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# “Defined Contribution” Health Plans: The Shape of Things to Come?

by David F. Ogden, FSA, and Michael G. Sturm, FSA

Faced with sharp increases in the cost of providing healthcare benefits to workers and seeing future healthcare cost trends on an upward spike, employers are exploring new ways to control expenses. Employers also recognize that there will be new pressures in the not-too-distant future, as the healthcare system contends with an aging population. In addition, as lawmakers and regulators take steps that burden health plans with more administrative complexities, benefit mandates, and greater potential liability, employers will pursue options that can control costs, limit employer exposure to lawsuits, and allow companies to focus on their core business—and get out of the healthcare business—while offering employees greater choices.

Defined contribution (DC) health benefit plan designs are now at the forefront of the emerging innovations in employer-sponsored healthcare benefits. This article examines the DC health plan concepts and features, their advantages and disadvantages, and the obstacles and challenges to their implementation.

## DC Health Plan Features

DC health arrangements generally refer to programs under which an employer specifies an amount of money it will contribute toward workers' healthcare coverage, and the employee then selects a health plan available on the open market. If the employee selects a plan that costs more than the amount contributed by the employer, he or she would have to pay the difference; if the plan chosen costs less, the employee could “pocket” the savings for future healthcare costs.

Although the concept is simple, there are significant issues raised about DC health programs and their implementation, including the following:

- *The Contribution*—Currently, many employers base their contribution on the cost of a specific benefit plan option. For example, many employers pay 50% to 100% of the single rate for a particular (typically, the lowest-priced) plan. Other employers pay the full cost less a fixed-dollar amount. In either case, the employer's contribution implicitly varies for each employee according to age (i.e., because the employee's contri-

bution is not age-specific and total healthcare costs increase with age). And it usually increases with healthcare cost inflation.

Most DC health plans maintain an age-adjusted employer contribution, but dissociate the employer's contribution from the cost of a specific benefit option and increase the employer's contribution independent of healthcare inflation. These features effectively decouple the employer's contribution from the cost of the health benefit, likely resulting in employees paying an increasing share of their healthcare costs.

Other DC health plans require the employer to contribute an equal amount to each employee for healthcare costs. This approach results in immaterial change if the employee is able to purchase coverage at a rate that reflects the average age of the whole group (i.e., composite rates across all ages). However, equal employer contributions by employee would result in a radical change if the employee had to purchase insurance in an age-rated marketplace, with the amount paid by older employees increasing significantly. Employers that change from the current situation (where contributions and premiums do not vary by age) must consider any applicable age discrimination laws.

- *Guarantee Issue*—Most DC health plans are designed so that the employee purchases health insurance in a competitive market where the health plan guarantees the issuance of health insurance at a rate that does not reflect the employee's health status. A few more radically defined employer-sponsored DC health plans may not provide this guarantee and simply give the employee an allowance (or voucher) to purchase health insurance. This amounts to providing nothing more than a pay raise with which the employee must purchase coverage in the individual health insurance market (which is aggressively medically underwritten).
- *Employee Choice*—Plans offering employees a choice of health benefit products are sometimes referred to as DC health plans. Choice can refer to several products offered by one carrier or multiple carriers in a “healthcare exchange” environment (i.e., where significantly more carriers than a typical multiple-carrier

situation are offered to a given group's employees). Additional choice is not unique to DC health arrangements. Multiple choice/cafeteria plans have been available for many years. However, the rapid changes in technology make it easier to administer a much larger portfolio of products from multiple carriers. People have come to expect more healthcare choices, given that financial/retirement products frequently offer many choices. There are several companies now working on providing many more offerings than traditionally offered under typical multiple-choice programs by leveraging use of the Internet.

- *Innovative Plan Design*—Some DC health plan arrangements include a personal spending account (PSA) feature, which generally provides for first dollar coverage (i.e., no cost sharing) for discretionary health benefits. Because PSA balances at the end of the plan year may roll over into the next year, employees have an incentive to use care prudently and/or remain with the carrier with which they have a positive PSA balance. PSAs are governed by tax code sections 105 and 106, which allow carryovers to be used only for healthcare, rather than section 125, which governs cafeteria plan arrangements and flexible spending accounts.

