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POST-RETIREMENT MEDICAL BENEFITS

Moderator: W. DAVID MCKINNIE, III
Panelists: JOHN M. BERTKO
DIANA J. SCOTT*
Recorder: SHERRY RAIMAN HABER

o The panel will review recent developments concerning design, accounting and funding for these benefits. Releases from the FASB and any proposed legislation will be included in the discussion. Actuarial methodology, assumptions and design issues will be considered from both a health and pension perspective.

MR. W. DAVID MCKINNIE, III: To discuss this topic, we are fortunate to have two experts with us: first, Diana Scott, a CPA previously with Price Waterhouse, who is currently the Project Director for the FASB post-retirement medical benefit review and for the preparation of the pending discussion draft. Second is John Bertko, a principal and actuary with Coopers & Lybrand, who is on the team currently conducting a field study of post-retirement medical benefits for the Financial Executives Institute. The recorder of this session is Sherry Haber, an actuary with TPF&C.

First, Diana will summarize the work currently being done and bring us up to date on the FASB situation, then John will cover the real world and what we're going to do with the FASB situation.

MS. DIANA J. SCOTT: To put this all in perspective for you, let's start with the simple example of Fred, a 50-year-old employee of one of your clients. Fred is expected to retire in about 10 years. He is currently single and he's lived a good life. Age 60 comes along: Fred retires, then falls in love with and marries a 25-year-old woman. Suddenly your client now has provided a health care coverage promise not only to Fred, but to his 25-year-old spouse for the rest of her life, which happens to be another 55 years. So a promise made today to start in 10 years could actually run 55 years beyond that date. We hope your clients don't have too many "Freds" working for them, but they do exist.

The Board's project focuses on postemployment benefits, but we are addressing post-retirement benefits first, because we believe they are more significant. We'll then come back to other benefits offered after employment but before retirement and see if any work is needed in that area.

The Board has defined post-retirement benefits as all forms of benefits (other than pensions) paid after retirement that an employee and his or her beneficiary

* Ms. Scott, not a member of the Society, is Project Manager for Postretirement Benefits other than Pensions at the Financial Accounting Standards Board in Stamford, Connecticut.

receive(s). Such benefits, provided either pursuant to a legal agreement or by means of an informal or formal arrangement, would include not only retiree health care, but life insurance, legal counseling services, tuition assistance, and so forth.

The Board first considered the issue of Other Post-retirement Employee Benefits (OPEB) in 1979 as part of the Pension Project. It was added to the agenda because financial statements lacked information about the cost and an employer's obligation to make these benefit payments. Further, because most large employers at that time were providing retiree health care and life insurance but no accounting standards requiring accrual existed, everyone was accounting for these benefits on a pay-as-you-go basis.

In 1979 the Board decided that it was still premature to even require disclosure. The project progressed along with the Pension Project and the Board issued a Discussion Memorandum noting that post-retirement health care and life benefits are a form of deferred compensation and that cash and terminal funding methods were inappropriate. A 1983 Discussion Memorandum addressed the subject again because it was decided that issues of post-retirement benefits, other than pensions, were being overshadowed by the focus on the Pension Project. The review of OPEB was spun off into its own project in February 1984. Later that year, the Board issued Statement 81, which requires employers to disclose their post-retirement life and health care plans, the recipients of coverage, the cost of the benefits, and accounting and funding policies.

The Board's Technical Bulletin 87-1 addresses situations in which employers voluntarily change their method of accounting for post-retirement health care and life insurance outside a pension plan. It says, in essence, you can do whatever you want to do. We didn't try to prescribe any methodology; it was an interim step until we could proceed further with the project, but we wanted to send out the signal that you should start thinking about accruing these benefits. If you want to do that, you can elect to reflect the impact retroactively or prospectively.

To put post-retirement health care into perspective, I want to cite a few statistics. A study done by the Department of Labor and others has estimated the obligations for unfunded post-retirement health care at $125 billion, and Joe Califano has estimated that it might be as high as $2 trillion. I think that range displays the uncertainty about how one would measure the obligation and exactly how many people would actually be covered. Studies have indicated that approximately 85% of companies with 1,000 or more employees are providing post-retirement health care coverage. Other studies have indicated that approximately 80% of retirees 65 and older are receiving post-retirement health care benefits from their former employers. Some people have said, "How are these really different from pension benefits and why should they be treated any differently?"

We have encountered some major differences, the most important of which is the definition of the form of the benefit. Pensions are typically a defined benefit, defined in terms of dollars; typical post-retirement health care plans say, "We'll provide you with health care coverage" but don't specify what that benefit might be. Plans usually say, "We will cover reasonable and customary charges." How does one determine a reasonable and customary charge in trying to project what the cost might be? Deciding on how to project those costs will be the basis of

your future valuations. Second, for post-retirement health care there really isn't as much of a measurement history to look to as for pensions.

