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- Can the Salt of Medicare Advantage Help Melt Your FASB or GASB Iceberg?
- The Perils of Poor Data for Long-Term Disability Plans

Cash Balancing Your Company's Retirement Income Program

by Jeff Lane

Many defined benefit plan sponsors with final pay formulas are either developing an exit strategy or trying to defend the continuation of the traditional pension plan to their Boards of Directors and/or investors. Maintaining the plan "as is" exposes the plan sponsor to cost volatility and bottom-line financial consequences in the future under the new accounting rules. Terminating the plan often carries staggering costs in today's low interest rate environment. Freezing the plan while sponsoring a new or improved defined contribution retirement vehicle to keep older employees "whole" can produce sizeable cost outlays. Performing the make-whole feat in a nonqualified plan addresses only key executives, while doing so for a broader class of employees through a pay bonus produces adverse tax consequences for participants. At the same time, employers remain concerned about employees' retirement income adequacy and security, and realize the value that defined benefit plans can offer.

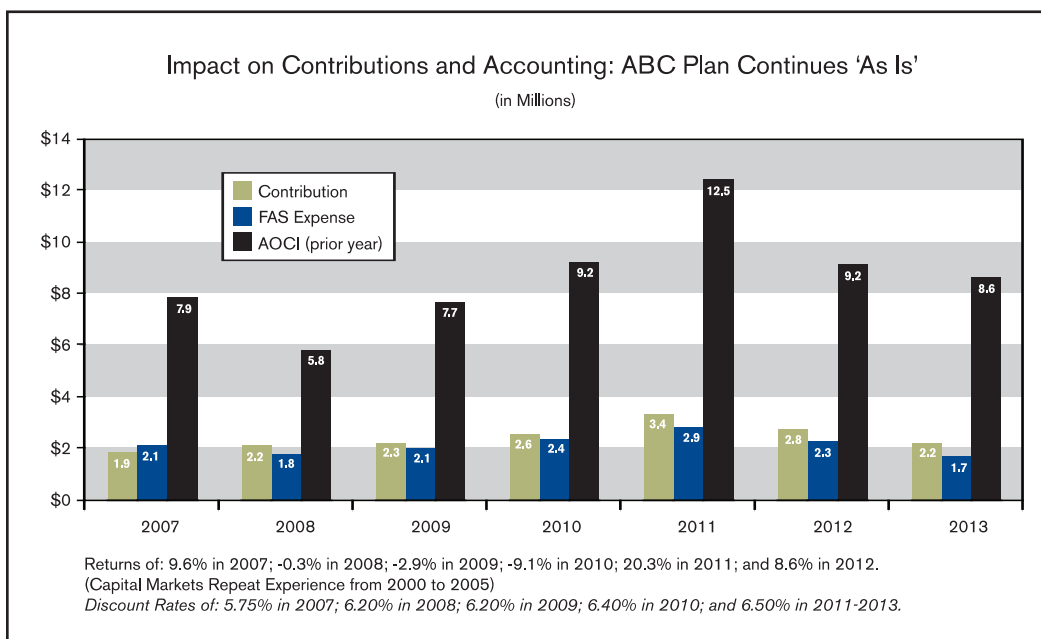
One possible solution to employers' dilemma is to modify the traditional defined benefit plan's final pay formula to a cash balance formula. This article explores the advantages and the effects of plan conversions.

Maintenance and Termination/Freeze Difficulties

If the sponsor continues the plan "as is," the exposure to large fluctuations in contributions and accounting expense—along with huge liabilities entered on the balance sheet—can burn the employer in the future. Modeling an illustrative ABC Company's sample traditional defined benefit plan with a portfolio comprised of 60% equities and 40% fixed income and subjecting it to the capital market experience from 2000 to 2005 produced the forecast of funding contributions and accounting results, as seen in Figure 1.

