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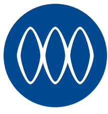

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Taking Stock of Option Expensing

by Glenn Bowen and John Hankerson

Option (ŏp' shən) - noun

1. A choice that is or can be taken
2. The right to buy or sell something, at a specified price during a specified time period (finance)
3. a. A retention and motivation tool designed to align an executive's interests with those of shareholders, thereby contributing to the success of a corporation, ultimately rewarding both the executive and shareholders through increased share value
   b. An opaque way of taking advantage of arcane historical accounting rules, possibly allowing recipients to benefit from general stock market increases that may have nothing to do with company performance
   c. Well at least they're "free"…
   d. …but what about the dilutive effects?

The controversy surrounding the accounting treatment of employee stock options (ESOs) has been hashed out ad infinitum in other forums, but with the issuance of Statement of Financial Accounting Standards No. 123 (revised 2004) "Share-Based Payment" (SFAS123(R)) in December 2004, expensing of ESOs becomes a reality this year. This article focuses on how fair value accounting for ESOs will affect employers and provides tips on how they can strategically compensate employees through performance-based options and other long-term incentives.

The Days that Used to Be

In 1972, one year prior to the opening of the Chicago Board Options Exchange, the Accounting Principles Board issued Opinion No. 25 "Accounting for Stock Issued to Employees" (APB25). Employers could account for ESOs using the "intrinsic value" method, in which the compensation expense for an ESO was determined as the excess of the market price over the strike price at the time that the number of shares granted and the strike price were first known. Thus a "plain vanilla" option (granted with a strike price equal to the current market price and with vesting only dependent on rendering future service) did not give rise to any compensation expense. This accounting treatment encouraged employers to offer "at-the-money" plain vanilla options almost to the exclusion of all other possible types of ESOs.

In 1993, the Financial Accounting Standards Board (FASB) issued an exposure draft that would have required fair value accounting—and expensing—for all stock-based compensation. After contentious and controversial deliberations, FASB issued Statement of Financial Accounting Standards No. 123 (SFAS123) in 1995, requiring footnote disclosure of ESO fair value, but allowing companies to continue recognizing compensation expense under APB 25. In the words of FASB, "The Board chose a disclosure-based solution for stock-based employee compensation to bring closure to the divisive debate on this issue—not because it believes that solution is the best way to improve financial accounting and reporting."

If at First You Don't Succeed…

…Try, try again. In March 2003, FASB once again added a project on stock-based compensation to its agenda. An exposure draft requiring fair value accounting was released in March 2004, followed by a 90-day public comment period and four public roundtable meetings. The response from the public once again was overwhelming, particularly when compared with that generated by the typical accounting pronouncement.

After a new round of deliberations on the exposure draft, FASB issued SFAS123(R) last December, requiring that public companies begin expensing ESOs as of the first quarter beginning after June 15, 2005. A delayed effective date of the first quarter beginning after December 15, 2005 applies to nonpublic companies and to public companies filing as small business issuers. All ESOs granted or modified after the effective date are to be accounted for and expensed under SFAS123(R). The outstanding unvested portions of prior grants are to be expensed using the fair values previously footnoted under SFAS123.

Under SFAS123(R), the fair value of the grant at the date of issuance must be determined and then recognized as compensation costs over the period from the date of issuance to the date of vesting. While SFAS123(R) does not mandate the option valuation model to be used, the following variables must be included in the option valuation: strike price, market price, expected volatility, expected life, expected dividends, and risk-free rate (see the sidebar on page 2).

What Other Options Do We Have?

While traditional, vanilla options may be declining in use, they are not likely to disappear from the compensation toolbox anytime soon. Many companies that have chosen to expense options in the past continue to use them to create a culture of ownership as well as a focus on value creation. And whether or not one agrees with FASB's decision, it does present an opportunity. The playing field for equity vehicles is nearly level with this change, and accounting rules are less likely to drive plan design in the future. That is good news and an opportunity that human resources professionals should not ignore.

The greatest opportunity lies in the use of performance-based options. Already a number of companies have embraced such plans. A performance-based option usually ties a vesting schedule to the achievement of predetermined objectives. These objectives can include achievement of certain financial goals (e.g., moving average sales or margin, cumulative income, or sales growth), division/unit operating performance, or return on assets. A more complex approach can tie the number of options granted to achieving one goal and vesting to another. But the power of performance-based options lies in their ability to link the reward with specific results so that employees are not the beneficiaries of equity market fluctuations that might not reflect real performance gains. In other words, a rising tide does not have to automatically lift all boats when it comes to rewards from option programs.

