RECORD OF SOCIETY OF ACTUARIES
1987 VOL. 13 NO. 1

POSTRETIREMENT MEDICAL CARE ISSUES

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Panelists: TERRY L. BRANSTETTER*
ROBERT W. KALMAN**
Recorder: MICHAEL JOHN MURRAY

- o Legal/regulatory developments
- o Benefit design, funding, vesting, accrual issues
- o Employer perspectives
- o Public policy implications

MR. RAYMOND P. WELNICKI: I am an Actuary at Aetna Life & Casualty, and I also serve on both the Health Insurance Association of America (HIAA) and American Council of Life Insurance (ACLI) Task Forces on postretirement medical care. I am pleased to have with me two individuals who are very involved in the issue of postretirement medical care.

Terry Branstetter has worked at DuPont for 21 years in various capacities: manufacturing, engineering and personnel. He currently has the responsibility for DuPont's health care benefits program and works primarily in the areas of benefits administration, design and policy. DuPont is a very progressive and innovative employer with respect to employee benefits programs, and Terry plays a key role in the design and operation of their programs.

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Social Security, Medicare, and the design and financing of postretirement medical plans. Immediately prior to joining Mercer in 1979, Bob served for over six years with the American Federation of State, County and Municipal Employees in Washington, D.C. Previously, he served as a consultant on health care financing to the National Institute of Mental Health and served on the employee benefits staff of Citibank in New York. Bob has published numerous articles, has testified before many federal, state and local governmental bodies and has been a frequent speaker on issues affecting Social Security, Medicare and employee benefit plans. Most recently he coauthored a study on the financing of postretirement medical benefits that will be published as a committee print of the U.S. House of Representatives Select Committee on Aging.

Our objective is to frame out the postretirement medical care issue and bring you up-to-date on recent developments and emerging trends. We hope to provide you with a basis for understanding the multiple dimensions of the issue, and we'd also like to impart some sense of urgency for you as actuaries to pay attention to this issue and to become involved in the emerging public debate over it.

I will provide an overview of the current environment including demographic trends, the present role of government, employers and employees, legislative, regulatory and judicial developments and Financial Accounting Standards Board (FASB) activity. Bob Kalman will then focus on plan design, funding and vesting considerations/issues, and Terry Branstetter will share his thoughts on postretirement medical benefits from an employer perspective.

Health care expenditures for individuals age 65 and over have been increasing very dramatically. Ten years ago these expenditures totalled $43 billion. By 1984 the health care spending bill had risen to $120 billion for individuals age 65 and over. This represented about one-third of the total health care expenditures for all age groups combined in the United States. The tally as a percentage of GNP increased in the same period from 2.3% to 3.3%. The annual growth rate in these figures is around 15% with about 2.3% due to increases in the elderly population and about 13% due to increased per capita spending. In 1984 costs for those over 65 were about $4,200 per individual with about 45% of that for hospital expenses, about 21% for physician expenses, and another 21% for

nursing home care. The balance was for miscellaneous medical supplies, drugs, dental, and so on.

Who paid for these expenditures? Well, overall, Medicare paid 49% of the bill. Medicaid and other government programs picked up another 18%. That left about 33% to be covered by the private sector. Of that, only about 7% came from private insurance programs; that is, insurance by individuals and group health insurance programs.

You may ask, if the private sector is picking up only one-third of the bill and if private insurance covers only 7% of the bill, is there really a major crisis looming ahead in the area of employer sponsored retirement programs? I think when you look deeper, the answer is a most definite yes.

It is important to recognize that only about 20% of today's retirees (those over age 65 who are currently retired) have postretirement medical care coverage. However, recent surveys indicate that 60% to 80% of active employees work for employers who provide postretirement medical care coverage. Some surveys have put the figure closer to the 90% range. Thus, the share of the health care bill absorbed by group health benefit plans will increase.

Additionally, the number of retirees is growing dramatically, coincident with the general aging of the population. In 1985 about 29 million people in the United States were age 65 or over and that represented about 20% of the population. The age 65 and older population is expected to grow about 10% a year for the next 10 years before slowing down somewhat. By the year 2010 about 23% of the total population will be over age 65 and that will increase to 31% by 2020 and to 40% by 2030.

At the same time that this population trend is emerging, there is a trend towards earlier retirement ages. In 1962 only 23% of surveyed employers reported that the average retirement age was 62 or less. In 1982 that had risen to 51%. The Senate Special Committee on Aging estimates that the labor force participation rate for males age 55 to 59 was about 88% in 1964 and had dropped to 64% in 1984. Those trends clearly indicate increasing cost pressures for postretirement medical benefits.

What about the scope of employer provided coverage? Well, it is fairly broad. The Senate Special Committee on Aging estimated that employer sponsored health insurance for retirees age 65 and over cost, on the average, about $942 per retiree in 1983. Further, the employer share of the premium cost was about 58%.

What do all these statistics and trends mean in terms of future costs? Various extrapolations have been done to estimate accrued liability for employer sponsored postretirement medical care benefits. In 1986 the Department of Labor estimated this liability at $98.1 billion. Now, more recently, Metropolitan Life Insurance working with the HIAA Task Force has estimated that the accrued liability for the Fortune 500 companies ranges from $140 billion to $350 billion. Put another way, the accrued liability for the Fortune 500 companies appears to fall in the range of between 10% and 25% of their combined assets.