ABC cannot stomach the prospects of having to report a reduction of equity on its balance sheet at the end of 2010 by an entry of \$12.5 million in Accumulated Other

Comprehensive Income (AOCI). The AOCI, which recognizes a portion of the present value of projected future benefit accruals and any other postretirement benefits such as retiree medical, will impact the company's credit rating and borrowing capacity. Its immediate reaction is, "Let's terminate the plan and enhance our defined contribution program." ABC is advised that the value of the defined benefit plan's annual accruals (i.e., normal cost) under the 2006 Pension Protection Act (PPA) is likely to be in the range of 14% of qualified payroll. The company wants to explore replacing the plan with a new defined contribution design that grants 8% on all pay plus an additional 5% on pay above the Social Security wage base. ABC assumes that the new defined contribution accounts will generate an annual average net investment return of 8%. Under such an assumption,

FIGURE 1


younger employees can reasonably get close to the benefit value that the defined benefit plan would have provided, but employees between the ages of 45 and 55 would experience a future benefit value loss of nearly one-third of the value provided by the current defined benefit plan.

ABC's current level of underfunding on a plan termination basis is about \$5.4 million. The magnitude of the shortfall may necessitate administering the plan several more years as ABC makes additional contributions to eliminate the termination shortfall while hoping that interest rates will eventually rise, thereby lowering the underlying termination liabilities. Concurrently, the company must fund the new defined contribution program at an expected annual contribution rate of just below 9% of pay. The defined contribution solution will solve ABC's accounting exposure but results in a significant reduction in benefits to its older employees that would have accrued if the defined benefit plan had not been terminated, as well as larger cash outlays in funding the new program and eliminating the termination shortfall for the defined benefit plan.

The Cash Balance Conversion Option

A conversion to a cash balance formula offers plan sponsors a viable means to gracefully exit the final pay formula environment. After several years of uncertainty about defined benefit pension plans with cash balance formulas, some employers have renewed their interest in providing defined benefits in light of the PPA's protections against age discrimination claims and establishment of a "safe harbor" method for converting plans from a traditional final pay plan. And although certain matters regarding cash balance plans remain to be clarified, the IRS regulations provide enough of a roadmap for plan sponsors to take action today. In addition, depending on the specific plan design and other factors, conversions could:

- provide the opportunity for the sponsor to have more stable and predictable costs than under the current final pay defined benefit design;
- eliminate the immediate accounting threat of having to include large liabilities on the employer's financial statements;
- prospectively reduce the interest rate volatility under the pension accounting rules;
- provide a tax-qualified plan vehicle for keeping current plan participants (or a select group of current participants) whole without the sponsor worrying about violating the tax code's minimum participation rules;
- scrap the need for a sponsor to juggle the funding of two separate plans and avoid the administrative costs of terminating the traditional defined benefit plan; and
- avoid transferring the entire investment risk onto plan participants who may lack the expertise and objectivity to properly manage their own portfolios, while also ensuring that the cash balance plan accounts can be converted to an annuity in a cost-efficient manner at retirement.

One additional help for all defined benefit plans—not just cash balance plans—came under the PPA's provision allowing sponsors to make larger tax deductible contributions to the plan in good financial years. The ability of a plan sponsor to build up a "rainy day" surplus can help prevent a repeat of

the recent history of not being able to contribute more during the prosperous 1990s, only to experience an extreme increase in mandated contributions starting in 2001. The prior funding constraints on building surplus assets during prosperous years to mitigate large increases in minimum contributions during lean years led to cost volatility, which may have been a key frustration leading some sponsors to abandon these plans.

Next on the Decision Tree

A plan sponsor that has committed to discarding its final pay formula must decide whether to immediately convert the employees' prior accrued benefits to a lump sum, which would be reflected in the underlying cash balance account, or leave the amounts as a frozen annuity (at least until retirement). A well funded plan could provide plan participants the economic windfall created by converting the accrued benefits immediately to lump sums in the current, historically low interest rate environment, allowing them to accumulate larger retirement account balances.

A plan that is not robustly funded could leave participants' prior accrued benefits as an annuity, at least until they retire or terminate employment. Doing so avoids locking in higher financial liabilities associated with the frozen annuities under the current low interest rate environment. Also, because the minimum present value of the prior accrued benefit must reflect any retirement subsidy earned at the eventual retirement date, a plan sponsor waiting to convert the accrued benefit can avoid having to make two calculations of the underlying value associated with the frozen accrued benefits. Converting immediately would entail keeping track of the cash balance account that is due to prior plan benefits separately from the accumulation of post-conversion pay credits and ensuring that the share of the account attributed to the prior benefits is no less than the present value of the subsidized annuity earned at retirement.