Management can't control costs the way they did with pensions. Typically, employers have not known what their costs were, and it's a bit more difficult to control something you don't even know exists. Also, you don't have the vesting provisions that you have with pensions. We have seen that plans will usually provide you with post-retirement health care coverage if you're entitled to an immediate pension benefit. Employers view that as "vesting on the date the person retires." Finally, even though some assumptions are essentially the same as pensions, their impact can be dramatically different.

Let's focus first on the three most troublesome issues in the project. The first one is whether there is an obligation meeting the definition of a liability that should be recognized on the employer's balance sheet. Fortunately, this issue is history. The second issue is how one would measure and attribute the benefits and the costs of benefits to service. The third major issue, which is what most employers are interested in, is the transition question. How will the obligation be measured and recognized at the date of initial application?

Turning to the first issue, the question of liability, the Board has tentatively concluded that post-retirement benefits such as health care are a form of deferred compensation that should be recognized on the basis of services rendered. In essence, a liability embodies a present duty or a responsibility that entails a probable future sacrifice of assets when a specified event occurs. The event obligating the employer has already occurred because service was rendered in the past, and the employer cannot avoid the future sacrifice. In looking at this last characteristic, we're looking at the employer's intent, not at the legal ramifications. Attorneys tell us that there is no obligation until the person actually vests. That's true according to the legal definition of vesting. However, if the employer intends to provide this benefit coverage, and if history and current actions indicate that the employer intends to do so, and there's no indication that the employer would not continue to provide the benefits, then we believe that the employer should account for the benefits over the years of service in which the benefit coverage is earned.

Once we knew a liability existed, we then had to address the question of whether or not it should be recognized. For accountants to recognize a liability, it has to meet four criteria. It has to meet the definition of a liability, which the Board believes has been met. It has to be measurable with a sufficient degree of reliability. It has to be relevant, which means it can make a difference in user decisions. And it has to be reliable -- that is, it has to be representationally faithful, verifiable, and neutral. Some would argue that you can't really measure these obligations with enough reliability. That's a qualitative question, because we believe that you can and that even though you may only be 50% or even 30% certain that your measurements are reasonable, that's better than knowing that you're 100% wrong. The Board believes that we would rather come up with a best estimate, recognizing that it will have some shortcomings, than to assume that there is no obligation, because we know that is 100% wrong.

We've essentially identified seven significant assumptions to make. You will want to consider many more, but of the seven we have focused on, three are unique to other postemployment benefits, particularly health care, and four are similar to pensions. The three that are unique to post-retirement health care

measurements are the annual incurred claim cost, the health care cost trend rate, and Medicare reimbursement.

The annual incurred claim cost, the basis of all other measurements, is the measurement in current dollars of the cost of providing coverage during each retirement year. If a given employee will retire at age 62 and has a life expectancy of 78 years, you would look to the cost of providing coverage today for someone 62, 63, 64, 65 through age 78, and that would be your annual incurred claim cost assumption. You then adjust that assumption by the health care cost trend rate (i.e., take your current cost and project it for what you think will be the cost during the years in which the claim would actually be incurred). The health care cost trend rate assumption incorporates not only medical inflation, but also advances in technology and a changing mix of utilization of services and delivery patterns. We then temper that with a Medicare reimbursement rate assumption and, for purposes of our document, the assumption that Medicare will provide the same level of coverage as currently provided. Because we are not anticipating any changes in the plan, it would be inconsistent to assume any Medicare changes. Therefore, we're measuring everything on the basis of the current environment and the employer's current promise.

The other four assumptions that are similar to pensions but have a different effect are the discount rate, turnover, retirement age, and dependent status. The discount rate is going to be very similar to the notion in FASB Statement 87; the one main difference is there is no such thing right now as a settlement rate, or a long-term settlement rate. So the discount rate would be a long-term interest rate that is expected to match the timing of your benefit payments.

The turnover assumption is similar to an assumption you're making in pension measurements, but it's much more dramatic in post-retirement health care because it decides if coverage will be all or nothing. Typically, if you leave the company before eligibility for an immediate pension benefit, you get no post-retirement health care coverage. Therefore, because it's really pivotal whether one is expected to retire with an immediate pension benefit, retirement age assumptions are crucial.

Retirement age would also affect how you would measure the coverage in terms of pre-65 versus post-65 coverage. Unlike pensions, where you would normally see an actuarially reduced pension benefit if a person retires early, we have a unique situation here, because if a person retires early you're promising coverage for a longer period of time and at a higher cost because the cost of coverage before 65 won't be reduced by Medicare reimbursement.