Clearly, then, the cost to employers of providing postretirement health benefits will siphon off even larger portions of employer revenues over the next 10, 20 and even 50 years. This assumes, of course, that these benefit programs will be continued and that employers will have the resources to continue financing them. Will they? Well, let's examine the recent developments in this area to see if they provide a clue to future activity.

In July 1986 LTV Corporation, which is the second largest steel producer in the United States, filed for bankruptcy. Immediately following the Chapter 11 filing, LTV discontinued medical coverage for their 78,000 retired employees. In response to this action and the resulting fallout, Congress approved a stopgap measure which required LTV and any other company filing for bankruptcy to continue postretirement medical benefits until May 15, 1987. To deal with this type of situation on a more permanent basis, Senator Metzenbaum and Congressman Stokes have recently introduced the Retiree Benefits Security Act of 1987. This bill would prevent employers who have filed for bankruptcy from terminating or modifying retiree medical plans without the approval of the court or the consent of the retirees' agents, such as a labor union. Further, a court could not modify benefits unless the change was necessary to facilitate a fair and equitable reorganization of the company.

This legislation provides some indication that Congress is concerned about continuation of retiree medical benefits. It's not, however, the only example. We are all too familiar with the COBRA legislation that was passed last year. Although not pointed directly at retiree benefits, COBRA does mandate a continuation of benefits for a period of 18 months or, if less, until the individual becomes eligible for Medicare. Also last year Congressman Rowland of Connecticut introduced a bill that would essentially "ERISA-fy" postretirement medical benefits. Although this appears to have been a testing of the waters rather than a genuine legislative priority, it nevertheless suggests that congressional interest in retiree health care benefit issues is growing.

More recently, the administration has surfaced two proposals that would also affect retiree health benefit plans. One is a proposal to expand Medicare to include catastrophic medical coverage. Basically, this coverage would cap a Medicare eligible's expenses for medical care at $2,000 per calendar year. The $2,000 limit would be adjusted annually for inflation. This proposal appears to be somewhat speculatively priced at about $4.92 per month per retiree. And on the surface it would appear to reduce the necessary scope of employer sponsored coverage for retirees.

The second recent proposal would permit employers to transfer surplus pension plan assets to a segregated funding vehicle in order to prefund the cost of retiree medical benefits, but only for existing retirees. These transferred assets would not be subject to the the 10% excise tax on asset reversions and the investment earnings would not be taxable to the employer. At the same time, however, Section 401(h) of the Internal Revenue Code would be eliminated, thus removing the sole tax favored vehicle for prefunding postretirement medical benefits for active employees.

These initiatives all point towards further Congressional attention to the subject of postretirement medical benefits. While these developments have been taking place, there has been activity on the judicial front. In *UAW vs. Cadillac Malleable Iron Company* the Michigan court ruled in 1982 that Cadillac could not terminate or modify postretirement medical benefits for existing retirees. The court indicated that there is a presumption of vesting in the absence of clear evidence to the contrary. On appeal, the Sixth Circuit Court disagreed that an intent to vest should be presumed or that it should be the sole determining factor.

However, it still affirmed the lower court's decision because it nevertheless found sufficient evidence to suggest intent on the part of the employer. So, they disagreed with the presumption argument but they did find evidence of actual intent to provide a vested lifetime benefit.

In 1983 the Sixth Circuit Court of Appeals decided another case, *International Union vs. Yardman.* Here the court indicated that retiree benefits are status benefits and they carry an inference that they will continue as long as the requisite status is maintained. The court cautioned that this inference standing alone is not sufficient to establish an intent to create interminable benefits. However, it can be a supporting factor and must be looked at. In 1984 a district court held in *Eardman vs. Bethlehem Steel* that plan documents were in some cases ambiguous, and in other cases silent, as to the employer's right to terminate or modify the retiree benefit program. Additionally, the court found evidence supporting the claim that the company had made oral and written representations to retiring employees that the benefits would continue for life.

Perhaps the most interesting case was the *White Farm Equipment* case in 1984. Here the Northern District Court of Ohio formulated a federal common law rule that benefits become vested upon retirement. This position was based on certain pre-ERISA cases in the pension area. Basically, the court said that Congress was silent as far as vesting goes in the area of postretirement medical benefits but that did not signify a congressional intent that those benefits are not vested. Rather the court contended that Congress left it up to the courts to develop and apply common law rules to deal with vesting of postretirement medical benefits. This decision was reversed by the Sixth Circuit Court in 1986. And here the court gave some further indication of developing trends, saying employers and employees can freely contract for postretirement benefits and the courts will interpret the terms of those contracts without regard to any supposed common law vesting requirements.

It's uncertain how other courts will respond in similar situations. One clear trend, however, that can be expected to be universally applied is that an employer cannot terminate or modify medical benefit plans for retirees unless the employer has unequivocally and consistently reserved the right to do so. Communications to employees must in all instances, whether in writing or orally, distinctly state that the benefits may be terminated or modified by the employer.

It remains to be seen whether even this will be enough to allow employers to terminate or modify plans.

