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Current Issues in Employee Benefits

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• Can the Rise of Consumerism Control Increasing Healthcare Costs?

• Controlled Groups: Implications for Qualified Plans

Preventive Medicine for Health and Welfare Plans

by Dawilla Madsen and Dominick Pizzano

Health and welfare (H&W) plan sponsors cannot be blamed for feeling more than a little rundown by the slew of compliance burdens currently facing them. An abundance of new regulations has created additional compliance requirements and more are expected later this year. In addition, the Department of Labor (DOL) appears to be intensifying its level of H&W audit activity. Accordingly, now is a good time for H&W plan sponsors to consider preemptive measures to ensure compliance. Conducting a plan self-examination can help employers detect and correct any deficiencies that could be diagnosed during a DOL audit.

An "Urgent Care" Issue

Recently, plan sponsors have been inundated with new statutory and regulatory requirements that must be reflected in H&W documents and procedures. In the past several years the fitness bar was raised, requiring the plan document and summary plan description (SPD) to receive inoculations of new language that reflect recent laws, such as the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act, and the Women's Health and Cancer Rights Act. In the same vein, the DOL's rules regarding SPD content mandate injections of even more verbiage.

Unfortunately, plan sponsors that postpone completion of these vaccinations leave their H&W programs susceptible to a noncompliance diagnosis in the event of a DOL examination. The most recent regulations for H&W SPDs were effective January 1, 2003 for calendar-

year plans, and the first day of the 2002 plan year for noncalendar-year plans. The new DOL procedures governing group health and disability claims became effective for claims filed on or after January 1, 2002. In addition, the DOL's proposed notice requirements under COBRA's healthcare continuation coverage provisions are expected to be finalized this year with an effective date shortly thereafter.

Compliance Pressure is Rising

The need for immediate and ongoing compliance in the H&W plan areas increased dramatically since the DOL stepped up its efforts to make "house calls." As evidenced by information on its Web site (www.dol.gov), the DOL will be allocating sizeable resources to target both civil and criminal violations. In addition to facing the risk of a DOL audit, plan sponsors are exposed to suits by participants either on their own or through the DOL for noncompliance.

H&W plan sponsors face a broad range of penalties—both criminal and civil—for failures to comply with the Employee Retirement Income Security Act (ERISA) and related regulations. This federal law governing employee benefit plans grants oversight authority to the DOL (as well as to other federal agencies, such as the IRS).

H&W plan sponsors thus have a significant stake in ensuring that their plans are sufficiently immunized from challenges by participants or a DOL audit due to ERISA deficiencies. This can only be achieved if plan sponsors strengthen their plans' resistance to these threats.

A “Wholeistic” Approach to Compliance

How can a plan sponsor fortify its plan against the potential ravages resulting from a DOL diagnosis of noncompliance? An effective prescription is to conduct a self-examination of its programs, either internally or with the external assistance of an attorney, accountant, or consultant. The self-examination process typically begins with a review of key documents and procedures described below and an evaluation of how closely the plan sponsor adheres to their terms and provisions to avoid administrative inconsistencies. Carefully and clearly worded plan documents and SPDs will dramatically reduce the risk of complications.

Documentation

Plan Documents

ERISA requires a written plan document for all H&W plans. Most plan sponsors use a “wraparound” plan document that describes all of the employer’s H&W programs by incorporating the various individual plan contracts by reference. In addition, a separate plan document is required for any cafeteria plan (even if it is a “premium-only” plan that allows participants to pay their health insurance premiums on a pretax basis). Too often, plan sponsors with insured programs (e.g., health or life insurance) are lulled into the false sense of security that responsibility for this documentation rests with the insurer. While the insurer provides the contract language, the ultimate responsibility for the plan documentation and its contents rests with the plan sponsor.

For those plan sponsors with self-insured programs, there are no contracts containing the benefit provisions that can be tied together with a wraparound plan. As a result, the task of preparing plan documentation is even more onerous because these self-insured sponsors must also make sure that all benefit provisions are included in the document in addition to any legally required language.