Self-directed health plans that allow employees to seek care from any provider, without the care being managed by the health plan, also are being offered. Another DC health plan innovation is an episodic payment-based health insurance product that provides a stated allowance for a diagnosis, payable as costs associated with the treatment are incurred. The insured pays for costs up to the out-of-pocket limit if the allowance is depleted. Under this type of arrangement, the carrier provides a significant amount of information on various medical conditions and associated provider fees on a web site, thereby allowing the insured to research the best option (price vs. reputation/quality of services) when obtaining care.

### Advantages and Disadvantages for Employers

From an employer's perspective, the ability to manage costs is probably the most significant advantage of adopting a DC health plan. But there are also implications to having healthcare cost obligations fixed, and employers that limit their contributions to an extremely low amount must consider the effects such cost shifting will have on their employees. For example, although DC health plans that completely de-couple the employer's contribution from the total health benefit costs can control the employer's year-to-year healthcare expenditures, employees could expect higher salaries to cover the health insurance premium. Employers that increase the plan's cost sharing also may find that doing so can be difficult to implement if employees view tax-free health benefits as more valuable than taxable wages. Because the employees' costs are likely to rise under a DC health arrangement and the increased costs will be more obvious than under current "defined benefit" health plans, an employer must be ready to deal with worker unhappiness, low morale, and employee turnover.

Employers implementing DC health benefits also could realize some administrative savings by providing employees a fixed contribution and access to a menu of plans. But the additional administrative work required in providing broad plan choices—and the attendant time and communications materials needed—might more than offset any

savings. In addition, some DC health plans are attractive because they can allow employers to avoid potential costs and/or liability under any current or prospectively ratified mandated benefit or "patient rights" legislation. Providing vouchers or money to workers to purchase health insurance does not carry the fiduciary responsibilities and obligations that providing health plans or insurance does.

One area of uncertainty with DC health plans is the taxation issue, especially for employers that simply provide employees a fixed-dollar amount and a menu of plans through an open market. Those amounts are considered wages to employees and are subject to additional payroll-related taxes (e.g., Social Security, Medicare) for both employers and employees.

### Incentives and Disincentives for Employees

From an employee's perspective, DC health plans offer workers an incentive to become involved in their healthcare management and costs, leading to avoidance of unnecessary or discretionary services. Having additional choices in providers and/or networks allows employees to select a plan that best suits their needs.

For employees, the issues raised by DC health arrangements encompass the following:

- The marketplace for the provision of health benefits may be transformed into one of individual insurance, particularly if the employer does not guarantee issue. This would lead to individuals with higher than average healthcare costs paying more in premiums (or perhaps even be declined insurance) than under a community-rated group insurance product, unless state regulation requires level premiums regardless of an individual's health status.
- When choosing an appropriate plan from among multiple options under a DC health arrangement, employees will have to spend more time than they now do.
- Younger/older employees are likely to experience a windfall/shortfall if employers do not vary contributions by age, since individuals would have to buy insurance in an age-rated marketplace. Although some proponents of this concept argue that young/healthy individuals will save the amounts not currently spent on healthcare for future healthcare costs, opponents counter that the less healthy/older individuals must pay higher costs without ever having the opportunity to save in their younger/healthier years. In addition, there is no guarantee that the younger/healthier employees will save the money for healthcare purposes in later years.
- The tax code sections governing PSAs prevent employers from giving tax-qualified vouchers to employees that can be taken as cash. This reduces the amount of flexibility that an employee has with the employer's contribution to healthcare costs (e.g., in a situation where the employer contributes more than the employee's costs, such as with level employer contributions and age-rated premiums).

### The Health Plan/Insurance Market

Ongoing changes in the health plan and insurance markets are also fueling interest in DC health arrangements. Internet-based health

plan administration, provider competition over quality and price, network customization by employees, and expansive choices are among the innovative responses now underway.