Exploring the Effects on the Plan Sponsor and Participants

An employer adopting a cash balance formula will typically consider the effect the conversion will have on current plan participants and the overall objective of the retirement income program. Many plan sponsors like the idea of progressively rewarding longer service employees. For plan sponsors migrating from a traditional pay formula, establishing a cash balance formula that varies pay credits with service and/or age generally has appeal and better shadows the increasing value of accruals under the traditional plan.

ABC decides to implement a "points-based" pay crediting formula, whereby contributions vary from 5% to 15%, depending on the sum of the participant's age plus two times years of service to date (5% for 20 points grading up to 15% after 100 points). Because ABC's traditional final pay formula was integrated with Social Security, the company also grants an additional 5% pay credit on wages above the Social Security wage base. The ongoing annual employer contribution for this new design is 10.6% of pay, which is almost 30% less than the ongoing normal cost of the traditional defined benefit plan. Also, the contributions under the cash balance plan design should be more stable and predictable than under the former final pay formula. If ABC can properly manage plan assets to stay ahead of accrued liabilities, its future plan contributions should be reliably around 10.6% of pay each year. If asset growth outpaces the accrued benefit liabilities, the contribution could be even less. ABC particularly likes the forecast of the accounting results, which were subject to the capital market performance from 2000 to 2005, as shown in Figure 2 (on page 3).

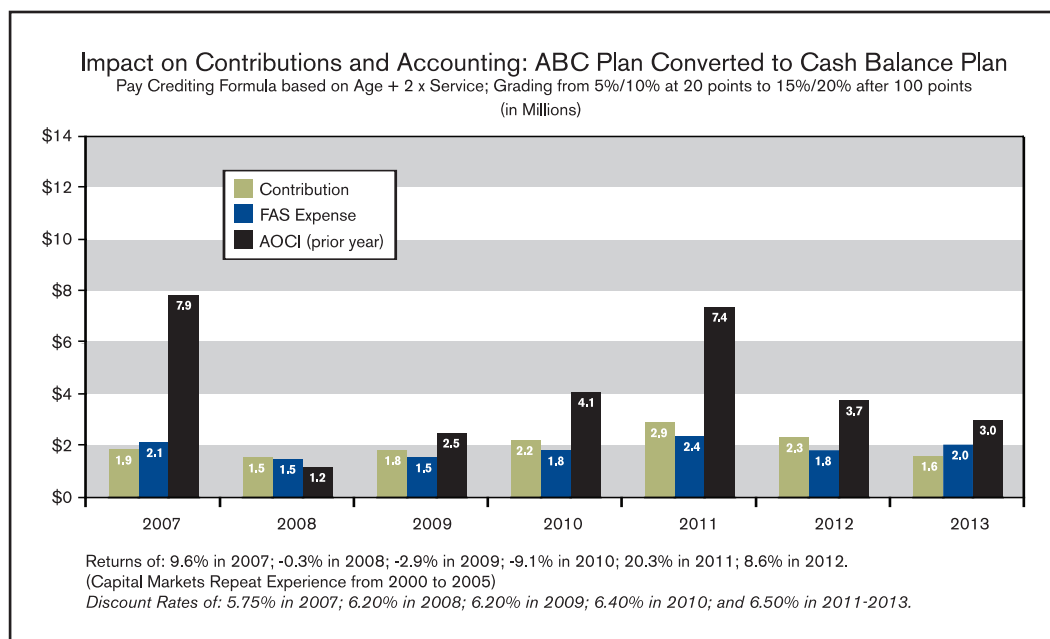
What particularly appeals to ABC is the manageable exposure of AOCI on the balance sheet, with a high entry of \$7.4 million at the end of 2010 when assets are subjected to a 9% loss. ABC is even more confident it can manage the accounting volatility beyond 2013, as plan liabilities become more predictable and “liability driven” investment strategies can help ensure that assets stay above these more predictable liabilities.

The new design’s impact on plan participants presents a different set of challenges for ABC: the age plus service cash balance plan still falls short of replacing the former traditional formula for older workers. One key reason is the assumed interest crediting rate on the cash balance accounts. ABC assumes the account balances will grow at a 5% annual interest crediting rate, versus the 8% per year investment returns under the defined contribution plan alternative. Over the past 21 years, the average yield on Moody’s AA bonds (20 or more years in duration) have been about 380 basis points less than a 60%/40% mix of the Standard and Poor’s 500 stock index/fixed income funds. When one considers the fees that are typically deducted from total returns in a defined contribution plan, the actual differential between the earnings on the cash balance plan and those on a defined benefit plan will likely be less than 3% per year. ABC also recognizes that the 60%/40% portfolio has been 5.5 times as risky as corporate bond yields over the past 21 years. Furthermore, if ABC is convinced that an equity weighted portfolio will far outpace corporate bond yields, then it can use the excess return either to lower employer contributions or increase the pay credit schedule for the cash balance plan. ABC concludes that a steady indexation of participants’ cash balance accounts using corporate bond yields and having professional advisors manage the investment risk offer the optimal approach for providing participants retirement income security.