SPDs

An SPD must be drafted in a manner that can be understood by the average employee and kept up-to-date, reflecting the current benefits available as well as any other provisions required by regulations. SPDs have always been required but there are plan sponsors that fail to meet this obligation. Sponsors with insured plans may

choose to use a wraparound SPD similar to the wrap-around documentation in order to tie together the materials provided by the insurer. Given that the ultimate responsibility for the SPD contents also rests with the plan sponsor, employers should not rely solely on the insurers to provide the appropriate materials.

Plan sponsors should note that because the final SPD regulations repealed a limited exemption to the SPD content compliance requirements for federally qualified health maintenance organizations (HMOs), HMOs are no longer immune from the SPD compliance requirements.

Forms 5500

ERISA requires most H&W plans to file an annual report (Form 5500) with federal agencies. Except for certain cafeteria plans, a plan with more than 100 participants at the beginning of a plan year must file a Form 5500 for that plan year regardless of whether it is funded, unfunded, or fully insured.

Plan sponsors that neglect their filing duties are exposed to even greater risk as a result of the DOL’s nonfiler enforcement program, particularly with the DOL encouraging participants to report possible nonfilers. Consequently, sponsors that have failed to file in the past should begin filing immediately and consider reporting and correcting the failure under the DOL’s Delinquent Filer Voluntary Compliance Program. This program offers reduced penalties for self-reporting and corrections.

Nondiscrimination Testing

Depending on the type of H&W plans, nondiscrimination testing may be necessary. Currently, this testing is required for all self-insured medical plans, dependent care assistance plans, cafeteria plans, group legal service plans, educational assistance plans, and group term-life insurance plans. As is the case with qualified retirement plans, the purpose of this testing is to ensure that the plans do not provide benefits that discriminate in favor of the highly paid employees. Unfortunately, in most cases regulations have not been issued to offer guidance in this complex area. Plan sponsors are responsible for providing nondiscriminatory benefits and must either perform these tests internally or seek the services of outside experts.

Administrative Notices and Procedures

Summary Annual Reports

Any H&W plan required to file a Form 5500 must provide each participant a Summary Annual Report (SAR) annually. An SAR contains a summary of the information reported to the IRS and the DOL on the Form 5500.

COBRA Notices

COBRA requires two notices: first, when coverage under the health plan commences (and includable as part of the SPD, under the proposed regulations); and second, after the plan administrator receives notice that a COBRA “qualifying event” has occurred.

Certificates of Coverage

When a participant loses coverage under a health plan (other than a plan that is part of a cafeteria plan) for any reason, HIPAA requires the plan to issue a “certificate of coverage,” which provides the participant documentation of such prior coverage.

Claims Procedures

The DOL’s final regulations require all H&W plans to maintain written claims procedures. The regulations provide detailed time limits for participant and plan administrator notifications about claims or appeals. If a plan fails to establish and maintain proper claims procedures, participants who are dissatisfied with a decision about an adverse claim are permitted to bypass the plan’s administrative appeals procedures and go directly to court to sue for benefits.

Penalties for Sick Plans

The earlier a plan can be diagnosed as sick, the quicker it can be given the proper medication and the better the prognosis is for a full recovery. Allowing the noncompliance infection to fester may result in it spreading to the

plan sponsor’s financials, with potential costly consequences that include:

- an IRS excise tax of \$100 per day for HIPAA or COBRA violations;
- a DOL penalty of up to \$1,100 for each day a Form 5500 is late; and
- an IRS penalty of \$25 per day for each day a Form 5500 is late.

Plan sponsors may also be liable for criminal penalties, which include monetary sanctions and possible imprisonment for knowingly and willfully breaching fiduciary duties, making false statements, or filing materially false or fraudulent returns with the IRS. Not providing an SPD or not filing a Form 5500 could qualify as such an action. In addition, a failure to satisfy the nondiscrimination tests may transform currently nontaxable benefits to taxable benefits for highly paid employees.

The Final Diagnosis and Prescription

In conclusion, while some H&W plan sponsors will find the required compliance efforts a hard pill to swallow, the cost of obtaining and maintaining a clean bill of health for their plans will likely pale in comparison to the potentially grave consequences of the alternative. Moreover, if they choose to strictly adhere to the recommended compliance regimen, they may very well experience pleasant side effects, such as long-term cost savings and improved employee relations. Of course, if their plans’ final diagnosis indicates the need for a specialist, outside legal counsel should be consulted.