But uncertainties remain for DC health plan developers. Employee choice can lead to adverse selection, where insurers are unable to accurately predict medical costs for their insured population. Current small-group rating regulations and/or the lack of economies of scale might make “healthcare exchanges” impractical or not possible for some employers. Current tax laws have not been tested with DC health plans. And the DC health plan concept blurs the line that currently distinguishes “group” and “individual” health insurance, raising questions as to whether and how to apply laws—such as COBRA continuation coverage and Health Insurance Portability and Accountability Act requirements—to these emerging programs.

**Are DC Health Plans Viable?**

Although many employers appear interested in DC health plans that provide employee choice, few are ready to commit to, much less

adopt, an arrangement that completely de-couples employer contributions from healthcare cost inflation and an employee’s age. The current competitive labor market, which makes finding and retaining employees difficult, is one factor constraining employers from implementing DC health plans.

If unemployment rises and profits fall, however, it is possible that a noticeable move towards full-fledged DC health benefits will emerge. The return of double-digit healthcare cost increases and improvements in technology have spawned consideration of the DC concept. In addition, to the extent that federal and state legislation and regulations or judicial decisions make the healthcare landscape for group plans and insurance more onerous or unmanageable, employer demand for solutions and innovations along the lines offered by DC health arrangements will grow.

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# Will You Survive a 401(k) Plan Audit?

by Christine Hinson, QPA, and Dawilla Madsen, CLU, APM

The thought of an Internal Revenue Service (IRS) or Department of Labor (DOL) audit can put fear and trembling into the heart of even the most stoic person. This fear is not unfounded. Qualified retirement plan sponsors and other plan fiduciaries may personally be held liable for civil or even criminal penalties if the agencies find actions that violate the Employee Retirement Income Security Act (ERISA). The qualified plan itself might face disqualification, or the plan sponsor could be subject to monetary sanctions for certain other violations. Although severe penalties and plan disqualification are not the norm, they are a distinct possibility. At the very least, an audit initiated by the federal agencies will cost plan sponsors time and money, not to mention the obvious anxiety.

This article focuses specifically on audits of 401(k) plans, examining the areas under review by the federal agencies and exploring “self-audits” and corrections programs as options that can be helpful to plan sponsors.

**Who Does the Audit?**

In the past, the IRS conducted the majority of 401(k) plan audits. Recently, however, the DOL has become a major player in the audit arena. Although there is some overlap, the IRS is primarily interested in plan documentation and plan operational compliance, while the DOL focuses on compliance with ERISA, particularly to ensure that plan participants’ rights are not violated.

**IRS Audits**

The IRS recently issued a compliance profile of 401(k) plans. From 1995-1997, the agency’s field offices audited 472 plans, 44% of which had defects. In releasing the results of the study, the IRS expressed the hope that the information compiled on violations would aid plan

Table 1

IRS COMPLIANCE PROFILE OF 401(K) PLAN DEFECTS	
AREA OF VIOLATION	NUMBER OF PLANS WITH VIOLATIONS
Hardship Distributions	68
Eligible Rollover Distributions	33
401(k)/401(m) Nondiscrimination Testing Failures	28
Loans	26
Benefits Other Than Matching Contributions Made Contingent on Elective Deferrals	24
Top-Heavy Requirement	18
Plan Not Qualified (Reason Not Given)	15
Coverage	14
Section 415 Failures	13
Nondiscrimination	13
Vesting	9
Prohibited Transactions (DOL and IRS Requirement)	8
Timely Transfer of Contributions to the Plan (DOL Requirement)	8

sponsors by identifying the likely areas of potential or existing violations. A sample of what the agency found is shown in Table 1.

Based on the law of averages, the chance of any plan having a violation is substantial. And because the IRS apparently will include qualified plan audits in its work plan for 2001, the chances of an audit are not diminished.

### DOL Audits

There are three primary areas the DOL currently has targeted for 401(k) audits:

- *Plan Investments*—The DOL is interested in the prudence and propriety of the plan's investments, and wants to ensure that each investment is examined thoroughly by the plan administrator and/or trustee before it is made and that it is reviewed on a regular basis.
- *Timely Deposits of Plan Assets*—The DOL's regulations require participant contributions to be deposited into the trust as soon as the monies can reasonably be segregated from the employer's general assets, but no later than 15 days after the end of the month in which the amounts are withheld. Many plan sponsors operate their plans as if the 15-day maximum is a safe harbor. The DOL's enforcement activities focus instead on ensuring that plan sponsors make the deposit on the earliest possible date.
- *Payment of Expenses*—The DOL has begun to examine how plan sponsors determine who pays various plan-related expenses. This area has been fraught with difficulties for plan sponsors because the agency previously provided little formal guidance as to which expenses are payable by the plan and which expenses must be paid by the employer or plan sponsor. The DOL recently issued new guidance, which should help employers in the determination, though complying with it will not necessarily be easy.

