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Current Issues in Employee Benefits

WINTER 2005-2006

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Noncalendar Year Plans: Navigating Medicare Part D

by Chris Girod and Andrea Burrell

The Medicare reforms enacted in 2003 created several cost-saving options for plan sponsors that provide prescription drug benefits to Medicare-eligible retirees. However, because the Medicare Part D program runs on a calendar year basis, it presents some unique challenges for plan sponsors with noncalendar year (non-CY) plans.

This article explores issues specific to non-CY plans for three of the options available to plan sponsors under Medicare Part D: obtaining the retiree drug subsidy; providing “wrap-around” plans; and offering a Part D plan using employer group waivers.

Retiree Drug Subsidy

Plan sponsors that provide retiree pharmacy benefits that are at least as rich as the standard Medicare Part D benefit (Standard Plan) are eligible to receive a 28% federal tax-free subsidy. To collect the retiree drug subsidy, plan sponsors must apply annually to the Centers for Medicare & Medicaid Services (CMS) and submit claim data to the agency for subsidy determinations. Medicare Part D regulations also require plan sponsors to provide certain notices to plan participants (see separate article on Communications, p.7). The application process, the determination of the subsidy amounts, and the notifications to participants each present some unique issues for non-CY plans seeking the subsidy.

Due Dates for Subsidy Applications

To collect the subsidy for plan years ending in 2006, plan sponsors were required to submit an application to CMS before October 31, 2005. Applications for subsequent plan years must be submitted at least 90 days before the beginning of each plan year. Plan sponsors can apply for a 30-day extension prior to the 90-day deadline.

Because plan sponsors will have to reapply during 2006 to collect the subsidy for plan years ending in 2007, an application submitted before October 31, 2005, will not entitle non-CY plans to a full year of the subsidy (e.g., the October 31, 2005,

application will only entitle a plan with a July 1 anniversary date to six months of the subsidy; the plan must reapply by March 31, 2006, to collect the subsidy for the full plan year from July 1, 2006, to June 30, 2007).

Some plan sponsors may also change their contribution rates on dates other than plan anniversaries. For example, a plan may have a July-to-June plan year but change contribution rates on April 1 due to labor agreements. A contribution rate change may affect whether the plan qualifies for the retiree drug subsidy. Therefore, plans making these off-anniversary contribution rate changes should communicate clearly and early with their actuaries to determine whether the changes will affect the plans' qualification for the subsidy.

Subsidy Amount

For non-CY plan years ending in 2006, the subsidy collected will be 28% of eligible drug spending incurred during the plan year (not the calendar year), subject to limits set by CMS. For plan years ending in 2006, the limits are such that the subsidy is based on each beneficiary's eligible drug spending between \$250 and \$5,000 incurred during the plan year. Claims incurred in the 2005 portion of the plan year accumulate toward the \$250 and \$5,000 limits for each beneficiary, but the plan collects the subsidy only on claims incurred during the 2006 portion of the plan year. Thus:

- If a beneficiary has no claims in the 2005 portion of the plan year, the subsidy will be based on claims incurred during the 2006 portion of the plan year that fall between \$250 and \$5,000.
- If a beneficiary has claims that exceed \$5,000 in the 2005 portion of the plan year, there will be no subsidy for this beneficiary for the plan year ending in 2006.
- If the beneficiary has incurred \$100 of claims during the 2005 portion of the plan year, the subsidy will be based on the claims

incurred in excess of \$150 in the 2006 portion of the plan year up to the point that total plan year claims exceed \$5,000.

For subsequent plan years, CMS will increase the \$250 and \$5,000 limits each calendar year. The total subsidy collected during each subsequent plan year will be based on claims incurred during the plan year subject to the limits published by CMS for the calendar year in which the plan year *ends* (e.g., for a plan year beginning on July 1, 2006, the subsidy collected will be based on the claims incurred during the plan year subject to the limits set by CMS for the 2007 calendar year). Because CMS might not have published these limits when the plan year begins, plan sponsors (such as those electing to collect the subsidy on a monthly or quarterly basis) must reconcile any differences in the subsidy based on the actual limits published and the limits assumed for the previous subsidy payments during the plan year.

Creditable Coverage Notifications

An employer’s plan provides “creditable coverage” if its benefits are at least as rich as the Standard Plan. An employer plan must provide notifications to participants as to whether the plan is creditable or noncreditable. The creditable coverage determina-

tion is based on the Standard Plan benefits for the calendar year in which the employer plan year begins. However, if Standard Plan coverage limits for the following calendar year have been published for more than 60 days, those new coverage limits must be used. This may be important for plan sponsors with anniversary dates that fall late in the calendar year.

Employer Wrap-around Plans

Some plan sponsors provide retiree drug plans that are secondary to a Medicare Part D plan. Commonly called “wrap” or “supplement,” these plans cover costs not paid by the Medicare Part D plan (e.g., deductibles, copays), and may have their own cost-sharing provisions and benefit limits. For wrap plans operating on a non-CY basis, key issues that arise relate to monthly patterns of wrap plan benefit costs and benefit changes.