Dawilla Madsen and Dominick Pizzano are compliance consultants in Milliman’s New York office. This article was peer reviewed by Gerald Kranson, a benefits consultant in the New York office.

Can The Rise Of Consumerism Control Increasing Healthcare Costs?

by Michael G. Sturm

Consumer-driven healthcare (CDHC) is touted by many as a means to manage employers' rising healthcare costs. But can consumerism be expected to hold down premium increases to the level of inflation? This article examines elements of the CDHC movement, how the players (i.e., consumers, employers, and providers) are affected, and whether savings will materialize from the CDHC movement.

Elements of the Consumer-Driven Movement

The term CDHC describes employer-sponsored health benefit plans with a variety of features that can be grouped in the following four categories:

1. *Employees are paying a greater share of the cost of healthcare coverage.* Not only are employers asking their employees to pay a greater share of health insurance premiums, employees are also shouldering a larger portion of medical costs at the point-of-service (e.g., through higher deductibles or copayments). Requiring workers to contribute more toward their healthcare is a typical employer reaction in an increasing-cost environment.

Health reimbursement accounts (HRAs) and the newly enacted health savings accounts (HSAs) represent an effort to provide an incentive for patients to shop more wisely for healthcare. And because HRAs and HSAs may be used to provide first-dollar coverage for routine care, the majority of healthcare consumers whose annual healthcare costs do not exceed the high deductibles associated with HRAs and HSAs view these benefit plan structures more favorably than a typical comprehensive major medical product with employee cost sharing starting at the first dollar spent. Table 1 (beginning on page 6) contains a detailed comparison of the various healthcare accounts.

HRAs are simply a method for large employers to emulate medical savings accounts (MSAs) that have been available in the small group and self-employed markets

for several years (and which expired at the end of 2003). The biggest difference is that MSAs are the employee's money and can be withdrawn in cash form. HRAs can never be taken in cash, but can accumulate from year-to-year and be used to pay for eligible healthcare expenses such as cost sharing at the point-of-service (i.e., copays, deductibles, coinsurance, etc.) and future premium contributions (e.g., COBRA, Medicare supplement, etc.). HSAs are similar to HRAs with the primary difference being that the account is owned by the employee and can therefore be taken in cash without eliminating the employer's health and welfare plan's tax-favored status.

Another way employers shift some of their healthcare costs to employees is to set a scheduled amount that the health plan will pay providers for specific treatments or services (e.g., an office visit). The healthcare consumer pays nothing if he or she sees a provider with a fee less than the scheduled benefit, but would either have to negotiate a charge-off for any higher provider fee or pay the difference. Similarly, a plan might give employees a fixed dollar amount to spend on a given diagnosis (e.g., a knee replacement), requiring costs exceeding that amount to be paid by the consumers.

2. *More employers are offering a greater choice, at both enrollment and at the point-of-service.* Although large employers have long given their employees a choice of plans (e.g., carriers or cost sharing features), choice has become pronounced in the mid-size and small-group markets. When an employer implements choice, the risk pool generally fragments, with healthy employees selecting certain plans and less healthy employees opting for other plans. Adverse selection is not too significant when one carrier insures the whole group. However, adverse selection becomes a more significant issue when two or more carriers insure one group.

In addition, some carriers advertise that healthcare consumers can see any provider they wish through their "self-

directed” health plan. However, many of these plans require cost sharing if the consumer does not use a network provider, thereby in fact offering consumers a preferred provider arrangement rather than complete “choice” on an equal (i.e., same out-of-pocket cost) basis.

3. *A limited, but growing number of consumers are shopping for value.* Information about diseases and providers has never been more abundant. This information is being supplied to consumers by CDHC carriers through Internet portals as a concession to increased cost sharing. Employers are hoping their employees will shop for services more wisely given the increased cost sharing. Wise shopping may come in the form of electing a more efficient provider, i.e., one with the lowest total cost per care episode, factoring in both the number of procedures and the cost per procedure for a given episode. Reviewing other treatment approaches is another form of efficient shopping.