Besides legislative and judicial activity, further pressure on postretirement medical benefits is beginning to emerge from the FASB. As I'm sure you know, FASB now requires companies to disclose current costs for nonpension postretirement benefits in the footnotes to annual reports. This is a preliminary step in FASB's further development of accounting requirements for these benefits. It is expected that FASB will issue an exposure draft of proposed accounting treatment for these benefits some time next year. The likelihood is that the draft will propose required expensing of these benefits over the working lifetimes of the employees. Even in the case where the employer reserves the right to modify or terminate the plan, we may very well see an expensing requirement. From FASB's perspective, a critical factor is whether the employer expects to continue benefits under reasonable circumstances. If the assumption is that the employer will continue the benefits, the reservation by the employer of termination or modification rights will probably not exempt the employer from having to accrue the benefits over the working lifetimes of employees.

Various surveys have indicated that many companies will discontinue postretirement medical benefits if the cost must be accrued over the working lifetimes of the employees. The impact on the capital and surplus accounts of many employers would be substantial if the accrued liability were required to be posted on the balance sheet. Consequently, I think we can expect a fairly heated debate with FASB if they take an aggressive posture on this issue. I think it's fairly likely that FASB will do so at least with respect to the exposure draft.

To summarize the environment then, we see costs increasing, the number of retirees growing, and pressure mounting from Congress, the courts and FASB to provide greater accountability, commitment and security for postretirement medical benefits. The next few years will be very challenging for employers, and for those of us who provide benefit plan assistance to employers. With that as background, Bob Kalman will give you some further perspectives on funding, vesting, accrual, and plan design issues.

MR. ROBERT W. KALMAN: What I plan to do is discuss some specific postretirement medical plan design, funding and vesting issues and the environment

in which these plans currently operate. When I talk about environment, I'm referring to the changing factors that have come into play since postretirement medical plans were first introduced.

First, I'd like to relate some of the basic similarities and differences between employer-sponsored postretirement medical plans and defined benefit pension plans. Postretirement medical benefits are another form of retirement income, essentially a medical care annuity. The fundamental difference between these medical care annuities and pension plan annuities is that a medical plan provides benefits in the form of services or reimbursement for services rendered, while defined benefit pension plans provide cash income. In both cases, entitlement is earned over the working lifetime of employees, usually based on retirement after a defined age and period of service. But unlike pension benefits, the level of postretirement medical benefits is not related to an employee's length of service with the employer.

Ordinarily, all retirees who qualify for postretirement medical benefits are offered the same benefits regardless of service. Coverage usually is extended as well to spouses and dependents. In a defined benefit pension plan, the level of benefits depends upon an employee's age, years of service and salary history based on final average salary or career average salary. Thus, an employee retiring at age 60 with 5 or 10 years of service could receive the same postretirement medical benefits as someone who has completed 40 years of service with the same employer, even though the employee with shorter service will be receiving significantly lower pension benefits.

Furthermore, most private sector plans do not automatically index pension benefits to increases in inflation. Medical reimbursement plans essentially offer an open-ended automatic cost-of-living provision, since benefits paid by an employer's medical plan from year-to-year implicitly reflect each year's increase in the cost of medical care. Medical plans with fixed dollar deductibles actually offer benefits that increase more rapidly than the cost of living.

Pension plans and postretirement medical plans are financed differently. Defined benefit pension plans in the private sector are funded over the working lifetime of employees as are many public sector plans. The liability for pension benefits already accrued is widely recognized as an obligation of the employer and must

be disclosed. The cost of these plans is clearly recognized as an expense associated with employment. In contrast, the cost of postretirement medical plans in the private sector has been treated as an expense only when benefits are paid. Because retiree medical benefits earned by active employees are due in the future, an employer's current liability for these accrued benefits goes unreported and usually unfunded. As Ray mentioned, FASB issued Statement No. 81 which requires that, beginning in 1985, private employers report in footnotes to their financial statement the existence of a postretirement medical plan and how the cost of these benefits are being met. We can expect in the next year or so that FASB will issue new rules affecting the expensing of post-retirement medical plans.

The environment within which employer sponsored retiree medical plans operate has changed dramatically since these plans were first offered. When these plans were introduced, American products were recognized as superior in the world marketplace and American manufacturers were not severely threatened by foreign competition. Today, foreign competition is a major factor and American companies are increasing manufacturing overseas or buying components of their end products in world markets. Labor costs have become a major factor in the ability of American companies to compete.

When these plans were introduced, medical costs were not seen as a major issue and with few retirees (and no advance recognition of cost), medical benefits were not seen as a significant cost factor. Today, however, medical costs have become an issue of major concern to American business and to top management. Employee demographics have shifted for some companies, and those companies that have downsized their work forces may have more retirees than active employees.

When these plans were introduced, benefit packages were often generally improved and the major issue facing employers was how to split an expanded pie. Today, quite often the pie is shrinking and the key issue facing employers focuses on how to allocate the reductions in available resources.

When retiree medical benefits were introduced, employers believed that they had an unconditional right to modify the plans, and that there was no long-term promise. Today, the situation is unclear, and employers find that they may not

modify their plans unilaterally because court decisions, rather than legislation, have been defining the framework within which these plans may operate.

When retiree plans were introduced, Medicare was expanding and it was believed that the total share of medical bills paid by Medicare would grow. Today, Medicare has reduced its reimbursement levels and shifted costs to employers in various ways, and further cost shifting is expected.