Benefit Cost Patterns for Employer Plan

The presence of deductibles and coverage gaps in the Standard Plan, as well as the other cost-sharing provisions, could result in an unusual pattern of monthly benefit expenses for the primary plan, and therefore also for the secondary employer plan. To use a grossly simplified example, if every participant has \$250 in drug spending every month and the employer wrap plan has a

TABLE 1

MONTH	WRAP PLAN HAVING JAN. 1 ANNIVERSARY				WRAP PLAN HAVING OCT. 1 ANNIVERSARY			
	PAID BY PART D PLAN	PAID BY EMPLOYER WRAP PLAN	PAID BY PARTICIPANT	TOTAL	PAID BY PART D PLAN	PAID BY EMPLOYER WRAP PLAN	PAID BY PARTICIPANT	TOTAL
JAN	\$0.00	\$0.00	\$250.00	\$250.00	\$0.00	\$250.00	\$0.00	\$250.00
FEB	\$187.50	\$0.00	\$62.50	\$250.00	\$187.50	\$62.50	\$0.00	\$250.00
MAR	\$187.50	\$0.00	\$62.50	\$250.00	\$187.50	\$62.50	\$0.00	\$250.00
APR	\$187.50	\$0.00	\$62.50	\$250.00	\$187.50	\$62.50	\$0.00	\$250.00
MAY	\$187.50	\$0.00	\$62.50	\$250.00	\$187.50	\$62.50	\$0.00	\$250.00
JUN	\$187.50	\$62.50	\$0.00	\$250.00	\$187.50	\$62.50	\$0.00	\$250.00
JUL	\$187.50	\$62.50	\$0.00	\$250.00	\$187.50	\$62.50	\$0.00	\$250.00
AUG	\$187.50	\$62.50	\$0.00	\$250.00	\$187.50	\$62.50	\$0.00	\$250.00
SEPT	\$187.50	\$62.50	\$0.00	\$250.00	\$187.50	\$62.50	\$0.00	\$250.00
OCT	\$0.00	\$250.00	\$0.00	\$250.00	\$0.00	\$0.00	\$250.00	\$250.00
NOV	\$0.00	\$250.00	\$0.00	\$250.00	\$0.00	\$0.00	\$250.00	\$250.00
DEC	\$0.00	\$250.00	\$0.00	\$250.00	\$0.00	\$250.00	\$0.00	\$250.00
	\$1,500.00	\$1,000.00	\$500.00	\$3,000.00	\$1,500.00	\$1,000.00	\$500.00	\$3,000.00

\$500 pharmacy deductible, the monthly pattern of costs for a calendar year plan and a non-CY plan (Oct. 1 anniversary) would be as shown in Table 1.

These claim patterns and benefit changes should be considered when reviewing plan experience reports or when performing financial projections.

Benefit Changes

Participants in wrap plans may change Medicare Part D plans during Medicare's "annual coordinated election period." In addition, even if participants do not change Medicare Part D plans, the benefits provided by each participant's Medicare Part D plan may change on every January 1. Therefore, the wrap plan documents for a non-CY plan may need to be updated off-anniversary. Ideally, the wrap plan documents should be sufficiently flexible so that changes in each participant's primary coverage will not require updates to the employer plan documents. Claims adjudication software, however, may need to be updated whenever the primary coverage benefits change.

Employer Group Waiver Plans

Plan sponsors may provide customized Medicare Part D plans to their retirees by either: purchasing a customized group plan from a Medicare Advantage organization or a Prescription Drug Plan sponsor that sells employer group plans; or contracting directly with CMS to become a Part D Plan that provides benefits exclusively to its own retirees. Such customized plans are known as "Employer Group Waiver Plans" (EGWPs) and "Direct EGWPs," respectively. Non-CY plans that elect to become an EGWP or a Direct EGWP encounter variable payments from CMS and ineligibility for federal reinsurance amounts.

Plan Design Requirements

To be an EGWP or Direct EGWP, one plan design requirement is that the retiree pharmacy benefits must be at least as rich as the Standard Plan benefits in total. Plan sponsors with non-CY plans can meet this requirement by providing benefits throughout the plan year that are at least as rich as the Standard Plan for the calendar year in which the plan year *begins*.

An additional plan design requirement is that plan sponsors cannot increase the out-of-pocket limit at which catastrophic cover-

age begins during the plan year. As a result, non-CY plan sponsors cannot increase the out-of-pocket limit on January 1 when CMS indexes the Standard Plan out-of-pocket limit.

Payments from CMS Will Change During the Employer Plan Year

By electing to become an EGWP or a Direct EGWP, benefit costs will be offset by monthly payments from the government for each eligible beneficiary. CMS will reset the basis for these payments every calendar year. Non-CY plans should be aware that these payments will not be uniform throughout the plan year when making financial projections.

