



SOLUTIONS

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ADDRESSING FINANCIAL MARKET TURMOIL

Turmoil in the financial markets is the top news story (other than the election propaganda) and affects virtually all sectors of society. The insurance industry has not been spared. With the insurance operations of American International Group (AIG) as the most obvious example, the financial stability of insurance companies has rightly become a prominent concern for many insurance buyers. This uncertainty has led to questions about how their company's insurance programs will be affected and what should be done, if anything.

Do not panic. Take a thoughtful approach. While there is no one answer for all situations, there are some basic considerations that should be part of the analysis and decision making process. These are the same considerations made during a renewal strategy meeting. The perspective here has a casualty emphasis but the basic ideas have application to other coverage lines as well. For simplicity, AIG is often used as the company of reference but the same process can apply for any insurer – only the details change.

Stepping back from AIG shock

Seeing the drop in the ratings of AIG was a disconcerting event for the industry, due, in part to the dominant stature that AIG holds. Now that some time has passed, there is additional information worth consideration:

- There have been numerous articles and statements, many from insurance regulators, affirming the solvency of insurance companies and emphasizing that the assets of the AIG insurance subsidiaries would be protected from any parental bankruptcy proceedings should they ever occur.
- AIG's current Best rating is A, IV (negative outlook) and S&P rating is A+. Absent the "negative outlook" the ratings are similar to many of the insurers that are AIG competitors.
- AIG has been willing to provide an endorsement that allows pro-rata cancellation should its Best rating drop below A- or the Standard & Poors (S&P) below BBB.

While every client must do its own assessment of AIG's status, all relevant information should be considered in the analysis. For instance, financial security may be the strongest consideration, but what about loss of talent?

The Current Partner

Why is any current insurer engaged over another? There are usually several reasons why coverage has been bound with an insurer. Financial strength, coverage terms, premium, service and relationship may have all played a part in the decision. Would a new insurer be an improvement using relevant criteria? It is important to review the advantages that led to your binding with your current insurer and, if necessary, which you would be willing to sacrifice.

A Clean Break?

You can switch insurers at any time; however, for business relationships with long-term liability, it is likely that you will still have to deal with the replaced insurer on open claims, incurred but not reported claims, and on the settlement of any security obligations.

Depending on your program structure, this may or may not be a large concern. However, reduction of existing liability is seldom a quick process.

The New Deal

When an insurer's rating drops, many insurers are eager to replace that company's coverage for concerned buyers and may be making changes in their marketing approach; including, but not limited to, expanded risk



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appetites, higher excess limits being offered and attractive security on loss-sensitive programs. Will these appetites last or are they opportunistic? Are these insurers making a long term commitment? Can or will they offer the same coverages in the future? How will they change premium over an extended period of time?

The AIG story has been the most publicized and dramatic, but they are not the only insurer in the news. Whether from investment or underwriting loss, it is hard to find a property-casualty insurer that had positive 3rd quarter results and most have weaker investment portfolios. While it is impossible to predict, one should consider the possibility that other insurers could experience negative outcomes from their activities.

While it is often difficult, try to determine whether there is long-term viability in any new or expanded offerings from insurers. Remember it is important to consider your insurer's standing in relation to any covenants you have entered into that address their financial ratings. If you are contemplating making an insurer change, make sure you can articulate the compelling reasons for doing so.

Currently some of our clients have requested mid-term marketing, some have requested renewal alternatives, some have renewed without alternatives, and some clients have changed carriers. It varies by line of insurance and the insurer.

Much has happened in the last month and more changes will take place. The market appears to be changing and could turn hard in the near future. This will complicate the management of an insurance program. As trusted advisors, we communicate regularly with our clients to keep you up to date.

Contributed by Hays Companies Risk Department

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

On October 3, 2008, President Bush signed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008. This Act amends the original Mental Health Parity Act which was signed into Law in 1996.