ABC’s solution for older workers is to put any employee who is at least age 45 with five years of service on a more generous pay credit formula than the 5%-15% schedule, after ensuring that other plan qualifications (e.g., nondiscrimination) are satisfied. This group’s schedule grades from 7.5% at 20 points to 20% after 100 points, which results in a total employer annual contribution of 13.3% of pay (2.7%/year higher than the single pay credit schedule). The extra employer contribution of 2.7% per year will gradually diminish over time but allows ABC to keep this select group of older workers virtually whole. In the worst case scenario, these employees on average would lose 12% of the prior plan’s age 65 benefit value and would leave with higher total benefit values at most of the earlier termination ages under the new design.

One of the drawbacks to converting the traditional defined benefit formula to a cash balance plan compared to transitioning to an exclusive

FIGURE 2



defined contribution plan arrangement is that the former requires the plan sponsor to disclose the impact of the change on projected benefits while the latter does not. However, ABC’s adoption of the more generous formula for older participants allows it to disclose more favorable outcomes than if it were to adopt a single schedule for all participants. ABC will also have to adopt a three-year cliff vesting schedule, replacing the plan’s current five-year cliff schedule.

Conclusion

Many employers contemplating a change from its traditional defined benefit plan will look exclusively to a defined contribution plan as the only viable alternative. Often, the decision is based on the recent negative publicity over cash balance plans and the desire to follow the footsteps of other organizations that have left the traditional defined benefit plan environment. However, the cash balance conversion actually can allow employers to accomplish many of the same goals they seek with converting to a defined contribution plan and can give participants more retirement income security. A cash balance plan also may provide the qualified plan vehicle for keeping a select group of current participants whole while not running afoul of the tax code’s nondiscrimination rules, a problem often encountered by smaller employers. Furthermore, a cash balance plan can help participants avoid the common mistakes—investing too conservatively or too aggressively, or transferring monies after funds have dramatically risen or fallen—that are frequently associated with participant-directed accounts.

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Can the Salt of Medicare Advantage Help Melt Your FASB or GASB Iceberg?

by Patrick J. Dunks

A growing number of employers that sponsor medical coverage for Medicare-eligible retirees are investigating their options for meeting their obligations to retirees. Because accounting standards require plan sponsors to estimate the size of the retiree medical cost iceberg rather than just its tip, the realization and disclosure of the high cost of the benefits are driving employers to look for cost reduction measures.

This article explores Medicare Advantage (MA) as a viable option for plan sponsors. As the accounting rules force plan sponsors to grapple with high retiree healthcare costs, employers are reassessing their retiree medical programs and examining alternatives.

Accounting Standards

Accounting rules require employers to disclose their liabilities for retiree health programs. *Public and private companies and nongovernmental not-for-profit organizations* must report the amounts on their balance sheets, under the rules promulgated by the Financial Accounting Standards Board (FASB).

For state and local governmental employers, disclosures apply on a three-year phased-in basis (depending on the size of the governmental entity), under requirements issued by the Governmental Accounting Standards Board (GASB) in 2004. The GASB rule kicks in for the mid-sized entities—those with \$10 million to \$100 million in revenues—for fiscal years beginning after December 15, 2007, thus heightening the current interest in retiree health liabilities and plan alternatives.

Plan Sponsors' Options

Plan sponsors may be able to reduce costs by: toughening eligibility requirements; decreasing benefit levels; changing benefit coordination to less costly options; increasing retiree contributions; and/or providing benefits through MA plans.

Each of the first four will increase retirees' out-of-pocket costs and may require negotiations, particularly if benefits are contractually promised. The MA approach is simply a different way of delivering retiree medical benefits, whether they are contractually promised or provided on a voluntary basis. Providing benefits through MA plans can significantly reduce costs for Medicare-eligible retirees, helping to melt a portion of the plan sponsor's FASB or GASB iceberg.