Non-CY Plans Forego Federal Reinsurance

Calendar year plans that elect to become an EGWP or a Direct EGWP will have their costs offset by catastrophic reinsurance protection from CMS. This reinsurance pays 80% of a participant's drug costs once the participant reaches \$3,600 in out-of-pocket spending in 2006 (indexed in future years). **Non-CY plans, however,** are *not* eligible for this reinsurance. This can be a significant loss of revenue. For example, if a retiree with pharmacy benefits similar to the Standard Plan's benefits had annual drug claims of \$10,000 in 2006, the federal reinsurance would total almost \$4,000. The loss of reinsurance will be less important for richer plans (e.g., drug plans with low copays), because fewer participants will be likely to reach the out-of-pocket spending limit.

Conclusion

State and federal regulations and union contracts may make changing the plan year impossible for some plan sponsors. Non-CY plan sponsors should remain aware of the unique issues that result from the inconsistency between their plan year and the calendar year basis in which Medicare Part D operates.

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Offshore Pension Plans— Their Role in Global Pension Programmes

by *Stephen Ainsworth*

An offshore pension plan may be described as one located in the home country of neither the employer nor the covered employees and one that is established to provide benefits for the international staff of a multinational group. For example, a United Kingdom (UK) multinational company might establish an offshore pension plan in Guernsey to provide retirement benefits for its international staff working in Africa or Asia. The plan can sometimes also be used to encompass locally recruited staff in overseas locations where, by reason of economies of scale or because of the lack of local pension vehicles, arranging for retirement benefits through a global offshore pension plan is efficient.

This article explores the various issues of offshore pension plans, examining why companies set them up and the key issues to consider.

Reasons for Establishment

Why set up an offshore pension plan? In most cases, an employer does so because the alternatives have been considered and found unsuitable.

A multinational group generally might find retaining all its global employees in a single pension plan established in its home country impractical or impossible. In the case of a US multinational, for example, there are only limited circumstances in which secondes (e.g., professional employees on temporary assignments abroad) or employees of overseas subsidiary companies may be active members of a US tax-qualified pension plan. In recent years there has been some discussion about the possibilities of global (or at least pan-European) pension plans, but to date the taxation and social insurance difficulties have proved insurmountable. This may change in time, at least within the European Union (EU), since the 2003 Pensions Directive came into force. However, even if the regulatory, taxation, and social insurance obstacles can be overcome within the EU, most multinational groups will still have concerns because their activities extend beyond the EU boundaries.

The pension arrangements (if any) of the local overseas subsidiary are also unlikely to be suitable for international staff posted there for a limited period. Such arrangements will have been designed in the local currency to meet the needs of the local staff—taking into account the available social security benefits, expectations,

and the cost of living—without regard for the requirements of any international staff working in that location. In particular, international staff might not work in any location long enough to build up a full social security contribution record and might not qualify under any local vesting requirements for employment-based benefits either. Moreover, few international staff retire in the country of their assignment, and career expatriates with a series of overseas postings are unlikely to wish to accumulate small deferred benefits denominated in a variety of currencies—some of which might be from emerging market economies or payable from some developing countries—that typically cannot be transferred.

An additional reason for establishing an offshore pension plan (or more usually, for extending the scope of a plan already created for career expatriates) can be to provide pensions (or other termination benefits) for local staff where there are no suitable local investment vehicles for pension provision, or to gain from greater economies of scale when investing the assets.

Location Considerations

When selecting a location in which to establish an offshore pension plan, a number of features should be considered. Ideally, the offshore site should:

- have political and economic stability and a good reputation as an international finance centre;
- have no exchange controls to restrict the flow of income or outgo;
- have laws that, regardless of whether the location itself is tax-free, exempt offshore pension plans from local taxation, both on investment income and on the benefit payments, whether in annuity or lump-sum form;
- have regulatory authorities that take a helpful approach and are prepared to respond rapidly;
- impose minimal restrictions on benefit levels and offer flexibility to take benefits in a lump sum;
- recognise the concept of a trust and have its own trust law, if the plan is established under a trust;

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- provide appropriate (but not excessive) regulation of pension trusts and trustees;
- offer a range of support services to enable the offshore pension plan to be managed effectively;
- provide good communication links with the home country of the parent company, and ideally convenient air links so that corporate executives can easily visit the location; and
- be situated in a similar time zone as the parent company and share a common language to facilitate communications.

With the above considerations in mind, three types of locations generally appear suitable for offshore pension plans:

- *The home territory of the parent company.* UK multinationals, for example, could consider the UK itself for an “offshore” location through the facility to set up such funds under the current UK tax rules. This has the advantage that the offshore pension plan could be controlled and managed in the UK alongside the domestic UK pension plan. However, the future of such plans is uncertain in light of forthcoming changes in the UK tax rules on pensions.
- *Other “onshore” locations.* Switzerland, for example, could be considered, although the lack of recognition of the trust concept in much of mainland Europe is unlikely to make many European onshore locations attractive. One possible exception is Luxembourg, which has recently introduced two new funding vehicles as a possible solution to the pension provision of mobile employees within the EU. However, these are not trust-based arrangements and whether they will prove popular remains unclear.
- *International finance centres.* In practice, most offshore pension plans are established in one of these centres around the world due to the flexibility they offer. The choice of site will depend in part upon the location and time zone of the parent company. For US multinationals, offshore plans are often established in locations such as Bermuda or the Cayman Islands.