The five major types of postretirement plans are: medical expense reimbursement plans, Medicare supplement plans, cash plans, HMOs, and preferred provider organization plans (PPOs). These plans have a number of different financial risks associated with them, in addition to the risks associated with pension plans. These risks include direct changes in cost resulting from changes in the level of medical care prices; additional cost increases above changes in medical care price that result from leveraging of the deductible; changes in cost resulting from new technology that transforms the mode of treatment for a particular medical condition, changes in Medicare benefits and/or reimbursement procedures which alter the responsibility of plans coordinating their benefits with Medicare, and changes in the availability of HMOs and PPOs in the community which alter the cost structure of medical care in the community.

Under traditional medical reimbursement plans, it is the employer that bears most of these risks. In contrast, retirees usually bear a substantial risk with respect to Medicare supplement plans because the scope of benefits is less comprehensive and because benefits may be expressed in fixed dollar amounts that are not indexed for inflation and do not reflect reductions in Medicare benefits. Cash plans shift the risk of absorbing future increases in medical care price inflation and changes in medical practice entirely to the retiree. HMOs bear the risk of providing medical care to the retiree in a given year, but the cost is passed back to the employer on a longer term basis through rate increases (although this risk could be shared with retirees). As with traditional medical reimbursement plans, the employer and retirees share the risk under PPO arrangements. The PPO may also bear some risk depending upon how it is structured. PPOs can reduce costs only if it reduces utilization. Otherwise it simply shifts costs.

Employer plans generally were adopted with the expectation that the cost would be low and the plans could be terminated at any time subject to the business

needs and objectives of the employer. Costs are typically handled on a pay-as-you-go basis with no prefunding and no accrual of expenses while employees are working.

On the surface, employer-sponsored retiree medical plans with pay-as-you-go cost recognition produce low costs and work well when an employer's work force is growing and when there are few retirees. However, this system fails to disclose to management and shareholders that the company is accumulating a substantial deferred obligation to future retirees and future payments to current retirees. Whether or not this obligation is a legal liability, most large employers will pay it because the benefit was earned during a substantial period of employment with the company. Pay-as-you-go financing of benefits can be particularly troublesome for companies that have matured and have a large number of retirees relative to their active work force. It also can be traumatic for companies that are in declining industries. The very nature of retiree medical benefits exacerbates the effect of pay-as-you-go financing.

Defined benefit pensions are definitely determinable because they are based on a person's age at retirement, years of service and average salary. Retiree medical benefits are not readily predictable; the magnitude of benefit payments depends upon a person's health or ill health. Benefits are greatest for those who retire early. The early retirement window plans offered by many private employers over the past few years have increased employer retiree medical costs significantly.

Funding while employees are in active employment is a major avenue for securing the benefits of future retirees. Postretirement medical benefits may be prefunded under current law either through an Internal Revenue Code Section 501(c)(9) funded welfare plan trust or through a pension plan under Internal Revenue Code Section 401(h).

Until the enactment of DEFRA these approaches were considered by many to be suitable for funding postretirement medical benefits, although there was some uncertainty about the appropriate use of these trusts. DEFRA placed severe restrictions on employers that wanted to prefund their retiree medical benefits through a 501(c)(9) trust. For example, DEFRA requires that assumptions about future medical price inflation and future medical care utilization not be

recognized in actuarial calculations for determining employer cost for prefunding benefits. Thus, there is no reasonable basis for predicting the future cost of benefits and determining prefunded costs. Tax must be paid on investment income earned on reserves held for postretirement medical benefits. These and other restrictions have discouraged employers from using 501(c)(9) trusts to fund their postretirement medical benefits.

Under Section 401(h), medical benefits for retired employees and their families may be funded through an employer's pension or annuity plan on a tax deductible basis if certain conditions are met. For example, retiree medical benefits must be subordinate to the plan's pension benefits. They are considered subordinate if aggregate plan contributions for retiree medical benefits are 25% of aggregate pension plan costs. This requirement is a safe harbor. Contributions that are within this limit definitely meet 401(h) requirements. However, the rules are not clear about what the outside limits for benefits are to be considered subordinate, and how the 25% maximum contribution must be defined. If the 401(h) requirements are met, however, investment earnings on employer contributions are tax exempt (in contrast to treatment under Section 501(c)(9)).

Public policy requires private employers to prefund pension plans but discourages employers from prefunding retiree medical plans. From the perspective of employee and retiree income security, powerful arguments can be made for funding postretirement medical benefits. Public policymakers need to answer several questions about the appropriateness and consistency of current rules concerning the prefunding of retiree medical benefits. Should voluntary prefunding be permitted or encouraged? Should greater flexibility be allowed when retiree medical benefits are funded through defined benefit pension plans with surplus assets? Should those assets be made available for funding retiree medical benefits? Should prefunding of postretirement medical benefits be made mandatory? If prefunding were mandatory, should mature companies that have proportionately larger numbers of retirees and are in a weak financial position, be exempt from prefunding requirements or be permitted to meet less stringent rules? In responding to each of these questions, the effect on the economic security of retirees should be of paramount concern.

One of the practical problems with imposing new prefunding rules on employers is the potential effect these requirements could have on companies that have

experienced downsizing of their work force. The situation of companies in mature industries, such as steel, demonstrates the long-term adverse effects on retiree medical plans of financing these plans on a pay-as-you-go basis and not phasing in mandatory prefunding rules gradually over time.