MA in Brief

MA plans nearly always offer benefits beyond those under traditional Medicare arrangements to entice Medicare beneficiaries to enroll. The MA organization—such as a health maintenance organization (HMO) or a preferred provider organization (PPO)—contracts with the Department of Health and Human Services' Centers for Medicare &

Medicaid Services (CMS) to provide benefits in exchange for funding from the agency.

Plan sponsors may contract with an MA organization to provide coverage to their retirees on a group basis. If the plan sponsor obtains Medicare Part D prescription drug coverage through the MA organization in lieu of receiving the 28% Part D retiree drug subsidy (RDS), the MA organization receives a similar Part D subsidy, which will reduce the premium the MA organization charges the plan sponsor. This option is generally more appealing to state and local governments that are not subject to federal taxes. Alternatively, a plan sponsor may become an MA organization for its own retirees. If it does so, the plan sponsor takes on a substantial operational and compliance burden. Thus, most plan sponsors that opt for the MA route simply contract with MA organizations to avoid those burdens.

Until recently, most MA plans paid little attention to marketing to groups and instead focused on the individual market. Today's MA market is competitive, with group business attractive due to the large numbers of members that may be reached at a relatively low marketing cost. As MA organizations and plan sponsors gain greater experience with each other, more employer groups are likely to realize savings by offering MA plans.

MA and Medicare Wraparound Plans

Typically, retiree medical plans provided by employers wrap around Medicare benefits. Table 1 (on page 5) compares the general characteristics of MA and Medicare wraparound plans.

MA Products

In the individual market, a Medicare beneficiary's access to MA products is determined by his or her county of residence. The particular types of MA products available vary from county to county. In general, more than 90% of Medicare beneficiaries have access to at least one type of MA product. For group MA products, CMS regulations grant MA organizations significant flexibility to expand service areas so that nearly all groups covering Medicare-eligible retirees can obtain coverage through MA plans. Table 2 (on page 5) summarizes MA product types and group service area expansion limits.

MA organizations can only offer an employer group those products they sell to the individual market, but starting in 2008 can provide nonnetwork private fee-for-service (PFFS) and medical savings account group products without offering similar individual products. For each group, the MA organization and the group negotiate premiums and benefits. Groups should be able to use the highly competitive nature of the MA market to their advantage in negotiations.

Historically, HMO and PPO products have been most active in the MA market and thus, with group MA products. However, in some instances,

TABLE 1

CHARACTERISTICS OF MEDICARE ADVANTAGE AND MEDICARE WRAPAROUND PLANS		
Characteristic	Medicare Advantage	Wraparound
Interaction with Medicare Parts A and B benefits	Replaces traditional Parts A and B coverage. Additional coverage typically pays a portion of retirees' cost-sharing amounts and may include some non-Medicare services	Supplements traditional Medicare coverage by paying a portion of retirees' cost-sharing amounts after Medicare has first paid its share of the Part A or Part B service.
Group Benefits	Additional benefits beyond required Medicare benefits can be tailored to each employer group.	Can be tailored to each employer group in most states.
Part D (Prescription Drugs) benefits (optional)	Part D benefits provided by MA organization or through plan sponsor with Retiree Drug Subsidy (RDS). Benefit levels generally negotiable beyond minimum requirements. Coverage cannot be provided by a stand-alone Prescription Drug Plan (PDP).	Part D benefits provided by stand-alone PDP or through plan sponsor with RDS. Benefit levels generally negotiable beyond minimum requirements.
Revenue Sources	Risk-adjusted revenue paid by CMS plus plan sponsor premium (if any) negotiated between sponsor and MA organization.	Plan premium negotiated between plan sponsor and Medicare wraparound insurer. In community-rated states, rates may be set by insurer without negotiation.
Network	Many, but not all, MA plans are network products.	Most wraparound plans are not network products.
Utilization Management (UM)	MA plans may or may not employ UM techniques.	UM techniques are rarely used.
Regulation and Oversight	Federal authority—CMS—administers program.	State Insurance Department or, if applicable, federal (under ERISA).
Self-funding	Not usual, but possible.	Often.