As part of the question of who pays for what, 401(k) plan sponsors in particular need to be aware of the fees being charged for plan administration, fees that might include more than just a base recordkeeping fee. For example, recordkeeping fees hidden in asset management fees might result in costs to the participant that are more than the industry standard. Plan sponsors must understand how their fee structure works and be able to show that these fees are being monitored on a regular basis.

### Who Is Responsible?

When the IRS or DOL comes knocking, there should be no doubt who must answer. Plan fiduciaries, who ultimately are responsible for plan qualification, include any person who: exercises discretionary authority or control of the management or disposition of the plan assets; renders investment advice for a fee; or has discretionary authority or responsibility for plan administration. Thus, plan fiduciaries usually include the plan sponsor, plan administrator, and plan trustee.

ERISA requires all fiduciaries to operate the plan solely in the interest of participants and beneficiaries, and for the exclusive purpose of providing the benefits in accordance with the plan document and related instruments. Fiduciaries also are responsible for selecting investments with care, skill, prudence, and diligence, and for diversifying investments to minimize the risk of large losses.

### Being Prepared

Plan sponsors and other fiduciaries cannot guard against a 401(k) audit. But they can be prepared. Being prepared can make an audit less onerous and costly.

Plan sponsors hire actuaries, consultants, attorneys, internal auditors, investment managers, and other benefit professionals to assist them in numerous ways. In most cases, the day-to-day administration falls on an in-house human resource professional, whose responsibilities include more than just administration of the qualified plan. Often, this employee will not have attended professional seminars or outside training on the latest requirements governing qualified plans. Therefore, it is a good idea to have benefits professionals periodically review the plan in operation and design to ensure a clean bill of health before a potential audit.

One of the best ways to be prepared—and to alleviate some of the anxiety—is to perform a self-audit of a plan's administration before the IRS or DOL shows up on the doorstep. Even the IRS has acknowledged the importance of a self-audit. At a recent American Bar Association program on plan audits, an IRS official said the agency is not likely to ask for information obtained by a self-audit, but that the plan sponsor might want to share it with the IRS to indicate interest in plan compliance, a factor that is considered when negotiating monetary sanctions.

### Scope of the 401(k) Self-Audit

Based on the IRS's and DOL's current activities, the scope of a 401(k) self-audit should be comprehensive. Generally, a self-audit should review the plan's compliance with ERISA, the Internal Revenue Code requirements, and corresponding regulations and other guidance. Specifically, areas to focus on include the following:

- *Plan Documentation*—Plan sponsors should verify that all necessary documents exist, are signed, and are in compliance. This includes the plan document and all amendments, summary plan descriptions (SPDs), summary of material modifications, and trust agreements. The plan document and amendments should be reviewed for timely adoption and recent IRS determination letters. The SPD should be reviewed for distribution compliance and to ensure it is up-to-date. The trust agreement should reflect the most recent trustee and investment procedures.

Any administrative procedures (e.g., loans, qualified domestic relations orders, claims distributions, and the plan's investment policy) should be reviewed to ensure the plan is being operated in accordance with its terms and provisions. Administrative forms—particularly those relating to elections, distributions, spousal consents, loans, withdrawals, and withholding—should be reviewed for compliance and accuracy.

The last three annual report filings (Form 5500), summary annual reports, and financial statements, as well as a copy of the fidelity bond covering those years, should be maintained for ready access.

- *Plan Operations*—Certain items may undergo random sampling to ensure their accuracy. Are eligibility requirements under a plan's enrollment procedures administered correctly? Is service credited correctly, especially for re-hires, when computing vesting

percentages? Under the plan's distribution procedures, are all appropriate notices and elections regarding rollovers, withholding, and spousal consent (if applicable) being provided to plan participants on a timely basis? Is there necessary, appropriate documentation for hardship distributions and plan loans? Are participant contribution deposits made on a timely basis?