Another potential benefit of performance options is that they will be preferable from an accounting standpoint under the new standard because of a lower fair value—and thus a resulting lower expense—than vanilla options. This lower value is the direct result of including performance goals as part of the plan, a feature that reduces the projected gain under most option pricing models.

Not an Option

In fact, options galore now exist as a result of FASB's change. Now employers can truly structure long-term incentives and design specific programs to meet corporate goals without favoring one approach because it is preferable from an accounting standpoint. As a result, many companies are replacing their equity plans with "blended" plans that combine features of multiple vehicles to meet multiple objectives.

For example, employee retention has always been an important objective in most long-term plans using stock options. But options are only effective as retention mechanisms when they are "in the money" and in it in a large way. Restricted stock plans function as a powerful and effective retention tool because they are always in the money (except, of course, in the direst of circumstances). Traditional restricted stock plans were often "give-aways," where the restriction was tied to the passage of time. Such plans were not much different from merit-based salary increase programs that automatically boost pay for all, the only require-

The Models

Two of the most common models likely to be used in ESO valuation are the closed-form Black-Scholes formula and the open-form lattice (binomial) model.

Black-Scholes

The Black-Scholes formula was first published in 1973. Its basic formula consists of two terms that describe:

1) the expected benefit of acquiring a stock outright, and
2) the present value of paying the strike price at the expiration date.

The fair value of the option is determined by subtracting the second term from the first.

Because the original formula was developed to value exchange-traded European options, some ESO features violated implicit assumptions of the formula, requiring modifications to value ESOs. This model, for example, does not allow for the explicit recognition of some time-oriented characteristics of ESOs. The early exercise of an option was typically accounted for by making an ad hoc reduction of the option term to an "expected life," which was then used as a formula input. Nevertheless, the formula has been used by nearly all companies in complying with the disclosure provisions of SFAS123.

Lattice Models

Sometimes referred to as binomial models (which are actually a subset of the family of lattice models), this family of option pricing models can explicitly accommodate time-oriented features, such as vesting restrictions and early exercise behavior, that are typically found in ESOs.

Intrinsic value and remaining time value are calculated at each node along a lattice of potential stock price paths, and discounted subject to vesting and early exercise conditions to determine the grant date fair value of the option.

Because the model develops values at each time step, economic assumptions such as volatility and the risk-free rate of return can be assumed to vary through time. Lattice models can also be modified to explicitly value performance-based ESO features. At the other extreme, if all assumptions are simplified to those used in the Black-Scholes formula, both models will yield the same fair value.

Required Inputs

Dividends—expected dividends during the option term

Expected life—the expected time until exercise, forfeiture, or expiration of an option

Market price—the current price that a stock is trading for in the market at the date an option is granted

Risk-free rate—the interest rate used to discount potential future cash flows to the grant date

Strike price—the amount an employee must pay to exercise the ESO

Volatility—a measure of the expected fluctuation in the market price of the stock

ment being that the employee has survived another year. Restricted stock tied only to the passage of time will buy employee retention, but at a high cost. While many companies are embracing this approach, shareholders will see the absence of performance requirements as a serious blot on such programs. On the other hand, restricted stock with performance-based restrictions is promising. As the proposed accounting rules will level the playing field and produce a lower fair value for restricted stock if performance restrictions are added, companies will appropriately rethink the use of time-based restrictions.

Strategic Planning

Most companies also need a compensation tool that focuses on sustained performance or "value creation." Stock options can serve this role in many situations. Frequently, however, employers need to improve the line of sight between employees and the results/rewards. Cash-based long-term plans can do this in a powerful way, allowing a company to identify specific performance metrics that are directly under the control of the employee. This is particularly true in large firms where divisions or lines of business may have little influence over share price and a cash-based plan would provide a strong link between results and rewards.

In addition, long-term incentive plans are often designed to provide a link between shareholders and management, to align the interests of both. Stock options alone provide only one side of that link—the upside. Management is not faced with the same value equation as shareholders who face downside risk as well as upside potential. Restricted stock in concert with options may be a blend that more strongly aligns management with ownership.