The overriding emphasis of the Act is to eliminate covered plan limitations that reduce the benefits paid for either mental health or addiction conditions. The old Act allowed plans to have visit/day limits but not annual or lifetime dollar maximums for mental health.

Addiction was not addressed.

Under the new Act, plans are not required to cover either mental health or addiction conditions. However, if the plans offer any coverage for either condition, they must comply with the new Law. In addition, employers with 50 or less employees are exempted from the Law. State, local and tribal governments may elect to be exempted from these requirements.

Plans that can prove, by an actuarial cost determination, that implementing the new benefits will increase their cost by more than 2% in the first year and 1% in subsequent years will be exempt for the following year. However, the plan needs to operate under the new rules for the first six months of the plan year before this assessment may be made.

Plans with renewal dates beginning on/after October 4, 2009 are required to comply with the new rules. Plans maintained pursuant to existing collective bargaining agreements do not need to comply until the later of 1/1/2009 or the expiration of the current contract.

The Law/Act also allows the states to have more stringent rules than required by this Act/Law. Where state law is not as strong, the federal rules will apply.

Since this Law/Act was just signed in October, the DOL/EBSA has not had a chance to issue preliminary regulations that describe in more detail what is intended. For example, there are no definitive definitions of either mental health or addiction conditions contained in the Law. The Law merely indicates that these are as defined "by the plan or applicable state or federal Law."

Employers need to be aware that this Law will affect their renewals on/after 10/4/09. This will entail reviewing existing contract language, comparing it to the regulations (still to be issued), and making any required changes. This Law/Act impacts both fully-insured and self-funded/insured plans.

IRS RELEASES FINAL REGULATIONS IMPACTING DEFINITION OF DEPENDENT

In late July the IRS released final regulations addressing the rules applicable to the determination of a child's dependent status if the child's parents:

- are divorced,
- are legally separated under a decree of separate

maintenance,

- are separated under a written separation agreement, or
- live apart at all times during the last six (6) months of the calendar year.

The regulations (available at <http://edocket.access.gpo.gov/2008/pdf/E8-15044.pdf>) were issued under Section 152 of the Internal Revenue Code (the “Code”). Section 152 of the Code is relevant in determining whether:

- providing medical, dental, or vision coverage to a child is taxable to the employee,
- expenses incurred by the child may be reimbursed under a health flexible spending account (“FSA”) or a health reimbursement arrangement (“HRA”),
- expenses incurred by the child may be reimbursed on a tax-free basis from a health savings account (“HSA”), and
- the child is a “qualifying individual” for purposes of a dependent care FSA.

The rules contained in these final regulations impact *group health plans* (including major medical, dental, health flexible spending accounts, and health reimbursement arrangements) and *dependent care flexible spending accounts* (a/k/a dependent care expense reimbursement plans or dependent care assistance plans).

General Rule – Custodial Parent

Under Section 152 of the Code, a child is a “qualifying child” of a parent only if, among other things, the child resides with the parent for more than half of the year. If a child otherwise satisfies the requirements of a “qualifying child” with respect to both parents, but the parents do not file a joint federal income tax return, the child is the qualifying child of only one parent. The parent that can treat the child as a “qualifying child” is the parent with whom the child resided for the longest period of time or, if the child resides with both parents for the same amount of time, the parent with the highest adjusted gross income. As a result of the application of this general rule, in divorce or separation situations, *typically only the custodial parent can treat a child as a dependent for purposes of the Code.*

Note: Special rules apply if the child is not the “qualifying child” of either parent and the parents seek to treat the child as a “qualifying relative.”

Special Rule – Non-Custodial Parent

A non-custodial parent may claim a child as a qualifying child if the requirements of Code Section 152 (e) are satisfied. Generally, those requirements are satisfied if:

- the child qualifies as a dependent of one of the parents;
- the parents (both parents together) of the child provide more than half of the child support for the calendar year;
- the child is in the custody of one or both parents for more than half of the calendar year;
- the parents are divorced, legally separated under a decree of separate maintenance, separated under a written separation agreement, or live apart at all times during the last six (6) months of the calendar year; and
- the custodial parent releases the right to claim the child as a dependent.