- *Annual Compliance Testing*—Plan sponsors must ensure that annual compliance testing is performed and all applicable forms are filed with the IRS and DOL. Among the many tests that sponsors must perform are: coverage testing; identification of highly compensated employees; nondiscrimination testing; and monitoring of benefits and compensation limits. These tests can be complicated and are subject to annual regulatory changes.
- *Annual Forms Completion*—Because the completion of annual forms—such as Form 5500 or Form 1099R for reporting of plan distributions—can be time consuming and confusing for the average human resource practitioner, this area may be delegated to third-party professionals.

### Correction Programs

Because plan disqualification has a significant adverse effect on participants and sponsors, the IRS and DOL have implemented comprehensive programs for plan sponsors to identify defects and violations and to make corrections.

- The IRS recently issued a revised 90-page procedure for its Employee Plans Compliance Resolution System (EPCRS). The EPCRS's programs provide for self-correction (SCP), voluntary correction with IRS approval (VCP), and corrections when the violation is found upon an audit (Audit CAP). The SCP does not require a fee or impose a monetary sanction, but it is not foolproof against a future audit. The VCP requires a submission fee and Audit CAP assesses a monetary sanction against the plan sponsor. But under both programs, the correction is approved by the IRS.

Therefore, the issue will not be raised in a subsequent audit covering actions that occurred prior to the correction date.

- The DOL's Voluntary Fiduciary Correction Program, a mere 34 pages, does not require a fee nor does it impose a monetary sanction. Under this program, plan fiduciaries may voluntarily apply for relief from civil or criminal penalties under ERISA—but not under the tax code—as a result of certain fiduciary violations. It covers violations such as delinquent employee contributions, prohibited loans, improper valuation of assets, and payment of excessive plan expenses.

Both programs require adherence to specific procedures, detailed documentation, and possibly negotiations with either the IRS or DOL (or both). Plan sponsors may wish to consider using the services of benefits compliance experts to help navigate a corrections program.

### Conclusion

An audit by the DOL or IRS can be costly in time and expense, not to mention anxiety. To alleviate the audit-related stress, a qualified 401(k) plan sponsor should periodically perform a self-audit for compliance. Doing so can give the sponsor peace of mind, knowing that the plan is being administered in accordance with its terms and the various laws and regulations. A self-audit also can pinpoint areas of potential and real problems.

Keeping a qualified 401(k) plan in compliance is a major responsibility. But, with frequently changing rules, statutory revisions, and turnover in an employer's human resources department, ensuring compliance can be daunting. If your plan performs self-audits and you are willing to open your books, you will be in a sound position to negotiate with the DOL or IRS, should they call to perform an audit of their own.

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# Information Technology in Benefits Plan Administration

by Craig Burma

Benefits administration in the technology-connected economy brings an increasing focus on the role employers play in communicating with their employees. In traditional top-down organizations, technology investments tend to focus on improving mission critical functions such as manufacturing or transaction systems. Meanwhile, front-line systems managing employee benefits communications, retirement plan call centers, and related administrative tasks are unsupported with technology investments and receive little attention from an employer's information technology staff. But today's competitive marketplace and enabling technologies are increasing employer awareness of the capabilities of new applications and their effects on employee participation in benefits administration.

This article describes the changes directly linked to technology developments now taking place in benefits administration. Specific information technologies (IT) are spotlighted, showing their ability to automate processes, strengthen ties to employees, and reduce administrative costs.

## Employee-Centric and Employer-Centric Focus

A lot of money earmarked for retirement investments is still passing through the Internet into the financial markets. This is what is fueling the growth and development of multiple communications channels between employers, employees, and third-party recordkeepers. This new interaction dovetails with a market led by the largest, most investment-savvy generation ever, in their peak years of earning, saving, consuming, and investing. Despite all the questions about the driving force behind this "new economy," the transformation of the role of the employee-consumer is a significant part of this revolution.