Benefit Design

Historically, many offshore pension plans were established on a defined benefits basis to reflect the benefit design of the multinational’s home pension plan. Minor adjustments might be made to reflect the overseas service. For example, benefits might be based upon a notional home country salary or adjustments made for differences in social insurance accruals. As a variation, a “base country” approach has sometimes been adopted, whereby a base country would be determined for each of the international staff

and benefits provided on the same basis as local staff working in that base country, regardless of where the international staff are posted from time to time. A further variation has been to determine a special benefit structure for all international staff, perhaps with a higher accrual rate or a lower pension age than for comparable staff in the multinational’s home pension plan.

However, defined benefit structures are often too inflexible to provide for all the variations encountered in the employment conditions for international staff. There can be as many variations from the standard benefit package as there are employees in the offshore pension plan. In addition, defined benefit structures can be complex in practice to administer. While allowing for the effect of differing social insurance accruals for each employee might be equitable, determining just what those accruals are in some countries can prove exceedingly difficult in practice. Although this is a problem for funding calculations, it becomes a major concern for benefit calculation purposes, when benefits are to be brought into payment (or a transfer payment made) before the social insurance benefits fall due.

Thus, a defined contribution structure is particularly suitable for international staff. Designing a defined contribution arrangement is easier, with contribution rates determined to fund a target level of benefits (where this is desired), rather than to have a rigid defined benefit structure. Such an approach also streamlines the documentation required because there is no longer any need to draft detailed schedules of benefit rules. Instead, standard defined contribution documentation can be adopted, supplemented by individual employee letters setting out any target benefits to be provided on a case-by-case basis.

Accordingly, in common with trends elsewhere in North America and the UK, most new offshore pension plans are set up on a defined contribution basis and some existing defined benefit arrangements are being converted to defined contribution schemes.

Another trend is to establish offshore pension plans on a “master trust” approach, so that a number of different plans (with different benefit designs, or perhaps funded by different companies within the multinational group) can be provided within a single trust. This can prove more cost effective than setting up separate trusts. It can also provide a central funding vehicle for local pension plans operated by subsidiaries within the group that do not have suitable investment vehicles in their particular locations.

To cope with the unexpected, flexibility of plan provisions should be aimed for wherever possible. This can often be more readily achieved with a pension plan in an offshore location than in

heavily regulated onshore locations. For example, the offshore site might be able to permit the payment of retirement benefits in lump-sum form when required and to permit the accumulation of unallocated (surplus) reserves and/or for their return to the employing companies as agreed from time to time.

Trusteeship and Administration

Central to the establishment and operation of a successful offshore plan is the appointment of a suitable trustee and administrator. The trustee should be based in the chosen offshore location to demonstrate control and management there (and not in the home country of the multinational). This will help to avoid taxation or regulatory problems in the home territory. The better-regulated international finance centres have not only introduced their own trust laws, but also have regulations governing professional trustees. Thus, a check should be made to ensure that the intended trustee is fully licensed in the chosen territory.

While the trusteeship should be performed in the offshore territory, delegating some administrative functions back to the multinational's pensions department in the home territory remains possible. The plan sponsor would be advised to have the accounting functions performed in the offshore territory, but the membership administration (being the more technically complex part of the operations) can be delegated back, though an appropriate administration agreement should be put in place to demonstrate that ultimate control remains with the trustee.

Similarly, investment management need not be carried out in the offshore territory. Offshore pension plans are more commonly investing in the pooled funds of major financial institutions. Most defined benefit plans are of a size that direct investment into securities may be only of marginal advantage relative to pooled fund investment. In the case of defined contribution schemes, this simplifies the unit allocation process among plan participants.

Establishment and Operation

The offshore pension plan would be established by means of a trust deed and rules. An attorney in the offshore territory should review the documentation to ensure compliance with local laws. The documentation should be submitted for approval (or confirmation of exemption from local taxation) to the offshore territory's income tax office and any other relevant regulatory body there; the usual procedure is to submit a

draft for clearance before execution if the provisions are at all nonstandard.

Before proceeding, the plan sponsor also should check out the taxation and regulatory position for the offshore pension plan in each of the locations where the intended employees are based. In particular, employee contributions to an offshore pension plan are not usually tax deductible, and so making the plan noncontributory is typical. If employer contributions were taxable to the employee as a benefit in kind (generally the case with US taxpayers), then the employer might have to gross up pay or otherwise recompense the employee.

Communication with plan participants is important to the success of any pension plan, and is particularly so for offshore pension plans because employees are physically remote from both the head office and the trustees and administrators. In addition to the usual benefit statements and booklets, setting up other communication lines is helpful. Telephone help lines can be useful, although time zone differences sometimes make them impractical. A more common substitute nowadays is an email helpline to the administrator's offices, supplemented by Internet access to a dedicated plan website with secure access to employee information and (for defined contribution schemes) individual account balances.