4. *Carriers are streamlining administration.* Carriers are using the Internet (and to a lesser extent voice-operated systems) to achieve administrative efficiencies. These efficiencies include real-time group-specific rate quotes, employee enrollment, plan selection and identification card issuance, electronic claim submissions, maintenance of HRA/HSA balances, access to health libraries for research, provider prices (or indications of relative price), and debit card balances for HRAs, HSAs and flexible spending accounts.

Early in the evolution of CDHC, there were proponents who envisioned that employers would give each employee a set amount of money to purchase health insurance, thereby limiting costs and allowing for fixed future costs. These “pure” defined contribution health plans have not been widely adopted due to the tax consequences (i.e., the possible loss of tax deductibility of employers’ contributions) and underwriting issues (i.e., fragmentation of risk as defined earlier in this article).

How the Players are Affected

Consumers are affected by CDHC in a number of ways. First, an individual’s out-of-pocket costs will likely rise unless the

employee remains relatively healthy and the employer increases costs for the less healthy through point-of-service cost sharing (rather than through premium increases). Second, more consumers might have more benefit options (e.g., a low option benefit plan funded largely by their employer and a high option benefit plan for which they can pay the difference in premiums). Lastly, consumers will have increased information (e.g., prices, treatment choices, provider quality scores) that will help them shop for healthcare with more discrimination than in the past. This will result in consumers spending more time researching their options.

Employers may be surprised by how little their costs change after implementing certain CDHC plan features. Although many employers have been told that HRAs/HSAs will give them insurance rate relief, savings estimates from certain carriers offering HRAs/HSAs appear optimistic. An employer’s costs could increase if its advisor overestimates savings due to benefit plan changes or it must hire another vendor to manage an HRA/HSA account. Employers also will have to communicate the new product offerings to employees, some of which are confusing to explain even for seasoned healthcare professionals.

Providers will have more informed patients, with some expecting to share in treatment decisions. In addition, higher cost sharing will result in more bad debt for providers. Providers will likely recover this bad debt through a marginal increase in premiums due to commercial insurance carriers (as they have done in the past).

Will Savings Materialize?

The promise of CDHC lowering healthcare costs is mainly embedded in the HRA/HSA/fixed-payment-per-episode concepts and the hope that consumers will shop more wisely, resulting in more efficient healthcare spending since many medical decisions are made without cost in mind. Giving consumers a greater financial stake in their healthcare spending should result in more efficient purchases. For example, patients might:

- Incur fewer provider visits. That is, they will think twice whether their fever or stomachache warrants a physician visit. A concern is that consumers will forego care,