Finally, what I call the "Sleeper Assumption" or dependent status. No one focused on this assumption until recently, but dependent status can double or quadruple the employer's benefit obligation. I once visited an employer to talk about the valuation and he said, "We aren't sure, first of all -- we don't know who we're covering." He said, "We don't know if these people have any dependents or not; our measurement could be anywhere from 10% to 70% of net worth." Now, that's a fairly significant difference. I've also seen a plan that provided coverage not only to the employee, and the employee's spouse, dependent children, parents, and in-laws who lived with them, but also aunts and uncles who lived with them!

Let's focus on measurement. The staff had identified three possible objectives in an attribution approach. You can do what Statement 87 does and try to measure the obligation and changes in it. In the absence of a benefit formula defining benefits in terms of an individual's years of service, you may want to look to an approach that allocates either costs or benefits. We wanted to cover all of the bases and didn't want to be criticized for merely accepting Statement 87 without exploring the alternatives. So we have pursued approaches that fulfill each of those three objectives.

Let me run through some of our considerations. We contrasted how benefits would be allocated under a benefit approach versus a cost approach. We found that the former would provide a level amount of future benefit coverage, implying that benefits are earned ratably. Under the latter, the future benefit coverage attributed to each year would decline with the passage of time. This implies that proportionally more benefits are earned in the early years than the later years. We found that kind of relationship somewhat troubling. When we looked at an allocation of costs, incorporating an interest assumption, we found that costs will rise with the passing of time and approaching retirement, but the increase is somewhat more dramatic under a benefit approach than under a cost approach. We didn't necessarily find that as troublesome because as a person gets closer to retirement and is closer to earning the benefit coverage, considering the fact that inflation will raise costs over time, we did not think it was inappropriate that the cost would also be higher.

We considered three different approaches. The first was a benefit requisite years of service approach patterned after Statement 87 methodology, attempting to measure an obligation and changes in it by looking at a benefit formula or an implied benefit formula. We decided that if a plan provides that you can collect these benefits along with an immediate pension benefit and that you can get an immediate pension benefit at age 55 with 10 years of service, then the implied benefit formula -- what we call "requisite service period" -- is the 10 years of service from age 45 to age 55.

Conceptually, all this made sense; where we ran into trouble was with the plans that said, "You'll be entitled to this coverage if you're working for the employer when you attain age 55 or age 65." What that implied was that service on one day was pivotal, because it decided whether or not you earned the benefit coverage, so one could argue that the benefit accrual period was one day! We felt that that was illogical, since the benefit is exchanged for service. The Board tentatively concluded that we would have to prescribe a substantive, or a minimum requisite service period, which we found troublesome, since it means you're relying on an approach simply because it gives you a benefit formula, then you say, "In some cases I don't like that benefit formula, so in some cases I'll follow it, but in others I won't." We said that is internally inconsistent, so we pursued the aggregate cost approach and a benefit years of service approach that would ratably allocate benefits to years of service.

The Board ultimately rejected the benefit years of service approach because they agreed that it was internally inconsistent. They also rejected the aggregate cost approach, partly because of the relationship of how benefits would be attributed to years of service, but also because they felt the staff had not demonstrated that a cost approach was superior to a benefit approach, which is closer to Statement 87. We are now focusing on a benefit years of service approach that will ratably allocate benefits over service to the date a person is first eligible for benefit coverage. So, if you have a "55 plus 10" eligibility requirement, and

you have an employee who you think will meet it, but will continue to work until age 62, our approach would have you fully attribute the present value of his benefit coverage by age 55. Service in years 55 through 62 would be charged with interest only, like Statement 87. Where a plan provides maximum coverage with 20 years of service, later years of service do nothing to increase the benefit coverage, and you would attribute only to the first 20 years of service and interest thereafter.

The big debate now is whether the benefit to be attributed to the date of first eligibility is the vested or "walk-away" benefit obligation, which would assume that the person leaves tomorrow, or the expected benefit obligation (EBO), which considers the expected retirement age assumption. My view is that we should use the EBO. It seems illogical to make an assumption about an expected retirement date to determine whether or not the person will be entitled to benefit coverage, but to ignore that in the measurement process. I also think that it's illogical to choose which future events are going to be incorporated into a measurement. The other side of the coin, however, is that a balance sheet is a picture taken at a point in time; one can argue that on the date a person is eligible he or she can elect to leave the company tomorrow and the employer has promised to provide health care coverage. But the EBO approach is more logical and palatable to employers because a vested benefit obligation approach means that you would be attributing a higher benefit obligation to the service to date of first eligibility, but then when the person doesn't retire, it's viewed as a giveback of benefits, so until they do retire you have negative service costs for the amount of the obligation that they have foregone.

Another issue to be resolved is plan initiation and amendments. It seems that the Board will state that plan initiation and amendments would be accounted for in the same way as under Statement 87. In essence, you would measure the change in the present value of the EBO attributable to service before the event, i.e., allocate benefits in the absence of a benefit formula. If there is a benefit formula telling you how to define benefits or attribute benefits to individual years of service, you follow it. But most plans don't do that; in the absence of a benefit formula you'll attribute ratably. Consistent with that approach, one would assume that all plan changes should be attributed ratably, as opposed to treating some as prospective and some as retroactive.