Conclusion

Offshore pension plans have a continuing and expanding role in global pension programmes. While the EU's initiatives to encourage cross-border and pan-European pension provisions are to be commended, they are unlikely to replace the need for well designed and targeted offshore pension plans. And because most multinational companies do not confine their operations to EU countries, the adoption of the EU Pensions Directive is unlikely to see the demise of the offshore pension plan. In fact, the demand for such plans is expected to continue as companies increasingly find the need to conduct their businesses internationally.

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Communicating Medicare Part D—for 2006 and Beyond

by Denise Foster and Kirk Kusick

Two weeks into the January 2006 launch of the Medicare prescription drug program, 7.4 million Medicare-eligible retirees had retained their employer drug coverage, 6.4 million of whom are retirees whose participation will mean a 28% subsidy for their plan sponsors. Nearly 24 million Medicare beneficiaries now have prescription drug coverage.

As a plan sponsor, are you pleased with the results of the numbers of individuals you retained or who rejected coverage in your plan? Were you overwhelmed with questions about the Medicare Part D program from plan participants? Do you understand the communications compliance requirements? Are you prepared going forward?

This article examines lessons learned from plan sponsors' communication efforts in the launch of Medicare Part D benefits for 2006, and offers tips to ensure a successful action plan for 2006 and later years.

Learning from Experience

Last fall the scurry to communicate the new program and how it affected different groups was evident nationwide. Plan sponsors grappled with the technical aspects of determining whether the drug coverage was "actuarially equivalent" to—and thus "creditable" under—the Part D program and whether to adopt plan design changes, while also tackling the significant challenges of preparing appropriate communication materials.

Looking forward, keep these points in mind:

- *Be prepared to help dual-eligible participants.* About 6.2 million participants who were eligible for Medicare and Medicaid were automatically enrolled in a drug plan and many encountered initial system glitches. The automatic enrollment could adversely affect the participants (and applicable family) coverage under their employer plan and the plan sponsor's 28% tax-free federal subsidy. Upon a request, plan sponsors should be prepared to provide retirees information explaining how to opt out of a Medicare drug plan. Dual-eligible participants can opt out of, or change, plans at anytime. Other participants are allowed to change once each year during open enrollment.
- *Don't forget your actives.* Even if you do not sponsor a retiree medical plan, you are required to send a creditable/noncreditable coverage notice to Medicare Part D-eligible individuals.

Communications to active employees who are Medicare eligible—or who might have spouses or disabled children who are covered by the employment-based plan—are necessary.

- *Factor initial enrollment period deadlines into your creditable/noncreditable coverage notice mailings.* Unless you intend to send (or already sent last fall) creditable/noncreditable coverage notices to all participants, you will need to anticipate the initial enrollment period for each individual (which will depend on his or her 65th birthday). The regulations require plan sponsors to notify participants before their initial enrollment period for Medicare Part D begins (i.e., three months before the month they reach age 65). This means that if you do not broadly send annual reminders by November 15, you'll need to distribute "birthday reminders."
- *Remind participants that missing the initial enrollment period will be expensive.* A lifetime premium increase penalty applies for those who go 63 days or more without creditable prescription drug coverage. The longer participants go without creditable coverage, the higher the premium will be when they join. For example, if they miss the May 15 deadline to enroll in a plan for 2006 and enroll in coverage for 2007, their premiums for 2007 and all later years will be 7% more than others who had continuous creditable coverage (i.e., a 1% penalty applies for each of the seven months without creditable coverage after May 15, 2006, and before 2007 benefits begin).
- *One letter or brochure is not enough.* People still feel overwhelmed and confused about Medicare Part D and how it affects any current coverage. They still have questions: Will my employer-sponsored plan cover prescription drugs anymore? How will coordination of benefits work, if at all? If I drop employer-sponsored coverage, can I later rejoin the plan? Must I send prescription drug claims to a different administrator than the one handling medical claims? Strategically placed reminders using different communication vehicles will be helpful in reinforcing key messages.
- *Acknowledge retirees' unique needs.* Communicating to retirees can be a challenge. They are often on the move, either traveling or between residences. In print, certain colors (blues and greens) and typical font sizes (smaller than 12 point) are harder to read. Some of the most valuable Medicare Part D information is best accessed through the Internet, yet computer usage and capabilities of an aging population can vary greatly, with one estimate indicating

that 22% of Americans 65 years and older use the Internet. This really means 78% *don't* use the most valuable resource available. Referring to the website in retiree communications can still be helpful, however, because 77% of the 18-29 year-olds (likely grandchildren) and 75% of the 30-49 year-olds (possibly children) are heavy Internet users.

Your 2006 Action Plan

As a plan sponsor (even if you do not provide a retiree medical plan) you are required to send a creditable/noncreditable coverage notice to Medicare Part D-eligible individuals at the following times:

- before **November 15** each year (the start of the Medicare Part D annual enrollment period);
- before an individual's **initial enrollment period** for Medicare Part D (three months before individuals are first eligible plus the month they become eligible and three months after—a total of seven months);
- before the **effective date of coverage** in your plan;
- when prescription drug coverage **changes so that it is no longer creditable or becomes creditable**; and
- whenever a beneficiary **requests** it.