Propelled by significant technology investments, recordkeepers performing benefits administration tasks for employers have the capacity not only to link their systems to an employer's human resource management applications, but also to extend these links to plan participants and other outsourced administrative service providers (see Diagram 1).

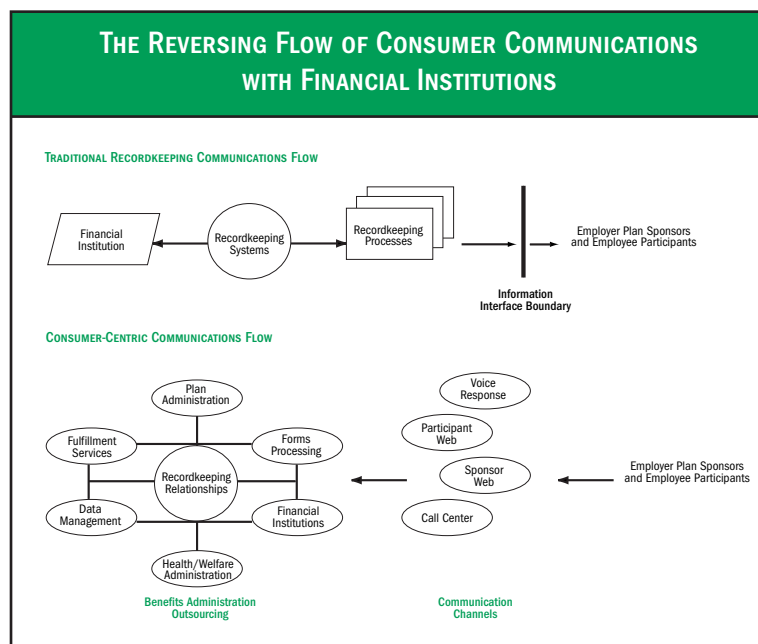
A good recordkeeper creates value for its clients by providing transactional efficiencies and gains their loyalty by developing client-centric systems that take into account each plan's uniqueness. Increasingly, customer relationship management, human resource systems integration, efficient forms processing, and fulfillment services for participant communications—operational areas formerly neglected in IT investments—are becoming the primary focus of technology investments to meet the voracious information appetite of employee plan participants and employer plan sponsors.

Recordkeepers have responded with fully developed self-service web-based applications and integrated voice response (IVR) systems. Yet no single system has eclipsed the role of any other. Rich website content prompts complex participant questions for experienced, highly trained call center representatives with integrated information systems at their fingertips. Many call centers report more than half of all calls from participants start as self-service transactions—on the web or through IVR—that are not completed successfully. Although this appears to contradict process improvements, the opposite may be true: these calls show that participants are engaged, interested, and willing to pursue a resolution, rather than simply throwing up their hands and giving up.

## Outsourcing and Convergence in the Market

The 1999 Financial Services Reform Act cleared the way for banks, securities firms, and insurers to offer multiple services. Perhaps more importantly, this law unleashed the potential for integrating disparate information systems to maximize opportunities for the cross-selling of financial products and services. This environment fueled the development of technologies to connect legacy systems (older information systems containing valuable business data and processing capabilities) to customer-facing applications. Companies implementing, supporting, and training on these technologies have benefited significantly.

Diagram 1



Outsourcing employer business transactions, including benefits administration, is fueled by increasingly efficient inter-company communications and commerce systems. When an employer maintains a plan administrative process in-house, it bears the total cost of the effort instead of the marginal cost of outsourcing the function to a recordkeeping specialist who performs the tasks as a core business. These “value chains” of outsourced business processes are shared on many levels between an employer and a recordkeeping vendor. For these value chains to be successful, however, it is imperative that systems be linked to effectively connect in a superior fashion to intra-company communications, while presenting a consistent “look and feel” to employees.