A Comparison of Healthcare Accounts

Feature		Type of Account																												
		Flexible Spending Account (FSA)		Health Reimbursement Account (HRA)		Health Savings Account (HSA)		Medical Savings Account (MSA)																						
Eligibility	Buyers	All Employers				All Employers, Individuals		Small Employers, Self-Employed Individuals																						
	Enrollees	Any Active Employee or Retiree of a Benefit Plan				Medicare Eligibles Cannot Contribute																								
	Coverage Requirements	None		None; Typically High Deductible Plan		<table border="1"> <thead> <tr> <th>Feature</th> <th>Single</th> <th>Family</th> </tr> </thead> <tbody> <tr> <td>Min Deductible</td> <td>\$1,000</td> <td>\$2,000</td> </tr> <tr> <td>Max Out-of-Pocket</td> <td>\$5,000</td> <td>\$10,000</td> </tr> <tr> <td colspan="3">Inflation-adjusted, 100% Preventive Allowed</td> </tr> </tbody> </table>	Feature	Single	Family	Min Deductible	\$1,000	\$2,000	Max Out-of-Pocket	\$5,000	\$10,000	Inflation-adjusted, 100% Preventive Allowed			<table border="1"> <thead> <tr> <th>Feature</th> <th>Single</th> <th>Family</th> </tr> </thead> <tbody> <tr> <td>Deductible</td> <td>\$1,700-2,500</td> <td>\$3,350-5,050</td> </tr> <tr> <td>Max Out-of-Pocket</td> <td>\$3,350</td> <td>\$6,150</td> </tr> <tr> <td colspan="3">Inflation-adjusted, 100% Preventive Allowed</td> </tr> </tbody> </table>	Feature	Single	Family	Deductible	\$1,700-2,500	\$3,350-5,050	Max Out-of-Pocket	\$3,350	\$6,150	Inflation-adjusted, 100% Preventive Allowed	
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Funding	Who Funds It?	Employer and/or Employee		Employer		Any Combination of Employer, Employee, and Family Member (subject to gift tax)		Employer or Employee, not Both																						
	Must Account Be Set Up Outside of General Assets?	No and Rarely Is				Yes																								
	Maximum Annual Contribution?	Unlimited—Set by Employer				100% of Deductible with "Catch-up" Allowed		65%/75% of Single/Family Deductible																						
	Tax Deductibility of Contributions	Employer	Deductible				"Above the Line" Tax Deduction (i.e., employers avoid FICA, FUTA, etc. on contributions and all employees get deduction whether they itemize or not)																							
	Employee	Deductible		Not Applicable, Employee Does Not Contribute																										
Accumulation	Can it Rollover/Transfer?	No		Rollover: Yes, Transfer: No		Rollover: Yes. They can also be transferred to another.		HSA or MSA																						
	Is it Portable (upon termination)?	No		Optional, but rarely made portable		Yes																								
Disbursements	What's Included in Eligible Expenses?	Qualified Medical Expenses (QMEs)		Employer-Controlled: Can be QME, Plan Covered Expense, or Narrower		Any QME and Certain Health Insurance Premiums Including: Long-term Care, Continuation Coverage, Payments while receiving Unemployment, Not Medigap Medicare Part A/B, Medicare HMO, employee's share of active or retiree premiums																								
	Can Balance be Taken in Cash?	No				Yes																								
	Tax Consequences	Spent on Eligible Expenses	Not Applicable				Tax-free																							
		Cash-out (due to event) ¹					Taxed as Ordinary Income																							
		Cash-out (no event) ¹					Taxed as Ordinary Income + 10% Penalty Tax		Taxed as Ordinary Income + 15% Penalty Tax																					
Options at Death	Employer Obligated to Pay Member(s)' Costs Through Policy Year, Then Keeps Remainder		Employer Usually Keeps, but Could Vary Based on Plan Set-up		Can Transfer Tax-free to Spouse's Account; Taxed as Income for Other Beneficiaries																									
Miscellaneous	Who Owns it?	Employer				Employee																								
	Permitted Trustees	Anyone				Banks, Life Insurance Companies, Health Insurers, and Other IRS-qualified Trustees																								

¹ Events include death, disability, or Medicare-eligibility.

resulting in more expensive costs at a later date.

Therefore, many plan designs cover preventive care at 100% or make a provision that only a portion of the HRA/HSA is eligible to roll over to the following year (e.g., by limiting 75% of an account to roll over, patients have an incentive to use 25% on care in the current year).

- Question the value of the services provided, resulting in fewer services per visit. For example, the number of duplicate x-rays might diminish. There is little incentive to question the duplication of these services when the health plan pays for them.
- Use providers with lower costs per procedure. This result will likely save some costs, especially if the payor has incentives in the plan for the patients to differentiate network providers based on price (e.g., charging a higher copay for expensive network providers). However, providers are resisting publication of their prices due to a variety of reasons, including the fact that a prima facie comparison of unit prices absent other information (e.g., quality, experience, etc.) can be misleading, and competitive “price war” fears.
- Purchase prescription drugs with more discretion. Generic drug usage (although already quite high in most plans) will likely further increase as the remaining “hold-outs” realize that generic drugs are biologically equivalent to brand-name counterparts. In addition, more patients will likely try therapeutic equivalents (or less expensive nontherapeutic equivalents first) when the price differences are significant.

On the other hand, costs might not significantly decrease (or could possibly increase) because:

- Discretionary costs are a small percentage of total expenditures. Most healthcare costs are incurred for valid reasons and cannot be eradicated by giving a patient an incentive (through a savings account) to forego medical services.
- CDHC features do not always result in lower provider fees.
- Low costs per procedure (for a given provider) do not necessarily result in low total costs. That is, a given provider might have lower per procedure costs but order

twice as many procedures as another provider with higher costs per procedure. For example, a given primary care physician might have difficulty diagnosing a common condition and refer a patient to a specialist or order tests that would not be necessary with a more efficient (and likely more expensive) physician.