As companies refashion their stock-based reward plans to align employee incentives with corporate objectives, they will face the need for a suitable method to value the equity programs. Compensation and benefits consultants can provide both the necessary ESO pricing models and insights an employer needs to design strategic programs that produce desired results.

Conclusion

There has not been a better time to retool incentive programs than today, in response to not only accounting rule changes, but also the need to tightly align rewards programs with shareholders. What better opportunity to partner with the corporate board and with senior management to improve the effectiveness of a compensation program so that it:

- focuses on critical performance objectives;
- aligns executives with shareholders;
- improves the performance-pay linkage;
- enhances retention of key employees;
- improves the line of sight between results and rewards; and
- encourages real ownership among executives.

Long-term incentive plans of tomorrow are likely to contain multiple elements as today's companies recognize that multiple compensation approaches are necessary to create lasting shareholder value. Plain vanilla stock options can still play a long-term incentive role, but they no longer will occupy the primary or even preferred place among reward elements.

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A Guide to Administrative Costs for Defined Contribution Plans

by Douglas Conkel

Recent corporate and securities industry scandals have renewed retirement plan sponsors' focus on their overall fiduciary responsibilities. This, in turn, has led fiduciaries to reexamine fundamental issues such as the fee/service arrangements their retirement programs currently employ.

This article explains the administrative costs associated with retirement plans, with an emphasis on the fees that apply in 401(k) and other defined contribution programs.

Fiduciary Duties

What is a retirement plan fiduciary? The Employee Retirement Income Security Act (ERISA) defines a fiduciary as one who: exercises discretionary authority or control over the management of an employee benefit plan or the disposition of its assets; gives investment advice about plan funds or assets for a fee or compensation or has the authority to do so; or is designated to carry out fiduciary responsibilities by a named fiduciary. Fiduciaries typically include the plan administrator, the plan sponsor, members of any employee benefit oversight committee(s), the plan trustee, and outside investment managers.

Because fiduciaries are responsible for protecting the retirement plan's assets payable to participants and beneficiaries, ERISA requires that expenses (including investment-related ones) charged to the plan be reasonable in light of the services provided. ERISA also holds fiduciaries responsible for prudently selecting and monitoring plan invest-

ments and service providers. Consequently, a fiduciary must evaluate the level of services provided and the fees charged for these services that are borne by plan participants.

Investment-related Fees

Although they comprise the lion's share of a plan's fees, investment expenses are the most difficult to comprehend because they typically are directly deducted as a percentage of assets from the plan's investment options. These charges pay for investment management, marketing and distribution, commissions to brokers, finders' fees, and administrative (shareholder services) costs.

To understand how various investment-related charges are used to compensate a retirement plan's service providers, a familiarity with some terminology is necessary.

- *Revenue Sharing Fees* are paid to third-party providers for services performed in connection with a fund's shareholders. The fees typically cover administrative services provided by the third-party administrator instead of the mutual fund (e.g., maintaining the individual account balances and providing participant statements).

- *Annuity Wrap Fees* are charged on variable annuity products for administration, investment management, and insurance. These fees are "wrapped" around (i.e., in addition to) the contract's existing, underlying fund's expense ratios.

- *Sub-Transfer Agent Fees* are used to compensate other parties for shareholder accounting services. Transfer agents and sub-transfer agents track and record who owns how many fund's shares. For retirement plans, the plan's recordkeeper often performs these functions instead of the transfer agent and are thus considered a sub-transfer agent eligible for compensation.

- *12b-1 Fees* are paid by mutual funds for marketing and distribution, including, for example, commissions to brokers.

All of the fund-level fees described above are collectively referred to in this article as "investment-based fees" and they represent mechanisms to transfer dollars from the various investment options to a plan's service providers. These fees are disclosed in the aggregate in the mutual fund's prospectus or the annuity contract, but the disclosure typically does not spell out how much is paid to specific parties (e.g., recordkeeper, trustee, or investment advisor). Such disclosure may or may not be provided to the plan sponsor; some providers furnish more detailed disclosure than others.

Paying Plan Expenses at the Investment Level

Investment-based fee arrangements can be beneficial to plan sponsors and participants, provided that the fiduciaries can determine how much is being paid to the various service providers and for what services.