There's a bit of controversy here because some people allege that if a plan amendment does not affect retirees or people eligible for benefit coverage, it may be viewed as prospective. It seems to me that when you're allocating, you're saying that there is no benefit formula to look to so I would think that we're going to end up having a retroactive treatment.

We're also going to reconfirm with the Board their tentative conclusion that plan assets are defined as in Statement 87: assets that are legally restricted or segregated to pay benefit payments. We're going to bring up to the Board the notion that it is very difficult to fund these benefits currently; there may not be such a thing as plan assets. We do want to bring to their attention that there may be nothing that meets the definition of plan assets for awhile.

In addition, we plan to readdress the issue of how one accounts for gains and losses. Today, we feel the accounting would be exactly the same as under Statement 87, where you would have an option to use a corridor approach (you could elect either immediate or delayed recognition of gains and losses). The one caveat is that if an employer elects to recognize gains and losses

immediately, then any gain should be limited to a gain exceeding the unrecognized transition obligation. It would be illogical to permit a company to recognize a gain on an amount that they haven't even run through the income statement.

We're also going to be addressing a few other open issues, such as how one would measure and recognize the transition obligation. We've talked a lot about how one would measure it. It seems that the transition obligation will be measured as the present value of the EBO for retirees, for people eligible for retirement and benefit coverage, then a proportionate amount for all other actives who are expected to become entitled to benefit coverage on the basis of the proportion of service rendered in the period to the date of first eligibility. We'll also be talking about whether or not a minimum liability should be prescribed and, if so, how to define it. We'll be talking about how one measures the obligation in a business combination which is accounted for as a purchase. I think these issues would be fairly similar to Statement 87.

The issues that we haven't addressed at all yet, but plan to address, are disclosure, settlements or curtailments, the transition period, and the effective date, which is expected to be 1991 or 1992 (the Board will decide this in probably another month and a half).

We're expecting to put out an exposure draft in the third quarter of 1988, probably in late August or early September. We plan to have a public hearing in the first quarter of 1989, and issue a final document by the end of 1989. I would encourage all of you to respond to the exposure draft; that's how we can evaluate whether or not our suggestions make any sense. Finally, I would urge you to encourage your clients to start identifying the planned participants and their dependents, to compile data on those participants, and to start developing an annual incurred claim cost.

MR. JOHN M. BERTKO: What we're going to try to do is touch on some of the actuarial aspects. I'd like to comment on where I think the future lies for us when the exposure draft comes out and when the obligation will be effective. I think you can divide this into two categories. One is for the financial community: Many people will be asking, "Why are those numbers so big; how did you calculate them?" This question is still evolving. We need to be able to explain this coherently to everyone.

I want to stress that valuing post-retirement medical benefits takes a mix of pension and group health skills. On the health care side, the two key skills are determining the baseline cost and setting the trend assumption. I think many pension actuaries would look at this and say, "Isn't this just another benefit to be valued?" It's more complicated than that. Setting trend assumptions is considerably different from setting pension plan assumptions. On the other side, there are health care actuaries who are beginning to work on this and have other things to learn. For example, if you were defining a pension allocation method, would you be comfortable doing that? We need to talk about population models: who's going to be receiving the benefits? We need to talk about the cash flow: virtually every company today is expensing on a pay-as-you-go basis. When we calculate the liabilities and the expense associated with that, it's going to be contrasted against what the cash flow is like today, which is the pay-as-you-go approach. You will also have to determine the accounting expense, learn why it's done that way, and be able to explain it to your clients and their accountants.

A number of large projects are going on. Our project is a field test of the post-retirement medical benefits that's being conducted concurrently with Diana Scott's FASB work. What is this field test? It's sponsored by the Financial Executives Research Foundation, an educational and research foundation of the Financial Executives Institute, and is endorsed by many of the largest companies in the country. A field test looks at what the exposure draft will say, examining real data and asking, "What are the results of that?" We're going to be doing sensitivity analyses and we'll look at the alternatives, being prepared to let companies comment on what the exposure draft does to their financial statements. We have assembled a team of actuaries, economists, and accountants.

Calculating the post-retirement medical benefit liability requires five steps. *Step 1* is to determine the benefits and the eligibility, including the incurred claim cost. You have a set of benefits, you've been making changes, and you need to know what those changes cost today. Eligibility is a wide open issue. Who's getting the benefits? In the field test we gathered data from 28 sponsoring employers -- very large corporations, for the most part. Their data range from excellent data, from very good human resource information systems where we've got historical accounts, including a back status indicator and good information on virtually every dependent, to poor data, where we've gone to the employers and said, "Who are you paying benefits for?" and they replied, "I guess our carriers know that." In some cases we're going to carriers' eligibility files and mixing them together. *Step two* is to calculate the baseline costs, which combines the incurred claim cost with whomever you've got in there. You need to know who those eligible people are, create, for example, a 1988 baseline cost, then roll that forward. *Step three* is to project both the costs and the population forward. Projecting the population is relatively easy -- you've got pension models that do that. Again, you will need a greater emphasis on some of the turnover decrements and some of the early retirement decrements. *Step four* is to calculate the cash flows and the present values. *Step five* is to do the accounting expense and use the allocation method to determine that expense.