For companies in this situation, the work force usually is older. Our research has shown that imposing mandatory prefunding of postretirement medical benefits on these companies probably would be counterproductive because it would not improve long-term benefit security of active employees. In fact the cost of prefunding may lead to further reductions in the work force or reductions in other benefits or pay. It also might encourage some employers to terminate their retiree medical plans to the extent that the law would permit. In an extreme situation, the cost of prefunding could even force a company into bankruptcy.

We all know that vesting is a guaranteed right to an employer provided benefit. Pension benefits are subject to minimum vesting standards under U.S. pension law. In contrast, there are no federal statutory vesting rules governing employer sponsored retiree medical plans either for terminating employees or for retiring employees. In both cases, benefit entitlement is acquired only after working for a number of years and usually retiring on an employer sponsored pension after completing active employment. However, some recent court decisions suggest, as Ray has pointed out, that retiree medical benefits do vest at retirement if an employer has taken any action that can be construed as having created such a promise. Some observers have argued that the status of retirement in and of itself creates such a promise.

Several public policy issues related to vesting need to be addressed. Should employers be required to grant employees a vested right to retiree medical benefits upon reaching normal or early retirement age? If so, under what conditions and what benefits should be provided? Should a vested benefit be granted to employees before reaching retirement age? If so, under what conditions and what benefits should be provided? If Congress requires that employers offering postretirement benefits include a vesting provision, would plans that have specified expiration dates or other limiting benefits be permitted to continue? One of the challenges in examining the vesting issue is to define a benefit after vesting which is viable to the employer -- that is, provides limits, responds to change, etc., and protects the employee or retiree.

Designing a vested benefit requires examination of what benefits should be vested and when vesting should occur. Vesting is possible in different time periods. Vesting can occur only at retirement or, for those who terminate before retirement, after specified periods of service.

There are several methods of linking vesting to medical benefits. One method of determining a vested benefit for employees who leave before retirement is to provide for vesting in the form of a cash payment based on the value of existing retiree medical benefits. For example, if the post-65 benefit is valued at $300 for the retiree in the current year and if the rules require vesting of 50% of the benefit after 10 years, then the retiree would be entitled to an additional income payment of 50% of $300 (possibly indexed) as payment for the employer's share of retiree medical plan costs.

Vesting also can be linked to the employer's portion of retiree plan premium; the employer's contribution would be higher for those with longer service. For example, an employer may pay 50% of the retiree plan premium upon completion of 10 years, 75% after 20 years, and 100% after 30 years. Some employers have adopted this approach. Employer sponsored medical plans frequently require that the retiree pay part or all of the cost of benefits so that even if the benefit is vested, benefits are conditional on the payment of future contributions by the retiree.

In evaluating the appropriateness of vesting from a public policy perspective, a key issue is the effect that such a requirement would have on the overall security of plan participants. A mandatory vesting requirement could be counterproductive if it discourages employers from offering retiree medical benefits altogether, or induces employers to reduce or limit the benefit because of cost. Before any specific requirements are seriously considered, it is essential that mandatory vesting be evaluated from this particular perspective.

In summary, there is a delicate balance between the employer's desire to protect employees and the need for doing what is right for the business and the shareholders. In a difficult business climate, the balance becomes even more delicate. In addition, factors that add cost to employers may lead to lost business, particularly to overseas competitors, and may result in lost jobs and less business for American companies. Many manufacturers in basic industry are in financial

trouble and this has compounded the problem of continuing to provide retiree medical benefits.

Most employers are very concerned about future federal legislation, and the adverse affects such legislation may have on their plans. They are also concerned about how to keep their businesses viable. Business uncertainty, existing retiree medical plans' liabilities (which may or may not be legal liabilities) and potential legislation are viewed by most employers with great alarm. If public policymakers want employer sponsored coverage to continue, they need to demonstrate an understanding of and sensitivity to these issues.

MR. TERRY L. BRANSTETTER: As Ray has told you, I work for DuPont and I plan to discuss the employer perspective on postretirement medical care issues. Included in the discussion are the cost issues, both nationally and at DuPont, the DuPont pensioner demographics and cost containment strategies that we've developed, the expansion of Medicare and future product needs. As Ray has mentioned, my responsibilities are in the medical programs' policy, design and administration, and not the financial aspects, including funding and liabilities. I leave that part to you all. I'm going to tread pretty lightly in this area.

A story I heard recently may help put this topic in perspective. It seems that this fellow had made some bad investments and had lost all his assets and his money. The debtors were at his door and he'd lost his job. He didn't know where to turn. He decided to turn to the Lord. He said, "Lord, you know my situation, I'm just down and out, my luck's gone sour, I lost all my money and all my assets. The only way I know to come out of this is to win the lottery and I need your help in doing so." A week passed and nothing happened. So he repeated his plea to the Lord. Another week passed. He said, "Lord, this is the third time I'm coming to you asking for your assistance. You know my plight. I don't have any money, the bills are stacking up. All I've asked is for you to help me win this lottery and I can't understand why you're not helping me." The Lord from above answered him by saying, "Son, meet me half way. Buy a ticket."