Investment-based fees such as revenue sharing were created in part to accommodate market demands for simple pricing. Most plan sponsors like the simplicity of knowing that the plan's fund options cover the cost of some or all of a predetermined list of services. Investment-based fees also help to minimize explicit administrative fees that would otherwise be paid by the employer or allocated as an expense to the plan. Because investment-based fees are allocated to all shareholders in the mutual fund via the daily net asset value (NAV), explicit expenses allocated to plan participants may be reduced or eliminated.

Retirement plan participants certainly have a right to know the expenses being allocated to their individual accounts. Yet participants typically do not understand the expenses charged to their retirement accounts. Most fees, even at bargain basement prices, are viewed negatively by participants. But reasonable fees paid at the fund level (via the NAV) help reduce some of the inexperienced investor's anxiety about the fees necessary to administer a qualified retirement plan with individual accounts. Depending on the demographics of the company, paying for administrative expenses at the fund level may actually keep more employees in the plan.

Investment-based fees, although offering a simple way to cover plan expenses, often are either not disclosed or poorly disclosed to the plan fiduciaries. Thus, plan fiduciaries cannot determine the level of fees they are paying and to which services those fees apply. Unless both the fees and services are evaluated, it is impossible for a plan sponsor to judge if the fees are reasonable with respect to the services being provided to the plan.

Because investment-based fees are incorporated in the fund's/contract's expense ratio and thus reduce the investment option's overall return, earnings derived from a particular fund should benefit the participants who have a balance in such a fund. For the fee arrangement to be equitable, a fund option's investment-based fees should be earmarked to the participants in that option. Otherwise, participants in the options that pay more in revenue sharing fees end up paying a larger portion of the administrative cost.

Example: Assume that under a simple plan with two funds, each with the same market value, the recordkeeper determines it needs fees of 35 basis points (bps) to cover the services provided. The fees are derived by assessing 30 bps from participants in the bond fund and 40 bps from those in the equity fund.

TABLE 1

Revenue Sharing Fees to the Recordkeeper for Administrative Services

Bond Fund	30 basis points (.30%)
Equity Fund	40 basis points (.40%)

The above example in Table 1 on page 4 will generate 35 bps for the recordkeeper; however, participants in the equity fund pay 57% (40bps/70bps) of the fees while participants in the bond fund pay 43% (30bps/70bps) of the fees.

If the recordkeeper instead were to apply the 35 bps fee at the fund level, the following allocation of fees occur:

TABLE 2

Fund Option	Recordkeeper Fee	Revenue Sharing	Net Fee (Credit) to Participants-Allocated Directly to Participants
Bond Fund	35 bps	30 bps	5 bps
Equity Fund	35 bps	40 bps	(5 bps)

By applying the administrative fee at the fund level, participants in both fund options pay the same administrative expense.

Some plan sponsors and advisors believe that recordkeeping fees in general should not be asset based but rather participant based. The Department of Labor's *Field Assistance Bulletin 2003-3* confirms that plan sponsors may charge participants reasonable recordkeeping fees either pro rata (based on assets) or per capita (based on the number of participants). Arguments can be made on both sides concerning this issue and are beyond the scope of this article, and plan sponsors need to decide which is best for their plan.

Evaluating Fees

All too commonly, plan sponsors fail to fully understand the total fee arrangement for ongoing retirement plan administration. Some sponsors think the "administrative services" provided to the plan are free when in fact, due to higher investment expense ratios, they may be paying a premium rate for basic services. As part of their fiduciary duties, plan sponsors should evaluate the service providers that are paid from plan assets, including:

- brokers;
- recordkeepers;
- trustees;
- investment managers;
- investment advisors;
- consultants; and
- auditors.

All fees from all service providers should be gathered and compared, including the investment management fees. The contract with a service provider ideally will provide general information on the services and fees, but a plan sponsor should also question whether the provider receives any other revenue. Note that the day-to-day contact person at the service provider might not know if additional income is being generated from plan assets.

Various fee worksheets that are helpful in organizing fee information are available from the DOL and benefits industry websites. In addition, consultants and advisors can assist plan sponsors in evaluating service providers to ensure that the fees being charged are reasonable relative to the services. Advisors should be independent and provide a fee-based service.

Assessing Services

Plan sponsors also must determine whether the fees paid are reasonable for the services provided. A detailed evaluation of the services and how they are delivered is critical. Depending on the sponsor's needs, certain services may be more valuable to the plan and participants, and thus justify a premium by a provider that can deliver superior services.