Setting assumptions, the key task, is an educational process. I've divided assumptions into two main areas: economic and demographic. The former are perhaps trickier. First, in setting the trend assumption you've got to consider very carefully the current trend versus the long-term trends. The newspapers have cited trends from 20-70%. If you project the trend for any period of time beyond a few years, the result is an enormous impact of health care as a percentage of the GNP. If you have a spread between the rate at which the economy and health care costs grow of 2, 3, or 4%, you very quickly find that health care, if projected out, reaches 100% of the economy. That won't happen without a major restructuring, and to talk about it in that sense is probably not a good way to go. What is the relationship with general inflation? What is medical care inflation? We're looking at the relationships with other econometric models. In particular, the Health Care Finance Administration (HCFA) and Data Resources, Inc. (DRI) have models used for retirees under Medicare. By the year 2000, HCFA projects that health care, including long-term care, will be about 15% of the GNP -- quite a boost from today's 11%. Where will the restructuring come in? Economists have worked on this program much longer than we have, and we ought to be using some of their knowledge.

Aging is an obvious consideration. In our project, we're trying to answer questions about how fast costs rise with aging. Using one company in our field test as a basis, we found that health care costs went up 4% per year of age. Utilization and technology are clearly a part of setting the trend rate. What

number should you choose? How should those integrate? How should cost shifting in Medicare integrate with what happens with employers?

A second major economic assumption is the discount rate. The tentative conclusion is that it's to be set as a long-term obligation matching the benefit payouts. Since no one's been funding, and you can't go into an insurance company and settle the obligation, where do you get that number? Maybe you look at the cost of funds: what is the alternative for a company that's going to be making these payouts? Since it's not being funded, maybe you look to the company's internal earnings rate. Third, what is the tax implication? Since you don't have a tax shelter, do you use a pretax or a posttax value? Since benefits were not tax deductible today, if you prefund it and they are ultimately tax deductible, is this tax question really a matter of timing more than anything else?

I have grouped the assumptions into old and new categories, the former being the typical ones used in pension plans. The main comment here is that retirement rates are critical because: (1) benefits are not actuarially reduced to begin at an earlier age, (2) when you retire before 65, the benefit can be two to three times as much as a post-retirement benefit, and (3) there is a longer lifetime during which payments occur. We've done back-of-the-envelope calculations of post-retirement liability where needed. In a merger or acquisition, you need to know what post-retirement liability there is to talk about: is it $10 million, $100 million, or $1 million? When you put it on a balance statement or a financial statement it needs to be done more carefully.

In the new assumptions, we talk about dependent coverage. It has been very important for pension plans because joint and survivor benefits are actuarially equivalent, so if you have an 80% or 60% or 40% assumption, it doesn't really matter. The age differential doesn't matter very much there. I'll add to Diana's example of the 60-year-old with a 25-year-old wife a 1-year-old child. If he or she goes to college, we're going to be paying benefits on that particular child for the next 24 years.

I would say that choice of health plan would have some impact, not as critical as the number of dependents, since we found there are relatively few retirees in HMOs. In California, particularly government plans, the HMOs have had a much bigger penetration: as much as 70% of the actives and 20%, 30%, or 40% of the retirees in some areas. HMOs will probably become more important. Choice of PPOs, multiple option plans, and triple choices will make an impact.

Retiree and dependent contributions are important. Dependent contributions may be claimed to be a dependent payoff in some cases. Fourth, large employers frequently reimburse Medicare Part B contributions.

For those of you who want to learn more about this issue, a number of sources are either available now or soon will be available. First, the November Employee Benefit Research Institute (EBRI) study is a good source of modeling information. Second, the International Actuarial Standards Board has been assembling a standards draft for retiree medical benefits, which cites the need for representing a range of answers, whereas in a pension answer you have a single number. Because we don't know as much about trends, this range is important. Third, a new set of study notes coming out will be very helpful as a central source of data for the various parts of issues, plan design, funding, legal issues, and setting the baseline costs.

MR. MICHAEL D. SYDLASKE: I guess it's obvious that Medicare Part B reimbursement is an OPEB benefit, but maybe it's not totally obvious. The second question is, "What guidance would you expect FASB to provide about what the plan is?" Some employers are very clear about just exactly what their plan is; other employers, particularly with respect to how much someone will contribute to the plan in the future, are very hazy about what their strategy is and what is likely to happen in the future. Sometimes their view of the plan differs from what anyone believes the plan will turn out to be three years from now, especially with regard to dependent contributions. What guidance can you give me in this area?