The notice must be given during the 12 months before the event; the regulations do not specify other time limits. Thus, if you send an annual notice before each November 15, you will satisfy the first two requirements above with a single mailing.

Noncalendar year plans must follow the same requirements as calendar year plans although the timing of their notifications will differ. For example, a noncalendar year plan starting July 1 can satisfy the first two requirements by including a creditable/non-creditable coverage notice with its open enrollment materials sent in May. To ensure that future years' notifications are sent before an individual's initial enrollment period (and within the 12-month time frame), open enrollment mailings should be sent on the same day each year.

Table 1 shows the important dates to keep in mind for 2006.

Effective Strategies

To ensure a successful communications program this year and going forward, plan sponsors should be prepared by considering the audience, using appropriate media, and having answers to such questions as, "What's happening? When? Why is it hap-

pening? What do I have to do? By when? Where do I go with questions?" A sound plan of action will incorporate the following:

- Identify those who are Medicare-eligible and enroll them in your medical/prescription drug plan for the first time; consider including the creditable/noncreditable notice in your new-hire enrollment packet.
- Incorporate creditable/noncreditable notices in the annual open enrollment materials distributed sometime before November 15, 2006. Be sure to make the notice conspicuous—the regulations require a reference to the proper section in at least 14-point font in a separate box, bold, or offset on the first page.
- If you have not distributed or do not intend to distribute a broad communication to participants, set up a process to notify them three months before the month they turn age 65; the creditable/noncreditable coverage notice must accompany this communication.
- Communicate clearly any changes to your prescription drug benefits to all participants; explain where to get more details and how to access the preferred drug list. Consider using the Centers for Medicare and Medicaid Services (CMS) preferred terminology in your explanations to achieve consistency and reduce confusion. CMS provides a list at <http://www.cms.gov/partnerships/downloads/preferredterms.pdf> and notes that list changes often.
- Make sure your summary plan description clearly describes how the plan coordinates (or does not coordinate) prescription drug benefits with Medicare.
- Provide information on your prescription drug program each fall (even if you make no benefit changes), particularly if you want the

TABLE 1

2006 TIMELINE	
April	Good time to remind those who may no longer have creditable coverage to explore other options, including Medicare Part D (so they avoid the premium increase)
May 15	Last day to join a Medicare part D plan offering coverage for 2006
November 15	First day of Medicare Part D enrollment for 2007 coverage
December 31	Last day to join a plan offering Medicare part D coverage for 2007

subsidy for those who are Medicare-eligible. Participants will need to understand their current benefits so they can make a comparison during Medicare Part D enrollment (November 15 – December 31 each year). Plan sponsors have a unique opportunity to take advantage of the awareness deriving from Medicare Part D and use it as a gateway to further educate their retirees and employees on ways to control costs.

- Post the creditable/noncreditable coverage notice on your benefit website, noting applicable plans.

Measuring Success

How do you define a successful communication effort? Is it the number of retirees who retained your plan and didn't sign up for Medicare Part D—or, depending on your plan design, the number who *did* sign up for Medicare Part D? Is success a quick reduction in the number of calls to your human resources or benefits department? Or is it simply compliance with the new regulations?

Before you begin any communication effort—regardless of how complex—ask yourself what success would look like for your organization. Articulate what you are trying to achieve with your communications and create a strategy that is aligned with those objectives. For the most potent messages, confirm what behaviors you want to drive. What are you trying to get people to do—or not do? Approaching your employee and retiree communications this way will ensure the effort is worthwhile and makes a difference.

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Reducing Retirement Plan Benefits: An Operating Guide to the Unkindest Cut

by Dawilla Madsen and Dominick Pizzano

Cutting benefits in a qualified retirement plan can be viewed as analogous to surgery, given the statutory and regulatory requirements protecting participants' rights and plan sponsors' desire to avoid staff infections by maintaining employee morale. Participants must be prepped in advance of the procedure, certain benefits are too vital to be removed without complications ensuing, and the more radical the benefit reduction, the greater the need to implant new benefits to avoid losing the participants.

This article presents an overview of the tax code's complex "protected benefit" rules and offers an operating guide for successfully performing this delicate procedure. Governmental plans and nonelecting church plans generally are not subject to these rules.

The Gray Anatomy of the Plan

While the dividing line is sometimes more blurred than bright, the IRS regulations separate the body of the plan into two groups: protected benefits and nonprotected benefits. Protected benefits are a plan's vital organs and are generally resistant to reduction to the extent participants have already accrued the benefits. The rules identify four protected areas:

- *Retirement-type benefits*, which generally cover the amount of the accrued benefit, the method of calculating the amount, and the participant's right to receive benefits on a certain date. For example, the rules prohibit a plan from being amended to suspend benefits upon a participant's reemployment with respect to benefits that accrued prior to the effective date of the amendment.
- *Early retirement benefits*, which represent the right under the terms of a plan for a participant to commence receiving a retirement-type benefit after severance from employment with the employer and before reaching the plan's normal retirement age.
- *Optional forms of benefit* payments available under the terms of the plan, including the form, timing, commencement, and medium of distribution.
- *Retirement-type subsidy*, which results when the actuarial value of a retirement-type benefit is greater than the actuarial value of the accrued benefit payable at the plan's normal retirement date (e.g., an early retirement benefit that is reduced for early commencement by an amount that is less than a full actuarial reduction that would apply if a participant was not eligible for early retirement).