TABLE 2

MA Product Type	General Description	Group Service Area Expansion Allowances*
HMO and Provider-Sponsored Organizations (includes point-of-service plans (POS))	Network product with greatest use of UM techniques. Service areas are determined by MA plan on a county-by-county basis.	Can expand service area to additional counties in states where individual product is offered, as long as the plan pays noncontracted providers at Medicare allowable levels.
PPO	Network product with lower use of UM techniques than HMO. Service areas are determined by MA plan on a county-by-county basis.	Can expand service area to additional counties in states where individual product is offered, as long as the plan pays noncontracted providers at Medicare allowable levels and treats covered services as network benefits in the additional counties.
Regional PPO (RPPD)	Network product with lower use of UM techniques than HMO. Service areas are predefined by CMS and include one or more complete states.	No expansion allowed.
Private Fee-for-Service (PFFS)	Typically a nonnetwork product with limited UM. Where network is available, usage is optional for members. Service areas are determined by MA plan on a county-by-county basis.	For nonnetwork products, can expand nationwide. For network PFFS plans, can expand service area to additional counties in states where individual product is offered.
Medical Savings Account (MSA)	Typically, a nonnetwork product with no UM. Where network is available, use is optional for members. Service areas are determined by MA plan on a county-by-county basis.	For nonnetwork products, can expand nationwide. For network MSA plans, can expand service area to additional counties in states where individual product is offered.

* For network products, an MA organization can contract to provide care through other MA organizations that meet network adequacy requirements in a service area outside its usual service area.

the limited service expansion ability and the network requirement have created hurdles that groups were not willing to overcome. More recently, the PFFS product availability is exploding. Nonnetwork PFFS products may be a good fit for many employer groups, given the ability to expand service areas nationwide. Also, PFFS products can often match existing, negotiated, plan designs more precisely than HMO or point-of-service (POS) plans that include incentives for using providers within the network or that require primary care physicians to authorize care from other healthcare providers.

Reducing Costs on the Bottom Line

MA products will be more financially advantageous—in comparison with Medicare wraparound plans—to groups in areas where the cost for an MA organization to provide traditional Medicare benefits is less than the revenue it receives from CMS. In general, this occurs when: an MA organization negotiates contracts with providers to pay less than the Medicare allowed fees; an MA organization reduces the cost of care through utilization management; an MA organization enhances revenue through coding improvements; and/or CMS payment rates are higher than Medicare costs in the area. In such situations, the MA organization is required to spend the “surplus” revenue on extra benefits for members. Extra benefits often take the form of reducing traditional Medicare cost sharing, providing non-Medicare benefits, and/or paying for all or some of Part D premiums. Under Medicare wraparound approaches, each of these items is usually already paid for by the group plan. If benefits are not enhanced when con-

verted to an MA product, at least a portion of that cost can be covered by CMS subsidies and therefore should reduce group premiums.

Because the relationship between MA revenue and traditional Medicare benefit costs varies widely from county to county, MA plans will not always have group premiums that are lower than Medicare wraparound products. Premium reduction success depends heavily on where retirees reside. In many large metropolitan areas, realizing premium reductions may require using HMO or PPO MA products that effectively contain costs. In many rural areas, the only MA product available is often a PFFS plan. Thus, for large groups with retirees in many areas of the country, combinations of MA products and/or wraparound products may provide the group with the best value.

Conclusion

Many employers took the practical approach of applying for the RDS when Medicare Part D first was enacted. There simply was not enough time to consider all available options. With some experience behind them and with FASB and GASB rules shedding new light and hard data on employers’ retiree medical liabilities, plan sponsors are finding alternatives that can reduce costs. MA products provide a potential means to do so.

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The Perils of Poor Data for Long-Term Disability Plans

by Daniel D. Skwire and Tasha S. Khan

The liabilities a self-funded employer incurs for long term disability (LTD) plans can be quite large—often in excess of \$100,000 per disabled employee, and sometimes much more for a highly compensated one. Because these liabilities can have a substantial impact on employers’ financial statements and because of greater public scrutiny of companies’ accounting practices, many companies are now placing a much higher priority than in the past on the integrity of the data used to determine their LTD plan liabilities.

This article examines the implications of erroneous data on LTD liabilities in public and private self-funded employers, highlighting specific types of data elements that are most subject to errors. The information presented is based on auditing claims when performing LTD plan valuations.