MS. SCOTT: With regard to the first question, yes, Medicare Part B reimbursement is a form of post-retirement health care benefit coverage. With regard to the second question, we're not looking down the road, we're looking at the employer's promise today and the basis for their payment today. You wouldn't try to anticipate what changes will be made. I think that from now on employers will look at their plans more carefully and decide how they should amend their plans, but we would not anticipate that. There has to be some basis on which they're making payments today -- as we view it, that's the benefit promise today. We acknowledge that it may not be a well-written document; it may be only what they have said orally.

MR. SYDLASKE: Determining the cost is sometimes a puzzle. Some of them have formulas for dependent contribution as "X"% of expected cost, rather than "dependent contributions will be a fixed amount." But in the first case, where it's a percentage of cost, I think those are a hope rather than a plan.

MS. SCOTT: But if that is the arrangement as it exists today, then if you are making an assumption that your projected costs would be $25,000 and the retirees would pick up 20% of this, you would assume that the employer's cost is going to be reduced to $20,000.

MR. SYDLASKE: There are avenues for employer manipulation here, especially if the employer declares that employee contributions will escalate forever at a rate such that they pay 60% of the costs. Who knows whether that will happen, but it's an easy one-time fix for OPEB accounting for a year or two.

MS. SCOTT: I think that employers are going to have to write up their plans and provide summary plan descriptions (SPDs). They're starting to recognize that they will probably lose in court if they don't have a plan document to point to and can only say, "The personnel person told me this," or "That's my understanding." They're trying to write plan documents that will at least identify the benefit coverage provided and are trying to disclaim any future continuation of the plan, although that's rather weak.

MR. SHERMAN B. LIEBERMAN: I have one question for Diana and one for John. First, is there a multiemployer plan exemption for the FASB statement, as in Statement 87?

MS. SCOTT: Multiemployers would be incorporated probably in the same way as in Statement 87. We have worked with a few multiemployers on getting data on the types of coverage multiemployer plans provided. In most cases, it's largely a defined contribution plan or the cost is borne by the retiree. So it looks as if it may end up being the same as in Statement 87, but we have not addressed that with the Board. I still have a lot more reading to do on it.

MR. LIEBERMAN: In some cases the present active plan has simply been continued through the retiree welfare plan. I fear that each individual employer may have to ask his actuary to come up with FASB numbers for his post-retirement plan.

MS. SCOTT: To the extent the coverage is continued, it would be a defined benefit plan and Statement 87 would apply, unless for some reason it's not the same kind of a promise and the employer is not committed. It could be that the employers are contributing to a master trust, and the master plan has a defined contribution plan.

MR. LIEBERMAN: John, some of these multiemployer continuation plans have a lifetime maximum of, say, $50,000 or $100,000. Is it appropriate when we're valuing these benefits to anticipate increases in those maximums?

MR. BERTKO: You've asked what is probably the toughest valuation question here. The EBRI study assumed that the lifetime maximum increased forever. I think that if it's a fairly high maximum, like $100,000, in practice it's had no effect on limiting benefits. And if it's a maximum on a major medical piece of a base plus major medical plan, it will still have no effect. As part of the field test, we are continuing to wrestle with how to adequately address that. One company in the field test has a $10,000 limit that will obviously be affected, and the answer, I think, in that case, is "Yes, it is appropriate."

MR. LIEBERMAN: Even if we were to project these claim costs for 30, 40, or 50 years, then the $50,000 and $100,000 might become effective at that point?

MR. BERTKO: That's absolutely true.

MR. LIEBERMAN: So would it be appropriate to say that we've been doing it both ways, increasing it and including some trend assumptions in there?

MR. BERTKO: I think that's the right way to do it: have a sensitivity analysis of what it looks like with and without an assumption about the maximum.

MR. JAMES P. LARKIN: I understand that stock life insurance companies have to adopt the FASB rule to recognize liability however it is defined. Does anyone know how this applies to mutual companies? My understanding is that we can ignore this FASB obligation.

MS. SCOTT: Unless I understood why the mutual insurance industry should be excluded, it would not be.

MR. LARKIN: I've been told by Connecticut Mutual's accountants that we are not on GAAP accounting, and therefore can pretend we don't have this liability, or at least defer recognizing this liability. Can anyone comment on this? It would seem imprudent to me not to recognize this liability, but it's a question whether one has to, or whether one would like to. I don't think anyone wants to.

MS. SCOTT: From our perspective, the forthcoming documents will represent a standard that any company purporting to prepare financial statements in accordance with GAAP must follow. If your statements don't purport to do that, presumably you could elect not to follow the standards, although it's really valuable information that lenders and others may require in any case.