I think the analogy there is that you're going to be helped but you're going to have to help yourself some. That's the way employers are now looking at our benefit plans, primarily health care benefits. We're willing to help our

employees and our pensioners but we want them to meet us half way; we want them to cost share a little bit and be better consumers in health care.

Implementation of Medicare's prospective payment system, Diagnostic Related Groups (DRGs), is causing major changes in the health care industry. Length of in-hospital stays are decreasing, but simultaneously people are making more outpatient visits and there is greater use of nursing homes and home care institutions, hence the long-term care cost problems of the aged. These changing use patterns are continuing to drive up health care costs, affecting both the public and private sectors. But U.S. total health care costs in 1986 not just the Medicare cost, was $465 billion. This, of course, is over $1.2 billion a day and is projected to be greater than $500 billion, or half a trillion dollars, in 1987. That's a phenomenal cost and compares to $289 billion that the United States spent in total defense cost. It's 11% of our gross national product, proportionately the highest of any developed nation in the world. Medical care inflation, at 7.7%, is seven times that of all other items, the widest differential in the last 30 years. The private sector spent 58%, as Ray had said earlier, and the public sector spent 42%. I think this reflects continued cost shifting by the federal government: the TEFRA, DEFRA, COBRA, OMBRA-type legislations. The per capita cost is $1,870.

Now let's look at DuPont's cost. In 1986 we spent $248 million on health care -- approximately $218 for our health, medical and surgical (HMS) benefit plans, and $32 million for dental. Our dental plan costs only grew 2% last year. It's pretty much a self-contained preventive type plan with ten fee schedules. Last year per capita cost for dental was $228 and HMS was $1,571, for a total value of approximately $1,800. If you look at medical benefits over the period from 1975 through 1983, DuPont's health care cost grew at about 13% per annum. And this was about 40% above what the medical component of the CPI. However, in the last three years, 1984 through 1986, our cost has grown an average annual increase of 6% compared to about 7% for the nation. The federal programs, DRGs, etc., have helped, but a major influence on this development, we think, was the institution of our corporate program, our DuPont medical care assistance program (MEDCAP) in 1984.

MEDCAP offers two options. One's a traditional option and one is a comprehensive type option. The traditional option has a major medical function with it that

requires a premium. The comprehensive option does not require a premium and is a more catastrophic type 90% copay hospital benefit. We have the same plan for all of our employees and pensioners. We make no distinction, except that pensioners greater than 65 on Medicare have a carve out type program. (Medicare is primary and DuPont is secondary.)

DuPont is very sensitive to pensioner concerns to the point of being called paternalistic by a lot of folks. We have an organization of about 20 people that deals strictly with pensioner relations. This organization has a manager and two supervisors that deal daily with pensioner problems and concerns and that's their total responsibility and function. They answer about 3,800 telephone calls per week, over the several toll-free lines. We have 68,000 pensioners and survivors, and it might be of interest to you that we have two that are over 102 years old. One of them is here in Nashville as a matter of fact. (We have a plant in Old Hickory which is a suburb of Nashville.)

We have 411 retirees that are over 90 years old, so we have a problem with aging. We've got an older pensioner population. Our growth trends since 1980 are pretty much offsetting, however, since we have about 200 pensioners die a month and we have about 200 new pensioners a month. However, the group of survivors of our pensioners is growing rather rapidly. Our annual health care costs for our pensioners is $88.4 million and it is increasing at a rate of about 26% a year. As Ray and I discussed this morning, we figure the accrued liability for current and future retirees may be in the order of $1.6 to $2 billion. Our average annual per capita increase is about 11% over the last three years. Our less than 65 per capita cost is $2,549 and our greater than 65 per capita cost is $1,056. Our health care plan is a self-insured, pay-as-you-go administrative services only (ASO) type arrangement. Our national carriers are Aetna, CIGNA, and the Blues.

We are very interested in the President's proposal to allow funding from pension fund excess. We aren't sure currently of the ramifications of doing so and don't agree that the excess should be used only for funding of current retirees and not future retirees.

Our cost containment strategies are primarily all in benefit design and provider type controls. Our precertification and continued stay review programs for

hospitalization and our individual case management program saved us about $3 million last year. We're into psychiatric case management this year, at a cost of about $16 million for psychiatric care, but we think we can reduce that by 10% with better management. We have the mandatory outpatient second surgical opinion type programs.

We're also getting involved in wellness incentives. We have a wellness program called Health Horizons to improve the quality of life while at the same time reducing health care costs. It's primarily preventative care programs such as smoking cessation, blood pressure controls, weight control, exercise programs, etc. We have a study in progress, and hope to put something into effect in 1988, whether our deductibles should be graduated by salary or wage level. Is it fair that the guy out there making less than $25,000 pays the same deductible as the guy that's making over $100,000? We're looking at single person versus family deductibles and whether we should have just individual deductibles. We're also looking at putting in incentives to reduce those deductibles. If you're willing to take care of yourself, if you're willing to utilize the wellness program that we're working with, the smoking cessation, the blood pressure controls, the weight controls, you may not need a deductible because you're a healthy person and you're trying to help us help you.

As I said before our plans are the same whether you're an active employee or a pensioner. Our cost containment strategies are also virtually the same whether you're an active employee or a pensioner. We even require HMOs and PPOs to offer the same benefit design and the same costing for our pensioners and our active employees. If they won't do this we don't want to do business with them.