The Need for Data Integrity

Employers that self-insure their LTD plans are accustomed to dealing with the technical complexities of disability benefit formulas, claim administration practices, funding changes, and annual valuations. One crucial factor that underlies successful plan performance is the employer’s ability to maintain accurate data on its employees covered by LTD benefits.

LTD claim data is used to measure historical experience, which provides the basis for estimating an employer’s future contribution rates and identifying plan changes. It is also used to compute the plan’s liabilities for disabled employees, as required by accounting standards (i.e., FAS 112 for

publicly held companies, and GASB 43 and 45 for public-sector pension plans and employers). A lack of timely and accurate data can have a significant impact on the funding and valuation of LTD plans.

The 2002 Sarbanes-Oxley Act also heightened the importance of data integrity for publicly held companies by including transparency and disclosure demands. Among the law’s many obligations imposed on such employers are two critical items related to data integrity:

- Companies must evaluate and disclose the effectiveness of their internal financial controls, including information technology (IT) systems.
- Chief executive officers and chief financial officers must certify the company’s financial reports.

Measuring Data Integrity

As part of our work performing LTD valuations, we are often asked to undertake claim audits that, among other things, determine the quality of plan data. Over the course of many such audits, we have maintained records on the frequency and types of errors. We examined the combined results from approximately a dozen claim audits, during which we reviewed nearly 1,200 claims. Most of these claims were selected using random processes designed to estimate the error rate in the underlying population with a 5% margin of error and a 95% confidence level.

When assessing issues of data integrity, we compared the electronic data maintained for each claim with the original documents used by claim examiners to determine the amount payable on each claim. Table 1 summarizes our findings on the frequency of errors in the electronic data.

Nearly 10% of the claims had some type of error in the electronic data maintained by the company or its claim administrator for that claim. Not all of these errors had a material financial impact. For instance, an incorrectly coded elimination period for a claim that had been paid for many years would probably have no effect on a company's financial statements. But 6.7% of the claims had errors that affected the calculation of the liability for that claim, and 1.6% of the claims had errors that altered the amount being paid to the claimant each month. These situations pose a major concern for employers, which desire not only fair and accurate payments to their disabled employees, but also a liability calculation that represents an accurate measurement of their obligation for future payments.

Table 2 provides further detail on the types of errors found.

The two most common types of errors pertained to benefit amounts and benefit end dates. The complex nature of LTD benefits means that a large volume of data must be maintained to pay and value each claim correctly. The calculation of the benefit amount alone, for example, depends on factors such as salary, benefit percentage, Social Security offsets, Workers' Compensation offsets, cost-of-living increases, part-time work earnings, maximum benefits, and minimum benefits, among others. Thus, the fact that the relative frequency of errors related to benefit amounts is so high was not entirely unexpected.

We were somewhat surprised, however, to see a large occurrence of errors related to the scheduled benefit end date (i.e., the date on which disability benefits would end if the claimant did not recover or die while eligible for benefits). What would seem to be a straightforward calculation based on the plan design and the claimant's birthdate and date of disability appears to pose something of a challenge, perhaps because this value is often calculated manually by claim administrators. Another complicating factor is the use of benefit schedules designed to comply with the Age Discrimination in Employment Act (ADEA). These benefit schedules have a simple structure (e.g., payable to age 65) for employees who become disabled at younger ages, but a more complex structure for those who become disabled at older ages. A majority of the errors we observed were at older ages of disability.

The Impact of Poor Data

To estimate the potential financial impact of data errors on LTD plans, we performed liability calculations for LTD claims and estimated the impact of some of the most common types of errors we observed in our audits.

Example 1: Benefit End Dates

A common error is for benefit end dates to be computed under the assumption that all benefits end on the insured's 65th birthday when, for claimants who become disabled at age 60 or older, benefits are generally paid under the terms of an ADEA benefit schedule that extends beyond age 65. Table 3 compares the ratio of the correct liability for an ADEA benefit period to the incorrect liability that assumes benefits end at age 65.