MR. MORTON B. HESS: Our health insurance program is fully insured with the same benefits (except for the Medicare carve-out) and the same premiums for actives and retirees. Should the present cost be based on actual experience of the retiree group, or on the projection of the premium, which is technically the employer's liability for that group?

MR. BERTKO: Let me answer from the actuarial perspective. For any large group, certainly for an employer, the presence of insurance is really a pay-now versus pay-later type of issue, and the employer bears the full risk -- with the possibility, of course, of leaving the insurer with the deficit if the carrier is changed. It would seem that the liability to be recognized here is the one that represents the liability for retirees; segregation of claim costs between retirees and actives is appropriate and you would base it on real experience, as opposed to average experience, over the active and retiree group.

MR. HESS: The problem is that the law requires us to have an insured product and a uniform premium for everyone in the plan. We've made a tentative valuation of $8 billion to $10 billion, on the basis of premium. Because of the Medicare carve-out, the actual post-retirement liability is smaller than the average and I've recommended being able to change the premium. As of now, it would appear to me that we would have to use the premium rather than the actual benefits as the base.

MR. BERTKO: I guess I would disagree with that. Unless you're community rated, your average premium is determined by claims, which happen to be both active and retiree claims. The fact that state law requires you to use the average premium for budget purposes may be independent of the question of what you recognize for financial statement purposes. Second, also recognize that the FASB project doesn't directly affect you. You get to wait a few more years, presumably until the Governmental Accounting Standards Board (GASB) says something.

MR. HESS: My understanding is that on this issue the GASB will follow, not lead.

MR. BERTKO: Yes, I believe so.

MS. SCOTT: That is a good point there.

MR. DONALD S. GRUBBS, JR.: If a plan covers both actives and retirees and plan assets are not allocated between them, would it be necessary to allocate those assets and, if so, how?

MS. SCOTT: I don't think you can arbitrarily allocate assets. The definition is that the assets are dedicated solely to payment of the retiree health benefits; unless they were specifically set aside for retirees, it would be viewed as not meeting that definition and therefore would not reduce the benefit obligation.

MR. BERTKO: I would add that there may be a practical question as to how the assets came into being. More typically, if they're just incurred but not reported claim reserves that would already be set aside, any other existing assets may not be part of that.

MR. DAVID R. GODOFSKY: As you mentioned, the demographic assumptions will be much more sensitive here than they are in pension funding. I'd like to know

whether the FASB is going to consider giving some guidance to actuaries or accountants about the demographic assumptions like what you see in FASB 87 about economic assumptions, in order to provide some kind of standardization. What concerns me is that Company A is going to use a retirement age of 64 and Company B is going to use a retirement age of 61 and it may triple the liability.

MS. SCOTT: We would not specify what you would use for retirement age because that's a company-by-company estimate. What we will do is provide guidance on the types of things that should be considered -- for example, in demographics, where you expect your retirees to locate during retirement. It's our role to set a general standard to be followed; when it comes to the specific application of that standard, we would look to the actuaries, accountants, and employers to develop the best estimate with respect to that assumption for that company.

MR. GODOFSKY: Under FASB 87, technically the auditor or the internal accountants in the company determine the assumptions; the actuary primarily certifies that the calculations were done accurately, unless the auditors ask for some additional certification with respect to the assumptions. Is it going to be the same type of arrangement with OPEB benefits, or are you going to ask for some kind of certification on the actuary's demographic assumptions?

MS. SCOTT: That's an auditing, not an accounting, consideration, and auditing standards would typically require a consultation with the actuaries who developed the assumptions. I presume that post-retirement benefits would be the same. Actuaries are crucial to all of these measurements, and should be used to assist in developing the assumption.

MR. GODOFSKY: Looking at demographic assumptions, does the same situation hold for the economic assumptions -- specifically, the medical trend assumption?

MS. SCOTT: We will not constrain that at all; in fact, at one point we attempted to acknowledge how difficult it is to come up with a trend assumption and we suggested to the Board that you would assume a trend assumption equal to your discount rate. They would not accept that. We then said, "What if parameters were set around the trend rate and we assume that the difference between the discount rate and the trend rate will not exceed a prescribed percentage point spread?" Again, they rejected it. I decided to give it one more try, and they absolutely rejected any notion of the assumption of a spread between the trend rate and the discount rate. Each assumption should be the best estimate with respect to that individual assumption. We will give very general guidance because we need a statement that will have a shelf life of more than two years, and if some better information becomes available in two years or five years, we would expect that people developing assumptions would look to that best information.

MR. LARRY W. MITCHELL*: I want to pick up on your answer to Don Grubbs' question. I hope I did not hear you say that you must maintain separate assets for retirees; I hope you said you could keep them commingled in a trust fund as long as you had separate accounting.