- Employees cannot receive unused HRA balances in cash. Some feel this dilutes the consumer’s incentive to shop prudently. A stronger incentive exists with HSAs and MSAs, in which unused amounts accrue to the employee. However, MSAs were not available to the large group market (i.e., employers with more than 50 eligible employees) and the favorable tax treatment for MSAs expired at the end of last year.
- Consumers may elect more expensive providers after doing some research. Many people believe that a higher fee is an indicator of higher quality.
- The suggestion that significant savings exist is predicated on there being a fair amount of inefficiency in the current system. Few people would argue that the current US healthcare system is 100% efficient. The questions are, “How much inefficiency exists?” and “How much can CDHC features reduce the inefficiency?” Simply lowering our funding for healthcare services will at some point result in lower quality.
- Employers/employees electing the HRA/HSA features will have additional costs in hiring a vendor to maintain and administer the accounts.

Conclusion

CDHC could make the healthcare system more efficient. How much more efficient cannot be easily quantified. The answer will lie with HRAs/HSAs and fixed-payment concepts and how much motivation consumers will have to shop more wisely. Savings estimates due to CDHC quoted by some carriers are optimistic.

Mike Sturm is a consulting actuary in Milliman’s Milwaukee office. This article was peer reviewed by Dave Ogden, a consulting actuary in the Milwaukee office.

Controlled Groups: Implications for Qualified Plans

by Suzanne D. Smith and Kara W. Tedesco

Regardless of its size, a business needs to know whether it is part of a controlled group. The relationship that a business has with others within a controlled group can affect retirement plan administration and compliance because the members of the controlled group are treated as a single employer for certain retirement plan rules.

This article provides an overview of what a controlled group is and how this status affects retirement plans. In an age of business acquisitions or divestitures, awareness of the controlled group issues and knowledge of the rules are critical in maintaining the qualified status of a retirement plan.

What is a Controlled Group?

A controlled group is two or more employers that are “related,” determined by a degree of common ownership. The related employers may be any combination of for-profit corporations, partnerships, limited liability companies, sole proprietorships, unincorporated businesses, tax-exempt organizations, or any other type of business.

A frequently asked question is whether the type of work performed by businesses in a controlled group can be completely different from each other. For example, can a hair salon and a waste management company be a controlled group? The answer is yes. There is no requirement that the lines of work performed by each business be similar. If two or more employers satisfy the test for the relationship of a “parent-subsidary” or a “brother-sister” relationship, the employers are members of a controlled group.

Parent-Subsidiary Relationship

The test for a parent-subsidary relationship is much simpler than the test for the brother-sister relationship. A parent-subsidary relationship exists where one business owns at least 80% of one or more other businesses through stock ownership or voting power.

In its simplest configuration, a parent-subsidary controlled group has only two members—the parent and the subsidiary. *For example:* Company A owns 80% of Company

B. Therefore, Company A and Company B have a parent-subsidary relationship and represent a controlled group.

However, the controlled group can be complex, with multiple businesses and multiple levels:

- *Multiple Businesses Example.* Company C owns 80% of Company D, 85% of Company E, and 90% of Company F. These four companies make up a controlled group, with Company C as the common parent in the parent-subsidary relationship.
- *Multiple Levels Example.* Company G owns 80% of Company H and 85% of Company I. In addition, Company H owns 90% of Company J, 95% of Company K, and 100% of Company L. All six companies are part of a controlled group based on the parent-subsidary relationship (see Figure 1).

Brother-Sister Relationship

A brother-sister relationship involves five or fewer common owners (direct or indirect) and is determined via a two-step process (illustrated in Table 1 on page 10).