For claims incurred at higher ages of disability, the liability for an ADEA benefit schedule is significantly higher than if benefits are paid only to

TABLE 1

OVERALL ERROR RATES IN LTD CLAIM FILES	
Description	% of Claims
Claims with one or more errors	9.8%
Claims with errors affecting liabilities	6.7%
Claims with errors affecting payments	1.6%

TABLE 2

DISTRIBUTION OF ERRORS BY TYPE OF PROBLEM	
Type of Problem	% of Total Errors Found
Benefit End Date	31%
Benefit Amount	21%
Cost-of-Living Increases	11%
Minimum Benefit Amount	11%
Date of Birth or Date of Disability	10%
Recovery of Retroactive Social Security Benefits	3%
Cause of Disability	2%
Other	12%
Total	100%

TABLE 3

IMPACT OF INCORRECT BENEFIT END DATES FOR ADEA BENEFIT SCHEDULES	
Ratio of Correct Liability to Incorrect Liability	
Age at Disability	Liability Ratio
60	108%
61	111%
62	131%
63	179%
64	414%

age 65, and the impact grows rapidly at older ages. This common type of error can result in a plan sponsor incurring significantly greater liabilities than it might have anticipated in funding its plan.

Example 2: Benefit Amounts

Many types of errors can occur in computing benefit amounts. The amounts and effective dates of benefit offsets (e.g., payments from Social Security or Workers' Compensation that are used to reduce LTD benefits) are often miscoded, for example. The failure to include minimum benefit amounts in calculations can also have adverse financial implications. Consider the example of a claimant who has a gross LTD benefit of \$3,000 per month, and benefit offsets of \$1,500 from Social Security and \$1,400 from Workers' Compensation. If the LTD plan has a minimum benefit equal to 10% of the gross benefit, the correct benefit amount is \$300. If the minimum benefit were improperly

coded in the electronic data, however, the plan might compute its liabilities based on a benefit amount of \$100 (i.e., \$3,000 - \$1,500 - \$1,400). The result would be a liability that was only one third as high as the correct value.

Example 3: Cost-of-Living Increases

There is considerable variation in the types of cost-of-living provisions contained in LTD plans. These features increase the benefit paid to a disabled employee each year by either a fixed percentage or a variable amount, often linked to inflation. Many plans specify that cost-of-living increases will apply for only a limited time, such as the first five years of disability. Table 4 compares the ratio of the correct liability for a claim that pays five years of cost-of-living increases to the incorrect liability that assumes the increases continue through age 65.

In this case, the correct liability is lower than the incorrect liability because the cost-of-living increases will expire after only five years.

Sources of Data Errors

Although there are many reasons data errors occur in LTD plans, the simplest case involves a typographical error, such as a miscoded date of birth or date of disability. Occasional errors of this type will occur in any large plan, although an audit process can minimize the frequency and impact.

Another source of errors is a claim administrator's lack of knowledge about the LTD plan's details. For example, an administrator might enter data that does not reflect a recent change in the plan design or fail to include a cost-of-living adjustment payable to a claimant. Employers can address this type of error by focusing on clear and regular communications with their claim administrators, as well as performing periodic on-site audits.

Perhaps the most challenging source of problems arises from underlying databases or computer systems, such as a faulty link between a claim administration system and a database with plan design information. If the claim administration system computes a benefit end date based on information from a plan design database, but the plan design database has inaccurate information or the claim data cannot be properly matched to the plan data, then frequent and recurring errors in benefit end dates may result. A careful audit will generally identify these problems, but a more detailed systems review may be necessary to find a permanent solution.

TABLE 4

IMPACT OF INCORRECT COST-OF-LIVING CALCULATION	
Assumes Unlimited Benefit Instead of Five-Year Benefit Ratio of Correct Liability to Incorrect Liability	
Age at Disability	Liability Ratio
25	87%
35	87%
45	91%
55	98%

Conclusion

Data integrity is important for all types of employee benefit plans but is particularly important for the valuation of LTD plans because employers' liabilities for these plans are large and very sensitive to seemingly small differences in the underlying data. In an era of increased scrutiny of the financial statements of both private- and public-sector employers, these organizations should make every effort to ensure that their self-insured LTD plan liabilities are computed with data that is as accurate as possible.

LTD plan sponsors that wish to evaluate or improve their data integrity should conduct periodic independent audits of their LTD claims and electronic data, including visits to the offices of any third-party administrators involved in the payment of LTD claims. Plan sponsors should also ensure that the annual valuation of an LTD plan includes a review of the reasonableness of the electronic claim data. This type of high-level review, while falling short of a full audit, can often identify key issues and concerns to address. With the right procedures in place, an employer can be confident that the liabilities for its LTD plan are determined using data that correctly reflects the benefits to be paid to its disabled employees.

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