The retail rate for plan administration services ranges from $75 per participant to $200 per participant annually, depending on the complexity and size of the plan. Expressed as an asset-based fee, the typical plan administration fee range is 0.5% to 2%, including investment management fees. Larger plans enjoy economies of scale and can bargain for lower rates, while the infrastructure required to administer a single plan makes costs higher for smaller employers.

Conclusion

Plan sponsors have embraced the simplicity associated with paying for plan-related administrative services via the investment options as a way to reduce explicit costs and maintain a budget-friendly service. However, the lack of information concerning payments from the investment options to cover plan expenses adds to the difficulties a fiduciary faces in determining whether the level of fees is reasonable with respect to the services being provided. Therefore, sponsors need to fully understand their providers' fee arrangements and service offerings to discharge their fiduciary duties.

Plan sponsors and fiduciaries should ask, "Will a lack of quality and customer service ultimately cost the organization more internal time and effort? Will recurring administrative errors, lack of proactive guidance, and continuous turnover at the service provider create a credibility problem for the employer and participants? With less-than-desirable service, will participants still value their retirement program?"

A complete and thorough understanding of the fee arrangements and services will provide plan sponsors the information they need to ensure that their retirement program is in the best interest participants and beneficiaries.

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Obstacles Thwarting Improved Treatment for Depression

by Steve Melek

With healthcare costs once again rapidly on the rise, employers are renewing their efforts to find innovative ways to manage and control the costs of providing health benefits for their employees. Most plan sponsors are reluctant to shift costs to employees or to reduce benefits, which may result in lower employee morale and place the employer at a competitive disadvantage in attracting and retaining valuable employees. There is, however, one area of significant cost that many employers have overlooked—the management of the cost of depression.

This article examines how the current healthcare system generally treats depression and explores strategies employers should consider to improve care while overcoming some of the flaws in the system that add costs.

Depression and Its Costs

Depression is the number one mental disorder in the US, affecting close to 10% of the population at some point during the year. Depression also significantly contributes to increased primary care costs, prescription drug costs, disability claims, absenteeism, and loss of productivity. Studies have shown that:

- Employees with depression incur more sick days than those with hypertension, back problems, heart disease, or diabetes, and per-capita health and disability costs of depression are as high as those of diabetes and heart disease.
- The annual cost of depression (excluding disability costs) to US employers is estimated at $44 billion in lost productivity, with over 80% of such costs coming from "presenteeism" or reduced performance while at work.
- The average annual health expenditures for patients with depression is more than four times that of patients with no depression claims.
- Between 1987 and 2000, spending on mental disorders increased from $9.9 billion to $34.4 billion, representing the largest percentage increase in spending among the 15 most common medical conditions.