FIGURE 1

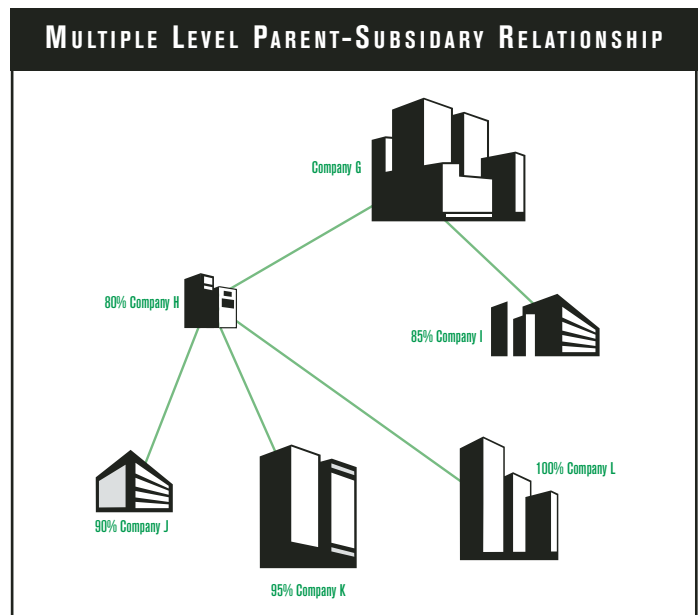


TABLE 1

BROTHER-SISTER RELATIONSHIP			
All Owners	Ownership Interest in Company Y	Ownership Interest in Company Z	Identical Ownership
Alice*	40%	20%	20%
Ben*	30%	40%	30%
Carol*	15%	20%	15%
Doug	15%	0%	
Elaine	0%	20%	
Combined Ownership for Common Owners (Common owners are identified with an *)	85%	80%	65%

Step 1: Five or fewer common owners must have 80% or more combined ownership or voting power in each business (the 80% test). To satisfy the 80% test, the common owners must have a combined ownership interest of 80% or more in a company (e.g., Company Y) and a combined ownership interest of 80% or more in another company (e.g., Company Z). The last row in Table 1 shows that the combined ownership for Company Y is 85% and Company Z is 80%, and thus the 80% test is satisfied.

Step 2: The common owners must have more than 50% identical ownership (the 50% test). The right-hand column of Table 1 shows the amount of ownership that is identical, reflecting the smaller percentage of ownership by each owner in both Company Y and Company Z. The 50% test is satisfied if the total identical ownership is more than 50%. The total identical ownership illustrated in the table is 65%, and thus the 50% test is satisfied.

The left-hand column of Table 1 identifies all the owners of the businesses being tested. An owner who has an interest in both of the businesses is considered a common owner for purposes of the test. In Table 1, the common owners who have an interest in both Company Y and Company Z are identified with an asterisk. Owners Doug and Elaine are not common owners and, therefore, their interests are not considered in the brother-sister relationship test.

Because both the 80% test and the 50% test are satisfied, Company Y and Company Z are a controlled group based on a brother-sister relationship.

To complicate matters, ownership for purposes of the brother-sister relationship includes ownership by attribution, ascribing ownership to an individual due to his or her family or business relationships. For example, in Table 1, if Ben is married to Carol, then his interest could be attributed to Carol, thereby increasing or decreasing ownership percentages for both Carol and Ben in each of the companies.

Implications of Controlled Group Status

Businesses identified as a controlled group are treated as a single employer for certain retirement plan rules, including the following:

- *Eligibility.* All employment service with any member of the controlled group must be counted for retirement plan eligibility purposes.
- *Vesting.* All service with any member of the controlled group is treated as service with the other members of the controlled group for plan vesting purposes.
- *Coverage.* When testing if a plan satisfies the rules for minimum coverage (i.e., in general, benefiting at least 70% of nonhighly compensated employees (NHCEs)), all members of the controlled group are treated as a single employer.

The most difficult part about performing this test may be the data gathering for the whole controlled group, particularly if there is a business acquisition or disposition. A transition rule, however, allows the plan(s) of the controlled group to be considered as having satisfied the coverage test in the plan year of the business transaction and the next plan year, provided that the plan(s) passed the coverage test at the time of the transaction. This transition rule gives businesses a chance to make any necessary adjustments before having to satisfy the coverage requirement when members of the controlled group have changed.