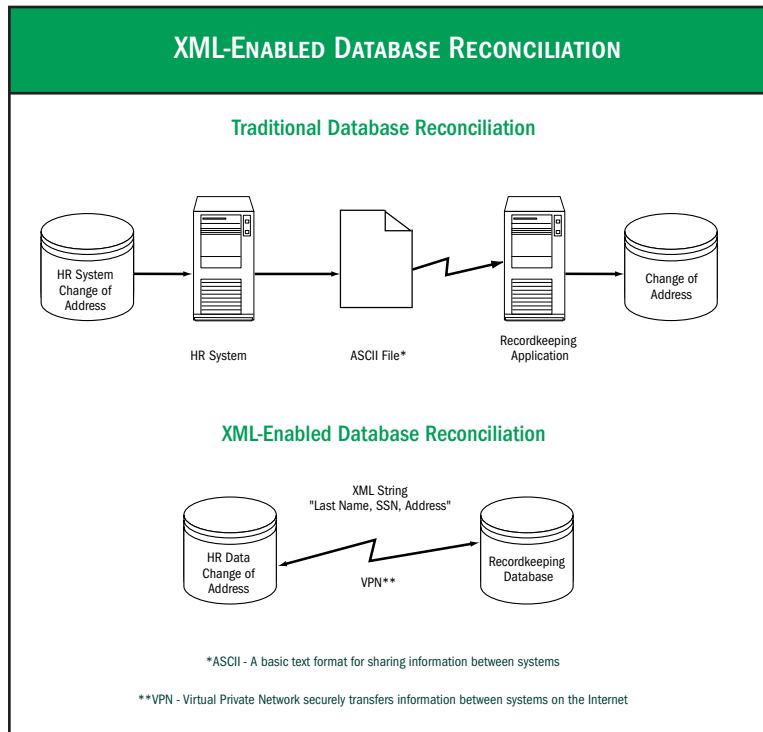
For an employer’s retirement programs, employees demand a single vendor for defined benefit, defined contribution, cash balance, and deferred compensation plans. They require real-time access to information about all their accounts in one location. Employers, meanwhile, want real-time access to plan data and information about the interactions of all employees within the plans. In addition, recordkeepers are realizing the need to drive down unit costs by outsourcing plan administration activities while maintaining control of the overall relationship with their employer clients. This demand led to the formation of service bureaus offering forms processing, call center services, data management, communications fulfillment, and even plan administration itself, all in an effort to lower costs by building economies of scale.

**Technologies in the Spotlight**

Some of the innovative technologies creating the seamless information and communication flows imperative in today’s benefits administration environment include:

- *Customer Relationship Management*—CRM is an emerging class of software that stresses the value of tracking customer information at all stages and across all communications channels. The changing role of consumers, and market forces pushing toward services integration spurred financial institutions to quickly adopt CRM technology. In benefits administration, recordkeepers use CRM systems to track the history of every call center contact or employee interaction via the web, IVR, or email, with a particular emphasis on faster resolution of open issues with employees and real-time information for employers on the use of these communication channels by employees.
- *Extensible Markup Language*—HyperText Markup Language (HTML) tells an Internet browser how to format data on a computer screen. Extensible Markup Language (XML) goes further by specifying what the information “is,” using terms that a database can understand. XML “talks to” databases the way HTML “talks to” browsers—it tells remote databases what the data is and where to put the information. XML, however, has significance beyond merely presenting and exchanging database information with the web. It is also used to create structures for communicating with legacy systems and to deploy information on wireless devices. With XML, employees can change information on the 401(k) plan’s recordkeeper’s website, bypassing

Diagram 2



human resource systems, which today typically require that text files, along with many other pieces of data, be sent to the recordkeeper in an update (see Diagram 2). Use of XML provides an interchange between the employer’s Human Resources Information System (HRIS) database and the recordkeeper’s database in real-time, keeping them in sync.

- *Knowledge Management*—This concept is equal parts business process reengineering and information systems, and its purpose is to link structured and unstructured information to a recordkeeper’s transactional engine. An employer’s recordkeeper may use knowledge management to: gather commonly asked employee questions; manage the images of paper forms; and document ad hoc communications with employers.

This information is generally held in knowledge repositories that let employers capture in a user-friendly forum best practices, experiences, and lessons learned. Using threaded discussions, bulletin boards, and integrated support areas, recordkeepers eliminate duplication of work across multiple clients. Efficient forms imaging/processing systems offer significant cost savings as well. Several Internet-based solutions allow recordkeepers to scan documents locally and upload them to a secure storage facility on the Internet. Indexes of scanned forms then link to the knowledge repository. Document management systems create a central repository of electronic files, giving recordkeepers the ability to “check-in” files from office applications and retain historical versions of the same document without renaming the document.