Can “Protected Benefits” be Cut without Killing the Plan?

Generally, the answer is “no.” However, the rules permit plan amendments that either reduce or completely eliminate protected benefits under certain circumstances if they are adopted prior to the effective date of such reduction or elimination. The most common of these “operable” protected benefits are:

- **Statutory Cutbacks.** If a law requires a protected benefit to be reduced or eliminated, the plan must be amended to comply. Under these circumstances, the IRS will issue guidance on the amendment procedure. In addition, an employer stock ownership plan may be amended to provide for a distribution that is not in stock in order to meet diversification requirements mandated by statute.
- **Distribution Options** Joint-and-survivor annuity (J&SA) options may be eliminated if all options are actuarially equivalent to each other and the options with the smallest and largest survivor percentages are retained.

Optional forms of benefits in defined contribution (DC) plans may be eliminated if a lump-sum distribution is available at the same time and under the same terms as the optional form being eliminated. This cutback is only available for benefit commencement dates that occur after the amendment is adopted and must not eliminate the J&SA required under a money purchase DC plan. In addition, a DC plan may be amended to eliminate a noncash medium of distribution.

Plans may also be amended to permit: a *de minimis* change in the timing of the payment of benefits (i.e., within two months for a distribution upon termination and within six months for an in-service withdrawal); modifications or the elimination of hardship withdrawal provisions; and a reduction or elimination of the amount of a mandatory cash-out (up to maximum of \$5,000).

- **Other Defined Benefit (DB) Plan Optional Forms.** Until very recently, these forms could not be reduced or eliminated. Employers whose

plans were merged with the plans of other employers as a result of an acquisition often found this restriction particularly vexing since they had no recourse but to maintain the multiple DB plans’ various optional forms of benefits. Although these multiple optional forms could be eliminated for future benefit accruals or new participants, doing so usually was not practical because of increased administrative costs and potentially negative impact on employee morale of having separate forms available for different groups of participants.

Recent rules provide for three alternative procedures for the elimination or reduction of an optional form of benefit. A comprehensive description of these detailed and complicated procedures would require a lengthy stay; the following is only a “same-day” summary. **The redundancy alternative** generally permits a plan sponsor to eliminate optional forms of benefit that are redundant effective as of a commencement date that is at least 90 days after the date the amendment is adopted. **The core option alternative** enables plan sponsors to remove any optional form of benefit that is not a core option effective as of a commencement date that is at least four years after the date the amendment is adopted. The rules define core options as: (a) a straight life annuity; (b) a 75% J&SA (or both a 50% and 100% J&SA in lieu of the 75% option); (c) a 10-year certain and life annuity; and (d) the most valuable option for a participant with a short life expectancy (usually a subsidized J&SA or a lump-sum option). **The de minimis value alternative** permits a plan to eliminate or reduce benefits (even early retirement benefit or

TABLE 1

NONPROTECTED BENEFITS	
ANCILLARY BENEFITS	OTHER RIGHTS AND FEATURES
<ul style="list-style-type: none"> • Certain Disability Benefits, including benefits payable under a DB plan that are in addition to the normal retirement benefit • Certain Death Benefits, including death benefits under DB plans other than those that are part of an optional form of benefit (for example, while a stand-alone lump-sum death benefit of \$5,000 is included under this category, the qualified preretirement survivor annuity is not, and thus would be protected) • Plant Shutdown Benefits or Other Similar Benefits, if they are provided in a DB plan, do not continue past retirement age, and do not affect the payment of the accrued benefit • Social Security Supplements under DB Plans • Life, Accident, or Health Insurance Benefits 	<ul style="list-style-type: none"> • Plan Loans • Certain Rights, including the right to make after-tax contributions and the right to a matching contribution, as well as the right to direct investments and the right to a particular form of investment (e.g., investments in employer securities) • Specified Dates, including those designated for valuation and the allocation of contributions, forfeitures, and earnings, as well as the time for making contributions (provided no conditions for receiving contributions and/or forfeitures for a plan year are changed after the condition is already satisfied) • Administrative and Operational Procedures, including provisions relating to the particular dates on which notices are given and by which elections must be made, and mechanical procedures for allocating investment experience among accounts in DC plans

retirement-type subsidies) that create significant burdens and complexities for the plan and its participants as long as the elimination does not adversely affect the rights of any participant in more than a *de minimis* manner.

In addition, proposed rules, which are slated to be effective in 2007, allow plans to be amended under certain circumstances to eliminate optional forms (other than core forms) that have not been elected or utilized in a look-back period of generally two years.