We have no prefunding strategy at this time. Though there's a lot of talk in our shop, of course, and a lot of talk in government, we don't feel like much is going to come of it. We think that when the economy sours and we see more situations, adverse situations as Ray spoke of with LTV, then there will be mandated legislation. If mandated, we would probably create a trust fund with the utilization of our excess pension assets. We would probably get into benefit design changes to reduce our liabilities, and probably get into some kind of defined contribution versus a defined benefit level to project a dollar per year known liability.

Ray talked about the expansion of Medicare and I'll talk a little bit more about that. The Bowen proposal is, of course, to charge an additional $4.92 per month Part B premium to all Medicare recipients. In our case that would amount to about $3 million. DuPont has mixed emotions about this. We think that maybe we like it. It could be a way for us to recover the cost of some of the primacy provisions that have been put upon us in the 1980s, DEFRA, TEFRA, OMBRA, COBRA type things. So maybe we can get $3 million of that back. But at the same time, as I told you earlier, being paternalistic we probably will pay this additional cost. The major issue in the Bowen proposal is that of preemption status. Being a self insured pay-as-you-go program we are pre-empted from the mandates in most states because they only mandate insured programs. But the Bowen proposal would remove that. Therefore, we would be liable for all the mandates in all the different states rather than just the mandates of Delaware where we're incorporated.

We believe in protection of our employees and pensioners from catastrophic situations but not in accepting the total long-term care liability. The product needs we have include the health benefits trust. We currently have $12 billion in our pension fund. We calculated that about $3.8 billion of that is in excess. That fits very nicely with the President's proposal of utilizing these excess pension funds in our welfare programs. We could pretty well fund all our programs with that kind of money, or just the interest off that money, if they don't restrict us with so many negative ramifications that we can't use it the way we want to use it. So the idea's good but whether or not we'll be able to do what we'd like to with our excess pension funds remains to be seen.

We've talked about company owned life insurance policies although we are not seriously considering them at this time. This would be buying policies for all of our constituency and cashing in on them to pay their health care costs when they die. Ray touched on the subject of guarantees of access to coverage. We have a mixed bag here since it really doesn't affect us directly. We're a large corporation and we provide health care to our constituency. Indirectly, however, it has to affect us. It affects the small corporations that can't afford it. If they have to put it in they have to charge more for their goods. They are our vendors so they're going to charge us more money and in the long run it's going to cost us.

Defined contribution of course, versus defined benefit, lessens our liability and produces a known cost. If some of the legislation goes through we'll probably have to do that.

What can you actuaries expect? We think you can expect high demands for your services. We're going to need a lot of help in measuring our liabilities. We will also need help responding to all the legislative changes and the product design changes that are going to be necessary. So we see for actuaries, consultants and all ERISA attorneys what we call the full employment act. I believe it's going to be a large need and I think you're going to be able to help us to a great degree in managing these costs and the designs of these programs.

MR. MICHAEL E. MORFE: Mr. Branstetter, how do you deal with the situation when Medicare provides a fuller benefit than your active plan? For example, you mentioned you had a 10% coinsurance on your hospital base; whereas we know that Medicare pays basically 100% of the benefit after the deductible.

MR. BRANSTETTER: Our retiree medical benefits program is a carve out program. So that means that we pay after Medicare has already paid. If Medicare has paid 100% of the bill there's no benefit payment under our plan.

MR. MORFE: So it's not exactly the same as your active plan on that particular piece because there's no Medicare underneath the active plan that's paying 100% of the hospital bill.

MR. BRANSTETTER: That's right.

MR. MORFE: Do your active employees see that as any kind of a disparity or do they just hope that they make it there?

MR. BRANSTETTER: They know they're going to be there some day.

MR. STEPHEN A. MESKIN: I'd like to pose some design questions for retirees who are over age 65. When we look at the design for retirees over age 65 we might want to think about their needs. And one of the things that most plans provide for is balance billing, i.e., Part B expenses in excess of what Medicare allows. Seventy percent of the Medicare claims are paid on assignment, so most

retirees don't need to have that amount covered. On the other hand there are things that aren't covered by Medicare which most plans don't cover, particularly drugs, catastrophic protection which may be covered fairly soon, and long-term care. If I were looking at it from the needs of the retirees I would say we won't pay any more than the 20% that Medicare doesn't pay, for what it allows, but we will pay for your drugs and maybe we'll pay something towards long-term care.

MR. WELNICKI: I think you're right that if you looked at the total claim dollars that are paid under employer sponsored retirement programs, particularly a carve out plan, you'll find that most of those dollars do go, in fact, for the Medicare unallowables, commonly called balance billing. Again, I think we're seeing a trend in employer plans to provide more complete coverage such as greater lifetime maximums, so I think employers feel that they are providing the catastrophic end of the spectrum. They may not be providing the drugs, vision care and dental benefits but most employers probably feel that they are providing at least that catastrophic care element. It would be interesting to see what Terry feels about this.

MR. BRANSTETTER: That's right, Steve. For instance, we have a $1,000 out-of-pocket limit which takes care of a retiree's catastrophic situation. And we also pay 80% for the cost of drugs after the deductible. So we already have some of those things.

MR. WELNICKI: As a follow-up question, Terry, if I could put you on the hot seat here for a minute, would it make sense for an employer to take a position that basically says that we will not cover the charges that a physician makes above the Medicare allowable but we will instead use that money to provide, for example, long-term care?