- *Structure Object Access Protocol*—SOAP offers significant advances in connecting software used in existing websites to a common platform. SOAP enables one application or software object to transact

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information with another website on the Internet, without regard to the computer operating system, the browser, or other aspects of the platform used by either system. For example, when a participant requests a termination package online, traditionally the request form is processed as a transaction in the recordkeeper's database. In the SOAP model, information entered creates transactions in both the recordkeeper's database and an outsourced fulfillment center's system, which is completely transparent to the user. The transaction is recorded and fulfillment completed without double-entering database information and manually transferring extracts to the fulfillment center.

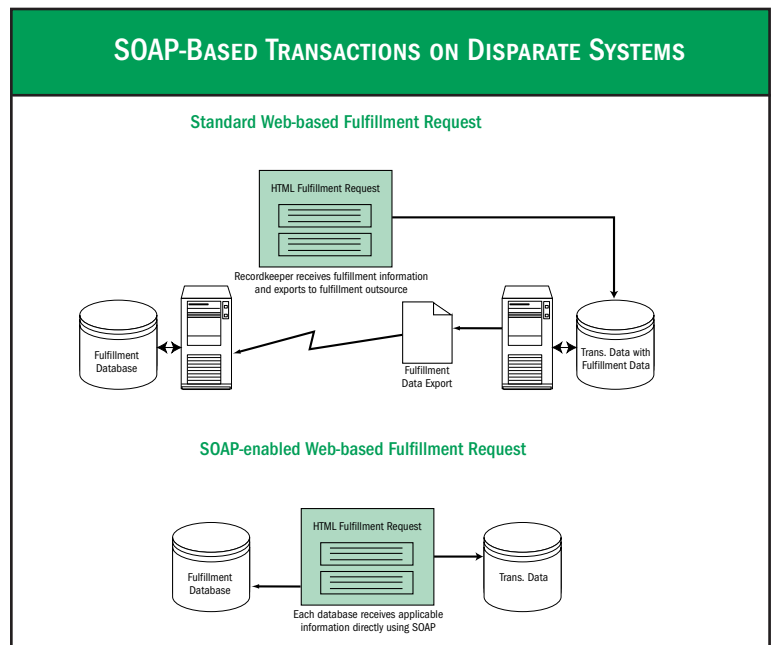
- *Biztalk*—Ordinarily, the transfer of massive amounts of data between systems requires a programmer to design an interface that enables systems to talk to each other. Biztalk is a program that facilitates information exchanges between recordkeepers and employers without the involvement of a programmer. Recordkeepers using Biztalk can translate, consolidate, verify, and track their communication histories with financial institutions and other vendors through one consistent easy-to-use interface.

## Front-Line Best Practices

For employers and recordkeepers, leading-edge technologies will remain difficult to analyze from a return on investment perspective, even with an understanding of the role of the customer, the marketplace, and the various technologies used in the current exchanges. In terms of benchmarking their efforts, however, the following are examples of best practices that can be effective measuring tools for employers and recordkeepers in assessing future investments in information technology:

- reliable access to all plan information and transactions from multiple channels, including web, IVR, and call centers;
- seamless handoff between communication channels;
- a clear understanding of procedures for tracking and resolving participant questions in a timely manner;
- communication on every channel tracked historically and analyzed for performance;

Diagram 3



- a knowledge management system allowing for the growth of best practices, retrieval of forms, and coordinated storage of ad hoc communications to employers;
- dynamic web content that is easily shared with external remote websites;
- information portability and synchronization via XML; and
- an effective cross-functional team that manages an ongoing schedule of technology integration projects.

## Conclusion

Employee demands for advanced benefits administration services and employer eagerness to be progressive with technology are clearly the driving forces behind these innovative approaches to systems integration. Their demands are leading to dynamic changes in the technology systems of employers, recordkeepers, and other outsourced service providers. Only those service providers creating a seamless interface, on the front lines—among an employer, its benefits services, and its employees—and across multiple communication channels will prosper.

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