A plan may exclude employees of related entities if it can satisfy the coverage test and, in the case of a defined benefit plan, the minimum participation requirement. However, the plan may fail the coverage test if one (or more) business in the controlled group is excluded from the plan that is being tested and another plan is not maintained.

Example. Company V and Company W are a controlled group. Company V sponsors a retirement plan. Company W does not participate in V's plan and does not maintain a separate plan. Based on data in Table 2, V's plan passes coverage since the coverage ratio is at least 70%.

- *Annual Additions.* The plans of all members of the controlled group are combined to determine whether the limits for annual additions are exceeded for an individual. For 2003, the annual additions limit for

defined contribution plans is the lesser of \$40,000 or 100% of compensation.

Example. Q Inc. and R Inc. are members of a controlled group and each maintains a 401(k) profit-sharing plan. Harry works for both companies, earning \$15,000 from Q Inc. and \$40,000 from R Inc. The compensation from both companies is combined to determine Harry's maximum annual additions. Harry's annual additions limit is \$40,000, which is less than his combined compensation of \$55,000.

For purposes of this limit only, the "at least 80%" threshold used in the parent-subsidiary controlled group determination is lowered to a "more than 50%" test.

Example. Corporation T is a 51% owner in SS Partnership. Unrelated individual K owns the remaining 49% of SS. T and SS do not satisfy the 80% test, but they are considered a controlled group for the annual additions limit.

- *Top Heavy.* All plans of the controlled group members are treated as a single employer for determining the "key employees" and the top-heavy ratio.
- *Nondiscrimination Testing.* The members of a controlled group are treated as a single employer for nondiscrimination testing. However, if separate plans are maintained by separate businesses in the controlled group, the plans do not have to be aggregated for nondiscrimination testing unless they were aggregated for coverage testing.

TABLE 2

MINIMUM COVERAGE AND PARTICIPATION REQUIREMENTS			
	Company V	Company W	Data for the Controlled Group
Total Employees	40	15	55
Total Highly Compensated Employees (HCEs)	4	1	5
Benefiting HCEs	4	0	4
Total NHCEs	36	14	50
Benefiting NHCEs	28	0	28

Coverage calculation: Using the data for the Controlled Group, Benefiting NHCEs divided by Total NHCEs over Benefiting HCEs divided by Total HCEs.

$$28/50 \div 4/5 = 70\% = \text{Pass}$$

- **Deductibility.** For purposes of determining the amount a plan sponsor may deduct for its plan contributions, the employers of a controlled group are not treated as a single employer unless the other members of the controlled group are participating employers in the plan.
- **Minimum Participation.** For defined benefit plans only, the controlled group is treated as a single employer in general, but for purposes of testing under the minimum participation requirements, the employer may not aggregate two or more plans. The minimum participation test requires a plan to benefit the lesser of: 50 employees; or the greater of (a) two employees or (b) 40% of all employees.

Example. Using data from the Table 2 example, Company V passes the minimum participation test because Company V's plan benefits 32 employees, which is more than 40% of all employees.

Separate Lines of Businesses

If a controlled group has difficulty passing the coverage or nondiscrimination tests, or if the individual companies making up the group are so widely spread and remote as to make data gathering for the controlled group nearly impossible, establishing a qualified separate line of business (QSLOB) may provide a practical solution. A plan under a QSLOB can be tested separately for coverage, as well as for the defined benefit plan minimum participation test. And, if coverage is tested separately to the plan

in a QSLOB, nondiscrimination testing can also be performed separately rather than on the controlled group. To qualify as a QSLOB, the individual companies that otherwise would make up the separate line of business must:

- be organized and operated separately;
- have separate financial accountability;
- have a separate workforce and separate management;
- provide property or services to customers;
- have at least 50 nonexcludable employees;
- notify the IRS of its election to be a QSLOB; and
- satisfy one of the IRS's six safe harbor "administrative scrutiny" requirements.

Conclusion

Qualified retirement plans are affected by their corporate relationships. The ownership interests and related employers of a business are an important part of a retirement plan's administration and compliance activities and can affect the qualified status of controlled group members' plans. The issues can be complex and can require a high level of technical analysis, and care should be taken to ensure that retirement plans of related employers are operated properly.

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