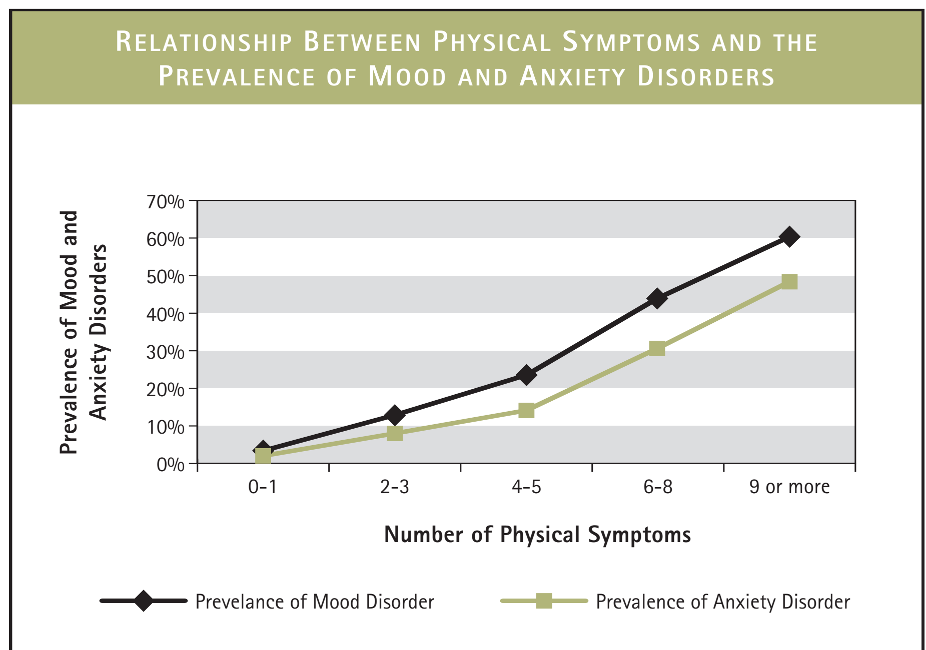
The Rise of Managed Behavioral Care

Most employers are aware of their direct costs of providing specialty behavioral healthcare services, which are commonly purchased through a managed behavioral healthcare organization (MBHO). These organizations provide for treatment of behavioral disorders by specialists such as psychiatrists, psychologists, social workers and other therapists, and include acute inpatient services as well as routine outpatient services.

MBHOs proliferated in the 1990s, largely in response to the rapidly increasing costs of mental healthcare. MBHOs contract with healthcare payers and accept capitation rates (carve-outs) to manage the specialty behavioral health needs of a health plan or employer's population. Under such capitated arrangements, MBHOs typically are motivated to keep down the use of specialty behavioral healthcare services.

Evidence indicates that MBHOs have been successful in decreasing wasteful spending and improving efficiency. MBHOs today cover about two-thirds of the private insurance market. For most individuals with private insurance, this means that their mental health benefits are administered separately from their physical health benefits.

FIGURE 1



Obstacle 1: Misdiagnosis and Ineffective Treatment

The problem with providing care on two discrete tracks is that mental and physical health cannot be easily separated. Mental illness often manifests itself in physical symptoms such as headaches, chest pain, fatigue, back pain, numbness, and dyspnea. As the number of physical symptoms a person suffers from increases, so does his or her likelihood of a psychiatric disorder. Figure 1 on page 6 illustrates the relationship between the number of physical symptoms presented in primary care settings and the prevalence of a mood or an anxiety disorder, suggesting that multiple physical symptoms could signify a potentially treatable mood or anxiety disorder.

Other studies have shown that mental health conditions, when occurring alongside physical conditions such as diabetes and heart disease, may impair an individual's ability to seek and stay on treatment, thereby potentially increasing morbidity. Administering mental and physical health through two distinct healthcare "silos" can make treating either condition more difficult.

When patients seek treatment for a mental condition, most will first visit a primary care physician (PCP). Only 3% - 6% of the insured population will seek treatment by a behavioral health specialist in any year. All others go untreated or obtain care through their PCPs. Some researchers have estimated that close to 75% of patients seeking primary care treatment have behavioral or psychosocial issues affecting their health.

Because of the social stigma surrounding depression, patients also are often reluctant to discuss feelings of sadness, worry, or loneliness. Many of them are more comfortable complaining of physical ailments or symptoms to their doctors and will neglect to mention feelings that could lead to mental health treatment. Unfortunately, most PCPs have little time to adequately assess these patients and are often insufficiently trained to diagnose mental health conditions. One study has shown that PCPs correctly diagnosed only 28% of patients with self-reported severe depression.

In these cases, the PCP will treat the physical symptoms. The individual may experience temporary relief but will often return with different or more persistent complaints, only to once again be treated by their PCP. This cycle perpetuates the use of inappropriate resources, increases costs, and leaves the patient inadequately treated.

Obstacle 2: Insufficient Coordination of Treatment

While MBHOs have reined in the costs of specialty mental healthcare, prescription drug costs for mental disorders have soared (see Figure 2). Prescription drug costs for mental health conditions could soon exceed the costs of all other mental health services combined.