MR. BRANSTETTER: That's certainly a possibility. I think it's worth thinking about.

MR. EARL L. HOFFMAN: It would appear in most retiree medical plans for Medicare eligibles that the retiree has almost all of his medical expenses covered either by Medicare or by the plan itself. Do you feel that in these plans there are meaningful incentives for the employee to use a PPO?

MR. BRANSTETTER: We offer 64 HMOs and PPOs nationwide to our population. We only have about 10,000 people, both active employees and pensioners, currently in these HMOs and PPOs. We have dissuaded the use of HMOs up to this point because we knew they were our most costly type of coverage from an adverse selection situation. We are more inclined today to offer HMOs and PPOs because we now have learned to negotiate both benefit design and financial arrangements with them. At this time, however, we don't have that many people older than 65 in HMOs or PPOs.

MR. KALMAN: I think one of the biggest disincentives for participation in an HMO and perhaps a PPO for people aged 65 and over is that many retirees move away from the HMO/PPO service area. I believe this is a bigger impediment than whether the indemnity or service benefit plan provides complete coverage when combined with Medicare.

MR. WELNICKI: Just one other observation on that. You may be aware that HCFA is involved in various demonstration projects including employer at risk or what they call "HBO" programs, health benefits organizations. Under these programs, the employer or an employer/insurance company combination would assume the Medicare risk for a 95% capitation. This would allow integration of Medicare with the Medicare supplement coverage that the employer offers. I think most employers or insurance companies that have looked at those demonstration projects are very antsy about how they will work. I think that under a structure like that, though, you could create more of an incentive to use a PPO. However, the basic premise that you raise, Earl, is correct. It's very difficult to encourage people to use a PPO when only a small share of the expenses are left after Medicare.

MR. ANTHONY J. HOUGHTON: My comments are very personal, and are not related to anything our companies might be advising clients. It seems to me with the knowledge our professions have about how high these liabilities are, how much they might grow in the future, and how little has been funded already, I wonder why more companies aren't doing things such as providing a contribution toward a plan, whatever the plan will cost, at some rate per year of service. We've also mentioned the fact that someone who works 10 years and qualifies for a full plan may be getting something well out of line with his pension compared to someone who works 30 years. I would think somebody would

say that paying $5 per month while someone is not eligible for Medicare and $2.50 per month when someone is eligible for Medicare, times the years of service, would provide a reasonable contribution.

Retirees would have guaranteed access to benefits and, if given a choice, they could then choose the benefits that they would finance with the premium differential over and above the company's contribution. The company would have the right from time to time to maybe raise its contribution amounts. If you don't do that, I think boards of directors and executive officers of companies may be subject to shareholder litigation if there's recognition at some point in time that you suddenly have a company with no net worth because you have an obligation well beyond your surplus. Stockholders may say "Gosh why didn't you ever think about these things? Why didn't you put a limit on the obligations, at least prospectively, after you recognized the problem? Why did you sign a blank check for an amount which may be ridiculous compared to someone's compensation?" I even have a feeling that maybe if someone like the PBGC has to pick up these liabilities they may also have some criticism of people who didn't do anything to put limits on the amount of company obligations.

MR. WELNICKI: I have a couple of comments on that. One is that the issue is not whether or not these costs will be incurred over time. They clearly will be. The real question and the real issue is how will that expenditure be funded? Who will fund it? What is the role of government, what is the role of the employer, what is the role of the employee? I think in order to have a three-legged stool, if that's really the type of system we want, you have to make sure that each leg is placed in the right position. Otherwise, it will topple. And when you really begin thinking about it, it's a fair bet that employers probably don't want the government to take over the entire program. Larry Atkins with the Senate Select Committee on Aging has indicated that that ought to be what government should do, take over the entire post-65 liability over time. I don't think employers would tend to agree to that. I think when you get into that situation the employer loses control over the benefit program.

On the other hand, can employers really bear that cost? Employers are beginning to recognize that they can't manage the open-ended liabilities that are emerging. Yet if you get into a situation such as you're talking about, Tony, aren't you really just increasing the pension income benefit for the individual? I

think that what you say has a lot of truth to it and on the surface at least, it appears to be an improved way to go for an employer. I'm not sure, though, that it leads to a very sound overall system. There are no simple solutions in this area. As you dig deeper, you begin to realize that if you put a cap on the liability that one party bears then you don't have a cap on the liability of another party. If you remove it from the employer then somebody else has an open-ended liability and I think you'll see the dynamics are very complex.

MR. KALMAN: I'd like to add a point. If you look at the big picture, we have several different forces working simultaneously. We have most employers currently financing benefits on a pay-as-you-go basis primarily because there is no incentive to advance fund. We have a possibility of some significant cutbacks in Medicare benefits and further cost shifting to employer plans on the horizon. We have FASB in the process of developing rules on employer's expensing for retirees' medical benefits. We have Congress thinking about how to guarantee active employees and current retirees income security in the medical area. And I can go on and on and on. An employer trying to advance fund today can't solve all his problems himself. There are other forces at work beyond his control, principally Medicare benefit levels. In general, the forces that are currently destabilizing the environment of postretirement medical plans need to be brought under control before any kind of reasonable solution can be developed.