The regulations contain information regarding the application of the special rule. The regulations include twenty (20) examples applying the rules.

Application to Group Health Plans and HSAs— Very Important Clarification

As described in guidance issued by the IRS after the final regulations were released (Revenue Procedure 2008-48), the Code sections governing:

- which dependents may receive tax-favored coverage under a group health plan,
- for which dependents expenses may be reimbursed under a health FSA or HRA, and
- for which dependents expenses may be reimbursed on a tax-free basis under an HSA,

provide that if the other requirements of the special rule described above are satisfied, both parents may treat the child as a dependent even if the custodial parent does not release the right to claim the child as a dependent.

Note: The terms of the Group Health Plan will define the dependents eligible for coverage subject to any applicable state laws; the IRS Regulations provide guidance on how the cost for a non-qualified dependent should be treated.

Application to Dependent Care FSAs

In most cases, to be a “qualifying individual” under a

IRS RELEASES FINAL REGULATIONS IMPACTING DEFINITION OF DEPENDENT, cont.

dependent care FSA, an individual must be a qualifying child under Section 152. Although the special rule in Section 152(e) described above applies in determining who is a qualifying child under Section 152, the dependent care FSA rules indicate, for purposes of determining whether a child is a qualifying individual, if the requirements of the special rule regarding children of divorced or separated parents are satisfied, then the child is the qualifying child (and thereby the qualifying individual) of the custodial parent.

Caution: This is different from how the special rule applies in other contexts (e.g., group health plans and HSAs). As a result, in some cases, a child will not be a “qualifying individual” of a non-custodial parent for purposes of the dependent care FSA, but will be considered a dependent of that parent for purpose of the group health plans and HSAs.

Action Items

In light of the final regulations, it is recommended the following actions be taken:

- Review and, if necessary, revise any forms or descriptive materials being used for the purpose of identifying whether children covered under your medical, dental, or vision plans are tax dependents.
- Review and revise group health plan (e.g., medical, dental, and vision plans), health FSA, and HRA documentation to accurately describe which individuals are dependents for tax purposes, as clarified in the final regulations.
- Review and revise dependent care FSA documentation to accurately describe which individuals are “qualifying individuals” for purposes of dependent care FSAs.

- If a high deductible health plan is offered with an HSA, review any descriptive materials distributed to employees about HSA distributions to ensure they accurately describe which individuals are dependents for whom tax-free distributions may be taken, as clarified in the final regulations.

Contributed by Hitesman and Associates, P.A., a prominent Minnesota law firm

WHO, WHAT, WHEN...

Recently we had a commercial firm spray our facility for insects and other pests. After a couple of days one of our employees said she didn't feel well and wanted to go home. We offered to give her a ride but she decided to drive herself. On her way home she ran into another vehicle, injuring the other driver. We've been told that it may be possible for the other driver to sue us for his injuries. Is that true?

A court case (*Bussard v. Minimed Inc.*, 105 Cal. App. 4th 798, Cal. App., 2nd Dist.) found the employer liable in a similar case. Normally companies are liable only for injuries caused by the employee when that person is acting within the course of employment. However, if the company should have and could have identified a potential risk and did nothing to prevent it, it can be held liable for any resulting injuries.

It is important to be proactive where illness/injury related complaints might cause accidents outside of the normal plan definitions. This may mean providing transportation to employees' homes or to medical care if needed. Another time, proactive planning can help avoid a lawsuit involving impaired driving when employees work long or late-night hours or from events where alcohol is served.

Also, check to see if your corporate auto policy has a “Hired and Non-owned Auto” provision in case the injured party decides to sue.



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