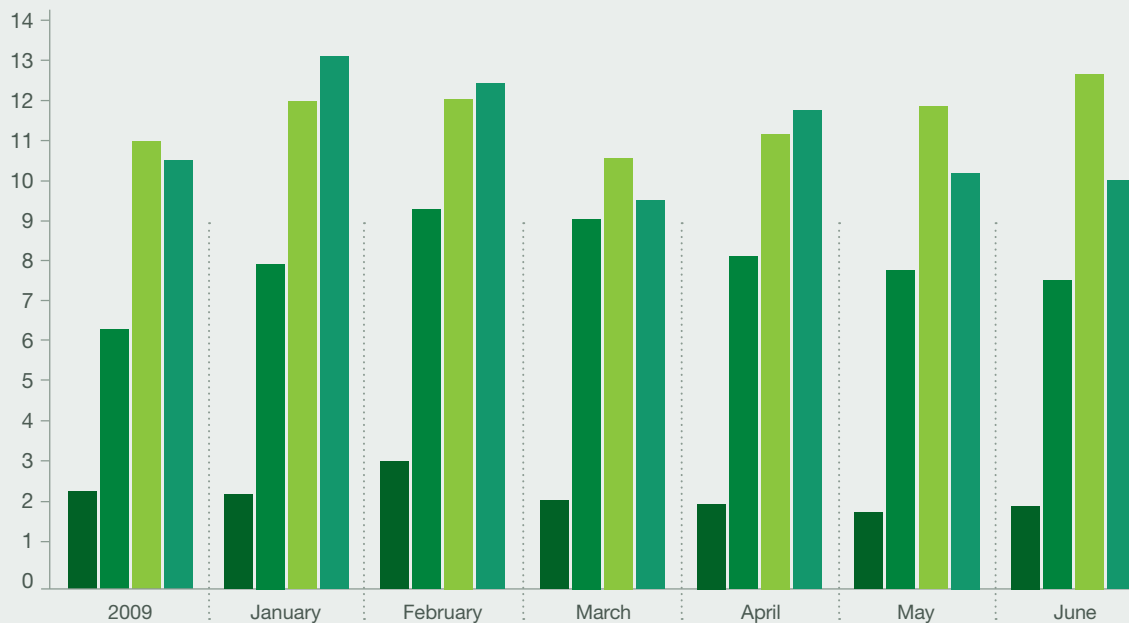


Figure 4

Retirement

This is a positive shift considering the extraordinary fiduciary responsibilities plan sponsors now face. Running a retirement plan in today's complex world and ensuring that participants are ready for retirement is a daunting task. The best opportunity a plan sponsor has to meet all of their plan obligations is to work with an expert advisor — a professional who can help manage and mitigate fiduciary risk. A professional who understands your obligations and challenges, and who can create real solutions.

Finding the right advisor can be a challenge in and of itself. There are many considerations for a plan sponsor seeking an advisor. A plan sponsor should:

- Hire a quality advisor who is a retirement plan professional — someone who primarily focuses on the retirement plan business. Retirement plans are complex and comprehensive in nature. Just as you would hire an attorney to address your legal concerns, you should hire a professional to address your plan responsibilities.
- Expect an advisor to clearly articulate his service model and fees from the beginning. Require that an advisor provide a full service model that can support all plan needs — not just the investment process.
- Ask whether the advisor is a fiduciary to the plan and whether he will claim fiduciary status in writing.
- Employ an advisor and his team to work with participants. Not only can they help participants reach their goals, they can help explain the new fee disclosure. Participants are not accustomed to seeing their fees, so most will not be able to determine what is reasonable.

The new normal presents many challenges to employees and employers in connection with retirement planning. Plan sponsors will have to navigate through many different obstacles to help participants achieve the goal of retirement readiness, including understanding the shifting legislative and regulatory landscape, focusing on analyzing and benchmarking plan fees.

Ultimately, plan sponsors should engage an expert advisor to help them achieve retirement readiness. By engaging such an expert advisor, plan sponsors will have the ability to navigate the new normal and find specific solutions to their participant's retirement planning needs.

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