* Mr. Mitchell, not a member of the Society, is an Attorney with Cotkin, Collins & Franscell in Los Angeles, California.

MS. SCOTT: To define it as a plan asset, the asset would have to be legally restricted and segregated, at least under the present definition.

MR. MITCHELL: Let us assume, for example, that we have a Voluntary Employees Beneficiary Association (VEBA) 501(c)(9) trust in which medical benefits are provided for both actives and retirees and all assets are commingled. You're saying we now have to split the trust?

MS. SCOTT: At this point, it's the problem of funding just the retiree piece, and prefunding these benefits. Particularly for the retiree piece, right now they aren't segregated and, as I said, very few plans would meet the definition of having plan assets.

MR. MITCHELL: Then why is it necessary to have segregated assets?

MS. SCOTT: The only reason for segregated assets is an accounting notion of legal rate of offsets. We're reducing the benefit obligations to the extent that assets exist that can legally be used to offset that obligation. To the extent that those assets can be used for any other purpose, they can't be viewed as reducing that obligation for balance sheet purposes. That's the only reason.

MR. BRADLEY C. FOWLER: I thought I heard that there would be a choice between immediate versus delayed gain and loss recognition. By "immediate," did you mean to say 100% recognition of any gain or loss in the year of the event subject to that one constraint that you mentioned?

MS. SCOTT: If that's what the company would like to do, it can do that under Statement 87, but it has to recognize that if you elect to go that route, you have to take all losses in the year that they occur as well.

MR. FOWLER: I thought that Statement 87 ordinarily uses only expected working lifetime even if you used no corridor.

MS. SCOTT: You can elect immediate recognition under Statement 87.

MR. FOWLER: It seems as if settlements and curtailments are going to be a much larger issue in this area, since by and large there is no vesting. When a large organization disposes of a unit or closes a facility, virtually the entire obligation goes away, except for those people who are actually retired or do retire. Will there be considerable discussion of recognition of those kinds of events?

MS. SCOTT: We will be addressing settlements and curtailments in the latter part of May; right now settlements are pretty much a moot point. I don't know how you describe them. We will be addressing curtailment situations.

MR. WILLIAM P. BURKE: Is there any thought that FASB might look at the concept of preexpensing part of the medical costs of the active work force to recognize an aging work force and the underlying implications of the large run-up in medical costs and inflation, so as to preexpense some of those future benefits?

MS. SCOTT: I want to be sure I understand the question. You're asking whether we would accrue not only for expected retirement coverage for actives but also future active coverage for actives?

MR. BURKE: If the average cost right now for an active employee were $3,000 but if you were to look at it on a projected basis with the run-up in inflation and medical care costs, perhaps you might want to expense $5,000 per active worker now, recognizing that you have a negative expense somewhere down the road, so as to come out even at the end when all the active workers have retired. Is there any thought to balancing that out?

MS. SCOTT: No, absolutely not.

MR. BURKE: Why not?

MS. SCOTT: The reason is the notion of matching costs with revenues; in an active situation, the exchange is that I will provide service for you today in return for coverage today. So to attribute a greater amount than the costs of this year's coverage would be an inappropriate matching of costs and related revenues.

MR. H. ROBERT EPLEY, III: Diana, in all the deliberations of the Board and the staff on OPEB, have there been any considerations of modifying FAS 87 after this is over?

MS. SCOTT: Yes, there have been. I don't think that Statement 87 will be modified; it looks as though there will be an interpretation that will probably result from the Board meeting, because as part of the discussion leading up to the obligation that should be attributed to service to the date of first eligibility we were arguing over what Statement 87 does. Someone would point to a paragraph and say, "Well, this paragraph is a vested benefit obligation," and someone else would say, "But this paragraph is an expected benefit obligation." After two Board meetings like that, the Board instructed the staff to analyze Statement 87 to find out exactly what it requires. That has been done and has been presented to the Board. We also had to explore all other accounting literature to see how this issue has been addressed, and found it hasn't been addressed in the concept statements or in other standards. I think the Board may ultimately put a miniproject on the agenda to consider the conceptual obligation that should be accrued. We happen to agree that the EBO is the notion underlying Statement 87. I think we will now have to interpret some of those paragraphs in Statement 87 that would lead one to a vested benefit obligation notion. You may or may not be familiar with a huge Italian pension issue -- a person can leave today and take benefits worth more dollars than the ultimate benefit obligation because the ultimate benefit obligation would be present-valued. The staff's interpretation was that you have to fully accrue the walkaway benefit, even though you don't think the person is going to leave. Talk about controversy: nobody supported that notion other than the staff and the Italians. What may happen right now is you can go either way: vested or expected. I think we'll put out an interpretation that would tell you to go one way or the other and would also clarify other Statement 87 paragraphs that aren't precise enough on what we mean by vested benefit obligation and the actuarial present value of a vested benefit obligation.