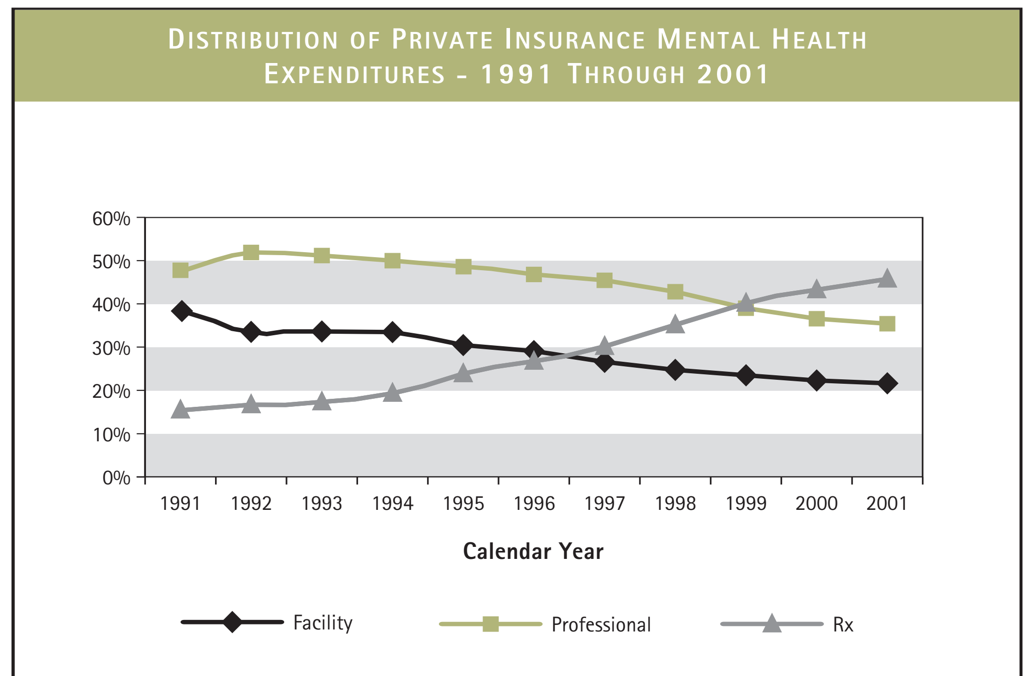
Patients sometimes will recognize their symptoms as depression and visit their PCPs to request anti-depressant medication. Unfortunately, many of these patients often have unreasonable expectations of the length of time required for the drugs to make them feel better. Most of these medications require close monitoring and intensive patient education because of side effects that occur before the individual begins to feel any benefit. With PCPs seeing more than 30 individuals in a day—a little more than 15 minutes per patient—there is not enough time to assess mental health problems, much less provide the counseling and support the patient needs. PCPs often fail to automatically schedule the appropriate number of follow-up visits to monitor the drug treatment efficacy and help educate and coach the patient. The result all too often is that the patient gives up on treatment prematurely.

Insufficient treatment might also be due to a PCP's use of outdated or ineffective clinical guidelines for the treatment of depression. Various studies have found a lag between state-of-the-art treatment options for depression and actual clinical practice of as much as three to five years.

Overcoming the Obstacles

Employers should ask their health plans and MBHOs about their efforts to increase the education of their network PCPs in diagnosing and treating depression, as well as push for improved collaboration

FIGURE 2



between the PCPs and behavioral specialists. Today's PCPs might not be adequately equipped to treat mental illness, but they are usually the first caregiver sought in the diagnosis and treatment of depression. PCPs thus need better education regarding clinical guidelines for depression and improved communication and collaboration with behavioral health specialists.

Employee education can also help to increase awareness and understanding of the course of the disease, to provide knowledge of available treatment options, and to reduce the social stigma associated with depression. Employers can increase workplace education campaigns for depression and other mental disorders. Employee assistance programs (EAPs) also offer an opportunity for employee education activities. A key component of this education should include the proper use of antidepressants.

Insured benefits for mental illnesses should also be reviewed. Benefit designs that create barriers to access—such as higher copayment requirements or benefit limits for specialty behavioral healthcare—can be counter-productive. Such obstacles can keep patients from seeking the right kind of mental healthcare and instead lead them to seek more frequent care of physical symptoms in medical settings.

Implementing new program designs will entail upfront costs for employers. But overall costs can be reduced through decreased healthcare costs, increased productivity, less absenteeism, fewer disability claims, and better quality of life. Employers often are the primary payers when it comes to healthcare costs. They need to continue to seek more creativity from their health plans and healthcare providers to ensure more efficient and effective treatments.

Conclusion

The fact remains that the cost of healthcare is increasing rapidly. The segregated system of mental and physical healthcare might actually be driving some of these increases. By focusing on systems that give patients the right mental healthcare at the right time, by improving provider and patient education on mental health issues, by improving patient adherence to drug treatment regimens, and by aligning incentives in the physical and behavioral healthcare benefit plans and delivery systems, healthcare can be greatly improved, along with the employer's bottom line.

Steve Melek is a consulting actuary in Milliman's Denver office. This article was peer reviewed by Jon Shreve, also a consulting actuary in the Denver office.

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