Benefits That Are Not Protected

While the IRS covers protected benefits, it treats ancillary benefits and certain other rights and features more like cosmetic surgery: as much as participants may enjoy the benefits derived, they are not essential and thus excludable. Some nonprotected benefits are shown in Table 1.

In addition, *future protected benefits that participants have not yet accrued* are not protected from cutbacks. This stipulation does not rule out any reductions to these benefits but instead requires that they cannot be eliminated or reduced by a plan amendment without grandfathering the previously existing benefit. In a DC plan, this means that the reduction can only apply to that portion of the participant's account balance attributable to contributions made on or after the date the amendment is adopted. For DB plan reductions, the grandfathered benefit will not only include the participant's accrued benefit calculated as of the date of the amendment's adoption, but also the associated actuarial equivalencies and optional forms.

Proper Bedside Manner

To reduce or eliminate any benefit (i.e., protected or not), participants must be properly notified. Any material amendment to a plan requires a Summary of Material Modification (SMM) to be distributed to plan participants not less than 210 days following the end of the plan year in which the amendment is effective. However, proper bedside manner probably dictates an earlier notification date to soften the blow of the reduction in benefits.

Additional requirements apply under the Employee Retirement Income Security Act (ERISA) and the Labor Department's (DOL) regulations for a significant reduction in: the rate of future benefit accrual; an early retirement benefit; or a retirement-type subsidy in a DB or money purchase pension plan. For such reductions, plan sponsors must provide a notice at least 45 days (15 days for plans with fewer than 100 participants) in advance of the plan amendment. In general, the plan administrator must provide the notice to participants and alter-

nate payees whose future benefit accrual rates "may reasonably be expected to be significantly reduced" by the amendment and to any employee organizations representing them.

The notice must be written so that it can be understood by the average plan participant and provide enough information so that the affected individual can grasp the magnitude of the reduction. This magnitude standard will be satisfied if at least one illustrative example is provided in the notice.

If a notice is required but not provided, the plan sponsor may be liable for a \$100 per person per day excise tax until the notice is provided. Furthermore, in the case of an intentional failure to satisfy the notice requirements, all applicable individuals will be entitled to continue to accrue benefits under the provisions of the plan prior to the amendment to the extent it provides a more favorable benefit.

Implant Options

Radical benefit reductions (e.g., freezing a DB pension plan) may leave the morale of employees in critical condition. To increase the odds of workers' employment survival rate, the reduction procedure should be accompanied by a simultaneous influx of some new benefits that is communicated at the same time (perhaps even as part of the ERISA notice). These replacement benefits are often delivered through either a new DC plan or by a redesign of an existing DC plan. While these attempts to resuscitate the company's overall retirement program might not be as valuable as the original DB plan benefit for some employees, they can help in the morale restoration process – especially with younger employees who will have longer periods to accumulate DC plan amounts before retirement.

Unfortunately, the loss of a DB plan will have a much more deleterious effect on employees closer to retirement age because their employment will most likely not survive the extended recovery period necessary for DC plan accumulations to produce healthy results. There are some riskier implant procedures that attempt to stabilize the weakened benefit condition of this senior group, including:

- Age-Weighted Benefit Allocation Formulas, which use both age and compensation as primary factors in allocating employer DC plan contributions. When initially implemented, these plans will usually favor senior executives who are older and more highly compensated than rank-and-file employees. However, it can be argued that the higher allocation rates in most age-weighted, profit-sharing plans are all broadly available because everyone has the ability to age and grow into the higher rates that the older participants are currently enjoying. Since age-weighted plans are

tested for nondiscrimination by focusing on future benefits rather than current contributions under the IRS's regulations, these arrangements face nondiscrimination test failures if employee demographics shift so as to no longer produce passing results.

- Nonqualified Deferred Compensation Plans (NDCP), which may be structured on either a DC or DB plan basis. Although not available to rank-and-file employees or middle management, a DB NDCP can be designed to completely restore the qualified DB plan benefits that senior executives lose as a result of the reduction or freeze. However, any amounts set aside to fund such benefits must remain at risk (i.e., until all benefits are completely distributed, the funds must remain available to the employer's creditors in the event of insolvency). In addition, in recent years, Congress and the IRS have increased the amount of governmental scrutiny over these plans, as well as the penalties for noncompliance with the new rules governing them.

Closing Up

While the final decision never is nor should be easy, employers often find themselves facing a prognosis that presents them

with a multitude of valid reasons for cutting benefits. Whether it is in response to dangerously elevated cost levels, redundant benefits, competitive forces, or for cosmetic reasons, an employer that "scrubs in" as a qualified plan sponsor needs to be aware that the oversight board (the IRS and DOL) prohibits them from recklessly hacking away. In most cases, the reductions must be planned with surgical precision well in advance to ensure sufficient prep time for the participants affected by the procedure. Even if all the regulatory conditions are met, the reduction may need to be accompanied by an infusion of replacement benefits to sustain employee morale and prevent defection to competitors. Accordingly, plan sponsors should not attempt any such procedures without first calling in appropriate benefits specialists for a second opinion.

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